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ABBREVIATIONS and GLOSSARY for OB ULTRASOUND IMAGING GUIDELINES

ACOG	American College of Obstetricians and Gynecologists
AFI	amniotic fluid index
AFP	alpha-fetoprotein
CST	contraction stress test
B-mode (brightness)	a two dimensional imaging procedure, B-mode ultrasound is the basis for all static and real time B-scan images
BPP	Biophysical Profile. BPP combines data from two sources (ultrasound imaging and fetal heart rate monitoring), BPP measures the baby's heart rate, muscle tone, movement, breathing, and amount of amniotic fluid
D & C	dilatation and curettage
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
FHR	fetal heart rate
hCG	human chorionic gonadotropin
IDDM	insulin-dependent diabetes mellitus
FGR	Fetal growth restriction; an estimated or actual weight of the fetus below 10 th percentile for gestational age
M-mode	an ultrasound imaging technique in which structure movement can be depicted in a wave-like manner; primarily used in cardiac and fetal cardiac imaging
macrosomia	estimated fetal weight of greater than 4000 or 4500 grams
monochorionic twins	twins developed from one oocyte (egg) developing with a single chorions (membrane that forms the fetal part of the placenta)
NICU	Neonatal Intensive Care Unit
NST	fetal non-stress test
oligohydramnios	diminished amniotic fluid volume (AFV) for gestational age; definitions include: 1.) amniotic fluid index (AFI) < 10 at < 30 weeks gestation, 2.) AFV < 500ml at 32-36 weeks gestation, 3.) maximum deepest pocket of < 2cm, and, 4.) AFI of < 5cm or < the 5 th percentile for gestational age
PACS	Picture Archiving and Communications System
polyhydramnios	excessive amniotic fluid for gestational age; definitions include: 1.) amniotic fluid index (AFI) > 18 at < 30 weeks gestation, 2.) AFV > 1,700-1,900 ml during the last two months of pregnancy, 3.) AFI > 24cm
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"

GENERAL GUIDELINES

Required Documentation

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

The following information must be submitted with each request:

- Anticipated date of service
- Expected date of delivery
- Gestational age at date of service
- Results of prior ultrasound studies if available

Inappropriate Uses of OB Ultrasound

- ✓ Obstetrical ultrasound studies cannot be authorized for payment for individuals who do not have a positive pregnancy test or clinical evidence of a pregnancy (fetal heart tones)
- ✓ Obstetrical ultrasound is **not** appropriate for the following:
 - Sex determination only.
 - To provide a keepsake or souvenir picture.

Practice Note:

Guidelines support performing one nuchal translucency scan (CPT[®] 76813) and one fetal anatomic scan (CPT[®] 76805) per pregnancy at the appropriate time frame as the only routine ultrasounds in a low risk pregnancy. Additional fetal ultrasounds might be appropriate if there is a documented medical necessity indication.

Reference:

1. Reddy UM, Abuhamad AZ, Levine D, Saade GR. Fetal imaging. Obstetrics and Gynecology, 2014; 123.
2. ACOG Practice Bulletin No.175: *Ultrasound in pregnancy*. December 2016.

OB-1~Abdominal Pain or Trauma

OB-1.1 Abdominal Pain

For abdominal pain or trauma that presents without bleeding:	
1.	Initially CPT® 76815 and/or CPT® 76817 for limited ultrasound when medically indicated, OR • CPT® 76801 and/or CPT® 76817 when complete ultrasound has not yet been performed, if less than 14 weeks, OR • CPT® 76805 (plus CPT® 76810 if more than one fetus) if equal to or greater than 14 weeks, when complete fetal anatomic scan CPT® 76805 is planned and has not yet been performed.
2.	See also <u>OB-13~Vaginal Bleeding</u>

OB-1.2 Trauma

1. 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.

2. Management of outpatient trauma implies that the trauma was not serious enough to be treated as inpatient. The major risk is abruptio placentae:

Monitor for uterine contractions for those >20 weeks.

- CPT® 76805 [plus CPT® 76810 if more than one fetus] when complete fetal anatomic scan CPT® 76805 is planned and has not yet been performed, *or*
- CPT® 76815 or CPT® 76816
 - Additionally, if greater than 24 weeks, BPP CPT® 76818 or CPT® 76819 or CPT® 76815 for AFI can be considered.
- Other advanced imaging may be indicated, send for Medical Director review.

OB-2~Abnormal Fetal Position or Presentation

OB-2.1 Abnormal Fetal Position or Presentation

- ✓ Confirmation of suspected abnormal fetal position or presentation (transverse or breech presentation):
 - An ultrasound can be performed at 36 weeks gestation or greater to determine fetal position to allow for external cephalic version.
 - Ultrasound to determine fetal position is not necessary prior to 36 weeks gestation unless delivery is imminent.

Coding Notes

Report one of the following:

- CPT[®] 76805 [plus CPT[®] 76810 if more than one fetus] for complete fetal anatomic scan when complete fetal anatomic scan CPT[®] 76805 is planned and has not yet been performed, *or*
- CPT[®] 76815 for limited ultrasound.

Practice Note

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

References:

1. ACOG Practice Bullitin Number 161, February 2016.

OB-3~Alloimmunization/Rh Isoimmunization/Other Causes of Fetal Anemia/Parvo/Hydrops

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.

OB-3.1 Alloimmunization/RH Isoimmunization/Other Causes of Fetal Anemia

Imaging for Alloimmunization/ RH Isoimmunization:	
1.	Ultrasound (CPT [®] 76815 or CPT [®] 76816) every 2 to 4 weeks to assess fetal growth starting after performance of the fetal anatomic scan CPT [®] 76811 at 16 weeks or greater. If less than 16 weeks, send to MD Review.
2.	Weekly BPP (CPT [®] 76818 or CPT [®] 76819) or NST starting at 32 weeks or sooner depending on fetal condition
3	3a. Weekly fetal middle cerebral artery MCA Doppler (CPT[®] 76821) starting at 20 weeks or sooner depending on fetal condition when any one of the following maternal antibody titers are $\geq 1:8$ • Anti-D antibody, and/or • Anti-Duffy antibody and/or • Anti-Kidd antibody 3b. With Anti-Kell antibody (any antibody titer) MCA Doppler (CPT[®] 76821) once weekly. 3c. Evidence of fetal hydrops on previous imaging once weekly MCA Doppler (CPT[®] 76821) Because MCA-PSV increases across gestation, results should be adjusted for gestational age. Measurements can be initiated as early as 16 weeks of gestation if there is a past history of early severe fetal anemia or very high titers. The optimal interval between examinations has not been determined, but should be one to two weeks based on clinical experience and what is known about progression of fetal anemia in this setting

OB-3.2 Parvovirus B-19

- ✓ **Parvovirus B-19** (Fifth Disease): ultrasound (CPT[®] 76816) every 2 to 4 weeks to assess fetal growth starting at time of known exposure and continuing for 8-10 weeks post-exposure.
 - Weekly BPP (CPT[®] 76818 or CPT[®] 76819) or NST starting at time of known exposure if ≥ 24 weeks gestation and continuing for 8-12 weeks post-exposure.
 - Weekly fetal middle cerebral artery (MCA) Doppler (CPT[®] 76821) starting at time of known exposure, if 16 weeks or greater and continuing for 8-12 weeks post-exposure.

OB-3.3 Twin Anemia Polycythemia Sequence

- ✓ **Twin anemia polycythemia sequence**: ultrasound (CPT[®] 76816) every 2 weeks to assess fetal growth.
 - Fetal middle cerebral artery (MCA) Doppler (CPT[®] 76821) evaluation of each fetus *every 1-2 weeks*.

OB-3.4 Fetal Hydrops Associated with Polyhydramnios

- ✓ **Fetal hydrops associated with Polyhydramnios**: if diagnosed with hydrops, image according to **OB-3.1**.

Practice Notes

Rhesus isoimmunization/alloimmunization is the process through which fetal Rh⁺ red blood cells enter the circulation of an Rh negative mother causing her to produce antibodies which can cross the placenta and destroy the red blood cells of the current Rh⁺ fetus in subsequent Rh⁺ pregnancies.

Twin anemia polycythemia sequence “TAPS” may occur spontaneously in up to 5% of monochorionic twins and may also develop after incomplete laser treatment in TTTS cases. As with TTTS the underlying mechanism is thought to be abnormal placental vascular anastomoses. One twin develops anemia and the other polycythemia. One of the features suggesting towards the diagnosis is discordance in fetal middle cerebral artery peak systolic velocity (MCA-PSV) measurements

Peak systolic velocity (PSV) of the fetal middle cerebral artery can be used as a substitute for amniocentesis to evaluate a fetus at risk for anemia due to Rhesus isoimmunization/alloimmunization

References:

1. Mari G, Deter RL, Carpenter RL, Rahman F, et al. Noninvasive diagnosis by Doppler ultrasonography of fetal anemia due to maternal red-cell alloimmunization. Collaborative Group for Doppler Assessment of the Blood Velocity in Anemic Fetuses. *N Engl J Med*. 2000; 342(1):9.
2. Lopriore E, Slaghekke F, Oepkes D et-al. Clinical outcome in neonates with twin anemia-polycythemia sequence. *Am. J. Obstet. Gynecol.* 2010;203 (1): 54.e1-5.

3. Slaghekke F, Kist WJ, Oepkes D et-al. Twin anemia-polycythemia sequence: diagnostic criteria, classification, perinatal management and outcome. *Fetal. Diagn. Ther.* 2010; 27 (4): 181-90.
4. Suzuki S. Twin anemia-polycythemia sequence with placental arterio-arterial anastomoses. *Placenta.* 2010; 31 (7): 652.
5. Gucciardo L, Lewi L, Vaast P et-al. Twin anemia polycythemia sequence from a prenatal perspective. *Prenat. Diagn.* 2010;30 (5): 438-42.
6. Weingertner AS, Kohler A, Kohler M., et-al. Clinical and placental characteristics in four new cases of twin anemia-polycythemia sequence. *Ultrasound Obstet Gynecol.* 2010; 35 (4): 490-4.
7. ACOG Bulletin No. 75. *Management of Alloimmunization During Pregnancy.* August 2006, reaffirmed 2016.
8. Lamont RF, Sobel JD, Vaisbuch E, Kusanovic JP, Mazaki-Tovi S, Uldbjerg N, Romero R. Parvovirus B19 infection in human pregnancy. *BJOG* 2011; 118:1750186.
9. Reddy UM, Filly RA, Copel JA. Prenatal Imaging: Ultrasonography and Magnetic Resonance Imaging. *Obstetrics and Gynecology* 2008; 112:145
10. ACOG Bulletin No. 4. *Prevention of Rh D Alloimmunization.* May 1999.
11. Mari G, Norton ME, Stone J, et al. SMFM Clinical guidelines No. 8: The Fetus at Risk for Anemia: Diagnosis and Management. *Am J Obstet Gynecol.* [In press.]
12. *Ultrasound Obstet Gynecol. Guidelines: role of ultrasound in twin pregnancy, 2016;47(2): 247-263)*
13. Parvovirus B19 Infection in Pregnancy SOGC No. 316, December 2014

OB-4~Amniotic Fluid Abnormalities

OB-4.1 Amniotic Fluid Abnormalities

For suspected polyhydramnios or oligohydramnios:	
1.	One ultrasound is appropriate
2.	CPT® 76805 [plus CPT® 76810 if more than one fetus] for complete fetal anatomic scan when complete fetal anatomic scan CPT® 76805 is planned and has not yet been performed, <i>or</i> If complete fetal anatomic scan CPT® 76805 was previously performed: CPT® 76815 for limited ultrasound, or CPT® 76816 for complete ultrasound
For confirmed diagnosis of polyhydramnios :	
1.	One ultrasound (CPT® 76816) every 2 to 4 weeks for fetal growth
2.	a. Weekly biophysical profile (BPP) (CPT® 76818 or CPT® 76819) and/or AFI CPT® 76815, and/or NST (CPT® 59025) b. Twice-weekly biophysical profile (BPP) (CPT® 76818 or CPT® 76819) and/or AFI CPT® 76815, and/or NST (CPT® 59025) if AFI $\geq$ 30 or maximum deepest vertical pocket is $\geq$ 10cm
3.	One time fetal echo if initial echo has not already been performed (CPT® 76825 and/or CPT® 76827 and/or CPT® 93325. All requests for follow-up echo go to Medical Director review.
For confirmed diagnosis of oligohydramnios :	
1.	One ultrasound (CPT® 76816) every 2 to 4 weeks for fetal growth
2.	Weekly biophysical profile (BPP) (CPT® 76818 or CPT® 76819), and/or AFI CPT® 76815, and/or NST (CPT® 59025)
3.	Weekly umbilical artery Doppler (CPT® 76820)

Practice Notes

Polyhydramnios refers to excessive amniotic fluid volume. It is determined with AFI ≥ 24 cm or (**greater than the 95th percentile by gestational age**), or maximum deepest vertical pocket ≥ 8 cm.

Oligohydramnios refers to diminished amniotic fluid volume. At 30 weeks or greater, it is determined with AFI ≤ 5 cm by measuring fluid in each of the four quadrants or by the maximum single deepest vertical pocket ≤ 2 cm (is the best definition of oligohydramnios). At less than 30 weeks, oligohydramnios is determined by a gestation age cut off of ≤ 5 percentile,.

Polyhydramnios can be an early presenting finding of fetal hydrops associated with fetal anemia. Middle cerebral artery Doppler is commonly used to diagnose whether this fetal anemia is present or not (See **OB 3.1**).

