



## **OBSTETRICAL ULTRASOUND IMAGING GUIDELINES**

*Version 3.0; Effective 02-21-2014*

### **MedSolutions, Inc. Clinical Decision Support Tool for Obstetrical Ultrasound Imaging**

Common symptoms and symptom complexes are addressed by this tool. Imaging requests for patients with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician may provide additional insight.

*This version incorporates MSI accepted revisions prior to 12/31/13*

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## OBSTETRICAL ULTRASOUND IMAGING GUIDELINES

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## ABBREVIATIONS and GLOSSARY for OB ULTRASOUND IMAGING GUIDELINES

<b>ACOG</b>	American College of Obstetricians and Gynecologists
<b>AFI</b>	amniotic fluid index
<b>AFP</b>	alpha-fetoprotein
<b>CST</b>	contraction stress test
<b>B-mode (brightness)</b>	a two dimensional imaging procedure, B-mode ultrasound is the basis for all static and real time B-scan images
<b>BPP</b>	<b>Biophysical Profile.</b> 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
<b>D &amp; C</b>	dilatation and curettage
<b>dichorionic twins</b>	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
<b>Doppler</b>	involves measuring a change in frequency when the motion of vascular flow is measured
<b>EDC</b>	Estimated Date of Confinement; determined from the first day of the last menstrual cycle
<b>FHR</b>	fetal heart rate
<b>hCG</b>	human chorionic gonadotropin
<b>IDDM</b>	insulin-dependent diabetes mellitus
<b>IUGR</b>	intrauterine growth restriction; an estimated or actual weight of the fetus below 10 <sup>th</sup> percentile for gestational age
<b>M-mode</b>	an ultrasound imaging technique in which structure movement can be depicted in a wave-like manner; primarily used in cardiac and fetal cardiac imaging
<b>macrosomia</b>	estimated fetal weight of greater than 4000 or 4500 grams
<b>monochorionic twins</b>	twins developed from one oocyte (egg) developing with a single chorions (membrane that forms the fetal part of the placenta)
<b>NICU</b>	Neonatal Intensive Care Unit
<b>NST</b>	fetal non-stress test
<b>oligohydramnios</b>	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 <sup>th</sup> percentile for gestational age
<b>PACS</b>	Picture Archiving and Communications System
<b>polyhydramnios</b>	excessive amniotic fluid for gestational age; definitions include: .) 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
<b>PROM</b>	preterm rupture of membranes
<b>quad screen</b>	alpha-fetoprotein (AFP), estriol, human chorionic gonadotropin (hCG), inhibin A
<b>real time scan</b>	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**

**Inappropriate Uses of OB Ultrasound**

- ✓ Obstetrical ultrasound studies cannot be authorized for payment for individuals who do not have a positive pregnancy test.
- ✓ Obstetrical ultrasound is **not** appropriate for the following:
  - sex determination only
  - to provide a keepsake or souvenir picture
  - Uterine artery Doppler screening (CPT<sup>®</sup>93975 or CPT<sup>®</sup>93976)
    - Uterine artery Doppler screening shows promise to predict preeclampsia, but there is currently insufficient evidence-based data regarding timing of the study, appropriate serum markers, and time interventions for delivery.

**Practice Notes**

Uterine Artery Doppler: There is currently insufficient data to generate appropriateness criteria for uterine artery Doppler (CPT<sup>®</sup>93975, CPT<sup>®</sup>93976), and this procedure is considered investigational at this time. The evidence does not currently support routine screening with uterine artery Doppler in any patient group. There are no standards for study technique, gestational age, and abnormal test thresholds. Furthermore, there are no published randomized studies that assess the use of uterine artery Doppler in first trimester pregnancies or in high-risk pregnancies.

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**) and monochorionic twin pregnancies (see **OB-17.1**)

In the preterm SGA fetus, middle cerebral artery (MCA) Doppler has limited accuracy to predict acidaemia and adverse outcome; it should not be used to time delivery. In the 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.

