Programs and resources to help women through every stage of life

Women’s health programs and policies

www.aetna.com
This manual is designed to help health care professionals understand our women’s health programs and policies.
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Introduction

Women’s health programs are an important part of our medical management efforts.

This initiative includes programs that facilitate a holistic member view, consider multiple diseases and conditions across all benefits plans, and deliver individualized programs based on a member’s unique needs and preferences.

This manual is designed to help you understand our women’s health programs and policies. Some of the programs may not be available to members who select a primary care physician (PCP) affiliated with an independent practice association (IPA), physician medical group, integrated delivery system or other provider group. To determine eligibility, contact us at the phone number listed on the member’s Aetna ID card.

Changes in policy are generally released through:

- Our Aetna OfficeLink Updates™ newsletter for health care professionals
- Our public website at www.aetna.com
- Our secure provider website on NaviNet® at https://navinet.navimedix.com/
Before you access the information in this manual, review these important highlights:

- **Patient advocacy** — Physicians are advocates on behalf of their Aetna patients. Please familiarize yourself with the “Member Rights and Responsibilities” section of our Office Manual for Health Care Professionals. You’ll find it on our secure member website at https://navinet.navimedix.com/

- **Informed consent** — Physicians are responsible for providing their patients with all information relevant to their condition(s). This includes all health care alternatives, even if an option is not covered by their plan, as well as potential risks and benefits of each.

- **Patient emergencies** — If Aetna members need emergency care, they’re covered 24 hours day, 7 days a week, anywhere in the world.

- **Providing medical information** — Physicians are responsible for providing Aetna with the complete and accurate medical information required to make appropriate coverage determinations (that is, diagnosis, clinical information and/or services provided).

- **Independent contracting** — As indicated in all Aetna provider agreements, participating providers are not employees or agents of any Aetna affiliate.

- **Information about coverage** — If you’re unsure if a particular service is covered under a member’s plan, contact us using:
  - Our secure provider website at https://navinet.navimedix.com/
  - Our dedicated Provider Services — For health maintenance organization (HMO)-based and Medicare plans, 1-800-624-0756, for all other plans, 1-888-MD-Aetna (1-888-632-3862)

- **Appeals** — You may appeal adverse benefits determinations and provider reimbursement decisions. In addition, members and some physicians may have the right to an external review if the circumstances of the appeal meet certain criteria. To find out more about our dispute and appeal process, just go to the “Health Care Professionals” section at www.aetna.com. Then click on “Dispute & Appeal Process.”

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### Key phone numbers and contacts

- **Beginning Right maternity program**  
  1-800-272-3531

- **Infertility case management program**  
  1-800-575-5999

- **Breast Health Education Center**  
  1-888-322-8742

- **BRCA genetic testing program**  
  1-877-794-8720

- **Obstetric ultrasound enhancement program**  
  1-800-624-0756

- **Non-stress test (NST) enhancement program**  
  1-800-624-0756

- **Provider Services**  
  - HMO-based and Medicare plans: 1-800-624-0756  
  - All other plans: 1-888-MD-Aetna (1-888-632-3862)

### Online resources

- **Women’s health information** — Visit the “Individuals & Families” section of our public website at www.aetna.com. Then, under “Healthier Living Resources,” click on “Women’s Health.” Here you’ll find general women’s health information and details on women’s health programs. Topics include:  
  - Advice for moms-to-be  
  - Understanding and treating breast and ovarian cancers  
  - Helpful tips for every stage of a woman’s life

- **Our secure provider website** — Search for physicians, hospitals and other health care professionals at https://navinet.navimedix.com/. You can also access the site at www.aetna.com. Under “Health Care Professionals,” click on “Secure Provider Website.” Once on the site, register or log in with your user name and password. Features of this website include:  
  - Online professional claims submission (HCFA/CMS 1500) for physicians and physician groups
- Data-entry screens for online claim inquiries and eligibility, and real-time referral and precertification transactions
- Online electronic remittance advice/electronic funds transfer (ERA/EFT) enrollment form
- The ability to update your office profile
- Information on automatic studies
- The Office Manual for Health Care Professionals

**Clinical Policy Bulletins** — Go to [www.aetna.com](http://www.aetna.com).

**Preventive services guidelines** — Go to our secure provider website at [https://navinet.navimedix.com/](https://navinet.navimedix.com/). After logging in, choose “Aetna Health Plan” under “My Health Plans.” Then go to Support Center > Clinical Resources > Preventive Services Guidelines.

**Pharmacy services and tools** — Visit the “Health Care Professionals” section at [www.aetna.com](http://www.aetna.com). Then under “Products & Programs for Health Care Professionals,” click on “Pharmacy Services.” Here you’ll find information on:
- Aetna Specialty Pharmacy® medicine support services including medication ordering, shipping and delivery
- Our formulary
- Pharmacy Clinical Policy Bulletins

**Aetna BRCA Precertification Information Request Form** — To get the form:
- Visit the “Health Care Professionals” section at [www.aetna.com](http://www.aetna.com). Then go to Resources for Health Care Professionals > Forms > Medical Precertification.
- Call us at **1-800-624-0756**.
Gynecologic programs, policies and reimbursement

Primary and preventive gynecologic services (HMO, Aetna Health Network Only™ plans and Aetna Health Network Option™ plans)

Direct-access/prior authorization policies
Our direct-access obstetrics and gynecology policy covers services provided by a member’s obstetrician/gynecologist (Ob/Gyn) without a referral from her primary care physician (PCP). A woman may also elect to have her annual primary health care exam performed by her PCP.

The Ob/Gyn should notify the member’s PCP about the services and treatment plan developed as a result of any direct-access visits.

In some areas, the Ob/Gyn may function as the member’s PCP and may refer the member to any participating provider, including specialists, for any covered, medically necessary services. For more information, call us at 1-800-624-0756.

Billing
The annual gynecologic primary and preventive visit should be billed using the E&M codes for preventive visits (99384 – 99387 and 99394 – 99397).

All other visits should be coded using standard E&M codes.

Your office should collect the appropriate copayment from the member for these services. Refer to the member’s Aetna ID card for copayment information.

Radiology services (HMO, Aetna Health Network Only plans and Aetna Health Network Option plans)

Gynecology ultrasounds (for example, CPT codes 76830, 76831, 76856 and 76857) may be performed in the Ob/Gyn office without a referral or prior authorization and are reimbursed on a fee-for-service basis.

If the Ob/Gyn doesn’t provide office-based gynecology ultrasounds, members should be referred to a participating radiology center with a valid physician’s order.

In areas where radiology services are capitated, the member should be referred to the capitated site associated with her PCP.

For capitated radiology centers in the area, members should contact their PCP or call the number on their Aetna member ID card.

Automatic studies for gynecologic services (HMO, Aetna Health Network Only plans and Aetna Health Network Option plans)

Automatic studies are services for which we compensate providers when the services are performed in the specialist’s office, regardless of whether the procedure itself was specifically indicated on the referral.

In general, these are procedures that are integral to the evaluation of the problem that led to the referral to the specialist.

