Welcome to your go-to guide.

Everything you need to know about our women's health programs and policies.

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It’s all here.

We know it’s a lot of information — but it’s important.

This guide will help you understand our women’s health programs and policies. So you can support your patients through all of life’s stages.

And we’ll be right there with you.

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Everything you're looking for, right here.

We've got your back.

We know that women's health programs are an important part of the care you provide your patients.

You're there to help them through each step, no matter what life brings. And we're here to support you as you do it.

That's why we offer programs with a holistic approach. These programs consider multiple conditions and diseases across all benefit plans. That way, we can deliver individual programs based on your patients' unique needs and preferences.

This guide gives you all the information about 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)
- A physician medical group
- An integrated delivery system or other provider group

But it's easy to determine eligibility. Just call us at the phone number on the member's Aetna ID card.

We let you know about changes in policy through:

- Our Aetna OfficeLink Updates™ newsletter
- Our public website at **aetna.com**
- Our provider website on NaviNet® at **https://navinet.navimedix.com**.

Before you get started

Here is some information you'll want to keep handy.

- **Patient advocacy** — You're an advocate on behalf of your Aetna patients. The "Member Rights and Responsibilities" section of our Office Manual for Health Care Professionals covers what you need to know. You'll find it at **https://navinet.navimedix.com**.
- **Informed consent** — As a physician, you're responsible for providing your patients with all the information relevant to their condition. This includes all health care alternatives, even if an option isn't covered by their plan, along with the potential risks and benefits of each.
- **Patient emergencies** — If our members need emergency care, they're covered 24 hours day, 7 days a week, anywhere in the world.
- **Providing medical information** — You're responsible for giving us the complete, accurate information we need to make appropriate coverage determinations for your patients. That includes the diagnosis, clinical information and services provided.
- **Independent contracting** — As indicated in our provider agreements, if you're a participating provider, you are not an employee or agent of any Aetna affiliate.
- **Information about coverage** — We want to make it easy for you to know what's covered. If you're unsure whether a member's plan covers a service, you can contact us using:
  - Our provider website at **https://navinet.navimedix.com**
  - Our dedicated Provider Service Centers — for health maintenance organization (HMO)-based and Medicare plans, **1-800-624-0756**; for all other plans, **1-888-MDAetna (1-888-632-3862)**
- **Appeals** — You may appeal adverse benefits determinations and provider reimbursement decisions. And 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 "Providers" section at **aetna.com**. Click "Working with us," then "Dispute & appeals process."

Key phone numbers

- Aetna Maternity Program
  1-800-272-3531
- Infertility precertification unit
  1-800-575-5999
- Breast Health Education Center
  1-888-322-8742
- BRCA genetic testing program
  1-877-794-8720
- Provider Services
  - HMO-based and Medicare plans: **1-800-624-0756**
  - All other plans: **1-888-MD-Aetna (1-888-632-3862)**

Helpful online resources

- **Women's health information** — Go to **aetna.com** and search for "Women's Health." You'll find resources addressing the specific health needs of women and details on our 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
- **Important provider information** — Use our provider website at **https://navinet.navimedix.com**. Or access the site at **aetna.com**. Select "Providers," then click the "Aetna provider website" link on the right.

  Just register or log in to search for physicians, hospitals and other health care professionals. Here, you'll find:
  - 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
  - Information on automatic studies
  - The Office Manual for Health Care Professionals

  You can also update your office profile on our provider website.

- **Clinical Policy Bulletins** — Go to **aetna.com**.
- **Preventive services guidelines** — Go to our provider website at **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 "Providers" section at **aetna.com**. Then under "Products & programs" click on "Pharmacy services." Here you'll find information on:
  - Aetna Specialty Pharmacy® medicine and support services including medication ordering, shipping and delivery
  - Our formulary
  - Pharmacy Clinical Policy Bulletins
- **Aetna BRCA Precertification Information Request Form** — There are two ways to get the form:
  - Visit the "Providers" section at **aetna.com**. Then under "Resources & reports" select "Forms," then "Medical Precertification."
  - Call us at **1-800-624-0756**.

We're here to help — online or by phone.

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 PCP perform her annual primary health care exam.