Polyhydramnios may also present as a finding of cardiac dysfunction, fetal arrhythmias or cardiac malformation. Fetal echocardiography is commonly performed to determine if any other conditions are present or not (See **OB-7 Fetal Echocardiogram**)

References:

1. *Am J Obstet Gynecol* 1990;162:1168-1173
2. ACOG Practice Bulletin No.175: *Ultrasound in pregnancy*. December 2016.
3. American Pregnancy Association. *Low amniotic fluid levels: Oligohydramnios*. January 2007 <http://www.americanpregnancy.org/pregnancycomplications/lowamnioticfluidoligohydramnios.htm>. Accessed September 25, 2009
4. Chitkara U, Wilkins I, Lynch L, Mehalek K, Berkowitz RL. The Role of Sonography in Assessing Severity of Fetal Anemia in Rh- and Kell-Isoimmunized Pregnancies. *Obstet Gynecol* 1988;71:393-398.

OB-5~Fetal Anatomic Scan

OB-5.1 Initial Screening for Fetal Anomalies

- ✓ A fetal anatomic scan to screen for anomalies is ideally performed at 18 to 20 weeks, but **MUST** be performed after week ≥ 16 . If less than 16 weeks, send to MD review.
 - Reported as CPT[®] 76805 if the patient is NOT high risk.
 - If pregnancy is high risk report as (CPT[®] 76811). A detailed fetal anatomic scan (CPT[®] 76811) is performed by a Maternal Fetal Medicine (MFM) specialist, Perinatologist, Radiologist, or AIUM or ACR accredited facilities as the screening anatomic study.
 - See: **OB-11~HIGH RISK PREGNANCY**

OB-5.2 Follow-Up

- ✓ Follow-up ultrasounds CPT[®] 76816) can be performed every 3 to 6 weeks to evaluate fetal growth if pregnancy is high risk.
 - See: **OB-11~HIGH RISK PREGNANCY**
- ✓ Follow-up ultrasound (CPT[®] 76815 or CPT[®] 76816 can be performed if indeterminate, incomplete or equivocal finding on initial fetal anatomic scan. A limited ultrasound CPT[®] 76815 if limited to a follow up of a single item.
- ✓ Detailed anatomy ultrasound CPT[®] 76811 can be performed if not previously performed when initial fetal anatomic scan CPT[®] 76805 is abnormal.
 - See: **OB-11~HIGH RISK PREGNANCY**

Coding Notes

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

References:

1. Society of Maternal Fetal Medicine. White Paper on Ultrasound Code 76811. May 24, 2004. http://www.askleslie.net/rads/White_Paper_on_Ultrasound_Code_76811.pdf. Accessed May 10, 2010
2. ACOG practice bulletin no. 175: *Ultrasound in pregnancy*. December 2016
3. AIUM CPT 76811 Consensus Report on the Detailed Fetal Anatomic Ultrasound Examination: Indications, Components, and Qualifications. *February 6, 2014*
4. Society for Maternal-Fetal Medicine, with the assistance of Vincenzo Berghella, MD. Progesterone and preterm birth prevention: translating clinical trials data into clinical practice. *Am J Obstet Gynecol*. 2012;206(5):376-386.
5. The Perinatal Quality Foundation. www.perinatalquality.org. Accessed May 13, 2013.
6. CLEAR: Cervical Length Education and Review. www.perinatalquality.org/CLEAR. Accessed May 13, 2013.
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8. Berghella V, et al. Cerclage for short cervix on ultrasonography in women with singleton gestations and previous preterm birth. A meta-analysis. *Obstet Gynecol*. 2011;117(3):663–671.
9. American Medical Association. CPT—Current Procedural Terminology. www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-pra.... Accessed May 13, 2013.

10. Centers for Disease Control and Prevention. International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). www.cdc.gov/nchs/icd/icd9cm.htm. Accessed May 21, 2013.

OBSTETRICAL ULTRASOUND IMAGING GUIDELINES

OB-6~No Fetal Heart Tone/Decreased Featal Movement

OB-6.1 No Fetal Heart Tone/Decreased Fetal Movement

✓ Ultrasound is appropriate to confirm suspected fetal demise.

The following is supported during the first trimester:	
1.	• Prior to considering ultrasound for absence of fetal heart tone at less than 12 weeks, fetal heart tone should be repeated at 12 weeks gestation. • Ultrasound imaging is supported, prior to 12 weeks gestation, in the setting of absent fetal heart tones accompanied by other maternal signs or symptoms (such as cramping, vaginal bleeding, etc.). Report <i>one</i> of the following: ○ CPT[®] 76801 (plus CPT[®] 76802 if more than one fetus) and/or CPT[®] 76817 if a complete ultrasound has not yet been performed; or ○ CPT[®] 76815 for limited ultrasound and/or CPT[®] 76817 • Note: CPT[®] 76816 can only be used after CPT[®] 76805 has been performed, therefore should not be done in the first trimester.
The following is supported during the second and third trimester:	
1.	• If less than 24 weeks gestation, report one of the following: ○ CPT[®] 76805 if a complete fetal anatomic scan is planned and has not yet been performed during this pregnancy [plus CPT[®] 76810 if more than one fetus]; or ○ CPT[®] 76816 if a complete ultrasound was done previously; or ○ CPT[®] 76815 for limited ultrasound; and/or ○ CPT[®] 76817 for a transvaginal ultrasound
2.	• If pregnancy is greater than or equal to 24 weeks, initial evaluation is usually done by fetal non-stress test (CPT[®] 59025) with: 1) AFI (CPT[®] 76815); or ultrasound (CPT[®] 76815) to document fetal heart activity or BPP (CPT[®] 76819) if 24 weeks or greater; or 3) contraction stress test (CST) and AFI. No imaging is necessary if: ○ NST is reactive and AFI is normal; or ○ CST is negative ○ If NST/AFI has not been done, an ultrasound can be performed. • For ultrasound, if pregnancy is greater than or equal to 22 weeks, report <u>one</u> of the following: ○ CPT[®] 76805 if a complete fetal anatomic scan is planned and has not yet been performed during this pregnancy [plus CPT[®] 76810 if more than one fetus]; or ○ CPT[®] 76816 if a complete ultrasound was done previously; or ○ CPT[®] 76815 for limited ultrasound, and/or ○ CPT[®] 76818 or CPT[®] 76819 for BPP or CPT[®] 76815 (AFI) with an NST (CPT[®] 59025) can be substituted for a BPP but not ordered on the same day of service.

OB-7~Fetal Echocardiography (ECHO)

The minimal use of color Doppler alone, when performed for anatomical structure identification during a standard ultrasound procedure, is not separately reimbursable.

OB-7.1 Indications for Fetal Conditions

- Fetal echocardiography (Initial study-CPT®76825 or repeat study-CPT® 76826) (repeat echo must go to MD review),
- Doppler echocardiography (Initial study-CPT®76827 or repeat study-CPT® 76828) (repeat echo must go to MD review), and
- Doppler color flow velocity mapping (CPT®93325) can be ordered together or separately for the following conditions:

1.	Transabdominal fetal echo is usually not performed prior to 16 weeks
2.	Abnormal or suspected abnormal fetal cardiac evaluation on fetal anatomic scan. There must be documentation (provided as hard copy or acknowledged verbally by provider) that the four chamber cardiac study was abnormal or suspected abnormal on the anatomic scan in order for fetal echo to be indicated.
3.	If a heart abnormality is found, a Fetal ECHO (CPT® 76825 and/or CPT® 76827) may be approved for preparation of delivery.
4.	Suspected or known fetal arrhythmia (to define the rhythm and its importance)
5.	If fetal structural cardiac disease is suspected, fetal echo can be performed to evaluate fetal cardiac structure and function
6.	Known fetal extra-cardiac anomaly
7.	As a screening study if there is a family history of a first degree relative with a history of congenital heart disease (CHD) or cardiac anomaly
8.	As a screening study typically performed at <u>22-26 weeks gestation</u> (may be performed earlier if anomaly is suspected on prior ultrasound) if maternal non-diet-controlled diabetes is present (See: <u>OB-11~HIGH RISK PREGNANCY</u>)
9.	Suspected or known fetal chromosomal abnormalities (fetal aneuploidy)
10.	Single umbilical artery (two vessel cord), abnormality of umbilical cord, placenta or intraabdominal venous anomaly
11.	Fetal hydrops (See: <u>OB-3~Alloimmunization/Rh Isoimmunization/Other Causes of Fetal Anemia/Parvo/Hydrops</u>)
12.	Monochorionic twins/TTTS
13.	IVF pregnancies
14.	• Exposure of fetus to: • Lithium • Excessive alcohol • Anti-seizure medication, e.x. hydantoin • SSRI • Birth control pills • Ace inhibitors • Folate antagonists (methotrexate) • Anticonvulsants

	• Retinoic acid • Thalidomide • Amphetamines • Cocaine • NSAIDS (Ibuprofen, Indomethacin) 2nd and 3rd trimester • Vitamin A greater than 10,000 units per day • Opiates • Benzodiazepines • Other teratogen exposure to the fetus with a known association for cardiac anomalies
15.	Abnormal Fetal Nuchal Translucency scan ($\geq 3.5\text{mm}$) during current pregnancy. ○ Can also perform CPT[®] 76811 if not previously performed or if patient is being referred to another specialist (MFM, Perinatologist or Radiologist) for a second opinion. Otherwise, perform CPT[®] 76816.
16.	Polyhydramnios

OB-7.2 Indications for Maternal Conditions

For Maternal Conditions:	
1.	• All diabetes except gestational diabetes mellitus not on medication unless HbA1C is $>7\%$ Sjogren's Syndrome Systemic lupus erythematosus_with Anti-Ro/SSA or anti-La/SSB antibodies present • Rubella infection • Collagen vascular diseases • Phenylketonuria
2.	Presence of other maternal conditions associated with cardiac anomalies (such as parvovirus, CMV, Coxsackie virus, Toxoplasmosis)
3.	Family history of a first degree relative to the fetus with a congenital heart defect (such as family history of Marfan syndrome or Noonan syndrome)
4.	Seizure disorder

Coding Notes

- ✓ Requests for repeat fetal echo will be forwarded to Medical Director review.
- ✓ CPT[®] 76825 and CPT[®] 76827 are performed only once per fetus
- ✓ Follow-up echocardiograms are reported as CPT[®] 76826
- ✓ Follow-up Doppler fetal echocardiograms are reported as CPT[®] 76828
- ✓ If a Fetal Echo is ordered for an individual who **HAS NOT** had a previous echo in the pregnancy, and the clinical criteria are met, then the Fetal Echo may be approved using the following CPT[®] codes for the **initial** echo:
 - CPT[®] 76825 and/or CPT[®] 76827 and/or CPT[®] 93325 (add on code for color mapping)
 - Requests for repeat studies CPT[®] 76826 and/or CPT[®] 76828 (limited/follow-up study) will be forwarded to Medical Director review.

Practice Note:

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

References:

1. ACC/AA/ASE Committee to Update the 1997 Guidelines for the Clinical Application of Echocardiography, 2003; 42(5):954-970.
2. Donofrio MT, Moon-Grady AJ, Hornberger LK, Copel JA, et al. Diagnosis and treatment of fetal cardiac disease: A scientific statement from the American Heart Association. *Circulation*, 2014; May.
3. Marc Gewillig, Stephen C. Brown, Luc De Catte, Anne Debeer, Benedicte Eyskens, Veerle Cossey, Dominique Van Schoubroeck, Chris Van Hole, Roland Devlieger Premature foetal closure of the arterial duct: clinical presentations and outcome. *European Heart Journal*. DOI: <http://dx.doi.org/10.1093/eurheartj/ehp128> 1530-1536 First published online: 23 April 2009 .
4. Brucato A. Prevention of congenital heart block in children of SSA-positive mothers. *Rheumatology (Oxford)*, 2008;47 Suppl 3:iii35-7. doi: 10.1093/rheumatology/ken153.
5. *Ultrasound Obstet Gynecol* 2001; 18: 610–614 Incidence of major structural cardiac defects associated with increased nuchal translucency but normal karyotype T. GHI, I. C. HUGGON, N. ZOSMER and K. H. NICOLAIDES

OB-8~Fetal Growth Problems

OB-8.1 Fetal Growth Restriction-Small for dates

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:	
1.	One ultrasound can be performed if there is more than a 3 week difference in fundal height and gestational age report <u>one</u> of the following: CPT [®] 76805 (plus CPT [®] 76810 if more than one fetus), if a complete ultrasound has not yet been performed during this pregnancy, or CPT [®] 76816 if a complete ultrasound was performed previously.
2.	In order to evaluate fetal growth and confirm the diagnosis of FGR following the initial ultrasound, one follow-up ultrasound (CPT [®] 76816) can be performed 2-4 weeks following the initial ultrasound
3.	For clinical situations that have a higher probability of FGR such as maternal hypertension, maternal diabetes, previous stillbirth, etc. See: <u>OB-11~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:	
1.	Ultrasound (CPT [®] 76816) every 2 to 4 weeks to assess fetal growth starting at 22-24 weeks
2.	Starting at 22-24 weeks, weekly biophysical profile (BPP) (CPT [®] 76818 or CPT [®] 76819) or AFI (CPT [®] 76815) with NST
3.	Starting at 22-24 weeks, weekly umbilical artery Doppler (CPT [®] 76820); if umbilical artery dopplers are abnormal, daily BPP's CPT [®] 76818 or CPT [®] 76819 may be considered
4.	MCA Doppler (CPT [®] 76821) Start at 34 weeks, weekly if the doppler CPT [®] 76820 is normal.

OB-8.2 Macrosomia-Large for Dates

The ACOG definition of macrosomia: Estimated fetal weight of greater than 4000 grams (DM) or 4500 grams (non-DM); $\geq 90^{\text{th}}$ percentile or greater for gestational age.