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).

However, MCA Doppler may be a more useful test in SGA/IUGR fetuses detected after 32 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/IUGR fetus with normal umbilical artery Doppler.

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12. Severi FM, Bocchi C, Visentin A, Falco P, Cobellis L, Florio P, et al. Uterine and fetal cerebral Doppler predict the outcome of third-trimester small-for-gestational age fetuses with normal umbilical artery Doppler. *Ultrasound Obstet Gynecol* 2002;19:225–8.
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14. Sciscione AC, Hayes EJ. Uterine artery Doppler flow studies in obstetric practice. *American J Obstet Gynecol*, 2009; 121-126.
15. Stampalija T, Alfrevic Z, Gyte G. Doppler in obstetrics: evidence from randomized trials. *Ultrasound Obstet Gynecol*. 2010;36(6):779-80.
16. ACOG Practice Bulletin #134: Fetal Growth Restriction, May 2013.

**OB-1~Abdominal Pain or Trauma**

**OB-1.1 Abdominal Pain or Trauma**

For abdominal pain or trauma that presents without bleeding:	
1.	Ultrasound can be performed (CPT <sup>®</sup> 76815 or CPT <sup>®</sup> 76816, and/or CPT <sup>®</sup> 76817
2.	See also <b><u>OB-28~Vaginal Bleeding</u></b>
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	
Management of outpatient trauma implies that the trauma was not serious enough to be treated as inpatient. The major risk is abruption placentae:	
Monitor for uterine contractions for those >20 weeks which could include BPP (CPT <sup>®</sup> 76818 or CPT <sup>®</sup> 76819).	
<ul style="list-style-type: none"><li>• Women having contractions less than one every 10 minutes during 4 hours of monitoring are not at risk and do not need additional monitoring</li><li>• Women having contractions more frequently (more than one every 10 minutes during 4 hours of monitoring) are at risk and additional monitoring is indicated</li><li>• Ultrasound does not appear to be sensitive in predicting abruption, but an evaluation with CPT<sup>®</sup>76805 (if not previously done) or CPT<sup>®</sup>76815, or CPT<sup>®</sup>76816 can be performed if a complete US was done previously.</li><li>• No further imaging indicated unless cramping and/or bleeding is present</li></ul>	

**Reference**

1. ACOG Educational Bulletin, Number 251, September 1998 (Reaffirmed 2010)

**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):
  - Ultrasound to determine fetal position is not necessary prior to 35 weeks gestation unless delivery is imminent or version is being considered
  - If clinically indicated, an ultrasound can be performed at 35 weeks gestation or greater to determine fetal position

**Coding Notes**

Report one of the following:

- CPT<sup>®</sup>76805 [plus CPT<sup>®</sup>76810 if more than one fetus] if a complete ultrasound has not yet been performed, *or*
- CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816 if a complete ultrasound was performed previously

## OBSTETRICAL ULTRASOUND IMAGING GUIDELINES

### **OB-3~Alloimmunization/Rh Isoimmunization/Other Alloimmunization/Other Causes of Fetal Anemia**

- ✓ Fetal anemia and hydrops may be a result of immune conditions, such as red-cell *or* Kell alloimmunization or non-immune hydrops caused by parvovirus B19 infection.

#### **OB-3.1 Alloimmunization/RH Isoimmunization**

<b>Imaging for RH Isoimmunization:</b>	
1.	Ultrasound (CPT <sup>®</sup> 76815 or CPT <sup>®</sup> 76816) every 2 to 4 weeks to assess fetal growth starting after performance of the fetal anatomic scan at 16-20 weeks
2.	Weekly BPP (CPT <sup>®</sup> 76818 or CPT <sup>®</sup> 76819) or NST starting at 32 weeks or sooner depending on fetal condition
3.	<p>Weekly fetal middle cerebral artery (MCA) Doppler (CPT<sup>®</sup>76821) starting at 20 weeks or sooner depending on fetal condition</p> <p>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</p> <p>Because MCA-PSV increases across gestation, results should be adjusted for gestational age. <b>Measurements can be initiated as early as 16 weeks of gestation if there is a past history of early severe fetal anemia</b>, otherwise Doppler evaluation is begun later since intrauterine intravascular transfusions are very difficult before 20 weeks of gestation. 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.</p>

#### **OB-3.2 Other Alloimmunization**

Requests will be forwarded to Medical Director review.

