



CLINICAL GUIDELINES

OB Ultrasound Imaging Policy

Version 3.0

Effective November 15, 2020



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.

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Obstetrical Ultrasound Imaging Guidelines	
Abbreviations and Glossary for OB Ultrasound Imaging Guidelines	6
OB-1: Obstetrical Ultrasound Imaging General Guidelines	7
OB-1.0: Obstetrical Imaging	8
OB-1.1: Required Documentation	8
OB-1.2: Inappropriate Use of OB Ultrasound	8
OB-1.3: Ultrasound Code Selection	9
OB-2: Uncertain Dates	12
OB-2.1: Uncertain Dates/Unknown Last Menstrual Period (LMP)	13
OB-3: Intrauterine Device (IUD)	14
OB-3.1: Locate an Intrauterine Device (IUD)	15
OB-4: Infertility	16
OB-4.1: History of Infertility	17
OB-4.2: Present Pregnancy with ART Treatment (IVF)	17
OB-4.3: Recurrent Pregnancy Loss	17
OB-5: Vaginal Bleeding and/or Abdominal/Pelvic Pain/Cramping	18
OB-5.1: Abdominal/Pelvic Pain	19
OB-5.2: Vaginal Bleeding	19
OB-5.3: Ectopic Pregnancy	19
OB-5.4: Spontaneous Abortion/Threatened/Missed Abortion	20
OB-5.5: Hydatidiform Mole	20
OB-6: Fetal Aneuploidy and Anomaly Screening	21
OB-6.1: First Trimester Screening	22
OB-6.2: Second Trimester Screening	23
OB-7: Fetal Anatomic Scan	24
OB-7.1: Fetal Anatomic Scan	25
OB-7.2: Fetal Anatomic Scan – Follow-up	25
OB-8: Third Trimester Imaging	27
OB-8.1: Third Trimester Imaging – Ultrasound	28
OB-9: High Risk Pregnancy	29
OB-9.0: High Risk General Information	30
OB-9.1: High Risk Group One – Risk Factors	30
OB-9.2: High Risk Group Two – Findings on Ultrasound that May Require Further Imaging	33
OB-9.3: High Risk Group Three – High BMI (>30 kg/m ²)	34
OB-9.4: High Risk Group Four – Macrosomia	35
OB-9.5: High Risk Group Five – Zika and COVID-19 Virus	35

OB-9.6: High Risk Group Six – Pre-Gestational Diabetes	37
OB-9.7: High Risk Group Seven Gestational Diabetes	38
OB-9.8: Hypertensive Disorders in Pregnancy	39
OB-9.9: History of Spontaneous Pre-Term Delivery/History of PPROM	41
OB-9.10: History of Stillbirth	42
OB-10: High Risk Medications and Substances	45
OB-10.1: Medications and Substances that Qualify for a Detailed Fetal Anatomic Scan	46
OB-11: Multiple Gestations	48
OB-11.1: Suspected Multiple Gestations	49
OB-11.2: Known Dichorionic Multiple Gestations	49
OB-11.3: Known Monochorionic-Diamniotic or Monochorionic-Monoamniotic Multiple Gestations	50
OB-12: Fetal Echocardiography (ECHO)	53
OB-12.1: Fetal Echocardiography – Coding	54
OB-12.2: Indications for Fetal Conditions	54
OB-12.3: Indications for Maternal Conditions	55
OB-12.4: Medication or Drug Exposure	55
OB-13: Fetal MRI	57
OB-13.1: Indications for Fetal MRI	58
OB-14: Abnormal Fetal Position/ Presentation	60
OB-14.1: Abnormal Fetal Position or Presentation	61
OB-15: Adnexal Mass/Uterine Fibroids and Uterine Anomalies	62
OB-15.1: Adnexal Mass	63
OB-15.2: Uterine Fibroids in Pregnancy	63
OB-15.3: Uterine Anomalies in Pregnancy	64
OB-16: Alloimmunization/Rh Isoimmunization/ Other Causes of Fetal Anemia/Parvo/Hydrops	66
OB-16.1: Alloimmunization/Rh Isoimmunization	67
OB-16.2: Exposure to Parvovirus B-19	68
OB-16.3: Twin Anemia Polycythemia Sequence	68
OB-16.4: Other Fetal Hydrops/Nonimmune Hydrops	68
OB-16.5: Other Causes of Fetal Anemia	69
OB-17: Amniotic Fluid Abnormalities/ Oligohydramnios/Polyhydramnios	70
OB-17.1: Amniotic Fluid Abnormalities	71
OB-18: Cervical Insufficiency/Current Preterm Labor	73
OB-18.1: Cervical Insufficiency	74

OB-18.2: Cerclage in Place in Current Pregnancy	74
OB-18.3: Current Preterm Labor	74
OB-19: No Fetal Heart Tones/Decreased Fetal Movement	76
OB-19.1: No Fetal Heart Tones	77
OB-19.2: Decreased Fetal Movement	77
OB-20: Fetal Growth Problems (FGR and Macrosomia)	78
OB-20.1: Fetal Growth Restriction Current Pregnancy	79
OB-20.2: Macrosomia – Large for Dates Current Pregnancy	80
OB-21: Placental and Cord Abnormalities	81
OB-21.1: Single Umbilical Artery (Two Vessel Cord)	82
OB-21.2: Persistent Right Umbilical Vein (PRUV)	82
OB-21.3: Placental/Cord Abnormalities	83
OB-21.4: Subchorionic Hematoma/Hemorrhage (Placental Hematoma)	84
OB-21.5: Suspected Abruptio Placentae	85
OB-21.6: Previa (Placenta Previa and Vasa Previa)	85
OB-21.7: Placenta Accreta Spectrum (Accreta, Increta, Percreta)	87
OB-22: Late-term/Post-term Pregnancy	89
OB-22.1: Late-term/Post-term Pregnancy	90
OB-23: Preterm/Prelabor Rupture of Membranes	91
OB-23.1: Current Preterm/Prelabor Rupture of Membranes (PPROM)	92
OB-23.2: Current Prelabor Rupture of Membranes (PROM)	92
OB-24: Previous C-section or History of Uterine Scar	93
OB-24.1: Previous C-section or History of Uterine Scar	94
OB-25: Termination of Pregnancy – Imaging	95
OB-25.1: Imaging for Planned Pregnancy Termination	96
OB-26: Trauma	97
OB-26.1: Trauma – Imaging	98
OB-27: Unequal Fundal Size and Dates	99
OB-27.1: Unequal Fundal Size and Dates	100
OB-28: Procedure Coding Basics for Established Pregnancy	101
OB-28.1: Procedure Coding Basics for Established Pregnancy General Considerations	102
OB-28.2: Required Elements for Complete First Trimester Ultrasound	102
OB-28.3: Required Elements for Second or Third Trimester Fetal Anatomic Evaluation Ultrasound	103

OB-28.4: Required Elements for a Detailed Fetal Anatomic Evaluation Ultrasound	104
OB-28.5: Fetal Nuchal Translucency	105
OB-28.6: Limited and Follow-up Studies	106
OB-28.7: Obstetric Transvaginal Ultrasound	106
OB-28.8: Biophysical Profile (BPP)	107
OB-28.9: Fetal Doppler	107
OB-28.10: Duplex Scan	108
OB-28.11: Fetal Echocardiography	108
OB-28.12: 3D and 4D Rendering	109

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)	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 weight of the fetus at or below 10 th percentile for gestational age; and/or abdominal circumference of the fetus at or below 10th percentile for gestational age
M-mode	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: maximum deepest pocket of ≤ 2 cm and/or AFI of ≤ 5 cm or <the 5 th percentile for gestational age if <30 weeks.
PACS	Picture Archiving and Communications System
polyhydramnios	AFI ≥ 24 cm 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"

OB-1: Obstetrical Ultrasound Imaging General Guidelines

OB-1.0: General Guidelines	8
OB-1.1: Required Documentation	8
OB-1.2: Inappropriate Use of OB Ultrasound	8
OB-1.3: Ultrasound Code Selection	9

OB-1.0: General Guidelines

- This document offers an in-depth, indication driven guide to obstetrical imaging
- Ultrasound assessment is an accurate method of determining gestational age, fetal number, viability, and placental location, and it is recommended for all pregnant patients.
- Normal (Low Risk) Pregnancy Imaging
 - ◆ Per ACOG, in the absence of other specific indications, the optimal time for a single ultrasound examination is at 18 to 22 weeks of gestation (but may be performed any time after 14 weeks). This timing allows for a survey of fetal anatomy in most women and an accurate estimation of gestational age. If <16 weeks gestation, send to Medical Director Review.
 - Report a fetal anatomy ultrasound CPT® 76805 for a normal/low risk pregnancy.
 - ◆ Current SMFM guidelines state that CL screening in singleton gestations without a prior spontaneous PTB cannot yet be universally mandated.
 - Transvaginal ultrasound (CPT® 76817) may be considered if the transabdominal cervical length (CL) is ≤ 3.6 cm or in certain circumstances of poor cervical visualization on transabdominal ultrasound
 - ◆ Fetal Nucal Translucency (CPT® 76813) can be considered if Cell-Free DNA (cfDNA) is not planned or has not already been performed, as they are both screening tools for fetal aneuploidy
- 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:
 - ◆ Expected date of delivery
 - ◆ Gestational age at date of service
 - ◆ Results of prior ultrasound studies if available
- 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)

OB-1.1: Required Documentation

- See **OB-1.0: General Guidelines**

OB-1.2: Inappropriate Use of OB Ultrasound

- See **OB-1.0: General Guidelines**
- Obstetrical ultrasound is **not** medically indicated for the following:
 - ◆ Sex determination only
 - ◆ To provide a keepsake or souvenir picture

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 (for each additional fetus) are reported for complete studies performed during the first trimester (<14 weeks). These codes 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® 76813 and CPT® 76814 (each additional fetus) are used to report 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® 76805 and CPT® 76810 (for each additional fetus) are used to report complete studies (anatomy scan) performed during the second and third trimester, in a normal (low risk) pregnancy. These studies 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® 76811 and CPT® 76812 (for each additional fetus) describe an extensive fetal ultrasound evaluation and detailed anatomic survey and are used only when the study includes this service. These studies 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. This detailed fetal anatomic evaluation is generally performed by those with special skills to perform this study, such as a Maternal Fetal Medicine specialist (Perinatologist), or a Radiologist with advanced training in fetal imaging. In circumstances where a detailed fetal anatomy (CPT® 76811) is indicated but access is limited due to geographic or other constraints, a standard fetal anatomy survey (CPT® 76805) may be authorized instead at the appropriate gestational age.
CPT® 76817 is used to report a transvaginal ultrasound. The other OB ultrasound codes are used for transabdominal studies.
CPT® 76816 is used to report a follow up study, such as a growth scan or follow up on anatomy when more than one area requires reexamination. <ul style="list-style-type: none"> ◆ 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 describes a limited or 'quick look' study <ul style="list-style-type: none"> ◆ It can be used at any gestational age for various indications, including quick look for AFI assessment, fetal heart beat, fetal position or placental location etc. ◆ It may be used specifically for 'dating' (when indicated) in those that don't meet gestational age criteria for dating with CPT® 76801 or are too early for anatomy scan (i.e. >14 weeks but <16 weeks) ◆ It is also used to report a modified BPP.
CPT® 76818 (includes non-stress test) and 76819: are used to report a Biophysical profile (BPP), a test for antepartum fetal surveillance.
CPT® 76820 describes Doppler velocimetry of the umbilical artery.

CPT® Code Guidance

CPT® 76821 describes Doppler velocimetry of the middle cerebral artery.

CPT® 76825 describes fetal echocardiography and CPT® 76827 describes the Doppler portion of the echocardiogram. These codes should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office or there is a new medical indication for ultrasound.

CPT® 76826 describes a follow up fetal echocardiography and CPT® 76828 describes a follow up Doppler portion of the echocardiogram.

CPT® 93325 may be added for color mapping in conjunction with fetal echocardiography procedures.

CPT® 93976 describes a limited duplex scan and is used during pregnancy for characterizing the pattern and direction of blood flow in arteries and veins. It can be used to report fetal umbilical-placental flow evaluation (accreta or other placental or cord abnormalities).

CPT® 74712 and CPT® 74713 (for each additional fetus) are used to report a fetal MRI (indicated for more in depth imaging of certain fetal abnormalities).

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® 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)
- SMFM suggest that ductus venosus, middle cerebral artery, or uterine artery Doppler use for routine clinical management of early- or late-onset FGR *is not recommended* (GRADE 2A)
- The minimal use of color Doppler alone (CPT® 93976), when performed for anatomical structure identification, during a standard ultrasound procedure, is not separately reimbursable.

