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Aetna Better Health®
of New Jersey

Contents

Provider Newsletter

Winter 2025

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

New Jersey Head Start Program

Aetna Better Health® of New Jersey values the importance of working relationships with Early Intervention and Head Start programs in the coordination of health care services for children.

The New Jersey Early Head Start and Head Start programs work together to ensure families receive high quality, comprehensive early education services that address education, health, oral health, mental health, disabilities, nutrition, social services, family engagement, and parent leadership.

To learn more or refer a member to the Head Start Program, visit the website:

New Jersey Head Start Association

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Topical Fluoride Varnish for Children

Role of Primary Care Providers (PCPs) in Dental Care

PCPs must perform basic oral screening for all members, remind them of the need for two annual preventive dental visits and perform yearly cavity assessments on all children through age twenty (20). A referral to a dentist by one year of age or soon after the of eruption the first primary tooth is recommended.

We encourage medical providers to apply fluoride varnish to children's teeth, perform dental assessments and promote routine oral heath visits for our young members. These services combine for reimbursement as an all-inclusive service and bill with a CPT code. They can be provided up to four times a year. This frequency is separate from services a dentist provides.

PCPs play a critical role in their patient's dental health by referring them to their dental home and dentist after they are seen for a medical visit. The member's dental home is listed on the front of their Aetna Better Health® of New Jersey dental ID card.

The member can also call Liberty Dental Plan at **1-855-225-1727** to find at dentist or to answer any questions they may have.

Importance of Oral Health in Children

Children begin to get their primary teeth during the first year of life. By age 6 or 7 years, they start to lose their primary teeth, which eventually are replaced by permanent teeth. Preventive dental care helps prevent tooth decay and identify other oral diseases. Tooth decay that is not treated can lead to pain, loss of teeth, and loss of self-confidence. Children who experience tooth pain may have difficulty eating or sleeping properly and may miss days of school. Early dental care will establish a lifetime of good oral habits.

Advance Directives

Please remind your patients to creative an advance directive for you to have in the medical record.

There are two types of advance directives in New Jersey:

1. Proxy directive
2. Living will (also known as an instruction directive) Your patients, our members can decide whether they want to have one of these or both.

If the member already has an advance directive, we suggest you remind them to:

- Sign and date it
- Keep a copy for yourself
- Give a copy to your health care surrogate
- Give a copy to all your providers
- Take a copy with you if you go to the hospital or emergency room
- Keep a copy in your car (if you have one).

Learn more on the State of New Jersey site.

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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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Breast Cancer Prevention

Many factors over the course of a lifetime can influence your patient's breast cancer risk.

Please remind your patients, our members they can help lower their risk of breast cancer by taking care of their health in the following ways:

- Keep a healthy weight
- Be physically active
- Choose not to drink alcohol, or drink alcohol in moderation
- If they are taking, or have been told to take, hormone replacement therapy or oral contraceptives (birth control pills), ask their doctor about the risks and find out if it is right for them
- Breastfeed their children, if possible
- Talk to you if they have a family history of breast cancer or inherited changes in their BRCA1 and BRCA2 genes.

Source: Centers for Disease Control & Prevention

Cervical Cancer Prevention

To prevent cervical cancer, remind your patients, our member to get vaccinated early and have regular screening tests.

The HPV vaccine protects against the types of HPV that most often cause cervical, vaginal, and vulvar cancers.

Two screening tests that can help prevent cervical cancer or find it early:

- The Pap test (or Pap smear) looks for precancers, cell changes on the cervix that might become cervical cancer if they are not treated appropriately.
- The HPV test looks for the virus (human papillomavirus) that can cause these cell changes.

Source: Centers for Disease Control & Prevention

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Billing Guidance Outline for Sickle Cell Disease (SCD) Gene Therapies

Applicable Drugs:

Casgevy: J3392 - Injection, exagamglogene autotemcel, per treatment

Lyfgenia: J3394 - Injection, lovotibeglogene autotemcel, per treatment

Claim Submission:

1) The drug cost of the SCD gene therapy must be excluded from any facility or institutional claim and not be submitted as part of a bundled payment, such as a diagnosis-related group (DRG) or ambulatory payment classification (APC).
2) The provider must submit a separate professional claim on the CMS 1500 form, or the corresponding electronic version 837P, for direct reimbursement of the drug's ingredient cost.
3) The drug ingredient cost submitted in the "charges" field on the CMS 1500 or 837P claim must be equal to the actual acquisition cost on the corresponding purchase invoice.
4) The invoice from the supplier demonstrating the provider's actual acquisition cost must be submitted as an attachment to the claim.
5) SCD gene therapies must not be acquired at the 340B price or be dispensed from 340B inventory.
6) Claims must include the national drug code (NDC), associated HCPCS code, the unit of measure, and the number of units of the drug administered.
7) Claims should adhere to standards and guidance outlined by the Medicaid managed care plan or the State, including Newsletter Volume 19, Number 18 dated May 19, 2009, which is available on njmmis.com under "Newsletters & Alerts."
8) Drug costs may also be billed as a pharmacy point-of-sale claim, in those cases professional claims for drug costs that have already been paid via a pharmacy point-of-sale system will be considered duplicative and not reimbursed.

Billing Codes for Drug Administration, Cell Collection and Conditioning:

1) Providers should utilize appropriate billing codes for associated services; manufacturer billing guides may be referred to for suggested applicable codes:
2) Casgevy Billing and Coding Guide: https://www.casgevyhcp.com/sites/default/files/coding-and-billing-guide.pdf
3) Lyfgenia Billing and Coding Guide: https://www.lyfgenia.com/-/media/lyfgenia/launch%20com/files/billing-and-coding-guide.pdf

Reporting:

1) The managed Medicaid plan will report to the State's Pharmacy Unit all prior authorization requests for a SCD gene therapy within 14 calendar days of the PA request.
2) The managed Medicaid plan will report to the State's Pharmacy Unit all submitted claims for a SCD gene therapy within 14 calendar days of receipt.
3) The managed Medicaid plan will report to the State's Pharmacy Unit all paid claims for a SCD gene therapy within 14 calendar days of payment.

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Billing Guidance Outline for Sickle Cell Disease (SCD) Gene Therapies *(cont.)*

Provider Requirements:

1) Payment for Sickle Cell Disease (SCD) Gene Therapies to model beneficiaries is conditional on provider adherence to the following requirements:
    a) The provider must be a member of the Center for International Blood and Marrow Transplant Research (CIBMTR) patient registry and
    b) The provider must participate in the study related to SCD gene therapies.

Enhance patient health with Aetna Better Care rewards

As a valued provider, we encourage you to inform your patients about the Aetna Better Care rewards program. This initiative rewards members for engaging in healthy activities such as annual dental visits, lead screening for children, and timely initial prenatal visits.

Incentive program details:

1) **Annual Dental Visit:** Members aged 0-20 years who complete one dental visit per calendar year can earn a $30 gift card.

2) **Lead Screening for Children:** Children aged 6 months to 2 years can earn a $30 gift card for completing one lead screening by age 2. One incentive is offered per calendar year.

3) **Pregnancy care:** $30 for going to the first prenatal visit in the first trimester (or within 42 days of becoming a plan member) (pregnant members, once per pregnancy)

Benefits and usage

Patients can use these gift cards to purchase essential items at participating stores like CVS, Walmart, Dollar General and many more. Each member can earn a maximum of $50 per year. If a member qualifies for two rewards, the first reward is $30, and the second is $20. Please inform patients that it may take up to 60 days following the completion of the qualifying service for the gift card to arrive.

Registration process

Patients can register by calling Member Services at **1-855-232-3596 (TTY: 711).**

Encouraging your patients to participate in this program can lead to better health outcomes and provide them with tangible rewards for their proactive health management.

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Nursing Facility Transitions

In Aetna Better Health of New Jersey's contract with the New Jersey Department of Human Services (DHS), Division Medical Health and Assistance Services (DMHAS), Care Management is the lead on developing the Transition Plan which supports members who have the ability or desire to transition from the Nursing Facility (NF) and reside safely with supports in the community.

Nursing Facility Staff

To ensure members receive the full support needed for a safe and successful transition back to the community, it is essential that our Transition of Care team is informed of upcoming discharges as early as possible. Timely notification enables us to coordinate services effectively and avoid disruptions in care that could impact health outcomes. Inform our Care Management staff as soon as possible after becoming aware of the member's wish to leave the NF, this includes:

- Members currently authorized under Medicare A
- Those members planning to leave AMA
- Members planning to leave the state

Aetna Better Health of New Jersey Contacts

- MLTSS Care Management: **1-833-346-0122**
- Call Member Services: **1-855-232-3596**
- Christine Miller, RN BSN, Associate Clinical Manager/NF Transition MFP/Liaison: **millerc15@aetna.com**
- Keith Loniewski, LSW, Community Member Advocate: **loniewskik@aetna.com**

Provider Advisory Committee (PAC)

Aetna Better Health of New Jersey encourages provider participation on key medical committees. We particularly seek providers who serve members with special healthcare needs or members who meet nursing home level of care to assure that these populations have their needs represented. Through committee participation providers have the opportunity to provide input to our Quality programs as well as our processes and policies.

