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Aetna Better Health®
of New Jersey

Contents

Provider Newsletter

Fall 2025

21st Century Cures Act Requirement

Effective May 2025, Aetna Better Health® of New Jersey will deny claims if you are not compliant with the 21st Century Cures Act enrollment requirement.

How to be compliant

You must enroll as a fee-for-service or a 21st Century Cures Act health care provider. The application is available for download at www.njmmis.com (under Communications, see Provider Enrollment Application). The mailing address to submit the application and credentials is:

Provider Enrollment Gainwell Technologies
P.O. Box 4804
Trenton, NJ 08650

If you have questions about the 21st Century Cures Act Enrollment process for NJ FamilyCare, please contact the NJMMIS provider enrollment unit at **609-588-6036.**

Questions?

If you have questions regarding how or why you were identified as a provider who needs to enroll in the NJ FamilyCare Program, please contact Aetna Better Health of New Jersey at **1-855-232-3596**.

Provider Network Update

Effective **September 1, 2025**, Aetna Better Health® of New Jersey will not be accepting new applications for DME or Laboratory Providers to join our network.

Aetna Better Health® of New Jersey

Member Language Profile: Understanding Our Members' Communication Needs

Communication and language barriers are associated with inadequate quality of care and poor clinical outcomes, such as higher hospital readmission rates and reduced medication adherence. People with limited English proficiency or those who experience limited vision or hearing may need an interpreter, and those with vision impairment may need materials presented in alternative formats while receiving care in order to ensure equitable care.

Primary language is reported by members upon enrollment. While most our members' primary languages are Unknown (61.5%), 27.5% are English-speaking followed by Spanish at approximately 6%.

	Top Ten Languages Reported at Enrollment	2024	
		#	% of Membership
1	ENGLISH	30,149	27,53%
2	SPANISH	6,730	6.15%
3	PORTUGUESE	185	0.17%
4	ARABIC	141	0.13%
5	RUSSIAN	129	0.12%
6	FRENCH	121	0.11%
7	MANDARIN	116	0.11%
8	TURKISH	98	0.9%
9	GUJARATI	96	0.9%
10	HAITIAN CREOLE	82	0.8%
	NOT REPORTED	3,556	3.25%
	UNKNOWN	67,374	61.52%

To assist with translation and interpretation services, you or the member can call our Interpretation Services at **1-800-385-4104 (TTY: 711)**.

For more information on our member demographics, please see Aetna Better Health of New Jersey's 2025 Population Assessment found on Availity.

Doula Services Are Covered for Members

A doula supports the pregnant mom through pregnancy and the postpartum period with education and emotional and physical support.

Please review the Medicaid Newsletter on the program and also the next steps if you are interested in offering Doula Services. Once a doula is enrolled in NJ Medicaid and has their Medicaid FFS identification number, please email Alexander Mclean, Chief Operating Officer. He will arrange for a contracting representative to reach out to you to walk you through our simplified enrollment process.

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Family Planning

This article outlines the expectations of participating health care providers related to family planning services and minors' rights to consent and confidentiality.

Please note this article relates to expectations under participating provider contracts with Aetna Better Health of New Jersey and is not legal or compliance advice.

In accordance with maintaining and implementing our Quality Assessment and Performance (QAPI) program, participating health care providers must:

- Maintain medical records in a current, detailed, organized and comprehensive manner in accordance with customary medical practice, applicable laws, and accreditation standards.
  - Establish a policy/procedure for *managing minor patients' right to consent and confidentiality related to family planning.*
  - Provide a copy of this policy/procedure to Aetna Better Health® of New Jersey for audit purposes and upon request.

The below summarizes the expectations of participating providers under state law:

- Health care providers, that manage health needs of minors, must comply with state laws that govern the right to consent and privacy for minors.
- Minors in the state of NJ have the right to provide consent for:
  - Contraceptives/family planning: with limitations
  - STI care
  - HIV/AIDS care
  - Pregnancy care
  - Mental health outpatient care
  - Alcohol/drug abuse treatment
  - Sexual Assault treatment/examination
- For treatments that minors have a right to provide consent, health care providers are permitted, but not required, to inform the parents/guardians of a minor. Special standards on disclosure include the following:
  - HIV/AIDS: confidential and may only be disclosed with written informed consent of the minor.
  - Mental health information: mental health professionals are limited in disclosing certain information to parents or others without a minor's consent.
  - Drug/alcohol: confidential information between health care provider and minor patient.
  - Sexual assault: parents or guardian must be notified immediately, unless the medical provider feels disclosure would not be in the minor patient's best interest.