See also: **OB-11~HIGH RISK PREGNANCY** and **OB-16~MACROSOMIA**

For Suspected Macrosomia:	
1.	In a low risk pregnancy, ultrasound is generally not indicated to estimate fetal weight before 30 weeks gestation.
2.	At 30 weeks gestation or greater, if there more than 3 week difference in fundal height and gestational age, one ultrasound can be performed to evaluate for macrosomia if clinically indicated (report <u>one</u> of the following: CPT® 76805 [plus CPT® 76810 if more than one fetus] if a complete fetal anatomic scan is planned and has not yet been performed, or CPT® 76816 if a complete ultrasound was done previously) (See: <u>OB-26~Unequal Fundal Size and Dates</u>)
For Known Macrosomia≥90th percentile	
1.	Repeat imaging is generally not necessary unless needed to plan for delivery or if there are other high risk indications. At > 30 weeks gestation, (CPT® 76816) every 2-4 weeks only if other high risk indicatio(s) are present.
2.	If no other high risk indication present, one CPT® 76816 at 37 weeks to plan for delivery.

References:

1. *Obstetrics and Gynecology* 2008;112:145-157
2. ACOG Practice Bulletin No.134: *Fetal Growth Restriction*. May 2013
3. ACOG Practice Bulletin No. 173: *Fetal Macrosomia*. Nov. 2016.
4. Copel JA, Bahtiyar MO. A practical approach to fetal growth restriction. *Obstetrics & Gynecology*, 2014; 123.
5. D. OROS, F. FIGUERAS, R. CRUZ-MARTINEZ, E. MELER, M. MUNMANY and E. GRATACOS. Longitudinal changes in uterine, umbilical and fetal cerebral Doppler indices in late-onset small-for-gestational age fetuses. *Ultrasound Obstet Gynecol* 2011; 37: 191–195 Published online 14 January 2011 in Wiley Online Library (wileyonlinelibrary.com).
6. *Ultrasound Obstet Gynecol* 2000; 15: 209±212. Fetal cerebral blood flow redistribution in late gestation: identification of compromise in small fetuses with normal umbilical artery Doppler. R. HERSHKOVITZ, J.C.P. KINGDOM, M. GEARY and C.H. RODECK
7. *Neonatology* 2015;108:269-276
8. Brain-Sparing in Intrauterine Growth Restriction: Considerations for the Neonatologist. Cohen E.^{a,b} · Baerts W^a · van Bel F.^a

OB-9~ Placental or Cord Abnormalities

OB-9	PLACENTAL OR CORD ABNORMALITIES
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OB-9~ Placental or Cord Abnormalities

OB-9.1 Vasa Previa

- ✓ Vasa previa: Vasa previa is a condition in which the umbilical vessels, unsupported by either the umbilical cord or placental tissue, traverse the fetal membranes of the lower segment above the cervix.”
- ✓ Ultrasound (CPT® 76817 and/or CPT® 76815 or CPT® 76816) every 2 to 4 weeks to assess cervical length starting at 28 weeks. If earlier, requests will be sent to Medical Director review.
- ✓ Amniocentesis is no longer required or recommended for lung maturity.

OB-9.2 Placental or Cord Abnormalities

For the following conditions, ultrasound (CPT® 76817 and/or CPT® 76815 or CPT® 76816) every 2 to 4 weeks starting at 28 weeks until delivery. If earlier, requests will be sent for Medical Director review.

- Placental infarction
- Circumvallate shape
- Placental hemangioma
- Succenturiate placenta or accessory lobe
- Chorionangioma
- Velamentous insertion of the umbilical cord
 - Ultrasounds above and weekly BPP (CPT® 76818 or CPT® 76819) or AFI (CPT® 76815) with NST starting at 32 weeks

OB-9.3 Subchorionic Hematoma or Placental Hematoma

Subchorionic Hematoma or Placental Hematoma	
First, Second and Third Trimester	
1.	Ultrasound can be performed for follow-up of a known subchorionic hematoma or placental hematoma (CPT® 76815, or CPT® 76816 if a complete fetal anatomic scan was done previously, and/or CPT® 76817) if the last ultrasound was performed greater than seven days ago.
2.	Ultrasound imaging may be repeated earlier than seven days if there are new or worsening symptoms such as an increasing amount of vaginal bleeding or increasing cramping or pain.
3.	No further ultrasound is needed if the follow-up ultrasound 7 days following the hemorrhage shows that the hemorrhage has resolved, and there is no further cramping and/or bleeding, and the fetus is growing as determined by size equal dates, in the first trimester.
4.	If pregnancy is in second or third trimester follow <u>OB- 9.4 Abruptio placentae</u>

OB-9.4 Suspected Abruptio Placentae

Suspected Abruptio Placentae	
Second and Third Trimesters	
1.	Ultrasound is appropriate for suspected abruptio placentae CPT® 76805 [plus CPT® 76810 if more than one fetus] and/or CPT® 76817 if a complete fetal anatomic scan has not yet been performed during this pregnancy, or • CPT® 76815 for limited ultrasound and/or CPT® 76817, or • CPT® 76816 if a complete fetal anatomic scan was done previously, and/or CPT® 76817 for a transvaginal ultrasound
2.	Ultrasound is appropriate to follow-up a known abruption (CPT® 76815 or CPT® 76816 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-9.5 Placenta Previa

Placenta Previa	
Second and Third Trimesters	
1.	For suspected placenta previa, ultrasound can be performed (CPT® 76805 [plus CPT® 76810 if more than one fetus] (and/or CPT® 76817) if a complete fetal anatomic scan has not yet been performed during this pregnancy, or • CPT® 76815 for limited ultrasound and/or CPT® 76817, or • CPT® 76816 if a complete fetal anatomic scan was done previously, and/or CPT® 76817 for a transvaginal ultrasound)
2.	For known placenta previa , one routine follow-up ultrasound can be performed at 28-32 weeks (CPT® 76815 or CPT® 76816 and/or CPT® 76817). If placenta previa is still present, one follow-up ultrasound (CPT® 76815 or CPT® 76816 and/or CPT® 76817) can be performed at 35-37 weeks. Amniocentesis is no longer required or recommended for lung maturity. If persistent placenta previa, BPP (CPT® 76818 or CPT® 76819) weekly, starting at 32 weeks. Follow-up ultrasound can be performed at any time if bleeding occurs (CPT® 76815 or CPT® 76816 and/or CPT® 76817).

OB 9.6 Placenta Accreta/Placenta Percreta

- ✓ For suspected placenta accreta, ultrasound can be performed at > 32 weeks, or 1 to 2 weeks prior to planned delivery for surgical planning (CPT® 76805 [plus CPT® 76810 if more than one fetus] (and/or CPT® 76817) if a complete fetal anatomic scan has not yet been performed **or**
 - CPT® 76815 for limited ultrasound and/or, CPT® 76817, **or**
 - CPT® 76816 if a complete fetal anatomic scan was done previously, **and/or** CPT® 76817 for a transvaginal ultrasound)

- ✓ If the ultrasound is inconclusive or equivocal, send to MD review.
- ✓ MD can approve Pelvic MRI without contrast (CPT® 72195) if indicated. If only placenta or maternal pelvis is imaged without fetal imaging

Practice Note

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

Reference:

1. ACOG Committee Opinion No. 560: Medical indicated late-preterm and early-term deliveries. May 2013.

OB-10~First Trimester Screening

OB-10.1 First Trimester Screening

First trimester screening includes biochemical markers and fetal nuchal translucency (FNT) (CPT® 76813). Conducted together, these screenings can identify risk for specific chromosomal abnormalities (e.g. Down's syndrome, Trisomy-18).

Nuchal translucency is completed between 11 and 13 6/7 weeks (CRL between 44 and 83 millimeters). An abnormal Fetal Nuchal Translucency scan, ≥ 3.5 mm, may indicate an increased risk for cardiac defects, abdominal wall defects, diaphragmatic hernia, and genetic syndromes in euploid fetuses; whereas, a nuchal translucency ≥ 2.5 mm may indicate an increased risk for aneuploidy (imaging should be based upon the MOM for NT and biochemical markers).

“... the use of ultrasound codes CPT® 76801/ CPT® 76802 should be indication driven and should not be routinely done whenever an ultrasound for nuchal translucency (CPT® 76813/ CPT® 76814) is requested. In cases where there is either a maternal and/or fetal indication then the CPT® 76801 code can indeed be billed along with the nuchal translucency screening (CPT® 76813/ CPT® 76814).” (Society for Maternal-Fetal Medicine)

First Trimester Screening:	
1.	Ultrasound is the initial imaging for the first trimester screening, to evaluate fetal nuchal translucency.
2.	If the nuchal translucency is abnormal, the following tests can be performed: • Fetal anatomic ultrasound(CPT® 76811) at 16 weeks or greater weeks • Amniocentesis • CVS • Fetal echocardiogram (NT ≥ 3.5 mm)
3.	Abnormal FNT with normal aneuploidy screen and normal chromosomes (as measured by chorionic villus sampling or amniocentesis) should be evaluated with a fetal echo (CPT® 76825 and/or CPT® 76827 and/or CPT® 93325) and fetal ultrasound (CPT® 76811).

Coding Notes

- CPT® 76813 and CPT® 76814 should be performed only by those certified by the Fetal Medicine Foundation or Nuchal Translucency Quality Review Program (NTQR).
- Report as CPT® 76813 (plus CPT® 76814 if more than one fetus).
- CPT® 76813 can be performed once per pregnancy if the pregnancy is 11 to 13 6/7 weeks.

- If FNT is abnormal, CPT[®] 76811 is usually performed by a Maternal Fetal Medicine (MFM) specialist, Perinatologist, Radiologist, or facility/physician with AIUM certification (with advanced training in fetal imaging) after 16 weeks.
- The use of ultrasound codes (CPT[®] 76801/ CPT[®] 76802) should be indication driven and should not be routinely done whenever an ultrasound for nuchal translucency (CPT[®] 76813/ CPT[®] 76814) is requested. In cases where there is either a maternal and/or fetal indication, then the CPT[®] 76801 code can indeed be billed along with the nuchal translucency screening (CPT[®] 76813/ CPT[®] 76814).

References:

1. ACOG Practice Bulletin No.77: *Screening for fetal chromosomal abnormalities*. Jan. 2007, reaffirmed 2013.
2. Raniga S, Desai PD, and Parikh H. *Ultrasonographic soft markers of aneuploidy in second trimester: Are we lost?* MedGenMed, January 11, 2006, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1681991/>. Accessed May 10, 2010
3. http://www.acog.org/publications/patient_education/bp165.cfm. Accessed May 3, 2010
4. ACOG Practice Bulletin No. 44: *Neural Tube Defects*. July 2003.
5. Society for Maternal and Fetal Medicine (SMFM), coding committee. SMFM's white paper on billing combination of 76801 and 76813.

OB-11~High Risk Pregnancy

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OBSTETRICAL ULTRASOUND IMAGING GUIDELINES

OB-11~High Risk Pregnancy

This list is not all inclusive. Other conditions may exist which are not listed. These conditions should be discussed with the Medical Director.

IMAGING FOR ABOVE CONDITIONS	
1.	- Perform one ultrasound in the first trimester to establish dates, and report one of the following: - CPT[®] 76801 [plus CPT[®] 76802 if more than one fetus] if a complete ultrasound has not yet been performed, and/or CPT[®] 76817 for a transvaginal ultrasound indicated. - CPT[®] 76813 if between 11 0/7 to 13 6/7 weeks gestation and fetal nuchal translucency scan is being performed.
2.	- Detailed Fetal Anatomic Scan CPT[®] 76811 ideally performed between 18-20 weeks, but be performed after 16 weeks when criteria is met: Performance of the specialized fetal anatomic evaluation should be limited to those with special skills to perform this study, such as Maternal Fetal Medicine specialists, Perinatologists, and Radiologists (<i>with advanced training in fetal imaging</i>). - There is no prior approval for a CPT[®] 76811 for the current pregnancy.
3.	- Starting at 22 to 24 weeks, follow-up growth scans (CPT[®] 76816) every 3-6 weeks. - Starting at 32 weeks, weekly BPP (CPT[®] 76818 or CPT[®] 76819) or AFI (CPT[®] 76815) with NST.