References

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OB-2: Uncertain Dates

OB-2.1: Uncertain Dates/Unknown Last Menstrual Period (LMP) 13

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

- If there is a difference between the clinical size of the uterus on pelvic exam, **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:
 - ◆ When thought to be <14 weeks - CPT® 76801 (plus CPT® 76802 for each additional fetus) and/or CPT® 76817 if a complete ultrasound has not yet been performed or
 - ◆ CPT® 76815 and/or CPT® 76817
- When thought to be ≥14 weeks and there is a difference between the clinical size of the uterus on abdominal exam **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® 76805/CPT® 76811 if high risk if complete fetal anatomic scan has not yet been performed or
 - ◆ CPT® 76815 and/or CPT® 76817

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OB-3: Intrauterine Device (IUD)

OB-3.1: Locate an Intrauterine Device (IUD)

15

OB-3.1: Locate an Intrauterine Device (IUD)

- Can report CPT® 76801 and/or CPT® 76817 if <14 weeks and a complete ultrasound has not yet been performed or
- CPT® 76815 and/or CPT® 76817 if complete ultrasound has already been performed
- 3-D Rendering (CPT® 76376/CPT® 76377) may be added for “Lost” IUD (inability to feel or see IUD string).

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OB-4: Infertility

OB-4.1: History of Infertility	17
OB-4.2: Present Pregnancy with ART Treatment (IVF)	17
OB-4.3: Recurrent Pregnancy Loss	17

OB-4.1: History of Infertility

- If there is a history of infertility treatment (CPT® 76801 [plus CPT® 76802 for each additional fetus] and/or CPT® 76817 if <14 weeks, for dating) or
- CPT® 76815 and/or CPT® 76817
- 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**

OB-4.3: Recurrent Pregnancy Loss

- Ultrasound imaging is supported if there is a history of at least 2 consecutive or 3 non-consecutive clinical miscarriages/losses at <20 weeks gestation (CPT® 76801 [plus CPT® 76802 for each additional fetus] and/or CPT® 76817 if <14 weeks, for dating) or
- CPT® 76815 and/or CPT® 76817
- Repeat ultrasound is not usually necessary unless there are new clinical indications. Send requests for repeat imaging to Medical Director Review

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

OB-5.1: Abdominal/Pelvic Pain	19
OB-5.2: Vaginal Bleeding	19
OB-5.3: Ectopic Pregnancy	19
OB-5.4: Spontaneous Abortion/Threatened/Missed Abortion	20
OB-5.5: Hydatidiform Mole	20

OB-5.1: Abdominal/Pelvic Pain

For abdominal/pelvic pain that presents without bleeding:

- Initially CPT® 76815 and/or CPT® 76817 **or**
- CPT® 76801 and/or CPT® 76817 if complete ultrasound has not yet been performed, and is <14 weeks **or**
- CPT® 76805 (plus CPT® 76810 for each additional fetus) if ≥14 weeks, when complete fetal anatomic scan (CPT® 76805) is planned and has not yet been performed **or**
- CPT® 76816 (if a complete ultrasound CPT® 76801 or CPT® 76805 or CPT® 76811 has previously been performed)

OB-5.2: Vaginal Bleeding

First Trimester

- Initially CPT® 76815 and/or CPT® 76817 **or**
- CPT® 76801 and/or CPT® 76817 if complete ultrasound has not yet been performed, and is <14 weeks

Second and Third Trimesters

- Limited CPT® 76815 and/or CPT® 76817 **or**
- CPT® 76805 (plus CPT® 76810 for each additional fetus) if ≥14 weeks, when complete fetal anatomic scan CPT® 76805 has not yet been performed, and/or CPT® 76817 **or**
- CPT® 76816 and/or CPT® 76817
- CPT® 93976 (limited duplex scan) may be indicated as an add-on, (See **OB-21: Placental and Cord Abnormalities**).
- Additionally, starting at 26 weeks, BPP (CPT® 76818 or CPT® 76819) can be considered.
- For suspected placental abruption, (See **OB-21.5: Suspected Abruption Placentae**).
- If vaginal bleeding with +KB (Kleihauer-Betke) – fetomaternal hemorrhage – at risk for fetal anemia and hydrops CPT® 76821 may be indicated, send to Medical Director Review

OB-5.3: Ectopic Pregnancy

Ectopic Pregnancy

First Trimester

- Signs and symptoms of ectopic pregnancy include pain and/or bleeding. However, imaging may also be indicated without pain and bleeding, if there is a history of ectopic pregnancy or with non-doubling hCG.
 - ◆ CPT® 76815 and/or CPT® 76817 **or**
 - ◆ CPT® 76801 and/or CPT® 76817 if complete ultrasound has not yet been performed, and is <14 weeks
 - ◆ Once an adnexal mass is confirmed, Color Doppler ultrasonography (CPT® 93976) may be useful to evaluate the vascular characteristics
- ◆ 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

OB-5.4: Spontaneous Abortion/Threatened/Missed Abortion

- Imaging may be indicated with or without vaginal bleeding to evaluate for threatened or missed abortion.
 - ◆ CPT® 76801 and/or CPT® 76817 if complete ultrasound has not yet been performed, and is <14 weeks **or**
 - ◆ CPT® 76815 and/or CPT® 76817 **or**
 - ◆ CPT® 76805 (plus CPT® 76810 for each additional fetus) if ≥14 weeks, when complete fetal anatomic scan CPT® 76805 has not yet been performed, and/or CPT® 76817
 - ◆ Repeat ultrasound (CPT® 76815 and/or CPT® 76817) may be appropriate at weekly intervals in the setting of rising or non-falling serum hCG levels or if unable to confirm viable IUP (fetal pole with + cardiac activity)
 - ◆ 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.

OB-5.5: Hydatidiform Mole

Hydatidiform Mole

First, Second and Third Trimester

- Ultrasound can be performed for diagnosis of hydatidiform mole
 - ◆ CPT® 76801 and/or CPT® 76817 if complete ultrasound has not yet been performed, and is <14 weeks, **or**
 - ◆ CPT® 76815 and/or CPT® 76817 **or**
 - ◆ CPT® 76805 (plus CPT® 76810 for each additional fetus) if ≥14 weeks, when complete fetal anatomic scan CPT® 76805 has not yet been performed, and/or CPT® 76817
 - ◆ 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**
- History of a Molar Pregnancy: Early ultrasound can be performed (CPT® 76801 if <14 weeks, or CPT® 76815 and/or CPT® 76817) to rule out a recurrent molar pregnancy

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OB-6: Fetal Aneuploidy and Anomaly Screening

OB-6.1: First Trimester Screening	22
OB-6.2: Second Trimester Screening	23

OB-6.1: First Trimester Screening

- First trimester screening includes biochemical markers and fetal nuchal translucency (NT) (CPT® 76813) assessment. An increased Fetal Nuchal Translucency (NT ≥ 3.0 mm), may indicate a fetus with aneuploidy (e.g. Down's syndrome, Trisomy 18) but may also indicate an increased risk for cardiac defects or other structural defects or genetic syndromes in euploid fetuses.
- Nuchal translucency is most accurate when performed between 11 and 13 6/7 weeks, but can be performed if the crown rump length (CRL) measures between 44-83 mm regardless of gestational age (range 10 4/7 to 14 weeks).

First Trimester Screening:	
➤	Ultrasound CPT® 76813 (plus CPT® 76814 for each additional fetus) is the initial imaging for the first trimester screening, to evaluate fetal nuchal translucency
➤	If increased Fetal Nuchal Translucency (NT ≥ 3.0 mm): <ul style="list-style-type: none"> ◆ Fetal anatomic ultrasound (CPT® 76811) at ≥ 16 weeks ◆ cfDNA, Amniocentesis or CVS may be performed
➤	An abnormal fetal NT (≥ 3.0 mm) with normal chromosomal analysis (as measured by cfDNA, CVS or amniocentesis) should be evaluated with a fetal echo (CPT® 76825 and/or CPT® 76827 and/or CPT® 93325) and a detailed fetal anatomy ultrasound (CPT® 76811)

- Cell-Free DNA (cfDNA) can be performed any time after 10 weeks gestation and is currently the most sensitive screening test for Down's syndrome per the American College of Medical Genetics and Genomics (99% accurate).
- Fetal NT (CPT® 76813) is NOT recommended if cfDNA is planned or has already been performed, as they are both screening tools for fetal aneuploidy
- Those with a positive cfDNA should be offered diagnostic testing (amniocentesis or CVS) and a detailed anatomy scan (CPT® 76811) at ≥ 16 weeks. See **OB-9.1: High Risk Group One – Risk Factors**.
- A “no call” or indeterminate result can occur (risk is higher with maternal obesity), which also has a higher risk of aneuploidy. These patients should be managed as if positive.

Coding Notes

- CPT® 76813/CPT® 76814 can be performed once per pregnancy, and should be performed only by those certified by the Fetal Medicine Foundation or Nuchal Translucency Quality Review Program (NTQR).
- 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/CPT® 76802 code can indeed be billed along with the nuchal translucency screening (CPT® 76813/CPT® 76814).

OB-6.2: Second Trimester Screening

Second Trimester Screening:

- A fetal anatomy ultrasound (CPT® 76805) and/or QUAD screen can be performed during the second trimester to detect fetal aneuploidy, neural tube defects, and other anatomical defects.
 - ◆ See **OB-7.1: Fetal Anatomic Scan**
- If the quad screening is abnormal, a detailed anatomy 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 aneuploidy as well as open neural tube defects (ONTD).

- Maternal serum alpha-fetoprotein (MSAFP) can be done at 15 to 20 weeks to screen for neural tube defects in those that have had cfDNA or NT screen.
- The “quad” screen (AFP (alpha-fetoprotein), hCG (human chorionic gonadotropin), uE (Unconjugated estriol), dimeric inhibin-A) is the most commonly used test for the second trimester.
- A penta screen (quad screen markers + hyperglycosylated hCG) may be done in lieu of a quad screen.
- 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.

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OB-7: Fetal Anatomic Scan

OB-7.1: Fetal Anatomic Scan	25
OB-7.2: Fetal Anatomic Scan – Follow-up	25

OB-7.1: Fetal Anatomic Scan

- Per ACOG, in the absence of other specific indications, the optimal time for a single ultrasound examination is at 18 to 22 weeks of gestation (but may be performed any time after 14 weeks). This timing allows for a survey of fetal anatomy in most women and an accurate estimation of gestational age. If <16 weeks gestation, send to Medical Director Review.
 - ◆ Report a fetal anatomy ultrasound CPT® 76805 for a normal/low risk pregnancy.
- If pregnancy **is** high risk report a detailed fetal anatomy ultrasound (CPT® 76811). This is generally performed by a Maternal Fetal Medicine (MFM)/Perinatologist, or a Radiologist at an AIUM or ACR accredited facility. See **OB-9: High Risk Pregnancy**
- Current SMFM guidelines state that CL screening in singleton gestations without a prior spontaneous PTB cannot yet be universally mandated.
 - ◆ Transvaginal ultrasound (CPT® 76817) may be considered if the transabdominal cervical length (CL) is ≤ 3.6 cm or in certain circumstances of poor cervical visualization on transabdominal ultrasound

OB-7.2: Fetal Anatomic Scan – Follow-up

- Follow-up ultrasounds (CPT® 76815 to assess a single item or CPT® 76816 if multiple areas to be assessed) can be performed once for incomplete or equivocal finding on initial fetal anatomic 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))
- If pregnancy is high risk See **OB-9: High Risk Pregnancy** or other applicable high risk guideline.
- Detailed anatomy ultrasound CPT® 76811 can be performed if not previously performed when initial fetal anatomic scan CPT® 76805 is abnormal. See **OB-9: High Risk Pregnancy**

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OB-8: Third Trimester Imaging

OB-8.1: Third Trimester Imaging – Ultrasound

28

OB-8.1: Third Trimester Imaging – Ultrasound

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| <ul style="list-style-type: none">➤ Imaging in the third trimester is indicated for bleeding, pain, absent fetal heart tones, decreased fetal movement and/or other high-risk indications.<ul style="list-style-type: none">◆ See specific guidelines based on indication |
| <ul style="list-style-type: none">➤ For suspected breech position, See <u>OB-14: Abnormal Fetal Position/Presentation</u> |