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HEDIS Measures

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of performance measures in the healthcare industry, developed by the National Committee for Quality Assurance (NCQA). These measures help assess the quality of care provided by health plans and are essential for improving patient outcomes. Below is a brief overview of several important HEDIS measures:

URI – Appropriate treatment for Upper Respiratory Infection

Measure Definition: Members with a diagnosis of upper respiratory infection who were not dispensed an antibiotic. For members 3 months of age and older.

Measure Requirements: Submit all diagnoses on claims if more than one diagnosis is present when prescribing antibiotics.

Service Date Range: July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.

LOB: Commercial, Medicaid and Medicare

CBP – Controlling High Blood Pressure

Measure Definition: Members with a diagnosis of hypertension (HTN) and adequately controlled blood pressure (<140/90 mm HG) during the measurement year. For members 18 to 85 years of age.

Measure Requirements: Most recent systolic and diastolic blood pressure reading and service date or exclusion code.

Service Date Range: Measurement year

LOB: Commercial, Medicaid and Medicare

SPC – Statin Therapy for Patients with Cardiovascular Disease

Measure Definition: Percentage of members who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria:

1. Received statin therapy Members who were dispensed at least one high- intensity or moderate- intensity statin medication in the measurement year.
2. Statin adherence 80 percent Members who remained on a high-intensity or moderate- intensity statin medication for at least 80% of the treatment period.

For male members 21 to 75 years of age and female members 40 to 75 years of age.

Measure Requirements: No special requirements

Service Date Range: Measurement year

LOB: Commercial, Medicaid and Medicare

HDO - Use of Opioids at High Dosage

Measure Description: The proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the measurement year.

Numerator Compliance: Members whose average MME was ≥90 during the treatment period.

LOB: Commercial, Medicaid and Medicare

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HEDIS Measures (continued)

DEV-CH - Developmental Screening in the First Three Years of Life

Measure description: For members 1-3 years of age, percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second or third birthday.

Strategies for increasing developmental screening understanding and utilization

- Educate parents to monitor for developmental milestones such as taking a first step, smiling for the first time, waving "bye, bye" crawling, walking, etc.
- Educate on risk factors for developmental delays that include:
  - Preterm birth
  - Low birth weight
  - Lead exposure
  - Long lasting health problems or conditions.
- Advise parents that developmental screening tools will not provide a diagnosis but can assist in determining if a child is developing according to standard developmental milestones.

CCP - The Contraceptive Care

Measure description: Postpartum Women measure (CCP) looks at women ages 15 to 44 who had a live birth, and among those, the percentage that:

1. Were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery.
2. Were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.

The first rate is an intermediate outcome measure, and it is desirable to have a high percentage of women who are provided the most effective or moderately effective contraceptive methods during the postpartum period. The second rate is an access measure, and the focus is on making sure that women have access to LARC methods during the postpartum period.

These rates are reported at two points in time: contraceptive provision within 3 days of delivery is used to monitor the provision of contraception in the immediate postpartum period, while contraceptive provision within 60 days of delivery is used to monitor the provision of contraception throughout the postpartum period.

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HEDIS Measures (continued)

AMM - Antidepressant Medication Management

Measure description: Assesses adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications.

Two rates are reported:

- Effective Acute Phase Treatment: Adults who remained on an antidepressant medication for at least 84 days (12 weeks).
- Effective Continuation Phase Treatment: Adults who remained on an antidepressant medication for at least 180 days (6 months).

HDO - Use of Opioids at High Dosage

Measure description: The percentage of persons 18 years of age and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the measurement period.

ADD-E - Follow-Up Care for Children Prescribed ADHD Medication

Measure description: The percentage of persons newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 300-day (10 month) period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported:

- Initiation Phase. The percentage of persons 6–12 years of age with a prescription dispensed for ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.
- Continuation and Maintenance (C&M) Phase. The percentage of persons 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.