The Ob/Gyn should tell 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. Call us at **1-800-624-0756** to learn more.

Billing

Bill annual gynecologic primary and preventive visits using the E&M codes for preventive visits (99384 – 99387 and 99394 – 99397).

Code all other visits using standard E&M codes.

Please collect the appropriate copayment from the member for these services. See the member's 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. These are reimbursed on a fee-for-service basis.

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

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

To find capitated radiology centers in the area, members can 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 pay 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 critical to the evaluation of the problem that led to the referral to the specialist.

Note that payment isn't guaranteed for studies on the automatic studies list. We'll use our standard processing guidelines to determine payment.

To see a list of automatic studies for Ob/Gyns, go to **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

We cover HPV DNA screening 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 College of Obstetricians and Gynecologists (ACOG) (2014).

HPV DNA testing in women younger than age 30 isn't a covered benefit for primary cervical cancer screening. This policy is also consistent with ACOG guidelines (2014).

For more information, refer to Clinical Policy Bulletin #0443. See our Clinical Policy Bulletins at **aetna.com**. Or find them on our provider website at **https://navinet.navimedix.com**.

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 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 you to be reimbursed properly, 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 Nurse (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 help them make informed choices about their treatment and recovery. Members can fill out a breast survey on their member website to be referred to the center. Members participating in the program may get:

- Personalized nurse care coordination
- Education about breast cancer

For more information about the Breast Health Education Nurse, 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.

For more information, refer to Clinical Policy Bulletin #0227. Access our Clinical Policy Bulletins on our public website at **aetna.com**. Or find them on our provider website at **https://navinet.navimedix.com**.

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
According to 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 **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 **aetna.com** > Providers > Resources & reports > 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 provider.

Some clarifying details.

*Members with HMO-based plans in Alaska, Florida and Louisiana may require referrals for all radiology services provided in hospital-based radiology settings. Mammography services (CPT codes 77061, 77062, 77063, 77065, 77066, 77067) 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 have been determined (through both independent formal genetic counseling and quantitative risk tool assessment) to have at least a 10 percent pretest 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, just call us at **1-877-794-8720**. You'll be asked to leave a message but rest assured, we will get right back to you.

Genetic counseling

Genetic cancer counseling is available face-to-face and by phone. 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 "Providers" section at **aetna.com**. Then under "Helpful links," click "Online provider directory." If you want InformedDNA, type the word "Genetics" into the Search box. Enter a city or ZIP code. Click "Enter." The first listing will be "Genetic Conditions." Click on it.

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

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

Contraception

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

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

Capitated lab services for women's health services

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

Refer Aetna members to our network lab providers, like Quest Diagnostics, for covered services.

If you refer an Aetna member to an out-of-network lab, you must tell them you're doing so and document the out-of-network referral. They 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 see our Clinical Policy Bulletins on our public website at **aetna.com**. Or find them on our provider website at **https://navinet.navimedix.com**.

HPV DNA testing

Routine cervical cancer screening isn't recommended until after age 21. When not otherwise excluded by the member's benefits plan, we cover primary HPV DNA screening 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 or 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 younger than 30 years of age. It may also be covered as a follow-up when there are 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 see our Clinical Policy Bulletins at **aetna.com**. Or find them on our provider website at **https://navinet.navimedix.com**.

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

- American Cancer Society
  cancer.org
- American College of Obstetricians and Gynecologists
  acog.org
- American Society for Colposcopy and Cervical Pathology
  asccp.org

HPV vaccine

The HPV vaccine should be given to both girls and boys. It should be first administered at age 11 or 12, but can be given as early as age 9 up through age 26. If the vaccination series is started before the fifteenth birthday, then only two doses are recommended. If started on or after the fifteenth birthday, then three doses are recommended.

For more information, see Clinical Policy Bulletin #0443. You can access our Clinical Policy Bulletins on our public website at **aetna.com**. Or find them on our provider website at **https://navinet.navimedix.com**.

National Infertility Unit

Our National Infertility Unit helps eligible members coordinate covered treatment-level infertility and infertility-related genetic testing (preimplantation genetic testing) 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 if a member is eligible, call the phone number listed on the member's 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, search for and click on "women's health" on **aetna.com**. Then click "Learn more about infertility and its treatment."