For more information about joining the PAC, please call our Quality Management Department. In addition, interested providers may contact the Medical Director with any questions or inform their Provider Relations Representative if they wish to participate. Aetna Better Health of New Jersey can be reached by calling **1-855-232-3596**. Please ask for the relevant department.

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Key preventive vaccines

Vaccines, like flu and RSV shots, act like special shields that may help protect you and your loved ones from getting sick. And, if you do get sick, they can help ease symptoms. Here are some key ones to ask your provider about. Vaccines, such as influenza and RSV immunizations, serve as an important preventive measure to help reduce the risk of illness for patients and their families. In addition to lowering the likelihood of infection, these vaccines can also lessen the severity of symptoms if illness occurs. Below is verbiage you can consider using when discussing the following key vaccines with your patients.

Flu

Every year, a new flu vaccine is available to help protect against the most common types of flu viruses. It's best to get this shot in the fall, before flu season starts. This way, you'll be ready to face the winter months.

Pneumococcal

This vaccine helps protect against pneumonia, which is a serious lung infection. It's especially important for older adults and people with certain health conditions like asthma, heart disease or diabetes.

Shingles

Shingles is a painful rash that can happen if you've had chickenpox. The vaccine may help prevent this from happening.

RSV

RSV, or respiratory syncytial virus, is a common virus that can cause cold-like symptoms. And it can be dangerous for adults 65 and older and people with weak immune systems.

COVID-19

This is a virus that causes serious illness especially in older adults. The vaccine may help protect you from getting sick and spreading the virus to others.

Tdap

Tdap protects against:

- Tetanus
- Diphtheria
- Pertussis

Get a booster shot every 10 years to stay protected.

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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Hysterectomy and Sterilization Requests

Hysterectomy is a covered service if the primary medical indication for the hysterectomy is other than sterilization. Specific Medicaid requirements must be met and documented on the Hysterectomy Receipt of Information form (FD 189). A copy of the form is available at on our website. You must attach it to the claim prior to submission. Claims for hysterectomy and sterilization must be sent by mail/paper and cannot be electronic.

We require providers to submit a properly completed FD-189 form with the request for precertification for all non-emergent hysterectomies.

Claim payment for a hysterectomy that lacks a copy of the Hysterectomy Receipt of Information form may only be made if the physician performing the hysterectomy certifies that:

- The woman was already sterile and the cause of sterility is stated
- The hysterectomy was required because of a life-threatening emergency and a description of the emergency is stated.

Specific Medicaid requirements must be met and documented on the HHS 687 Consent for Sterilization form. The form must be completed and signed by the member at least 30 days in advance of both female and male sterilization procedures.

If the procedure is performed less than 30 days from the consent form execution date due to a premature birth, the expected date of birth must be noted in the consent form. A copy of the form is on our website. The form must be attached to the claim prior to submission. The individual who has given voluntary consent for a sterilization procedure must be at least 21 years old at the time the consent is obtained and must be a mentally competent person.

Electronic Verification Visits (EVV)

Aetna Better Health of New Jersey values our partnership with your practice to serve the people in the state of New Jersey by providing quality health care and accessible medically-necessary services. Our providers are one of the most critical components of our service delivery approach and we are grateful for your participation. Providers delivering services in the home must meet EVV Phase 2 (Skilled Nursing and Therapy Services) compliance requirements. The six required EVV elements include:

1. Type of service performed;
2. Individual receiving the service;
3. Date of the service;
4. Location of service delivery;
5. Individual providing the service;
6. Time the service begins and ends

The following services requires EVV when rendered in a home or assisted living setting: Skilled Nursing, Home Health, Private Duty Nursing, Personal Care Services (Individual and Group), and Therapies (Speech, Physical, Occupational, Cognitive).