Clinical Policy Bulletins

Clinical Policy Bulletins state our policy about the medical necessity or investigational status of medical technologies and other services to help with coverage decisions. A national review team creates the bulletins and bases them on:

- Published medical literature
- Formal technology assessments
- Structured evidence reviews
- Evidence-based consensus statements
- Expert opinions
- Evidence-based guidelines from professional and public health entities

Aetna® clinical policy bulletins | Aetna medical clinical policy bulletins

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Behavioral Health Integration

Please be advised that the Behavioral Health Integration is approaching the end of the extended transition phase on October 31, 2025 and while the Managed Care Organizations are currently auto-approving requests for services requiring prior authorization (PA), providers are required to request PA or risk denials for lack of prior authorization. In general, Behavioral Health services that require prior authorization are those at the more acute and/or intensive services of the level of care spectrum; office-based behavioral health outpatient services (e.g. Office-based therapy/ medication management, etc.) do not require a PA for providers in-network with Aetna Better Health of New Jersey but would for out-of-network providers. Services requiring PA include:

Mental Health Services

- Acute Inpatient Mental Health
- Higher Intensity Outpatient (e.g. Acute Partial, Partial Hospital, Partial Care)
- Pyschological/Neuropsych Testing
- TMS/ECT
- ABA/DIR

Substance Use Treatment

- Detoxification (e.g. Medically Managed IP Withdrawal Management - ASAM 4.0; Medically Monitored Intensive IP Withdrawal Management ASAM 3.7)
- Higher Intensity SUD Outpatient (e.g. IOP - ASAM 2.1; SUD Partial Care ASAM 2.5)

Provider may submit prior authorization requests 24/7 through any one of the following options:

- Option 1
  - Call us at:
    - Aetna Better Health of New Jersey: 1-855-232-3596
    - Aetna Assure Premier Plus (HMO D-SNP): 1-844-362-0934
- Option 2
  - Click the authorization form below and fax request to:
    - Aetna Better Health of New Jersey
      Medical Authorization Form
      Fax: 1-844-404-3972
    - Aetna Assure Premier Plus (HMO D-SNP)
      Medical Authorization Form
      1-833-322-0034
- Option 3
  - Availity Provider Portal. Click below to register.
    - Aetna Better Health of New Jersey: Provider Portal
    - Aetna Assure Premier Plus (HMO D-SNP): Provider Portal

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Updated Preventive Screening Recommendations

As part of our commitment to delivering high-quality care and ensuring the health and well-being of our members, we would like to inform you of important updates to the preventive screening recommendations based on the latest guidelines from the Centers for Disease Control and Prevention (CDC). These screenings are essential for early detection and prevention of various health conditions, and we encourage you to integrate these recommendations into your practice.

1. Pap Smear (PN)
    a. Age Group: 50 and up
    b. Recommendation: Women aged 50 and older should continue to receive regular Pap smears as part of cervical cancer screening. The frequency of screening may vary based on individual health history and previous results.
2. Zoster Vaccine
    a. Age Group: 50 and up
    b. Recommendation: The CDC recommends that adults aged 50 and older receive the shingles vaccine (Zoster) to reduce the risk of shingles and its complications.
3. Mammogram
    a. Age Group: 40 to 74
    b. Recommendation: Women aged 40 to 74 should have regular mammograms to screen for breast cancer. The frequency of screening may depend on individual risk factors and previous mammogram results.
4. Colonoscopy
    a. Age Group: 45 to 75
    b. Recommendation: Adults aged 45 to 75 should undergo regular colon cancer screenings, including colonoscopy, to detect any abnormalities early. This is especially important for those with a family history of colorectal cancer.
5. Prostate Screening
    a. Age Group: 55 to 69
    b. Recommendation: Men aged 55 to 69 should discuss prostate cancer screening with their healthcare provider. Shared decision-making is encouraged to determine the best approach based on individual risk factors.

Action Steps for Providers:

- Review Patient Records: Assess your patient population to identify individuals who are due for these preventive screenings based on the updated age guidelines.
- Educate Patients: Discuss the importance of these screenings with your patients, addressing any concerns they may have and emphasizing the role of early detection in improving health outcomes.

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Prescribing Opioids

Research shows that opioids are not always the best pain relief options for chronic pain. Safer alternatives that don't use opioids should always be tried if possible.