***Inclusion of these organizations and websites 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.

Aetna Maternity Program

The goal of the Aetna Maternity Program is to help your patients achieve a healthy term delivery. It provides educational materials, and eligible members receive case management throughout their pregnancies.

Member eligibility

The Aetna Maternity 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 see if a member is eligible for the program, call the number listed on the member's Aetna card.

Member enrollment

To begin the program enrollment process or learn more about the program, give us a call at **1-800-272-3531**. Members can also enroll via their member website.

Program content

We'll provide members with educational materials throughout their pregnancy, including:

Welcome packet

After enrolling in the program, members get a welcome packet that includes information about:

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

Second trimester educational mailing

Members get 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 their eighth month, members get an educational packet. It includes information about the timing of delivery and postpartum concerns:

- Waiting for Baby educational video at **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

We have special services to support moms-to-be.

Pregnancy survey

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

We assign a nurse case manager to members with certain high-risk factors. The amount of time and involvement of the case manager depends on the risk factor and the chronicity of the problem.

We provide case management for these risk factors, as well as others not listed here:

- 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 (younger than 19 and older than 35 years) and African American women
- Active preterm labor
- Multiple gestation
- Smoking
- Current depression or anxiety and/or history of postpartum depression

Case management of high-risk-pregnancy activities

Nurses provide education and outreach focused on the high-risk factors we identify. These 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

Women who are at high risk for preterm labor will be given focused education and support throughout their engagement in Aetna's Maternity Program. Our experienced OB clinicians will provide case management that aligns with the plan of care from the member's OB provider.

Preterm Labor Education is a tool intended to prevent preterm birth and recurrent preterm birth by educating women about their risks and when and how to report symptoms. Some members with a history of preterm birth will be prescribed progesterone injections, which have been shown to prevent recurrence of preterm birth by up to 35%.

Our experienced OB nurses will complete a condition-specific Preterm Labor Assessment at the first encounter with all members who are identified at risk for preterm labor. The clinicians respond to the assessment with basic education about specific risks and preventive strategies regarding preterm labor, and advise that further discussion will occur throughout the pregnancy. After 20 – 22 weeks, the assessment is extended to elicit changes in preterm labor status, questions or need, and includes additional targeted education that is gestationally appropriate.

Aetna Maternity Nurses will provide ongoing case management which includes, but is not limited to:

- Outreach calls every 4 – 6 weeks, scheduled at the member's convenience
- Promotion of health including nutrition, hydration, dental care, exercise and immunizations
- Review of antenatal screening, scheduled OB visits and reporting symptoms to the provider
- Discussion of appropriate NICU level at delivering hospital
- Encouraging self-monitoring of related conditions that could trigger symptoms
- Email communication that includes, but is not limited to, links/instructive videos covering these topics:
  - What is preterm labor/how to recognize symptoms
  - Next steps if you have symptoms: hydration and monitoring, including instructions for palpation of the uterus for contractions
  - ER/urgent care planning: what to do when symptoms occur outside of office hours
  - 39-week elective delivery initiative
  - General pregnancy education and member-specific content
- Collaboration with other Aetna Teams or UM if member is hospitalized for any reason

Smoke-Free Moms-to-Be smoking cessation program

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

- An educational brochure
- A cigarette substitute
- Telephone support from an Aetna Maternity Program nurse case manager throughout the pregnancy
- Support from nurses who are Certified Tobacco Education Specialists

Pregnancy and postpartum depression screening

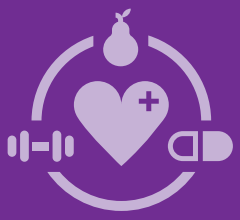
Our Aetna Maternity Program and Aetna Behavioral Health teams are committed to reducing the severity, duration and impact of depression during pregnancy and after delivery.

We use a screening tool upon enrollment and postpartum to help identify members who may be at risk for depression and anxiety. The nurses assess mood and support at each follow up call, and offer resources and referrals as needed. AMP nurses have a program-dedicated BH Specialist available for consultation as needed.

