Aetna Better Health® of New Jersey
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NEW POLICY UPDATES

CLINICAL PAYMENT, CODING AND POLICY CHANGES

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

Effective for dates of service beginning **November 1, 2025**:

New Jersey Medicaid-Policy Guidelines

Ineligible NPI

This policy identifies situations when any service is billed by a DME supplier, and both the referring and ordering National Provider Identifier (NPI) are ineligible.

Per CMS Policy, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier claims must contain a referring or ordering National Provider Identifier (NPI) of a provider with an eligible specialty who is enrolled in Medicare in an approved status

NDC and Non-Specific Crosswalk

According to the Food and Drug Administration (FDA), providers are required to report National Drug Codes (NDC) with certain HCPCS codes. The NDC must match the HCPCS code being reported.

This policy identifies situations in which a HCPCS drug code reported with non-specific language, such as miscellaneous, unclassified, NEC, NOS, etc. is billed with a National Drug Code (NDC) number and the NDC number does not match a non-specific HCPCS code in the NDC Crosswalk.

Duplicate Claim Logic for Drugs

This policy identifies situations when a vaccine code is billed and the same submitted code with the same submitted units has been billed on a different

claim by any provider and any claim type for the same date of service. The second code received will be denied as a duplicate submission based on criteria that may include but is not limited to subscriber/member number, dependent number, date of service, procedure code, and units.

Risankizumab (J2327)

This policy identifies situations when Risankizumab (J2327) is billed with a diagnosis of regional enteritis or ulcerative colitis and a liver function test (80050, 80053, 80076, 82977, 84450, 84460) has not been billed in the previous 27 days by any provider.

According to the FDA-approved package insert/prescribing information and the pharmaceutical compendia, patients being treated with Risankizumab [intravenous] should not begin a new treatment cycle if liver functions are elevated. Therefore, without a liver function test billed in the previous 27 days, Risankizumab will be denied.

Infliximab

This policy identifies situations when Infliximab (J1745, Q5103, Q5104, Q5109, Q5121) is billed for more than five unique visits every 26 weeks.
Additional Criteria:

- By any provider
- Any claim type
- Diagnosis of regional enteritis [adult]
- Patient's age is greater than or equal to 18 years

Per the FDA-approved package insert/prescribing information and the pharmaceutical compendia, when Infliximab is used for regional enteritis, it should not be administered more frequently than five times every 26 weeks.