OB 11.1: High Risk Group One- Risk Factors

HIGH RISK PREGNANCY – Risk Factors	
a.	Socio-Demographic Risk Factors
	Age less than or equal to 17 years of age
	Age greater than or equal to 35 years of age at the estimated date of confinement (EDC)
b.	Lifestyle Related Risk Factors
	Drug or alcohol use during current pregnancy (See also <u>OB-29~High Risk Medications and Substances</u>)
	10 or more cigarettes a day (1/2 pack a day)
	Maternal history of substance abuse (See also <u>OB-29~High Risk Medications and Substances</u>)
c.	Health Condition Related Risk Factors

	Acquired Immune Deficiency Syndrome/HIV Positive
	Anemia severe, less than 8 grams Hgb or 24% Hct
	Antiphospholipid Syndrome/Autoimmune disease
	Asthma (poorly controlled or steroid dependent)
	Bariatric surgery
	Cardiac (maternal) disease/fetal congenital heart disease
	Cholestasis of pregnancy (abn bile acids, 2-3 times normal)
	Chronic liver disease
	Chronic medical condition that may affect fetal growth due to utero-placental insufficiency
	Cystic Fibrosis/Known carrier of genetic diseases
	Heart disease – New York Heart Association class III or IV or arrhythmia
	Hemoglobinopathies
	Hyperthyroidism
	Hypothyroidism (poorly controlled)
	Maternal malnutrition
	Maternal blood clotting disorder/thrombophilia (Antiphospholipid Syndrome, Factor V Leiden mutation, Antithrombin III deficiency, Protein C/Protein S deficiency, etc.)
	PKU
	Renal disease such as pyelonephritis, glomerulonephritis, lupus, or persistent protein in the urine
	Seizure disorders
	Sickle cell disease (SS), including sickle cell trait (AS, SC, etc)
	Systemic lupus
	Systemic malignancy
	Thrombophilia - hereditary and acquired such as Factor V Leiden Mutation
d.	Previous pregnancy related risk factors
	History of fertility drugs and treatment/ART Conception with assisted reproductive technologies/ART
	History of two or more miscarriages (less than 20 weeks)
	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)
	Prior pre-term delivery (See: <u>OB-14~Cervical Insufficiency</u>)
	Prior pregnancy with placental abnormality (Infarcts, Accreta)
	Prior pregnancy with SGA (baby weighing <2500 grams at term or less than the 10 th percentile of expected weight)
	<u>Prior pregnancy with adverse outcome (early onset preeclampsia < 32 weeks, stillbirth, abruption, FGR)</u>
	Rh sensitization/Isoimmunization (See: <u>OB-3~Alloimmunization/Rh Isoimmunization/Other Causes of Fetal Anemia/Parvo/Hydrops</u>)
	Two or more elective terminations of pregnancy in the second trimester
e.	Current pregnancy related risk factors
	Abnormal MSAFP/Low PAPP_A/Known chromosomal abnormalities/abnormal FNT
	Gastroschisis in current pregnancy
	History of fertility drugs and treatment/ART Conception with assisted reproductive technologies/ART
	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)
	Rh sensitization/isoimmunization (See: <u>OB-3~Alloimmunization/Rh Isoimmunization/Other Causes of Fetal Anemia/Parvo/Hydrops</u>)
	Thickened nuchal fold ≥ 6 mm at 16 to 20 weeks (if CPT [®] 76811 shows adequate heart views, then no indication for echo)
	No prenatal care prior to 28 weeks
f.	Maternal Infections
	Cytomegalovirus (CMV)
	Malaria
	Parvovirus
	Rubella
	Syphilis, untreated
	Toxoplasmosis
	Tuberculosis

OB 11.2: High Risk Group Two – Findings on Ultrasound

11.2-a: High Risk Group Two a.

If the following conditions are found upon routine imaging:

- Shortened femur identified in fetus of current pregnancy
- Shortened humerus identified in fetus of current pregnancy
- Pyelectasis of >4mm at 20 weeks identified in fetus of current pregnancy
- Echogenic bowel identified in fetus of current pregnancy

Fetal anatomic scan is ideally performed at 18 to 20 weeks, but must be performed after 16 weeks (CPT® 76811)

One follow-up scan (CPT® 76816) in third trimester

11.2.b: High Risk Group Two b.

If the following conditions are found upon routine imaging:

- Choroid plexus cyst (present in 30% to 50% of all Trisomy 18 fetuses). Follow-up imaging not needed if targeted scan is normal.
- Echogenic intracardiac foci (present in 15% to 30% of all Down Syndrome fetuses). Fetal echo or follow-up ultrasound are not warranted
- Prior pregnancy with a congenital anomaly
- Chromosomal abnormalities with previous pregnancy

Fetal anatomic scan is ideally performed at 18 to 20 weeks, but must be performed after 16 weeks (CPT® 76811)

OB 11.3: High Risk Group Three – BMI

11.3a: BMI 30 to 34

- Obesity (BMI 30-34)

- Perform one ultrasound in the first trimester to establish dates, and report one of the following:
 - CPT® 76801 [plus CPT® 76802 if more than one fetus] if a complete ultrasound has not yet been performed, and/or CPT® 76817 for a transvaginal ultrasound indicated.
- CPT® 76813 if between 11 0/7 to 13 6/7 weeks gestation and fetal nuchal translucency scan is being performed.

Fetal anatomic scan is ideally performed at 18 to 20 weeks, but must be performed after 16 weeks (CPT® 76811)

One follow-up scan (CPT® 76816) at 30 to 34 weeks

11.3b: BMI 35-39

- Obesity (BMI 35-39)

- Perform one ultrasound in the first trimester to establish dates, and report one of the following:
 - CPT® 76801 [plus CPT® 76802 if more than one fetus] if a complete ultrasound has not yet been performed, and/or CPT® 76817 for a transvaginal ultrasound indicated.

• CPT[®] 76813 if between 11 0/7 to 13 6/7 weeks gestation and fetal nuchal translucency scan is being performed.
Fetal anatomic scan is ideally performed at 18 to 20 weeks, but must be performed after 16 weeks (CPT [®] 76811)
Growth scan (CPT [®] 76816) at 32 and 36 weeks, and CPT [®] 76818 or CPT [®] 76819 (BPP) or CPT [®] 76815 (AFI) CPT [®] 59025 (NST)*weekly starting at 36 weeks

11.3c: BMI ≥ 40

• Obesity (BMI ≥ 40)
• Perform one ultrasound in the first trimester to establish dates, and report one of the following: ○ CPT[®] 76801 [plus CPT[®] 76802 if more than one fetus] if a complete ultrasound has not yet been performed, and/or CPT[®] 76817 for a transvaginal ultrasound indicated. • CPT[®] 76813 if between 11 0/7 to 13 6/7 weeks gestation and fetal nuchal translucency scan is being performed.
Fetal anatomic scan is ideally performed at 18 to 20 weeks, but must be performed after 16 weeks (CPT [®] 76811)
Growth scan (CPT [®] 76816) at 32 and 36 weeks
CPT [®] 76818 or CPT [®] 76819 (BPP) or CPT [®] 76815 (AFI) CPT [®] 59025 (NST) weekly starting at 32 weeks
If A1C is greater than 7, fetal echo CPT [®] 76825 and/or CPT [®] 76827 and/or CPT [®] 93325 after 18 weeks

Practice Note:

The obesity protocol that was introduced in 2011 included recommendations for early gestational diabetes mellitus screening and an overall pregnancy weight gain of 11–20 pounds in all classes of obesity. A baseline 24 hour urine protein collection was recommended for class II and class III obese patients based on their increased risk of developing gestational diabetes mellitus and preeclampsia^{3, 9, 10, 11, 12} in addition to serial growth scans and nonstress tests also being utilized.

Delivery by the estimated due date was recommended for each class of obesity meeting the following criteria: (1) class III obese (pre-pregnancy body mass index of 40 kg/m² or greater) alone, (2) class II obese (pre-pregnancy body mass index of 35–39.9 kg/m²) and a diagnosis of gestational diabetes mellitus or large for gestational age, or (3) class I obese (pre-pregnancy body mass index of 30–34.9 kg/m²) plus a diagnosis of gestational diabetes mellitus and large for gestational age fetus. large for gestational age/macrosomia was defined as an estimated fetal weight of greater than the 95th percentile.

OB 11.4: High Risk Group Four – Previous C-Section

If patient has had a previous Cesarean section
One ultrasound can be performed to confirm dates
✓ CPT®76801 [plus CPT®76802 if more than one fetus] if a complete ultrasound has not yet been performed, OR CPT®76815 for limited ultrasound if complete ultrasound has already been performed and/or CPT®76817 for a transvaginal ultrasound indicated if less than 14 weeks.
✓ 76805 for fetal anatomic scan is ideally performed between 18-20 weeks, but must be performed after 16 weeks, if earlier send to MD Review.
One growth scan (CPT®76816) at 32 weeks and one growth scan between 36 and 38 weeks (CPT®76816)

OB 11.5 High Risk Group Five

11.5a: Prior Pregnancy with Macrosomia

Prior pregnancy with macrosomia (baby weighing >4000 grams at term or greater than the 90 th percentile of expected weight)
Perform one ultrasound in the first trimester to establish dates, and report one of the following: • CPT®76801 [plus CPT®76802 if more than one fetus] if a complete ultrasound has not yet been performed, OR CPT®76815 for limited ultrasound if complete ultrasound has already been performed and/or CPT®76817 for a transvaginal ultrasound indicated if less than 14 weeks. • CPT®76813 if between 11 0/7 to 13 6/7 weeks gestation and fetal nuchal translucency scan is being performed.
One targeted scan (CPT®76811) in second trimester ≥ 16 weeks
One growth scan (CPT®76816) at > 30 weeks

11.5.b: Current Pregnancy with Macrosomia

See: **OB-8.2 Macrosomia-Large for Dates**

OB 11.6 High Risk Group Six: Zika Virus

Suspected exposure without symptoms: ✓ CPT®76801 [plus CPT®76802 if more than one fetus] if a complete ultrasound has not yet been performed, OR CPT®76815 for limited ultrasound if complete ultrasound has already been performed and/or CPT®76817 for a transvaginal ultrasound indicated if less than 14 weeks; ✓ Starting at 16 weeks, Growth scan (CPT® 76816) every 3-4 weeks to monitor for findings such as intracranial calcifications and microcephaly,
Suspected exposure with symptoms or known disease: ✓ CPT®76801 [plus CPT®76802 if more than one fetus] if a complete ultrasound has not yet been performed, OR CPT®76815 for limited ultrasound if complete ultrasound has

already been performed and/or CPT[®]76817 for a transvaginal ultrasound indicated if less than 14 weeks; ✓ Detailed fetal anatomic scan (CPT[®] 76811) may be performed at 16 weeks gestation or greater. ✓ Growth scan, (CPT[®] 76816) every 3-4 weeks to monitor for findings such as intracranial calcifications and microcephaly, starting at 16 weeks. ✓ If diagnosed FGR or abdominal circumference $\leq$10 percentile then follow FGR imaging (OB-8.1)
If intracranial calcifications, microcephaly or other abnormalities emerge, send to MD review. In these cases, imaging would follow the algorithm of other viruses that cause congenital infection (OB 11.1f).

OB 11.7: High Risk Special Considerations

For the following conditions, please follow the links for appropriate imaging.
History of late fetal death (greater than or equal to 20 weeks) (See OB-23~Stillbirth History)
Oligohydramnios or polyhydramnios (See OB 4: Amniotic Fluid Abnormalities)
Premature rupture of membranes (PROM) (See OB 21: Preterm/Premature Rupture of Membranes)
Vasa previa/placenta accrete/placental abnormalities (See OB 9: Placental or Cord Abnormalities)
Abnormal nuchal translucency (See OB 10: First Trimester Screening)
Multiple Gestations (See OB 17: Multiple Gestations)

OB-11.8: High Risk Group 8- Pre-Gestational Diabetes On oral medications or insulin

CPT[®]76801 [plus CPT[®]76802 if more than one fetus] if a complete ultrasound has not yet been performed, OR CPT[®]76815 for limited ultrasound if complete ultrasound has already been performed and/or CPT[®]76817 for a transvaginal ultrasound indicated if less than 14 weeks

If patient as pre-gestational diabetes and is on oral medication or insulin:			
Test	When	Frequency	Codes
Fetal anatomic scan	16 to 20 weeks	Once	CPT [®] 76811
Fetal echo (initial) Requests for follow-up go to MD review	Starting at 18-24 weeks	Once	CPT [®] 76825 and/or CPT [®] 76827 and/or

Ultrasound (for fetal growth)	Starting at viability 23-24 weeks	Every 2 to 4 weeks	CPT [®] 76816*
Biophysical Profile (BPP) or NST*	If complicated by additional risk factors, perform between 26 and 28 weeks	Up to twice weekly	CPT [®] 76818 or CPT [®] 76819 (BPP) or CPT [®] 76815 for AFI CPT [®] 59025
Biophysical Profile* (BPP) or NST**	Starting at 32 weeks	Up to twice weekly	CPT [®] 76818 or CPT [®] 76819 (BPP) or CPT [®] 76815 (AFI) CPT [®] 59025 (NST)*
Umbilical artery Doppler (if FGR diagnosed)	Upon diagnosis of FGR	Weekly	CPT [®] 76820
For a poorly controlled diabetic, requests for a repeat fetal echocardiogram will be sent to MD review. (<i>HbA1C > 7 is associated with fetal anomalies and adverse outcomes. Reference Table 1 below</i>)			
*Starting at 32 weeks, AFI CPT[®] 76815 can be substituted for BPP but not for the same day of service. **NST is not currently prior authorized by eviCore healthcare for any health plan. ***If there has not been a prior anatomical scan, this can be done at greater than 20 weeks.			

Practice Note:

Table 1

Serious adverse outcomes (congenital malformations and/or perinatal mortality) in offspring of women with type 1 diabetes and background population according to peri-conceptional glycemic control

A1C (%) ⁻	z score (SD > mean)	Number of patients	Congenital malformations (%)	RR (95% CI) vs. background population	Perinatal mortality (%)	RR (95% CI) vs. background population	Serious adverse outcome (%)	RR (95% CI) vs. background population
≥10.4	≥10	55	10.9	3.9 (1.8–7.8) [‡]	5.5	7.3 (2.5–19.8) [‡]	16.3	4.7 (2.5–8.1) [‡]
8.9–10.3	7.0–9.9	128	3.9	1.4 (0.6–3.1)	6.3	8.3 (4.2–15.9) [‡]	7.8	2.2 (1.2–3.9) [‡]
7.9–8.8	5.0–6.9	182	5.0	1.8 (0.9–3.3)	3.3	4.4 (2.0–9.4) [‡]	7.7	2.2 (1.3–3.6) [‡]
6.9–7.8	3.0–4.9	284	4.9	1.8 (1.0–2.9)	2.8	3.8 (1.9–7.3) [‡]	7.7	2.2 (1.5–3.3) [‡]

A1C (%) [*]	z score (SD > mean)	Number of patients	Congenital malformations (%)	RR (95% CI) vs. background population	Perinatal mortality (%)	RR (95% CI) vs. background population	Serious adverse outcome (%)	RR (95% CI) vs. background population
<6.9	<3.0	284	3.9	1.4 (0.8–2.4)	2.1	2.8 (1.3–6.1) [‡]	5.6	1.6 (1.0–2.6)
Background population (n = 70,089)			2.8	1.0	0.75	1.0	3.5	1.0

*Standard reference 5.4 ± 1.0 (mean $\pm$ 2 SD) in the nondiabetic background population.