Diabetes case management for pregnant members

Aetna Maternity Program nurse case managers:

- Will provide education and support in alignment with the provider's plan of care
- Will educate and refer as needed for diabetic education or nutritional counseling, based on plan benefit
- Will encourage member to utilize services provided by her OB with additional Aetna RD as needed



Providing extra support for moms-to-be who need it.

Other important notes

Getting obstetric care

Members with a positive pregnancy test (either a home urine pregnancy test or blood test) can get 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 Aetna Maternity Program at **1-800-272-3531** to begin the enrollment process. To enroll in the program, members must complete the pregnancy survey. Please tell members that they must call the Aetna Maternity Program or log in to their member website at **aetna.com** to take the survey and complete the enrollment process.

Once enrolled, all eligible members get:

- Educational materials in English or Spanish
- The opportunity to complete a pregnancy survey
- Nurse case management, if the pregnancy survey identifies that they are at risk for certain medical conditions such as:
  - Preterm birth
  - Chronic hypertension
  - Gestational diabetes
- Access to our smoking cessation program

Members who enroll in the Aetna Maternity Program before 16 weeks' gestation receive a gift.

Call the Aetna Maternity Program at **1-800-272-3531** to:

- Register eligible members
- Access case management services
- Learn more about the program

Prenatal care access standards

Appointments for routine obstetric visits and urgent conditions must be available to members within reasonable time frames.

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

First visit for obstetric care	Within three weeks in the first trimester; within two weeks in the second or third trimesters
Urgent visits	Within 24 hours
Postpartum visit	Within the first 3 weeks postpartum

While there may be times appointment availability may not meet these standards, your office must generally be able to keep this degree of access. In group practices, members should be offered the option of seeing another provider in the office if their physician can't meet these standards.

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

Just a few final things to note

The Aetna 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 ID card to find out if a particular patient is eligible to participate in this program.

Obstetric policies and reimbursement

Global obstetric fee

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

Services reimbursed outside of the global obstetric fee include:

Inpatient visits provided for the below are considered part of the global obstetric fee and are not subject to payment on a fee-for-service basis:

- The day before delivery
- The three postpartum days for vaginal delivery
- The five postpartum days for cesarean delivery

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 the unconfirmed pregnancy.

Reimbursement for obstetric ultrasounds remains on a fee-for-service basis for members enrolled in indemnity and preferred provider organization (PPO)-based plans.

Note: We don't require prior authorization from the Aetna 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 network.

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

Perinatology services

On the next two pages, you'll find some of the more frequently used services that a perinatologist performs. 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 and Quality Point-of-Service® plans. Referrals can be done through our provider website at **https://navinet.navimedix.com**.

Procedure CPT codes	ICD codes considered medically appropriate	What you should know
Routine fetal ultrasounds: 76801, 76802, 76805, 76810, 76815, 76816, 76817, NT76813 and NT76814	See Clinical Policy Bulletin #0199 for ICD codes.	
Detailed fetal ultrasounds: 76811, 76812	See Clinical Policy Bulletin #0199 for ICD codes.	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.
Genetic counseling: 99243, 96040 and S0254	See Clinical Policy Bulletin #0189 for ICD codes.	