### **OB-3.3 Other Causes of Fetal Anemia**

- ✓ **Parvovirus B-19** (Fifth Disease): ultrasound (CPT<sup>®</sup>76815 or CPT<sup>®</sup>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<sup>®</sup>76818 or CPT<sup>®</sup>76819) or NST starting at time of known exposure and continuing for 8-10 weeks post-exposure.
  - Weekly fetal middle cerebral artery (MCA) Doppler (CPT<sup>®</sup>76821) starting at time of known exposure and continuing for 8-10 weeks post-exposure
  
- ✓ **Twin anemia polycythemia** sequence: ultrasound (CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816) every 2 to 3 weeks to assess fetal growth.
  - Fetal middle cerebral artery (MCA) Doppler (CPT<sup>®</sup>76821) evaluation of each fetus every 2-3 weeks.

### **Practice Notes**

The use of fetal middle cerebral artery Doppler (CPT<sup>®</sup>76821) for the diagnosis of fetal anemia due to other causes, such as feto-maternal hemorrhage and non-immune hydrops (other than Parvo), has yet to be determined.

Rhesus isoimmunization/alloimmunization is the process through which fetal Rh<sup>+</sup> 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<sup>+</sup> fetus in subsequent Rh<sup>+</sup> 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

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10. ACOG Bulletin No. 4. *Prevention of Rh D Alloimmunization.* May 1999.

**OB-4~AMNIOTIC FLUID ABNORMALITIES**

**OB-4.1 Amniotic Fluid Abnormalities**

<b>For suspected polyhydramnios or oligohydramnios:</b>	
1.	One ultrasound is appropriate
2.	If a complete ultrasound has not yet been performed during this pregnancy, report <u>one</u> of the following: <ul style="list-style-type: none"> <li>• CPT<sup>®</sup>76805 (plus CPT<sup>®</sup>76810 if more than one fetus)</li> </ul>
3.	If a complete ultrasound was done previously, report: <ul style="list-style-type: none"> <li>• CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816</li> </ul>
<b>For confirmed diagnosis of polyhydramnios:</b>	
1.	One ultrasound (CPT <sup>®</sup> 76816) every 2 to 4 weeks for fetal growth
2.	Weekly biophysical profile (BPP) (CPT <sup>®</sup> 76818 or CPT <sup>®</sup> 76819) or AFI CPT 76815, or NST (CPT <sup>®</sup> 59025)
<b>For confirmed diagnosis of oligohydramnios:</b>	
1.	One ultrasound (CPT <sup>®</sup> 76816) every 2 to 4 weeks for fetal growth
2.	Weekly biophysical profile (BPP) (CPT <sup>®</sup> 76818 or CPT <sup>®</sup> 76819), or AFI CPT 76815, or NST (CPT <sup>®</sup> 59025)
3.	Weekly umbilical artery Doppler (CPT <sup>®</sup> 76820)

**Practice Notes**

Polyhydramnios refers to excessive amniotic fluid volume. At 30 weeks or greater, it is determined with AFI greater than 24cm, or maximum deepest vertical pocket equal to or greater than 8cm.

Oligohydramnios refers to diminished amniotic fluid volume. At 30 weeks or greater, it is determined with AFI less than 5cm or maximum vertical pocket less than 2cm.. At less than 30 weeks, oligohydramnios is determined by AFI less than 10.

Polyhydramnios is an early presenting finding of fetal hydrops associated with fetal anemia. Middle cerebral artery Doppler is commonly used to diagnose whether this condition is present or not.