Reference

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OB-9: High Risk Pregnancy	
OB-9.0: High Risk General Information	30
OB-9.1: High Risk Group One – Risk Factors	30
OB-9.2: High Risk Group Two – Findings on Ultrasound that May Require Further Imaging	33
OB-9.2.1: Soft Markers for Aneuploidy	33
OB-9.2.2: Other Findings on Ultrasound that May Require Further Imaging	33
OB-9.3: High Risk Group Three – High BMI (>30 kg/m ²)	34
OB-9.3.1: Class I Obesity - Pre-pregnancy BMI 30 to 34.9	34
OB-9.3.2: Class II Obesity - Pre-pregnancy BMI 35-39.9	34
OB-9.3.3: Class III Obesity - Pre-pregnancy BMI ≥40	34
OB-9.4: High Risk Group Four – Macrosomia	35
OB-9.4.1: Prior Pregnancy with Macrosomia	35
OB-9.4.2: Current Pregnancy with Suspected or Known Macrosomia	35
OB-9.5: High Risk Group Five – Zika and COVID-19 Virus	35
OB-9.5.1: Zika Virus	35
OB-9.5.2: COVID-19 Virus	36
OB-9.6: High Risk Group Six – Pre-Gestational Diabetes	37
OB-9.6.1: Pre-Gestational or Early Diagnosed Diabetes - not on Medication	37
OB-9.6.2: Pre-Gestational or Early Diagnosed Diabetes - on Medication	37
OB-9.7: High Risk Group Seven Gestational Diabetes	38
OB-9.7.1: Gestational Diabetes - Diet-Controlled (GDM-A1)	38
OB-9.7.2: Gestational Diabetes (GDM-A2) on Medications	38
OB-9.8: Hypertensive Disorders in Pregnancy	39
OB-9.8.1: Screening in High Risk Groups	39
OB-9.8.2: Current Chronic Hypertension not on Medication	39
OB-9.8.3: Current Chronic Hypertension on Medication	39
OB-9.8.4: Gestational Hypertension (GH, preeclampsia, toxemia)	40
OB-9.9: History of Spontaneous Pre-Term Delivery/History of PPROM	41
OB-9.9.1: Spontaneous Preterm Delivery ≤34 Weeks; History of PPROM ≤34 weeks	41
OB-9.9.2: History of Spontaneous Preterm Delivery >34 weeks <37 weeks; History of PPROM >34 weeks <37 weeks	41
OB-9.10: History of Stillbirth	42

OB-9.0: High Risk General Information

High Risk Pregnancy General Information:

- A Detailed Fetal Anatomic Scan (CPT® 76811/CPT® 76812 for each additional fetus) is ideally performed between 18 to 20 weeks, but can be performed after 16 weeks when criteria is met.
- This detailed fetal anatomic evaluation is generally performed by those with special skills to perform this study, such as a Maternal Fetal Medicine specialist (Perinatologist), or a Radiologist with advanced training in fetal imaging.
- 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® 76805, CPT® 76810, 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))
- SMFM suggest that ductus venosus, middle cerebral artery, or uterine artery Doppler use for routine clinical management of early- or late-onset FGR *is not recommended* (GRADE 2A)

OB-9.1: High Risk Group One – Risk Factors

HIGH RISK PREGNANCY – Risk Factors
Socio-Demographic Risk Factors (maternal age)
➤ Age ≥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 (marijuana use -See <u>OB-10.1: Medications and Substances that Qualify for a Detailed Fetal Anatomic Scan</u>)
➤ ≥10 cigarettes a day
➤ Other nicotine exposure (e-cigs, vaping, chewing, patch) send to Medical Director Review
➤ Maternal history of IV drug abuse
➤ Current use of Suboxone, Subutex, Methadone

Practice Notes

Several studies noted lower birth weights among offspring exposed to marijuana. These findings were more pronounced among women who used more marijuana, particularly during the first and second trimesters (at least weekly during the pregnancy). CPT® 76811 may be indicated (See **OB-10.1: Medications and Substances that Qualify for a Detailed Fetal Anatomic Scan**), however, given the limited evidence for antenatally detected abnormal growth, serial growth ultrasounds may not be indicated in the absence of other findings concerning for growth restriction

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, <8 grams Hgb or 24% HCT
- Asthma (poorly controlled or steroid dependent)
- Autoimmune disease (e.g. Multiple Sclerosis, Immune Thrombocytopenic Purpura)
- 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, Alpha and Beta thalassemia minor (trait) or major)
- History of endometrial ablation or Uterine Artery embolization
- Inflammatory Bowel Disease (Ulcerative colitis, Crohn's Disease)
- Liver disease e.g., Cholestasis of pregnancy, Hepatitis
- Maternal malnutrition (BMI <18.5); Send to Medical Director Review for poor weight gain
- PKU
- Renal disease eg glomerulonephritis, persistent protein in the urine, renal insufficiency
- Seizure disorders– on antiepileptic medication
- Systemic malignancy
- Thyroid disorder (e.g. hyperthyroidism, poorly controlled hypothyroidism)

Previous pregnancy related risk factors

- Prior pregnancy with adverse outcome (early onset preeclampsia ≤ 34 weeks, abruption, accreta, previous uterine rupture, or FGR at any gestational age, nonimmune hydrops, ect.).
- Prior pregnancy with SGA (baby weighing <2500 grams at term or FGR less than the 10th percentile of expected weight)
- For stillbirth See **OB-9.10: History of Stillbirth**

Current pregnancy related risk factors

- Abnormal 1st or 2nd trimester screen (e.g. MSAFP; Low PAPP_A, etc.) Known chromosomal abnormalities; or abnormal cfDNA
- Major Fetal anomaly such as gastroschisis, fetal ventriculomegaly, fetal hydronephrosis (>10mm), fetal congenital heart disease, sustained fetal arrhythmias (See **OB-16.5: Other Causes of Fetal Anemia**)
- 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)
- Abnormal Fetal Nuchal Translucency ≥ 3.0 mm; Thickened nuchal fold found on second trimester imaging ≥ 6 mm up to 22 weeks
- No prenatal care prior to the third trimester

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 and COVID-19 Virus See **OB-9.5: High Risk Group Five: Zika and COVID-19 Virus**

Imaging For Above Conditions

- CPT® 76801 [plus CPT® 76802 for each additional fetus] if <14 weeks and a complete ultrasound has not yet been performed, **and/or**
- CPT® 76817 for a transvaginal ultrasound or
- CPT® 76815 can be performed for dating or quick look follow-up if ≥14 weeks but <16 weeks
- Detailed Fetal Anatomic Scan CPT® 76811 ≥16 weeks when criteria is met
- Starting at 23 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)

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

OB-9.2.1: Soft Markers for Aneuploidy

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| <ul style="list-style-type: none"> ➤ If the following 'soft markers' are found in fetus of current pregnancy on routine imaging: <ul style="list-style-type: none"> ◆ Shortened long bones (femur and/or humerus) identified Pyelectasis of ≥ 4 mm at 20 weeks (For Hydronephrosis defined as ≥ 10mm, See <u>OB-9.1: High Risk Group One - Risk factors</u>) ◆ Echogenic bowel ◆ Hypoplastic nasal bone ◆ See <u>OB-9.2.2: Other Findings on Ultrasound that May Require Further Imaging</u> for Fetal Echogenic intra-cardiac focus and/or choroid plexus cyst |
| <ul style="list-style-type: none"> ➤ Detailed Fetal anatomic scan ≥ 16 weeks (CPT[®] 76811). |
| <ul style="list-style-type: none"> ➤ One follow-up scan (CPT[®] 76816) in third trimester |

OB-9.2.2: Other Findings on Ultrasound that May Require Further Imaging

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| <ul style="list-style-type: none"> ➤ If the following conditions are found in fetus of current pregnancy on routine imaging: <ul style="list-style-type: none"> ◆ Choroid plexus cyst ◆ Echogenic intra-cardiac foci (Fetal echo or follow-up ultrasound are not warranted) ◆ Prior pregnancy with a chromosomal and/or structural congenital anomaly ◆ Current pregnancy with suspected fetal anomaly on routine anatomic survey |
| <ul style="list-style-type: none"> ➤ Detailed fetal anatomic scan ≥ 16 weeks (CPT[®] 76811) |

OB-9.3: High Risk Group Three – High BMI (>30 kg/m²)

- CPT® 76801 [plus CPT® 76802 for each additional fetus] if <14 weeks and a complete ultrasound has not yet been performed, **and/or** :
- CPT® 76817 for a transvaginal ultrasound or
- CPT® 76815 can be performed for dating if ≥14 weeks but <16 weeks and a complete ultrasound has not yet been performed
- Detailed fetal anatomic scan ≥16 weeks (CPT® 76811)

OB-9.3.1: Class I Obesity - Pre-pregnancy BMI 30 to 34.9**Class I Obesity (BMI 30-34.9)**

- After first and second trimester imaging as outlined above, Report **One** follow-up scan (CPT® 76816) between 32 to 36 weeks
 - ◆ If unable to clinically assess fundal height due to body habitus growth scan (CPT® 76816) can be considered in the early third trimester with follow up in 4 weeks

OB-9.3.2: Class II Obesity - Pre-pregnancy BMI 35-39.9**Class II Obesity (BMI 35-39.9)**

- After first and second trimester imaging as outlined above, Report:
 - ◆ Growth scans (CPT® 76816) every 4 weeks starting in the third trimester (>28 weeks)
 - ◆ BPP (CPT® 76818 or CPT® 76819) or a modified BPP (CPT® 76815) weekly starting at 36 weeks

OB-9.3.3: Class III Obesity - Pre-pregnancy BMI ≥40**Class III Obesity (BMI ≥40)**

- After first and second trimester imaging as outlined above, Report:
 - ◆ Growth scans (CPT® 76816) every 4 weeks starting in the third trimester (>28 weeks)
 - ◆ BPP (CPT® 76818 or CPT® 76819) or modified BPP (CPT® 76815) weekly starting at 32 weeks

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)

- Report one of the following in the first trimester to establish dates:
 - ◆ CPT® 76801 [plus CPT® 76802 for each additional fetus] if <14 weeks and a complete ultrasound has not yet been performed, **and/or**
 - ◆ CPT® 76817 for a transvaginal ultrasound or
 - ◆ CPT® 76815 (limited ultrasound) can be performed for dating if an ultrasound has not already been performed, and ≥14 weeks and <16 weeks
- A detailed fetal anatomy scan (CPT® 76811) at ≥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**
- See **OB-27: Unequal Fundal Size and Dates**

OB-9.5: High Risk Group Five – Zika and COVID-19 Virus

OB-9.5.1: Zika Virus

Suspected exposure without symptoms

- Report one of the following:
 - ◆ CPT® 76801 [plus CPT® 76802 for each additional fetus] if <14 weeks and a complete ultrasound has not yet been performed, **and/or**
 - ◆ CPT® 76817 for a transvaginal ultrasound or
 - ◆ CPT® 76815 (limited ultrasound) can be performed for dating if an ultrasound not already been performed and ≥14 week and <16 weeks
- Fetal anatomic scan CPT® 76805 or CPT® 76811 at ≥16 weeks.
- If test positive or if symptoms developed, See below.

Suspected exposure with symptoms or known infection

- Report one of the following
 - ◆ CPT® 76801 [plus CPT® 76802 for each additional fetus] if <14 weeks and a complete ultrasound has not yet been performed, **and/or**
 - ◆ CPT® 76817 for a transvaginal ultrasound or
 - ◆ CPT® 76815 (limited ultrasound) can be performed for dating if an ultrasound not already been performed and ≥14 week and <16 weeks
- Fetal anatomic scan CPT® 76805 or CPT® 76811 at ≥16 weeks.
- If FGR diagnosed then follow FGR imaging **OB-20.1: Fetal Growth Restriction Current Pregnancy**

OB-9.5.2: COVID-19 Virus

Person Under Investigation (PUI) for infection or known infection

- Report one of the following:
 - ◆ CPT® 76801 [plus CPT® 76802 for each additional fetus] if <14 weeks and a complete ultrasound has not yet been performed, **and/or**
 - ◆ CPT® 76817 for a transvaginal ultrasound or
 - ◆ CPT® 76815 (limited ultrasound) can be performed for dating if an ultrasound not already been performed and ≥14 week and <16 weeks
- Fetal anatomic scan CPT® 76805 or CPT® 76811 at ≥16 weeks.
- Growth scan (CPT® 76816) every 3 to 4 weeks starting at 23 weeks (See **OB-9.1: High Risk Group One - Risk factors**).
- If FGR diagnosed then follow FGR imaging **OB-20.1: Fetal Growth Restriction Current Pregnancy**
- BPP or other imaging requests – send to Medical Director Review

Practice Notes

SMFM recommendation during COVID pandemic:

- Combine dating/NT to one ultrasound based on LMP. If ultrasound earlier in the first trimester (e.g., <10 weeks) is indicated due to threatened abortion, pregnancy of unknown anatomic location, may consider foregoing NT ultrasound and offering cell free DNA screening for those desiring early aneuploidy screening
- Perform Anatomy Ultrasound at 20-22 weeks and if needed, consider follow up views in 4-8 weeks rather than 1-2 weeks.
- If serial cervical length assessments are indicated, consider stopping after anatomy u/s if transvaginal cervical length ≥35 mm, or if prior preterm birth at >34 weeks
- BMI >40: schedule anatomy at 22 weeks to reduce risk of suboptimal views/need for follow up
- If Growth Ultrasounds indicated – recommend a single third trimester growth at 32 weeks.
- Follow up previa/low lying placenta at 34-36 weeks

OB-9.6: High Risk Group Six – Pre-Gestational Diabetes**OB-9.6.1: Pre-Gestational or Early Diagnosed Diabetes - not on Medication**

Test	When	Frequency	Codes
First Trimester Ultrasounds	<14 weeks	Once	CPT® 76801 and/or CPT® 76817
Dating Ultrasound if no prior dating and ≥14 weeks	14-16 weeks	Once	CPT® 76815
Fetal anatomic scan	≥16 weeks	Once	CPT® 76811
Fetal echo (initial) Requests for follow-up go to Medical Director Review	Starting at ≥16 weeks	Once	CPT® 76825 and/or CPT® 76827 and/or CPT® 93325
Ultrasound (for fetal growth)	Starting in the 3 rd trimester	Every 3 to 6 weeks	CPT® 76816
Biophysical Profile (BPP) or modified BPP	Starting at 32 weeks	Once per week	CPT® 76818 (BPP) or CPT® 76819 (BPP) or CPT® 76815 (modified BPP)

OB-9.6.2: Pre-Gestational or Early Diagnosed Diabetes - on Medication

Test	When	Frequency	Codes
First Trimester Ultrasounds	<14 weeks	Once	CPT® 76801 and/or CPT® 76817
Dating Ultrasound if no prior dating and ≥14 weeks	14-16 weeks	Once	CPT® 76815
Fetal anatomic scan	≥16 weeks	Once	CPT® 76811
Fetal echo (initial) Requests for follow-up go to Medical Director Review	Starting at ≥16 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*	Starting at 32 weeks (may start at ≥26 weeks if complicated by additional risk factors)	Up to twice weekly	CPT® 76818 (BPP) or CPT® 76819 (BPP) or CPT® 76815 (modified BPP)
Umbilical artery Doppler (if FGR diagnosed)	Upon diagnosis of FGR if ≥23 weeks	Weekly	CPT® 76820

Practice Notes

- Per ACOG - 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}) ≥6.5%, a fasting plasma glucose ≥126 mg/dL, or a 2-hour glucose of ≥200 mg/dL on a 75-g oral glucose tolerance test, it is considered pre-gestational diabetes.

