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Provider Newsletter

Summer 2026

Provider Directory

Members can access the provider directory by visiting [AetnaBetterHealth.com/NewJersey/find-provider](https://www.aetna.com/members/benefits/dental) or calling Member Services at **1-855-232-3596**. For a listing of NJ Smiles Dental providers (for children 0-3 years old), visit [AetnaBetterHealth.com/NewJersey/members/benefits/dental](https://www.aetna.com/members/benefits/dental).

Pharmacy Guidelines (Restrictions/Preferences)

Aetna Better Health[®] of New Jersey’s pharmacy prior authorization (PA) processes are designed to approve only the dispensing of medications deemed medically necessary and appropriate.

Our pharmacy PA process will support the most effective medication choices by addressing drug safety concerns, encouraging proper administration of the pharmacy benefit, and determining medical necessity. Typically, we require providers to obtain PA prior to prescribing or dispensing the following:

- Injectables dispensed by a pharmacy provider
- Non-formulary drugs that are not excluded under a State’s Medicaid program
- Prescriptions that do not conform to Aetna Better Health[®] of New Jersey’s evidence-based utilization practices (e.g., quantity level limits, age restrictions or step therapy)
- Brand name drug requests, when an “A” rated generic equivalent is available [Pharmacy authorization guidelines](#) and PA forms are available on our website.

Suspect Fraud? Report it – Aetna’s Special Investigations Unit (SIU)

Billions of dollars are lost to healthcare fraud each year.

It impacts the quality of healthcare and results in higher costs. The SIU is responsible for Aetna's anti-fraud program and leads the fight against health care fraud, waste, and abuse (FWA). Through our efforts to combat FWA, we help preserve the integrity and availability of healthcare resources. And that's how we help people on their path to better health.

Mission Statement

To protect the health and financial wellness of the people we serve by leading the fight against health care fraud, waste, and abuse as we help to build a healthier world.



Provider FWA

- Falsifying medical records
- Billing for services or items they didn't receive
- Giving services that members don't need (medically unnecessary)

Member FWA

- Lending, selling, or giving a health plan ID card to someone else
- Getting medicines or services they don't need
- Forging or changing prescriptions from providers

Click to Report FWA

Interpretation Services

Telephone interpretive services are provided at no cost to members or providers. Personal interpreters can also be arranged in advance. Sign language services are also available. These services can be arranged in advance by calling Aetna Better Health® of New Jersey's Member Services Department at **1-855-232-3596 (TTY 711)**. Member Services is available 24 hours a day, 7 days a week.



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Critical Incidents for MLTSS Member

Critical Incident is an occurrence involving the care, supervision, or actions involving a Member that is adverse in nature or has the potential to have an adverse impact on the health, safety, and welfare of the Member or others. Critical incidents also include situations occurring with staff or individuals or affecting the operations of a facility/institution/school.

Examples of a Critical Incident:

1. Unexpected death of a member
2. Media involvement or the potential for media involvement
3. Physical abuse (including seclusion and restraints both physical and chemical)
4. Psychological/verbal abuse
5. Sexual abuse and/or suspected sexual abuse
6. Fall resulting in the need of medical treatment
7. Medical emergency resulting in need for medical treatment
8. Medication error resulting in serious consequences
9. Psychiatric emergency resulting in need for medical treatment
10. Severe injury resulting in the need of medical treatment
11. Suicide attempt resulting in the need for medical attention
12. Neglect/mistreatment, caregiver (paid or unpaid)
13. Neglect/mistreatment, self
14. Neglect/mistreatment, other
15. Exploitation, financial
16. Exploitation, theft
17. Exploitation, destruction of property
18. Exploitation, other
19. Theft with law enforcement involvement
20. Failure of member's Back-up Plan
21. Elopement/wandering from home or facility
22. Inaccessible for initial/on-site meeting
23. Unable to contact
24. Inappropriate or unprofessional conduct by a provider involving member
25. Cancellation of utilities
26. Eviction/loss of home
27. Facility closure, with direct impact to member's health and welfare
28. Natural disaster, with direct impact to member's health and welfare
29. Operational breakdown
30. Other

If you encounter a critical incident with a MLTSS member, please complete the [MLTSS Critical Incident Reporting Form](#).

You can report Critical Incidents by phone to **1-833-346-0122** or by fax to **959-900-6054**. Provider Services **1-855-232-3596**.



Monitoring Metabolic Risks of Antipsychotic Meds

APM assesses the percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year. Antipsychotic prescribing for children and adolescents has increased rapidly over the year. These medications can elevate a child's risk for developing serious metabolic health complications associated with poor cardiometabolic outcomes in adulthood. Given these risks and the potential lifelong consequences, metabolic monitoring (blood glucose and cholesterol testing) is an important component of ensuring appropriate management of children and adolescents on antipsychotic medications. For more information, visit the [NCQA website](#).