*Significantly higher than background population at significance level of 0.05 relative risk (RR)

OB-11.9 High Risk Group Nine Gestational Diabetes

11.9a: Gestational Diet Controlled

If patient has gestational diabetes and it is diet controlled:			
Test	When	Frequency	Codes
Fetal anatomic scan	16 to 20 weeks***	Once	CPT [®] 76805 CPT [®] 76811
Ultrasound (for fetal growth)	Starting at 32 weeks	Every 4 weeks	CPT [®] 76816*
Biophysical Profile* (BPP) or NST**	Starting at 34 to 36 weeks	Once weekly if diet controlled.	CPT [®] 76818; or CPT [®] 76819 (BPP); or CPT 76815 (AFI) with CPT [®] 59025 (NST)*
Maternal diet-controlled diabetes refers to patients that have a diagnosis of any type of diabetes (including diet-controlled gestational diabetes mellitus (GDM) and diet controlled pre-gestational diabetes mellitus), but require no medication for their diabetes. If HbA1C is >7%, then they are not controlled and should follow guidelines for medication utilized for control see <u>OB-11.9b</u> (oral / insulin)			
*Starting at 35 weeks, AFI CPT [®] 76815 can be substituted for BPP but not for the same day of service. **NST is not currently prior authorized by eviCore healthcare for any health plan. ***If there has not been a prior anatomical scan, this can be done at greater than 20 weeks.			

OB 11.9b: Gestational Diabetes on Oral Medications or Insulin

If patient has gestational diabetes and is on oral medication or insulin:			
Test	When	Frequency	Codes
Fetal anatomic scan	16 to 20 weeks***	Once	CPT [®] 76805 CPT [®] 76811
Fetal echo (initial) Requests for follow-up go to MD review	Starting at 18-24weeks	Once	CPT [®] 76825 and/or CPT [®] 76827 and/or CPT [®] 93325

Ultrasound (for fetal growth)	Starting at viability 23-24 weeks	Every 2 to 4 weeks	CPT [®] 76816*
Biophysical Profile (BPP) or NST*	If complicated by additional risk factors , perform between 26 and 28 weeks	Up to twice weekly	CPT [®] 76818 or CPT [®] 76819 (BPP) or CPT 76815 for AFI CPT [®] 59025 (NST)*
Biophysical Profile* (BPP) or NST**	Starting at 32 weeks	Up to twice weekly	CPT [®] 76818 or CPT [®] 76819 (BPP) or CPT 76815 (AFI) CPT [®] 59025 (NST)*
Umbilical artery Doppler (if IUGR diagnosed)	Upon diagnosis of IUGR	Weekly	CPT [®] 76820
For a poorly controlled diabetic, requests for a repeat fetal echocardiogram will be sent to MD review. (If HbA1C is >7%, fetal echo can be performed in the third trimester to assess for ventricular hypertrophy)			
*Starting at 32 weeks, AFI CPT [®] 76815 can be substituted for BPP but not for the same day of service.			
**NST is not currently prior authorized by eviCore healthcare for any health plan.			
***If there has not been a prior anatomical scan, this can be done at greater than 20 weeks.			

OB-11.10 Hypertension

Current chronic hypertension, on and not on prescribed medications, and/or History of preeclampsia, and/or H x o f FGR:

One time uterine artery Doppler (CPT[®] 93976) evaluation prior to <16 weeks gestation. Uterine artery Doppler is not indicated > 16 weeks. If test is abnormal at less than 16 weeks, a repeat test can be considered at 20-22 weeks gestation after starting baby aspirin. (CPT[®] 93976) (See **OB-28.10 Duplex Scan (Uterine Artery)**)

If patient has one of the following hypertension-related conditions:

Chronic hypertension **not on** prescribed hypertension medication:

Perform one ultrasound in the first trimester to establish dates, and report one of the following:

- ✓ CPT[®]76801 [plus CPT[®]76802 if more than one fetus] if a complete ultrasound has not yet been performed, OR CPT[®]76815 for limited ultrasound if complete ultrasound has already been performed and/or CPT[®]76817 for a transvaginal ultrasound indicated if less than 14 weeks;
- ✓ CPT[®] 76813 if between 11 0/7 to 13 6/7 weeks gestation and fetal nuchal translucency scan is being performed.
- ✓ One US at 16-20 weeks (CPT[®] 76811- Detailed fetal anatomic section); and one US (CPT[®] 76816) at 30-34 weeks only.

(If blood pressure is elevated from baseline, see Gestational Hypertension (GH) below)

Chronic hypertension **on** prescribed hypertension medication:

Perform one ultrasound in the first trimester to establish dates, and report one of the following:

- ✓ CPT[®]76801 [plus CPT[®]76802 if more than one fetus] if a complete ultrasound has not yet been performed, OR CPT[®]76815 for limited ultrasound if complete ultrasound has already been performed and/or CPT[®]76817 for a transvaginal ultrasound indicated if less than 14 weeks.

One Fetal Nuchal Translucency between 11 0/7 to 13 6/7 weeks gestation	CPT [®] 76813
One Detailed Fetal Anatomic Scan at 16 weeks gestation or greater	CPT [®] 76811
US every 3 to 4 weeks starting at viability 23-24 weeks gestation	CPT [®] 76816
Starting at 32 weeks, weekly biophysical profile (BPP) or NST* If other risk factors are present, may start at 26-28 weeks.	CPT [®] 76818 or CPT [®] 76819 or CPT [®] 76815

	for AFI
If diagnosed FGR, weekly umbilical artery Doppler (See OB-8.1)	CPT [®] 76820

Gestational Hypertension (GH, preeclampsia, toxemia):	
Starting at time of diagnosis, growth US every 3-4 weeks; If FGR, Oligohydramnios, or Severe preeclampsia, growth US every 2-4 weeks.	CPT [®] 76816
Starting at time of diagnosis, weekly BPP or NST*; If FGR or Oligohydramnios is also present, twice weekly BPP or NST*	CPT [®] 76818 or CPT [®] 76819 or CPT [®] 76815 for AFI
Only if FGR or Oligohydramnios is present, twice weekly Umbilical Artery Doppler	CPT [®] 76820
MCA Doppler (CPT [®] 76821), Starting at 34 weeks. Once weekly only following a normal 76820 Doppler	
*NST (CPT [®] 59025) is not currently prior authorized by eviCore healthcare for any health plan	

OB-11.11 Single Umbilical Artery

If single umbilical artery is found on initial imaging:	
Detailed anatomic ultrasound at 16 weeks or greater	CPT [®] 76811
Fetal echocardiogram at 22-24 weeks	CPT [®] 76825 and/or CPT [®] 76827 and/or CPT [®] 93325
Follow-up ultrasound to evaluate fetal growth at 28-32 weeks and then every 2 to 4 weeks if more than one clinical high risk factors is documented	CPT [®] 76816
Weekly BPP or NST starting at 36 weeks	CPT [®] 76818 or CPT [®] 76819 (BPP) or CPT [®] 76815 (AFI) CPT [®] 59025 (NST)*

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2. ACOG Practice Bulletin No. 132: *Antiphospholipid Syndrome*. December 2012.
3. ACOG Practice Bulletin No. 125: *Chronic Hypertension in Pregnancy*. February 2012.
4. ACOG Practice Bulletin No. 45: *Antepartum Fetal Surveillance*. July 2014.
5. ACOG Practice Bulletin No. 137: *Gestational Diabetes Mellitus*. August 2013.
6. ACOG Practice Bulletin No. 33: *Diagnosis and Management of Preeclampsia and Eclampsia*. January 2002.
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OB-12~History of Infertility

OB-12.1 History of Infertility

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

OB-12.2 Present Pregnancy with use of Fertility Drugs and Treatment (ART)

- ✓ Follow high risk imaging, **OB-11~HIGH RISK PREGNANCY**

OB-13~Vaginal Bleeding

OB-13	VAGINAL BLEEDING
OB-13.1 VAGINAL BLEEDING AND/OR ABDOMINAL/PELVIC CRAMPING/PAIN	45
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OB-13~Vaginal Bleeding

See also: **OB-1~Abdominal Pain or Trauma**

OB-13.1 Vaginal Bleeding and/or Abdominal/Pelvic Cramping/Pain

Vaginal Bleeding and/or Abdominal/Pelvic Cramping/Pain	
First Trimester	
1.	Initially CPT® 76815 and/or CPT® 76817 for limited ultrasound when medically indicated, OR CPT® 76801 and/or CPT® 76817 may be performed once when medically indicated for complete ultrasound.
Second and Third Trimesters	
1.	CPT® 76815 or CPT® 76816 and/or CPT® 76817

OB-13.2 Ectopic Pregnancy

ECTOPIC PREGNANCY	
First Trimester	
<i>Signs and symptoms of ectopic pregnancy include pain and/or bleeding</i>	
1.	Initially CPT® 76815 and/or CPT® 76817 for limited ultrasound when medically indicated, OR CPT® 76801 and/or CPT® 76817 may be performed once when medically indicated for complete ultrasound.
2.	If patient has a history of ectopic pregnancy with non-doubling hCG without pain and without bleeding, ultrasound can be performed (CPT® 76801 and/or CPT® 76817) to confirm an intrauterine pregnancy
3.	If ectopic pregnancy is being treated non-surgically with Methotrexate, imaging may be required per <u>OB-1~Abdominal Pain or Trauma</u> or the imaging guidelines above for ectopic pregnancy.

OB-13.3 Spontaneous Abortion

SPONTANEOUS ABORTION	
1.	For <u>spontaneous abortion</u> (miscarriage), ultrasound can be performed to evaluate threatened or missed abortion (with or without vaginal bleeding prior to 20 weeks). - Initially CPT® 76815 and/or CPT® 76817 for limited ultrasound when medically indicated, OR - CPT® 76801 and/or CPT® 76817 may be performed once when medically indicated for complete ultrasound - Repeat ultrasound (CPT® 76815, or CPT® 76816, and/or CPT® 76817) is appropriate in the setting of rising or non-falling serum hCG levels at weekly intervals. - Ultrasound imaging can be repeated earlier than seven days if there are new symptoms.
2.	For <u>complete spontaneous abortion</u>, ultrasound is generally not indicated if there is no pain, no ongoing bleeding, and hCG levels are decreasing

OB-13.4 Hydatidiform Mole

Hydatidiform Mole	
First, Second and Third Trimester	
1.	Ultrasound can be performed for diagnosis of <u>hydatidiform mole</u> - Initially CPT® 76815 and/or CPT® 76817 for limited ultrasound when medically indicated, OR - CPT® 76801 and/or CPT® 76817 may be performed once when medically indicated for complete ultrasound. Following treatment with D & C and/or Methotrexate, serial serum hCG values are measured until they become negative. - Ultrasound may be necessary for follow-up (CPT® 76815, or CPT® 76816, and/or CPT® 76817) if hCG titers are not decreasing as expected, are increasing following treatment, or if there is onset of pain despite falling hCG titers.

References:

1. ACOG Committee Opinion No. 560: Medical indicated late-preterm and early-term deliveries. May 2013.
2. ACOG Committee Opinion No. 529: Placenta accreta. July 2012.

OB-14~Cervial Insufficiency/History of Preterm Delivery/Current Preterm Labor
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OB-14.1 Cervical Insufficiency/History of Preterm Delivery

1.	Ultrasound is supported at 16 weeks or greater: CPT[®] 76805 [plus CPT[®] 76810 if more than one fetus] and/or CPT[®] 76817 once, if a complete fetal anatomic scan has not yet been performed during this pregnancy for any one of the following: • History of prior precipitous delivery • Personal history of cervical insufficiency (without cerclage placement in the current 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]) Starting after the fetal anatomic scan at 16 weeks or greater, ultrasound (CPT[®]76815) every 2 to 4 weeks and/or transvaginal ultrasound (CPT[®] 76817) every 2 weeks until 24 weeks
2.	Ultrasound CPT[®]76801[plus CPT[®]76802 if more than one fetus] if a complete ultrasound has not yet been performed once in first trimester, OR CPT[®]76815 for limited ultrasound if a complete ultrasound 76801 has already been performed and/or CPT[®]76817 for transvaginal ultrasound once in first trimester (less than 14 weeks) for any one of the following: • Personal history of preterm delivery <32 weeks • Personal history of preterm premature rupture of membranes <32 weeks • Cerclage in place in current pregnancy • Presence of uterine anomaly (See OB-27.1) • Current pregnancy is twins, triplets, or other multiple gestation (See OB-17.1) • Preterm labor with current pregnancy <34 weeks Ultrasound is supported at 16 weeks or greater: CPT[®]76811 [plus CPT[®]76812 if more than one fetus] and/or CPT[®] 76817 once, if a complete detailed fetal anatomic scan has not yet been performed during this pregnancy for any one of the above conditions. Starting after the fetal anatomic scan at 16 weeks or greater, ultrasound (CPT[®]76815 or CPT[®]76816) can be performed every 2 to 4 weeks and/or transvaginal (CPT[®] 76817) every 2 weeks, starting at 16 weeks or greater until 32 weeks for any one of the above conditions.
3.	If funneling or abnormally shorten cervix ≤ 25 mm (2.5cm) is found, ultrasound (CPT[®] 76816) every 2 to 4 weeks for the duration of the pregnancy and/or (CPT[®]76817) for transvaginal ultrasound weekly until 32 weeks.

