CLINICAL GUIDELINES

OB Ultrasound Imaging Policy

Version 1.0

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eviCore healthcare Clinical Decision Support Tool Diagnostic Strategies: This tool addresses common symptoms and symptom complexes. Imaging requests for individuals with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist and/or individual's Primary Care Physician (PCP) may provide additional insight.

Obstetrical Ultrasound Imaging Guidelines

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Abbreviations and Glossary for OB Ultrasound Imaging Guidelines

ACOG	American College of Obstetricians and Gynecologists
AFI	amniotic fluid index
AFP	alpha-fetoprotein
CST	contraction stress test
B-mode (brightness)	a two dimensional imaging procedure, B-mode ultrasound is the basis for all static and real time B-scan images
BPP	**Biophysical Profile** includes the ultrasound variables: fetal breathing, muscle tone, and movement as well as amniotic fluid volume. BPP may be performed with or without a non-stress test (NST) which involves fetal heart rate (FHR) monitoring.
D & C/D & E	dilatation and curettage/ Dilation and Evacuation
dichorionic twins	twins having distinct chorions (membrane that forms the fetal part of the placenta), including monozygotic twins (from one oocyte [egg]) separated within 72 hours of fertilization and all dizygotic twins (from two oocytes fertilized at the same time
Doppler	involves measuring a change in frequency when the motion of vascular flow is measured
EDC	Estimated Date of Confinement; determined from the first day of the last menstrual cycle
EDD	Estimated Date of Delivery
FHR	fetal heart rate
hCG	human chorionic gonadotropin
IDDM	insulin-dependent diabetes mellitus
FGR	Fetal growth restriction; an estimated or actual weight of the fetus below 10^{th} percentile for gestational age
M-mode	an ultrasound imaging technique in which structure movement can be depicted in a wave-like manner; primarily used in cardiac and fetal cardiac imaging
macrosomia	estimated fetal weight of greater than 4000 or 4500 grams
monochorionic twins	twins developed from one oocyte (egg) developing with a single chorions (membrane that forms the fetal part of the placenta)
NICU	Neonatal Intensive Care Unit
NST	fetal non-stress test
oligohydramnios	diminished amniotic fluid volume (AFV) for gestational age; definitions include: 1.) maximum deepest pocket of ≤ 2cm, and, 2.) AFI of ≤ 5cm or < the 5^{th} percentile for gestational age if < 30 weeks.
PACS	Picture Archiving and Communications System
polyhydramnios	1.) AFI ≥ 24cm, or maximum vertical pocket of ≥ 8 cm
PROM	preterm rupture of membranes
quad screen	alpha-fetoprotein (AFP), estriol, human chorionic gonadotropin (hCG), inhibin A
real time scan	considered the most common type of ultrasound; a 2-dimensional scan that reflects structure and motion over time, scanning and display of images are run at a sufficiently rapid rate so that moving structures can be viewed moving at their natural rate; frame rates ≥ 15 frames per second are considered “real time”

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OB-1: Obstetrical Ultrasound Imaging General Guidelines

OB-1.1: Required Documentation

An evaluation of pregnancy with history and physical exam (an initial office visit) is necessary prior to obstetric ultrasound imaging requests

- The following information must be submitted with each request:
  - Anticipated date of service
  - Expected date of delivery
  - Gestational age at date of service
  - Results of prior ultrasound studies if available

OB-1.2: Inappropriate Use of OB Ultrasound

Obstetrical ultrasound studies cannot be authorized for payment for individuals who do not have a positive pregnancy test or clinical evidence of a pregnancy (fetal heart tones)

- Obstetrical ultrasound is **not** appropriate for the following:
  - Sex determination only
  - To provide a keepsake or souvenir picture

Practice Note

In the absence of other specific indications, the optimal time for a single ultrasound examination is at 18 to 22 weeks of gestation. This timing allows for a survey of fetal anatomy in most women and an accurate estimation of gestational age.[2]

OB-1.3: Ultrasound Code Selection

- See **OB-28: Procedure Coding Basics for Established Pregnancy**
  - It is not appropriate to report non-obstetrical pelvic ultrasound procedure codes (CPT® 76830, CPT® 76856, and CPT® 76857) if pregnancy has already been diagnosed.

CPT® Code Guidance
CPT® 76801 and CPT® 76802 are reported for complete studies performed during the first trimester (<14 weeks). CPT® 76801 and CPT® 76802 (second twin in multiple pregnancy) should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication for ultrasound.
CPT® 76805 and CPT® 76810 (second twin in multiple pregnancy) are used to report complete studies (anatomy scan) performed during the second and third trimester. CPT® 76805 and CPT® 76810 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication for ultrasound.
CPT® 76802, CPT® 76810, CPT® 76812, and CPT® 76814 are “add-on” codes used to report each additional fetus.
CPT® 76817 is used to report a transvaginal ultrasound. The other OB ultrasound codes are used for transabdominal studies.

CPT® Code Guidance
CPT® 76816 is used to report follow up studies requiring more information, such as growth scans or follow up on anatomy when more than one area is examined. ◆ CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy) CPT® 76815 is used to report limited follow-up studies.
CPT® 76811 and CPT® 78612 (second twin in multiple pregnancy) describe an extensive fetal ultrasound evaluation and detailed anatomic survey and are used only when the study includes this service. CPT® 76812 is an add-on for each additional fetus. In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.
CPT® 76813 and CPT® 76814 (second twin in multiple pregnancy) codes are for nuchal translucency screening: an ultrasound measurement of the clear (translucent) space at the back of the fetal neck to assess risk for Down Syndrome (Trisomy 21), Trisomy 18, and other genetic disorders.
CPT® 76818(includes non-stress test) and 76819: Biophysical profile is designed to predict the presence or absence of fetal asphyxia and includes evaluation of fetal breathing movements, gross fetal body movements, fetal tone, amniotic fluid volume with and without non-stress test.
CPT® 76820 describes Doppler velocimetry of the umbilical artery.
CPT® 76821 describes Doppler velocimetry of the middle cerebral artery.
CPT® 76825 describes fetal echocardiography and should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication for ultrasound. CPT® 76826 (follow up) codes are used for subsequent or follow up fetal echocardiography. CPT® 76827 describes the Doppler portion of the echocardiogram and should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication for ultrasound. CPT® 76828 (follow up) describe Doppler portion of subsequent or follow up echocardiogram. CPT® 93325 may be added for color mapping in conjunction with fetal echocardiography procedures.
CPT® 93976 is used to report uterine artery Doppler evaluation.
CPT® 74172 and CPT® 74173 (for each additional gestation) describe fetal MRI (used to imaging the fetus), if maternal pelvis is imaged without fetal imaging (placenta accreta spectrum disorders) MRI pelvis without contrast 72195 should be used.

References

1. Reddy UM, Abuhamad AZ, Levine D, Saade GR. Fetal Imaging: Executive Summary of a Joint Eunice Kennedy Shriver National Institute of Child Health and Human Development, Society for Maternal-Fetal Medicine, American Institute of Ultrasound in Medicine, American College of Obstetricians and Gynecologists, American College of Radiology, Society for Pediatric Radiology, and Society of Radiologists in Ultrasound Fetal Imaging Workshop. Obstetrical & Gynecological Survey. 2014;69(8):453-455. doi:10.1097/01.ogx.0000453817.62105.4a.
Practice Bulletin No. 175: Ultrasound in Pregnancy. Obstet Gynecol. 2016;128(6):e241-e256. Reaffirmed 2018. doi:10.1097/AOG.0000000000001815.

OB-2: Uncertain Dates

OB-2.1: Uncertain Dates/Unknown Last Menstrual Period (LMP)

- The **low-risk pregnancy** that has no other indications for ultrasound should have a fetal anatomic ultrasound (CPT® 76805) performed at 16 weeks or greater. The timing can be determined by fundal height. (See: **OB-7: Fetal Anatomic Scan**).
- If there is a difference between the clinical size of the uterus on pelvic exam, if thought to be < 14 weeks, or on abdominal exam if thought to be > 14 weeks; **and** the date of the last menstrual period is uncertain or there have been irregular periods in the past year, one ultrasound can be performed to confirm dates:
  - (CPT® 76801) [plus CPT® 76802 if more than one fetus] and/or CPT® 76817 for a transvaginal ultrasound if less than 14 weeks and a complete ultrasound has not yet been performed or
  - CPT® 76805 (plus CPT® 76810 if more than one fetus) if equal to or greater than 14 weeks when complete fetal anatomic scan CPT® 76805 is planned and has not yet been performed or
  - CPT® 76815

Practice Note

Per ACOG Committee Opinion 688, March 2017: “Pregnancies without an ultrasonographic examination confirming or revising the estimated due date before 22 0/7 weeks of gestation should be considered suboptimally dated.”

In low risk pregnancy, the anatomy scan, generally done at 18-20 weeks, can also be used to establish/confirm due date.

In the absence of other specific indications, the optimal time for a single ultrasound examination is at 18 to 22 weeks of gestation. This timing allows for a survey of fetal anatomy in most women and an accurate estimation of gestational age”... Practice Bulletin No. 175: Ultrasound in Pregnancy. Reaffirmed 2018

References

1. Practice Bulletin No. 175: Ultrasound in Pregnancy. Obstet Gynecol. 2016;128(6):e241-e256. Reaffirmed 2018. doi:10.1097/AOG.0000000000001815.
2. Reddy UM, Abuhamad AZ, Levine D, Saade GR. Fetal Imaging: Executive Summary of a Joint Eunice Kennedy Shriver National Institute of Child Health and Human Development, Society for Maternal-Fetal Medicine, American Institute of Ultrasound in Medicine, American College of Obstetricians and Gynecologists, American College of Radiology, Society for Pediatric Radiology, and Society of Radiologists in Ultrasound Fetal Imaging Workshop. Obstetrics & Gynecology. 2014;123(5):1070-1082. doi:10.1097/aog.0000000000000245.
3. ACOG Committee Opinion No 700: Methods for Estimating the Due Date. Obstet Gynecol. 2017;129(5):e150-e154. doi:10.1097/AOG.0000000000002046.
   ACOG Committee Opinion Number 688: Management of Suboptimally Dated Pregnancies, Obstetrics & Gynecology; March 2017-Volume 129-Issue 3-p e29-e32. Reaffirmed 2019. doi:10.1097/AOG.0000000000001949.

OB-3: Intrauterine Device (IUD)

OB-3.1: Locate an Intrauterine Device

- Ultrasound can be performed to locate an intrauterine device (IUD) (CPT® 76801 and/or CPT® 76817 if a complete ultrasound has not yet been performed)
- CPT® 76815 for limited ultrasound, if complete ultrasound has already been performed, and/or CPT® 76817 for a transvaginal ultrasound
- 3-D Rendering (CPT® 76376/76377) may be added for "Lost" IUD (inability to feel or see IUD string).

References

1. Nowitzki KM, Hoimes ML, Chen B, Zheng LZ, Kim YH. Ultrasonography of intrauterine devices. Ultrasonography. 2015;34(3):183-194. doi:10.14366/usg.15010.
2. ACOG Committee Opinion No 672 Clinical challenges of long-acting reversible contraceptive methods. Obstetrics & Gynecology. 2016;128(3):e69-e77. Reaffirmed 2019. doi:10.1097/aog.0000000000001644.
3. Verma U, Astudillo-Dávalos FE, Gerkowicz SA. Safe and cost-effective ultrasound guided removal of retained intrauterine device: our experience. *Contraception*. 2015;92(1):77-80. doi:10.1016/j.contraception.2015.02.008.
4. Prabhakaran S and Chuang A. In-office retrieval of intrauterine contraceptive devices with missing strings. *Contraception*. 2011;83(2):102-106. doi:10.1016/j.contraception.2010.07.004.

OB-4: Infertility

OB-4.1: History of Infertility

- Ultrasound imaging is supported if there is a history of infertility treatment (CPT® 76801 [plus CPT® 76802 if more than one fetus] and/or CPT® 76817 for transvaginal ultrasound
- Repeat ultrasound is not usually necessary unless there are new clinical indications

OB-4.2: Present Pregnancy with ART Treatment (IVF)

- Follow high risk imaging, see **OB-9: High Risk Pregnancy**

Reference

1. Kondapalli LA, Perales-Puchalt A. Low birth weight: is it related to assisted reproductive technology or underlying infertility? Fertility and Sterility. 2013;99(2):303-310. doi:10.1016/j.fertnstert.2012.12.035.

OB-5: Vaginal Bleeding and/or Abdominal/Pelvic Pain/Cramping

OB-5.1: Abdominal Pain

For abdominal pain that presents without bleeding:
➢ Initially CPT® 76815 and/or CPT® 76817 for limited ultrasound when medically indicated **or** ➢ CPT® 76801 and/or CPT® 76817 when complete ultrasound has not yet been performed, if less than 14 weeks **or** ➢ CPT® 76805 (plus CPT® 76810 if more than one fetus) if equal to or greater than 14 weeks, when complete fetal anatomic scan CPT® 76805 is planned and has not yet been performed or ➢ CPT® 76816-Should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

OB-5.2: Vaginal Bleeding and/or Abdominal/Pelvic Pain

First Trimester
➢ Initially CPT® 76815 and/or CPT® 76817 for limited ultrasound when medically indicated **or** ➢ CPT® 76801 when complete ultrasound has not yet been performed, if less than 14 weeks and/or CPT® 76817 may be performed once when medically indicated for complete ultrasound.
Second and Third Trimesters
➢ CPT® 76815 and/or CPT® 76817 or ➢ CPT® 76805 (plus CPT® 76810 if more than one fetus) if equal to or greater than 14 weeks, when complete fetal anatomic scan CPT® 76805 is planned and has not yet been performed and/or CPT® 76817 or ➢ CPT® 76816) and/or CPT® 76817 ◆ (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy) ➢ Limited ultrasound 76815 and/or CPT® 76817 or ➢ Additionally, 26 weeks, BPP CPT® 76818 or CPT® 76819 or a modified BPP CPT® 76815 can be considered ➢ See **OB-21.5: Suspected Abruptio Placentae**

Reference

1. ACOG Practice Bulletin No. 200: Early Pregnancy Loss. Obstet Gynecol. 2018;132(5):e197-e207. doi:10.1097/AOG.0000000000002899.

OB-5.3: Ectopic Pregnancy

Ectopic Pregnancy
First Trimester
➢ Signs and symptoms of ectopic pregnancy include pain and/or bleeding
◆ Initially CPT® 76815 and/or CPT® 76817 for limited ultrasound when medically indicated **or** ◆ CPT® 76801 when complete ultrasound has not yet been performed, if less than 14 weeks and/or CPT® 76817 may be performed once when medically indicated for complete ultrasound ◆ Once an adnexal mass is confirmed, Color Doppler ultrasonography (CPT 93975) may be useful to evaluate the vascular characteristics
◆ If patient has a history of ectopic pregnancy with non-doubling hCG without pain and bleeding, ultrasound can be performed (CPT® 76801 and/or CPT® 76817) to confirm an intrauterine pregnancy
◆ If ectopic pregnancy is being treated non-surgically with Methotrexate, imaging may be required per **OB-5: Vaginal Bleeding and/or Abdominal/Pelvic Pain/Cramping** or the imaging guidelines above for ectopic pregnancy

Reference

1. ACOG Practice Bulletin No. 193: Tubal Ectopic Pregnancy. Obstet Gynecol. 2018;131(3):e91-e103. doi:10.1097/AOG.0000000000002560.
2. Practice Bulletin No. 174: Evaluation and Management of Adnexal Masses. Obstet Gynecol. 2016;128(5):e210-e226. doi:10.1097/AOG.0000000000001768.

OB-5.4: Spontaneous Abortion/Threatened/Missed Abortion

➢ For spontaneous abortion/threatened/missed abortion (miscarriage), ultrasound can be performed to evaluate threatened or missed abortion (with or without vaginal bleeding prior to 20 weeks) ◆ Initially CPT® 76815 and/or CPT® 76817 for limited ultrasound when medically indicated **or** ◆ CPT® 76801 when complete ultrasound has not yet been performed, if less than 14 weeks and/or CPT® 76817 may be performed once when medically indicated for complete ultrasound ◆ CPT® 76805 (plus CPT® 76810 if more than one fetus) if equal to or greater than 14 weeks, when complete fetal anatomic scan CPT® 76805 is planned and has not yet been performed and/or CPT® 76817 ◆ Repeat ultrasound (CPT® 76815 or CPT® 76816 and/or CPT® 76817) is appropriate in the setting of rising or non-falling serum hCG levels at weekly intervals ■ CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy) ◆ Ultrasound imaging can be repeated earlier than seven days if there are new symptoms
➢ For complete spontaneous abortion, ultrasound is generally not indicated if there is no pain, no ongoing bleeding, and hCG levels are decreasing

Reference

1. ACOG Practice Bulletin No. 200: Early Pregnancy Loss. Obstet Gynecol. 2018;132(5):e197-e207. doi:10.1097/AOG.0000000000002899.