Our Prior Authorization process assures that, when they are needed, current treatment recommendations are being used. All Long-Acting opioids require Prior Authorization, review our guides for more information.

All Short Acting opiates in New Jersey have a five-day supply limit for members 18 years and older or a three-day supply limit for members less than 18 years of age. In addition, all opiates are limited to a 90 Morphine Equivalent Dosing (MED) per day. Members with pain due to active cancer, palliative care, or end-of-life care are exempt from these requirements. Evidence of a treatment plan, risk assessment and counseling must be submitted along with a completed Opioid Prior Authorization (PA) form. Visit our website to download prior authorization form.

MH Partial Care (PC) and PC Transportation

Aetna Better Health of New Jersey Partial Care and transportation Billing codes:

- H0035 – Partial Care Base code
- A0090 UC
- A0120 UC
- A0425 UC – must be billed with A0090 UC, A0120 UC

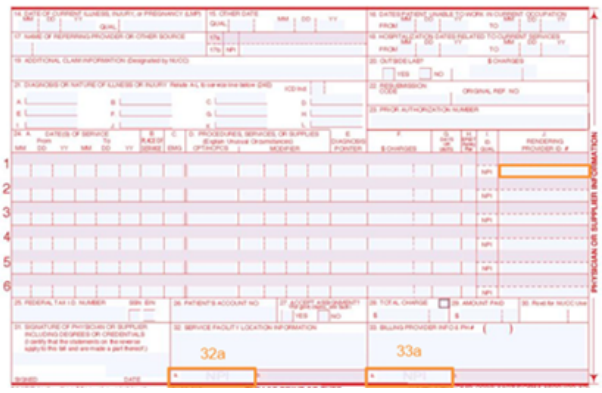
Partial Care (PC) Transportation claims must be billed on the same date of service as the H0035 UC claim

Bill Partial Care (PC) Transportation under Clinical/ Facility, NOT under an individual rendering provider.

Providers should bill for 2 units of MH PC transportation on the same claim if a member is transported both to and from the place of service.

Aetna | Make sure NPI numbers match guidance from MCO - CMS 1500

Three sections on CMS 1500 form for NPI numbers



NPIs must match MCO billing requirements

Three sections to enter NPI:
- 24J – Rendering provider
- 32a – NPI of facility
- 33a – NPI of billing provider

If billing as a clinic/facility:
- Type 2 NPI of clinic/facility in 24J, 32a, 33a

If billing as an individual:
- Type 1 NPI in 24J, 32a, 33a

If billing individually under a group:
- Type 1 NPI of practitioner in 24J
- Type 2 NPI in 32a, 33a

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Psychotherapy Billing

Aetna Better Health of New Jersey covers psychotherapy services rendered by Outpatient Mental Health and Substance Use clinics as well as Independent Individual practitioners.

While standard psychotherapy sessions typically run from 35 to 50 minutes in duration (eg. 90832-34), Aetna Better Health of New Jersey recognizes that there are times when longer session durations are appropriate if medically necessary.

When billing these longer session durations, providers may use CPT code 90837 for session exceeding 53 minutes or longer.

These longer sessions should be supported by meticulous documentation including session start and stop times as well clinical documentation to support these longer session times and to avoid post-service audits and/or billing issues.

Billing these codes might also require modifiers to clarify the types of service rendered such as, for example:

- HF = Substance Use Program
- HE = Mental Health Program
- SA = Non-physician provider
- AF = Physician provider

Reimbursement may vary based on these codes, modifiers, places of Services and Practitioner types; for example:

- 90837 HF – billing as a facility = $43.21
- Some providers may be eligible for the higher 90837 base rate of $90.26 (eg. MDs, DOs, NPs, etc.) or $76.72 (eg. LPCs, LCSWs, etc.), but this higher base rate will require each individual provider to be independently credentialed as rendering.
- These rates can be seen on the NJMMIS website