**References**

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**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 0/7
  - Reported as CPT<sup>®</sup>76805 unless a detailed fetal anatomic scan (CPT<sup>®</sup>76811) is performed by a Maternal Fetal Medicine (MFM) specialist, Perinatologist, Radiologist, or AIUM or ACR accredited facilities as the screening anatomic study.
  - Pregnancy must be high risk to support CPT<sup>®</sup>76811.  
See: **OB-11~High Risk Pregnancy**

**OB-5.2 Follow-Up**

- ✓ Follow-up ultrasound (CPT<sup>®</sup>76816) can be performed if there were equivocal or abnormal findings on the initial Fetal Anatomic Scan.
  - Additional follow-up ultrasounds (CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816) can be performed every 2 to 4 weeks to evaluate fetal growth if known fetal anomaly or if pregnancy is high risk.

## Coding Notes

Fetal Anatomic Scan Coding Notes	
CPT <sup>®</sup> 76805	<p>A complete transabdominal ultrasound (CPT<sup>®</sup>76805) is defined in CPT<sup>®</sup> as including the following elements:</p> <ul style="list-style-type: none"> <li>• Determination of the number of fetuses and amniotic/chorionic sacs</li> <li>• Measurements appropriate for gestation (≥14 weeks)</li> <li>• Survey of intracranial/spinal/abdominal anatomy</li> <li>• Four-chambered heart</li> <li>• Umbilical cord insertion site</li> <li>• Placenta location</li> <li>• Amniotic fluid assessment</li> <li>• Examination of maternal adnexa, when visible</li> </ul>
CPT <sup>®</sup> 76810	CPT <sup>®</sup> 76810 is an add-on code used with the primary procedure CPT <sup>®</sup> 76810 to report each additional fetus if there is a multiple gestation
CPT <sup>®</sup> 76805 CPT <sup>®</sup> 76810	CPT <sup>®</sup> 76805 and CPT <sup>®</sup> 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 <sup>®</sup> 76805 CPT <sup>®</sup> 76810 CPT <sup>®</sup> 76811 CPT <sup>®</sup> 76812	<p>CPT<sup>®</sup>76811 and CPT<sup>®</sup>76812 are defined in CPT<sup>®</sup> as including all of the requirements listed for procedures CPT<sup>®</sup>76805 and CPT<sup>®</sup>76810. The pregnancy must be considered “high risk” to support CPT<sup>®</sup>76811 and CPT<sup>®</sup>76812. In addition, the report must also document detailed anatomic evaluation of the following elements:</p> <ul style="list-style-type: none"> <li>• Fetal brain/ventricles</li> <li>• Face</li> <li>• Heart/outflow tracts and chest anatomy</li> <li>• Abdominal organ-specific anatomy</li> <li>• Number/length/architecture of limbs</li> <li>• Detailed evaluation of the umbilical cord and placenta</li> <li>• Other fetal anatomy as clinically indicated</li> </ul>
CPT <sup>®</sup> 76812	CPT <sup>®</sup> 76812 is an add-on code used with the primary procedure CPT <sup>®</sup> 76812 to report each additional fetus in a multiple gestation.
CPT <sup>®</sup> 76811	The reporting of CPT <sup>®</sup> 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](http://www.askleslie.net/rads/White_Paper_on_Ultrasound_Code_76811.pdf). Accessed May 10, 2010