Rights and Responsibilities

It is our policy that no provider unfairly discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, or any other basis that is prohibited by law. Please refer to the [member Rights and Responsibilities Section](#) of our Provider Manual. Ensure your staff members are aware of these requirements and the importance of treating members with respect and dignity.

In the event that we receive information that a member is not being treated in accordance to our policy, we will initiate an investigation and report the finding to the Quality Management Oversight Committee. Further action may be taken by us if deemed necessary.

You can review the [Rights and responsibilities](#) section of our website for more information.

HEDIS Tips in Caring for People Diagnosed with a Serious Mental Health Issue

HEDIS measure: SSD – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Measure definition: Patients 18 – 64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test annually.

Tips:

1. Encourage members to share contact information among all Medical, Behavioral/Mental Health or Substance Use Disorder Providers.
2. Facilitate coordination of care between Medical and Behavioral/Mental Health and Substance Use Disorder Providers to ensure tests are administered and results shared in a timely manner.
3. Engage members in treatment discussions explaining the importance of having these tests administered.
4. Create an HbA1c and LDL-C testing reminder in your EHR for each member who is taking antipsychotic medications, regardless of known diabetes diagnosis.



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How to Refer Members to Our Care Management Program

Do you have a patient in need of care management?

We can help your patients (who have the conditions below) enhance their self-management skills:

- Behavioral health and substance abuse
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure
- Coronary artery disease
- Diabetes
- Other conditions
- Pregnancy outreach and high-risk obstetrics (OB)
- Special health care needs

Care managers educate members about their condition and how to prevent worsening of their illness or any complications. The goal is to maintain, promote or improve their health status.

To create a quality-focused, cost-effective care plan, care managers collaborate with:

- The member
- Member's family
- PCP
- Psychiatrist
- Substance abuse counselor
- Other health care team members

To identify members that are the right fit for care management, we may use referrals from:

- Our health information or special needs lines
- Members
- Caregivers
- Providers
- Practitioners

Integrated care management means your patient only has one care manager, even if they also take part in:

- Care Management
- Condition Management

To refer your patients, our members to Care Management, you can call Member Services at **1-855-232-3596 (TTY: 711)**.

Pediatric ADHD HEDIS Follow Up and Tips

All children who are prescribed medications to treat attention-deficit/hyperactivity disorder (ADHD) need follow-up care to assure that the response to medication and dosage is appropriate. Please review the ADHD HEDIS measure information below and tips on how to meet the measure.

HEDIS measure: ADD–Follow Up Care for Children Prescribed ADHD Medication

Measure definition: Children 6–12 years of age, newly prescribed with ADHD medication, who had at least 3 follow-up visits within a 10-month period, one of which was within 30 days of when the ADHD medication was dispensed.

Two rates are reported:

- **Initiation Phase:** A follow up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.
- **Continuation Phase:** Children that remained on the ADHD medication for at least 210 days and, in addition to the visit in the Initiation Phase, had at least 2 follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Tips:

1. When prescribing a new ADHD medication for a patient, schedule the initial follow up appointment before the patient leaves the office.
2. Only prescribe 14-21 days worth of the medication when starting or changing prescription.
3. Schedule the initial follow up for the 2-3 week period corresponding to the prescription.
4. Explain to the parent the importance of follow up care with the provider who prescribed the medication and who will evaluate the medication.
5. Provide no refills unless the child has the initial follow up visit.
6. After the initial follow up visit, schedule at least 2 more visits over the next 9 months to check the child's progress.
7. Encourage parents/caregivers to ask questions about their child's ADHD symptoms.
8. Always coordinate care between all clinicians in your patient's treatment team.

Tdap Vaccine Reminder for Providers

The Tdap vaccine helps protect against tetanus, diphtheria, and pertussis (whooping cough). Providers are encouraged to assess vaccination status during routine visits and recommend Tdap vaccination according to current CDC guidelines.

The CDC recommends a one-time Tdap dose for adults who have not previously received it and Tdap vaccination during every pregnancy, preferably between 27 and 36 weeks gestation, to help protect newborns from pertussis.

For a complete recommendations and clinical guidance, visit the CDC Tdap webpage: cdc.gov/vaccines/hcp/current-vis/tdap.html



Community-Based Palliative Care (CBPC) Program

The Community-Based Palliative Care (CBPC) program offers interdisciplinary, community-based services designed to improve quality of life, manage symptoms, and support members and caregivers while curative treatment continues. Services are provided in non-inpatient settings and include care planning and coordination, symptom management, medication review, psychosocial counseling, spiritual support, and 24/7 telephonic access to care support.

CBPC services are delivered by an interdisciplinary team (IDT) that includes a Medical Director, Lead IDT Clinician, Registered Nurse, Licensed Mental Health Practitioner, and Chaplain, with additional team members incorporated based on member needs.

Members may qualify for CBPC based on a serious illness diagnosis and evidence of reduced quality of life, including functional decline or recent acute care utilization. Eligible conditions may include cancer, congestive heart failure, COPD, chronic kidney disease, dementia, neurological disorders, and other serious adult and pediatric conditions.