Inclusion of a study on the automatic studies list doesn’t guarantee payment. Rather, payment will be made according to our standard processing guidelines.

To access a list of automatic studies for Ob/Gyns, go to our secure provider website at https://navinet.navimedix.com/.

After logging in, select “Aetna Health Plan” under “Plan Central,” then “Referrals” and “Automatic Studies by Specialty.”

Cervical cancer screening services

Human papillomavirus (HPV) DNA screening
Aetna covers HPV DNA screening in conjunction with either conventional Pap smears or liquid-based cytology for primary cervical cancer screening of women ages 30 and older, when not otherwise excluded by the member’s benefits plan.

Women who receive negative results on both tests should be rescreened no more frequently than every three years. This policy is consistent with guidelines from the American Congress of Obstetricians and Gynecologists (ACOG) (2003).

HPV DNA testing in women less than age 30 isn’t a covered benefit for primary cervical cancer screening. Again, this policy is consistent with ACOG guidelines (2003).

Breast health (all products)

Referral policies
Members have direct access to gynecologists who, in addition to providing routine care, may authorize referrals for specialty care for related services. Gynecologists may refer members for consultations (which include automatic studies) to the following specialties without a primary care physician (PCP) referral:
• Breast surgery
• General surgery
• Gynecologic oncology
• Oncology
• Urology
• Urogynecology

Mammography
Members have direct access for mammography services at contracted radiology facilities. A referral isn’t necessary. For proper reimbursement, the member must present a valid physician’s order to a participating radiology facility. In areas with capitated radiology arrangements, you should send members to the capitated site associated with their PCP.

Breast cancer
Our Breast Health Education Center (available to HMO, Aetna Health Network Only and Aetna Health Network Option plan members only) identifies members who have been newly diagnosed with breast cancer within the prior year and offers services to assist them in making informed choices regarding their treatment and recovery. Members can fill out a breast survey on their secure member website to be referred to the center. Members participating in the program may receive the following:
• Personalized nurse care coordination
• Education about breast cancer

For more information about the Breast Health Education Center, call 1-888-322-8742 from 8:00 a.m. to 4:30 p.m. ET.

BRCA: genetic testing for breast and ovarian cancer (all products)
Confidential molecular susceptibility testing for breast and/or ovarian cancer (BRCA testing) is covered for members who meet medical appropriateness criteria. All BRCA testing must be precertified.


We may also cover BRCA testing for non-Aetna members when the information is needed to adequately assess risk in the Aetna member and the non-member doesn’t have other coverage for this testing. Such coverage requires prior authorization and is subject to the terms of the subscriber’s benefits plan.

How to get BRCA testing approval for a member
In accordance with our Clinical Policy Bulletin #0227, all BRCA testing must be precertified. We have a national network of contracted providers that offer BRCA services. They also offer a support network of genetic counselors who are experts in inherited cancers. And they can help you select the right BRCA test. You’ll find these providers listed in our online directory at www.aetna.com.

To get approval for BRCA testing:
1. Complete our BRCA Precertification Information Request Form and fax it to us at 860-975-9126 for review and approval. You’ll find the form at www.aetna.com > Health Care Professionals > Resources for Health Care Professionals > Forms > Medical Precertification. A list of our contracted providers is on the form.
2. Fill out the contracted provider’s testing request form. To get the form, contact the contracted provider.

*Members with HMO-based plans in Alaska, Florida and Louisiana may require referrals for all radiology services provided in hospital-based radiology settings. In Texas only, mammography services (CPT codes 76890, 76891 and 76892) may be performed in an Ob/Gyn office without a referral or prior authorization and be reimbursed on a fee-for-service basis.

**Completion of an Aetna BRCA Precertification Information Request Form doesn’t guarantee payment. Payment of covered benefits is subject to the provider’s contract, the member’s eligibility on the dates of services rendered and specific provisions of the member’s health benefits plan.
3. If we approve testing, send our BRCA Precertification Information Request Form, the contracted provider’s testing request form and the member’s specimen to the contracted provider.

4. There is an “Other” category on our BRCA Precertification Information Request Form. This is for women who don’t meet any criteria listed, but for whom it’s been determined (through both independent formal genetic counseling and quantitative risk tool assessment) to have at least a 10 percent pre-test probability of carrying a BRCA1 or BRCA2 mutation. **For this category only**, fax a three-generation pedigree and formal genetic counseling and quantitative risk assessment results directly to us at 860-975-9126.

For more information, leave a message for us at 1-877-794-8720. We’ll call you back as soon as possible.

**Genetic counseling**

Face-to-face and telephonic genetic cancer counseling are available. These services are available without a referral from the member’s PCP.

For a list of our contracted genetic counseling providers, including our telephonic provider, InformedDNA, see our online provider directory. Just go to the “Health Care Professionals” section at www.aetna.com. Then click on “Online Provider Directory.”

For more information about genetic cancer counseling through InformedDNA, call 1-800-975-4819 or go to www.informeddna.com.

Individuals affiliated with IPAs must get approval through their IPA prior to using telephonic genetic counseling.

**Capitated lab services for women’s health services**

(HMO, Aetna Health Network Only plans and Aetna Health Network Option plans)

Refer your patients who are Aetna members to our network lab providers, such as Quest Diagnostics, for covered services.

If you do refer an Aetna member to an out-of-network lab, you must tell the member you’re doing so and document the out-of-network referral. The member must understand and accept the possibly higher costs.

Covered lab studies include, but aren’t limited to:

- Beta hCG
- Glucose screening
- Prenatal panel
- Serum analyte tests for aneuploidy screening in pregnancy (see Clinical Policy Bulletin #0464)
- Cell-free DNA testing (see Clinical Policy Bulletin #0464)
- Cytogenetic studies
- Cystic fibrosis carrier testing (see Clinical Policy Bulletin #0140)
- Basic infertility screening labs (see Clinical Policy Bulletin #0327)
- Sexually transmitted diseases (see Clinical Policy Bulletin #0433)
- Cervical cancer screening, cytology and HPV testing

You can access our Clinical Policy Bulletins on our public website at www.aetna.com. Or find them on our secure provider website at https://navinet.navimedix.com/.

**Contraception**

(HMO, Aetna Health Network Only plans and Aetna Health Network Option plans)

To determine coverage, call us at 1-800-624-0756.
**HPV DNA testing**

When not otherwise excluded by the member’s benefits plan, we cover primary HPV DNA screening in conjunction with either conventional Pap smears or liquid-based cytology for primary cervical cancer screening of women ages 30 and older.

ACOG recommends that women over age 30 who have both a normal Pap smear and no evidence of HPV infection be screened for cervical cancer no more frequently than every three years. Our clinical policy for cervical cancer screening coverage is consistent with these recommendations.

HPV testing is covered as a reflex or triage test that follows a Pap smear laboratory result of atypical squamous cells of undetermined significance in women of any age, including women less than 30 years of age. It may also be covered as a follow-up of abnormal histologic results, consistent with the guidelines of the American Society for Colposcopy and Cervical Pathology.