**OB-6~Fetal Distress/Decreased Fetal Movement**

**OB-6.1 Fetal Distress**

**The following is supported during the second or third trimester:**

1.	<p>If greater than or equal to 22 weeks, initial evaluation is usually by fetal non-stress test (NST) with AFI or contraction stress test (CST) and amniotic fluid index (AFI). The standard is NST AFI combined.</p> <p>No imaging is necessary if NST is reactive and AFI is normal or CST is negative, but if NST has not been done, ultrasound can be performed.</p> <p>CPT<sup>®</sup>76805 if a complete ultrasound has not yet been performed during this pregnancy [plus CPT<sup>®</sup>76810 if more than one fetus], or CPT<sup>®</sup>76816 if a complete ultrasound was done previously</p>
2.	<p>Ultrasound is appropriate to confirm suspected fetal death if less than 22 weeks gestation, report one of the following:</p> <ul style="list-style-type: none"> <li>• CPT<sup>®</sup>76805 if a complete ultrasound has not yet been performed during this pregnancy [plus CPT<sup>®</sup>76810 if more than one fetus], or</li> <li>• CPT<sup>®</sup>76816 if a complete ultrasound was done previously, and/or</li> <li>• CPT<sup>®</sup>76817 for a transvaginal ultrasound</li> </ul>
3.	<p>Ultrasound if appropriate to confirm suspected fetal death if greater than or equal to 22 weeks gestation, report <u>one</u> of the following:</p> <ul style="list-style-type: none"> <li>• CPT<sup>®</sup>76805 if a complete ultrasound has not yet been performed during this pregnancy [plus CPT<sup>®</sup>76810 if more than one fetus],or</li> <li>• CPT<sup>®</sup>76816 if a complete ultrasound was done previously, or</li> <li>• CPT<sup>®</sup>76818 or CPT<sup>®</sup>76819 for biophysical profile or CPT<sup>®</sup>76815 (AFI) can be substituted for a BPP but not ordered on the same day of service.</li> </ul>

**OB-7~Fetal Echocardiography (ECHO)**

**OB-7.1 Indications for Fetal Conditions**

**Fetal echocardiography, Doppler echocardiography and Doppler color flow velocity mapping can be ordered together or separately for the following fetal conditions:**

1.	Transabdominal fetal echo should <u>NOT</u> be performed prior to 16 weeks
2.	Abnormal or suspected abnormal fetal cardiac evaluation on fetal anatomic scan: <ul style="list-style-type: none"> <li>• There must be documentation (provided as hard copy or acknowledged verbally by provider) that the four chamber cardiac study was abnormal on the anatomic scan in order for fetal echo to be indicated</li> </ul>
3.	If a heart abnormality is found <u>after 22 weeks gestation</u> , a Fetal ECHO (CPT <sup>®</sup> 76825 or CPT <sup>®</sup> 76826) may be approved for preparation of delivery.
4.	Suspected or known fetal arrhythmia (to define the rhythm and its importance)
5.	To identify fetal structural cardiac disease and evaluate fetal cardiac function
6.	Known fetal <b>extra</b> -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 at <u>22-26 weeks gestation</u> if maternal non-diet-controlled diabetes is present (See <b><u>OB-11~High Risk Pregnancy</u></b> )
9.	Suspected or known fetal chromosomal abnormalities (fetal aneuploidy)
10.	Single umbilical artery (see <b><u>OB-5~Fetal Anatomic Scan</u></b> )
11.	Non-immune fetal hydrops (See <b><u>OB-3.3 Fetal Anemia</u></b> )
12.	Monochorionic twins
13.	IVF pregnancies
14.	<ul style="list-style-type: none"> <li>○ Exposure of fetus to:                     <ul style="list-style-type: none"> <li>• Lithium</li> <li>• Excessive alcohol</li> <li>• Anti-seizure medication</li> <li>• SSRI</li> </ul> </li> <li>○ Birth control pills</li> <li>○ Other teratogen exposure to the fetus with a known association for cardiac anomalies</li> </ul>
15.	Abnormal Fetal Nuchal Translucency scan (>3.4mm) during current pregnancy. <ul style="list-style-type: none"> <li>• Can also perform CPT<sup>®</sup>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<sup>®</sup>76816.</li> </ul>

## OB-7.2 Indications for Maternal Conditions

<b>For Maternal Conditions:</b>	
1.	Presence of maternal lupus
2.	Presence of other maternal conditions associated with cardiac anomalies (such as phenylketonuria)
3.	Family history of a first degree relative to the fetus with a congenital heart defect.