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2025 CAHPS Survey Results

	Measure	NJ 2025 CAHPS Results Summaries	2025 CSS Medicaid Avg.	2024 NCQA QC National Avg. Medicaid HMO
Adult CAHPS Survey	Rating of Personal Doctor	66.30%	68.02%	69.18%
	Rating of Specialist Seen Most Often	62.19%	66.59%	67.69%
	Rating of All Health Care	52.21%	55.84%	56.80%
	Rating of Health Plan	54.39%	58.55%	61.47%
	Getting Needed Care	76.96%	80.21%	81.45%
	Getting Care Quickly	78.94%	77.77%	82.82%
	How Well Doctors Communicate	93.03%	92.56%	92.95%
	Customer Service	89.11%	88.84%	89.18%
	Coordination of Care	84.30%	82.71%	85.64%
Child CAHPS Survey	Rating of Personal Doctor	72.87%	76.43%	76.45%
	Rating of Specialist Seen Most Often	68.18%	73.09%	72.82%
	Rating of All Health Care	67.52%	71.04%	69.62%
	Rating of Health Plan	63.95%	70.44%	71.31%
	Getting Needed Care	77.67%	82.58%	83.33%
	Getting Care Quickly	83.13%	85.33%	86.31%
	How Well Doctors Communicate	91.21%	92.80%	93.88%
	Customer Service	87.82%	88.08%	88.29%
	Coordination of Care	79.58%	81.96%	83.50%
	Children With Chronic Conditions (CCC)			
	Access to Prescription Meds	87.61%	90.44%	89.23%
	Access to Specialized Services	57.03%	69.81%	70.99%
	Getting Needed Information	85.95%	90.71%	90.96%
	Doctor Who Knows Child (% Yes)	89.87%	91.19%	91.28%
	Care Coordination for CCC (% Yes)	71.66%	75.94%	75.65%

Note: For 2025 CAHPS, NCQA will be releasing 2025 Health Plan Ratings in the Fall of 2025.

The results presented in this report use the 2024 benchmarks released by NCQA to estimate the 2025 Health Plan ratings; therefore, the Health Plan Ratings scores presented in this report should be treated as estimates. Results are presented for NCQA's top-box rates (% 9+10 or % Usually+Always). At least 100 valid responses must be collected for a measure to be reportable by NCQA. A lighter display is used to indicate that a result is not reportable by NCQA due to insufficient denominator (less than 100 responses).

CAHPS: Reference guide for physicians, with best practices

The **Consumer Assessment of Healthcare Providers and Systems (CAHPS®)** program is a tool for assessing patients' experiences with their health plan, personal doctor, specialists and health care in general. This survey has become the national standard for measuring and reporting on the experiences of consumers with their health plans. CAHPS is a mandated regulatory/accreditation survey sent to a randomly selected number of health plan members.

The suggestions below are provided to help you enhance your patients' health care experience.

CAHPS member survey questions	Industry best-practices for physicians
Getting appointments and care quickly	
When care was needed right away, how often did you get care as soon as you needed it?	Patients who are aware of potential scheduling timelines can plan for time needed and adjust accordingly. Notify patients by text, phone or in the waiting room if there are wait time delays. This helps manage patient expectations. Advocate for your patient and ask if they have transportation available for their appointment.
How often did you see the person you came to see within 15 minutes of your appointment time?	
How often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?	
Getting needed care	
How often did you get an appointment to see a specialist as soon as you needed?	Patients who understand why types of care, tests or treatments are essential are more likely to adhere to a care plan and seek the care that is recommended and needed. Encourage practice staff to provide patients with support in identifying in-network specialist care and services (e.g., labs, imaging, radiology).
How often was it easy to get the care, tests, or treatment needed?	

CAHPS member survey questions	Industry best-practices for physicians
How well doctors communicate	
Were things explained to you in a way you could understand?	Effective communication with patients is key to improving patient engagement. Health literacy techniques, such as not using medical jargon and having the patient (or their caregiver) repeat back their plan-of-care instructions in their own words, can break down communication barriers.
How often did your personal doctor spend enough time with you?	
Coordination of care	
For scheduled appointments, how often did your doctor have your medical records or other information about your care?	Patients report having a more optimal experience when their providers are familiar with their history at the time of their appointments. Offering to walk through registration and use of your patient portal will go a long way in helping patients access their medical records and test results in a timely manner. New and established patients without an appointment in the last year should be encouraged to schedule their Medicare Annual Wellness Visit and a physical. This will ensure annual preventive exams are scheduled and care is coordinated on behalf of the patient.
When your doctor ordered a blood test, X-ray, or other test for you, how often did: • someone from the doctor's office follow up to give you those results? • you get results as soon as you needed them?	
How often did your doctor seem informed and up to date about the care you got from specialists?	
How often did you and your doctor talk about the prescription medicines you were taking?	
How often did you get the help that you needed from your doctor's office to manage your care among different providers and services?	
Overall rating of health care quality	
Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?	Patient councils are great for helping clinical practices understand the patient's experience with the practice's process-improvement initiatives.