OB-9.7: High Risk Group Seven Gestational Diabetes**OB-9.7.1: Gestational Diabetes - Diet-Controlled (GDM-A1)**

If patient has gestational diabetes and it is diet controlled:			
Test	When	Frequency	Codes
Fetal anatomic scan	≥16 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 weeks	Once weekly if diet controlled.	CPT® 76818 (BPP) or CPT® 76819 (BPP) or CPT® 76815 (modified BPP)

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

If patient has gestational diabetes and is on oral medication or insulin:			
Test	When	Frequency	Codes
Fetal anatomic scan	≥16 weeks	Once	CPT® 76811
Fetal echo (initial) Requests for follow-up go to Medical Director Review	≥16 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	Starting at 32 weeks (may start at ≥26 if complicated by additional risk factors)	Up to twice weekly	CPT® 76818 (BPP) or CPT® 76819 (BPP) or CPT® 76815 (modified BPP)
Umbilical artery Doppler (if FGR diagnosed)	Upon diagnosis of FGR if ≥23 weeks	Weekly	CPT® 76820

OB-9.8: Hypertensive Disorders in Pregnancy

OB-9.8.1: Screening in High Risk Groups

- SMFM state that uterine artery Doppler has limited diagnostic accuracy and clinical utility in predicting FGR, SGA birth, and perinatal mortality. As such, its use for screening in high risk groups *is not recommended* (GRADE 2A)

OB-9.8.2: Current Chronic Hypertension not on Medication

Test	When	Frequency	Codes
First Trimester Ultrasounds	<14 weeks	Once	CPT® 76801 and/or CPT® 76817
Dating Ultrasound if no prior dating and ≥14 weeks	14-16 weeks	Once	CPT® 76815
Fetal anatomic scan	≥16 weeks	Once	CPT® 76811
Ultrasound (for fetal growth)	In the third trimester (>28 weeks)	Every 4-6 weeks	CPT® 76816

If blood pressure is elevated from baseline, See **OB-9.8.4: Gestational Hypertension (GH, preeclampsia, toxemia)** below

OB-9.8.3: Current Chronic Hypertension on Medication

Test	When	Frequency	Codes
First Trimester Ultrasounds	<14 weeks	Once	CPT® 76801 and/or CPT® 76817
Dating Ultrasound if no prior dating and ≥14 weeks	14-16 weeks	Once	CPT® 76815
Detailed Fetal Anatomic Scan	≥16 weeks	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 complicated by additional risk factors may start at ≥26 weeks)	Weekly	CPT® 76818 (BPP) or CPT® 76819 (BPP) or CPT® 76815 (AFI)
Umbilical artery Doppler (if FGR diagnosed) See <u>OB-20.1: Fetal Growth Restriction Current Pregnancy</u>	Upon diagnosis of FGR if ≥23 weeks	Weekly	CPT® 76820

OB-9.8.4: Gestational Hypertension (GH, preeclampsia, toxemia)

Test	When	Frequency	Codes
Fetal anatomic scan	≥16 weeks	Once	CPT® 76805 or CPT 76811 if other high risk issues and if not previously completed
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 CPT® 76815
Umbilical artery Doppler OB-20.1: Fetal Growth Restriction Current Pregnancy	Starting at time of diagnosis of FGR or Oligohydramnios	Twice weekly	CPT® 76820

Practice Note

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 in 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
Gestational hypertension	Hypertension diagnosed after 20 weeks of gestation, in a woman with a previously normal blood pressure.
Preeclampsia	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	Convulsive manifestation of the hypertensive disorders of pregnancy and is among the more severe manifestations of the disease.

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

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

- For initial imaging:
 - ◆ CPT® 76801 [plus CPT® 76802 for each additional fetus] if <14 weeks and a complete ultrasound has not yet been performed, **and/or**
 - ◆ CPT® 76817 for a transvaginal ultrasound or
 - ◆ CPT® 76815 (limited ultrasound) can be performed for dating if an ultrasound not already been performed and ≥14 week and <16 weeks
- Fetal Anatomy Ultrasound CPT® 76805 or CPT® 76811 [plus CPT® 76810 or CPT® 76812 for each additional fetus] if ≥16 weeks and a complete fetal anatomic scan has not yet been performed during this pregnancy.
- CPT® 76817 and/or CPT® 76815 every 2 weeks, starting at ≥16 weeks until 24 weeks
- Starting after the fetal anatomic scan at ≥23 weeks, ultrasound (CPT® 76816) can be performed every 3 to 6 weeks until delivery
- Starting at 32 weeks, weekly BBP CPT® 76818 or CPT® 76819 or modified BPP CPT® 76815
- If funneling or short cervix ≤25 mm (2.5 cm) is found on a transvaginal ultrasound in a singleton pregnancy
 - ◆ CPT® 76816 may be performed after a complete ultrasound every 3 to 4 weeks **and/or**
 - ◆ CPT® 76817 and/or CPT® 76815 every 1 to 2 weeks until 32 weeks
 - ◆ Note: CPT® 76815 should not be done on same date of service as CPT® 76816
- For current preterm labor See **OB-18.3: Current Preterm Labor**

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

- For initial imaging:
 - ◆ CPT® 76801 [plus CPT® 76802 for each additional fetus] if <14 weeks and a complete ultrasound has not yet been performed, **and/or**
 - ◆ CPT® 76817 for a transvaginal ultrasound or
 - ◆ CPT® 76815 (limited ultrasound) can be performed for dating if an ultrasound not already been performed and ≥14 week and <16 weeks
- An anatomy ultrasound CPT® 76805 or CPT® 76811 [plus CPT® 76810 or CPT® 76812 for each additional fetus] **and/or** CPT® 76817 if >16 weeks and a complete fetal anatomic scan has not yet been performed during this pregnancy.
- CPT® 76815 and/or CPT® 76817 every 2 weeks, starting at ≥16 weeks until 24 weeks
- Starting after the fetal anatomic scan at ≥23 weeks, ultrasound (CPT® 76816) can be

performed every 3-6 weeks until delivery

- If funneling or short cervix ≤ 25 mm (2.5 cm) is found on a transvaginal ultrasound in a singleton pregnancy
 - ◆ CPT® 76816 may be performed after a complete ultrasound every 3 to 4 weeks **and/or**
 - ◆ CPT® 76817 and/or CPT® 76815 every 1 to 2 weeks until 32 weeks
 - ◆ Note: CPT® 76815 should not be done on same date of service as CPT® 76816
- For current preterm labor See **OB-18.3: Current Preterm Labor**

OB-9.10: History of Stillbirth

- For initial imaging:
 - ◆ CPT® 76801 [plus CPT® 76802 for each additional fetus] if <14 weeks and a complete ultrasound has not yet been performed, **and/or**
 - ◆ CPT® 76817 for a transvaginal ultrasound or
 - ◆ CPT® 76815 (limited ultrasound) can be performed for dating if an ultrasound not already been performed and ≥ 14 week and <16 weeks

- Fetal anatomic scan at ≥ 16 weeks (CPT® 76811)
- 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

- A history of stillbirth is not an indication for fetal echo. Per 2020 ACOG bulletin – no mention of recommendation for echo – just detailed anatomy US. If demised fetus had a confirmed cardiac anomaly on autopsy, or if the detailed anatomy scan on either the demised fetus or the current pregnancy had findings suspicious for cardiac anomaly, then echo may be indicated.

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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

46

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

- A detailed fetal anatomy ultrasound (CPT® 76811) is indicated for maternal use of the following:

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, enalapril, 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
Leflunomide
Lithium
Methimazole
Methotrexate
Methyl mercury
Misoprostol
Mycophenolate mofetil
Oral contraceptives
Paramethadione
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, marijuana/cannabinoids)

High Risk Medications/Substances
Tetracyclines
Thalidomide
Trifluoperazine
Trimethadione
Valproic acid

- If another high risk indication see appropriate guideline for any further imaging

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.

- Several studies noted lower birth weights among offspring exposed to marijuana. These findings were more pronounced among women who used more marijuana, particularly during the first and second trimesters (at least weekly during the pregnancy). CPT® 76811 may be indicated, however, given the limited evidence for antenatally detected abnormal growth, serial growth ultrasounds may not be indicated in the absence of other findings concerning for growth restriction.
- 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: Suspected Multiple Gestations	49
OB-11.2: Known Dichorionic Multiple Gestations	49
OB-11.3: Known Monochorionic-Diamniotic or Monochorionic-Monoamniotic Multiple Gestations	50

OB-11.1: Suspected Multiple Gestations

For Suspected multiple pregnancies:

- CPT® 76801 [plus CPT® 76802 for each additional fetus] and/or CPT® 76817 if a complete ultrasound has not yet been performed and is <14 weeks, or
- CPT® 76815 and/or CPT® 76817 can be performed for dating if an ultrasound not already been performed and ≥14 week and <16 weeks, or
- CPT® 76805 and CPT® 76810 for each additional fetus if ≥14 weeks if a dating ultrasound or a complete anatomy ultrasound has not yet been performed during this pregnancy

OB-11.2: Known Dichorionic Multiple Gestations

For Known dichorionic multiple pregnancies:

- CPT® 76811 and CPT® 76812 for each additional fetus at ≥16 weeks if a complete detailed anatomic scan (CPT® 76811) has not yet been performed during this pregnancy. If requested prior to 16 weeks, send to Medical Director Review.
- Growth ultrasound (CPT® 76816) can be performed every 4 to 6 weeks after diagnosis.
- Universal cervical length (CL) screening with transvaginal ultrasound (CPT® 76817) is NOT recommended in twin gestations. However, transvaginal ultrasound (CPT® 76817) may be considered if the cervical length (CL) is <3.6 cm on trans-abdominal ultrasound (as with singleton pregnancies – See **OB-7.1: Fetal Anatomic Scan**), or in certain circumstances of poor visualization with trans-abdominal ultrasound. Send all these requests to Medical Director Review.
- BPP (CPT® 76818 or CPT® 76819) **or** modified BPP (CPT® 76815) may be performed starting at 32 weeks or sooner if additional risk factors
- If FGR or growth discordance ≥20% is diagnosed, can perform:
 - ◆ UA Doppler (CPT® 76820) weekly
 - If UA Dopplers are abnormal (significantly elevated or absent or reversed end diastolic flow), then more frequent testing (twice per week or even daily) BPPs (CPT® 76818 or CPT® 76819) and/or UA Dopplers (CPT® 78620) may be considered. Send all these requests to Medical Director Review.
- If IVF dichorionic twins, report initial fetal echo as CPT® 76825 and/or CPT® 76827 with or without CPT® 93325. Trans-abdominal fetal echo is usually not performed prior to 16 weeks. See **OB-12.3: Indications for Maternal Conditions**
- If other high risk factors, See **OB-9: High Risk Pregnancy**

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

For Known monochorionic-diamniotic or monochorionic-monoamniotic multiple pregnancies

