Aetna Better Health® of New Jersey
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NEW POLICY UPDATES

CLINICAL PAYMENT, CODING AND POLICY CHANGES

We regularly augment our clinical, payment and coding policy positions as part of our ongoing policy review processes. In an effort to keep our providers informed, please see the chart below of upcoming new policies.

Effective for dates of service beginning **November 1, 2026**:

Obstetric Transvaginal Ultrasound and Obstetric Transabdominal Ultrasound -
Transvaginal ultrasound (76817) and obstetric transabdominal ultrasound services (76801-76802, 76805-76810, or 76811-76812) may be performed during the same encounter to evaluate the pregnancy.

However, when both services are reported together, the transvaginal ultrasound is considered included in the primary obstetric ultrasound service and does not warrant separate reimbursement, unless distinct and independent circumstances support billing both procedures.

Effective **November 1, 2026**, Aetna Better Health® of New Jersey will deny claims for non-obstetric pelvic ultrasounds when billed with transvaginal ultrasounds.

Pet Scan Diagnosis Requirements-

The new policies will define guideline (diagnosis, etc.) requirements for the following:

PET scan diagnosis requirements

This policy identifies situations where PET services (78608, 78811, 78812, 78813, 78814, 78815, 78816) reported with modifier PI have been billed without an appropriate oncologic diagnosis on the claim.

According to CMS Policy, PET procedures performed to inform the initial treatment strategy of tumors (modifier PI) must be reported with an appropriate diagnosis.

Reference Information -CMS Internet Only Manuals

Therapy Service Modifiers GN, GO, and GP

Over the past several years, <<Health Plan>> has been implementing payment policies that reflect guidelines set forth by industry authorities. Our goal is to process claims consistently and in accordance with best practice standards. Beginning with claims processed on <<Date>>, we will be instituting new payment policies for Therapy Service Modifiers GN, GO, and GP The policies mirror those by CMS.

The new policies will define guideline (modifiers, etc.) requirements for therapy services.

These policies identify situations when a therapy modifier is inappropriately appended on a facility outpatient claim. These situations may include but are not limited to:

- If revenue code 042X (physical therapy) is billed with any modifier other than GP (physical therapy)
- If revenue code 043X (occupational therapy) is billed with any other modifier other than GO (occupational therapy)
- If revenue code 044X (speech therapy) is billed with any modifier other than GN (speech therapy)
- If revenue code 042X (physical therapy), 043X (occupational therapy), or 044X (speech therapy) is billed and an appropriate therapy modifier has not been appended to the same line

Reference Information

CMS Claims Processing Manual

Lymphedema Compression Treatment Items -

The new policies will define guideline (diagnosis, etc.) requirements for the following:

Lymphedema Compression Treatment Items

Based on CMS Policy, gradient compression treatment items are used in the treatment of lymphedema. An appropriate diagnosis must be present on the claim.

This policy identifies situations when Lymphedema compression treatment items (A6515-A6530, A6533-A6541, A6549, A6552-A6589 or A6593-A6611) are billed without a diagnosis of Lymphedema.

Reference Information - CMS Claims Processing Manual/CMS Transmittals