OB-14.2 Current Preterm Labor

For contractions, CPT® 76805 [plus CPT® 76810 if more than one fetus] and/or CPT® 76817 if a complete fetal anatomic scan has not yet been performed during this pregnancy; if a complete fetal anatomic scan was performed previously, CPT® 76815 or CPT® 76816, and/or CPT® 76817.

References:

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4. ACOG Practice Bulletin No.48: *Cervical Insufficiency*. Reaffirmed 2008
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OB-15~Intrauterine Device (IUD)

OB-15.1 Locate an Intrauterine Device – Any Trimester

- ✓ Ultrasound can be performed to locate an intrauterine device (IUD) (CPT[®] 76801 and/or CPT[®] 76817 if a complete ultrasound has not yet been performed)
 - CPT[®] 76815 for limited ultrasound, if complete ultrasound has already been performed, and/or CPT[®] 76817 for a transvaginal ultrasound.

OB-16~Macrosmia

See: **OB-8.2 Macrosomia-Large for Dates MACROSOMIA**

See: **OB-11.5~ HIGH RISK GROUP FIVE MACROSOMIA**

OB-17~Multiple Pregnancies

OB-17.1 Multiple Pregnancies

For **Suspected** multiple pregnancies:

Ultrasound is appropriate to confirm **suspected** multiple pregnancy (CPT[®] 76801[plus CPT[®] 76802 if more than one fetus]) if less than 14 weeks. If greater than 14 weeks, a complete anatomic scan (CPT[®] 76805 [plus CPT[®] 76810 if more than one fetus]) if not performed during this pregnancy. CPT[®] 76815 or CPT[®] 76816 if a complete anatomic scan was done previously, and/or CPT[®] 76817 for a transvaginal ultrasound.

For **Known dichorionic** multiple pregnancies:

CPT[®] 76811[plus CPT[®] 76812 if more than one fetus] if greater than 14 weeks if a complete detailed anatomic scan CPT[®] 76811 has not yet been performed during this pregnancy

Follow-up ultrasounds for all **known dichorionic** multiple pregnancies (CPT[®] 76816 and/or CPT[®] 76817):

- Ultrasound (CPT[®] 76816) every 2 to 4 week to assess fetal growth starting at 23 to 24 weeks gestation
- Transvaginal ultrasound (CPT[®] 76817) every 2 to 4 weeks to assess cervical length until 32 weeks
- Weekly BPP (CPT[®] 76818 or CPT[®] 76819) or NST with 76815 (AFI) starting at 32 weeks or sooner if additional risk factors
- Twice weekly BPP can be considered in rare clinical circumstances. These requests will be forwarded for Medical Director review.
- If discordant twins (15% to 25% difference in actual weight between twins), twice weekly BPP plus ultrasound (CPT[®] 76816) every 2 to 4 weeks, AND umbilical artery Doppler (CPT[®] 78620) weekly; for twice weekly imaging send to MD review.
- If FGR is diagnosed, weekly umbilical artery Doppler and/or Middle Cerebral Artery Doppler (CPT[®] 76820 and/or CPT[®] 76821)
- If IVF dichorionic twins, report initial fetal echo as CPT[®] 76825 and/or CPT[®] 76827 and/or CPT[®] 93325. Transabdominal fetal echo is usually not performed prior to 16 weeks. Follow-up echo requests will be sent to Medical Director review.
- If other high risk factors, see **OB-11~HIGH RISK PREGNANCY**.

Continued . . .

OB-17.1 Multiple Pregnancies *Continued...*

For Known monochorionic-diamniotic or monochorionic- monoamniotic multiple pregnancies:	
1.	CPT[®] 76811 [plus CPT[®] 76812 if more than one fetus] if greater than 14 weeks if a complete detailed anatomic scan CPT[®] 76811 has not yet been performed during this pregnancy. In addition to the imaging listed above for dichorionic pregnancies, <u>monochorionic-diamniotic- or monochorionic-monoamniotic-twins</u> also receive: • Ultrasound (CPT[®] 76816) every 2-4 weeks to assess fetal growth starting at 16 weeks gestation • Weekly BPP (CPT[®] 76818 or CPT[®] 76819) or NST with 76815 (AFI) starting at 32 weeks, sooner if additional risk factors are present. • Fetal middle cerebral artery (MCA) Doppler (CPT[®] 76821) every 2- 3 weeks starting at 16 weeks with the diagnosis of twin-twin transfusion syndrome (TTS) and 26 weeks for monitoring TTS and twin anemia polycemia sequence (TAPS). If requested earlier than 26 weeks, send to MD review. • If Twin to Twin Transfusion syndrome is suspected due to one twin failing to grow compared with the other twin, daily evaluation (CPT[®] 76815), and/or CPT[®] 76818 or CPT[®] 76819) and/or umbilical artery Doppler (CPT[®] 76820) can be performed to aid in planning imminent delivery. • If discordant twins (15% to 25% difference in actual weight between twins), twice weekly BPP plus ultrasound (CPT[®] 76816) every 2 to 4 weeks, AND umbilical artery Doppler (CPT[®] 76820) weekly • Daily fetal testing may be indicated if umbilical Doppler is abnormal. <u>These requests will be forwarded for Medical Director review.</u> • Fetal echo CPT[®] 76825 and/or CPT[®] 76827 and/or CPT[®] 93325 for initial echo. Transabdominal fetal echo is usually not performed prior to 16 weeks. For follow-up echo, send to MD review. • If FGR is diagnosed, weekly umbilical artery Doppler and/or Middle Cerebral Artery Doppler (CPT[®] 76820 and/or CPT[®] 76821)
2.	Triplets or higher Multiple Pregnancy receive same imaging as monochorionic- diamniotic- and monochorionic- monoamniotic- twins. These requests will be forwarded for Medical Director review.

References:

1. ACOG Practice Bulletin No. 56: *Multiple Gestation: Complicated Twin, Triplet, and High Order Multi-Fetal Pregnancy*. October 2004.
2. ACOG practice bulletin no.: 144. May 2014. Multi fetal gestations: twin triplet and higher order multi fetal pregnancies.
3. Ultrasound Obstet Gynecol 2016; 47: 247–263

OB-18~Pelvic Mass or Neoplasm

See: **OB-27~Uterine Anomalies/Adnexal/Pelvic Masses/Ovarian Cysts or Mass**

OB-19~Polyhydramnios/Oligohydramnios

See: **OB-4~AMNIOTIC FLUID ABNORMALITIES**

OBSTETRICAL ULTRASOUND IMAGING GUIDELINES

OB-20~Post Date Pregnancy

OB-20.1 Post Date Pregnancy

1.	Follow-up ultrasound (CPT [®] 76816) every 2 weeks ($\geq$ 40weeks gestation) to evaluate fetal growth
2.	• Weekly biophysical profile (BPP) (CPT[®] 76818 or CPT[®] 76819) or AFI (CPT[®] 76815) with NST starting at 40 weeks • Then twice weekly BPP (CPT[®] 76818 or CPT[®] 76819) or AFI (CPT[®] 76815) with NST at 41 weeks or greater

Practice Note

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

Reference:

1. ACOG Practice Bulletin 146. *Management of Late-Term and Postterm Pregnancies*. August, 2014.

OB-21~Preterm/Premature Rupture of Membranes

See also: **OB-4~AMNIOTIC FLUID ABNORMALITIES**

See Also: **OB-14.2 Current Preterm Labor**

OB-21.1 Preterm Premature Rupture of Membranes (PPROM)

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

OB-21.2 Premature Rupture of Membranes (PROM)

- ✓ Greater than or equal to 37 weeks. **Requests will be forwarded to Medical Director review.**

References:

1. ACOG Practice Bulletin 139. *Premature Rupture of Membranes*. October , 2013
2. ACOG Practice Bulletin No. 127: *Management of Preterm Labor*. June 2012.
3. ACOG Practice Bulletin No. 130: *Prediction and Prevention of Preterm Birth*. October 2012. Reaffirmed 2014.

OB-22~Second Trimester Screening

OB-22.1 Second Trimester Screening

See: **OB-5.1 Initial Screening for Fetal Anomalies**

Two studies, a quad screen and ultrasound, are done during the second trimester to detect fetal aneuploidy, neural tube defects, and other anatomical defects.

1.	All women may have one ultrasound (CPT [®] 76805) (to examine fetal anatomy) greater than 16 weeks, optimal after 18 weeks
2.	If the quad screening is abnormal, an ultrasound (CPT [®] 76811) may also be performed.

Practice Notes

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

1. AFP
2. hCG
3. uE
4. dimeric inhibin-A

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.

References:

1. ACOG Practice Bulletin No. 77: Screening for Fetal Chromosomal Abnormalities, 2007. *Reaffirmed 2013.*
2. Driscoll DA, Gross SJ. ACMG Practice Guidelines: Screening for fetal aneuploidy and neural tube defects. *Genetics in Medicine*, 2009, 11(11): 818-821.

OB-23~Stillbirth History or Risk of Stillbirth

OB-23.1 Imaging

Women with a history of stillbirth:
- CPT[®]76801 [plus CPT[®]76802 if more than one fetus] if a complete ultrasound has not yet been performed, OR CPT[®]76815 for limited ultrasound if complete ultrasound has already been performed and/or CPT[®]76817 for a transvaginal ultrasound indicated if less than 14 weeks - Fetal anatomic scan at 16 weeks or greater (CPT[®] 76811) - Ultrasound (CPT[®] 76816) every 2 to 4 weeks to assess fetal growth starting at 23-24 weeks or two weeks before prior pregnancy loss. - Weekly BPP (CPT[®] 76818 or CPT[®] 76819) or CPT[®] 76815 for AFI with NST (CPT[®] 59025) starting at 32 weeks or two weeks before prior pregnancy loss
Women at risk for still birth:
See <u>OB-11~HIGH RISK PREGNANCY</u>, group one

References:

1. ACOG Practice Bulletin No.102: *Management of Stillbirth*. March 2009.Reaffirmed 2012.
2. Towers CV, Carr MH. Antenatal fetal surveillance in pregnancies complicated by fetal gastroschisis. *Am J Obstet Gynecol* 2008, 198: 686.
3. Silver RM, Varner MW, Reddy U, Goldenberg R, et al. Work-up of stillbirth: a review of the evidence. *Am J Obstet Gynecol* 2007, 196(5): 433-444.
4. Garodosi J, Madurasinghe V, Williams M, Malik A, Francis A. Maternal and fetal risk factors for stillbirth: population based study. *BMJ*, 2013; 346.

OB-24~Third Trimester Imaging

OB-24.1 Third Trimester Imaging - Ultrasound

1.	Imaging in the third trimester is indicated for bleeding, pain, absent fetal heart tone, decreased fetal movement and/or other high-risk indications. (see <u>OB-11~HIGH RISK PREGNANCY</u>)
2.	For suspected breach position, see: OB-2~Abnormal Fetal Position or Presentation

Reference:

1. ACOG Practice Bulletin No. 175: *Ultrasound in pregnancy*. December 2016.

OB-25~Uncertain Dates

OB-25.1 Uncertain Dates

1.	The low risk pregnancy that has no other indications for ultrasound should have a Fetal Nuchal translucency (CPT® 76813 completed between 11 and 13 6/7 weeks and a fetal anatomic ultrasound (CPT® 76805) performed at 16 weeks or greater. The timing can be determined by fundal height. (See: <u>OB-5~FETAL ANATOMIC SCAN</u>).
2.	If the patient has had irregular menstrual periods in the year prior to the current pregnancy with an indeterminate fundal height on pelvic examination, then one ultrasound can be performed to confirm dates (CPT® 76801) [plus CPT® 76802 if more than one fetus] and/or CPT® 76817 for a transvaginal ultrasound if a complete ultrasound has not yet been performed. CPT® 76815 or CPT® 76816 if a complete ultrasound was done previously and was inconclusive for confirming pregnancy dates, and/or CPT® 76817 for a transvaginal ultrasound)
3.	If there are maternal risk factors present, (see <u>OB-11~HIGH RISK PREGNANCY</u>), such that knowing the EDC is critical to managing the pregnancy, one ultrasound can be performed to confirm dates: • (CPT® 76801 [plus CPT® 76802 if more than one fetus] (and/or CPT® 76817) if a complete ultrasound has not yet been performed CPT® 76815 or CPT® 76816 if a complete ultrasound was done previously and was inconclusive for confirming pregnancy dates, and/or CPT® 76817 for a transvaginal ultrasound) Follow-up ultrasound should not be performed for “Uncertain Dates.” Repeat imaging should only be performed for specific indications such as vaginal bleeding, pain, known or suspected fetal growth restriction (FGR), known or suspected oligohydramnios or polyhydramnios, etc.

References:

1. ACOG Practice Bulletin No.175: *Ultrasound in pregnancy*. December 2016.
2. *ACOG Committee Opinion*, Number 297, *Nonmedical Use of Obstetric Ultrasound*. August 2004.
3. *ACR Practice Guideline for the Performance of Obstetrical Ultrasound*, Effective 10/1/07.
4. *AIUM Practice Guideline for the Performance of Obstetric Ultrasound Examinations*, 2007.
5. Reddy UM, Abuhamad AZ, Levine D, Saade GR. Fetal imaging. *Obstetrics and Gynecology*, 2014; 123: 1070-82.

OB-26~Unequal Fundal Size and Dates

OB-26.1 Unequal Fundal Size and Dates

Unequal fundal size is defined as more than a 3 week difference in fundal height and gestational age at **23 weeks gestation or greater**.