OB-5.5: Hydatidiform Mole

See also: **PV-16.1: Molar Pregnancy and GTN**

Hydatidiform Mole
First, Second and Third Trimester
➢ Ultrasound can be performed for diagnosis of hydatidiform mole ◆ Initially CPT® 76815 and/or CPT® 76817 for limited ultrasound when medically indicated **or** ◆ CPT® 76801, when complete ultrasound has not yet been performed, if less than 14 weeks, and/or CPT® 76817 may be performed once when medically indicated for complete ultrasound ◆ CPT® 76805 (plus CPT® 76810 if more than one fetus) if equal to or greater than 14 weeks, when complete fetal anatomic scan CPT® 76805 is planned and has not yet been performed, and/or CPT® 76817 ◆ Following treatment with D & C and/or Methotrexate, serial serum hCG values are measured until they become negative ◆ Ultrasound may be necessary for follow-up (CPT® 76830.and CPT® 76856 or CPT® 76857 if hCG titers are not decreasing as expected, are increasing following treatment, or if there is onset of pain despite falling hCG titers. ◆ See **PV-16.1: Molar Pregnancy and GTN**

References

1. National Comprehensive Cancer Network (NCCN) Guidelines Version 1.2019 – August 2018. Gestational Trophoblastic Neoplasia, available at: https://www.nccn.org/professionals/physician_gls/pdf/gtn.pdf. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines™) for Central Nervous System Tumors Cancer V1.2018. – March 20, 2018 ©2018 National Comprehensive Cancer Network, Inc. All rights reserved. The NCCN Guidelines™ and illustrations herein may not be reproduced in any form for any purpose without the express written permission of the NCCN. To view the most recent and complete version of the NCCN Guidelines™, go online to NCCN.org.

OB-6: Fetal Aneuploidy and Anomaly Screening

OB-6.1: First Trimester Screening

- First trimester nuchal translucency is not necessary if cfDNA is done
  - First trimester screening includes biochemical markers and fetal nuchal translucency (FNT) (CPT® 76813). Conducted together, these screenings can identify risk for specific chromosomal abnormalities (e.g. Down's syndrome, Trisomy-18)
  - Nuchal translucency is completed between 11 and 13 6/7 weeks (CRL between 44 and 83 mm) but can be performed if the crown rump length (CRL) measures between 44-83mm regardless of gestational age. An abnormal Fetal Nuchal Translucency scan, with a nuchal translucency measurement of ≥ 3.0 mm, may indicate an increased risk for cardiac defects, abdominal wall defects, diaphragmatic hernia, and genetic syndromes in euploid fetuses; whereas, a nuchal translucency ≥ 2.5mm may indicate an increased risk for aneuploidy (imaging should be based upon the MOM for NT and biochemical markers).
  - "… the use of ultrasound codes CPT® 76801/ CPT® 76802 should be indication driven and should not be routinely done whenever an ultrasound for nuchal translucency (CPT® 76813/ CPT® 76814) is requested. In cases where there is either a maternal and/or fetal indication then the CPT® 76801 code can indeed be billed along with the nuchal translucency screening (CPT® 76813/ CPT® 76814)." (Society for Maternal-Fetal Medicine)

First Trimester Screening:
➢ Ultrasound is the initial imaging for the first trimester screening, to evaluate fetal nuchal translucency
➢ If the nuchal translucency is abnormal (≥ 2.5mm), the following tests can be performed: ◆ Fetal anatomic ultrasound (CPT® 76811) at 16 weeks or greater ◆ Amniocentesis ◆ CVS ◆ Fetal echocardiogram (NT ≥ 3.0 mm)
➢ Abnormal FNT with normal aneuploidy screen and normal chromosomes (as measured by chorionic villus sampling or amniocentesis) should be evaluated with a fetal echo (CPT® 76825 and/or CPT® 76827 and/or CPT® 93325) and fetal ultrasound (CPT® 76811)

Coding Notes

- CPT® 76813 and CPT® 76814 should be performed only by those certified by the Fetal Medicine Foundation or Nuchal Translucency Quality Review Program (NTQR)
- Report as CPT® 76813 (plus CPT® 76814 if more than one fetus)
- CPT® 76813 can be performed once per pregnancy if the pregnancy is 11 to 13 6/7 weeks (44mm – 83mm) but can be performed if the CRL measures between 44-83mm regardless of gestational age
- If FNT is abnormal, CPT® 76811 is generally performed by a Maternal Fetal Medicine (MFM)/Perinatologist, Radiologist, or facility/physician with AIUM certification (with advanced training in fetal imaging) after 16 weeks
- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more

desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.

- CPT 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition.
- The use of ultrasound codes (CPT® 76801/CPT® 76802) should be indication driven and should not be routinely done whenever an ultrasound for nuchal translucency (CPT® 76813/CPT® 76814) is requested. In cases where there is either a maternal and/or fetal indication, then the CPT® 76801 code can indeed be billed along with the nuchal translucency screening (CPT® 76813/CPT® 76814)

OB-6.2: Second Trimester Screening

- See also: **OB-7.1: Initial Screening for Fetal Anomalies**

Two studies, a quad screen and ultrasound, are done during the second trimester to detect fetal aneuploidy, neural tube defects, and other anatomical defects.
➢ A fetal anatomic scan to screen for anomalies is ideally performed at 18 to 20 weeks but may be performed after week ≥ 16. If less than 16 weeks, send to MD review
➢ If the quad screening is abnormal, an ultrasound (CPT® 76811) may also be performed.

Practice Notes

Multiple marker screening is used in the second trimester (15 to 20 weeks) to screen for trisomies 21 and 18 as well as open neural tube defects (ONTD).
The “quad” screen is the most commonly used test for the second trimester.

The quad screen measures four substances:
1. AFP (alpha-fetoprotein)
2. hCG (human chorionic gonadotropin)
3. uE (Unconjugated estriol)
4. dimeric inhibin-A

A penta screen may be done in lieu of a quad screen, the penta screen includes hyperglycosylated hCG in addition to the quad screen markers.

The “penta” screen measures five substances:
1. AFP
2. hCG
3. hyperglycosylated hCG
4. uE
5. dimeric inhibin-A

- Maternal serum alpha-fetoprotein (MSAFP) can be done at 15 to 20 weeks to screen for neural tube defects if quad or penta is not performed. (Those that have had cfDNA or NT screen will need MSAFP tested separately in the mid-trimester to screen for open neural tube defect).
- Combined, integrated or sequential screening (first and second trimester screening)

may also be used and provides a higher detection rate than a single screening.

- Providers often wait for the results of the quad screen before ordering CPT® 76805. If the quad screen is abnormal, they may request CPT® 76811 in lieu of CPT® 76805.
- Cell-Free DNA Testing-cfDNA
- First trimester nuchal translucency screening is not necessary if cfDNA is performed as they are both screenings for fetal aneuploidy.
- Cell-free fetal DNA (cfDNA) has been noted to be the most sensitive screening test for Down syndrome per the American College of Medical Genetics and Genomics.
- Testing can be offered as early as the 10th week of pregnancy.
- With a negative cfDNA test, it is very unlikely the fetus has trisomy 21, 13 or 18. Other chromosomal abnormalities may also be identified. The sex and Rh status of the baby may be included. The American College of Medical Genetics and Genomics (ACMG) recommends against using this test to screen for microdeletions or any autosomal aneuploidies other than 13, 18 and 21.
- A woman with a positive cfDNA should be offered diagnostic testing (amniocentesis or CVS). A detailed anatomy scan 76811 is indicated at 16 weeks or greater. See: **OB-9.1: High Risk Group One – Risk Factors**.
- A "no call" or indeterminate result can occur (risk is higher with maternal obesity), but this has a higher risk of chromosomal abnormality than a normal result. The patient should be offered amniocentesis or CVS testing.
- Note that cfDNA does not screen for neural tube defects. Patients should be offered screening for open neural tube defects with maternal serum AFP (MSAFP) or ultrasound (usual anatomy scan- CPT® 76805 or CPT® 76811 depending on risk factors)

References

1. ACOG Practice Bulletin: No.187: Neural Tube Defects. Obstet Gynceol. 2017 Dec;130(6):e279-e290. doi: 10.1097/AOG.0000000000002412.
2. Society for Maternal and Fetal Medicine (SMFM), coding committee, October 2017. SMFM's white paper on billing combination of 76801 and 76813.
3. ACOG Practice Bulletin No. 162 Prenatal diagnostic testing for genetic disorders. Obstetrics & Gynecology. 2016;127(5). Reaffirmed 2018. doi:10.1097/aog.0000000000001405.
4. ACOG Practice Bulletin No. 163: Screening for Fetal Aneuploidy. Obstet Gynecol. 2016;127(5):e123-e137. Reaffirmed 2018. doi:10.1097/AOG.0000000000001406.
5. ACOG Practice Bulletin No. 175: Ultrasound in Pregnancy. Obstet Gynecol. 2016;128(6):e241-e256. Reaffirmed 2018. doi:10.1097/AOG.0000000000001815.
6. Gregg AR, Skotko BG, Benkendorf JL, et al. Noninvasive prenatal screening for fetal aneuploidy, 2016 update: a position statement of the American College of Medical Genetics and Genomics. Genetics in Medicine. 2016;18(10):1056-1065. doi:10.1038/gim.2016.97.
7. Norton ME, Biggio JR, Kuller JA, Blackwell SC. Society for Maternal-Fetal Medicine (SMFM) Consult Series | #42: The role of ultrasound in women who undergo cell-free DNA screening. American Journal of Obstetrics and Gynecology. 2017;216(3):B2-B7. doi:10.1016/j.ajog.2017.01.005.
8. Donofrio MT, Moon-Grady AJ, Hornberger LK, et al. Diagnosis and Treatment of Fetal Cardiac Disease. Circulation. 2014;129(21):2183-2242. doi:10.1161/01.cir.0000437597.44550.5d.

OB-7: Fetal Anatomic Scan

OB-7.1: Initial Screening for Fetal Anomalies

- A fetal anatomic scan to screen for anomalies is ideally performed at 18 to 20 weeks, but may be performed after week ≥ 16. If less than 16 weeks gestation, send to MD review
  - CPT® 76817 transvaginal ultrasound can be considered if the cervical length is less than or equal to 3.6 cm with transabdominal fetal anatomic ultrasound measurement on CPT® 76805 and/or CPT® 76811
  - Reported as CPT® 76805 if the patient is **not** high risk
  - If pregnancy **is** high risk report as (CPT® 76811). A detailed fetal anatomic scan (CPT® 76811) is generally performed by a Maternal Fetal Medicine (MFM)/Perinatologist Radiologist, or AIUM or ACR accredited facilities as the screening anatomic study. See: **OB-9: High Risk Pregnancy**

OB-7.2: Fetal Anatomic Scan – Follow-up

- Follow-up ultrasounds (CPT® 76816) may be considered every 3 to 6 weeks to evaluate fetal growth if pregnancy is high risk per **OB-9: High Risk Pregnancy** or other applicable high risk guideline.
- Follow-up ultrasound (CPT® 76815 or CPT® 76816) can be performed if indeterminate, incomplete or equivocal finding on initial fetal anatomic scan once as needed after an anatomy ultrasound regardless of gestational age. A limited ultrasound CPT® 76815 if limited to a follow up of a single item.
- Detailed anatomy ultrasound CPT® 76811 can be performed if not previously performed when initial fetal anatomic scan CPT® 76805 is abnormal.

Practice Notes

Fetal Anatomic Scan - Coding Notes	
CPT® 76805	➢ A complete transabdominal ultrasound (CPT® 76805). See: **OB-28.3: Required Elements for Second or Third Trimester Fetal Anatomic Evaluation OB Ultrasound**
CPT® 76810	➢ CPT® 76810 is an add-on code used with the primary procedure CPT®76810 to report each additional fetus if there is a multiple gestation
CPT® 76805 CPT® 76810	➢ CPT® 76805 and CPT® 76810 should only be reported once per pregnancy unless the mother changes to a new medical caregiver at a new office, and there is a new medical indication for ultrasound
CPT® 76811 CPT® 76812	➢ CPT® 76811 and CPT® 76812 are defined as including all of the requirements listed for procedures CPT® 76805 and CPT® 76810 plus additional detailed anatomic examination. The pregnancy must also be high risk to support CPT® 76811 and CPT® 76812. In addition the report must include the detailed elements found in OB-28.4. See: **OB-28.4: Required Elements for a Detailed Fetal Anatomic Evaluation OB Ultrasound**
CPT® 76812	CPT® 76812 is an add-on code used with the primary procedure CPT® 76812 to report each additional fetus in a multiple gestation
CPT® 76811	➢ The reporting of CPT® 76811 only once per pregnancy, per practice (per NPI) is appropriate CPT® 76811 should only be reported once per pregnancy unless the mother changes to a new medical caregiver at a new office, and there is a new medical indication for ultrasound

Fetal Anatomic Scan - Coding Notes	
CPT® 76811	➢ In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead
CPT® 76815	➢ CPT® 76815 describes a limited or "quick look" study used to report one or more of the elements listed in the code definition, i.e. "fetal heartbeat", placental location or fluid check
CPT® 76816	➢ CPT® 76816 describes a follow-up ultrasound (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), trans-abdominal approach, per fetus. ◆ The use of this CPT code is reserved for subsequent follow up ultrasound only; i.e. an ultrasound must have been performed previously. ◆ Components include: Focused assessment of fetal size by measuring BPD, abdominal circumference, femur length, or other appropriate measurement; and amniotic fluid volume ◆ Detailed re-examination of a specific organ or system known or suspected to be abnormal ◆ (there is no interval requirement when ordered as follow-up for an indeterminate anatomy scan) ◆ CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

References

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9. Jain S, Kilgore M, Edwards RK, Owen J. Revisiting the cost-effectiveness of universal cervical length screening: importance of progesterone efficacy. American Journal of Obstetrics and Gynecology. 2016;215(1). doi:10.1016/j.ajog.2016.01.165.
10. AIUM-ACR-ACOG-SMFM-SRU Practice Parameter for the Performance of Standard Diagnostic Obstetric Ultrasound Examinations. Journal of Ultrasound in Medicine. 2018;37(11). doi:10.1002/jum.14831.

OB-8: Third Trimester Imaging

OB-8.1: Third Trimester Imaging – Ultrasound

- Imaging in the third trimester is indicated for bleeding, pain, absent fetal heart tone, decreased fetal movement and/or other high-risk indications, see: **OB-9: High Risk Pregnancy**
- For suspected breech position, see: **OB-14: Abnormal Fetal Position/Presentation**

Reference

1. Practice Bulletin No. 175: Ultrasound in Pregnancy. Obstet Gynecol. 2016;128(6):e241-e256. Reaffirmed 2018. doi:10.1097/AOG.0000000000001815.

OB-9: High Risk Pregnancy

High Risk Pregnancy Special Considerations

For the following conditions, please follow the links for appropriate imaging:
➢ Fetal Growth Restriction and Macrosomia see: **OB-20: Fetal Growth Problems (FGR and Macrosomia)**
➢ History of late fetal death (greater than or equal to 20 weeks) See: **OB-9.10: History of Stillbirth**
➢ History of Prior C-section See: **OB-24: Previous C-section or History of Uterine Scar**
➢ Multiple Gestations see: **OB-11: Multiple Gestations**
➢ Oligohydramnios or polyhydramnios see: **OB-17: Amniotic Fluid Abnormalities/Oligohydramnios/Polyhydramnios**
➢ **OB-18.3: Current preterm labor**
➢ Premature rupture of membranes (PROM) See: **OB-23.1: Current Preterm Prelabor Rupture of Membranes (PPROM)**
➢ Diabetes: **OB-9.6: High Risk Pre-Gestational Diabetes** and **OB-9.7: High Risk Group Seven Gestational Diabetes**
➢ Hypertension/pre-eclampsia see **OB-9.8: Hypertension**
➢ Rh sensitization/isoimmunization See: **OB-16: Alloimmunization/Rh Isoimmunization/Other Causes of Fetal Anemia/Parvo/Hydrops**
➢ Vasa previa/placenta accrete/placental abnormalities see: **OB-21: Placental or Cord Abnormalities**

OB-9.1: High Risk Group One – Risk Factors

OB-9.1.1: Risk factors

HIGH RISK PREGNANCY – Risk Factors
Socio-Demographic Risk Factors (maternal age)
➢ Age greater than or equal to 35 years of age at the estimated date of confinement (EDC)
Lifestyle Related Risk Factors (legal or illicit drug/alcohol use)
➢ Recreational drug or alcohol use during current pregnancy
➢ 10 or more cigarettes a day ➢ Other nicotine exposure (e-cigs, vaping, chewing, patch) send to medical review
➢ Maternal history of IV drug abuse ➢ Current use of Suboxone, Subutex, Methadone.

