Name: August 2026 OLU provider newsletter
Subject: Aetna monthly OfficeLink Updates, August 2026 — policy changes and updates
Preheader: Learn about important policy updates, material changes and amendments

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August 2026

This month's policy changes and reminders

We regularly review and adjust our clinical, payment and coding policies. Review our policies and claim edits on our provider portal on Availity®.* Just go to **Payer Space > Resources > Expanded Claim Edits**.

Policy changes

Changes to medical plan drug lists

On October 1, 2026, we'll update our medical plan drug lists. These changes support our commitment to high-quality, cost-effective health care. Some of your patients may already be taking these drugs. If your patients have an existing authorization in place for the impacted drugs, this change won't affect them until their current authorization's expiration date.

You'll be able to view the changes online as early as August 1, 2026. They'll be posted on our **Precertification lists and medical preferred drug information** page.

No action required for current prior authorizations (PA)

If you're currently managing patients with a PA for a drug that moved to non-preferred status, you don't need to initiate the PA process again. In addition, if the patient needs to remain on the current medication through the remainder of their current PA, there's no medical exception needed.

Changes to our National Precertification List (NPL)

These updates apply to both our commercial and Medicare members, unless otherwise noted.

Effective August 1, 2026, we'll require precertification for the following drugs:

- Ranluspec® (ranibizumab-hkdz) (J3490, J3590, C9399)
- Tregzi ®(T cells-vldq) (J3490, J3590, C9399)
- Decnupaz® (Pivekimab Sunirine-pvzy) (J3490, J3590, C9399, J9999)

Effective August 1, 2026, we'll require precertification and Site of Care review for the following drugs:

- Lumvoa® (veligrotug-vvze) (J3490, J3590, C9399)

Effective September 1, 2026, we'll require precertification for the following drugs:

- Sarclisa Escena® (isatuximab-irfc) (J3490, J3590, J9999)
- Revtorpyk® (gedatolisib) (J3490, J3590, J9999, C9399)

Effective October 1, 2026, we'll no longer require Site of Care review for the following drugs (precertification will remain):

- Datroway® (datopotamab deruxtecan-dlnk) (J9011)
- Omisirge® (omidubicel) (J3490, J3590, C9399, J9999)

Effective November 1, 2026, precertification will also be required for Site of Care for commercial for the following:

- Oziltus® (denosumab-mobz) (Q5165)

Submitting precertification requests

Submit precertification requests at least two weeks in advance and include the actual date of service in the request. To save time, request precertification online through our **provider portal on Availity**.* Doing so is fast, secure and simple.

You can also use your practice's Electronic Medical Record (EMR) system if it's set up for electronic precertification requests. Use our "Search by CPT® code" function on our **Precertification Lists** page to find out if the code requires **precertification**.**

If you need precertification for a specialty drug for a commercial or Medicare member, submit your request through Novologix®, which is also available on Availity®.

Note to Maine and Vermont providers: For commercial plans, your effective date for routine changes described in this article will be the statutory date of January 1, April 1, July 1 or October 1, whichever date follows the effective date(s) referred to in this article. Changes required by state or federal law, or pursuant to revisions of Current Procedural Terminology (CPT®) codes published by the American Medical Association, may be effective outside the statutory dates outlined above.

Upcoming changes to maternity care coding and reimbursement

Effective January 1, 2027, the American Medical Association (AMA), in collaboration with the American College of Obstetricians and Gynecologists (ACOG) and other specialty organizations, approved a significant restructuring of maternity care coding. These changes will move the industry away from the global maternity billing model and toward a more detailed, service-based coding framework.

What's changing?

Beginning January 1, 2027, global maternity codes will be retired and replaced with a service-level coding structure.

Under the new CPT® framework, maternity care will be reported across four distinct phases:**

- Antepartum (prenatal) care
- Labor management
- Delivery care
- Postpartum care

This change is intended to better reflect how maternity care is delivered today, including team-based and individualized care models.

What you should know

The AMA's CPT Editorial Panel approved:

- Deletion of 17 legacy maternity codes
- Addition of 12 new maternity care codes
- Revision of 6 existing codes

The overall coding framework is final, but implementation details, such as those related to operations and claims processing, are still to come.

Preventive prenatal office visits

Starting September 1, 2026, we encourage you to review the preventive prenatal office visit guidance available through our updated Routine Preventive Care Benefit Guidance statement on our **provider portal on Availity**.*

For patients expected to deliver in 2027, preventive prenatal visits on or after September 1, 2026 should be billed with the applicable E/M code, modifier TH and pregnancy diagnosis code(s).

More information

Consult these AMA resources to help you understand upcoming changes:

- **CPT 2027 Maternity Care Services Code Changes**
- **A Coding Primer: Previewing the CPT 2027 Restructure for Maternity Care Services Codes**
- **RVS Update Committee (RUC)**

Stay tuned for future communications as additional coding, valuation, reimbursement and fee schedule information becomes available.

Note to Texas providers: Changes described in this article will be implemented for fully insured plans written in the state of Texas only if such changes are in accordance with applicable regulatory requirements. Changes for all other plans will be as outlined in this article.

Reimbursement update for Surface Guided Radiation Therapy (SGRT)

This change applies to both our commercial and Medicare members.