CAHPS member survey questions	Industry best-practices for physicians
Flu shot	
Have you had a flu shot this year?	Patients who are well informed of the benefits and safety of the flu vaccine are more likely to get the vaccine. Knowing it is protective and won't make them sick also helps.
Cultural competence	
When you needed an interpreter at your doctor's office or clinic, how often did you get one?	Understand language preference and interpretation needs in advance of appointments to ensure resources are available.
Getting needed prescription drugs	
How often was it easy to use your prescription drug plan to get the medicines your doctor prescribed?	Consider these factors: drug availability and affordability, timely prescribing and up-to-date patient pharmacy choice. This results in patients getting the drugs they need.
How often was it easy to use your prescription drug plan to fill a prescription at your local pharmacy?	
How often was it easy to use your prescription drug plan to fill a prescription by mail?	

Lead screening in children

Fact sheet

Pediatric lead screening in children FAQs

	Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	Healthcare Effectiveness Data and Information Set (HEDIS)
Definition	The EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid	HEDIS is a comprehensive set of standardized performance measures used in the managed care industry to monitor performance and opportunities for quality improvement
Blood lead screening requirements	Every child enrolled in the **NJ FamilyCare program (Medicaid)**, must be given a blood lead test at the following ages: • Complete a blood lead test at **12 months** old (between 9 and 18 months) • **AND** again at **24 months** old (between 18 and 26 months) • Children between 26 and 72 months old who have **NOT** previously had a blood lead test should be tested immediately	Any blood lead test **after the age of 2** is considered late in HEDIS reporting Providers should educate parents/guardians regarding the importance of having their child tested for lead as well as keeping appointments Blood lead screenings should be completed **on or before their second birthday** – it must be a capillary or venous blood lead test
Verbal risk assessment	The verbal risk assessment must be asked at every visit with children who are between **6 months and 72 months** old. The verbal risk assessment must be documented in the medical record for each well-child visit starting at 6 months to 72 months old. To view a list of questions, visit **AetnaBetterHealth.com/newjersey/providers/resources/lead** If any answer is 'yes' or 'I don't know', the risk is considered high. All children at high risk need a blood lead test immediately, even if younger than 6 months old **The questions must be asked at every subsequent visit since risk can change. Regardless of risk, each child must be tested at 12 months and again at 24 months old.**	Not required to be completed under HEDIS guidelines. To better evaluate a child for a blood screening, we recommend completing a verbal risk assessment

Blood lead testing guidance

Screening blood lead testing may be performed by either a capillary sample (fingerstick) or a venous sample. However, all elevated blood levels (equal to or greater than **3.5** micrograms per one (1) deciliter) obtained through a capillary sample must be confirmed by a venous sample.

The frequency of screening blood testing depends upon the results of the verbal risk assessment.

For children determined to be at **low risk** for lead exposure, a screening blood lead test must be performed once between the ages of nine (9) and eighteen (18) months, **preferably at twelve (12) months**, and once between 18-26 months, **preferably at twenty-four (24) months**.

For children determined to be at **high risk** for high doses of lead exposure, a screening blood test must be performed at the time a child is determined to be a high risk beginning at six months of age if there is pertinent information or evidence that the child may be at risk at younger ages.

If a child between the ages of twenty-four (24) months and seventy-two (72) months has not received a screening blood lead test, the child must receive the blood lead test immediately, regardless of whether the child is determined to be a low or high risk according to the results of the verbal risk assessment.

Blood lead testing results

If the initial blood lead test results are **less than 3.5 micrograms per deciliter**, a verbal risk assessment is required at **every** subsequent periodic visit through seventy-two (72) months of age, with mandatory blood lead testing performed at 12 months and again at 24 months.

If the child is found to have a blood lead level equal to or greater than 3.5 micrograms per deciliter, Providers should use their professional judgment, in accordance with the N.J,A.C. 8:51 and CDC guidelines regarding patient management and treatment, as well as follow-up blood testing. Follow-up venous blood screening for the child, and blood lead testing for the other children and any pregnant women living in the household is recommended.