Health Condition Related Risk Factors or Chronic medical condition that may affect fetal growth due to utero-placental insufficiency (maternal diseases or conditions)
➢ Anemia severe, less than 8 grams Hgb or 24% HCT
➢ Asthma (poorly controlled or steroid dependent)
➢ Autoimmune disease
➢ Bariatric surgery
➢ Connective tissue disorders (lupus, RA, scleroderma, Sjogren's, etc.)
➢ DVT/PE or Maternal thrombophilia (Antiphospholipid Syndrome, Factor V Leiden mutation, Antithrombin III deficiency, Protein C/Protein S deficiency, Prothrombin gene mutation etc.)
➢ Genetic Carrier status e.g., Cystic Fibrosis/Known carrier of Spinal Muscular Atrophy (SMA), CF, Tay-Sachs genetic diseases
➢ Heart disease (Maternal) – New York Heart Association class III or IV greater or arrhythmia
➢ Hemoglobinopathies (e.g. sickle cell disease, Beta thalassemia etc)
➢ History of endometrial ablation or Uterine Artery embolization
➢ Hyperthyroidism
➢ Hypothyroidism (poorly controlled)
➢ Liver disease e.g., Cholestasis of pregnancy (abnormal bile acids), Hepatitis
➢ Maternal malnutrition (BMI < 18.5); Send to MD Review for poor weight gain
➢ PKU
➢ Renal disease eg glomerulonephritis, persistent protein in the urine, renal insufficiency
➢ Seizure disorders– on antiepileptic medication
➢ Systemic malignancy

Previous pregnancy related risk factors
➢ If **no** known cause of miscarriages < 20 weeks): ◆ 2 or more miscarriages and currently ≥ 35 years old; **or** ◆ 3 or more miscarriages and currently < 35 years old
➢ Prior pregnancy with SGA (baby weighing < 2500 grams at term or FGR less than the 10th percentile of expected weight)
➢ Prior pregnancy with adverse outcome (early onset preeclampsia ≤ 34 weeks, abruption, accreta or FGR at any gestational age, nonimmune hydrops). ➢ For stillbirth see **OB-9.10: History of Stillbirth**
➢ Rh sensitization/Isoimmunization in prior pregnancy. In current pregnancy see: **OB-16: Alloimmunization/Rh Isoimmunization/Other Causes of Fetal Anemia/Parvo/Hydrops**
Current pregnancy related risk factors
➢ Abnormal 1st or 2nd trimester screen (i.e. MSAFP; Low PAPP_A) Known chromosomal abnormalities; or abnormal cfDNA
➢ Any 'significant' structural anomaly (such as gastroschisis, fetal ventriculomegaly), fetal congenital heart disease, sustained fetal arrhythmias
➢ ART Conception with assisted reproductive technologies (IVF)
➢ Grand multiparity: must have completed 5 or more pregnancies of greater than 20 weeks gestation, living or stillbirth (does not include current pregnancy; twins count as 1 pregnancy)
➢ Thickened nuchal fold found on second trimester imaging ≥ 6mm up to 22 weeks (if CPT® 76811 shows adequate heart views, then no indication for echo); abnormal Fetal Nuchal Translucency ≥2.5mm
➢ No prenatal care prior to 28 weeks
Maternal Infections (not exposure)
➢ Acquired Immune Deficiency Syndrome/HIV Positive
➢ Chicken Pox/Varicella
➢ Cytomegalovirus (CMV)
➢ Malaria
➢ Known parvovirus in current pregnancy post fetal treatment. See**: OB-16.2: Exposure to Parvovirus B-19**
➢ Rubella
➢ Syphilis, untreated
➢ Toxoplasmosis
➢ Tuberculosis
➢ For Zika Virus see **OB-9.5: High Risk Group Five: Zika Virus**

OB-9.1.2: Imaging for high risk group one risk factors

Imaging For Above Conditions
➢ Perform one ultrasound in the first trimester to establish dates, and report one of the following: ◆ CPT® 76801 [plus CPT® 76802 if more than one fetus] if a complete ultrasound has not yet been performed, **and/or** ◆ CPT® 76817 for a transvaginal ultrasound indicated
➢ Detailed Fetal Anatomic Scan CPT® 76811 ideally performed between 18 to 20 weeks, but be performed after 16 weeks when criteria is met ◆ The specialized fetal anatomic evaluation (CPT® 76811 and CPT® 76812) is generally performed by those with special skills to perform this study, such as Maternal Fetal Medicine specialists, Perinatologists, and Radiologists with advanced training in fetal imaging. ◆ There is no prior approval for a CPT® 76811 for the current pregnancy ◆ In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead. ◆ CPT® 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition
➢ Starting at 23 follow-up growth scans (CPT® 76816) every 3 to 6 weeks ◆ CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)
➢ Starting at 32 weeks, weekly BPP (CPT® 76818 or CPT® 76819) or modified AFI (CPT® 76815)

OB-9.2: High Risk Group Two – Findings on Ultrasound that May Require Further Imaging

OB-9.2.1: High Risk Group Two a.

➢ If the following conditions are found upon routine imaging: ◆ Shortened femur identified in fetus of current pregnancy ◆ Shortened humerus identified in fetus of current pregnancy ◆ Pyelectasis of > 4 mm at 20 weeks identified in fetus of current pregnancy ◆ Echogenic bowel identified in fetus of current pregnancy ◆ Hypoplastic nasal bone in current pregnancy
➢ Fetal anatomic scan is ideally performed at 18 to 20 weeks but must be performed after 16 weeks (CPT® 76811).
➢ One follow-up scan (CPT® 76816) in third trimester

OB-9.2.2: High Risk Group Two b.

➢ If the following conditions are found upon routine imaging: ◆ Choroid plexus cyst (present in 30% to 50% of all Trisomy 18 fetuses). Follow-up imaging not needed if targeted scan is normal ◆ Echogenic intra-cardiac foci (present in 15% to 30% of all Down syndrome fetuses). Fetal echo or follow-up ultrasound are not warranted ◆ Prior pregnancy with a congenital anomaly ◆ Chromosomal abnormalities with previous pregnancy
➢ Fetal anatomic scan is ideally performed at 18 to 20 weeks but must be performed after 16 weeks (CPT® 76811)

Practice Notes

- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.
- CPT® 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition.
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

OB-9.3: High Risk Group Three – BMI

OB-9.3.1: Pre-pregnancy BMI 30 to 34.9

Obesity (BMI 30-34)
➢ Perform one ultrasound in the first trimester to establish dates and report one of the following: ◆ CPT® 76801 [plus CPT® 76802 if more than one fetus] if a complete ultrasound has not yet been performed, **and/or** ◆ CPT® 76817 for a transvaginal ultrasound indicated
➢ Fetal anatomic scan is ideally performed at 18 to 20 weeks but must be performed after 16 weeks (CPT® 76811)
➢ **One** follow-up scan (CPT® 76816) between 32 to 36 weeks

OB-9.3.2: Pre-pregnancy BMI 35-39.9

Obesity (BMI 35-39)
➢ Perform one ultrasound in the first trimester to establish dates, and report one of the following: ◆ CPT® 76801 [plus CPT® 76802 if more than one fetus] if a complete ultrasound has not yet been performed, **and/or** ◆ CPT® 76817 for a transvaginal ultrasound indicated
➢ Fetal anatomic scan is ideally performed at 18 to 20 weeks but must be performed after 16 weeks (CPT® 76811)
➢ Growth scan (CPT® 76816) at 32 and 36 weeks, **and**
➢ CPT® 76818 or CPT® 76819 or a modified BPP CPT® 76815 weekly starting at 36 weeks

OB-9.3.3: Pre-pregnancy BMI ≥ 40

Obesity (BMI ≥ 40)
➢ Perform one ultrasound in the first trimester to establish dates, and report one of the following: ◆ CPT® 76801 [plus CPT® 76802 if more than one fetus] if a complete ultrasound has not yet been performed**, and/or** ◆ CPT®76817 for a transvaginal ultrasound indicated
➢ Fetal anatomic scan is ideally performed at 18 to 20 weeks but must be performed after 16 weeks (CPT® 76811)
➢ Growth scan (CPT® 76816) at 32 and 36 weeks
➢ CPT® 76818 or CPT® 76819 or modified BPP CPT® 76815 weekly starting at 32 weeks

Practice Notes

- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.
- CPT 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition.
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy).

The obesity protocol that was introduced in 2011 included recommendations for early gestational diabetes mellitus screening and an overall pregnancy weight gain of 11 to 20 pounds in all classes of obesity. A baseline 24-hour urine protein collection was recommended for class II and class III obese patients based on their increased risk of developing gestational diabetes mellitus and preeclampsia in addition to serial growth scans and nonstress tests also being utilized. Delivery by the estimated due date was recommended for each class of obesity meeting the following criteria: (1) class III obese (pre-pregnancy body mass index of 40 kg/m^2 or greater) alone, (2) class II obese (pre-pregnancy body mass index of 35 to 39.9 kg/m^2) and a diagnosis of gestational diabetes mellitus or large for gestational age, or (3) class I obese (pre-pregnancy body

mass index of 30 to 34.9 kg/m^2) plus a diagnosis of gestational diabetes mellitus and large for gestational age fetus. Large for gestational age/macrosomia was defined as an estimated fetal weight of greater than the 95th percentile.

OB-9.4: High Risk Group Four – Macrosomia

OB-9.4.1: Prior Pregnancy with Macrosomia

Prior pregnancy with macrosomia (baby weighing > 4000 grams at term or greater than the 90th percentile of expected weight)
➢ Perform one ultrasound in the first trimester to establish dates, and report one of the following: ◆ CPT® 76801 [plus CPT® 76802 if more than one fetus] if a complete ultrasound has not yet been performed, **or** CPT® 76815 for limited ultrasound if complete ultrasound has already been performed, and/or CPT® 76817 for a transvaginal ultrasound, indicated if less than 14 weeks.
➢ One targeted scan (CPT® 76811) in second-trimester ≥ 16 weeks
➢ One growth scan (CPT® 76816) in the third trimester

OB-9.4.2: Current Pregnancy with Suspected or Known Macrosomia

➢ See: **OB-20.2: Macrosomia – Large for Dates Current Pregnancy** and **OB-27: Unequal Fundal Size and Dates**

Practice Notes

- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.
- CPT 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition.
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

OB-9.5: High Risk Group Five – Zika Virus

- Suspected exposure without symptoms:
  - CPT® 76801 [plus CPT® 76802 if more than one fetus] if a complete ultrasound has not yet been performed, **or** CPT® 76815 for limited ultrasound if complete ultrasound has already been performed, **and/or** CPT® 76817 for a transvaginal ultrasound indicated if less than 14 weeks
  - Anatomy scan CPT® 76805 (plus CPT® 76810 if more than one fetus) if a complete ultrasound has not yet been performed during this pregnancy
  - If test positive or if symptoms developed, see below.
- Suspected exposure with symptoms or known disease:
  - CPT® 76801 [plus CPT® 76802 if more than one fetus] if a complete ultrasound has not yet been performed, **or** CPT® 76815 for limited ultrasound if complete ultrasound has already been performed, and/or CPT® 76817 for a transvaginal ultrasound, indicated if less than 14 weeks;
  - Detailed fetal anatomic scan (CPT® 76811) may be performed at 16 weeks gestation or greater.
  - Growth scan, (CPT® 76816) every 3 to 4 weeks to monitor for findings such as intracranial calcifications and microcephaly, starting at 16 weeks.
  - If diagnosed FGR or abdominal circumference ≤ 10 percentile then follow FGR imaging **OB-20.1: Fetal Growth Restriction Current Pregnancy**
- If intracranial calcifications, microcephaly or other abnormalities emerge, send to MD review. In these cases, imaging would follow the algorithm of other viruses that cause congenital infection **OB-9.1.1: Risk factors**

Practice Notes

- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.
- CPT 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition.
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

OB-9.6: High Risk Group Six – Pre-Gestational Diabetes

- If diabetes is diagnosed prior to pregnancy or in the first trimester or early second trimester with the standard diagnostic criteria of a hemoglobin A_{1c} (HbA_{1c}) of 6.5% or greater, a fasting plasma glucose of 126 mg/dL or greater, or a 2-hour glucose of 200 mg/dL or greater on a 75-g oral glucose tolerance test, it is considered pre-gestational diabetes. (*Adapted from Pregestational diabetes mellitus. ACOG Practice Bulletin No. 201. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;132:e228-48.)*

OB-9.6.1: Pre-Gestational Diabetes - not on medication

Test	When	Frequency	Codes
First Trimester Ultrasounds	< 14 weeks	Once	CPT® 76801 and/or CPT® 76817
Fetal anatomic scan	≥ 16 weeks	Once	CPT®76811
Fetal echo (initial) Requests for follow-up go to MD review	Starting at ≥ 18 weeks	Once	CPT® 76825 **and/or** CPT® 76827 **and/or** CPT® 93325
Ultrasound (for fetal growth	One at the time of diagnosis then starting at 32 weeks	Every 3 to 6 weeks	CPT®76816
Biophysical Profile (BPP) or modified BPP	Starting at 32 weeks	Once per week	CPT®76818 or CPT®76819 (BPP) or modified BPP CPT 76815 (AFI)

OB-9.6.2: Pre-Gestational Diabetes on Oral Medications or Insulin

If patient has pre-gestational diabetes and is on oral medication or insulin:			
Test	**When**	**Frequency**	**Codes**
First Trimester Ultrasounds	< 14 weeks	Once	CPT® 76801 and/or CPT® 76817
Fetal anatomic scan	16 to 20 weeks	Once	CPT® 76811
Fetal echo (initial) Requests for follow-up go to MD review	Starting at ≥ 18 weeks	Once	CPT® 76825 **and/or** CPT® 76827 **and/or** CPT® 93325
Ultrasound (for fetal growth)	Starting at viability 23 weeks	Every 2 to 4 weeks	CPT® 76816
Biophysical Profile (BPP) or AFI with NST*	If complicated by additional risk factors, perform > or equal to 26	Up to twice weekly	CPT® 76818 or CPT® 76819 or CPT® 76815 for AFI with NST
Biophysical Profile (BPP) or modified BPP	Starting at 32 weeks	Up to twice weekly	CPT® 76818 or CPT® 76819 (BPP) or modified BPP CPT® 76815
Umbilical artery Doppler (if FGR diagnosed)	Upon diagnosis of FGR if >23 weeks	Weekly	CPT® 76820

Practice Notes

- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.
- CPT 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition.
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

OB-9.7: High Risk Group Seven Gestational Diabetes

OB-9.7.1: Gestational Diet-Controlled (GDM-A1)

If patient has gestational diabetes and it is diet controlled:			
Test	**When**	**Frequency**	**Codes**
Fetal anatomic scan	16 to 20 weeks	Once	CPT® 76805
Ultrasound (for fetal growth)	Once at the time of diagnosis, then starting at 32 weeks	Every 4 weeks	CPT® 76816
Biophysical Profile (BPP) or modified BPP	Starting at 34 to 36 weeks	Once weekly if diet controlled.	CPT® 76818 **or** CPT® 76819 **or modified BPP** CPT® 76815 *

OB-9.7.2: Gestational Diabetes (GDM-A2) on Oral Medications or Insulin

If patient has gestational diabetes and is on oral medication or insulin:			
Test	**When**	**Frequency**	**Codes**
Fetal anatomic scan	16 to 20 weeks	Once	CPT® 76811
Fetal echo (initial) Requests for follow-up go to MD review	Greater than 18 weeks	Once	CPT® 76825 **and/or** CPT® 76827 **and/or** CPT® 93325
Ultrasound (for fetal growth)	Starting at viability 23 weeks	Every 2 to 4 weeks	CPT® 76816
Biophysical Profile (BPP) or modified BPP	If complicated by additional risk factors perform between ≥26	Up to twice weekly	CPT® 76818 **or** CPT® 76819 **or** modified BPP CPT® 76815
Biophysical Profile(BPP) or modified BPP	Starting at 32 weeks	Up to twice weekly	CPT® 76818 **or** CPT® 76819 **or** modified BPP CPT® 76815
Umbilical artery Doppler (if FGR diagnosed)	Upon diagnosis of FGR if >23 weeks	Weekly	CPT® 76820

Practice Note

- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.
- CPT 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition.
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

OB-9.8: Hypertension

OB-9.8.1: Current Chronic Hypertension

Current chronic hypertension, on and not on prescribed medications, and/or History of preeclampsia, and/or History of FGR:
➢ One time uterine artery Doppler (CPT® 93976) evaluation prior to < 16 weeks gestation. Uterine artery Doppler is not indicated > 16 weeks. ➢ If test is abnormal at less than 16 weeks, a repeat test can be considered at 20 to 22 weeks gestation after starting baby aspirin. (CPT® 93976) (See: **OB-28.10: Duplex Scan (Uterine Artery)**

OB-9.8.2: Hypertension-related Conditions

If patient has one of the following hypertension-related conditions:			
➢ Chronic hypertension not on prescribed hypertension medication:			
Test	**When**	**Frequency**	**Codes**
First Trimester Ultrasounds	< 14 weeks	Once	CPT® 76801 and/or CPT® 76817
Fetal anatomic scan	≥16 weeks	Once	CPT® 76811
Ultrasound (for fetal growth)	30-34 weeks	Once	CPT® 76816
If blood pressure is elevated from baseline, see **Gestational Hypertension (GH)** below			

Chronic hypertension on prescribed hypertension medication:			
Test	**When**	**Frequency**	**Codes**
First Trimester Ultrasounds	< 14 weeks	Once	◆ CPT® 76801 and/or CPT® 76817
Detailed Fetal Anatomic Scan	16 weeks gestation or greater	Once	◆ CPT® 76811
Ultrasound (for fetal growth)	starting at viability 23 weeks gestation	Every 3 to 4 weeks	◆ CPT® 76816
Biophysical profile (BPP) or modified BPP	Starting at 32 weeks If other risk factors are present, may start at 26 weeks	Weekly	◆ CPT® 76818 **or** ◆ CPT® 76819 **or** modified BPP ◆ CPT® 76815
Umbilical artery Doppler (if FGR diagnosed) See: **OB-20.1: Fetal Growth Restriction Current Pregnancy**	Upon diagnosis of FGR if >23 weeks	Weekly	◆ CPT® 76820

Gestational Hypertension (GH, preeclampsia, toxemia):			
Test	**When**	**Frequency**	**Codes**
Growth US	Starting at time of diagnosis	Every 3 to 4 weeks If FGR, Oligohydramnios or severe preeclampsia (every 2 to 4 weeks)	◆ CPT® 76816
BPP or modified BPP	Starting at time of diagnosis	Once weekly If FGR or Oligohydramnios is also present, twice weekly	◆ CPT® 76818 **or** ◆ CPT® 76819 **or** modified BPP CPT® 76815
Umbilical artery Doppler	Starting at time of diagnosis of FGR or Oligohydramnios	Twice weekly	◆ CPT® 76820
MCA Doppler	If FGR is confirmed, starting at 34 weeks	Once weekly- only following a normal 76820 Doppler	◆ CPT® 76821

Practice Note

- ***Gestational hypertension*** is defined as a systolic blood pressure 140 mm Hg or more or a diastolic blood pressure of 90 mm Hg or more, or both, on two occasions at least 4 hours apart after 20 weeks of gestation, in a woman with a previously normal blood pressure.
- **Preeclampsia** is a disorder of pregnancy associated with new-onset hypertension, which occurs most often after 20 weeks of gestation and frequently near term. Although often accompanied by new-onset proteinuria, hypertension and other signs or symptoms of preeclampsia may present in some women in the absence of proteinuria.