For more information, see Clinical Policy Bulletin #0443. You can access our Clinical Policy Bulletins on our public website at [www.aetna.com](http://www.aetna.com). Or find them on our secure provider website at [https://navinet.navimedix.com/](https://navinet.navimedix.com/).

More information on cervical cancer screening recommendations is available through the following websites:

- American Cancer Society [www.cancer.org](http://www.cancer.org)
- American Congress of Obstetricians and Gynecologists [www.acog.org](http://www.acog.org)
- American Society for Colposcopy and Cervical Pathology [www.asccp.org](http://www.asccp.org)

**HPV vaccine**

We consider a quadrivalent HPV (types 6, 11, 16, 18) recombinant vaccine for cervical cancer a medically necessary preventive service for girls and women from 9 to 26 years of age.

The vaccine is a series of 3 shots for women 13 to 26 years of age, if not previously vaccinated at 11 or 12 years of age.

For more information, see Clinical Policy Bulletin #0443. You can access our Clinical Policy Bulletins on our public website at [www.aetna.com](http://www.aetna.com). Or find them on our secure provider website at [https://navinet.navimedix.com/](https://navinet.navimedix.com/).

**Infertility program**

Our National Infertility Unit helps eligible members coordinate covered treatment-level infertility services and provides them with information and guidance. The program is staffed by registered nurses, licensed practical nurses and infertility coordinators with expertise in infertility.

To determine a member’s eligibility, call the phone number listed on the member’s Aetna ID card.

Members who wish to access infertility benefits offered under their plan should call us at 1-800-575-5999. We’re here from 8 a.m. to 5 p.m. ET (7 a.m. to 3 p.m. PT).

Coverage may vary due to state mandates requiring infertility coverage and optional infertility riders available to employer groups with over 500 members.

For more information, including the registration form, go to the “Individuals & Families” section on [www.aetna.com](http://www.aetna.com). Then under “Healthier Living Resources,” select “Women’s Health,” then click on “Learn more about infertility and its treatment.”

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*Inclusion of the organizations and websites above does not constitute an endorsement by Aetna of the organizations nor their websites, and Aetna has no responsibility for the accuracy or currency of the content of the websites.*
Beginning Right maternity program

The goal of the Beginning Right maternity program is to help members and providers in achieving a healthy term delivery. It provides educational materials, and eligible members receive case management throughout their pregnancies.

Member eligibility
The Beginning Right program is available to most pregnant HMO-based plan members. Members of other health benefits plans may be eligible to participate in the program, depending on the individual employer-sponsored plan. To determine if a member is eligible for the program, call the number listed on the member’s Aetna ID card.

Member enrollment
To begin the program enrollment process or to learn more about the program, call us at 1-800-272-3531. Members can also enroll via their secure member website. Once on the site, members should go to “Health Programs,” then “Maternity Program.”

Program content
We’ll provide members with educational materials throughout their pregnancy, including:

Welcome packet
Upon enrolling in the program, the member receives a welcome packet that includes information about:

- Normal pregnancies
- Prenatal care
- Dental health
- High-risk pregnancy conditions
- Post-delivery care
- Postpartum depression
- Newborn care

Second trimester educational mailing
Participants receive an educational mailing at 14 weeks’ gestation. This includes information about:

- Signs and symptoms of preterm labor
- High-risk pregnancy conditions

Third trimester educational mailing
During the eighth month of pregnancy, participants receive an educational packet that includes the following related to timing of delivery and postpartum concerns:

- Waiting for Baby educational video at www.aetna.com/individuals-families/womens-health/pregnancy-information-video.html
- Information on the need for a postpartum visit four to six weeks after delivery
- Brochure with helpful guidance for the mother and health tips for the baby
- Immunization schedule for healthy infants and children, based on guidelines from the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices
- Procedures for adding a newborn to the member’s health plan coverage

Pregnancy risk survey
To enroll in the program, members must first complete a pregnancy risk survey. This survey identifies risk factors that may complicate a member’s pregnancy and for which we provide additional services.

Members with certain high-risk factors are assigned a nurse case manager. The extent of time and involvement of the case manager depends on the risk factor and the chronicity of the problem.

Risk factors for which we provide case management include:

- Pregnancy-induced hypertension or chronic hypertension
- Type 1 or 2 diabetes or gestational diabetes
- Hyperemesis (during acute treatment phase only)
- Women at risk for preterm birth, including those with a prior preterm delivery, women in the extremes of reproductive age (less than 19 and greater than 40 years), and African American women
- Active preterm labor
- Multiple gestation
- Smoking
- History of postpartum depression or depression
- Others not listed
Case management of high-risk pregnancy activities

Nurses provide education and outreach focused on the identified high-risk factors. Activities may include:

- Collaboration with obstetric providers to coordinate care
- Review of signs and symptoms of preterm labor during each member contact
- Specialized education and medically indicated home care services, including:
  - Preterm labor education program
  - Smoke-Free Moms-to-Be smoking cessation program

Preterm labor education program

Pregnant members identified through the pregnancy risk survey as being at risk for preterm labor (or whose physician requests certain services), are offered enrollment in the preterm labor education program if their plan offers home health care benefits. The program provides educational instruction to help members identify preterm labor. Program components may include one or more of the following:

- Education about the signs and symptoms of preterm labor by trained obstetric nurses
- If available in her area, a home nurse visit to review the symptoms of preterm labor and teach how to palpate for contractions
- Continued care coordination by a Beginning Right program nurse case manager if preterm labor occurs

Beginning Right follow-up of members requiring 17 alpha-hydroxyprogesterone caproate (17P) for a previous preterm birth

Members who self-inject with 17P will be contacted weekly by a Beginning Right nurse case manager during the first month of treatment and monthly until delivery. All others are contacted the first week to verify start date and monthly until delivery.

African American preterm labor education program

African American women are 1.5 times as likely as non-Hispanic white women to experience a preterm delivery. For this reason, we developed a comprehensive preterm labor education and support program targeting pregnant African American members.

The primary goals of the program are to:

- Improve member and physician awareness of the increased risk of premature birth for African American women
- Implement member education programs that increase member knowledge of how and when to best access care and participate in treatment decisions

Program components offered to all self-identified African American pregnant members include:

- Educational information on preterm birth
- Telephone outreach at 24 weeks’ gestation by a clinician nurse to offer enrollment in the preterm labor education program
- A home nurse visit, if available in the member’s area, to review the signs and symptoms of premature labor and instructions on how to self-palpate for contractions
- Periodic calls from Beginning Right nurse case managers to review signs and symptoms of preterm labor

Smoke-Free Moms-to-Be smoking cessation program

If a pregnant member indicates on the pregnancy risk survey that she smokes, we’ll offer her the opportunity to participate in Smoke-Free Moms-to-Be, our nicotine-free smoking cessation program. This program includes:

- An educational brochure
- A cigarette substitute
- Contact with a Beginning Right nurse case manager throughout the pregnancy

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Pregnancy and postpartum depression screening

The Beginning Right maternity program, in collaboration with Aetna Behavioral Health, has developed a pregnancy and postpartum depression screening program.