We're updating SGRT reimbursement to promote consistent billing practices and accurate claim adjudication.

What's changing?

Effective November 1, 2026, we'll limit the use of CPT® code 77436 (SGRT) to one reimbursement for the entire course of treatment, regardless of the number of individual treatment sessions.**

What you should know

You should review your billing practices and ensure that:

- CPT® code 77436 is billed only once per course of treatment
- Supporting documentation reflects the treatment planning and simulation services performed

Claims submitted with multiple units of CPT® code 77436 during the same course of treatment may be subject to denial or adjustment in accordance with this reimbursement policy.

You're encouraged to review internal billing processes and make any necessary changes before the effective date to minimize claim impacts and potential administrative rework.

For additional information, please refer to the Radiation Therapy Payment Policy located on our **provider portal on Availity**.*

Note to Washington State providers: For commercial plans, your effective date for changes described in this article will be communicated to you following regulatory review.

Note to Texas providers: Changes described in this article will be implemented for fully insured plans written in the state of Texas only if such changes are in accordance with applicable regulatory requirements. Changes for all other plans will be as outlined in this article.

Note to Maine and Vermont providers: For commercial plans, your effective date for routine changes described in this article will be the statutory date of January 1, April 1, July 1 or October 1, whichever date follows the effective date(s) referred to in this article. Changes required by state or federal law, or pursuant to revisions of Current Procedural Terminology (CPT®) codes published by the American Medical Association, may be effective outside the statutory dates outlined above.

Claims validation enhancement for home ESRD services

These changes apply to both our commercial and Medicare members.

Effective November 14, 2026, we'll implement a claims validation enhancement for professional claims billed with End-Stage Renal Disease (ESRD) home dialysis monthly management services. This change will apply to CPT® codes 90963–90966 and is intended to promote accurate billing and align reimbursement with appropriate Place of Service (POS) reporting requirements.**

What's changing?

Beginning November 14, 2026, we'll review professional claims submitted with CPT® codes 90963–90966 for POS appropriateness. We will deny claims billed with an inappropriate POS . This change is consistent with Centers for Medicare & Medicaid Services (CMS) guidance and supports accurate reporting of home dialysis management services.

Affected codes

The following ESRD home dialysis monthly management services are included in this change:

- 90963 — ESRD-related services for home dialysis, patients younger than 2 years
- 90964 — ESRD-related services for home dialysis, patients 2–11 years
- 90965 — ESRD-related services for home dialysis, patients 12–19 years
- 90966 — ESRD-related services for home dialysis, patients 20 years and older

What this means for you

You should review your billing processes to ensure that you report CPT® codes 90963–90966 with the appropriate POS before claim submission. Submitting these services with an inappropriate POS may result in claim denial beginning November 14, 2026.

Note to Texas providers: Changes described in this article will be implemented for fully insured plans written in the state of Texas only if such changes are in accordance with applicable regulatory requirements. Changes for all other plans will be as outlined in this article.

Note to Maine and Vermont providers: For commercial plans, your effective date for routine changes described in this article will be the statutory date of January 1, April 1, July 1 or October 1, whichever date follows the effective date(s) referred to in this article. Changes required by state or federal law, or pursuant to revisions of Current Procedural Terminology (CPT®) codes published by the American Medical Association, may be effective outside the statutory dates outlined above.

Claim and Code Review Program (CCRP) update

This update applies to our commercial, Medicare and Student Health members.

Our program evaluates claims against industry coding guidelines such as those from the Centers for Medicare & Medicaid Services (CMS), American Medical Association Current Procedural Terminology (CPT®) coding standards and evidence-based guidelines from nationally recognized professional health care organizations and public health agencies.**

Beginning November 23, 2026, you may see new claim edits. These are part of our CCRP. These edits support our continuing effort to process claims accurately for our commercial, Medicare and Student Health members. You can view these edits on our **provider portal on Availity**.*

For coding changes, go to Aetna Payer Spaces > Resources. In the search bar, search for "expanded claim edits."

Except for Student Health, you'll also have access to our code edit lookup tools. To find out if our new claim edits will apply to your claim, log in to Availity®. You'll need to know your Aetna® provider ID number (PIN) to access our code edit lookup tools.

We may request medical records for certain claims, such as high-dollar claims, implant claims, anesthesia claims and bundled services claims, to help confirm coding accuracy.

Note to Washington State providers: For commercial plans, your effective date for changes described in this article will be communicated to you following regulatory review.

Note to Texas providers: Changes described in this article will be implemented for fully insured plans written in the state of Texas only if such changes are in accordance with applicable regulatory requirements. Changes for all other plans will be as outlined in this article.

Note to Maine providers: For commercial plans, your effective date for routine changes described in this article will be the statutory date of January 1, April 1, July 1 or October 1, whichever date follows the effective date(s) referred to in this article. Changes required by state or federal law, or pursuant to revisions of Current Procedural Terminology (CPT®) codes published by the American Medical Association, may be effective outside the statutory dates outlined above.

You can always find this information on our provider portal on Availity.*

You can also use our Code Edit Lookup tools on Availity®. Just go to **Payer Space > Applications > Code Edit Lookup Tools**. Keep your Aetna® provider ID number handy to access them.

Availity portal

*Availity® is available only to providers in the U.S. and its territories.