- **Eclampsia** is the convulsive manifestation of the hypertensive disorders of pregnancy and is among the more severe manifestations of the disease.

From ACOG Practice Bulletin 202 Gestational Hypertension and Preeclampsia December 2018

Table 1. American College of Obstetricians and Gynecologists Definitions of Hypertensive Disorders

Disorder	Definition
Hypertension in pregnancy	Systolic blood pressure ≥140 mm Hg or diastolic BP ≥90 mm Hg, or both, measured on two occasions at least 4 hours apart
Severe-range hypertension	Systolic blood pressure ≥160 mm Hg or diastolic BP ≥110 mm Hg, or both, measured on two occasions at least 4 hours apart
Chronic hypertension	Hypertension diagnosed or present before pregnancy or before 20 weeks of gestation; or hypertension that is diagnosed for the first time during pregnancy and that does not resolve it the postpartum period
Chronic hypertension with superimposed preeclampsia	Preeclampsia in a woman with a history of hypertension before pregnancy or before 20 weeks of gestation

From ACOG Practice Bulletin 203 Chronic Hypertension in Pregnancy January 2019

- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.
- CPT 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition.
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

OB-9.9: History of Pre-Term Delivery/History of PPROM

OB-9.9.1: Preterm Delivery ≤ 34 Weeks; History of PPROM ≤ 34 weeks

- Ultrasound CPT® 76801 [plus CPT® 76802 if more than one fetus] if a complete ultrasound has not yet been performed once in first trimester **and/or** CPT® 76817 for transvaginal ultrasound once in first trimester (less than 14 weeks) to establish dates
- Ultrasound is supported at 16 weeks or greater: CPT® 76811 [plus CPT® 76812 if more than one fetus] **and/or** CPT® 76817 if a complete detailed fetal anatomic scan has not yet been performed during this pregnancy.
- Starting after the fetal anatomic scan at 23 weeks or greater, ultrasound (CPT® 76816) can be performed every 3 to 6 weeks until delivery

- (CPT® 76815 and/or CPT® 76817) every 2 weeks, starting at 16 weeks or greater until 24 weeks
- Starting at 32 weeks, weekly BBP CPT® 76818 or CPT® 76819 or modified BPP CPT® 76815

OB-9.9.2: History of Preterm Delivery > 34 weeks < 37

- CPT® 76801 [plus CPT® 76802 if more than one fetus] if a complete ultrasound has not yet been performed **and/or** CPT® 76817 for a transvaginal ultrasound indicated if less than 14 weeks to establish dates
- (CPT® 76815 and/or CPT® 76817) every 2 weeks, starting at 16 weeks or greater until 24 weeks
- An anatomy ultrasound is supported at 16 weeks or greater: CPT® 76805 [plus CPT® 76810 if more than one fetus] **and/or** CPT® 76817 if a complete fetal anatomic scan has not yet been performed during this pregnancy.

Practice Note

- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.
- CPT 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition.
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

OB-9.10: History of Stillbirth

- CPT® 76801 [plus CPT® 76802 if more than one fetus] if a complete ultrasound has not yet been performed, **or** CPT® 76815 for limited ultrasound if complete ultrasound has already been performed, **and/or** CPT® 76817 for a transvaginal ultrasound indicated if less than 14 weeks
- Fetal anatomic scan at 16 weeks or greater (CPT® 76811)
- Following fetal anatomy ultrasound, follow up ultrasound (CPT® 76816) every 2 to 4 weeks to assess fetal growth starting at 23 to 24 weeks or two weeks before prior pregnancy loss.
- Weekly BPP (CPT® 76818 or CPT® 76819) **or** modified BPP CPT® 76815 for starting at 32 weeks or two weeks before prior pregnancy loss

Practice Notes

- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.
- CPT 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition.
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

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OB-10: High Risk Medications and Substances

OB-10.1: Medications and Substances that Qualify for a Detailed Fetal Anatomic Scan

- Specific drugs that qualify for a detailed Fetal Anatomic Scan (CPT® 76811)
- If another high risk indication see appropriate guideline for any further imaging

High Risk Medications/Substances
Alcohol
Aminoglycosides (amikacin, gentamycin, kanamycin, tobramycin, and other mycins)
Amphetamines
Angiotensin II antagonists or blockers
Anti-neoplastics (cancer drugs)
Accutane/isoretinoin/retinoic acid
Aspirin – only if exposed less than 10 weeks gestation
Atenolol
ACE inhibitors (benzapril, captopril, enalopril, fosinopril, lisinipril, etc)
Anticonvulsants (phenytoin, carbamazepine, valproate, primidone, phenobarbital, Dilantin)
Azathioprine
Benzodiazepines (Diazepam (valium), etc)
Carbon monoxide
Chlordiazepoxide
Cocaine
Codeine
Cortisone
Coumadin/ warfarin
Cyclophosphamide
Cytarabine
Daunorubicin
Dextroamphetamine
Ergotamine
Fluconazole (and other anti-fungals)
Heparin
Lead
Lithium
Methimazole
Methotrexate
Methyl mercury
Misoprostol
Oral contraceptives
Paramethadione
Paroxetine/SSRI
Penicillamine
Primidone
Progesterones (exposure less than 12 weeks) and anti-progesterone drug RU486
Pregabalin/Lyrica
Quinine
Retinoic acid/retinoid medications
Selective serotonin reuptake inhibitors (SSRI)
Substance abuse (heroin, methadone, subutex, cocaine)

High Risk Medications/Substances
Tetracyclines
Thalidomide
Trifluroperazine
Trimethadione
Valproic acid

Practice Note

There may be other medications or drugs not included on this list that cause increased risk in pregnancy. These cases should be sent for medical director review.

- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.

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OB-11: Multiple Gestations

OB-11.1: For Suspected Multiple Gestations

For Suspected multiple pregnancies:
➢ CPT® 76801 [plus CPT® 76802 if more than one fetus] if a complete ultrasound has not yet been performed and/or CPT® 76817 for a transvaginal ultrasound indicated if less than 14 weeks

OB-11.2: For Known Dichorionic Multiple Gestations

For Known dichorionic multiple pregnancies:
➢ CPT® 76811[plus CPT® 76812 if more than one fetus] if greater than 16 weeks if a complete detailed anatomic scan CPT® 76811 has not yet been performed during this pregnancy. If prior to 16, send to MD review. ➢ Following an anatomy ultrasound, growth ultrasound (CPT® 76816) every 4 to 6 weeks starting at ≥ 23 weeks gestation ➢ Transvaginal ultrasound (CPT® 76817) is recommended only in twin gestations with significant cervical shortening ≤ 1.5 cm on a transabdominal evaluation ONLY if rescue cerclage is being considered. Send all these requests to MD Review ➢ Weekly BPP (CPT® 76818 or CPT® 76819) **or** modified BPP 76815 starting at 32 weeks or sooner if additional risk factors ➢ Twice weekly BPP can be considered in rare clinical circumstances. These requests will be forwarded for Medical Director review ➢ If discordant twins ≥ 20%. See practice note below. Twice weekly BPP plus ultrasound (CPT® 76816) every 2 to 4 weeks, **and** umbilical artery Doppler (CPT® 78620) weekly; for twice weekly imaging send to MD review ➢ If FGR is diagnosed, weekly umbilical artery Doppler **and/or** Middle Cerebral Artery Doppler (CPT® 76820 and/or CPT® 76821). If umbilical artery dopplers are abnormal (absent or reversed end diastolic flow), then more frequent BPPs (CPT® 76818 or CPT® 76819) may be considered (2x per week, or even daily) and twice weekly umbilical artery dopplers (CPT® 78620). ➢ If IVF dichorionic twins, report initial fetal echo as CPT® 76825 and/or CPT® 76827 and/or CPT® 93325. Transabdominal fetal echo is usually not performed prior to 16 weeks. Follow-up echo requests will be sent to Medical Director review ➢ If other high risk factors, see: **OB-9: High Risk Pregnancy**

OB-11.3: For Known Monochorionic-Diamniotic or Monochorionic-Monoamniotic Multiple Gestations

For Known monochorionic-diamniotic or monochorionic-monoamniotic multiple pregnancies
➢ CPT® 76811 [plus CPT® 76812 if more than one fetus] if greater than 14 weeks if a complete detailed anatomic scan CPT® 76811 has not yet been performed during this pregnancy. ➢ Follow an anatomy ultrasound, growth ultrasound (CPT® 76816) every 2 to 4 weeks starting at 16 weeks gestation. ➢ Transvaginal ultrasound (CPT® 76817) is recommended only in twin gestation with significant cervical shortening ≤ 1.5 cm on a transabdominal evaluation if rescue cerclage is a consideration. Send all these requests to MD Review ➢ Weekly BPP (CPT® 76818 or CPT® 76819) or modified BPP CPT® 76815, starting at 32 weeks, sooner if additional risk factors are present. ➢ Fetal middle cerebral artery (MCA) Doppler (CPT® 76821) every 2 to 3 weeks starting at 16 weeks to monitor for twin-twin transfusions syndrome (TTTS) and may be continued every 2 to 3 weeks to monitor for twin anemia polycythemia sequence (TAPS) until delivery. ➢ If Twin to Twin Transfusion syndrome is diagnosed daily evaluation with a limited ultrasound (CPT® 76815), **and/or** biophysical profile (CPT® 76818 or CPT® 76819) **and/or** umbilical artery Doppler (CPT® 76820)and/or middle cerebral artery (MCA) Doppler (CPT® 76821) can be performed to aid in planning intervention and/or imminent delivery ➢ If discordant twins ≥ 20%. See practice note below. Twice weekly BPP plus ultrasound (CPT® 76816) every 2 to 4 weeks, **and** umbilical artery Doppler (CPT® 78620) weekly. ➢ Daily fetal testing may be indicated if umbilical Doppler is abnormal. These requests will be forwarded for Medical Director for review. ➢ Fetal echo CPT® 76825 and/or CPT® 76827 and/or CPT® 93325 for initial echo. Transabdominal fetal echo is usually not performed prior to 16 weeks. For follow-up echo, send to MD review. ➢ If FGR is diagnosed, weekly umbilical artery Doppler CPT® 76820 and/or weekly Middle Cerebral Artery Doppler (CPT® 76821). If umbilical artery dopplers are abnormal (absent or reversed end diastolic flow), then more frequent BPPs (CPT® 76818 or CPT® 76819) may be considered (2x per week, or even daily) and twice weekly umbilical artery dopplers (CPT® 78620). ➢ If other high risk factors, see **OB-9.1: High Risk Group One – Risk Factors**
Triplets or higher Multiple Pregnancy receive same imaging as monochorionic- diamniotic- and monochorionic- monoamniotic- twins. These requests will be forwarded for Medical Director review.

Practice Notes

- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead
- CPT 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition.
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

Discordant twins

Birth weight discordance = (larger twin weight minus smaller twin weight) divided larger twin weight × 100.

Cervical Length Screening

Cervical length screening is not recommended in twin gestation. The use of a rescue cerclage when cervical dilation is present has been shown to be beneficial. For this reason, a cervical length under 1.5 cm is required for evaluation. In select cases, a TV ultrasound may be indicated. These require approval from the Medical Director. Cerclage is used in some cases of TTTS due to polyhydramnios causing the short cervix. Also, rescue cerclage is still used in those with a dilated cervix.

Surviving fetus(es) in multifetal pregnancy complicated by demise of one fetus/fetal reduction:

Fetal loss of one twin during the first trimester does not appear to increase the risk of FGR or preterm delivery in the surviving twin.

Loss for one fetus after 17 weeks gestation increases the risk of low birth weight and preterm delivery (compared to singleton pregnancies.) Multiple pregnancies affected by loss of one or more fetus(es) after 17 weeks or by fetal reduction should be imaged according to OB 16

Monochorionic twin pregnancies with demise of one twin after 17 weeks have 17% chance of major morbidity or mortality for the remaining fetus, these cases should be sent for Medical Director review.

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OB-12: Fetal Echocardiography (ECHO)

OB-12.1: Fetal Echocardiography – Coding

- The minimal use of color Doppler alone, when performed for anatomical structure identification during a standard ultrasound procedure, is not separately reimbursable.
- Transabdominal fetal echo is usually not performed prior to 16 weeks
- Fetal echocardiography (Initial study-CPT® 76825 or follow-up-CPT® 76826) (follow-up echo must go to MD review)
- Doppler echocardiography (Initial study-CPT® 76827 or follow-up-CPT® 76828) (repeat echo must go to MD review) and
- Doppler color flow velocity mapping (CPT® 93325) can be ordered together or separately for the following conditions:

OB-12.2: Indications for Fetal Conditions

➢ Abnormal or suspected abnormal fetal cardiac evaluation on fetal anatomic scan. ◆ There must be documentation (provided as hard copy or acknowledged verbally by provider) that the four chamber cardiac study was abnormal or suspected abnormal on the anatomic scan in order for fetal echo to be indicated
➢ Suspected or known fetal arrhythmia; sustained fetal tachycardia or bradyarrhythmia (to define the rhythm and assess for possible structural cardiac anomalies)
➢ Known fetal extra-cardiac anomaly, excluding cardiac echogenic foci and choroid plexus cyst see: **OB-9.2.2: High Risk Group Two b.**
➢ Congenital heart disease (CHD) or cardiac anomaly in a 1st degree relative of the proband (ie mother or father)
➢ Known fetal chromosomal abnormalities (fetal aneuploidy) or ultrasound findings of a suspected chromosomal abnormality.
➢ Single umbilical artery, Chorioangioma or Umbilical cord varix if evidence of fetal hydrops ➢ Intra-abdominal venous anomaly (persistent right umbilical vein)
➢ Fetal hydrops/effusion see: **OB-16: Alloimmunization/Rh Isoimmunization/Other Causes of Fetal Anemia/Parvo/Hydrops**
➢ Monochorionic twins/TTTS
➢ Abnormal Fetal Nuchal Translucency scan (≥ 3.0mm) during current pregnancy.
➢ Suboptimal visualization is not an indication for fetal echogram, unless documented suspicion of a cardiac anomaly of the fetus. A repeat limited (CPT®76815) or follow up ultrasound (CPT®76816) is indicated for suboptimal visualization.

OB-12.3: Indications for Maternal Conditions

For Maternal Conditions:
➢ Maternal pre-gestational DM
➢ Diabetes mellitus dx'd in the 1st trim
➢ Maternal gestational diabetes mellitus on medication
➢ Connective tissue diseases (SLE [Lupus], Sjogrens, RA, Scleroderma etc.) with Anti-Ro/SSA or anti-La/SSB antibodies present
➢ Rubella infection
➢ Phenylketonuria
➢ Presence of other maternal conditions associated with cardiac anomalies (such as parvovirus, CMV, Coxsackie virus, Toxoplasmosis)
➢ Family history of a first degree relative to the fetus with a , genetic conditions associated with CHD (such as family history of Marfan syndrome, 22q11.2 deletion syndrome (DiGeorge Syndrome) or Noonan syndrome)
➢ Seizure disorder
➢ IVF pregnancies

OB-12.4: Medication or Drug Exposure

- Lithium
- Excessive alcohol
- Anti-seizure medication, e.g. hydantoin
- Paroxetine
- Birth control pills
- Ace inhibitors
- Folate antagonists (methotrexate)
- Anticonvulsants
- Retinoic acid
- Thalidomide
- Amphetamines
- Cocaine
- NSAIDS (Ibuprofen, Indomethacin) 2nd and 3rd trimester
- Vitamin A greater than 10,000 units per day
- Opiates
- Benzodiazepines
- Other teratogen exposure to the fetus with a known association for cardiac anomalies

Coding Notes

- Requests for repeat fetal echo will be forwarded to Medical Director review
- CPT® 76825 and CPT® 76827 are performed only once per fetus
- Follow-up echocardiograms are reported as CPT® 76826
- Follow-up Doppler fetal echocardiograms are reported as CPT® 76828
- If a Fetal Echo is ordered for an individual who has not had a previous echo in the pregnancy, and the clinical criteria are met, then the Fetal Echo may be approved using the following CPT® codes for the initial echo:
- CPT® 76825 and/or CPT® 76827 and/or CPT® 93325 (add on code for color mapping)
- Requests for follow-up studies CPT® 76826 and/or CPT® 76828 (limited/follow-up study) will be forwarded to Medical Director for review.
- Procedure code (CPT® 76827 or CPT® 76828) includes the evaluation of veins, arteries, and valves. Guidelines do not support the billing of a second code (CPT® 76820) and, therefore, the request is not indicated at this time.

Practice Note

- There are no formal guidelines for the type or the frequency of testing to detect fetal heart block, but performing weekly pulsed Doppler fetal echocardiography (CPT® 76828) from the 18th through the 26th week of pregnancy and then every other week until 32 weeks should be strongly considered. The most vulnerable period for the fetus is during the period from 18 to 24 weeks gestation. Normal sinus rhythm can progress to complete block in seven days during this high-risk period. New onset of heart block is less likely during the 26th through the 30th week, and it rarely develops after 30 weeks of pregnancy.