Procedure CPT codes	ICD codes considered medically appropriate	What you should know
Nuchal translucency (NT) testing: • 76813: Nuchal translucency testing • 76814: Nuchal translucency testing each additional gestation • 84704: hCG free Beta • 84163: PAPP A • 82105: AFP • 84702: hCG quantitative	See Clinical Policy Bulletins #0199 and #0464 for ICD codes.	ACOG recommends the following for NT screening: 1. Appropriate ultrasound training and ongoing quality monitoring programs are in place. 2. Sufficient information and resources are available to provide comprehensive counseling to women regarding the different screening options and limitations of these tests. 3. Access to an appropriate diagnostic test is available where screening test results are positive.
Cell-free DNA testing: 81420, 0009M, 81507	See Clinical Policy Bulletin #0464 for ICD codes.	
Amniocentesis: 59000 Ultrasound guidance for amniocentesis: 76946	See Clinical Policy Bulletin #0358 for ICD codes.	Amniocentesis based on patient demand is covered.
Chorionic villi sampling (CVS): 59015 CVS with ultrasound guidance: 76945	See Clinical Policy Bulletin #0358 for ICD codes.	CVS based on patient demand is covered.
NST: 59025	See Clinical Policy Bulletin #0088 for ICD codes.	
Biophysical profile (BPP): 76818	See Clinical Policy Bulletin #0088 for ICD codes.	
BPP without NST: 76819	See Clinical Policy Bulletin #0088 for ICD codes.	
Fetal echocardiograms: 76825, 76826, 76827, 76828, 93325	See Clinical Policy Bulletin #0106 for ICD codes.	Services must meet medical appropriateness criteria described in Clinical Policy Bulletin #0106.
Fetal umbilical artery Doppler: 76820	See Clinical Policy Bulletin #0088 for ICD codes.	Services must meet medical appropriateness criteria described in Clinical Policy Bulletin #0088.
Middle cerebral artery Doppler: 76821	See Clinical Policy Bulletin #0088 for ICD codes.	Services must meet medical appropriateness criteria described in Clinical Policy Bulletin #0088.
Percutaneous umbilical blood sampling (PUBS): 59012	See Clinical Policy Bulletin #0358 for ICD codes.	
Fetal transfusion: 36460	See Clinical Policy Bulletin #0449 for ICD codes.	
External cephalic version: 59412	See Clinical Policy Bulletin #0417 for ICD codes.	

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 "Providers" section at **aetna.com**. Then click "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. Visit **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 get the flu vaccine. Also, women at any stage of pregnancy with certain chronic medical conditions, such as asthma, diabetes mellitus or heart disease, should get the vaccination.

This vaccine is covered when administered to a pregnant woman. Physicians are reimbursed separately for this immunization. For more information, visit **cdc.gov**.

Postpartum visit

ACOG recommends that women visit their obstetric care provider within the first three weeks postpartum.[1] 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 including those related to postpartum depression and 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.), direct her 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 aren't 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**.

Thanks for hanging in there with us. We're almost done...

[1]American College of Obstetricians and Gynecologists, Committee Opinion No. 736. Optimizing Postpartum Care. May 2018. Available at: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Postpartum-Care. Accessed February 25, 2019.

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.

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 otherwise would 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 before 20 weeks. If a member is enrolled as an obstetric patient in the obstetric care provider's practice and 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 applies to all products when the following are true:

- The member is enrolled in the Aetna 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

We cover cell-free fetal nucleic acid screening 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
- Laboratory screening tests suggesting a chromosomal abnormality

Please 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)
- 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
- First trimester NT testing alone (without serum analyte screening) for multiple gestations
- 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
- Second trimester serum analyte screening (see Clinical Policy Bulletin #0464)

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

And some important screening information.

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 at **aetna.com**. Or find them on our 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.[2]

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 "indicated preterm delivery" (for example, PIH, diabetes, placenta previa)
- Gestational age at initiation of therapy greater than 23 weeks' gestation
- Member in active preterm labor and 17P being used as a tocolytic
- Member pregnant with twins

[2]American College of Obstetricians and Gynecologists, ACOG Practice Bulletin No. 130. Prediction and Prevention of Preterm Birth. October 2012 (reaffirmed 2018). Available at: https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Obstetrics/Prediction-and-Prevention-of-Preterm-Birth. Accessed February 25, 2019.

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

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

But if mandated by state law, we will consider provision of home births.

We've been doing most of the talking.

Now it's your turn — see the next page for answers to common questions.

[3]American College of Obstetricians and Gynecologists, ACOG Practice Bulletin No. 130. Prediction and Prevention of Preterm Birth. October 2012 (reaffirmed 2016).

Frequently asked questions

1. **Can I be reimbursed for gynecological ultrasounds performed during a routine gynecological visit without obtaining a referral?**

   Yes. Gynecological ultrasounds are paid fee-for-service. Please refer to Clinical Policy Bulletin #0199 for medical appropriateness criteria.

2. **Does Aetna cover the HPV vaccine?**

   Yes. We cover 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?**

   Our Breast Health Education Nurse 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. We cover 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 get approval for BRCA genetic testing?**

   To get a copy of our BRCA Precertification Information Request Form, go to aetna.com. You can also call us at **1-800-624-0756** for more details.

