Important information for your office

As published in the March 1, 2021, edition of Aetna OfficeLink Updates™

Changes to our National Precertification List (NPL)

As of **July 1, 2021**, these precertification changes apply:

- We'll require precertification for:
  - Cataract surgery
  - Sacroiliac joint fusion surgery
  - Knee arthroscopy with meniscectomy
  - Vertebral corpectomy procedures
  - Additional lower limb prosthetic codes including select foot, ankle and vacuum pump components
- Spinraza® (nusinersen) — precertification required for both the drug and site of care.

Submitting requests

Be sure to submit authorization requests at least two weeks in advance.

To save time, you can make your request online. Doing so is fast, secure and simple. You can submit most requests online through **our provider portal on Availity**. Or you can use the Electronic Medical Record (EMR) system portal.

Are you asking for drug prior authorization on a specialty drug for a commercial or Medicare member? Then submit your request through NovoLogix®, also available on Availity®.

Not registered for Availity?

Register online or call **1-800-AVAILITY (1-800-282-4548)**. For one-on-one support from us, call Aetna at **1-866-752-7021**. Then ask to talk with the Availity team.

You can use our "Search by CPT code" search function on our **Precertification Lists web page** to find out if the code needs precertification.

You can learn more about precertification under the General Information section of the **NPL**.

Third Party Claim and Code Review Program

Beginning **June 1, 2021**, you may see new claim edits. These are part of our Third Party Claim and Code Review Program. These edits support our continuing effort to process claims accurately. You can view these edits on our provider website.

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

For procedures considered incidental to another procedure or service, we may not allow modifier 59 to allow the incidental service.

You'll have access to our prospective claims editing disclosure tool. To find out if our new claim edits will apply to your claim, log in to the Availity provider portal. You'll need to know your Aetna® provider ID number (PIN) to get access.

To find out if our modifier 59 changes will apply to your claim, go to Aetna Payer Space > Applications > Code Edit Lookup Tools.

For all other coding changes, go to Aetna Payer Space > Resources > Expanded Claim Edits.

Note: This is subject to regulatory review and separate notification in Washington state.

Services related to a denied primary surgical procedure

As of **June 1, 2021**, we will deny all other services billed on an outpatient facility claim when we deny the primary surgical code billed with revenue codes 360, 361 or 369 as experimental and investigational, cosmetic or not medically necessary.

Examples of these other services include, but are not limited to:

- Anesthesia
- Labs
- Medical supplies
- Pharmacy
- Radiology procedures

Billing for allergy testing

Effective **June 1, 2021**, when you bill allergy testing (95004-95079) with rapid desensitization (95180) we will consider allergy testing mutually exclusive to rapid desensitization.

Changes to commercial drug lists begin on July 1, 2021

On **July 1, 2021**, we'll update our pharmacy drug lists.

You'll be able to view the changes as early as May 1, 2021. They'll be available on our **Formularies & Pharmacy Clinical Policy Bulletins** page.

Ways to request a drug prior authorization

- Submit your completed request form through our provider portal on **Availity**.
- For requests for nonspecialty drugs on Aetna Funding Advantage℠, Premier, Premier Plus, Small Group ACA and Value Plus plans, call the Precertification Unit at **1-855-240-0535 (TTY: 711)**. Or fax your completed **prior authorization request form** to **1-877-269-9916**.
- For requests for nonspecialty drugs on the Advanced Control, Advanced Control — Aetna, Standard Opt Out, Standard Opt Out — Aetna, Standard Opt Out with ACSF, Aetna Health Exchange and High Value formulary plans, call the Precertification Unit at **1-800-294-5979 (TTY: 711)**. Or fax your completed **prior authorization request form** to **1-888-836-0730**.
- For requests for drugs on the Aetna Specialty Drug List, call the Precertification Unit at **1-866-814-5506 (TTY: 711)**. Or fax your completed **prior authorization request form** to **1-866-249-6155**.

These changes will affect all drug lists, precertification, quantity limits and step-therapy programs.

For more information, call the Provider Help Line at **1-800-238-6279 (TTY: 711) (1-800-AETNA RX)**.

Important pharmacy updates

Medicare

Visit our **Medicare Drug List** to view the most current Medicare plan formularies (drug lists). We update these lists at least once a year.

Commercial — notice of changes to prior authorization requirements

Visit our **Formularies & Pharmacy Clinical Policy Bulletins** page to view:

- Commercial pharmacy plan drug guides with new-to-market drugs that we add monthly
- Clinical Policy Bulletins with the most current prior authorization requirements for each drug

New Jersey providers - Edits activated for billing modifiers 58, 78 and 79

As of **April 1, 2021**, we'll be activating edits for billing modifiers 58, 78 and 79 in New Jersey for fully insured and self-insured membership claims. We may request medical records for these services as provided to your New Jersey fully insured patient claims.*

These edits are an expansion of the edits, communicated in September 2020, that were reactivated for modifiers 25, 59 and the X series. Those edits became effective on December 1, 2020.

The medical records review program will not apply to self-insured membership claims. These new edits are part of our Third Party Claim and Code Review Program. They'll apply prior to finalizing claims for professional services and outpatient facilities.

We may request medical records for professional services provided to New Jersey fully insured patients* and billed with modifiers:

- 25, 59 and X series: effective **December 1, 2020**
- 58, 78 and 79: effective **June 1, 2021**

The new edits do not constitute a clinical review. Any edit applied will be based on industry-recognized coding guidelines. We will review the service, service history, changes in condition, diagnostic tests and the medical chart to determine if these services require separate payment. We allow charges for covered services not subject to the coding review.

- You can send medical records with your initial claim submissions for services provided to New Jersey fully insured patients.*
- If medical records are not provided and needed, Aetna® will request them.
- If a medical chart is requested but not submitted within 45 days, then the charges for the service billed with one of the modifiers listed above will be denied.

Keep in mind:

- We follow both New Jersey claims processing timelines, and appeal rights apply to any denied charges.
- You can submit medical records/notes via the following:
    - Fax number or address on the Explanation of Benefits (EOB) statement
    - The "Claim Status — Send Attachments" functionality through our provider portal on **Availity**.
- This program applies to certain claims for charges $25 or greater and billed with one of the modifiers listed above.

To find out if our new claims edits will apply to your claim, log in to the provider portal. Then, go to Aetna Payer Space > Application > Code Edit Look-up Tools. You'll need to know your Aetna® provider ID number (PIN) to gain access.

*New Jersey member ID cards indicate whether the member is covered under a fully insured plan or under a self-funded plan.

North Carolina providers - Important update about service codes

Individual service codes are being reassigned within contract service groups. Changes to an individual provider's compensation depends on the presence or absence of specific service groupings in their contract. These changes are shown below.

Unless noted, all updates are effective **June 1, 2021**.

Codes	**Provider types affected**	**What's changing**
90739	Physicians, specialists, primary care physicians, group physicians	Will be *added* to the immunization schedule called IMMVAC

Note to all providers, including Coventry providers: To view the March 1, 2021 OfficeLink Updates™ (OLU) online and link to all information in this flyer, go to aetna.com. Click on "Providers," then "News." Remember, OLU comes out in March, June, September and December.

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