



Three Sugar Creek Center, Suite 300
Sugar Land, TX 77478

SA-22621C3

Physicians of East Texas



Important information for your office

As published in the September 1, 2020, edition of Aetna OfficeLink Updates™

000501



Changes to our National Precertification List (NPL)

Important NPL update

Effective January 1, 2021, the following precertification changes will apply:

- We require precertification for hip surgery to treat impingement syndrome, and effective January 1, 2021, we are expanding to include labral repair.

The following new-to-market drugs require precertification:

- Tepezza™ (teprotumumab-trbw) — precertification required, effective May 1, 2020. This drug is included in the ophthalmic medical injectables category.
- Sarcisa® (isatuximab-irfc) — precertification required, effective May 28, 2020.
- Vyepi™ (eptinezumab-jjmr) — precertification for both the drug and site of care required, effective May 28, 2020. This drug is included in the calcitonin gene-related peptide receptor inhibitors category.

Effective July 9, 2020, the following new-to-market drugs require precertification:

- Sevenfact® (coagulation factor VIIa [recombinant]-jncw)
- Trodelvy™ (sacituzumab govitecan-hziy)
- Zeposia® (ozanimod)

We encourage you to submit precertification requests at least two weeks before the scheduled services.

To save time, request precertification electronically — it's fast, secure and simple. You can submit most precertification requests electronically through the provider website or by using your Electronic Medical Record (EMR) system portal.

You can find more information about precertification under the General Information section of the [NPL](#).

Third Party Claim and Code Review Program





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Accurate claims processing with our Third Party Claim and Code Review Program

Beginning **December 1, 2020**, 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.

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 provider portal. Then go to Aetna Payer Spaces > Applications > Code Edit Lookup Tools. You'll need to know your Aetna® Provider ID Number (PIN) to access.

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

Modifier 91 — genomic testing

Effective **December 1, 2020**, we are updating our list of genomic testing codes denied with modifier 91.

Once per lifetime edits

Effective **December 1, 2020**, we are updating our list of genomic testing codes that we pay once per lifetime.

Infectious agent detection

Effective **December 1, 2020**, we will deny CPT code 87801, infectious agent detection by nucleic acid (DNA or RNA), when billed on the same DOS with CPT codes 87501–87503 or 87631–87634.

Angioplasty services

As of **December 1, 2020**, we'll change our related services claim handling for outpatient cardiac angioplasty services.

We require providers to get precertification for non-emergent outpatient diagnostic left and right heart catheterization services. This can be done through our Enhanced Clinical Review program with eviCore healthcare. If you don't get precertification for the cardiac catheterization, or if the cardiac catheterization is denied by eviCore, then any related angioplasty procedure will also be denied.

Visit eviCore healthcare at [eviCore.com](https://www.eviCore.com) for a complete list of procedures that need an authorization.

Asking eviCore healthcare for approval

Go to [eviCore.com](https://www.eviCore.com).

- Call **1-888-693-3211 (TTY: 711)** (7 AM to 8 PM CT, Monday through Friday).
- Fax a request form (available online) to **1-844-822-3862**.



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Urgent requests

If a member needs services in less than 48 hours due to medically urgent conditions, please call eviCore healthcare for a fast review. Tell them the request is for urgent care.

What you should know

- Be sure that ordering physicians get authorizations and share the approval numbers with the facility performing the procedure when it is scheduled.
- eviCore healthcare will fax its approval decision to the ordering physicians and requested facilities.
- Approvals have authorization numbers and one or more CPT® codes specific to the approved services.
- If the service you ask for is different from what eviCore healthcare approves, the facility must contact eviCore healthcare for review and approval before submitting claims.
- If you perform services without approval, we may deny payment.
- We will determine coverage under the applicable policy according to the policy's terms and conditions and our policies and procedures.

Keep in mind

- If the service you ask for is not what eviCore healthcare approves, the facility must contact eviCore healthcare for approval before submitting claims.
- If you perform services without approval, we may deny payment.
- We base our final coverage decision on the applicable policy's terms and conditions along with our policies and procedures.

We're here to help

If you have questions, call eviCore healthcare at **1-888-693-3211 (TTY: 711)**. Or you can call Provider Services at:

- **1-800-624-0756 (TTY: 711)** for HMO and Medicare Advantage benefits plans
- **1-888-MD-AETNA (1-888-632-3862) (TTY: 711)** for all other plans

At eviCore.com, you can see their criteria and get request forms.

Convenience kits

Effective **December 1, 2020**, we will deny convenience kits as incidental to the primary procedure.

New York provides, new edits for billing modifiers 25, 59 and X series

Effective December 1, 2020, we will apply new edits for billing modifiers 25, 59 and X series in New York for fully insured membership claims. We already apply these same edits for self-insured membership claims.

These new edits are part of our Third Party Claim and Code Review Program and will apply prior to finalizing claims for professional services and outpatient facilities. This is not a clinical review; any edit applied will be based on industry-recognized coding guidelines. We will review the service, service history, changes in





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condition and diagnostic tests to determine if the services billed with modifiers 25, 59 and X require separate payment. We will allow charges for covered services not subject to the coding review.

Find out more about [the program](#).

New Jersey providers, edits reactivated for billing modifiers 25, 59 and X series

Effective December 1, 2020, we will be reactivating edits for billing modifiers 25, 59 and X series 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.

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 and will 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. This is not 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.

We want you to know the following:

- 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 modifiers 25, 59 or X series will be denied.

Keep in mind the following:

- 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 EOB
 - 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 modifiers 25, 59 or X series.

To find out if our new claims edits will apply to your claim, log in to the provider website. Then go to Plan Central > Aetna Claims Policy Information > Policy Information > Medical Records Program.

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



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Changes to commercial drug lists begin on January 1, 2021

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

You'll be able to view the changes as early as November 1, 2020. 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 website](#).
- For requests for nonspecialty drugs on Aetna Funding AdvantageSM plans, Premier, Premier Plus, Small Group ACA and Value Plus plans, call the Aetna Pharmacy 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 and High Value formulary plans, call the Aetna Pharmacy 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 Aetna Pharmacy 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 Pharmacy Management drug lists, precertification, quantity limits and step-therapy programs.

For more information, call the Aetna Pharmacy Management 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

Note to all providers, including Coventry providers: To view the September 1, 2020 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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