- CPT® 76811 and CPT® 76812 for each additional fetus if ≥16 weeks and a complete detailed anatomic scan (CPT® 76811) has not yet been performed (if earlier send to Medical Director Review).
- Universal cervical length (CL) screening with transvaginal ultrasound (CPT® 76817) is NOT recommended in twin gestations. However, transvaginal ultrasound (CPT® 76817) may be considered if the cervical length (CL) is <3.6 cm on trans-abdominal ultrasound (as with singleton pregnancies – See **OB-7.1: Fetal Anatomic Scan**), or in certain circumstances of poor visualization with trans-abdominal ultrasound. Send all these requests to Medical Director Review.
- CPT® 76816 (growth ultrasound) every 2 to 4 weeks starting at 16 weeks
- Fetal echo (CPT® 76825 and/or CPT® 76827) with or without color Doppler (CPT® 93325) is indicated (usually not performed <16 weeks).
 - ◆ Send all follow-up echo requests (CPT® 76826 and/or CPT® 76828) to Medical Director Review.
- MCA Doppler (CPT® 76821) and limited ultrasound (CPT® 76815) is indicated every 2 weeks starting at 16 weeks until delivery to monitor for Twin-Twin Transfusions Syndrome (TTTS) and/or Twin Anemia Polycythemia Sequence (TAPS).
 - ◆ If findings are suspicious for developing TTTS, more frequent imaging may be indicated, send to Medical Director Review.
- BPP (CPT® 76818 or CPT® 76819) or modified BPP (CPT® 76815) may be performed weekly starting at 32 weeks or sooner if additional risk factors
- If TTTS is diagnosed, up to daily evaluation can be performed to aid in planning intervention and/or imminent delivery. In these cases, may perform:
 - ◆ Limited ultrasound (CPT® 76815), and/or
 - ◆ BPP (CPT® 76818 or CPT® 76819) if >26 weeks or
 - ◆ UA Doppler (CPT® 76820) and/or
 - ◆ MCA Doppler (CPT® 76821)
- If FGR or growth discordance >20% is diagnosed, can perform:
 - ◆ UA Doppler (CPT® 76820) weekly
 - If UA Dopplers are abnormal (significantly elevated or absent or reversed end diastolic flow), then more frequent testing (twice per week or even daily) BPPs (CPT® 76818 or CPT® 76819) and/or UA Dopplers (CPT® 76820) may be considered. Send these requests to Medical Director Review.
- If other high risk factors, See **OB-9: High Risk Pregnancy**
- Triplets or higher order Multiple Pregnancy receive same imaging as monochorionic-diamniotic twins. These requests will be forwarded for Medical Director Review.

Practice Notes

- Birth weight discordance = (larger twin weight minus smaller twin weight) divided larger twin weight × 100.
- Universal CL screening with transvaginal ultrasound (CPT® 76817) is NOT recommended in twin gestations. In addition, Per ACOG - Cerclage placement (prophylactic or rescue) should be avoided in multifetal pregnancies. However, because several studies have shown that a one-time CL measurement ≤20 mm at

18-24 weeks may be an accurate predictor of preterm birth in multiple gestation, and because progesterone therapy might reduce the risk of neonatal morbidity and mortality associated with PTB, then a one-time transvaginal CL assessment may be considered if trans-abdominal CL measures ≤ 3.6 cm (as with singleton gestation- See: **OB-7.1: Fetal Anatomic Scan**). Transvaginal ultrasound (CPT® 76817) may be considered if the cervical length (CL) is ≤ 3.6 cm on trans-abdominal ultrasound (as with singleton pregnancies- See **OB-7.1: Fetal Anatomic Scan**), or in certain circumstances of poor visualization with trans-abdominal ultrasound.

- TTTS is diagnosed by the ultrasound findings of polyhydramnios in one twin (the recipient) and oligohydramnios in the other twin (the donor). If AFI is discordant between the twins (low but not < 2 cm in one and/or high but not > 8 cm in the other); weekly imaging (MCA and/or limited US) may be indicated to ensure not developing TTTS.
- 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, however, loss of one or more fetus(es) after 17 weeks gestation is associated with increased risk for FGR and PTB and should be imaged according to **OB-11: Multiple Gestations**. Monochorionic twin pregnancies with demise of one twin after 17 weeks have up to an 18% chance of major morbidity or mortality for the remaining fetus, these cases should be sent for Medical Director Review.
- In circumstances where CPT® 76811 cannot be performed See **OB-1.3: Ultrasound Code Selection**

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OB-12: Fetal Echocardiography (ECHO)

OB-12.1: Fetal Echocardiography – Coding	54
OB-12.2: Indications for Fetal Conditions	54
OB-12.3: Indications for Maternal Conditions	55
OB-12.4: Medication or Drug Exposure	55

OB-12.1: Fetal Echocardiography – Coding

- Transabdominal fetal echo is usually not performed prior to 16 weeks. If ordered prior to 16 weeks send to Medical Director Review.
- Fetal echocardiography (Initial study-CPT® 76825 or follow-up-CPT® 76826) and Doppler echocardiography (Initial study-CPT® 76827 or follow-up-CPT® 76828) and/or Doppler color flow velocity mapping (CPT® 93325) can be ordered together or separately for the following conditions:

OB-12.2: Indications for Fetal Conditions

- | |
|---|
| <ul style="list-style-type: none"> ➤ Known or suspected abnormal fetal cardiac evaluation on fetal anatomic scan. <ul style="list-style-type: none"> ◆ Known or suspected abnormality must be documented as hard copy or acknowledged verbally by provider of known or suspected fetal cardiac evaluation ◆ Suboptimal cardiac evaluation alone is not an indication for fetal echogram. If the 4-chamber view is adequate and there is no other suspicion of a cardiac abnormality, a fetal echocardiogram is not considered medically necessary. A follow up ultrasound (CPT® 76815 or CPT® 76816) is indicated for suboptimal visualization. |
| <ul style="list-style-type: none"> ➤ Fetal cardiac arrhythmia; sustained fetal tachycardia or bradyarrhythmia |
| <ul style="list-style-type: none"> ➤ Major fetal extra-cardiac anomaly, (excluding soft markers for aneuploidy: for example shortened long bones, pyelectasis, echogenic bowel, hypoplastic nasal bone, cardiac echogenic foci and choroid plexus cyst) See <u>OB-9.2: High Risk Group Two – Findings on Ultrasound that May Require Further Imaging.</u> |
| <ul style="list-style-type: none"> ➤ Congenital heart disease (CHD) in a 1st degree relative of the fetus (i.e. CHD in the mother, father, or sibling of the fetus) |
| <ul style="list-style-type: none"> ➤ Known fetal chromosomal abnormalities (fetal aneuploidy) or ultrasound findings of a suspected chromosomal abnormality (excluding soft markers as only ultrasound findings) |
| <ul style="list-style-type: none"> ➤ Single umbilical artery ➤ Chorioangioma or Umbilical cord varix (if suspicion of fetal hydrops) ➤ Fetal intra-abdominal venous anomaly (persistent right umbilical vein) |
| <ul style="list-style-type: none"> ➤ Fetal effusion (pericardial, pleural effusion, ascites, etc.) ➤ Fetal hydrops, See <u>OB-16: Alloimmunization/Rh Isoimmunization/Other Causes of Fetal Anemia/Parvo/Hydrops</u> |
| <ul style="list-style-type: none"> ➤ Monochorionic twins/TTTS |
| <ul style="list-style-type: none"> ➤ Abnormal Fetal Nuchal Translucency scan (≥3.0mm) during current pregnancy. |

OB-12.3: Indications for Maternal Conditions

For Maternal Conditions:

- Maternal pre-gestational DM or early diagnosed GDM (1st or early 2nd trimester)
- Maternal gestational diabetes mellitus on medication if HbA1C >6%
- Maternal connective tissue disease (SLE, RA, Sjogrens) with Anti-Ro/SSA or anti-La/SSB antibodies present
 - ◆ Weekly Doppler fetal echocardiography (CPT® 76828) from the 18th through the 26th week of pregnancy and then every other week until 30 weeks
- Phenylketonuria
- Infections associated with cardiac anomalies (such as parvovirus, Rubella, Coxsackie virus)
- Genetic conditions associated with CHD in a first degree relative of the fetus (e.g. Marfan syndrome, 22q11.2 deletion syndrome (DiGeorge Syndrome) or Noonan syndrome)
- Seizure disorder on antiepileptic medication
- IVF pregnancies

OB-12.4: Medication or Drug Exposure

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

Practice Note

- If HbA1c levels are >6%, fetal echocardiogram in the third trimester to assess for ventricular hypertrophy may be considered.
- With positive SSA/SSB antibodies, 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.
- Fetal echocardiography may be indicated with severe, unexplained polyhydramnios

if there are other suspicious findings on an anatomy scan. Send to Medical Director Review.

- An initial echo, CPT® 76825 and CPT® 76827 are performed only once per fetus/per facility (i.e. Maternal Fetal Medicine versus Pediatric Cardiology request)
- The minimal use of color Doppler (CPT® 93325) alone, when performed for anatomical structure identification during a standard ultrasound procedure, is not separately reimbursable.
- Procedure code (CPT® 76827 or CPT® 76828) includes the evaluation of veins, arteries, and valves. Guidelines do not support the billing of an additional code (CPT® 76820/CPT® 76821)

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OB-13: Fetal MRI

OB-13.1: Indications for Fetal MRI

58

OB-13.1: Indications for Fetal MRI

CPT® Code Guidance

- | |
|--|
| ➤ Fetal MRI (CPT® 74712); for each additional fetus (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 (CPT® 74712) [plus CPT® 74713 for each additional fetus] may be considered for assessment of known or suspected fetal/pregnancy abnormalities for surgical planning, and/or if an ultrasound is equivocal **and** additional information is needed for counseling purposes, for indications which may include the following:
 - ◆ Brain
 - Congenital anomalies
 - ventriculomegaly
 - corpus callosal dysgenesis
 - holoprosencephaly
 - posterior fossa anomalies
 - malformations of cerebral cortical development
 - microcephaly
 - 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
 - Bowel anomalies such as megacystis microcolon
 - Abdominal wall defect
 - Mass
 - abdominal–pelvic cyst
 - tumors (e.g. hemangiomas, neuroblastomas, sacrococcygeal teratomas, and suprarenal or renal masses)
 - Complex genitourinary anomalies (e.g. cloaca)
- ◆ Congenital Heart Disease (CHD)
- ◆ Skeletal dysplasia
- ◆ Multiple malformations
- ◆ Complications of monochorionic twins/TTTS (eg. Laser treatment of twins, demise of one twin, conjoined twins)
- ◆ Any suspected fetal anomaly associated with severe oligohydramnios or anhydramnios

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OB-14: Abnormal Fetal Position/ Presentation

OB-14.1: Abnormal Fetal Position or Presentation

61

OB-14.1: Abnormal Fetal Position or Presentation

- To confirm suspected abnormal fetal position or presentation (transverse or breech presentation) at ≥ 36 weeks gestation, report one of the following:
 - ◆ CPT® 76805 (plus CPT® 76810 for each additional fetus) when complete anatomy scan has not yet been performed in the pregnancy **or**
 - ◆ CPT® 76815 for limited ultrasound to check fetal position or CPT® 76816 if version is being considered and/or for delivery planning

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 before 36 weeks is not always accurate. Suspected fetal malpresentation should be confirmed by an ultrasound assessment. An ultrasound can be performed at ≥ 36 weeks gestation 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.
- Though rarely used anymore, there may still be occasional planned vaginal delivery of a breech presentation. There is not enough evidence to support the use of X-ray pelvimetry for deciding on mode of delivery in women whose fetuses have a cephalic presentation. However, pelvimetry in breech presentation may allow for better selection of the delivery route, with a significantly lower emergency caesarean-section rate noted in small trials. Send all pelvimetry requests to Medical Director Review.