1.	One ultrasound can be performed (CPT [®] 76805) if complete fetal anatomic scan is planned and has not been performed or CPT [®] 76816 if CPT [®] 76805 complete anatomic scan or detailed ultrasound CPT [®] 76811 has been done previously.
2.	Also see <u>OB-17~Multiple Pregnancies</u>
3.	See <u>OB-25~Uncertain Dates</u>
4.	See <u>OB-8~FETAL GROWTH PROBLEMS</u>

OB-27~Uterine Anomalies/Adnexal/Pelvic Masses/Ovarian Cysts or Mass

OB-27.1 Uterine Anomalies or Adnexal/Pelvic Masses

1.	Ultrasound can be performed for a known or suspected uterine anomaly and/or adnexal/pelvic mass.
2.	First trimester: CPT [®] 76801 [plus CPT [®] 76802 if more than one fetus] and/or CPT [®] 76817 for a transvaginal ultrasound if a complete ultrasound has not yet been performed. If a complete ultrasound was done previously CPT [®] 76815 and/or CPT [®] 76817 for a transvaginal ultrasound.
3.	Second or third trimester: CPT [®] 76805 [plus CPT [®] 76810 if more than one fetus] if a complete fetal anatomic scan has not yet been performed, or CPT [®] 76815 or CPT [®] 76816 if a complete fetal anatomic scan was done previously.
4.	Large Leiomyomata (fibroid) - Large fibroid defined as over 600 cm ³ - Fetal anatomic scan at 16 weeks or greater (CPT[®] 76805 or if meets criteria in <u>OB-11~HIGH RISK PREGNANCY</u>— CPT[®] 76811) - Transvaginal ultrasound (CPT[®] 76817) if pre-term labor or cervical insufficiency is of concern. If follow-up of cervical length is needed, see: <u>OB-14~Cervical Insufficiency/History of Preterm Delivery/Current Preterm Labor</u> - Ultrasound (CPT[®] 76815 or CPT[®] 76816) may be considered at 28-30 weeks and a repeat ultrasound at 34-36 weeks gestation (for those with fibroid volume >200cm³ –associated with increased risk of FGR see below). If FGR is present then proceed with monitoring per guidelines.
5.	Advanced imaging requests will be sent to Medical Director review.

Practice Note

The true incidence of fibroids during pregnancy is unknown. The reported rates vary from as low as 0.1% of all pregnancies to higher rates of 12. 5%. It seems that pregnancy has little or no effect on the overall size of fibroids despite the occurrence of red degeneration in early pregnancy. Fibroids, however, affect pregnancy and delivery in several ways, with abdominal pain, miscarriage, malpresentation, and difficult delivery being the most frequent complications. The major concerns occur late in pregnancy. These complications relate to preterm labor, placental abruption, fetal growth restriction, and fetal compression syndromes. The risk of preterm labor appears to correlate with the size of the fibroid (over 600 cm³) and/or the presence of multiple fibroids. Placental abruption has been reported to occur frequently in pregnancies complicated by fibroids.

Placentation over a fibroid appears to be strong risk factor for abruption. There does not appear to be any association of fetal growth restriction with small fibroids. However, when the fibroid volume is >200 cm³ fetal growth restriction

appears more commonly. Fetal compression syndrome is a direct result of large fibroids and is not associated with commonly found small fibroids. Finally, malposition or obstructed labor is associated with fibroids of the lower uterine segment.

References:

1. Buttram VC Jr, Reiter RC. Uterine leiomyomata: etiology, symptomatology, and management. *Fertil Steril* 1981; 36:433.
2. Qidwai GI, Caughey AB, Jacoby AF. Obstetric outcomes in women with sonographically identified uterine leiomyomata. *Obstet Gynecol* 2006; 107:376.
3. Exacoustòs C, Rosati P. Ultrasound diagnosis of uterine myomas and complications in pregnancy. *Obstet Gynecol* 1993; 82:97.
4. Strobelt N, Ghidini A, Cavallone M, et al. Natural history of uterine leiomyomas in pregnancy. *J Ultrasound Med* 1994; 13:399.
5. Laughlin SK, Baird DD, Savitz DA, et al. Prevalence of uterine leiomyomas in the first trimester of pregnancy: an ultrasound-screening study. *Obstet Gynecol* 2009; 113:630.
6. Stout MJ, Odibo AO, Graseck AS, et al. Leiomyomas at routine second-trimester ultrasound examination and adverse obstetric outcomes. *Obstet Gynecol* 2010; 116:1056.
7. Terry KL, De Vivo I, Hankinson SE, Missmer SA. Reproductive characteristics and risk of uterine leiomyomata. *Fertil Steril* 2010; 94:2703.
8. Lev-Toaff AS, Coleman BG, Arger PH, et al. Leiomyomas in pregnancy: sonographic study. *Radiology* 1987; 164:375.
9. Rosati P, Exacoustòs C, Mancuso S. Longitudinal evaluation of uterine myoma growth during pregnancy. A sonographic study. *J Ultrasound Med* 1992; 11:511.
10. Klatsky PC, Tran ND, Caughey AB, Fujimoto VY. Fibroids and reproductive outcomes: a systematic literature review from conception to delivery. *Am J Obstet Gynecol* 2008; 198: 357.
11. Lee HJ, Norwitz ER, Shaw J. Contemporary Management of Fibroids in Pregnancy. *Reviews in Obstetrics and Gynecology*. 2010;3(1):20-27.

OB-28~Procedure Coding Basics for Established Pregnancy
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OB-28	Procedure Coding Basis for Eestablished Pregnancy	
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OB-28~Procedure Coding Basics for Established Pregnancy

GENERAL CONSIDERATIONS

A Duplex scan describes:

1. An ultrasonic scanning procedure for characterizing the pattern and direction of blood flow in arteries and veins with the production of real time images integrating B-mode two dimensional vascular structure, and
2. Doppler spectral analysis, and
3. Color flow Doppler imaging

The use of a hand-held or any Doppler device that does not create a hard-copy output is considered part of the physical examination and is not separately billable. This exclusion includes devices that produce a record that does not permit analysis of bi-directional vascular flow.

The minimal use of color Doppler alone, when performed for anatomical structure identification, during a standard ultrasound procedure, is not separately reimbursable.

All obstetric ultrasound studies require permanently recorded images:

- These images may be stored on film or in a Picture Archiving and Communication System (PACS).
- Obstetric ultrasound services may not be billed without image recording.
- The use of a hand-held or any Doppler device that does not create a hard-copy output is considered part of the physical examination and is not separately reimbursable.

Ultrasound procedure codes include the preparation of a required final written report which should be included in the patient's medical record.

- Each procedure code has specific required elements which are described in this section.
- The report should document the results of the evaluation of each element or the reason any element is non-visualized.
- Documentation of less than the required elements requires the billing of the "limited" code for that anatomic region.
- Only one (1) limited exam may be billed per encounter.

OB-28.1 OB Ultrasound Code Selection

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	
The OB ultrasound CPT® codes should be selected based on the following criteria.	
The length of gestation:	• CPT® 76801 and CPT® 76802 are reported for complete studies performed during the first trimester (<14 weeks). • CPT® 76801 and CPT® 76802 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a medical indication for ultrasound. • CPT® 76805 and CPT® 76810 are used to report complete studies performed during the second and third trimester. • CPT® 76805 and CPT® 76810 should only be used once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a medical indication for ultrasound.
The number of fetuses:	• CPT® 76802, CPT® 76810, CPT® 76812, and CPT® 76814 are “add-on” codes used to report each additional fetus.
The imaging approach:	• CPT® 76817 is used to report a transvaginal ultrasound. The other OB ultrasound codes are used for transabdominal studies.
Whether the study is Complete or Limited:	• CPT® 76815 and CPT® 76816 are used to report limited or follow-up studies.
Whether a detailed fetal anatomic evaluation is performed:	• CPT® 76811 and CPT® 76812 describe an extensive fetal ultrasound evaluation and detailed anatomic survey and are used only when the study includes this service. • CPT® 76812 is an add-on for each additional fetus. • Any follow-up ultrasound for CPT® 76811 should be coded as CPT® 76816

OB-28.2 Required Elements for First Trimester OB Ultrasound

A complete first trimester transabdominal ultrasound (CPT® 76801 and CPT® 76802) is defined in CPT® as including the following elements:

- Determination of the number of gestational sacs and fetuses
- Gestational sac/fetal measurements appropriate for gestation (<14 weeks)
- Survey of visible fetal anatomic structures and placental evaluation when possible
- Qualitative assessment of amniotic fluid volume/gestational sac shape
- Examination of maternal uterus and adnexa

CPT® Code Guidance
It may not be possible to visualize the placenta during the early weeks of pregnancy. CPT® 76801 and/or CPT® 76802 may still be appropriately billed if the report documentation indicates placental anatomic structure could not be evaluated due to gestational age.
CPT® 76802 is an ‘add-on’ code reported in conjunction with the ‘primary procedure’ CPT® 76801 to report each additional gestation.
CPT® 76801 and CPT® 76802 should only be reported once per pregnancy unless the mother changes to a new medical caregiver at a new office and there is a medical indication for ultrasound. Follow-up studies to CPT® 76801 and CPT® 76802 should be reported as CPT® 76815 or CPT® 76816.

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

CPT® Code Guidance
A complete second or third trimester transabdominal ultrasound (CPT® 76805 and CPT® 76810) is defined in CPT® as including the following elements: ○ Head, face, and neck ● Lateral cerebral ventricles; ● Choroid plexus; ● Midline falx; ● Cavum septi pellucidi; ● Cerebellum; ● Cistern magna; and ● Upper lip ● A measurement of the nuchal fold may be helpful during a specific age interval to assess the risk of aneuploidy. ○ Chest/Heart ● Four-chamber view; ● Left ventricular outflow tract; and ● Right ventricular outflow tract. ○ Abdomen: ● Stomach (presence, size, and situs); ● Kidneys; ● Urinary bladder; ● Umbilical cord insertion site into the fetal abdomen; and

- Umbilical cord vessel number.
- Spine:
 - Cervical, thoracic, lumbar, and sacral spine.
- Extremities:
 - Legs and arms.
- Genitalia:
 - In multiple gestations and when medically indicated
- Placenta
 - Location
 - Relationship to internal os
 - Appearance
 - Placental cord insertion (when possible)
- Standard evaluation
 - Fetal number
 - Presentation
 - Qualitative or semi qualitative estimate of amniotic fluid
- Maternal anatomy
 - Cervix (transvaginal if cervical length is ≤ 3 cm)
 - Uterus
 - Adnexa
- Biometry
 - Biparietal diameter
 - Head circumference
 - Femur length
 - Abdominal circumference
 - Fetal weight estimate

CPT[®] 76810 is an 'add-on' code used with the 'primary procedure' CPT[®] 76805 to report each additional gestation.

CPT[®] 76805 and CPT[®] 76810 **should only be used once per pregnancy** unless the mother changes to a new medical caregiver at a new office and there is a medical indication for ultrasound. Follow-up studies to CPT[®] 76805 and CPT[®] 76810 should be coded as CPT[®] 76815 or CPT[®] 76816.

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

CPT® Code Guidance
Performance of the specialized fetal anatomic evaluation (CPT® 76811 and CPT® 76812) should be limited to those with special skills to perform this study, such as Maternal Fetal Medicine specialists, Perinatologists, and Radiologists (<i>with advanced training in fetal imaging</i>).
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 ventriclea • 4th ventriclea • Lateral ventriclesb • Cerebellar lobes, vermis, and cisterna magnab • Corpus callosuma • Integrity and shape of cranial vault • Brain parenchyma • Neck • Profile • Coronal face (nose/lips/lensa) • Palate, maxilla, mandible, and tongue • Ear position and size • Orbits ○ Chest/Heart • Aortic arch • Superior and inferior venae cavae • 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
 - Sex
- 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 (16–20 wk)
 - Nasal bone measurement (15–22 wk)
 - Humerus
 - Ulna/radius
 - Tibia/fibula

CPT[®] 76812 is an ‘add-on’ code used with the ‘primary procedure’ CPT[®] 76811 to report each additional gestation.

- These studies are usually performed at 18 – 20 weeks and are most often completed at tertiary referral centers with perinatology departments.
- Only one medically indicated procedure CPT[®] 76811 per pregnancy, per practice (per NPI) is appropriate. *Follow-up studies should be coded as CPT[®] 76815 or CPT[®] 76816

Reference:

1. Wax J, Minkoff H, Johnson A, et al. Consensus report on the detailed fetal Anatomic Ultrasound Examination. J Ultrasound Med 2014; 33:189–195.

OB-28.5 Fetal Nuchal Translucency

CPT[®] Code Guidance

CPT[®] 76813 and **CPT[®] 76814** describe ultrasound measurement of the clear (translucent) space at the back of the fetal neck to assess risk for Down Syndrome (Trisomy 21), Trisomy 18, and other genetic disorders.

- NT is 44-84 mm in CRL size. Gestational age approximately is 11-13 6/7 weeks.
- Biochemistry testing is 10-14 weeks.

The sonographer performing the study and the physician interpreting the study must be credentialed by the Maternal Fetal Medicine Foundation **or** Nuchal Translucency Quality Review Program (NTQR).

- CPT[®] 76814 is an add-on for each additional fetus.

Follow-up studies to CPT[®] 76813 and CPT[®] 76814 should be coded as CPT[®] 76815 or CPT[®] 76816.