If you are experiencing challenges, or have questions, please email **AetnaEVVCompliance@Aetna.com.** We want to keep you informed and up-to-date on all pertinent information. For more information, review EVV newsletter 32-28, and Updated Billing Policy for Home Health Care/Personal Care Services newsletter 33-11, located on the State's **NJMMIS website.**

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Member Acuity and Risk Adjustment (Long Term Institutionalization)

Aetna Better Health® of New Jersey's members have a broad distribution of health status, ranging from good health to multiple chronic illnesses. Collectively, the sickest members of any health plan require the most attention and care; they also drive the highest cost of care. To address this, New Jersey Medicaid funds Medicaid Managed Care plans based on a complex calculation that includes members' degree of morbidity (referred to as acuity) through the State's Risk Adjustment Payment Model. In this model, the more a plan's members have certain chronic conditions, the higher the Risk Score the State assigns to the plan. Accurate Risk Scoring requires that members with these conditions have all of their chronic conditions addressed at least yearly, recorded in medical records and documented in claims. Reporting on member acuity starts and ends with the provider.

Diagnosis coding in claims

Encounters are electronic documents created in the claims process and reported to the State of New Jersey, showing each service provided to members. The diagnosis codes in each encounter drive the calculation of each plan's Risk Score. Each time a member with a chronic condition has that condition addressed at a visit, the diagnosis should appear on the claim. It is critical that providers document all chronic illness diagnosis codes on every applicable claim. Evaluation of the codes and subsequent Risk Adjustment analysis is done by the State on a bi-annual basis. Thus, providers should include the diagnosis code on every patient claim at every visit when it was addressed to ensure that the diagnosis is captured and utilized in the most current encounter analysis.

Acute visits

Members with chronic conditions who may not have seen their provider for periodic checkups may still present for episodic or acute conditions. These visits are opportunities to address their chronic conditions. If your member visits you for an episodic or acute condition and a chronic condition is currently present and addressed during the visit, the chronic condition diagnosis should be coded and included on the claim.

For example, a member with type 2 diabetes presents to the office with bronchitis. During the visit, along with treatment of bronchitis, you also provide reminders on the management of diabetes and the risk of elevated blood-glucose levels related to the acute bronchitis. The claim should include both the diagnosis of acute bronchitis and the diagnosis of diabetes.

Our partnership

Aetna Better Health® of New Jersey is your partner in caring for all of our members, including our highest acuity members. We offer Integrated Care Management and our Quality program mails visit reminders and calls members, all in an effort to get them the care that they need.

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Balance Billing is Prohibited

Providers may not bill Aetna Better Health® of New Jersey members for any services that are covered by NJ Medicaid and/or Aetna Better Health® of New Jersey.

- Any member copayments you must collect are included in the benefit listing on our website. Please note that copayments are not considered balance billing.
- Per your contract with us, when a provider receives a Medicaid/NJFC FFS or managed care payment, the provider shall accept this payment as payment in full and shall not bill the beneficiary or anyone on the beneficiary's behalf for any additional charges.

NOTE: Providers can make payment arrangements with a member for services that are not covered by NJ Medicaid and Aetna Better Health® of New Jersey only when they notify the member in writing in advance of providing the service(s), and the member agrees. We want to make sure you are aware of these requirements because we value your partnership with us.

Federal and State laws are clear that providers are prohibited from balance billing Medicaid beneficiaries (42 USC 1395w-4(g)(3)(A), 42 USC 1395cc(a)(1)(A), 42 USC 1396a(n), 42 U.S.C. § 1396u-2(b)(6), 42 CFR 438.106, NJAC 11:24-9.1(d)9 and/or 15.2(b)7ii.

Before you decide to send accounts to any collection agency you may be using, it is critical that you **NOT** include Aetna Better Health® of New Jersey member accounts.

Providers who balance bill members could face the following consequences:

- Termination from the ABHNJ network
- Referral to the NJ Medicaid Fraud Division to open an investigation into the provider's action
- Referral to the Federal Department of Health & Human Services, US Office of Inspector General (HHS-OIG).

Extra Help During Pregnancy

Is any parent ever prepared enough for a new baby? If you have patients, our members that feel overwhelmed, we can help them stay healthy through their pregnancy and get the care they need.

Our team can help our members:

- Learn more about your pregnancy
- Make a care plan that's right for them
- Get services and care
- Work with health care providers, agencies and groups
- Get services after hours in a crisis
- Arrange services for children with special health care needs

Just call Member Services at **1-855-232-3596 (TTY: 711)**.

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Telephone and Appointment Availability Access

Reminder: The upcoming telephone access and appointment accessibility secret shopper calls will occur between Q4 2025 and Q1 2026.