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OB-13: Fetal MRI

OB-13.1: Indications for Fetal MRI

CPT® Code Guidance
➢ Fetal MRI (CPT® 74712) ; for each additional gestation (CPT® 74713)
➢ Do not report CPT® 74712 and CPT® 74713 in conjunction with CPT® 72195, CPT® 72196, CPT® 72197
➢ If only placenta or maternal pelvis is imaged without fetal imaging, use MRI pelvis (CPT® 72195)

- Fetal MRI may be considered for assessment of fetal anatomic structures after 18 weeks gestation for surgical planning (re: fetal anomalies), and/or if an ultrasound is equivocal **and** additional information is needed for counseling purposes, for indications including the following:
  - Brain
    - Congenital anomalies
      - ventriculomegaly
      - corpus callosal dysgenesis
      - holoprosencephaly
      - posterior fossa anomalies
      - malformations of cerebral cortical development
    - Screening fetuses with a family risk for brain anomalies
      - tuberous sclerosis
      - corpus callosal dysgenesis
      - malformations of cerebral cortical development
    - Vascular abnormalities
      - vascular malformations
      - hydranencephaly
      - Intra-uterine cerebrovascular accident (CVA)
  - Spine
    - Congenital anomalies
      - neural tube defects
      - sacrococcygeal teratomas
      - caudal regression/sacral agenesis
      - syringomyelia
      - vertebral anomalies
  - Skull, face, and neck
    - Masses of the face and neck
      - venolymphatic malformations
      - hemangiomas
      - goiter
      - teratomas
      - facial clefts
    - Airway obstruction
      - conditions that may impact parental counseling, prenatal management, delivery planning, and postnatal therapy

- Thorax
  - Masses
    - congenital pulmonary airway malformations (congenital cystic adenomatoid malformation; sequestration, and congenital lobar emphysema);
    - congenital diaphragmatic hernia
    - effusion
  - Volumetric assessment of lung
    - cases at risk for pulmonary hypoplasia secondary to oligohydramnios, chest mass, or skeletal dysplasias
- Abdomen, retroperitoneal and pelvis
  - Mass
    - abdominal–pelvic cyst
    - tumors (e.g. hemangiomas, neuroblastomas, sacrococcygeal teratomas, and suprarenal or renal masses)
    - complex genitourinary anomalies (e.g. cloaca)
    - renal anomalies in cases of severe oligohydramnios
    - bowel anomalies such as megacystis microcolon
- Complications of monochorionic twins
  - delineation of vascular anatomy prior to laser treatment of twins
  - assessment of morbidity after death of a monochorionic co-twin
  - improved delineation of anatomy in conjoined twins
- Fetal surgery assessment
  - meningomyelocele
  - sacrococcygeal teratomas
  - processes obstructing the airway (e.g. neck mass or congenital high airway obstruction)
  - complications of monochorionic twins needing surgery
  - chest masses

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OB-14: Abnormal Fetal Position/ Malpresentation

OB-14.1: Abnormal Fetal Position or Presentation

- Confirmation of suspected abnormal fetal position or presentation (transverse or breech presentation):
  - An ultrasound can be performed at 36 weeks gestation or greater to determine fetal position to allow for external cephalic version
  - Ultrasound to determine fetal position is not necessary prior to 36 weeks gestation unless delivery is imminent
- Report one of the following:
  - CPT® 76805 (plus CPT® 76810 if more than one fetus) for complete fetal anatomic scan when complete fetal anatomic scan CPT® 76805 is planned and has not yet been performed **or**
  - CPT® 76815 for limited ultrasound to check fetal position or CPT® 76816 if version planned/considered
    - CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

Practice Note

Fetal presentation should be assessed by abdominal palpation at 36 weeks or later, when presentation is likely to influence the plans for the birth. Routine assessment of presentation by abdominal palpation should not be offered before 36 weeks because it is not always accurate and may be uncomfortable. Suspected fetal malpresentation should be confirmed by an ultrasound assessment.

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OB-15: Adnexal Mass/Uterine Fibroids and Uterine Anomalies

OB-15.1: Adnexal Mass

- Ultrasound can be performed for a known or suspected adnexal/pelvic mass.
  - First trimester: CPT® 76801 [plus CPT® 76802 if more than one fetus] and/or CPT® 76817 for a transvaginal ultrasound to establish dates **or**
  - If a complete ultrasound was done previously CPT® 76815 and/or CPT®76817 for a transvaginal ultrasound. **or**
  - Second or third trimester: CPT® 76805 [plus CPT® 76810 if more than one fetus] if a complete fetal anatomic scan has not yet been performed, or CPT® 76815 or CPT® 76816 if a complete ultrasound scan was done previously.
- Following the initial ultrasound, follow up can be done once in each trimester,
  - CPT® 76805 [plus CPT® 76810 if more than one fetus] if a complete fetal anatomic scan has not yet been performed, **or**
  - CPT® 76815 or CPT® 76816 if a complete ultrasound was done previously.
- MRI pelvis (CPT® 72195) without contrast can be done if additional imaging is needed due to indeterminate findings of possible dermoid or endometrioma on ultrasound, or for suspected malignancy
- See **PV-5: Adnexal Mass/Ovarian Cysts**

Practice Note

The majority of adnexal mass in pregnancy are benign, the most common diagnoses are mature teratomas and corpus luteum or paraovarian cysts. Malignancy is reported in only 1.2-6.8% of pregnant patients with persistent mass.

Levels of CA-125 are elevated in pregnancy, a low-level elevation in pregnancy is not typically associated with malignancy.

OB-15.2: Uterine Fibroids in Pregnancy

- If more than one fibroid, total size of all fibroids should be used, ie-one fibroid at 2 cm and one 3 cm is total of 5 cm and imaging would be indicated as below:
  - Moderate (over 5 cm) and large (over 10 cm) fibroid(s):
    - First trimester: CPT® 76801 [plus CPT® 76802 if more than one fetus] and/or CPT® 76817 for a transvaginal ultrasound to establish dates
    - Fetal anatomic scan at 16 weeks or greater (CPT® 76805 or if meets criteria in **OB-9: High Risk Pregnancy**— CPT® 76811)
    - Starting after the fetal anatomic scan at 16 weeks or greater, if the fibroid is in the lower uterine segment or cervical fibroid then ultrasound (CPT® 76815) every 2 to 4 weeks and/or transvaginal ultrasound (CPT® 76817) every 2 weeks until 24 weeks
    - Starting after the fetal anatomic scan follow up Ultrasound (CPT® 76816) for growth at 23 weeks and then every 3 to 6 weeks.

Practice Note

- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.

- CPT 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition.
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)
- The true incidence of fibroids during pregnancy is unknown. The reported rates vary from as low as 0.1% of all pregnancies to higher rates of 12.5%. It seems that pregnancy has little or no effect on the overall size of fibroids despite the occurrence of red degeneration in early pregnancy. Fibroids, however, affect pregnancy and delivery in several ways, with abdominal pain, miscarriage, malpresentation, and difficult delivery being the most frequent complications. The major concerns occur late in pregnancy. These complications relate to preterm labor, placental abruption, fetal growth restriction, and fetal compression syndromes. The risk of preterm labor appears to correlate with the size of the fibroid (over 600 cm3) and/or the presence of multiple fibroids. Placental abruption has been reported to occur frequently in pregnancies complicated by fibroids.
- Placentation over a fibroid appears to be a strong risk factor for abruption. There does not appear to be any association of fetal growth restriction with small fibroids. However, when the fibroid volume is >200 cm^3 fetal growth restriction appears more commonly. Fetal compression syndrome is a direct result of large fibroids and is not associated with commonly found small fibroids. Finally, malposition or obstructed labor is associated with fibroids of the lower uterine segment.

OB-15.3: Uterine Anomalies in Pregnancy

- For uterine septum, uterine didelphys, unicornuate uterus, bicornuate uterus:
  - Ultrasound CPT® 76801[plus CPT® 76802 if more than one fetus] if a complete ultrasound has not yet been performed once in first trimester, or CPT® 76815 for limited ultrasound if a complete ultrasound CPT® 76801 has already been performed and/or CPT® 76817 for transvaginal ultrasound once in first trimester (less than 14 weeks)
  - Ultrasound is supported at 16 weeks or greater: CPT® 76805 or if there is concern for a bicornuate uterus, a detailed anatomy ultrasound CPT® 76811 should be considered and/or CPT® 76817
  - Starting after the fetal anatomic scan at 16 weeks or greater, ultrasound (CPT® 76815) every 2 to 4 weeks and/or transvaginal ultrasound (CPT® 76817) every 2 weeks until 24 weeks
  - Starting at ≥23 weeks, follow-up growth scans (CPT® 76816) every 3 to 6 weeks
  - Starting at 32 weeks, weekly BPP (CPT® 76818 or CPT® 76819) or modified BPP (CPT® 76815)

Practice Note

- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination

(CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.

- CPT 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition.
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

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OB-16: Alloimmunization/ Rh Isoimmunization/ Other Causes of Fetal Anemia/ Parvo/ Hydrops

OB-16.1: Alloimmunization/Rh Isoimmunization/ Other Causes of Fetal Anemia

- Fetal anemia and hydrops may be a result of immune conditions, such as red-cell or Kell alloimmunization, non-immune hydrops caused by parvovirus B19 infection or any other known acquired or congenital causes of fetal anemia.

Imaging for Alloimmunization/Rh Isoimmunization for any of the following indications:
➢ When any one of the following maternal antibody titers are ≥ 1:8 ◆ Rhesus antibodies (Cc/Dd/Ee) ◆ Anti-Duffy (anti-fya) antibody and/or ◆ Anti-Kidd antibody ➢ With Anti-Kell antibody (any antibody titer) ➢ Evidence of fetal hydrops on previous imaging ➢ Prior pregnancy associated with HDFN (hemolytic disease of the fetus and newborn)
The following imaging is indicated:
➢ Ultrasound (CPT® 76816) every 2 to 4 weeks to assess fetal growth starting after performance of the fetal anatomic scan CPT® 76811
➢ Weekly BPP (CPT® 76818 or CPT® 76819) or a modified BPP CPT® 76815 starting at 32 weeks or sooner depending on fetal condition
➢ Weekly fetal middle cerebral artery MCA Doppler (CPT® 76821) and a limited ultrasound CPT® 76815 starting at 16 weeks.

Practice Note

- Other antigens not listed above, may be associated with hemolytic disease of the fetus and newborn and may require fetal assessment as in OB-3.1 if maternal antibody titers are ≥1:8. Please send these cases to medical review. Some of these antigens include MNSsM, MNSsS, MNSss, MNSsU, MNSsMi, MSSsMT, Diego D1, Diego Di, PPPTj, Public antigen Yt, Public antigen En, Public antigen Co2. Private antigens-Biles, Good, Heibel, Radin, Wright, and ZD. Dia, Dib, PP1Pk, Far, Good, Lan, LW, Mta, U, Wra.
- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.
- CPT 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office **and** there is a new medical indication and/or change in condition.
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)
- Because MCA-PSV increases across gestation, results should be adjusted for gestational age. Measurements can be initiated as early as 16 weeks of gestation if there is a past history of early severe fetal anemia or very high titers. The optimal interval between examinations has not been determined, but should be one to two weeks based on clinical experience and what is known about progression of fetal

anemia in this setting

OB-16.2: Exposure to Parvovirus B-19

- Parvovirus B-19 (Fifth Disease):
  - Ultrasound (CPT® 76816) every 2 to 4 weeks to assess fetal growth starting after performance of the fetal anatomic scan CPT® 76811. Continue for 8 to 12 weeks post-exposure
    - CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)
  - Starting at time of known exposure weekly limited ultrasound 76815 until 26 weeks then weekly BPP (CPT® 76818 or CPT® 76819) or a modified BPP CPT® 76815 if ≥26 weeks gestation and continuing for 8 to 12 weeks post-exposure
  - Fetal middle cerebral artery (MCA) Doppler (CPT® 76821) every 1 to 2 weeks, starting at time of known exposure, if 16 weeks or greater and continuing for 8 to 12 weeks post-exposure

OB-16.3: Twin Anemia Polycythemia Sequence

- See: **OB-11.3: For Known monochorionic-diamniotic or monochorionic-monoamniotic multiple pregnancies**

OB-16.4: Fetal Hydrops Associated with Polyhydramnios

- Fetal hydrops associated with Polyhydramnios: if diagnosed with hydrops, image according to **OB-16.1: Alloimmunization/Rh Isoimmunization/Other Causes of Fetal Anemia**

OB-16.5: Sustained Fetal Tachycardia

- Sustained fetal tachycardia with a structurally normal fetal echocardiogram and fetal anemia is suspected as the cause of the tachycardia, may have CPT® 76821 one time

Practice Notes

- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.
- CPT 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition.
- Rhesus isoimmunization/alloimmunization is the process through which fetal Rh+ red blood cells enter the circulation of an Rh negative mother causing her to produce antibodies which can cross the placenta and destroy the red blood cells of the current Rh+ fetus in subsequent Rh+ pregnancies.

- Twin anemia polycythemia sequence (TAPS) may occur spontaneously in up to 5% of monochorionic twins and may also develop after incomplete laser treatment in twin-twin transfusion syndrome (TTTS) cases. As with TTTS the underlying mechanism is thought to be abnormal placental vascular anastomoses. One twin develops anemia and the other polycythemia. One of the features suggesting towards the diagnosis is discordance in fetal middle cerebral artery peak systolic velocity (MCA-PSV) measurements
- Peak systolic velocity (PSV) of the fetal middle cerebral artery can be used as a substitute for amniocentesis to evaluate a fetus at risk for anemia due to Rhesus isoimmunization/alloimmunization

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OB-17: Amniotic Fluid Abnormalities/ Oligohydramnios/ Polyhydramnios

OB-17.1: Amniotic Fluid Abnormalities

For **suspected** polyhydramnios or oligohydramnios:
➢ One ultrasound is appropriate for unequal size and dates see **OB-27: Unequal Fundal Size and Dates** and/or **OB-23: Preterm/Prelabor Rupture of Membranes**
For **confirmed** diagnosis of polyhydramnios: AFI ≥ 24cm or maximum deepest vertical pocket ≥ 8cm.
➢ Detailed Fetal Anatomic Scan (CPT® 76811) upon diagnosis if **not** already performed. ➢ Starting at ≥ 23 weeks, follow up ultrasound (CPT® 76816) if < 23 weeks, send to medical review ◆ AFI ≥ 24 cm to 30 cm or maximum deepest vertical pocket ≥ 8 cm to 10 cm, starting at ≥23 weeks, every 3 to 4 weeks for mild polyhydramnios; ◆ AFI > 30 or maximum deepest vertical pocket is > 10 cm Starting at ≥ 23 weeks, every 2 weeks for severe polyhydramnios; ➢ Weekly limited ultrasounds 76815 from 23-26 weeks ➢ BPP (CPT® 76818 or CPT® 76819) or CPT® 76815 for AFI with NST ◆ if maximum vertical pocket is ≥ 8 cm or if AFI ≥ 24 cm Starting at 26 weeks, weekly BPP (CPT® 76818 or CPT® 76819) or a modified BPP CPT® 76815. ◆ if maximum deepest vertical pocket is ≥ 10 cm or an AFI ≥ 30 Starting at 26 weeks, twice-weekly BPP (CPT® 76818 or CPT® 76819) or a modified BPP CPT® 76815
For **confirmed** diagnosis of **oligohydramnios:** AFI ≤ 5 cm or maximum vertical pocket ≤ 2 cm
➢ May have CPT® 76811 if not already performed ➢ Starting at ≥ 23 weeks, one ultrasound (CPT® 76816) ◆ Every 2 to 4 weeks for fetal growth; if < 23 weeks, send to medical review ➢ Weekly limited ultrasounds 76815 from 23-26 weeks ➢ Starting at 26 weeks, weekly biophysical profile (CPT® 76818 or CPT® 76819) or a modified BPP CPT® 76815, if maximum vertical pocket ≤ 2 cm or AFI ≤ 5 cm. If less than 26 weeks send to Medical director review ➢ Starting at time of diagnosis and is ≥23 weeks, weekly umbilical artery Doppler (CPT® 76820)

Practice Notes

- Polyhydramnios refers to excessive amniotic fluid volume. It is determined with AFI ≥ 24 cm (greater than the 95th percentile by gestational age), or maximum deepest vertical pocket ≥ 8 cm.
- Oligohydramnios refers to diminished amniotic fluid volume. At 30 weeks or greater, it is determined with AFI ≤5 cm by measuring fluid in each of the four quadrants or by the maximum single deepest vertical pocket ≤ 2 cm (is the best definition of oligohydramnios). At less than 30 weeks, oligohydramnios is determined by a gestation age cut off of ≤ 5 percentile
- Polyhydramnios can be an early presenting finding of fetal hydrops associated with fetal anemia. Middle cerebral artery Doppler is commonly used to diagnose whether this fetal anemia is present or not. See: **OB-16.1: Alloimmunization/Rh Isoimmunization/Other Causes of Fetal Anemia**.

- Polyhydramnios may also present as a finding of cardiac dysfunction, fetal arrhythmias or cardiac malformation. Fetal echocardiography is commonly performed to determine if any other conditions are present or not. See: **OB-12: Fetal Echocardiography (ECHO)**
- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.
- CPT 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition.
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

References

1. Practice Bulletin No. 175: Ultrasound in Pregnancy. Obstet Gynecol. 2016;128(6):e241-e256. Reaffirmed 2018. doi:10.1097/AOG.0000000000001815.
2. ACOG Practice Bulletin No. 145: Antepartum Fetal Surveillance. Obstet Gynecol. 2014;124(1):182-192. Reaffirmed 2019. doi:10.1097/01.AOG.0000451759.90082.7b.
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OB-18: Cervical Insufficiency/Current Preterm Labor

- For history of pre-term labor see: **OB-9.9: History of Pre-Term Delivery/History of PPROM**

OB-18.1: Cervical Insufficiency

- For any of the following:
  - History of prior precipitous delivery
  - History of cerclage in prior pregnancy
  - Over dilation of cervix during a termination of pregnancy
  - Cervical obstetrical laceration from a previous delivery
  - Surgical trauma to cervix (e.g. conization [CKC—cold-knife conization] or Loop Electrosurgical Excision Procedure [LEEP])
- Perform one ultrasound in the first trimester to establish dates, and report one of the following; CPT® 76801 [plus CPT® 76802 if more than one fetus] if a complete ultrasound has not yet been performed, and/or CPT® 76817 for a transvaginal ultrasound indicated
- Ultrasound is supported at 16 weeks or greater: CPT® 76805 (if other risk factors, see OB 11) **and/or** CPT® 76817 once if a complete fetal anatomic scan has not yet been performed during this pregnancy.
- At 16 weeks or greater, ultrasound (CPT® 76815) every 2 to 4 weeks **and/or** transvaginal ultrasound (CPT® 76817) every 2 weeks until 24 weeks

- If funneling or abnormally short cervix ≤ 25 mm (2.5 cm) is found on a transvaginal ultrasound in a singleton pregnancy
  - an ultrasound (CPT® 76816 after a complete ultrasound or CPT 76815) every 2 to 4 weeks until 34 weeks **and/or**
  - (CPT® 76817) for transvaginal ultrasound every 1 to 2 weeks until 32 weeks.