This program aims to reduce the severity, duration and impact of depression during and after pregnancy. The program uses a depression screening tool to help identify members who may be at risk for depression.

The antenatal depression screening is included on all pregnancy risk surveys performed by telephone or during the first telephone contact with members who complete the pregnancy risk survey on their secure member website at www.aetna.com. The postpartum screening is conducted for all members who qualify for postpartum calls. The first postpartum outreach is completed three to five weeks post-delivery, and then again three to four months post-delivery.

Women who screen as positive for antenatal or postpartum depression are offered access to an appropriate Aetna Behavioral Health provider or referred to their obstetric care provider if they don’t have behavioral health benefits. Where applicable, access is provided to Aetna Behavioral Health med/psych case managers. Other behavioral health programs or providers are also available.

Diabetic case management for pregnant members

Beginning Right nurse case managers work with the obstetric care provider to coordinate arrangements for diabetic education and nutritional counseling, consult with a perinatologist or an endocrinologist for diabetes management, and generate any prior authorizations required by the member’s plan.

Other important notes

Accessing obstetric care
Members with a positive pregnancy test (either home urine pregnancy test or blood test) may access obstetric care directly, without written prior authorization from a PCP.

Though precertification of delivery isn’t required, we ask obstetric care providers to call the Beginning Right maternity program at 1-800-272-3531 to begin the program enrollment process. To be considered enrolled in the program, the member must complete the pregnancy risk survey. We encourage you to inform the member that she must call the Beginning Right maternity program or log in to her secure member website at www.aetna.com to take the survey and complete the enrollment process.
Enrollment in the program will enable all eligible members to receive:

• Educational materials in English or Spanish
• The opportunity to complete a pregnancy risk survey
• Nurse case management for members identified by the pregnancy risk survey to be at risk for certain medical conditions, such as preterm birth, chronic hypertension or gestational diabetes
• Access to our smoking cessation program

Members who enroll in the Beginning Right program prior to 16 weeks' gestation receive a gift.

Prenatal care access standards
Appointments for routine obstetric visits, as well as for urgent conditions, must be available to members within reasonable time frames.

We’ve adopted the following standards for prenatal care appointment availability:

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>First visit for obstetric care</td>
<td>Within 3 weeks in the first trimester; within 2 weeks in the second or third trimesters</td>
</tr>
<tr>
<td>Urgent visits</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Postpartum visit</td>
<td>4 – 6 weeks after delivery</td>
</tr>
</tbody>
</table>

While there may be times during which appointment availability may not meet these standards, an office must generally be able to maintain this degree of access. In group practices, the member should be offered the option of seeing another provider in the office if an individual physician can’t meet the above standards.

If, for any reason, your office won’t be able to offer this level of appointment availability (other than the emergency standard) for more than four consecutive weeks, call us at 1-800-624-0756 as soon as possible.

The Beginning Right maternity program is subject to change without notice. Certain features may not apply in all cases.

Not all programs are available to all members. Call the number listed on the member’s Aetna ID card to find out if a particular patient is eligible to participate in the Beginning Right maternity program.

Contact the Beginning Right maternity program at 1-800-272-3531 to:

• Register eligible members
• Access case management services
• Learn more about the program
Obstetric policies and reimbursement

Global obstetric fee
(HMO, Aetna Health Network Only plans and Aetna Health Network Option plans)

Our global obstetric fee for HMO-based plans includes:

• All outpatient prenatal care
• Services for common pregnancy- and non-pregnancy-related medical conditions performed in an obstetric office
• Routine postpartum visits through six weeks after delivery

Services reimbursed outside of the global obstetric fee include:

• Inpatient visits provided on the day before delivery and the three postpartum days for vaginal delivery and five postpartum days for cesarean delivery are considered part of the global obstetric fee and aren’t subject to payment on a fee-for-service basis.
• Amniocentesis, chorionic villus sampling and biophysical profiles are reimbursed on a fee-for-service basis.
• Office visits and ultrasounds performed by the obstetric care provider on members presumed to be pregnant (based on a previous pregnancy test), who are found not to be pregnant, are reimbursed on a fee-for-service basis. Submit a claim for the office visit using the correct ICD code for unconfirmed pregnancy.

Note: We don’t require prior authorization from the Beginning Right maternity program for a pregnant member’s routine laboratory studies if done at the capitated laboratory associated with the member’s PCP. Or if there’s no capitated laboratory, at any participating laboratory in the relevant network.

The national laboratories provide a full range of laboratory services, including cystic fibrosis screening, cytogenic studies and other genetic services.

Obstetric ultrasound enhancement program
(HMO, Aetna Health Network Only plans and Aetna Health Network Option plans in select areas)

Obstetric ultrasounds performed in an obstetric office aren’t reimbursed on a fee-for-service basis for HMO-based plans in areas where the obstetric ultrasound enhancement program is in place. Rather, physicians who participate in our limited or complete obstetric ultrasound enhancement program receive a fixed reimbursement amount added to the global obstetric fee for obstetric ultrasounds performed in an office.

For information about whether the obstetric ultrasound enhancement program (limited or complete) is in place in a specific area, call us at the phone number listed on the member’s Aetna ID card.

These programs apply to obstetric ultrasounds only. Physicians who choose not to participate in either ultrasound program must refer all obstetric ultrasounds to participating radiology centers, facilities or perinatologists for obstetric ultrasound services.

Limited obstetric ultrasound enhancement program
(HMO, Aetna Health Network Only plans and Aetna Health Network Option plans)

Obstetric care providers who participate in the limited obstetric ultrasound enhancement program perform all necessary limited (first, second or third trimester) ultrasounds in their offices and receive an enhancement to their global obstetric fee, regardless of the number of limited ultrasounds performed. These ultrasound CPT codes include:

• 76801
• 76802
• 76815
• 76816
• 76817

Note: Complex obstetric ultrasounds (CPT codes 76805, 76810, 76811 and 76812) aren’t included in this program. To be compensated for performing these “complete” scans, physicians can participate in the complete obstetric ultrasound enhancement program described in the next section. Physicians who elect not to participate in either ultrasound enhancement program should send members who need these scans to participating radiology centers, facilities or perinatologists. Referrals or prior authorizations aren’t necessary for anatomic or “complete” ultrasounds.

Note: Ultrasounds to measure nuchal translucency (CPT codes 76813 and 76814) aren’t included in this program. CPT codes 76813 and 76814 can be performed in the office on a fee-for-service basis by credentialed clinicians.

*Reimbursement for obstetric ultrasounds remains on a fee-for-service basis for members enrolled in indemnity and preferred provider organization (PPO)-based plans.
Complete obstetric ultrasound enhancement program
(HMO, Aetna Health Network Only plans and Aetna Health Network Option plans)

Obstetric care providers who participate in the complete obstetric ultrasound enhancement program perform all necessary obstetric ultrasounds in their offices and receive an enhancement to their global obstetric fee, regardless of the number of ultrasounds performed. These ultrasound CPT codes include:

- 76801
- 76802
- 76805
- 76810
- 76815
- 76816
- 76817

CPT codes 76811 and 76812 aren’t included in this program, but are included in the global obstetric fee.