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

OB-15.1: Adnexal Mass	63
OB-15.2: Uterine Fibroids in Pregnancy	63
OB-15.3: Uterine Anomalies in Pregnancy	64

OB-15.1: Adnexal Mass

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| <ul style="list-style-type: none"> ➤ For a known or suspected adnexal/pelvic mass, may perform: <ul style="list-style-type: none"> ◆ CPT® 76801 [plus CPT® 76802 for each additional fetus] and/or CPT® 76817 to establish dates if <14 weeks or ◆ CPT® 76815 and/or CPT® 76817 if a complete ultrasound was previously performed or ◆ CPT® 76805 [plus CPT® 76810 if more than one fetus] if a complete fetal anatomic scan has not yet been performed and ≥14 weeks, or CPT® 76815 or CPT® 76816 if a complete ultrasound scan was done previously. |
| <ul style="list-style-type: none"> ➤ Following the initial ultrasound, follow up can be done once in each trimester <ul style="list-style-type: none"> ◆ CPT® 76805 [plus CPT® 76810 for each additional fetus] if a complete fetal anatomic scan has not yet been performed, or ◆ CPT® 76815 or CPT® 76816 if a complete ultrasound was previously performed. ◆ CPT® 76817 may be indicated for poor visualization of the adnexal mass in certain circumstances. |
| <ul style="list-style-type: none"> ➤ MRI Pelvis (CPT® 72195) without contrast can be done for indeterminate findings on ultrasound; for surgical planning and/or for suspected malignancy. |
| <ul style="list-style-type: none"> ➤ See PV-5: Adnexal Mass/Ovarian Cysts |

Practice Note

The majority of adnexal masses 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, i.e. one fibroid at 2 cm and one 3 cm is total of 5 cm and imaging would be indicated as below:
 - ◆ Moderate (>5 cm) and large (>10 cm) fibroid(s):
 - CPT® 76801 [plus CPT® 76802 for each additional fetus] and/or CPT® 76817 to establish dates if ≤14 weeks, or
 - CPT® 76815 can be performed for dating if ≥14 weeks but <16 weeks
 - Fetal anatomic scan (CPT® 76805 or CPT® 76811 if other high risk indication. See **OB-9: High Risk Pregnancy**) at ≥16 weeks.
 - If the fibroid is in the lower uterine segment or cervical fibroid then ultrasound (CPT® 76815) and/or transvaginal ultrasound (CPT® 76817) every 2 weeks between 16 to 24 weeks, and
 - Follow up ultrasound (CPT® 76816) every 3 to 6 weeks, starting at 23 weeks.
- Submucosal fibroid(s) of any size:
 - ◆ First trimester: CPT® 76801 [plus CPT® 76802 for each additional fetus] and/or CPT® 76817 to establish dates if <14 weeks.
 - ◆ If placentation is over a submucosal fibroid:
 - Follow up ultrasound (CPT® 76816) every 3 to 6 weeks, starting at 23 weeks

Practice Note

- Though pregnancy seems to have little or no effect on the overall size of fibroids, Fibroids affect pregnancy and delivery in several ways, with abdominal pain, miscarriage, malpresentation, and difficult delivery being the most frequent complications. 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, especially with placentation over a fibroid. Fibroid volumes >200 cm³ are more commonly associated with fetal growth restriction. Fetal compression syndrome is a direct result of large fibroids and is not commonly found with small fibroids. Finally, malposition or obstructed labor may be associated with fibroids of the lower uterine segment.

OB-15.3: Uterine Anomalies in Pregnancy

- For uterine septum, uterine didelphys, unicornuate uterus, bicornuate uterus:
 - ◆ CPT® 76801 [plus CPT® 76802 for each additional fetus] if a complete ultrasound has not yet been performed, or
 - ◆ If a complete ultrasound was previously performed, CPT® 76815 and/or CPT® 76817 **or**
 - ◆ CPT® 76805 or CPT® 76811 and/or CPT® 76817 at ≥16 weeks
 - ◆ CPT® 76817 and/or CPT® 76815 every 2 weeks at 16 to 24 weeks (See **OB-18.1: Cervical Insufficiency**)
 - ◆ CPT® 76816 every 3 to 6 weeks starting at ≥23 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.

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

OB-16.1: Alloimmunization/Rh Isoimmunization	67
OB-16.2: Exposure to Parvovirus B-19	68
OB-16.3: Twin Anemia Polycythemia Sequence	68
OB-16.4: Other Fetal Hydrops/Nonimmune Hydrops	68
OB-16.5: Other Causes of Fetal Anemia	69

OB-16.1: Alloimmunization/Rh Isoimmunization

Imaging for Alloimmunization/Rh Isoimmunization for any of the following indications:

- When any one of the following maternal antibody titers are $\geq 1:8$:
 - ◆ Rhesus antibodies (Cc/Dd/Ee)
 - ◆ Anti-Duffy (anti-fya) antibody
 - ◆ 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:

- CPT® 76801 [plus CPT® 76802 for each additional fetus] if < 14 weeks and a complete ultrasound has not yet been performed, **and/or**
- CPT® 76817 for a transvaginal ultrasound or
- CPT® 76815 can be performed for dating or quick look follow-up if ≥ 14 weeks but < 16 weeks
- Detailed Fetal Anatomic Scan (CPT® 76811) ≥ 16 weeks Ultrasound (CPT® 76816) every 2 to 4 weeks to assess fetal growth starting after fetal anatomic scan (CPT® 76811)
- Fetal middle cerebral artery (MCA) Doppler (CPT® 76821) and CPT® 76815 every 1 to 2 weeks starting at 16 weeks
- BPP (CPT® 76818 or CPT® 76819) or modified BPP (CPT® 76815) weekly, starting at 32 weeks or sooner depending on fetal condition

Practice Note

- 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.
- 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 and/or in subsequent Rh+ pregnancies.
- Other antigens not listed above, may be associated with hemolytic disease of the fetus and newborn and may require fetal assessment as in **OB-16.1: Alloimmunization/Rh Isoimmunization** if maternal antibody titers are $\geq 1:8$. Please send these cases to Medical Director Review. Some of these antigens include MNSsM, MNSsS, MNSsSs, 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.
- 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. 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. Because MCA-PSV increases across gestation, results are adjusted for gestational age.

- 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.

OB-16.2: Exposure to Parvovirus B-19

- Parvovirus B-19 (Fifth Disease):
 - ◆ CPT® 76801 [plus CPT® 76802 for each additional fetus] if <14 weeks and a complete ultrasound has not yet been performed, **and/or**
 - ◆ CPT® 76817 for a transvaginal ultrasound or
 - ◆ CPT® 76815 can be performed for dating or quick look follow-up if ≥14 weeks but <16 weeks
 - ◆ 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
 - ◆ Starting at time of known exposure weekly limited ultrasound (CPT® 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) and continuing for 8 to 12 weeks post-exposure

OB-16.3: Twin Anemia Polycythemia Sequence

- See **OB-11.3: Known Monochorionic-Diamniotic or Monochorionic-Monoamniotic Multiple Gestations**

OB-16.4: Other Fetal Hydrops/Nonimmune Hydrops

- Hydrops from any cause should be imaged according to **OB-16.1: Alloimmunization/Rh Isoimmunization**

OB-16.5: Other Causes of Fetal Anemia

- A 'one-time' MCA Doppler (CPT® 76821) assessment may be indicated if at high risk or suspicious for fetal anemia, for example, chorioangioma, umbilical vein varix, or finding of sustained fetal tachyarrhythmia or bradyarrhythmia - See **OB-12.2: Indications for Fetal Conditions** and **OB-21: Placental and Cord Abnormalities**.

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.

References

1. ACOG Practice Bulletin No. 181. Prevention of Rh D alloimmunization. *Obstet Gynecol* 2017(2); 130: 57-70. doi:10.1097/aog.0000000000002232.
2. ACOG Practice Bulletin No. 192. Management of Alloimmunization During Pregnancy. *Obstetrics & Gynecology*. 2018;131(3):e82-e90. doi:10.1097/aog.0000000000002528.
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OB-17: Amniotic Fluid Abnormalities/ Oligohydramnios/Polyhydramnios

OB-17.1: Amniotic Fluid Abnormalities

71

OB-17.1: Amniotic Fluid Abnormalities

For suspected polyhydramnios or oligohydramnios:

- Imaging may be indicated for unequal size and dates or suspected preterm/prelabor rupture of membranes. See
 - ◆ **OB-27: Unequal Fundal Size and Dates** and/or
 - ◆ **OB-23: Preterm/Prelabor Rupture of Membranes**

For confirmed diagnosis of polyhydramnios: AFI \geq 24cm or maximum deepest vertical pocket (MVP) \geq 8cm.

- CPT® 76811 (Detailed Fetal Anatomy) at diagnosis, if not previously performed
- CPT® 76816 starting at \geq 23 weeks (if $<$ 23 weeks, send to Medical Director Review)
 - ◆ Every 3 to 4 weeks for mild polyhydramnios (AFI 24 cm to 30 cm or MVP 8 cm to 10 cm)
 - ◆ Every 2 weeks for severe polyhydramnios (AFI $>$ 30 cm or MVP $>$ 10 cm)
- CPT® 76815 may be indicated weekly for antepartum fetal surveillance from 23-26 weeks
- BPP (CPT® 76818 or CPT® 76819) or modified BPP (CPT® 76815) for AFI with NST starting at 26 weeks
 - ◆ Weekly for mild polyhydramnios
 - ◆ Twice weekly for severe polyhydramnios

For confirmed diagnosis of oligohydramnios: AFI \leq 5 cm or maximum vertical pocket \leq 2 cm

- CPT® 76811 if not already performed; or
- CPT® 76816 every 2 to 4 weeks starting at \geq 23 weeks (if $<$ 23 weeks, send to Medical Director Review)
- CPT® 76815 may be indicated weekly for antepartum fetal surveillance from 23-26 weeks
- CPT® 76818 or CPT® 76819 or a modified BPP (CPT® 76815), weekly, starting at 26 weeks, (If $<$ 26 weeks send to Medical Director Review)
- CPT® 76820, weekly starting at time of diagnosis if \geq 23 weeks, (If $<$ 23 weeks, send to Medical Director Review)

Practice Notes

- 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**.
- Polyhydramnios may also present as a finding of cardiac dysfunction, fetal arrhythmias or cardiac malformation. Fetal echocardiography may be indicated if there are abnormal findings on an anatomy scan. 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.

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

OB-18.1: Cervical Insufficiency	74
OB-18.2: Cerclage in Place in Current Pregnancy	74
OB-18.3: Current Preterm Labor	74

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])
- CPT® 76801 [plus CPT® 76802 for each additional fetus] and/or CPT® 76817 once in first trimester (<14 weeks) if a complete ultrasound has not yet been performed or
- CPT® 76815 and/or CPT® 76817 for dating if ≥14 weeks and <16 weeks
- CPT® 76805 **and/or** CPT® 76817 at ≥16 weeks if a complete fetal anatomic scan has not yet been performed during this pregnancy
- CPT® 76815 **and/or** CPT® 76817 every 2 weeks from 16 to 24 weeks
- If funneling or short cervix ≤25 mm (2.5 cm) is found on a transvaginal ultrasound in a singleton pregnancy
 - ◆ CPT® 76816 may be performed after a complete ultrasound every 3 to 4 weeks **and/or**
 - ◆ CPT® 76817 and/or CPT® 76815 every 1 to 2 weeks until 32 weeks
 - ◆ Note: CPT® 76815 should not be done on same date of service as CPT® 76816

OB-18.2: Cerclage in Place in Current Pregnancy

- CPT® 76801 [plus CPT® 76802 for each additional fetus] and/or CPT® 76817 once in first trimester (<14 weeks) if a complete ultrasound has not yet been performed or
- CPT® 76815 and/or CPT® 76817 for dating if ≥14 weeks and <16 weeks
- CPT® 76805 or CPT® 76811 if other high risk factors [plus CPT® 76810/CPT® 76812 for each additional fetus] and/or CPT® 76817 once if a complete detailed fetal anatomic scan has not been performed
- CPT® 76816 can be performed every 3 to 6 weeks starting after the fetal anatomic scan at 16 weeks.
- Transvaginal (CPT® 76817 and/or CPT® 76815) every 2 weeks, starting at ≥16 weeks until 32 weeks if a rescue cerclage was placed.

OB-18.3: Current Preterm Labor

- Known preterm labor in current pregnancy (contractions PLUS cervical change) CPT® 76805 [plus CPT® 76810 for each additional fetus] 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 (CPT® 76816 no more than every 2 weeks) when symptomatic
- CPT® 76817 once or when symptomatic
- Biophysical profile (BPP) (CPT® 76818 **or** CPT® 76819) **or** modified BPP (CPT®

76815), once when symptomatic starting at 30 weeks; if <30 weeks send to Medical Director Review

- For history of pre-term labor, See **OB-9.9: History of Spontaneous Pre-Term Delivery/History of PPRM**

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.

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

OB-19.1: No Fetal Heart Tones	77
OB-19.2: Decreased Fetal Movement	77

OB-19.1: No Fetal Heart Tones

- Prior to considering ultrasound, fetal heart tone should be assessed with fetal hand-held or Doppler device

The following is supported during the first trimester:

- Ultrasound imaging is supported if ≥ 12 weeks gestation and unable to obtain fetal heart tones using a hand-held Doppler device.
- Ultrasound imaging is supported, if < 12 weeks gestation, in the setting of absent fetal heart tones, only if accompanied by other maternal signs or symptoms (such as cramping, vaginal bleeding, etc.) or if fetal heart tones had previously been heard using a fetal hand-held Doppler device, but now are unable to be heard by this method, regardless of symptoms.
- Report **one** of the following:
 - ◆ CPT® 76801 (plus CPT® 76802 for each additional fetus) and/or CPT® 76817 if a complete ultrasound has not yet been performed; or
 - ◆ CPT® 76815 and/or CPT® 76817

The following is supported during the second and third trimester:

- CPT® 76815 for limited ultrasound or
- CPT® 76805 (plus CPT® 76810 for each additional fetus) if ≥ 14 weeks, when complete fetal anatomic scan CPT® 76805 has not yet been performed or
- CPT® 76816 (requests should go to Medical Director Review)

OB-19.2: Decreased Fetal Movement

Report one of the following: limited ultrasound or modified BPP (CPT® 76815) or if ≥ 26 weeks BPP (CPT® 76818 or 76819) See **OB-28.8: Biophysical Profile (BPP)**

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 Macrosonia)

OB-20.1: Fetal Growth Restriction Current Pregnancy	79
OB-20.2: Macrosonia – Large for Dates Current Pregnancy	80

OB-20.1: Fetal Growth Restriction Current Pregnancy

- The ACOG definition of Fetal Growth Restriction (FGR): Estimated or actual weight of the fetus $\leq 10^{\text{th}}$ percentile for gestational age. “Abdominal Circumference $\leq 10^{\text{th}}$ percentile” also defines FGR.