OB-18.2: Cerclage in Place in Current Pregnancy

- Ultrasound CPT® 76801[plus CPT® 76802 if more than one fetus] if a complete ultrasound has not yet been performed once in first trimester, or CPT® 76815 for limited ultrasound if a complete ultrasound 76801 has already been performed and/or CPT® 76817 for transvaginal ultrasound once in first trimester (less than 14 weeks) for any one of the following:
  - Ultrasound is supported at 16 weeks or greater: CPT® 76811 [plus CPT® 76812 if more than one fetus] and/or CPT® 76817 once, if a complete detailed fetal anatomic scan has not been done.
  - Starting after the fetal anatomic scan at 16 weeks or greater, ultrasound (CPT® 76815 or CPT® 76816) can be performed every 3 to 6 weeks.
  - Transvaginal (CPT® 76817) every 2 weeks, starting at 16 weeks or greater until 30 weeks if a rescue cerclage was placed.

OB-18.3: Current Preterm Labor

- Known preterm labor in current pregnancy (contractions with cervical change) CPT® 76805 [plus CPT® 76810 if more than one fetus] **and/or** CPT® 76817 if a complete fetal anatomic scan has not yet been performed during this pregnancy; if a complete fetal anatomic scan was performed previously, CPT® 76815 **or** CPT® 76816 (76816 no more than every 2 weeks) when symptomatic
- CPT® 76817 once or when symptomatic
- Once or when symptomatic, biophysical profile (BPP) (CPT® 76818 **or** CPT® 76819) **or** modified BPP CPT® 76815 starting at 30 weeks; if less than 30 weeks send to MD review

Practice Notes

- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.
- CPT 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition.
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

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OB-19: Decreased Fetal Movement/ No Fetal Heart Tones

OB-19.1: No Fetal Heart Tones

The following is supported during the first trimester:
➢ Prior to considering ultrasound for absence of fetal heart tone at less than 12 weeks, fetal heart tone assessment should be repeated at 12 weeks gestation ➢ Ultrasound imaging is supported, prior to 12 weeks gestation, in the setting of absent fetal heart tones accompanied by other maternal signs or symptoms (such as cramping, vaginal bleeding, etc.) or if fetal heart tones that have previously been heard are now unable to ascertain, regardless of symptoms. Report **one** of the following: ◆ CPT® 76801 (plus CPT® 76802 if more than one fetus) and/or CPT® 76817 if a complete ultrasound has not yet been performed; or ◆ CPT® 76815 for limited ultrasound and/or CPT® 76817
The following is supported during the second and third trimester:
➢ CPT® 76815 for limited ultrasound or ➢ CPT 76816 requests should go to medical director review ◆ CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy) or ➢ CPT® 76805 (plus CPT® 76810 if more than one fetus) if equal to or greater than 14 weeks, when complete fetal anatomic scan CPT® 76805 is planned and has not yet been performed

OB-19.2: Decreased Fetal Movement

Report of one of the following: limited ultrasound or modified BPP (CPT® 76815) or if greater than or equal to 26 weeks BPP (CPT® 76818 or 76819)

References

1. Practice Bulletin No. 145: Antepartum Fetal Surveillance. Obstet Gynecol. 2014;124(1):182-192. Reaffirmed 2019. doi:10.1097/01.AOG.0000451759.90082.7b.
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OB-20: Fetal Growth Problems (FGR and Macrosomia)

OB-20.1: Fetal Growth Restriction Current Pregnancy

- The ACOG definition of Fetal Growth Restriction (FGR): Estimated or actual weight of the fetus ≤ 10th percentile for gestational age. "Abdominal Circumference ≤ 10th percentile" also defines FGR.

For Suspected FGR:
➢ One ultrasound can be performed if there is equal to or greater than a 3 week difference in fundal height and gestational age report **one** of the following: ◆ CPT® 76805 (plus CPT® 76810 if more than one fetus) if a complete ultrasound has not yet been performed during this pregnancy **or** ◆ CPT® 76816 if a complete ultrasound was performed previously
➢ In order to evaluate fetal growth and confirm the diagnosis of FGR following the initial ultrasound, one follow-up ultrasound (CPT® 76816) can be performed 2 to 4 weeks following the initial ultrasound
➢ For clinical situations that have a higher probability of FGR such as maternal hypertension, maternal diabetes, previous stillbirth, etc. See: **OB-9: High Risk Pregnancy**, or the specific guidelines for these clinical entities for guidance regarding follow-up ultrasounds to assess fetal growth
For Known FGR:
➢ Detailed Fetal Anatomic Scan (CPT® 76811) upon diagnosis if not already performed.
➢ After a fetal anatomy ultrasound, Ultrasound (CPT® 76816) every 2 to 4 weeks to assess fetal growth starting at 23 weeks. If <23 weeks, send to MD review.
➢ Prior to 26 weeks a limited ultrasound 76815 can be considered weekly. ➢ Starting at 26 weeks, weekly BPP (CPT® 76818 or CPT® 76819) or a modified BPP CPT® 76815
➢ Starting at 23 weeks, weekly umbilical artery Doppler (CPT® 76820); ◆ If severe FGR (efw <5% , AC <5), umbilical artery dopplers are abnormal (absent or reversed end diastolic flow) or with confirmed oligohydramnios, then more frequent BPPs (CPT® 76818 or CPT® 76819) may be considered (2x per week, or even daily) and twice weekly umbilical artery dopplers(CPT® 76820)
➢ MCA Doppler (CPT® 76821) start at 34 weeks, weekly if the umbilical artery doppler CPT® 76820 is normal

Practice Notes

"Traditional surveillance of the IUGR fetus has relied on fetal heart rate testing by cardiotocography or ultrasound-derived biophysical profile testing. Twice weekly nonstress testing with weekly amniotic fluid evaluation, or weekly biophysical profile testing, is commonly recommended."

- Doppler assessment of the fetus with intrauterine growth restriction. Berkley, Eliza et al. American Journal of Obstetrics & Gynecology, Volume 206, Issue 4, 300 - 308 Society for Maternal-Fetal Medicine Publications Committee, April 2012
- In the preterm SGA/FGR fetus, middle cerebral artery (MCA) Doppler has limited accuracy to predict acidemia and adverse outcome; it should not be used to time delivery. Most studies investigating MCA Doppler as a predictor of adverse outcome in preterm SGA/FGR fetuses have reported low predictive value, especially when umbilical artery Doppler is abnormal. In the largest study of predictors of neonatal outcome in SGA/FGR neonates of less than 33 weeks gestational age (n = 604), it

was not a statistically significant predictor of outcome on logistic regression, although MCA PI < –2 SDs was associated with neonatal death (LR 1.12, 95% CI 1.04–1.21) and major morbidity (LR 1.12, 95% CI 1.1–1.33).

- In addition it has been found that umbilical artery Doppler studies are less reliable after 34 weeks as IUGR at 34 weeks or greater is typically characterized my milder placental dysfunction.
- In the near-term SGA/FGR fetus with normal umbilical artery Doppler, an abnormal middle cerebral artery Doppler (PI <5th centile) has moderate predictive value for acidosis at birth and should be used to time delivery. MCA Doppler may be a more useful test in SGA/FGR fetuses detected after 34 weeks of gestation when umbilical artery Doppler is normal. Based on this evidence it is reasonable to use MCA Doppler to time delivery in the near term-term (34 weeks gestation or greater) SGA/FGR fetus with normal umbilical artery Doppler.
- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.
- CPT 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition.
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

OB-20.2: Macrosomia – Large for Dates Current Pregnancy

- The ACOG definition of macrosomia: Estimated fetal weight of greater than 4000 grams (DM) or 4500 grams (non-DM); ≥ 90th percentile or greater for gestational age
- See also: **OB-9.4.1: Prior Pregnancy with Macrosomia**

For Suspected Macrosomia:
➢ In a low risk pregnancy, ultrasound is generally not indicated to estimate fetal weight before 30 weeks gestation
➢ At 23 weeks gestation or greater, if there is greater than or equal to a3 week difference in fundal height and gestational age, one ultrasound can be performed to evaluate for macrosomia if clinically indicated report **one** of the following: ◆ CPT® 76805 [plus CPT® 76810 if more than one fetus] if a complete fetal anatomic scan is planned and has not yet been performed **or** ◆ CPT® 76816 if a complete ultrasound was done previously ➢ See also: **OB-27.1: Unequal Fundal Size and Dates**

For Known Macrosomia ≥ 90th percentile
➢ Repeat imaging is generally not necessary unless needed to plan for delivery or if there are other high risk indications. ◆ Imaging recommendations are usually guided by the cause of the fetal macrosomia (obesity, DM, etc.) See appropriate GL for indication
➢ If no other high risk indication present, one CPT® 76816 >37 weeks to plan for delivery

Practice Notes

- Ultrasound is imprecise in predicting fetal macrosomia. Prospective studies have shown that clinical estimates of macrosomia may be as predictive as estimates derived by ultrasonography
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

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Society for Maternal-Fetal Medicine Publications Committee, April 2012

OB-21: Placental or Cord Abnormalities

400 Buckwalter Place Boulevard, Bluffton, SC 29910 (800) 918-8924

OB-21.1: Single Umbilical Artery/Two Vessel Cord

If single umbilical artery is found on initial imaging:	
➢ Detailed anatomic ultrasound at 16 weeks or greater	CPT® 76811
➢ Fetal echocardiogram (not usually done >16 weeks)	CPT® 76825 **and/or** CPT® 76827 **and/or** CPT® 93325
➢ Follow-up ultrasound to evaluate fetal growth at 28 to 32 weeks and then every 3 to 6 weeks if more than one clinical high-risk factors are documented	CPT® 76816
➢ Weekly BPP or modified BPP starting at 36 weeks	CPT® 76818 **or** CPT® 76819 (BPP) or modified BPP CPT® 76815

Practice Note

- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.
- CPT 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition.
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

OB-21.2: Vasa Previa

- Vasa previa occurs when fetal blood vessels that are unprotected by the umbilical cord or placenta run through the amniotic membranes and cross over the internal cervical os.
- Fetal anatomic scan is ideally performed at 18 to 20 weeks but should be performed after 16 weeks (CPT® 76811)
- Once vasa previa is confirmed every 2 to 4 weeks to assess cervical length starting at 28 weeks:
  - Ultrasound CPT® 76817 and/or CPT® 76815 or CPT® 76816 and/or CPT® 93976 (limited duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs)
  - If earlier, requests will be sent to Medical Director review.
  - CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)
- Amniocentesis is no longer required or recommended for lung maturity.

OB-21.3: Placental or Cord Abnormalities

OB-21.3.1: Placental/Cord Abnormalities

Circumvallate shape
Placental hemangioma
Succenturiate placenta or accessory lobe
Marginal Cord Insertion
Velamentous insertion of the umbilical cord
Umbilical cord cyst

- Fetal anatomic scan is ideally performed at 18 to 20 weeks but should be performed after 16 weeks (CPT® 76811) and or CPT® 93976 (limited duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs)
  - Ultrasound CPT®76817 once to evaluate the placenta in relation to the cervix
- Ultrasound (CPT® 76816) and/or CPT® 93976 (limited duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs) every 3-6 weeks starting at 28 weeks until delivery
- Weekly BPP (CPT® 76818 or CPT® 76819) or a modified BPP CPT® 76815 starting at 32 weeks

OB-21.3.2: Other Placental/Cord abnormalities

Chorioangioma
Umbilical cord varix

- Fetal anatomic scan is ideally performed at 18 to 20 weeks but should be performed after 16 weeks (CPT® 76811) and/or CPT® 93976 (limited duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs)
- Ultrasound (CPT® 76816) and/or CPT® 93976 (limited duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs) every 3-6 weeks starting at the time of diagnosis until delivery after an anatomy ultrasound.
- If evidence of hydrops Fetal ECHO (CPT® 76825, 76827, 93325)
- Weekly BPP (CPT® 76818 or CPT® 76819) or a modified BPP CPT® 76815 starting at 32 weeks
- If turbulence develops within the UVV then weekly MCA dopplers recommended to assess for fetal anemia
- If fetal hydrops develops then image as per **OB-16.1: Alloimmunization/Rh Isoimmunization/Other Causes of Fetal Anemia**

Practice Note

- Umbilical cord varix (UVV) and chorioangiomas are rare but potentially serious abnormalities that may also be associated with fetal hydrops and perinatal loss.
- In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more

desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.

- CPT 76811 and CPT® 76812 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition.
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

OB-21.4: Subchorionic Hematoma or Placental Hematoma

Subchorionic Hematoma or Placental Hematoma
First, Second and Third Trimester
➢ Ultrasound can be performed for follow-up of a known subchorionic hematoma or placental hematoma (CPT® 76815, or CPT® 76816 if a complete ultrasound scan was done previously, and/or CPT® 76817) if the last ultrasound was performed greater than seven days ago. ◆ CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)
➢ Ultrasound imaging may be repeated earlier than seven days if there are new or worsening symptoms such as an increasing amount of vaginal bleeding or increasing cramping or pain.
➢ No further ultrasound is needed if the follow-up ultrasound 7 days following the hemorrhage shows that the hemorrhage has resolved, and there is no further cramping and/or bleeding, and the fetus is growing as determined by size equal dates, in the first trimester.
➢ If pregnancy is in second or third trimester follow **OB-21.5: Suspected Abruptio Placentae**

OB-21.5: Suspected Abruptio Placentae

Suspected Abruptio Placentae
Second and Third Trimesters
➢ Ultrasound is appropriate for **suspected** abruptio placentae **CPT® 76805** [plus CPT® 76810 if more than one fetus] and/or **CPT® 76817** if a complete fetal anatomic scan has not yet been performed during this pregnancy, and/or CPT® 93976 (limited duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs) ◆ CPT® 76815 for limited ultrasound and/or CPT® 76817, or ◆ CPT® 76816 if a complete ultrasound scan was done previously, and/or CPT® 76817 for a transvaginal ultrasound ■ CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)
➢ Ultrasound is appropriate to follow-up a **known** abruption (CPT® 76815 or CPT® 76816 if a complete ultrasound was done previously and/or CPT® 76817). ◆ The number and frequency of follow-up ultrasounds will depend on the degree of abruption and the presence or absence of ongoing signs and symptoms

OB-21.6: Placenta Previa

Placenta Previa
Second and Third Trimesters
➢ For **suspected** placenta previa one of the following ultrasound can be performed: ◆ CPT® 76805 [plus CPT® 76810 if more than one fetus] and/or CPT® 76817 if a complete fetal anatomic scan has not yet been performed during this pregnancy and/or CPT® 93976 (limited duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs) **or** ◆ CPT® 76815 for limited ultrasound and/or CPT® 76817 and/or CPT® 93976 (limited duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs) **or** ◆ CPT® 76816 if a complete ultrasound was done previously **and/or** CPT® 76817 for a transvaginal ultrasound and/or CPT® 93976 (limited duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs)
➢ For **known** placenta previa, one routine follow-up ultrasound can be performed at 28 to 32 weeks (CPT® 76815 or CPT® 76816 and/or CPT® 76817) ◆ If placenta previa is still present, one follow-up ultrasound (CPT® 76815 or CPT® 76816 and/or CPT® 76817) can be performed in 3-4 weeks ◆ Amniocentesis is no longer required or recommended for lung maturity ◆ If persistent placenta previa, BPP (CPT® 76818 or CPT® 76819) or a modified BPP CPT® 76815 weekly, starting at 32 weeks ◆ Follow-up ultrasound can be performed at any time if bleeding occurs BPP (CPT® 76818 **or** CPT® 76819) **or** CPT® 76815 **or** CPT® 76816 if a complete ultrasound was done previously **and/or** CPT® 76817)

Practice Note

"There is no evidence to guide the optimal time of subsequent imaging in pregnancies thought to have placenta previa. In stable patients it is reasonable to perform a follow-up ultrasonogram at approximately 32 weeks of gestation. This allows adequate time for "resolution" of low-lying placentas and avoids potentially unnecessary studies. It may be worthwhile to perform an additional study at 36 weeks of gestation (if the previa persists) to determine the optimal route and timing of delivery. There is no clear benefit from more frequent ultrasonograms (eg, every 4 weeks) in stable cases."

From: Abnormal Placentation. Placenta Previa, Vasa Previa, and Placenta Accreta. Robert M. Silver, MD. Obstet Gynecol 2015;126:654–68.

Low Lying Placenta

- One ultrasound (76815) and/or 76817 is supported between 28-32 weeks to check the placental location. Further requests will be forwarded to Medical Director review

Practice Note

- "For pregnancies beyond 16 weeks, if the placental edge is 2 cm or greater away from the internal os, the placental location should be reported as normal.
- If the placental edge is less than 2 cm from the internal os but not covering the internal os, it should be labeled as low lying.
- If the placental edge covers the internal cervical os, the placenta should be labeled as a placenta previa.