If a physician participating in the complete obstetric ultrasound enhancement program needs a “targeted” or second-opinion ultrasound, he or she can send the patient directly to a participating radiology center, facility or perinatologist for these studies. Under this program, referrals or prior authorizations aren’t necessary for targeted or second-opinion ultrasounds.

Eligibility requirements for the complete obstetric ultrasound enhancement program

All physicians in a practice who provide obstetric care to our members must be included in the application process. To be eligible to participate in the complete obstetric ultrasound enhancement program, physicians must be credentialed by either the American College of Radiology or the American Institute of Ultrasound in Medicine Accreditation Program. Contact either organization directly for more information:

Accreditation Program
American College of Radiology
1891 Preston White Drive
Reston, VA 20191
1-800-770-0145
www.acr.org
ultrasound-accred@acr.org

Accreditation Department
American Institute of Ultrasound in Medicine
Ultrasound Accreditation Program
14750 Sweitzer Lane, Suite 100
Laurel, MD 20707-5901
1-800-638-5352
www.aium.org
accreditation@aium.org

Non-stress test (NST) enhancement program*
(HMO, Aetna Health Network Only plans and Aetna Health Network Option plans)

For HMO-based plans, in areas where the NST enhancement program is in place, NSTs performed in an obstetric office setting aren’t reimbursed fee-for-service. Rather, physicians who participate in this program receive a fixed reimbursement amount in addition to the global obstetric fee for NSTs performed in the office setting.

Physicians who choose not to participate in the NST enhancement program should direct members to a participating facility or perinatologist with the appropriate prior authorization.

In areas where the NST enhancement program isn’t in place, NSTs can be performed without prior authorization and are reimbursed on a fee-for-service basis.

To determine whether the NST enhancement program is in place where you are, call us at 1-800-624-0756.

*This program doesn’t apply to members enrolled in indemnity or PPO-based plans. Non-stress tests for members enrolled in indemnity or PPO-based plans generally are reimbursed on a fee-for-service basis, depending on the provider’s contract and applicable policies. Preauthorization for these tests may be necessary, depending on the member’s plan design. For details, please call the precertification listed number on the member’s Aetna ID card.
**Perinatology services**

On the next two pages, you’ll find some of the more frequently used services performed by a perinatologist. These services don’t require prior authorization. But they may require evidence of medical appropriateness as a condition of reimbursement.

A referral from the Ob/Gyn or PCP to the perinatologist is required for: Aetna SelectSM EPO plans, Elect Choice® plans, HMO plans, Managed Choice® POS, Quality Point-of-Service® plans. Referrals can be done through our secure provider website at [https://navinet.navimedix.com/](https://navinet.navimedix.com/).

### Procedure CPT codes

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT codes</th>
<th>ICD codes considered medically appropriate</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultations:</td>
<td>99241 – 99245</td>
<td>640.00 – 676.94, V23 – V23.9, V28.3, V28.4</td>
<td></td>
</tr>
<tr>
<td>Office visits:</td>
<td>99201 – 99205 and 99211 – 99215</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine fetal ultrasounds:</td>
<td>76801, 76802, 76805, 76810, 76815, 76816, 76817, NT76813 and NT76814</td>
<td>See Clinical Policy Bulletin #0199 for ICD codes</td>
<td>One detailed fetal ultrasound (CPT code 76811) per member, per pregnancy, per practice is covered. Any follow-up of 76811 should be billed with another CPT code.</td>
</tr>
<tr>
<td>Detailed fetal ultrasounds:</td>
<td>76811, 76812</td>
<td>See Clinical Policy Bulletin #0199 for ICD codes</td>
<td></td>
</tr>
<tr>
<td>Genetic counseling:</td>
<td>99243</td>
<td>640.00 – 676.94, V22.0 – V23.9, V28.3, V28.4</td>
<td></td>
</tr>
<tr>
<td>Nuchal translucency testing:</td>
<td>• 76813: Nuchal translucency testing</td>
<td>See Clinical Policy Bulletins #0199 and #0464 for ICD codes</td>
<td>ACOG recommends the following for NT screening:</td>
</tr>
<tr>
<td></td>
<td>• 76814: Nuchal translucency testing each additional gestation</td>
<td></td>
<td>1. Appropriate ultrasound training and ongoing quality monitoring programs are in place.</td>
</tr>
<tr>
<td></td>
<td>• 84704: hCG free Beta</td>
<td></td>
<td>2. Sufficient information and resources are available to provide comprehensive counseling to women regarding the different screening options and limitations of these tests.</td>
</tr>
<tr>
<td></td>
<td>• 84163: PAPP A</td>
<td></td>
<td>3. Access to an appropriate diagnostic test is available where screening test results are positive.</td>
</tr>
<tr>
<td></td>
<td>• 82105: AFP</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 84702: hCG quantitative</td>
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<td></td>
</tr>
<tr>
<td>Cell-free DNA testing:</td>
<td>81420</td>
<td>See Clinical Policy Bulletin #0464 for ICD codes</td>
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<tr>
<td>Amniocentesis:</td>
<td>59000</td>
<td>640.00 – 676.94, V22.0 – V23.9, V28.3, V28.4</td>
<td>Amniocentesis based on patient demand is covered.</td>
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<tr>
<td>Ultrasound guidance for amniocentesis:</td>
<td>76946</td>
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<td></td>
</tr>
<tr>
<td>Procedure CPT codes</td>
<td>ICD codes considered medically appropriate</td>
<td>Comments</td>
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<tr>
<td>----------------------------------------------------------</td>
<td>--------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
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<td>Chorionic villi sampling (CVS): 59015</td>
<td>640.00 – 676.94, V22.0 – V23.9, V28.3, V28.4</td>
<td>CVS based on patient demand is covered.</td>
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<td>CVS with ultrasound guidance: 76945</td>
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<tr>
<td>Nt: 59025</td>
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<td>Biophysical profile (BPP): 76818</td>
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<td>BPP without Nt: 76819</td>
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<tr>
<td>Fetal echocardiograms: 76825, 76826, 76827, 76828, 93325</td>
<td>See Clinical Policy Bulletin #0106 for ICD codes</td>
<td>Services must meet medical appropriateness edits described in Clinical Policy Bulletin #0106.</td>
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<td>Fetal umbilical artery Doppler: 76820</td>
<td>See Clinical Policy Bulletin #0106 for ICD codes</td>
<td>Services must meet medical appropriateness edits described in Clinical Policy Bulletin #0106.</td>
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<td>Middle cerebral artery Doppler: 76821</td>
<td>See Clinical Policy Bulletin #0106 for ICD codes</td>
<td>Services must meet medical appropriateness edits described in Clinical Policy Bulletin #0106.</td>
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<td>Percutaneous umbilical blood sampling (PUBS): 59012</td>
<td>640.00 – 676.94, V22.0 – V23.9, V28.3, V28.4</td>
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</tr>
<tr>
<td>Fetal transfusion: 36460</td>
<td>640.00 – 676.94, V22.0 – V23.9, V28.3, V28.4</td>
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<td>External cephalic version: 59412</td>
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<td></td>
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<tr>
<td>Multiple births (vaginal)</td>
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<tr>
<td>Multiple births (cesarean)</td>
<td></td>
<td></td>
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</tbody>
</table>
Reproductive genetic counseling

For a list of our contracted genetic counseling providers, including our telephonic provider, InformedDNA, see our online provider directory. Just go to the “Health Care Professionals” section at www.aetna.com. Then click on “Online Provider Directory.”