When a child is found to have one confirmed blood lead level between 5 - 9 µg/dl, results must be reported to the local health department to facilitate a preliminary environmental evaluation.

When a child is found to have a confirmed blood lead level equal to or greater than ten (10) µg/dl, or two (2) confirmed consecutive tests one to four months apart with results between 5 - 9 µg/dl, Providers should cooperate with the local health department to facilitate an environmental intervention to determine and remediate the source of lead.

Collaboration with the local health department should include sharing information regarding the child's care, including the scheduling and results of follow-up blood lead tests.

All blood lead levels equal to or greater than 3.5 micrograms per deciliter must be reported to the Aetna Better Health of New Jersey's Care Management Team by emailing **AetnaBetterHealthNJ-CMReferral@aetna.com**.

CPT	LOINC	SNOMED	DESCRIPTION	HEDIS	EPSDT
83655	10368-9,10912-4, 14807-2, 17052-2, 25459-9, 27129-6, 32325-3, 5671-3, 5674-7, 77307-7	8655006 35833009	Lead test	✓	
83655 52			Lead test (52 modifier is used when there is a reduced service)		✓
36405 59			Venipuncture for children under 3 years old, scalp vein (59 modifier – distinct procedural service)		✓
36406 59			Venipuncture for children under 3 years old, other vein (59 modifier – distinct procedural service)		✓
36410 59			Venipuncture for children 3 years and older, non-routine (59 modifier – distinct procedural service)		✓
36415 59			Venipuncture for children 3 years and older, routine (59 modifier – distinct procedural service)		✓
36416 59			Collection of capillary blood specimen (finger, heel and ear stick) (59 modifier – distinct procedural service)		✓

Please reference the above lead screening and EPSDT related procedure codes to assist you in performing lead screenings. 83655 refers to analysis for lead level. Modifier -59 indicates distinct procedural service separate from a visit. 52 modifier is used when there is a reduced service.

Improving lead screening compliance

To help you complete testing on our members, we have contracted with Laboratory Corporation of America (LabCorp), including **MedTox Laboratories**, to provide our contracted physicians with a filter paper lead screening method that is fast, less invasive and easy. Supplies are provided at no charge to your office and, after the sample card(s) have been placed in the mail, results are delivered to you within 72 hours of receipt. **This is the best way to assure members are tested before leaving your office and to improve provider screening rates.**

For more information on using the MedTox technique and to set up your account, contact at **1-877-725-7241** or visit **medtox.com/program-services/filter-paper-lead-testing**.

More questions about lead screening in children?

- Contact Provider Services at **1-855-232-3596** or email **AetnaBetterHealth-NJ-ProviderServices@aetna.com**
- Visit the plan's website at **www.AetnaBetterHealth.com/newjersey/providers/resources/lead** for up-to-date lead screening in children resources

Verbal lead risk assessment

Aetna Better Health® of New Jersey
PO Box 818003
Cleveland, OH 44181-8003

Providers must do a verbal lead risk assessment for lead exposure at every visit with children who are between 6 months and 72 months of age. The verbal risk assessment must be documented in the medical record for each well-child visit starting at 6 months of age to 72 months of age.

Patient Name: _____ **DOB:** _____

Dates of verbal lead risk assessment:								
Below are the questions you'll want to ask:	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Does your child live in or regularly visit a house built before 1978? Does the house have chipping or peeling paint?	☐	☐	☐	☐	☐	☐	☐	☐
Was your child's day care center/preschool/babysitter's home built before 1978? Does the house have chipping or peeling paint?	☐	☐	☐	☐	☐	☐	☐	☐
Does your child live in or regularly visit a house built before 1978 with recent, ongoing or planned renovation or remodeling?	☐	☐	☐	☐	☐	☐	☐	☐
Have any of your children or their playmates had lead poisoning?	☐	☐	☐	☐	☐	☐	☐	☐
Does your child often come in contact with an adult who works with lead? (Examples: construction, welding, pottery or other trades practiced in your community)	☐	☐	☐	☐	☐	☐	☐	☐
Do you give your child home or folk remedies that may contain lead?	☐	☐	☐	☐	☐	☐	☐	☐

Responses
If all answers are negative, assume risk is low for high exposure.