- At the follow-up examination at 32 weeks, if the placental edge is still less than 2 cm from the internal os (low lying) or covering the cervical os (placenta previa), follow-up transvaginal imaging at 36 weeks' gestation is recommended."
- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

References

1. AIUM Practice Parameter for the Performance of Limited Obstetric Ultrasound Examinations by Advanced Clinical Providers. Journal of Ultrasound in Medicine. 2018;37(7):1587-1596. doi:10.1002/jum.14677.

OB-21.7: Placenta Accreta Spectrum/Placenta Percreta

- See **PV-15.2: Placenta Accreta/Placenta Accreta Spectrum/ Placenta Percreta**

OB-21.7.1: Suspected

- For **suspected** placenta accreta, ultrasound can be performed CPT® 76811 or CPT® 76805 and/or CPT® 76817 if a complete fetal anatomic scan has not yet been performed and/or CPT® 93976 (limited duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs) or
- CPT® 76815 for limited ultrasound and/or, CPT® 76817 and/or CPT® 93976 (limited duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs), **or**
- CPT® 76816 if a complete ultrasound was done previously, **and/or** CPT® 76817 for a transvaginal ultrasound and/or CPT® 93976 (limited duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs)
- If the ultrasound is inconclusive or equivocal then pelvic MRI without contrast (CPT® 72195) may be indicated

OB-21.7.2: Known

- For **known** placenta accrete/percreta, follow up growth ultrasounds can be performed every 2 to 4 weeks (CPT® 76816 if a complete ultrasound was done previously and/or CPT® 76817)
- BPP (CPT® 76818 or CPT® 76819) or a modified BPP CPT® 76815 weekly, starting at 32 weeks or sooner if indicated (other high-risk concerns)
- Follow-up ultrasound can be performed at any time if bleeding occurs (CPT® 76815 and/or CPT® 76817)
- MD can approve Pelvic MRI without contrast (CPT® 72195) if the ultrasound is indeterminate or advanced imaging is needed for surgical planning. MRI pelvis without contrast (CPT® 72195) is the appropriate code if only placenta or maternal pelvis is imaged without fetal imaging

Practice Note

When there are ambiguous ultrasound findings or suspicion of a posterior placenta accreta, with or without placenta previa, ultrasound may be insufficient. MRI is able to outline the anatomy of the invasion and relate it to the regional anastomotic vascular system and enable confirmation of parametrial invasion and possible ureteral involvement.

- CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

References

1. ACOG Practice Bulletin No. 204: Fetal Growth Restriction. Obstet Gynecol. 2019;133(2):e97-e109. doi:10.1097/AOG.0000000000003070.
2. Kilcoyne A, Shenoy-Bhangle AS, Roberts DJ, Sisodia RC, Gervais DA, Lee SI. MRI of Placenta Accreta, Placenta Increta, and Placenta Percreta: Pearls and Pitfalls. American Journal of Roentgenology. 2017;208(1):214-221. doi:10.2214/ajr.16.16281.
3. Jain C. ACOG Committee Opinion No. 723. Obstetrics & Gynecology. 2019;133(1):186. doi:10.1097/aog.0000000000003049.
4. Sinkey RG, Odibo AO, Dashe JS. Society for Maternal-Fetal Medicine (SMFM) #37: Diagnosis and management of vasa previa. American Journal of Obstetrics and Gynecology. 2015;213(5):615-619. doi:10.1016/j.ajog.2015.08.031.
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7. AIUM Practice Parameter for the Performance of Limited Obstetric Ultrasound Examinations by Advanced Clinical Providers. Journal of Ultrasound in Medicine. 2018;37(7):1587-1596. doi:10.1002/jum.14677.
8. ACOG Committee Opinion No. 764 Summary: Medically Indicated Late-Preterm and Early-Term Deliveries. Obstet Gynecol. 2019;133(2):400-403. doi:10.1097/AOG.0000000000003084.
9. Calì G, Giambanco L, Puccio G, Forlani F. Morbidly adherent placenta: evaluation of ultrasound diagnostic criteria and differentiation of placenta accreta from percreta. Ultrasound in Obstetrics & Gynecology. 2013;41(4):406-412. doi:10.1002/uog.12385.
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11. Tuuli MG, Norman SM, Odibo AO, Macones GA, Cahill AG. Perinatal Outcomes in Women With Subchorionic Hematoma. Obstetrics & Gynecology. 2011;117(5):1205-1212. doi:10.1097/aog.0b013e31821568de.
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19. SMFM Coding Committee White Paper: Coding for Placenta Accreta Spectrum

OB-22: Post-term/Late-term Pregnancy

OB-22.1: Post-term/Late-term Pregnancy

- Ultrasound is supported at ≥ 41 weeks gestation
  - CPT® 76816
    - Should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)
  - Twice weekly BPP (CPT® 76818 or CPT® 76819) or modified BPP CPT® 76815

Practice Note

In post-date pregnancy, uterine artery Doppler velocimetry (CPT® 93976) has not been found to be useful.

Reference

1. Practice Bulletin No. 146: Management of Late-Term and Postterm Pregnancies. Obstet Gynecol. 2014;124(2, PART 1):390-396. Reaffirmed 2019. doi:10.1097/01.AOG.0000452744.06088.48.

OB-23: Preterm/Prelabor Rupture of Membranes

See also: **OB-17: Amniotic Fluid Abnormalities/ Oligohydramnios/ Polyhydramnios**

See also: **OB-18.2: Cerclage in Place in Current Pregnancy**

OB-23.1: Current Preterm Prelabor Rupture of Membranes (PPROM)

- Less than or equal to 36 6/7 weeks. Requests will be forwarded to Medical Director review.
  - This is likely a hospital admission for evaluation and monitoring until delivery.
  - In rare cases, outpatient monitoring has been performed (refer to Medical Director for review)

OB-23.2: Current Prelabor Rupture of Membranes (PROM)

- Greater than or equal to 37 weeks. Requests will be forwarded to Medical Director for review.
  - This will likely result in a hospital admission for delivery

References

1. ACOG Practice Bulletin No.130: Prediction and Prevention of Preterm Birth. Obstet Gynecol. 2012;120(4):964-973. Reaffirmed 2018. doi:10.1097/AOG.0b013e3182723b1b.
2. Practice Bulletin No. 171: Management of Preterm Labor. Obstet Gynecol. 2016;128(4):e155-e164. Reaffirmed 2018. doi:10.1097/AOG.000000000000171
3. Practice Bulletin No. 188: Prelabor Rupture of Membranes. *Obstetrics & Gynecology.* January 2018;131(1):e1–e1464. (Interim Update-replaces No. 172) doi: 10.1097/AOG.0000000000002455.

OB-24: Previous C-section or History of Uterine Scar

OB-24.1: Previous C-section or History of Uterine Scar

Previous Cesarean section and/or uterine scar
➢ CPT® 76801 [plus CPT® 76802 if more than one fetus] if a complete ultrasound has not yet been performed, OR CPT® 76815 for limited ultrasound if complete ultrasound has already been performed, and/or CPT® 76817 for a transvaginal ultrasound indicated if less than 14 weeks ➢ CPT® 76805 for fetal anatomic scan is ideally performed between 18 to 20 weeks but must be performed after 16 weeks, if earlier send to MD Review ➢ One growth scan (CPT® 76816) at 32 weeks **and** one growth scan between 36 and 38 weeks (CPT® 76816) ◆ CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

References

1. Gyamfi-Bannerman C, Gilbert S, Landon MB, et al. Risk of Uterine Rupture and Placenta Accreta With Prior Uterine Surgery Outside of the Lower Segment. Obstetrics & Gynecology. 2012;120(6):1332-1337. doi:10.1097/aog.0b013e318273695b.
2. ACOG Practice Bulletin No. 205: Vaginal Birth After Cesarean Delivery. *Obstetrics & Gynecology*. 2019;133(2):110-127. doi:10.1097/aog.0000000000003078.

OB-25: Termination of Pregnancy – Imaging

OB-25.1: Imaging for Planned Pregnancy Termination

- For a planned pregnancy termination, ultrasound can be performed to determine intrauterine pregnancy and gestational age.
  - One complete ultrasound (CPT® 76801) and/or one transvaginal ultrasound CPT® 76817), if less than 14 weeks
  - If ≥ 14 weeks, send to MD review. Imaging may be indicated to confirmed EGA, placenta location, and/or fetal anomalies

References

1. ACOG Practice Bulletin No.143. Obstetrics & Gynecology. 2014;123(3):676-692.Reaffirmed 2016. doi:10.1097/01.aog.0000444454.67279.7d.
2. ACOG Practice Bulletin No. 135. Obstetrics & Gynecology. 2013;121(6):1394-1406. Reaffirmed 2017. doi:10.1097/01.aog.0000431056.79334.cc.

OB-26: Trauma

OB-26.1: Trauma – Imaging

Prior to 13 weeks:
Blunt trauma in the first trimester (prior to 13 weeks) generally does not cause pregnancy loss with the exception of profound hypotension: ◆ No imaging is indicated unless there is cramping and/or bleeding.
Between 13-20 weeks gestation:
➢ CPT® 76801 and/or CPT® 76817 when complete ultrasound has not yet been performed, if less than 14 weeks or ➢ Initially CPT® 76815 and/or CPT® 76817 for limited ultrasound when medically indicated **or** ➢ CPT® 76805 (plus CPT® 76810 if more than one fetus) if equal to or greater than 14 weeks, when complete fetal anatomic scan CPT® 76805 is planned and has not yet been performed. and/or CPT® 76817
After 20 weeks:
➢ CPT® 76805 (plus CPT® 76810 if more than one fetus) when complete fetal anatomic scan CPT® 76805 is planned and has not yet been performed, **or** ➢ CPT® 76815 or ➢ CPT® 76816 ◆ CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy) ➢ Additionally, starting at > 26 weeks, BPP CPT® 76818 or CPT® 76819 or modified BPP CPT® 76815 can be considered ➢ Other advanced imaging may be indicated, send for Medical Director review

Reference

1. Mendez-Figueroa H, Dahlke JD, Vrees RA, Rouse DJ. Trauma in pregnancy: an updated systematic review. American Journal of Obstetrics and Gynecology. 2013;209(1):1-10. doi:10.1016/j.ajog.2013.01.021

OB-27: Unequal Fundal Size and Dates

OB-27.1: Unequal Fundal Size and Dates

Unequal fundal size is defined as a discrepancy between weeks of gestational age and fundal height measurement of ≥3 cm and gestational age at **23 weeks gestation or greater**.

- One ultrasound can be performed (CPT® 76805) if complete fetal anatomic scan is planned and has not been performed **or**
- CPT® 76816 if CPT® 76805 complete anatomy scan or detailed anatomy ultrasound CPT® 76811 has been done previously.
  - CPT® 76816 (should not be performed prior to a CPT® 76801 or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy)

References

1. Pay A, Frøen J, Staff A, Jacobsson B, Gjessing H. Prediction of small-for-gestational-age status by symphysis-fundus height: a registry-based population cohort study. BJOG: An International Journal of Obstetrics & Gynaecology. 2015;123(7):1167-1173. doi:10.1111/1471-0528.13727.
2. Pay ASD, Wiik J, Backe B, Jacobsson B, Strandell A, Klovning A. Symphysis-fundus height measurement to predict small-for-gestational-age status at birth: a systematic review. BMC Pregnancy and Childbirth. 2015;15(1). doi:10.1186/s12884-015-0461-z.
3. ACOG Practice Bulletin No. 204: Fetal Growth Restriction. Obstet Gynecol. 2019;133(2):e97-e109. doi:10.1097/AOG.0000000000003070.

OB-28: Procedure Coding Basics for Established Pregnancy

OB-28.1: Procedure Coding Basics for Established Pregnancy General Considerations

- A Duplex scan describes:
  - An ultrasonic scanning procedure for characterizing the pattern and direction of blood flow in arteries and veins with the production of real-time images integrating B-mode two dimensional vascular structure, and
  - Doppler spectral analysis, and
  - Color flow Doppler imaging
- The use of a hand-held or any Doppler device that does not create a hard-copy output is considered part of the physical examination and is not separately billable. This exclusion includes devices that produce a record that does not permit analysis of bi-directional vascular flow.
- The minimal use of color Doppler alone, when performed for anatomical structure identification, during a standard ultrasound procedure, is not separately reimbursable.
- All obstetric ultrasound studies require permanently recorded images:
  - These images may be stored on film or in a Picture Archiving and Communication System (PACS).
  - Obstetric ultrasound services may not be billed without image recording.
  - The use of a hand-held or any Doppler device that does not create a hard-copy output is considered part of the physical examination and is not separately reimbursable.
- Ultrasound procedure codes include the preparation of a required final written report which should be included in the patient's medical record.
  - Each procedure code has specific required elements which are described in this section.
  - The report should document the results of the evaluation of each element or the reason any element is non-visualized.
  - Documentation of less than the required elements requires the billing of the "limited" code for that anatomic region.
  - Only one (1) limited exam may be billed per encounter.

OB-28.2: Required Elements for First Trimester OB Ultrasound

- Determination of the number of gestational sacs and fetuses
- Gestational sac/fetal measurements appropriate for gestation (< 14 weeks)
- Survey of visible fetal anatomic structures and placental evaluation when possible
- Qualitative assessment of amniotic fluid volume/gestational sac shape
- Examination of maternal uterus and adnexa
- A complete first-trimester transabdominal ultrasound (CPT® 76801 and CPT® 76802) is defined in CPT® as including the following elements:

CPT® Code Guidance
It may not be possible to visualize the placenta during the early weeks of pregnancy. CPT® 76801 and/or CPT® 76802 may still be appropriately billed if the report documentation indicates placental anatomic structure could not be evaluated due to gestational age.
It may not be possible to visualize the placenta during the early weeks of pregnancy. CPT® 76801 and/or CPT® 76802 may still be appropriately billed if the report documentation indicates placental anatomic structure could not be evaluated due to gestational age.
CPT® 76801 and CPT® 76802 should only be reported once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a medical indication for ultrasound. Follow-up studies to CPT® 76801 and CPT® 76802 should be reported as CPT® 76815

OB-28.3: Required Elements for Second or Third Trimester Fetal Anatomic Evaluation OB Ultrasound

CPT® Code Guidance
➢ A complete second or third trimester transabdominal ultrasound (CPT® 76805 and CPT® 76810) is defined in CPT® as including the following elements: ◆ Head, face, and neck ◆ Lateral cerebral ventricles ◆ Choroid plexus ◆ Midline falx ◆ Cavum septi pellucidi ◆ Cerebellum ◆ Cistern magna ◆ Upper lip ◆ A measurement of the nuchal fold may be helpful during a specific age interval to assess the risk of aneuploidy. ◆ Chest/Heart ◆ Four-chamber view ◆ Left ventricular outflow tract ◆ Right ventricular outflow tract ◆ Abdomen ◆ Stomach (presence, size, and situs) ◆ Kidneys ◆ Urinary bladder ◆ Umbilical cord insertion site into the fetal abdomen ◆ Umbilical cord vessel number ◆ Spine ◆ Cervical, thoracic, lumbar, and sacral spine ◆ Extremities ◆ Legs and arms ◆ Genitalia ◆ In multiple gestations and when medically indicated ◆ Placenta ◆ Location ◆ Relationship to internal os ◆ Appearance ◆ Placental cord insertion (when possible) ◆ Standard evaluation

CPT® Code Guidance
◆ Fetal number ◆ Presentation ◆ Qualitative or semi-qualitative estimate of amniotic fluid ◆ Maternal anatomy ◆ Cervix (transvaginal if cervical length is ≤ 3.6 cm) ◆ Uterus ◆ Adnexa ◆ Biometry ◆ Biparietal diameter ◆ Head circumference ◆ Femur length ◆ Abdominal circumference ◆ Fetal weight estimate
➤ CPT® 76810 is an 'add-on' code used with the 'primary procedure' CPT® 76805 to report each additional gestation.
➤ CPT® 76805 and CPT® 76810 **should only be used once per pregnancy** unless the mother changes to a new medical caregiver at a new office and there is a new medical indication for ultrasound. Follow-up studies to CPT® 76805 and CPT® 76810 should be coded as CPT® 76815 or CPT® 76816.

References

1. ACOG Practice Bulletin No.130: Prediction and Prevention of Preterm Birth. Obstet Gynecol. 2012;120(4):964-973. Reaffirmed 2018. doi:10.1097/AOG.0b013e3182723b1b.
2. Cho HJ, Roh H-J. Correlation Between Cervical Lengths Measured by Transabdominal and Transvaginal Sonography for Predicting Preterm Birth. Journal of Ultrasound in Medicine. 2016;35(3):537-544. doi:10.7863/ultra.15.03026.
3. Mcintosh J, Feltovich H, Berghella V, Manuck T. The role of routine cervical length screening in selected high- and low-risk women for preterm birth prevention. American Journal of Obstetrics and Gynecology. 2016;215(3). doi:10.1016/j.ajog.2016.04.027.
4. ACOG Practice Bulletin 175. Ultrasound in Pregnancy, 2016. Summary. Obstetrics & Gynecology. 2016; 128(6):1459-1460. Reaffirmed 2018. doi:10.1097/aog.0000000000001812.
5. Esplin MS, Elovitz MA, Iams JD, et al. Predictive Accuracy of Serial Transvaginal Cervical Lengths and Quantitative Vaginal Fetal Fibronectin Levels for Spontaneous Preterm Birth Among Nulliparous Women. *JAMA*. 2017;317(10):1047. doi:10.1001/jama.2017.1373.
6. Jain S, Kilgore M, Edwards RK, Owen J. Revisiting the cost-effectiveness of universal cervical length screening: importance of progesterone efficacy. American Journal of Obstetrics and Gynecology. 2016;215(1). doi:10.1016/j.ajog.2016.01.165.