Criteria for Nuchal Translucency (NT) Measurement

1. The first trimester screening is typically done between 11 and 13 6/7 weeks (CRL between 44 and 83 millimeters); abnormal Fetal Nuchal Translucency scan (if ≥ 2.5 mm there is an increased risk for aneuploidy, imaging should be based upon the MOM for NT and biochemical markers, ≥ 3.5 mm increased risk for cardiac defects, abdominal wall defects, diaphragmatic hernia, and genetic syndromes in euploid fetuses) during current pregnancy.
2. Margins of NT edges are clear
 - a. Clear image
 - b. Angle of insonation is perpendicular to NT space
 - c. Clear NT lines
3. Fetus in Mid Sagittal plane
 - a. Midsagittal view of fetal spine seen in cervical & thoracic region
 - b. Tip of nose seen in fetal profile
 - c. Third & fourth ventricle seen in CNS
 - d. Should not see ribs, stomach or heart
4. Fetus occupies majority of image
 - a. Image predominately filled by fetal head neck and thorax
 - b. The fetus should occupy $>50\%$ of image
5. Fetal head in neutral position
 - a. Amniotic fluid seen between chin and chest
 - b. Angle <90 degrees
6. Fetus observed away from amnion
7. Measurement
 - a. Use the + calipers
 - b. Place crosshairs on the inner edge, but not in the clear space
 - c. Measurement is perpendicular to long axis of the fetus
 - d. Measure at the widest space and use largest of 3 technically correct measurements

Adapted from Steven L. Warsof, MD, Prof. Ob-Gyn, Eastern Virginia Medical School - Director, Center for Advanced Fetal Therapy

Practice Note

“A nuchal translucency ultrasound consists of nuchal translucency measurement, a fetal crown rump length measurement, and assessment of fetal viability. These are not the components of a 76801 (first trimester ultrasound), therefore a 76801 should not be billed unless you have received permission, in writing, from the health plan to use the 76801 in this manner.” (Society for Maternal Fetal Medicine’s White Paper on Nuchal Translucency Billing 2006/2007:

http://www.ntqr.org/SM/Newsletters/NTEaminer_1.htm, November 10, 2006. Accessed September 30, 2010)

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® 76813/76814) is requested. In cases where there is either a maternal and/or fetal indication, then the CPT® 76801 code can indeed be billed along with the nuchal translucency screening (CPT® 76813/ CPT® 76814).

References:

1. Society for Maternal and Fetal Medicine (SMFM), coding committee. SMFM’s white paper on billing combination of 76801 and 76813.

OB-28.6 Limited and Follow-Up Studies

CPT® Code Guidance
CPT® 76815 describes a limited or “quick look” study used to report one or more of the elements listed in the code definition, i.e. “fetal heart beat, placental location or fluid check (re: modified BPP which is NST with CPT® 76815) ○ Reported only once, regardless of the number of fetuses, and only once per date of service ○ CPT® 76815 should never be reported with complete studies CPT® 76801/ CPT® 76802 and CPT® 76805/ CPT® 76810.
CPT® 76816 describes a follow-up study designed to reassess fetal size or re-evaluate one or more abnormalities previously revealed on ultrasound. ○ CPT® 76816 should be reported once per fetus evaluated in follow-up. ○ Modifier -59 is appropriately used on subsequent codes. For example, a follow-up of a twin pregnancy is reported: CPT® 76816 and CPT® 76816-59. ○ CPT® 76816 should never be reported with complete studies CPT® 76801, CPT® 76802 and CPT® 76805, CPT® 76810.

OB-28.7 Obstetric Transvaginal Ultrasound

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

OB-28.8 Biophysical Profile (BPP)

The BPP combines data from ultrasound imaging and fetal heart rate (FHR) monitoring and is designed to predict the presence or absence of fetal asphyxia and, ultimately the risk of fetal death in the antenatal period (appropriately performed >24 weeks; should NOT be performed prior to the time when the fetus would be viable outside of the uterus).

Typically all components of the BPP, such as breathing, are not present until 26 weeks gestation. However, BPP may be utilized below 26 weeks in cases of FGR (with Doppler studies). The following parameters are evaluated:

- Fetal breathing movements
- Gross fetal body movements
- Fetal tone
- Qualitative amniotic fluid volume, at least one vertical pocket 2 x 2 cm
- Reactive FHR (non-stress testing portion)

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

Practice Note:

If BPP ≤ 6, repeat BPP in 24 hours

OB-28.9 Fetal Doppler

MCA Doppler (CPT® 76821), starting at 34 weeks, if doppler CPT® 76820 is normal.

CPT® Code Guidance
CPT® 76820 describes Doppler velocimetry of the umbilical artery ○ Utilized for known FGR and known oligohydramnios, performed > 22 weeks gestation ○ Known twin to twin transfusion or known discordant twins, may be used <22 weeks and to MD review ○ Its use to predict preeclampsia, and stillbirth is considered investigational.

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

- 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.

Practice Notes

Middle Cerebral Artery Doppler (MCA): Doppler flow studies of the MCA are used in the assessment of the fetus at risk for anemia (see **OB-3~Alloimmunization/Rh Isoimmunization/Other Causes of Fetal Anemia/Parvo/Hydrops**) and monochorionic twin pregnancies (see **OB-17~Multiple Pregnancies**)

In the preterm SGA fetus, middle cerebral artery (MCA) Doppler has limited accuracy to predict acidemia and adverse outcome; it should not be used to time delivery. Most studies investigating MCA Doppler as a predictor of adverse outcome in preterm SGA fetuses have reported low predictive value, especially when umbilical artery Doppler is abnormal. In the largest study of predictors of neonatal outcome in SGA neonates of less than 33 weeks gestational age (n = 604), it was not a statistically significant predictor of outcome on logistic regression, although MCA PI < -2 SDs was associated with neonatal death (LR 1.12, 95% CI 1.04–1.21) and major morbidity (LR 1.12, 95% CI 1.1–1.33).

In the near-term SGA fetus with normal umbilical artery Doppler, an abnormal middle cerebral artery Doppler (PI < 5th centile) has moderate predictive value for acidosis at birth and should be used to time delivery. MCA Doppler may be a more useful test in SGA/FGR fetuses detected after 34 weeks of gestation when umbilical artery Doppler is normal. Based on this evidence it is reasonable to use MCA Doppler to time delivery in the near term-term (34 weeks gestation or greater) SGA/FGR fetus with normal umbilical artery Doppler.

References:

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4. Oros D, Figueras F, Cruz-Martinze R, Meler E, et al. Longitudinal changes in uterine, umbilical and fetal cerebral Doppler indices in late-onset small-for-gestational age fetuses. *Ultrasound Obstet Gynecol* 2011; 37: 191–195. DOI: 10.1002/uog.7738

OB-28.10 Duplex Scan (Uterine Artery)

Uterine artery Duplex (Doppler) scan (CPT® 93976), evaluation has been shown to predict adverse outcomes when **utilized in the first and second trimester, prior to 16 weeks**. The clinical utility however is limited to the

first trimester when low dose Aspirin therapy can be instituted to decrease the risk of adverse outcomes (chronic hypertension, preeclampsia, and possibly FGR). Provider certification, study technique, and abnormal test thresholds have been established by the Fetal Medicine Foundation (similar to certification process for Nuchal Translucency screening). The Society of Maternal Fetal Medicine (SMFM) has recommended the use of **CPT® 93976** only.

Treatment is now possible if started prior to 16 weeks gestation. Therefore, the use of Uterine Artery Doppler evaluation is now justified when utilized before 16 weeks gestation for patients with chronic hypertension or who are at risk for preeclampsia. The CPT® code recommended by SMFM is CPT® 93976 only. Send to Medical Director review if beyond 16 weeks gestation. One time only study.

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

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OB-28.11 Fetal Echocardiography

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

OB-28.12 3D and 4D RENDERING

There is currently insufficient data to generate appropriateness criteria for the use of 3D and 4D rendering in conjunction with ultrasound.

Current guidelines on ultrasonography in pregnancy from ACOG state: "The technical advantages of 3-dimensional ultrasonography include its ability to acquire and manipulate an infinite number of planes and to display ultrasound planes traditionally inaccessible by 2-dimensional ultrasonography. Despite these technical advantages, proof of a clinical advantage of 3-dimensional ultrasonography in prenatal diagnosis in general is still lacking. Potential areas of promise include fetal facial anomalies, neural tube defects, and skeletal malformations where 3-dimensional ultrasonography may be helpful in diagnosis as an adjunct to, but not a replacement for, 2-dimensional ultrasonography."

Yagel et al described the state of the science of 3D/4D ultrasound (3D/4D US) applications in fetal medicine. They noted that 3D/4D US applications are many and varied. Their use in fetal medicine varies with the nature of the tissue to be imaged and the challenges each organ system presents, versus the advantages of each ultrasound application. The investigators stated that 3D/4D US has been extensively applied to the study of the fetus. Fetal applications include all types of anatomical assessment, morphometry and volumetry, as well as functional assessment. The authors concluded that 3D/4D US provides many advantages in fetal imaging; however, its contribution to improving the accuracy of fetal scanning over rates achieved with 2D US, remains to be established.

Clinical use of 3D ultrasound should be on an individual basis. There can be specific reasons that require 3D ultrasound when 2D cannot be utilized. Such as determination of fetal growth when there is absence of lower limbs / femurs. Since, the femur length is vital in determination of fetal weight and growth. Fractional limb volume measurement of the humerus is required to evaluate for FGR.

A second clinical scenario is seen with gastroschisis. Since the fetal abdomen is small due to the defect present, there is artificially high rate of FGR. The cause of this is the use of the fetal abdominal circumference to determine growth. 3D Fractional limb volume measurement eliminates this issue and decreases false positives.

References:

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2. *Obstetrics and Gynecology* 2008; 112:145-157
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4. Merz E¹, Abramowicz JS. 3D/4D ultrasound in prenatal diagnosis: is it time for routine use? *Clin Obstet Gynecol*. 2012 Mar; 55(1):336-51. doi: 10.1097/GRF.0b013e3182446ef7.

OB-28.13 Fetal MRI

- ✓ Fetal MRI (CPT[®] 74712; CPT[®] 74713 for each additional gestation)
- ✓ 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)

Indications for fetal MRI

Fetal MRI may be considered for surgical planning (re: fetal anomalies) and/or if ultrasound is equivocal and additional information is needed for counseling purposes”

Fetal organs	Indication main category	Indication sub category
Brain	Congenital anomalies	Ventriculomegaly; corpus callosal dysgenesis; holoprosencephaly; posterior fossa anomalies; malformations of cerebral cortical development
	Screening fetuses with a family risk for brain anomalies	E.g. tuberous sclerosis; corpus callosal dysgenesis; malformations of cerebral cortical development
	Vascular abnormalities	Vascular malformations; hydranencephaly; infarctions; mono chorionic twin pregnancy complications
Spine	Congenital anomalies	Neural tube defects; sacrococcygeal teratomas; caudal regression/sacral agenesis; sirenomelia; vertebral anomalies

Fetal organs	Indication main category	Indication sub category
Skull, face and neck	Masses of the face and neck	Venolymphatic malformations; hemangiomas; goiter; teratomas; facial clefts
	Airway obstruction	Conditions that may impact parental counseling, prenatal management, delivery planning, and postnatal therapy
Thorax	Masses	Congenital pulmonary airway malformations (congenital cystic adenomatoid malformation; sequestration, and congenital lobar emphysema); congenital diaphragmatic hernia; effusion
	Volumetric assessment of lung	Cases at risk for pulmonary hypoplasia secondary to oligohydramnios, chest mass, or skeletal dysplasias
Abdomen, retroperitoneal and pelvis	Mass	Abdominal–pelvic cyst.; tumors (e.g. hemangiomas, neuroblastomas, sacrococcygeal teratomas, and suprarenal or renal masses); complex genitourinary anomalies (e.g. cloaca); renal anomalies in cases of severe oligohydramnios; and bowel anomalies such as megacystis microcolon
Complications of monochorionic twins		Delineation of vascular anatomy prior to laser treatment of twins; assessment of morbidity after death of a monochorionic co-twin, and improved delineation of anatomy in conjoined twins
Fetal surgery assessment		Meningomyelocele; sacrococcygeal teratomas; processes obstructing the airway (e.g. neck mass or congenital high airway obstruction); complications of monochorionic twins needing surgery; and chest masses.

References:

1. SN Saleem, Fetal MRI: An approach to practice: A review Journal of Advanced Research. Volume 5, Issue 5, September 2014, Pages 507–523
2. American College of Radiology (ACR), Society for Pediatric Radiology (SPR). ACR-SPR practice guideline for the safe and optimal performance of fetal magnetic resonance imaging (MRI). [online publication]. Reston (VA): American College of Radiology (ACR); 2010. p. 10 [cited 2010 October 1] Available from: <http://www.guidelines.gov/content.aspx?id=32509>.

OB-29~High Risk Medications and Substances

Specific drugs that qualify as risk factors in High Risk Pregnancy and qualify as medical indications for Specialized Fetal Anatomic Scan (CPT® 76811):

1. Alcohol
2. Amphetamines
3. Azathioprine
4. Carbamazepine
5. Carbon monoxide
6. Chlordiazepoxide
7. Cocaine
8. Codeine
9. Cortisone
10. Coumadin
11. Cyclophosphamide
12. Cytarabine
13. Daunorubicin
14. Dextroamphetamine
15. Diazepam (valium)
16. Dilantin (hydantoin)
17. Heparin
18. Lithium
19. Methotrexate
20. Methyl mercury
21. Oral contraceptives
22. Paramethadione
23. Penicillamine
24. Primidone
25. Progesterone
26. Quinine
27. Retinoic acid
28. Retinoid medications
29. Substance abuse (heroin, methadone, subutex, cocaine,)
30. Thalidomide
31. Trifluoperazine
32. Trimethadione
33. Valproic acid
34. Other medications or substances with a known teratogenic affect (such as pregnancy Category D or X)

OB-30~Imaging for Planned Pregnancy Termination

For a planned pregnancy termination, ultrasound can be performed.

- One complete ultrasound (CPT[®] 76801) and/or one transvaginal ultrasound (CPT[®] 76817), if less than 14 weeks
- If ≥ 14 weeks, send to MD review.