- All children at low risk need blood lead testing 'at 12 months of age (between 9-18 months) and again at 24 months (between 18-26 months).

If any answer is "yes" or "I don't know," assume risk is high.

- All children at high risk need testing immediately.

Risk can change, so be sure to ask these questions at every visit.

Screening schedule

Age	**Risk status**	**Blood lead**	**Hgb/Hct**	**Follow up**
6 months Date: _____	☐ Low risk ☐ High risk	Not recommended Yes _____ ug/dl	Not recommended Yes _____ g/dl _____%	☐ Yes ☐ No
12 months Date: _____	☐ Low risk ☐ High risk	Yes _____ ug/dl Yes _____ ug/dl	Yes _____ g/dl _____% Yes _____ g/dl _____%	☐ Yes ☐ No
18 months Date: _____	☐ Low risk ☐ High risk	Yes _____ ug/dl Yes _____ ug/dl	Yes _____ g/dl _____% Yes _____ g/dl _____%	☐ Yes ☐ No
24 months Date: _____	☐ Low risk ☐ High risk	Yes _____ ug/dl Yes _____ ug/dl	Yes _____ g/dl _____% Yes _____ g/dl _____%	☐ Yes ☐ No

Appointment availability standards

Aetna Better Health® of New Jersey emphasizes the importance of timely access to care for our members and expects our providers to uphold these standards.

In emergency situations, if a member calls or walks into your office, they should be directed to the emergency room (ER) immediately, as emergency care is not provided on-site. For urgent care appointments with a primary care provider, members should be scheduled within 24 hours of their call. Additionally, non-urgent care appointments should be arranged within 72 hours, while routine, regular, or preventive appointments must be scheduled within 28 days of the request. For baseline physicals, adult members should be accommodated within 180 days, and child members under 21 years old and adult clients of DDD should be seen within 90 days.

When it comes to specialist visits, we expect you to maintain the same commitment to accessibility. In emergency situations, members should again be directed to the ER. For urgent care appointments with specialists, please ensure that members are scheduled within 24 hours. Follow-up, preventive, or routine care appointments with specialists should be arranged within 28 days of the request.

Regarding OBGYN visits, emergency appointments should be handled by directing patients to the ER. Urgent care appointments with an OBGYN should be scheduled within 24 hours, and non-urgent appointments within 72 hours. Initial appointments for members who have had a positive pregnancy test should be scheduled within three weeks, while high-risk patients should be seen within three days. For members in their first or second trimester, initial appointments should be arranged within seven days of their request, and for those in their third trimester, within three days. Additionally, follow-up, preventive, or routine care appointments with an OBGYN should be scheduled within 28 days. We also expect that the wait time from registration to seeing the doctor is usually 45 minutes or less, and if a member calls after hours, they should receive a return call from a practitioner within 45 minutes.

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Other standards include:

- Lab and radiology services should be accessible within three weeks for routine appointments and 48 hours for urgent care, with a maximum waiting time of 45 minutes in the office.

Annual after-hour availability

Aetna Better Health of New Jersey is also required to conduct an annual study to assess the availability of PCPs for after-hour consultations. This study surveys our PCP network, randomly selecting providers to contact after business hours or on weekends. The evaluation will determine whether the telephone response from providers meets acceptable criteria.

When a patient calls after hours, the phone should typically be answered directly by a physician, nurse practitioner, or physician assistant. This direct response ensures that patients receive immediate attention from qualified healthcare professionals. If the call is answered by an automated system, the recorded message provides an option for the caller to reach a physician, nurse practitioner, or physician assistant, including the ability to page that individual if necessary.

When a caller selects the option to speak to a live party, they are again connected directly to a physician, nurse practitioner, or physician assistant, ensuring that their medical concerns are addressed promptly. Additionally, the recorded message specifies the timeframe within which the patient can expect a return call from an on-call provider, which is crucial for managing patient expectations. During the survey, the interviewer will introduce themselves and confirm they are speaking with a physician or physician assistant, emphasizing the importance of this communication in maintaining quality care.

Unacceptable responses include leaving messages for the provider without follow-up, instructing callers to go to the ER unnecessarily, or failing to answer the call. This study is essential to ensure that clients have access to care when they need it, even outside regular business hours.

Thank you for your commitment to providing timely and effective care to our members.