6. **Does Aetna cover genetic counseling?**

   Yes. We cover genetic counseling for members with medical indications that support it. Face-to-face or phone counseling is available. See our online provider directory at **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 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 Patient Registration Form to register with our National Infertility Unit. You'll find the form at **aetnainfertilitycare.com**.

   Once you've completed the form, you or the member can fax it to us at **1-860-607-7476**. We'll review the form and let the infertility specialist know if the member meets the initial criteria to start using her infertility treatment benefits. For more information, you or the member can call us at **1-800-575-5999**. Our hours of operation are Monday through Friday, 8 a.m. to 6 p.m. ET.

9. **Because Aetna no longer requires pregnancy precertification, is it necessary to notify you of a member's pregnancy?**

   No. But we do ask that you call the Aetna Maternity Program at **1-800-272-3531** to begin the program enrollment process. The member must complete the pregnancy survey to be considered for the program. We encourage you to inform the member that she must call the Aetna Maternity Program at **1-800-272-3531** or log in to her member website at **aetna.com** to complete the program enrollment process.

   Enrollment in the program provides all eligible members with:

   - Educational mailings
   - Our pregnancy 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 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 (ICD10 – O03.4, O03.9).

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 Z33.0 – Z34.93 and O20.0 – O94.

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 Z33.0 – Z34.93 and O20.0 – O94.

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

13. Do I need to contact the Aetna 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 Aetna 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)

14. 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.

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

Yes.

16. 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.

17. Does the Aetna 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.

18. What educational materials does the Aetna Maternity Program provide to members?

Program participants get 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 get two additional mailings: one at three to five weeks after delivery and one at three to four months after delivery.

Online resources for your patients

Here are some resources to share with your patients who may want to find out more online.†

Aetna member website	**aetna.com**
American Academy of Pediatrics	**aap.org**
American Cancer Society	**cancer.org**
American College of Obstetricians and Gynecologists (ACOG)	**acog.org**
American Diabetes Association	**diabetes.org**
American Heart Association	**heart.org**
American Lung Association	**lung.org**
American Medical Association	**ama-assn.org**
American Sexual Health Association	**ashasexualhealth.org**
Centers for Disease Control and Prevention (CDC)	**cdc.gov**
DocFind® online directory	**aetna.com/docfind**
Healthwise® Knowledgebase	**healthwise.net/aetna**
La Leche League International	**lalecheleague.org**
Men Stopping Violence	**menstoppingviolence.org**
National Committee for Quality Assurance (NCQA)	**ncqa.org**
National Domestic Violence Hotline, **1-800-799-SAFE (7233)**	**thehotline.org**
National Heart, Lung, and Blood Institute (NHLBI)	**nhlbi.nih.gov**
National Network to End Domestic Violence	**nnedv.org**
National Ovarian Cancer Coalition	**ovarian.org**
North American Menopause Society	**menopause.org**
U.S. Department of Agriculture	**usda.gov**

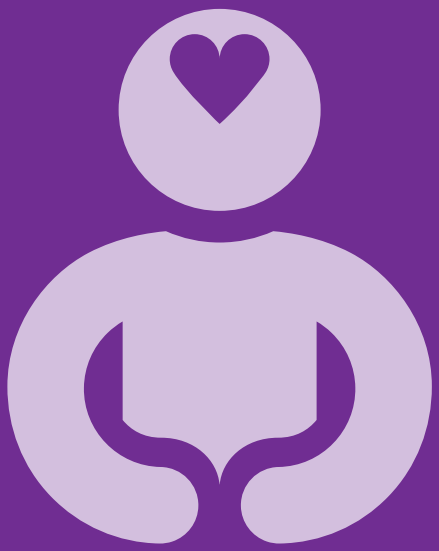
†Inclusion in this list does not constitute or imply endorsement by Aetna of any products or services described on these sites, or of any other material contained therein or of information obtained by calling the telephone numbers provided on the websites.

We're here for you.

For more information, call Provider Services:

- For HMO-based and Medicare plans:
  1-800-624-0756
- For all other plans:
  1-888-MDAetna (1-888-632-3862)

Or you can visit us online at **aetna.com**.



Just a few last details.

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 **aetna.com**.

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