For Suspected FGR:
<ul style="list-style-type: none"> ➤ If there a ≥ 3 week difference in fundal height and gestational age report one of the following: <ul style="list-style-type: none"> ◆ CPT® 76805 (plus CPT® 76810 for each additional fetus) if a complete ultrasound has not yet been performed during this pregnancy or ◆ CPT® 76816 if a complete ultrasound was performed previously
<ul style="list-style-type: none"> ➤ One follow-up ultrasound (CPT® 76816) can be performed in 2 to 4 weeks following the initial ultrasound to confirm FGR
<ul style="list-style-type: none"> ➤ For clinical situations that have a higher probability of FGR such as maternal hypertension, maternal diabetes, previous stillbirth, etc. See <u>OB-9: High Risk Pregnancy</u>, or the specific guidelines for these clinical entities for guidance regarding follow-up ultrasounds to assess fetal growth
For Known FGR:
<ul style="list-style-type: none"> ➤ Detailed Fetal Anatomic Scan (CPT® 76811) upon diagnosis if not already performed
<ul style="list-style-type: none"> ➤ Follow up ultrasound (CPT® 76816) may be performed every 2 to 4 weeks starting at 23 weeks if complete ultrasound previously performed. If < 23 weeks, send to Medical Director Review.
<ul style="list-style-type: none"> ➤ Between 23 to 26 weeks, a limited ultrasound/modified BPP (CPT® 76815) can be considered weekly.
<ul style="list-style-type: none"> ➤ Starting at 26 weeks, BPP (CPT® 76818 or CPT® 76819) or a modified BPP (CPT® 76815) may be performed weekly.
<ul style="list-style-type: none"> ➤ Starting at 23 weeks, umbilical artery (UA) Doppler (CPT® 76820) may be performed every 1-2 weeks
<ul style="list-style-type: none"> ➤ If severe FGR (EFW $< 3\%$, AC $< 3\%$), or with decreased end-diastolic velocity (S/D ratio, $> 95^{\text{th}}$ percentile for gestational age) or with confirmed oligohydramnios, then umbilical artery (UA) Doppler (CPT® 76820) may be performed weekly
<ul style="list-style-type: none"> ➤ With absent or reversed end diastolic flow more frequent BPPs (CPT® 76818 or CPT® 76819) and umbilical artery (UA) Doppler (CPT® 76820) may be considered (up to 2-3 times per week). If requested more frequently, or in all cases with reversed end diastolic flow, send to Medical Director Review.

Practice Notes

- An abnormal umbilical artery Doppler is defined as a PI, RI, or S/D ratio greater than the 95th percentile for gestational age or an absent or reversed end-diastolic velocity (AEDV or REDV).
- Those with REDV are usually hospitalized for closer surveillance and delivery planning.
- SMFM suggest that ductus venosus, middle cerebral artery, or uterine artery Doppler use for routine clinical management of early- or late-onset FGR is not recommended (GRADE 2A). In circumstances where CPT® 76811 cannot be performed See **OB-1.3: Ultrasound Code Selection**

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 for gestational age

- See **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, if there is a ≥3 week difference in fundal height and gestational age, may report **one** of the following:
 - ◆ CPT® 76805 [plus CPT® 76810 for each additional fetus] if a complete fetal anatomic scan has not yet been performed **or**
 - ◆ CPT® 76816 if a complete ultrasound was done previously
- See **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.
 - ◆ Additional imaging recommendations are usually guided by the cause of the fetal macrosomia (obesity, DM, etc.) See appropriate guideline 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

References

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OB-21: Placental and Cord Abnormalities	
OB-21.1: Single Umbilical Artery (Two Vessel Cord)	82
OB-21.2: Persistent Right Umbilical Vein (PRUV)	82
OB-21.3: Placental/Cord Abnormalities	83
OB-21.3.1: Placental/Cord Abnormalities	83
OB-21.3.2: Other Placental/Cord Abnormalities	83
OB-21.4: Subchorionic Hematoma/Hemorrhage (Placental Hematoma)	84
OB-21.5: Suspected Abruption Placentae	85
OB-21.6: Previa (Placenta Previa and Vasa Previa)	85
OB-21.6.1: Placenta Previa	85
OB-21.6.2: Vasa Previa	86
OB-21.7: Placenta Accreta Spectrum (Accreta, Increta, Percreta)	87
OB-21.7.1: Suspected	87
OB-21.7.2: Known	87

OB-21.1: Single Umbilical Artery (Two Vessel Cord)

If a single umbilical artery is found on initial imaging:	
➤ Detailed anatomic ultrasound at 16 weeks or greater	CPT® 76811
➤ Fetal echocardiogram (usually done >16 weeks)	CPT® 76825 and/or CPT® 76827 and/or CPT® 93325
➤ Follow-up ultrasound to evaluate fetal growth at ≥28 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.

OB-21.2: Persistent Right Umbilical Vein (PRUV)

If a PRUV is found on initial imaging:	
➤ Detailed anatomic ultrasound at 16 weeks or greater	CPT® 76811
➤ Fetal echocardiogram (usually done >16 weeks)	CPT® 76825 and/or CPT® 76827 and/or CPT® 93325
➤ Follow-up ultrasound to evaluate fetal growth at ≥28 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 32 weeks	CPT® 76818 or CPT® 76819 (BPP) or modified BPP CPT® 76815

OB-21.3: Placental/Cord Abnormalities

OB-21.3.1: Placental/Cord Abnormalities

Circumvallate Placenta

Placental hemangioma

Succenturiate placenta or accessory lobe

Hypo/Hyper-coiled Umbilical Cord

Marginal Cord Insertion

Umbilical cord cyst

Velamentous Cord Insertion

- Fetal anatomic scan can be performed after 16 weeks (CPT® 76805/CPT® 76811) and/or CPT® 93976 (limited duplex scan of arterial and venous)
- Ultrasound CPT® 76817 may be indicated to evaluate the placenta and/or cord in relation to the cervix
- Ultrasound (CPT® 76816) and/or CPT® 93976 (limited duplex scan) every 3-6 weeks starting at 28 weeks until delivery
- Weekly BPP or modified BPP (CPT® 76818/CPT® 76819 or CPT® 76815) starting at 32 weeks

Practice Note

- **Hypo/Hyper-coiled umbilical cord** - Several studies have reported an increased frequency of adverse pregnancy outcome, including congenital anomalies, growth restriction, fetal heart rate abnormalities, preterm birth, and intrauterine death in pregnancies with both hypocoiled and hypercoiled umbilical cord
- **Amniotic bands** may occur due to uterine synechiae (intrauterine adhesions), residual gestation sac of a demised twin, fibrin strands s/p bleeding, chorioamniotic separation or may be noted with a circumvallate placenta. In general, they are benign entities and are not associated with adverse pregnancy outcome, as such, do not need to be followed. Most providers will want at least one follow-up US after it is identified (typically at the time of fetal anatomy scan) to ensure that the finding is indeed benign and the band has not increased in size, nor is it restricting fetal growth or movement. Therefore, one f/u scan in the third trimester may be indicated. (Note – Amniotic Band SYNDROME is a very different entity which is NOT benign, and is associated with very increased risk of fetal anomalies – this would be imaged as in **OB-9: High Risk Pregnancy**).

OB-21.3.2: Other Placental/Cord Abnormalities

Chorioangioma Umbilical cord varix

- Detailed fetal anatomic scan can be performed after 16 weeks (CPT® 76811) with or without CPT® 93976 (limited duplex scan)
- Ultrasound (CPT® 76816) with or without CPT® 93976 (limited duplex scan) every 3-6 weeks starting at the time of diagnosis until delivery
- Weekly BPP (CPT® 76818 or CPT® 76819) or a modified BPP (CPT® 76815) starting

at 32 weeks

- Both chorioangioma and UVV can be associated with fetal anemia and/or low output heart failure. As such, MCA Dopplers (CPT® 76821) may be indicated e.g. If turbulence develops within the UVV
- If suspected or known hydrops, Fetal ECHO (CPT® 76825, CPT® 76827, CPT® 93325) may be indicated. If fetal hydrops develops then image as per **OB-16.1: Alloimmunization/Rh Isoimmunization**

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.

OB-21.4: Subchorionic Hematoma/Hemorrhage (Placental Hematoma)

Subchorionic Hematoma/Hemorrhage (Placental Hematoma)
<ul style="list-style-type: none"> ➤ Ultrasound can be performed for follow-up of a known subchorionic hematoma or placental hematoma <ul style="list-style-type: none"> ◆ CPT® 76815 and/or CPT® 76817 if the last ultrasound was performed greater than seven days ago or ◆ CPT® 76816 and/or CPT® 76817 if a complete ultrasound scan was performed ≥2 weeks ago
<ul style="list-style-type: none"> ➤ 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.
<ul style="list-style-type: none"> ➤ No further imaging is needed if the follow-up ultrasound shows that the hemorrhage has resolved.
<ul style="list-style-type: none"> ➤ If pregnancy is in second or third trimester follow <u>OB-21.5: Suspected Abruption Placentae</u>

OB-21.5: Suspected Abruption Placentae

Suspected Abruption Placentae	
Second and Third Trimesters	
<ul style="list-style-type: none"> ➤ For suspected abruption placentae: <ul style="list-style-type: none"> ◆ CPT® 76805 [plus CPT® 76810 for each additional 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) ◆ CPT® 76815 for limited ultrasound and/or CPT® 76817, or ◆ CPT® 76816 if a complete ultrasound scan was done previously, and/or CPT® 76817 ◆ Vaginal bleeding with +KB (Kleihauer-Betke) – fetomaternal hemorrhage – at risk for fetal anemia and hydrops CPT® 76821 may be indicated, send to Medical Director Review 	
<ul style="list-style-type: none"> ➤ Ultrasound is appropriate to follow-up a known abruption: <ul style="list-style-type: none"> ◆ 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: Previa (Placenta Previa and Vasa Previa)

OB-21.6.1: Placenta Previa

Placenta Previa	
Second and Third Trimesters	
<ul style="list-style-type: none"> ➤ For suspected placenta previa one of the following ultrasound can be performed: <ul style="list-style-type: none"> ◆ CPT® 76805 [plus CPT® 76810 for each additional 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) or ◆ CPT® 76815 for limited ultrasound and/or CPT® 76817 and/or CPT® 93976 (limited duplex scan) 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) 	
<ul style="list-style-type: none"> ➤ For known placenta previa: <ul style="list-style-type: none"> ◆ One routine follow-up ultrasound can be performed in the 3rd trimester (CPT® 76815 or CPT® 76816 and/or CPT® 76817) <ul style="list-style-type: none"> ■ 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 ◆ 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) 	

Low Lying Placenta

- Ultrasound (CPT® 76815 and/or CPT® 76817) is supported between 28-32 weeks one time 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 away from the internal os, the placental location should be reported as normal.
- If the placental edge is < 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 28-32 weeks, if the placental edge is still < 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.”
- “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.”²¹

OB-21.6.2: 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.

If a Vasa Previa is found on initial imaging:	
➤ Detailed anatomic ultrasound at ≥ 16 weeks	CPT® 76811
➤ Follow-up growth ultrasound every 3-6 weeks starting at ≥ 23 weeks	CPT® 76816
➤ Once vasa previa is confirmed cervical length screening every 2 to 4 weeks starting at 28 weeks ◆ If earlier request send to Medical Director Review	CPT® 76817 and CPT® 76816 or CPT® 76815
➤ BPP or modified BPP weekly starting at 32 weeks	CPT® 76818 or CPT® 76819 (BPP) or CPT® 76815

OB-21.7: Placenta Accreta Spectrum (Accreta, Increta, Percreta)

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

OB-21.7.1: Suspected

- For **suspected** placenta accreta:
 - ◆ 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) **or**
 - ◆ CPT® 76816 (if a complete ultrasound was done previously) or CPT® 76815 and/or CPT® 76817 and/or CPT® 93976 (limited duplex scan), **or**
 - ◆ If the ultrasound is inconclusive or equivocal then MRI Pelvis without contrast (CPT® 72195) may be indicated

OB-21.7.2: Known

- For **known** placenta accreta/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)
 - ◆ Medical Director can approve MRI Pelvis 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

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

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

90

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

- Ultrasound is supported at ≥ 41 weeks gestation
 - ◆ CPT® 76816
 - ◆ 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. Per SMFM - uterine artery Doppler has limited diagnostic accuracy and clinical utility in predicting FGR, SGA birth, and perinatal mortality.