Providers are encouraged to review the complete CBPC program requirements, eligibility criteria, care coordination expectations, and operational guidance in the Community-Based Palliative Care **Provider Manual** available on our website.

Role of Primary Care Providers (PCPs) in Dental Care

Primary Care Providers (PCPs) are essential in promoting dental health. They perform basic oral screenings, remind members of the need for two annual preventive dental visits, and conduct yearly cavity assessments for children up to age twenty. PCPs should refer children to a dentist by age one or soon after their first primary tooth erupts. Coordination between behavioral and physical health providers is crucial for accurate diagnosis and treatment of behavioral disorders, ensuring appropriate use of psychotropic medications.

PCPs are encouraged to apply fluoride varnish, perform dental assessments, and promote routine oral health visits. These services can be billed up to four times a year with a CPT code, separate from dental services.

After medical visits, PCPs should refer patients to their dental home, listed on their Aetna Better Health[®] of New Jersey dental ID card.



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Important Update: SUD Laboratory Services Integration & Upcoming Provider Training Opportunities

Aetna Better Health of New Jersey would like to remind providers of an important change impacting Substance Use Disorder (SUD) laboratory services for NJ FamilyCare members. Effective July 1, 2026, SUD laboratory services will transition from Medicaid Fee-for-Service (FFS) to management by Medicaid Managed Care Organizations (MCOs), including Aetna Better Health of New Jersey, as directed by the New Jersey Division of Medical Assistance and Health Services (DMAHS).

Services Included

- 80305, 80306, 80307 – Presumptive drug testing
- G0480, G0481 – Definitive drug testing

Key Information for Providers

No Prior Authorization Required: SUD laboratory services included in this integration will not require prior authorization.

Transition Period Billing Flexibility beginning July 1, 2026:

- In-network and out-of-network laboratories may bill Aetna Better Health of New Jersey.
- Claims submitted with a SUD diagnosis code will be accepted.
- Clean claims will be reimbursed at no less than the current Medicaid FFS rate.
- This payment floor does not apply to capitated arrangements.

Billing and Claims Submission Requirements

- Payer ID: 46320
- Timely Filing: Within 180 days from the date of service
- Submission Methods: Electronic submission (preferred), Availity (for participating providers), or paper claims

Network Participation

While contracting is not required during the transition period, laboratories are encouraged to explore participation in the Aetna Better Health of New Jersey network. Network participation supports long-term alignment with plan requirements and helps ensure a smooth transition after the temporary billing flexibility period ends.

Upcoming Behavioral Health Provider Trainings & Office Hours

To help providers stay informed and successfully navigate behavioral health integration initiatives, Aetna Better Health of New Jersey invites providers to attend upcoming training sessions and office hours.

Behavioral Health Integration Provider Trainings

- Thursday, July 9, 2026 – 12:00 PM
- Wednesday, July 22, 2026 – 12:00 PM

Registration: aetnabetterhealth.com/newjersey/providers/training-orientation.html



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Important Update: SUD Laboratory Services Integration & Upcoming Provider Training Opportunities

Behavioral Health Prior Authorization Office Hours

- Friday, July 31, 2026 – 10:30 AM

Registration: <https://lp.constantcontactpages.com/sv/KndnWBV/BHPAOfficeHoursQ126>

Provider Contacts

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Behavioral Health Administrator
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Senior Manager, Behavioral Health Network Management
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For general provider support, contact Provider Services at 1-855-232-3596.

Nursing Facility Transition

Nursing facility transitions help eligible members move from an institutional setting back into the community with the supports and services needed to live safely and independently. Providers play a key role in identifying members who may benefit from community-based care and collaborating with care management teams to ensure a smooth and successful transition.

Providers are encouraged to work closely with care management teams to support members interested in transitioning from an institutional setting to a home- and community-based environment. Together, we can help members receive the right care in the setting that best meets their needs.

Call Provider Services at **1-855-232-3596** to refer members.

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

Not required to be completed under HEDIS guidelines. To better evaluate a child for a blood screening, we recommend completing a verbal risk assessment



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 healthcare 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 Medicaid 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?

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?

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. Resources For Living (RFL), offered by Aetna can put your patients in touch with transportation resources.

Getting needed care

How often did you get an appointment to see a specialist as soon as you needed?

How often was it easy to get the care, tests, or treatment 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 well doctors communicate

Were things explained to you in a way you could understand?

How often did your personal doctor spend enough time with you?

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.

CAHPS: Reference guide for physicians, with best practices



CAHPS member survey questions

Industry best-practices for physicians

Coordination of care

For scheduled appointments, how often did your doctor have your medical records or other information about your care?

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?

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 Medicaid Annual Wellness Visit and a physical to ensure the conversations about their health, medications, and the care they receive from other providers. This will ensure annual preventive exams are scheduled and care is coordinated on behalf of the patient.

Overall rating of healthcare 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: Reference guide for physicians, with best practices



CAHPS member survey questions

Industry best-practices for physicians

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?

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?

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.

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.



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.