Rh immune globulin policy

Antenatal Rh immune globulin is available to Rh negative members by having blood drawn:

• In the PCP’s office and sent to a participating contracted or capitated laboratory. The obstetric care provider may then provide and administer Rh immune globulin either before or after the results of the lab test come back, as determined by the physician.

• In the obstetric care provider’s office and sent to a participating contracted or capitated laboratory. The RhoGAM can be obtained through our specialty pharmacy network. Just visit www.aetnaspecialtypharmacy.com. The Rh immune globulin can be administered by the obstetric care provider or PCP.

• At the hospital laboratory. The Rh immune globulin may be administered in the outpatient department of the hospital. No referral is needed for either the lab work or the Rh immune globulin administration at the hospital.

Flu vaccination

The CDC recommends that healthy pregnant women who are in their second or third trimester during the flu season receive the flu vaccine. Also, women at any stage of pregnancy with certain chronic medical conditions, such as asthma, diabetes mellitus or heart disease, should receive the vaccination. This vaccine is covered when administered to a pregnant woman. Physicians are reimbursed separately for this immunization. For additional information about the flu vaccine, visit www.cdc.gov.

Postpartum visit

ACOG recommends that women visit their obstetric care provider approximately four to six weeks after delivery. The visit should include:

• An interval history and physical exam to evaluate the patient’s current status, as well as her adaptation to the newborn

• Specific questions regarding breastfeeding

• An evaluation of weight, blood pressure, breasts and abdomen

• A pelvic examination and Pap smear, if appropriate

• Conception counseling and management

Payment for the postpartum visit is included in the global obstetric reimbursement fee.

Non-emergency, non-obstetric medical care

If a member has a non-emergency, non-obstetric medical need (for example, rashes, pneumonia, etc.), she should be directed either to her PCP (in plans that require the member to select a PCP) or to the appropriate participating physician (in other plans) for care and management. These services are not reimbursed on a fee-for-service basis to the member’s obstetric care provider. Rather, the obstetric care provider should notify the PCP or appropriate participating physician of the member’s medical problem and discuss any obstetric implications involved with the treatment of this problem. The PCP/physician will then determine if any further referrals to specialists are necessary.

In some areas, the obstetric care provider may function as the member’s PCP and may refer the member to any participating provider for any covered, medically necessary services. To find out the details in your specific area, call us at 1-800-624-0756.

Spontaneous abortions

An Ob/Gyn who provides care for a member with an incomplete, missed or completed spontaneous abortion (CPT codes 59812, 59820, 59821 and 59830) may be reimbursed for the office visit, as well as for related procedures, regardless of whether the member is formally enrolled for obstetric care with the provider. This acute care isn’t included in the global obstetric fee.

If a pregnancy results in a spontaneous abortion, the surgical procedure, necessary ultrasounds and prenatal care are paid at the Aetna Market Fee Schedule rate — regardless of whether or not there is a referral on file. All non-elective abortions are covered, unless specifically excluded under the member’s plan.

You should use office visit E&M codes when billing for these services, as well as the ICD code indicating a spontaneous abortion. Any ultrasounds done during the pregnancy that would otherwise have been included in the global obstetric fee should be billed with the ICD code indicating a spontaneous abortion.

The global fee for maternity care doesn’t apply when there’s a pregnancy loss prior to 20 weeks. If a member enrolled as an obstetric patient in the obstetric care provider’s practice loses her pregnancy spontaneously, she is responsible for only the single copayment to her obstetric care provider paid at the first obstetric visit. Although we adjust payment to a per-date-of-service payment of Aetna Market Fee Schedule rates, only a single member copayment is applied.

Instructions for billing portions of prenatal care and delivery

Physicians who provide total prenatal care and delivery should bill CPT code 59400 for a vaginal delivery, 59514 for a cesarean delivery, and 59610 for a vaginal birth after cesarean delivery. Physicians who provide some, but not all, of the prenatal care and delivery should bill for the portion of prenatal care according to the following CPT instructions:

- 59425: four to six prenatal visits
- 59426: seven or more visits
- Use standard E&M codes for fewer than four prenatal visits
  - 59409: vaginal delivery only
  - 59410: vaginal delivery and postpartum care
  - 59514: cesarean delivery only
- 59515: cesarean delivery and postpartum care
- 59614: vaginal birth after cesarean delivery and postpartum care
- 59612: vaginal birth after cesarean delivery only

High-risk pregnancy management enhancement

We pay an additional fee to the obstetric care provider for managing a high-risk pregnancy. This additional high-risk pregnancy management fee applies to all products when the following is true:

- The member is enrolled in the Beginning Right maternity program, if available.
- Risk Factors are identified.
- There’s an increase in the intensity and/or frequency of care throughout the pregnancy.
- Modifier 22 is added to the global obstetric fee claim.

When the obstetric care provider’s bill is submitted for global maternity care reimbursement, the request for enhanced reimbursement must include clinical documentation of the additional care provided during the pregnancy. This should include the obstetric care provider’s clinical summary and prenatal flow sheet, as appropriate.

Examples of diagnoses that qualify for the high-risk enhancement include, but aren’t limited to:

- Insulin-dependent diabetes
- Chronic hypertension on anti-hypertensive medication
- Premature labor, managed throughout pregnancy
- Chronic medical conditions that require weekly evaluation for uteroplacental insufficiency
- Obstetric or medical conditions requiring prolonged or repeated hospitalizations

Cell-free fetal nucleic acid screening

Cell-free fetal nucleic acid screening is covered for women at high risk for genetic chromosomal abnormalities in the fetus. High-risk conditions include maternal age greater than 35 at delivery, prior pregnancy with a chromosomal abnormality, abnormal fetal ultrasound or laboratory screening tests suggesting a chromosomal abnormality. (See Clinical Policy Bulletin #0464.)
First and second trimester non-invasive screening to provide individual risk assessment for fetal aneuploidy

The following screenings for fetal aneuploidy are covered medical services for all pregnant women. (See Clinical Policy Bulletin #0282.)

- First trimester nuchal translucency (NT) measurement results combined with the results of first trimester serum analyte tests that include pregnancy-associated plasma protein A (PAPP-A) plus beta-human chorionic gonadotropin (hCG) or
- Integrated, sequential or contingent screening: first trimester results (NT, PAPP-A and hCG) plus second trimester quad (maternal serum alpha-fetoprotein [MSAFP], unconjugated estriol, inhibin A and hCG) screening or
- First trimester NT testing alone (without serum analyte screening) for multiple gestations or
- Serum-integrated screening for pregnancies where NT measurement isn’t available or can’t be obtained: first-trimester (PAPP-A plus hCG) plus second trimester quad (MSAFP, unconjugated estriol, inhibin A and hCG) screening or
- Second trimester serum analyte screening (see Clinical Policy Bulletin #0464)

Preauthorization isn’t required for NT testing or the laboratory studies.