Reference

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OB-23: Preterm/Prelabor Rupture of Membranes

OB-23.1: Current Preterm/Prelabor Rupture of Membranes (PPROM)	92
OB-23.2: Current Prelabor Rupture of Membranes (PROM)	92

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

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

- If $\leq 36 \frac{6}{7}$ weeks - send to Medical Director Review.
 - ◆ This is likely a hospital admission for evaluation and monitoring until delivery.
 - ◆ Only in rare cases is outpatient monitoring performed

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

- If ≥ 37 weeks - send to Medical Director Review.
 - ◆ This will likely result in a hospital admission for delivery

References

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

OB-24.1: Previous C-section or History of Uterine Scar 94

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

Previous Cesarean section and/or uterine scar

- Ultrasound in the first trimester may be indicated to establish dates. Report one of the following:
 - ◆ CPT® 76801 [plus CPT® 76802 for each additional fetus] if a complete ultrasound has not yet been performed, and/or CPT® 76817 if <14 weeks, or
 - ◆ CPT® 76815 and/or CPT® 76817 for dating if ≥14 weeks and <16 weeks
- Fetal anatomic scan CPT® 76805 ≥16 weeks. (if requested earlier send to Medical Director Review)
- One growth scan (CPT® 76816) in the early third trimester (between 28-32 weeks) **and** one growth scan (CPT® 76816) for delivery planning later in third trimester (between 36-38 weeks)
- Transvaginal ultrasound, CPT® 76817 may be indicated for poor visualization of the lower uterine segment or if uterine wall thinning (dehiscence) is suspected.

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OB-25: Termination of Pregnancy – Imaging

OB-25.1: Imaging for Planned Pregnancy Termination

96

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 <14 weeks, or
 - ◆ CPT® 76815 and/or CPT® 76817, or
 - ◆ If ≥14 weeks, CPT® 76805 may be indicated, (there may be State mandated imaging prior to termination) send to Medical Director Review.

Practice Note

- In general, most ultrasound requests are approvable for planned pregnancy termination regardless of clinical information provided. Imaging may be indicated to confirm EGA, placenta location, and/or fetal anomalies.

References

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OB-26: Trauma

OB-26.1: Trauma – Imaging

98

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 <14 weeks or
- CPT® 76815 and/or CPT® 76817 or
- CPT® 76805 (plus CPT® 76810 for each additional fetus) if ≥14 weeks, when complete fetal anatomic scan CPT® 76805 and/or CPT® 76817 has not yet been performed

After 20 weeks:

- CPT® 76805 (plus CPT® 76810 for each additional fetus) when complete fetal anatomic scan (CPT® 76805) has not yet been performed, or
- CPT® 76815 and/or CPT® 76817 or
- CPT® 76816
- Additionally, starting at 26 weeks, BPP (CPT® 76818 or CPT® 76819) or modified BPP (CPT® 76815) can be considered
- Vaginal bleeding with +KB (Kleihauer-Betke) (feto-maternal hemorrhage) at risk for fetal anemia and hydrops, CPT® 76821 may be indicated, send to Medical Director Review.
- Other advanced imaging may be indicated, send for Medical Director Review

References

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OB-27: Unequal Fundal Size and Dates

OB-27.1: Unequal Fundal Size and Dates

100

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

- One ultrasound can be performed (CPT® 76805) if complete fetal anatomic scan is planned and has not been performed **or**
- CPT® 76816 if complete anatomy scan or detailed anatomy ultrasound (CPT® 76805/CPT® 76811) has been done previously
- Where fundus cannot be adequately palpated such as in obesity, leiomyomas, multiple gestations, See appropriate chapter

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OB-28: Procedure Coding Basics for Established Pregnancy

OB-28.1: Procedure Coding Basics for Established Pregnancy General Considerations	102
OB-28.2: Required Elements for Complete First Trimester Ultrasound	102
OB-28.3: Required Elements for Second or Third Trimester Fetal Anatomic Evaluation Ultrasound	103
OB-28.4: Required Elements for a Detailed Fetal Anatomic Evaluation Ultrasound	104
OB-28.5: Fetal Nuchal Translucency	105
OB-28.6: Limited and Follow-up Studies	106
OB-28.7: Obstetric Transvaginal Ultrasound	106
OB-28.8: Biophysical Profile (BPP)	107
OB-28.9: Fetal Doppler	107
OB-28.10: Duplex Scan	108
OB-28.11: Fetal Echocardiography	108
OB-28.12: 3D and 4D Rendering	109

OB-28.1: Procedure Coding Basics for Established Pregnancy

General Considerations

- All obstetric ultrasound studies require permanently recorded images which may be stored on film or in a Picture Archiving and Communication System (PACS). Obstetric ultrasound services may not be billed without image recording.
- 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.
- 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.

OB-28.2: Required Elements for Complete First Trimester Ultrasound

CPT® Code Guidance
<ul style="list-style-type: none"> ➤ CPT® 76801 and CPT® 76802 (for each additional fetus) can be performed up to and including 13 6/7 weeks gestation and is defined in CPT® as including the following elements: <ul style="list-style-type: none"> ◆ Number and size of gestational sacs and fetuses ◆ 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
<ul style="list-style-type: none"> ➤ CPT® 76801 and CPT® 76802 should only be reported once per pregnancy/per practice/facility unless the mother changes to a new medical caregiver at a new practice/facility and there is a new 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 Ultrasound

CPT® Code Guidance

- A complete second or third trimester transabdominal ultrasound (CPT® 76805 and CPT® 76810 for each additional fetus) 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 and Right ventricular outflow tracts
 - ◆ **Abdomen:** Stomach (presence, size, and situs); Kidneys; Urinary bladder; Umbilical cord insertion site into the fetal abdomen and number of vessels
 - ◆ **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) and overall Standard evaluation
 - ◆ Fetal number and Presentation
 - ◆ Qualitative or semi-qualitative estimate of amniotic fluid
 - ◆ **Maternal anatomy:** Cervix (transvaginal if cervical length is ≤ 3.6 cm), Uterus, and Adnexa
 - ◆ **Fetal Biometry:** Biparietal diameter, Head circumference, Femur length, Abdominal circumference, and Fetal weight estimate.
- CPT® 76805 and CPT® 76810 **should only be used once per pregnancy per practice/facility** unless the mother changes to a new medical caregiver at a new practice/facility and there is a new medical indication for ultrasound.
- Follow-up studies to CPT® 76805/CPT® 76810 should be coded as CPT® 76815 or CPT® 76816.

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

CPT® Code Guidance

- Detailed fetal anatomy scan (CPT® 76811 and CPT® 76812 for each additional fetus) is generally performed by those with special skills to perform this study, such as Maternal Fetal Medicine specialists (Perinatologists), or 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 and 4th ventricles; 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
 - ◆ **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 ≤ 3.6 cm); Uterus; Adnexa
- CPT® 76811 and CPT® 76812 **should only be used once per pregnancy per practice/facility** unless the mother changes to a new medical caregiver at a new facility and there is a new medical indication for ultrasound.
- Follow-up studies to CPT® 76811/CPT® 76812 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.

OB-28.5: Fetal Nuchal Translucency

CPT® Code Guidance

- CPT® 76813 and CPT® 76814 (for each additional fetus) describe ultrasound measurement of the clear (translucent) space at the back of the fetal neck
 - ◆ The first trimester screening is typically done between 11 and 13 6/7 weeks but can be performed if the crown rump length (CRL) measures between 44-83 mm regardless of gestational age (range 10 4/7 to 14 weeks)
- Abnormal Fetal Nuchal Translucency scan (≥ 3 mm) suggests an increased risk for aneuploidy. An NT ≥ 3 mm with normal aneuploidy testing may be a marker for cardiac defects, abdominal wall defects, diaphragmatic hernia, and genetic syndromes in euploid fetuses) during current pregnancy.
- The sonographer performing the study and/or the physician interpreting the study must be credentialed by the Maternal Fetal Medicine Foundation or Nuchal Translucency Quality Review Program (NTQR).
- 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 be billed along with the nuchal translucency screening (CPT® 76813/CPT® 76814).

Practice Note

- **Required elements of the CPT® 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
 - ◆ Measurement of the largest distance between the inner borders of the fetal nuchal translucency

OB-28.6: Limited and Follow-up Studies

CPT® Code Guidance
<p>➤ 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, for viability/dating (when indicated), or fluid check (re: modified BPP which is NST with CPT® 76815)</p> <ul style="list-style-type: none"> ◆ 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 (or with CPT® 76816 or BPP).
<p>➤ 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.</p> <ul style="list-style-type: none"> ◆ The use of this CPT code is reserved for subsequent follow up ultrasound only; i.e. complete ultrasound (CPT® 76801, CPT® 76805 or CPT® 76811) must have been performed previously. ◆ Components include: Focused assessment of fetal biometry, amniotic fluid volume and/or a detailed re-examination of a specific organ or system known or suspected to be abnormal on prior ultrasound. ◆ CPT® 76816 should be reported once per fetus evaluated in follow-up. ◆ CPT® 76816 should never be reported with complete studies (CPT® 76801, CPT® 76802 and CPT® 76805, CPT® 76810) or with a limited study (CPT® 76815). ◆ 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
<p>➤ CPT® 76817 is used to report an obstetrical transvaginal ultrasound and may be used to report TV cervical length assessment (when indicated), or in certain circumstances with poor visualization by transabdominal US assessment.</p>
<p>➤ CPT® 76817 is reported only once regardless of the number of fetuses.</p>

OB-28.8: Biophysical Profile (BPP)

CPT® Code Guidance

- CPT® 76818 includes non-stress testing.
- CPT® 76819 does not include the non-stress testing portion.
- BPPs, performed on more than one fetus, should be reported separately.

Practice Note

- The BPP is designed to predict the presence or absence of fetal asphyxia and, ultimately the risk of fetal death. 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® 76815 is used to bill a modified BPP which is NST with AFI
- Typically all components of the BPP, such as breathing, are not present until ≥26 weeks gestation. However, modified BPP may be utilized sooner in certain HR cases but should not be done prior to viability (23 weeks).
- If BPP ≤6, repeat BPP in ≤24 hours

OB-28.9: Fetal Doppler

CPT® Code Guidance

- CPT® 76820 describes Doppler velocimetry of the umbilical artery (UA Doppler)
 - ◆ 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 (viability).
 - ◆ 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).
 - ◆ 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**, **16.4: Other Fetal Hydrops/NonImmune Hydrops**; and **OB-11: Multiple Gestations**

Practice Notes

- SMFM suggest that ductus venosus, middle cerebral artery, or uterine artery Doppler use for routine clinical management of early- or late-onset FGR *is not recommended* (GRADE 2A).

OB-28.10: Duplex Scan

- A Duplex scan describes an ultrasonic scanning procedure for characterizing the pattern and direction of blood flow in arteries and veins. It produces real-time images integrating a B-mode two dimensional vascular structure, Doppler spectral analysis, and color flow Doppler imaging.
- **CPT® 93976** describes a limited duplex scan and is used during pregnancy to report uterine artery Doppler studies (done to report fetal umbilical-placental flow evaluation, accreta or other placental or cord abnormalities).
 - ◆ **CPT® 93975** describes a complete duplex scan. This code is **NOT** used in obstetrical imaging.
- The minimal use of color Doppler alone, when performed for anatomical structure identification, during a standard ultrasound procedure, is not separately reimbursable.

Practice Note

- SMFM state that uterine artery Doppler has limited diagnostic accuracy and clinical utility in predicting FGR, SGA birth, and perinatal mortality. As such, its use for screening in high risk groups is not recommended (GRADE 2A).

OB-28.11: Fetal Echocardiography

CPT® Code Guidance
<ul style="list-style-type: none"> ➤ CPT® 76825 describes a complete fetal echocardiography. ➤ CPT® 76827 describes a complete Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display <ul style="list-style-type: none"> ◆ It is usually billed along with CPT® 76825
<ul style="list-style-type: none"> ➤ CPT® 76826 describes a follow-up or repeat fetal echocardiogram <ul style="list-style-type: none"> ◆ It should never be billed with CPT® 76825 or more than once per fetus on any date of service ➤ CPT® 76828 is a follow-up or repeat Doppler fetal echocardiogram
<ul style="list-style-type: none"> ➤ Procedure code (CPT® 76827 or CPT® 76828) includes the evaluation of veins, arteries, and valves, and covers Doppler evaluation of the ductus venosus, ductus arteriosus, and PR Interval measurement as well as other vessels. Guidelines do not support the additional billing of CPT® 76820 and/or CPT® 76821. ➤ 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.
<ul style="list-style-type: none"> ➤ CPT® 93325 is used to report color mapping in conjunction with fetal echocardiography procedures CPT® 76825 – CPT® 76828. <ul style="list-style-type: none"> ◆ The use of color Doppler (CPT® 93325) alone, when performed for anatomical structure identification, during a standard ultrasound procedure, is not separately reimbursable.

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 Obstetrical ultrasound imaging.
 - ◆ Per ACOG, despite the technical advantages of 3-dimensional ultrasonography, proof of a clinical advantage of 3-dimensional ultrasonography in prenatal diagnosis, in general, is still lacking.

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