Please remember to develop and use telephone protocols for all of the following situations:

a. Answering the enrollee telephone inquiries on a timely basis.
b. Prioritizing appointments.
c. Scheduling a series of appointments and follow-up appointments as needed by an enrollee.
d. Identifying and rescheduling broken and no-show appointments.
e. Identifying special enrollee needs while scheduling an appointment, e.g., wheelchair and interpretive linguistic needs. (See also Article 4.5.)
f. Triage for medical and dental conditions and special behavioral needs for non-compliant individuals who are mentally deficient.
g. Response time for telephone call-back waiting times: after hours telephone care for non-emergent, symptomatic issues - within thirty (30) to forty-five (45) minutes; same day for non-symptomatic concerns; fifteen (15) minutes for crisis situations.
h. Scheduling continuous availability and accessibility of professional, allied, and supportive medical/dental/MLTSS personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.

Appointment Availability

- **Emergency Services.** Immediately upon presentation at a service delivery site.
- **Urgent Care.** Within twenty-four (24) hours. An urgent, symptomatic visit is an encounter with a health care provider associated with the presentation of medical signs that require immediate attention, but are not life-threatening.
- **Symptomatic Acute Care.** Within seventy-two (72) hours. A non-urgent, symptomatic office visit is an encounter with a health care provider associated with the presentation of medical signs, but not requiring immediate attention.
- **Routine Care.** Within twenty-eight (28) days. Non-symptomatic office visits shall include but shall not be limited to: well/preventive care appointments such as annual gynecological examinations or pediatric and adult immunization visits.
- **Specialist Referrals.** Within four (4) weeks or shorter as medically indicated. A specialty referral visit is an encounter with a medical specialist that is required by the enrollee's medical condition as determined by the enrollee's Primary Care Provider (PCP). Emergency appointments must be provided within 24 hours of referral.
- **Urgent Specialty Care.** Within twenty-four (24) hours of referral.
- **Baseline Physicals for New Adult Enrollees.** Within one hundred-eighty (180) calendar days of initial enrollment.
- **Baseline Physicals for New Children Enrollees and Adult Clients of DDD.** Within ninety (90) days of initial enrollment, or in accordance with EPSDT guidelines. (48) hours for urgent care.

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Telephone and Appointment Availability Access *(cont.)*

- **Prenatal Care**. Enrollees shall be seen within the following timeframes:
  - Three (3) weeks of a positive pregnancy test (home or laboratory)
  - Three (3) days of identification of high-risk
  - Seven (7) days of request in first and second trimester
  - Three (3) days of first request in third trimester
- **Routine Physicals.** Within four (4) weeks for routine physicals needed for school, camp, work or similar.
- **Lab and Radiology Services.** Three (3) weeks for routine appointments; forty-eight (48) hours for urgent care.
- **Waiting Time in Office.** Less than forty-five (45) minutes.
- **Initial Pediatric Appointments.** Within three (3) months of enrollment. The Contractor shall attempt to contact and coordinate initial appointments for all pediatric enrollees.
- **For dental appointments,** the Contractor shall be able to provide:
  - 1Emergency dental care, which is the immediate care, treatment and/or referral for emergent dental conditions, and defined previously as serious orofacial conditions which require immediate medical intervention, to avoid placing the health of the individual in jeopardy.
  - 2. Urgent dental care, which is defined as oral and/or dental conditions which require timely treatment to alleviate pain, address infection risk and avoid additional degradation of the teeth and/or other oral structures, within forty-eight (48) hours of member request.
  - 3. Routine non-symptomatic care and/or specialist referrals within twenty-eight (28) days of member request.
- **For MH/SUD appointments,** the Contractor shall provide:
  - 1. Emergency services immediately upon presentation at a service delivery site.
  - 2. Urgent care appointments within twenty-four (24) hours of the request.
  - 3. Routine care appointments within ten (10) days of the request.
- **Maximum Number of Intermediate/Limited Patient Encounters.** Four (4) per hour for adults and four (4) per hour for children.
- **For SSI and New Jersey Care** – ABD elderly and disabled enrollees, the Contractor shall ensure that each new enrollee or, as appropriate, authorized person is contacted to offer an Initial Visit to the enrollee's selected PCP. Each new enrollee shall be contacted within forty-five (45) days of enrollment and offered an appointment date according to the needs of the enrollee, except that each enrollee who has been identified through the enrollment process as having special needs shall be contacted within ten (10) business days of enrollment and offered an expedited appointment.

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