OB-28.4: Required Elements for a Detailed Fetal Anatomic Evaluation OB Ultrasound

CPT® Code Guidance
➢ Performance of the specialized fetal anatomic evaluation (CPT® 76811 and CPT® 76812) is generally performed by those with special skills to perform this study, such as Maternal Fetal Medicine specialists, Perinatologists, and Radiologists **(with advanced training in fetal imaging).**
➢ CPT® 76811 and CPT® 76812 are defined in CPT® as including all of the requirements listed for CPT® 76805 and CPT® 76810. In addition, the report must document detailed anatomic evaluation of the following elements: ◆ Head, face, and neck ◆ 3rd ventricle ◆ 4th ventricle ◆ Lateral ventricles ◆ Cerebellar lobes, vermis, and cisterna magna ◆ Corpus callosum ◆ Integrity and shape of cranial vault ◆ Brain parenchyma ◆ Neck ◆ Profile ◆ Coronal face (nose/lips/lenses) ◆ Palate, maxilla, mandible, and tongue ◆ Ear position and size ◆ Orbits ◆ Chest/Heart ◆ Aortic arch ◆ Superior and inferior vena cava ◆ 3-vessel view ◆ 3-vessel and trachea view ◆ Lungs ◆ Integrity of diaphragm ◆ Ribs ◆ Abdomen ◆ Small and large bowel ◆ Adrenal glands ◆ Gallbladder ◆ Liver ◆ Renal arteries ◆ Spleen ◆ Integrity of abdominal wall ◆ Spine ◆ Integrity of spine and overlying soft tissue ◆ Shape and curvature ◆ Extremities ◆ Number: architecture and position ◆ Hands ◆ Feet ◆ Digits: number and position ◆ Genitalia ◆ Gender

CPT® Code Guidance
◆ Placenta ◆ Masses ◆ Placental cord insertion ◆ Accessory/succenturiate lobe with location of connecting vascular supply to primary placenta ◆ Biometry ◆ Cerebellum ◆ Inner and outer orbital diameters ◆ Nuchal thickness (16 to 20 wk) ◆ Nasal bone measurement (15 to 22 wk) ◆ Humerus ◆ Ulna/radius ◆ Tibia/fibula ◆ Maternal Anatomy ◆ Cervix (transvaginal if cervical length is ≤ 3.6cm ◆ Uterus ◆ Adnexa
➤ CPT® 76812 is an 'add-on' code used with the 'primary procedure' CPT® 76811 to report each additional gestation. ➤ These studies are usually performed at 18 to 20 weeks and are most often completed at tertiary referral centers with perinatology departments. ➤ Only one medically indicated procedure CPT® 76811 per pregnancy, per practice (per NPI) is appropriate. CPT® 76811 **should only be used once per pregnancy** unless the mother changes to a new medical caregiver at a new office and there is a new medical indication and/or change in condition. *Follow-up studies should be coded as CPT® 76815 or CPT® 76816 ➤ In circumstances where the individual is deemed to have an increased risk for a fetal abnormality and does not have access to a provider who can perform the more desirable fetal and maternal ultrasound with detailed fetal anatomic examination (CPT® 76811) due to geographic or other constraints, a standard (after first trimester) fetal and maternal ultrasound (CPT® 76805) may be authorized instead.

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OB-28.5: Fetal Nuchal Translucency

CPT® Code Guidance
➢ CPT® **76813** and CPT® 76814 describe ultrasound measurement of the clear (translucent) space at the back of the fetal neck to assess risk for Down Syndrome (Trisomy 21), Trisomy 18, and other genetic disorders. ◆ NT is performed when the crown rump length 44-83 mm. This is typically at a gestational age of approximately 11 to 13 6/7 weeks ◆ CPT® 76813 can be performed if the CRL measures between 44-83mm regardless of gestational age ◆ Biochemistry testing is 10 to 14 weeks ➢ The sonographer performing the study and the physician interpreting the study must be credentialed by the Maternal Fetal Medicine Foundation **or** Nuchal Translucency Quality Review Program (NTQR). ◆ CPT® 76814 is an add-on for each additional fetus.
➢ The first trimester screening is typically done between 11 and 13 6/7 weeks (CRL between 44 and 83 millimeters); abnormal Fetal Nuchal Translucency scan (if ≥ 2.5 mm there is an increased risk for aneuploidy, imaging should be based upon the MOM for NT and biochemical markers, ≥ 3 mm increased risk for cardiac defects, abdominal wall defects, diaphragmatic hernia, and genetic syndromes in euploid fetuses) during current pregnancy.

Practice Note

➢ **Required elements of the 76813 ultrasound code include:**
- ◆ Fetal crown-rump measurement
- ◆ Observation of fetal cardiac activity
- ◆ Observation of the embryo at high magnification until the embryonic neck is in a neutral position and spontaneous embryonic movement allows for differentiation between the outer edge of the nuchal skin and the amnion
- ◆ At least three separate measurements of the largest distance between the inner borders of the fetal nuchal translucency
- ◆ Comparison of the largest nuchal translucency measurement from an acceptable image to crown-rump length and gestational age-specific medians
- ◆ Written documentation of each component of the examination and permanent documentation of ultrasound images.
- ◆ The use of ultrasound codes (CPT® 76801/ CPT® 76802) should be indication driven and should not be routinely done whenever an ultrasound for nuchal translucency (CPT® 76813/ CPT® 76814) is requested. In cases where there is either a maternal and/or fetal indication, then the CPT® 76801 code can indeed be billed along with the nuchal translucency screening (CPT® 76813/ CPT® 76814).

References

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OB-28.6: Limited and Follow-up Studies

CPT® Code Guidance
➢ **CPT® 76815** describes a **limited** or "quick look" study used to report one or more of the elements listed in the code definition, i.e. "fetal heartbeat", placental location or fluid check (re: modified BPP which is NST with CPT® 76815) ◆ Reported only once, regardless of the number of fetuses, and only once per date of service ◆ CPT® 76815 should never be reported with complete studies CPT® 76801/ CPT® 76802 and CPT® 76805/ CPT® 76810.
➢ **CPT® 76816** describes a **follow-up** ultrasound (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), trans-abdominal approach, per fetus. ◆ The use of this CPT code is reserved for subsequent follow up ultrasound only; i.e. An ultrasound must have been performed previously. ◆ Components include: Focused assessment of fetal size by measuring BPD, abdominal circumference, femur length, or other appropriate measurement; and amniotic fluid volume ◆ Detailed re-examination of a specific organ or system known or suspected to be abnormal ◆ CPT® 76816 should be reported once per fetus evaluated in follow-up. ◆ Modifier -59 is appropriately used on subsequent codes. For example, a follow-up of a twin pregnancy is reported: CPT® 76816 and CPT® 76816-59. ◆ CPT® 76816 should never be reported with complete studies CPT® 76801, CPT® 76802 and CPT® 76805, CPT® 76810. ◆ CPT® 76816 should not be performed prior to a CPT® 76801 and/or an anatomy scan CPT® 76805 (normal pregnancy) or Detailed anatomy scan CPT® 76811 (high risk pregnancy).

OB-28.7: Obstetric Transvaginal Ultrasound

CPT® Code Guidance
➢ **CPT® 76817** is used to report an obstetrical transvaginal ultrasound.
➢ **CPT® 76817** is reported only once regardless of the number of fetuses.
➢ Although an obstetrical transvaginal ultrasound and transabdominal ultrasound can be performed at the same sitting and reported as two codes, there is rarely a medical indication to perform both studies at once.

OB-28.8: Biophysical Profile (BPP)

- The BPP combines data from ultrasound imaging and fetal heart rate (FHR) monitoring and is designed to predict the presence or absence of fetal asphyxia and, ultimately the risk of fetal death in the antenatal period (appropriately performed > 24 weeks; should NOT be performed prior to the time when the fetus would be viable outside of the uterus).
- Typically all components of the BPP, such as breathing, are not present until 26 weeks gestation. However, BPP may be utilized below 26 weeks in cases of FGR (with Doppler studies).The following parameters are evaluated:
  - Fetal breathing movements
  - Gross fetal body movements
  - Fetal tone
  - Amniotic fluid volume, at least one vertical pocket 2 x 2 cm
  - Reactive FHR (non-stress testing portion)

CPT® Code Guidance
➢ CPT® 76818 includes non-stress testing.
➢ CPT® 76819 does not include the non-stress testing portion.
➢ If non-stress testing is performed without BPP, the appropriate code to use is CPT® 59025 (Fetal non-stress test). CPT® 59025 should not be reported with codes CPT® 76818 or CPT® 76819.
➢ Although obstetrical ultrasound (CPT® codes: CPT® 76805, CPT® 76810, CPT® 76815, CPT® 76816, CPT®76820) and BPP (CPT® 76818 and CPT® 76819) can be performed at the same sitting and reported as two codes, it is generally not necessary to perform both studies at once. ◆ There are certain clinical circumstances in which it would be medically indicated to perform both studies at once. ◆ Each study must have separate images, interpretations, and reports
➢ BPP and/or non-stress testing, performed on more than one fetus, should be reported separately. The use of modifier -59 on the second and subsequent studies is appropriate, depending on payer policy.

Practice Note

If BPP ≤ 6, repeat BPP in < or equal to 24 hours

OB-28.9: Fetal Doppler

CPT® Code Guidance
➢ CPT® 76820 describes Doppler velocimetry of the umbilical artery ◆ Utilized for known FGR; see: **OB-20.1: Fetal Growth Restriction Current Pregnancy** and known oligohydramnios See: **OB-17.1: Amniotic Fluid Abnormalities**, and is typically performed > 23 weeks gestation. It may also be indicated with known twin to twin transfusion or known discordant twins (See: **OB-11: Multiple Gestations**). Its use to predict preeclampsia, and stillbirth is considered investigational.
➢ CPT® 76821 describes Doppler velocimetry of the middle cerebral artery. ◆ MCA Doppler (CPT® 76821), starting at 34 weeks, in cases of fetal growth restriction if umbilical artery Doppler is normal. ◆ Performed as a substitute for amniocentesis to evaluate a fetus at risk for anemia due to Rhesus isoimmunization/alloimmunization, Twin anemia polycythemia sequence and non-immune hydrops caused by parvovirus B19 infection or any other known acquired or congenital cause of fetal anemia. See **OB-16.1: Alloimmunization/Rh Isoimmunization/Other Causes of Fetal Anemia** - **16.4: Fetal Hydrops Associated with Polyhydramnios**; and **OB-11: Multiple Gestations**

Practice Notes

- Middle Cerebral Artery Doppler (MCA): Doppler flow studies of the MCA are used in the assessment of the fetus at risk for anemia see: **OB-16: Alloimmunization/Rh Isoimmunization/Other Causes of Fetal Anemia/Parvo/Hydrops** and monochorionic twin pregnancies see: **OB-24: Previous C-section or History of Uterine Scar**
- In the preterm SGA/FGR fetus, middle cerebral artery (MCA) Doppler has limited accuracy to predict acidemia and adverse outcome; it should not be used to time delivery. Most studies investigating MCA Doppler as a predictor of adverse outcome in preterm SGA/FGR fetuses have reported low predictive value, especially when umbilical artery Doppler is abnormal. In the largest study of predictors of neonatal outcome in SGA/FGR neonates of less than 33 weeks gestational age (n = 604), it was not a statistically significant predictor of outcome on logistic regression, although MCA PI < –2 SDs was associated with neonatal death (LR 1.12, 95% CI 1.04–1.21) and major morbidity (LR 1.12, 95% CI 1.1–1.33).
- In addition, it has been found that umbilical artery Doppler studies are less reliable after 34 weeks as IUGR at 34 weeks or greater is typically characterized by milder placental dysfunction. Umbilical artery Dopplers are less reliable after 34 weeks because they assess flow only and not perfusion.
- In the near-term SGA/FGR fetus with normal umbilical artery Doppler, an abnormal middle cerebral artery Doppler (PI <5th centile) has moderate predictive value for acidosis at birth and should be used to time delivery. MCA Doppler may be a more useful test in SGA/FGR fetuses detected after 34 weeks of gestation when umbilical artery Doppler is normal. Based on this evidence it is reasonable to use MCA Doppler to time delivery in the near term-term (34 weeks gestation or greater) SGA/FGR fetus with normal umbilical artery Doppler.

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OB-28.10: Duplex Scan (Uterine Artery)

- Uterine artery Duplex (Doppler) scan (CPT® 93976), evaluation has been shown to predict adverse outcomes when utilized in the first and second trimester, prior to 16 weeks. The clinical utility, however, is limited to the first trimester when low dose Aspirin therapy can be instituted to decrease the risk of adverse outcomes (chronic hypertension, preeclampsia, and possibly FGR). Provider certification, study technique, and abnormal test thresholds have been established by the Fetal Medicine Foundation (similar to the certification process for Nuchal Translucency screening). The Society of Maternal Fetal Medicine (SMFM) has recommended the use of CPT® 93976 only.
- Prophylaxis is now possible if started prior to 16 weeks gestation. Therefore, the use of Uterine Artery Doppler evaluation is now justified when utilized before 16 weeks gestation for patients with chronic hypertension or who are at risk for preeclampsia.
- The CPT® code recommended by SMFM is CPT® 93976 only. Send to Medical Director review if beyond 16 weeks gestation. One time only study.

CPT® Code Guidance
CPT® 93975 describes a complete duplex scan and should be reported if an organ is evaluated in its entirety. A complete study involves the evaluation of the inflow and outflow vessels of one or more organs. This code is **NOT** used for obstetric imaging.
CPT® 93976 describes a limited duplex scan and should be reported when a complete study is not documented, for example, in the case of a follow-up study or a study of only the arterial flow.
CPT® 93976 is used to report a **fetal umbilical-placental flow study**.

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OB-28.11: Fetal Echocardiography

CPT® Code Guidance
➢ It is inappropriate to report codes CPT® 76825 – CPT® 76828 for the routine monitoring of fetal heart tones using a hand-held or any Doppler device that does not create a hard-copy output. Such fetal heart tone monitoring is considered part of the physical examination and is not separately billable
➢ CPT® 76825 describes fetal echocardiography, real time with image documentation (2D), with or without M-mode recording
➢ CPT® 76826: ◆ is a follow-up or repeat fetal echocardiogram ◆ should never be billed with CPT® 76825 ◆ should never be billed more than once on any date of service
➢ CPT® 76827 describes a complete Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display
➢ CPT® 76828: is a follow-up or repeat Doppler fetal echocardiogram
➢ CPT® 93325 is used to report color mapping in conjunction with fetal echocardiography procedures CPT® 76825 – CPT® 76828.
➢ Procedure code (CPT® 76827 or CPT® 76828) includes the evaluation of veins, arteries, and valves. Guidelines do not support the billing of a second code (CPT® 76820)

Practice Notes

- Doppler of the ductus venosus, Doppler of the ductus arteriosus, and PR Interval measurement.
  - **Ductus venosus Doppler:** This is billable when sampled as part of a fetal echocardiogram study. Initial evaluation is reported as 76827; follow-up as 76828. Ductus Venosus Doppler is not billed when it is the sole assessment performed.
  - **Ductus arteriosus Doppler:** This is often performed after another ultrasound study, so it is billed as 76828. If performed as part of an initial fetal echocardiogram evaluation, it is billed as 76827 then, and 76828 on subsequent studies.
  - **PR interval measurement:** This is often performed after another ultrasound study, so it is billed as 76828. If performed as part of an initial fetal echocardiogram evaluation, it is billed as 76827 then, and 76828 on subsequent studies.

OB-28.12: 3D and 4D Rendering

- There is currently insufficient data to generate appropriateness criteria for the use of 3D and 4D rendering in conjunction with ultrasound.
- Current guidelines on ultrasonography in pregnancy from ACOG state: "The technical advantages of 3-dimensional ultrasonography include its ability to acquire and manipulate an infinite number of planes and to display ultrasound planes traditionally inaccessible by 2-dimensional ultrasonography. Despite these technical advantages, proof of a clinical advantage of 3-dimensional ultrasonography in prenatal diagnosis, in general, is still lacking. Potential areas of promise include fetal facial anomalies, neural tube defects, and skeletal malformations where 3-dimensional ultrasonography may be helpful in diagnosis as an adjunct to, but not a replacement for, 2-dimensional ultrasonography."
- Yagel et al described the state of the science of 3D/4D ultrasound (3D/4D US) applications in fetal medicine. They noted that 3D/4D US applications are many and varied. Their use in fetal medicine varies with the nature of the tissue to be imaged and the challenges each organ system presents, versus the advantages of each ultrasound application. The investigators stated that 3D/4D US has been extensively applied to the study of the fetus. Fetal applications include all types of anatomical assessment, morphometry, and volumetry, as well as functional assessment. The authors concluded that 3D/4D US provides many advantages in fetal imaging; however, its contribution to improving the accuracy of fetal scanning over rates achieved with 2D US, remains to be established.
- Clinical use of 3D ultrasound should be on an individual basis. There can be specific reasons that require 3D ultrasound when 2D cannot be utilized. Such as determination of fetal growth when there is absence of lower limbs / femurs. Since the femur length is vital in determination of fetal weight and growth. Fractional limb volume measurement of the humerus is required to evaluate for FGR.
- A second clinical scenario is seen with gastroschisis. Since the fetal abdomen is small due to the defect present, there is artificially high rate of FGR. The cause of this is the use of the fetal abdominal circumference to determine growth. 3D Fractional limb volume measurement eliminates this issue and decreases false positives.

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