Credentialing requirements for fetal aneuploidy screening involving nuchal translucency measurement

To help ensure the accuracy of the NT screening, the ultrasonographer performing the NT measurement and the sonologist interpreting the NT measurement must be credentialed. The credentialing process in the United States is the Nuchal Translucency Quality Review Program (NTQR). NT credentialing has been promoted by numerous professional societies, including ACOG, the Society for Maternal-Fetal Medicine and the March of Dimes.

Note that a large number of genetics laboratories, including two Aetna-participating laboratories, Genzyme Genetics and Quest Diagnostics, require evidence of credentialing of NT measurements to combine NT measurement and serum analyte values and report results for Aetna members. More information about the NTQR process and online registration can be found at www.ntqr.org.

You can also access our Clinical Policy Bulletins on our secure provider website at https://navinet.navimedix.com/.
Other services covered for individual risk assessment for fetal aneuploidy

- Amniocentesis or CVS regardless of maternal age. (See Clinical Policy Bulletin #0358.)
- Quad screening (maternal age plus alpha fetoprotein, estriol, total beta-hCG and dimeric inhibin A) in the second trimester for women of any age who don’t undergo first trimester testing. (See Clinical Policy Bulletin #0464.)

You can access our Clinical Policy Bulletins on our public website at www.aetna.com. Or find them on our secure provider website at https://navinet.navimedix.com/.

Screening schemes that aren’t covered include:
- First trimester serum testing without NT testing
- NT testing without serum testing
- Cell-free DNA testing in women at low risk of fetal aneuploidy

Intramuscular progesterone therapy

Pregnant women who experienced a previous spontaneous preterm birth may be appropriate for intramuscular progesterone therapy (17 alpha-hydroxyprogesterone caproate, or 17P) in subsequent pregnancies. Weekly intramuscular administration of 250 mg of 17P from 15 through 20 completed weeks’ gestation and continued through 36 completed weeks of pregnancy has been shown to decrease the recurrent spontaneous preterm birth rate by up to 33 percent.\(^3\,4\)

Criteria for intramuscular progesterone therapy

- Previous spontaneous preterm birth at less than 37 weeks, including premature rupture of the membranes or "PROM"
- Gestational age at initiation of therapy is less than 23 weeks’ completed gestation
- Currently pregnant with a singleton pregnancy

Intramuscular progesterone therapy is not an appropriate treatment for:

- Previous preterm birth due to a medical complication or so-called “indicated preterm delivery” (for example, PIH, diabetes, placenta previa)
- Gestational age at initiation of therapy is greater than 23 weeks’ gestation
- Member is in active preterm labor and 17P is being used as a tocolytic
- Member is pregnant with twins
- Member with cerclage in place

Process to get intramuscular progesterone

The drug 17P is a compounded drug and available only through specialty pharmacies.

Optional covered services to support members requiring 17P

- Perinatology consult
- Home nurse visit for instruction in self-administration of an intramuscular injection
- Preterm labor education program

Home births

Aetna considers planned deliveries at home and associated services not medically appropriate. (See Clinical Policy Bulletin #0329.)

Note: Provision of home births will be considered if mandated by state law.

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\(^4\) American Congress of Obstetricians and Gynecologists.
Frequently asked questions

1. Can I be reimbursed for gynecological ultrasounds performed during a routine gynecological visit without obtaining a referral?
   Yes. Gynecological ultrasounds (CPT codes 76830, 76831, 76856 and 76857) are paid fee-for-service.

2. Does Aetna cover the HPV vaccine?
   Yes. Aetna covers the HPV vaccine for covered female members from 9 to 26 years of age. (See Clinical Policy Bulletin #0726.)

3. Does Aetna have a support program for female members diagnosed with breast cancer?
   Aetna's Breast Health Education Center is available for members newly diagnosed with breast cancer who are in an HMO, Aetna Health Network Only or Aetna Health Network Option plan.

4. Does Aetna cover BRCA genetic testing?
   Yes. Aetna covers BRCA genetic testing for members who meet one or more of the clinical criteria described in Clinical Policy Bulletin #0227. To learn more about our BRCA Genetic Testing Program, call 1-877-794-8720.

5. How can I obtain approval for BRCA genetic testing?
   To get a copy of Aetna’s BRCA Precertification Information Request Form, go to www.aetna.com.
   You can also call us at 1-800-624-0756 for more details.

6. Does Aetna cover genetic counseling?
   Yes. Aetna covers genetic counseling for members with medical indications that support it. Face-to-face or telephonic counseling is available. See our online provider directory at www.docfind.com for locations.

7. How can I find out what infertility benefits an Aetna member has?
   Call the number listed on the member’s Aetna ID card. We can also tell you if the member has a specific provider network.

8. How can an Aetna member access her infertility benefits?
   Most Aetna plans require precertification for infertility treatment level care. Once you have a plan for infertility treatment using injectable medication, artificial insemination or assisted reproductive technology procedures, use our Infertility Program Patient Registration Form to register with our National Infertility Unit. You’ll find the form at www.aetnainfertilitycare.com.
   Once you’ve completed the form, you or the member can fax it to us at 860-607-7476. We’ll review the form and let the infertility specialist know if the member meets the initial criteria to start using their infertility treatment benefits. For more information, you or the member can call us at 1-800-575-5999. Except for Thursdays, we’re here 8 a.m. to 5 p.m. ET (7 a.m. to 3 p.m. PT), Monday through Friday. On Thursdays, we close at 4 p.m. on the East coast only.

9. Because Aetna no longer requires pregnancy precertification, is it necessary to notify Aetna of a member’s pregnancy?
   No. But we do ask that you call the Beginning Right maternity program at 1-800-272-3531 to begin the program enrollment process. The member must complete the pregnancy risk survey to be considered for the program. We encourage you to inform the member that she must call the Beginning Right maternity program at 1-800-272-3531 or log in to her secure member website at www.aetna.com to complete the program enrollment process.
   Enrollment in the program provides all eligible members with:
   • Educational mailings
   • Our pregnancy risk survey
   • Nurse case management for members with selected medical problems who are classified as high risk
   • Free gift when member enrolls by completing the pregnancy risk survey by 16 weeks of pregnancy
10. How will I be reimbursed if an Aetna member miscarries after the first prenatal visit?
To be reimbursed for the visit and for any ultrasounds performed, submit the appropriate E&M and ultrasound codes with the diagnosis indicating spontaneous abortion (634.90).

11. Will I be reimbursed, in addition to the global obstetric fee, when I visit an Aetna member during an antepartum inpatient stay?
Yes. You’ll be reimbursed fee-for-service for each visit (CPT codes 99217 through 99239) you make to a member during an antepartum inpatient stay when billed with diagnosis codes V22 – V22.2, V27 – V39.2 and 640 – 677.

12. Will I be reimbursed for prenatal lab work performed in the office?
Yes. Lab studies (CPT codes 85013, 85018, 82947, 82948 and 82962) performed in the obstetric office setting on pregnant members will be reimbursed outside of the global obstetric fee when billed with diagnosis codes V22 – V22.2, V27 – V39.2 and 640 – 677.

For other lab work, use our network of participating labs. You’ll find these providers in our online directory at www.aetna.com. Or refer to this list: www.aetna.com/docfind/cms/assets/pdf/DocFind_PDF_Lab_List9_10.pdf.

13. Do I have to call the Beginning Right maternity program to get a referral for an ultrasound or non-stress test performed in the office?
In areas where the obstetric ultrasound enhancement program and/or the NST enhancement program are in place, you won’t be reimbursed for performing an ultrasound or NST in the office.

If you participate in these programs, you’ll receive an additional reimbursement to the global obstetric fee. If you don’t participate in these programs, you won’t be reimbursed for these studies if you perform them in your office.

To enroll in the obstetric ultrasound enhancement program and/or the NST enhancement program, call us at 1-800-624-0756.

14. Do I need to contact the Beginning Right maternity program to obtain a referral to send a member to a perinatologist?
No. When sending a member to a perinatologist for a consultation, referrals are required only for our Elect Choice, Select Choice HMO and QPOS plans. The following procedures performed by a perinatologist or hospital radiologist don’t need an additional referral from the Beginning Right maternity program:

• Obstetric ultrasounds (CPT codes 76801 through 76817)
• Fetal echocardiograms (CPT codes 76825 through 76828 and 93325)
• Fetal umbilical Doppler (CPT codes 76827, 76828)
• Middle cerebral artery Doppler (CPT codes 93875, 93886)

15. If I administer a RhoGAM injection, will I be reimbursed for the cost of the RhoGAM?
Yes. You must submit a CMS-1500 form for reimbursement or submit your bill electronically.

16. Will I be reimbursed for the cost of administering the RhoGAM injection?
Yes.

17. Can I submit a claim for extra payment above the global obstetric fee if I manage an Aetna member with a high-risk pregnancy?
Yes. Add modifier 22 to your global fee claim, along with documentation, such as office notes, that support an increased frequency or intensity of care.

18. Does the Beginning Right maternity program provide any services or educational materials for a member diagnosed with preterm labor?
Yes. Members with current preterm labor or a history of preterm labor or delivery will be categorized as high risk and followed throughout the pregnancy by a nurse case manager. We also offer our preterm labor education program, and members with a previous preterm birth may be eligible for intramuscular progesterone therapy.

For more information about the preterm labor education program or intramuscular progesterone therapy, call the Beginning Right program at 1-800-272-3531.
19. What educational materials does the Beginning Right maternity program provide to members?

Program participants receive educational mailings during their pregnancy. The welcome packet contains a brochure on pregnancy, fetal development and labor and delivery. The second mailing (at 14 weeks’ gestation) includes information on signs and symptoms of preterm labor. The third mailing (at 32 weeks’ gestation) includes information on delivery options, timing of delivery and the importance of testing for gestational diabetes. It also includes information on postpartum concerns, breastfeeding, newborn care, immunizations and a reminder to make an appointment for the postpartum visit. Members identified as at-risk or high-risk will receive two additional mailings at 3 – 5 weeks post-delivery and 3 – 4 months post-delivery.
## Other online resources

### Member resources *

<table>
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<tr>
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<th>Website</th>
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<tbody>
<tr>
<td>Aetna secure member website</td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
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<tr>
<td>American Academy of Pediatrics</td>
<td><a href="http://www.aap.org">www.aap.org</a></td>
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<tr>
<td>American Cancer Society</td>
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<td>American Congress of Obstetricians and Gynecologists (ACOG)</td>
<td><a href="http://www.acog.org">www.acog.org</a></td>
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<tr>
<td>American Diabetes Association</td>
<td><a href="http://www.diabetes.org">www.diabetes.org</a></td>
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<tr>
<td>American Heart Association</td>
<td><a href="http://www.heart.org">www.heart.org</a></td>
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<td>American Lung Association</td>
<td><a href="http://www.lung.org">www.lung.org</a></td>
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<tr>
<td>American Medical Association</td>
<td><a href="http://www.ama-assn.org">www.ama-assn.org</a></td>
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<tr>
<td>American Sexual Health Association</td>
<td><a href="http://www.ashastd.org">www.ashastd.org</a></td>
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<tr>
<td>Centers for Disease Control and Prevention (CDC)</td>
<td><a href="http://www.cdc.gov">www.cdc.gov</a></td>
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<tr>
<td>DocFind® online directory</td>
<td><a href="http://www.aetna.com/docfind">www.aetna.com/docfind</a></td>
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<tr>
<td>Healthwise® Knowledgebase</td>
<td><a href="http://www.healthwise.net/aetna">www.healthwise.net/aetna</a></td>
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<tr>
<td>iTriage® health care app</td>
<td><a href="http://www.itriagehealth.com">www.itriagehealth.com</a></td>
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<tr>
<td>La Leche League International</td>
<td><a href="http://www.lalecheleague.org">www.lalecheleague.org</a></td>
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<td>Men Stopping Violence</td>
<td><a href="http://www.menstoppingviolence.org">www.menstoppingviolence.org</a></td>
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<tr>
<td>National Committee for Quality Assurance (NCQA)</td>
<td><a href="http://www.ncqa.org">www.ncqa.org</a></td>
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<tr>
<td>National Domestic Violence Hotline, 1-800-799-SAFE (7233)</td>
<td><a href="http://www.ndvh.org">www.ndvh.org</a></td>
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<tr>
<td>National Heart, Lung, and Blood Institute (NHLBI)</td>
<td><a href="http://www.nhlbi.nih.gov">www.nhlbi.nih.gov</a></td>
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<tr>
<td>National Network to End Domestic Violence</td>
<td><a href="http://www.nnedv.org">www.nnedv.org</a></td>
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<tr>
<td>National Ovarian Cancer Coalition</td>
<td><a href="http://www.ovarian.org">www.ovarian.org</a></td>
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<tr>
<td>North American Menopause Society</td>
<td><a href="http://www.menopause.org">www.menopause.org</a></td>
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*Inclusion in this list does not constitute or imply endorsement by Aetna of any products or services described on these sites, or of any other material contained therein or information obtained by calling the telephone numbers provided on the websites.*
Individual coverage may vary in some states. In addition, certain self-funded plan sponsors may have non-standard benefits. To confirm a member’s eligibility for any specific benefits under an Aetna plan, call the toll-free Member Services telephone number on the member’s Aetna ID card.

Certain primary care providers are affiliated with integrated delivery systems or other provider groups (such as independent practice associations and physician-hospital organizations), and members who select these providers will generally be referred to specialists and hospitals within those systems or groups. However, if a system or group does not include a provider qualified to meet a member’s medical needs, members may request to have services provided by non-system or non-group providers. Member requests will be reviewed and require prior authorization from the system or group and/or Aetna to be a covered benefit.

Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to www.aetna.com.