### Coding Notes

- ✓ Requests for repeat fetal echo will be forwarded to Medical Director review.
- ✓ CPT<sup>®</sup>76825 and CPT<sup>®</sup>76827 are performed only once per fetus
- ✓ Follow-up echocardiograms are reported as CPT<sup>®</sup>76826
- ✓ Follow-up Doppler fetal echocardiograms are reported as CPT<sup>®</sup>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<sup>®</sup> codes for the **initial** echo:
  - CPT<sup>®</sup>76825 and/or **CPT<sup>®</sup>76827** and/or **CPT<sup>®</sup>93325** (add on code for color mapping)
  - Requests for studies CPT<sup>®</sup>76826 and/or CPT<sup>®</sup>76828 (limited/follow-up study) will be forwarded to Medical Director review.

### References

1. ACC/AA/ASE Committee to Update the 1997 Guidelines for the Clinical Application of Echocardiography, 2003;42(5):954-970.

**OB-8~FETAL GROWTH PROBLEMS**

**OB-8.1 Intrauterine Growth Restriction-Small for dates**

The ACOG definition of Intrauterine Growth Restriction (IUGR): Estimated or actual weight of the fetus below 10<sup>th</sup> percentile for gestational age. “Abdominal Circumference <10<sup>th</sup> percentile” also defines IUGR.

For <b>Suspected</b> IUGR:	
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 <sup>®</sup> 76805 [plus CPT <sup>®</sup> 76810 if more than one fetus], if a complete ultrasound has not yet been performed during this pregnancy, or CPT <sup>®</sup> 76815 or CPT <sup>®</sup> 76816 if a complete ultrasound was performed previously.)
2.	In order to evaluate fetal growth and confirm the diagnosis of IUGR following the initial ultrasound, one follow-up ultrasound (CPT <sup>®</sup> 76816) can be performed 2 weeks following the initial ultrasound
3.	For clinical situations that have a higher probability of IUGR such as maternal hypertension, maternal diabetes, previous stillbirth, etc., see <b><u>OB-11~High Risk Pregnancy</u></b> , or the specific guidelines for these clinical entities for guidelines regarding follow-up ultrasounds to assess fetal growth
For <b>Known</b> IUGR:	
1.	Ultrasound (CPT <sup>®</sup> 76815 or CPT <sup>®</sup> 76816) every 2 to 4 weeks to assess fetal growth
2.	Weekly BPP (CPT <sup>®</sup> 76818 or CPT <sup>®</sup> 76819) or NST
3.	Weekly umbilical artery Doppler (CPT <sup>®</sup> 76820)
4.	MCA Doppler may be a useful test in SGA/IUGR fetuses detected after 32 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/IUGR fetus with normal umbilical artery Doppler. (See: <b><u>OB-General Guidelines</u></b> )

## **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).

See also **OB-16~Macrosomia**

For <b>Suspected</b> 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, one ultrasound can be performed to evaluate for macrosomia if clinically indicated (report <u>one</u> of the following: CPT <sup>®</sup> 76805 [plus CPT <sup>®</sup> 76810 if more than one fetus] if a complete ultrasound has not yet been performed, or CPT <sup>®</sup> 76815 or CPT <sup>®</sup> 76816 if a complete ultrasound was done previously)
For <b>Known</b> Macrosomia:	
1.	Repeat imaging is generally not necessary unless needed to plan for delivery and is not usually indicated prior to 37 weeks gestation

## **References**

1. American College of Obstetricians and Gynecologists (ACOG). Fetal growth restriction. Washington (DC): American College of Obstetricians and Gynecologists; 2013 May. (ACOG Practice Bulletin no. 134.)
2. *Obstetrics and Gynecology* 2008;112:145-157
3. ACOG Practice Bulletin No.12: *Intrauterine Growth Restriction*. Reaffirmed 2008
4. ACOG Practice Bulletin No. 22: *Fetal Macrosomia*. 2000

**OB-9~FETAL HEART TONE**

**OB-9.1 Fetal Heart Tone**

The following is performed during the **First Trimester**:

Prior to considering ultrasound or other imaging for absence of fetal heart tone, evaluation of Fetal Heart Tones 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 *one* of the following:
  - CPT<sup>®</sup>76801 (plus CPT<sup>®</sup>76802 if more than one fetus) if a complete ultrasound has not yet been performed
  - CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816 if a complete ultrasound was performed previously; *and/or*
  - CPT<sup>®</sup>76817 for a transvaginal ultrasound

For absent fetal heart tones in the **Second or Third Trimesters**:

See **OB-6~Fetal Distress**

**OB-10~First Trimester Screening**

**OB-10.1 First Trimester Screening**

The first trimester screen measures biochemical markers and fetal nuchal translucency (FNT). Conducted together, these screenings can identify risk for specific chromosomal abnormalities (e.g. Down’s syndrome, Trisomy-18). The first trimester screening is typically done between 11 and 13 6/7 weeks; abnormal Fetal Nuchal Translucency scan ( $\geq 2.5\text{mm}$ ) during current pregnancy.

<b>First Trimester Screening:</b>	
1.	Ultrasound is the initial imaging for the first trimester screening, to evaluate fetal nuchal translucency.
2.	If the ultrasound is abnormal, the following tests can be performed: <ul style="list-style-type: none"> <li>• Fetal anatomic ultrasound at 16 weeks or greater weeks may be performed</li> <li>• Amniocentesis</li> <li>• CVS</li> </ul>
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 <sup>®</sup> 76825/ CPT <sup>®</sup> 76827) and fetal ultrasound (CPT <sup>®</sup> 76811).

**Coding Notes**

- ✓ CPT<sup>®</sup>76813 and CPT<sup>®</sup>76814 should be performed only by those certified by the Fetal Medicine Foundation or NTQR.
- ✓ Report as CPT<sup>®</sup>76813 (plus CPT<sup>®</sup>76814 if more than one fetus)
- ✓ CPT<sup>®</sup>76813 can be performed once per pregnancy if the pregnancy is 11 0/7 to 13 6/7 weeks gestation.
- ✓ If FNT is abnormal, CPT<sup>®</sup>76811 is usually performed by a Maternal Fetal Medicine (MFM) specialist, Perinatologist, or Radiologist after 16 weeks.

**References**

1. ACOG Practice Bulletin No.77: *Screening for fetal chromosomal abnormalities*. Jan. 2007.
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](http://www.acog.org/publications/patient_education/bp165.cfm). Accessed May 3, 2010
4. ACOG Practice Bulletin No. 44: *Neural Tube Defects*. July 2003.

**OB-11~HIGH RISK PREGNANCY**

<b>OB-11</b>	<b>Section Title</b>	
<b>11.1</b>	<b>Risk Factors</b>	<b>23</b>
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<b>11.3</b>	<b>Follow-Up Studies</b>	<b>26</b>
<b>11.4</b>	<b>SPECIAL CONSIDERATIONS</b>	
<b>11.4.1</b>	<b>Diabetes</b>	<b>27</b>
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## OBSTETRICAL ULTRASOUND IMAGING GUIDELINES

### **OB-11~HIGH RISK PREGNANCY**

#### **OB-11.1 Risk Factors**

Patients who have at least one of the following risk factors are classified as having a high-risk pregnancy.

<b>HIGH RISK PREGNANCY – Risk Factors</b>
<b>Socio-Demographic Risk Factors</b>
Pregnant women less than or equal to 17 years of age
Pregnant women greater than or equal to 35 years of age
<b>Lifestyle Related Risk Factors</b>
Drug or alcohol use during pregnancy
Maternal history of substance abuse
10 or more cigarettes a day (1/2 pack a day)
<b>Health Condition Related Risk Factors</b>
Acquired Immune Deficiency Syndrome
Anemia, severe, less than 8 grams Hgb or 24% Hct
Antiphospholipid Syndrome
Asthma - if poorly controlled or steroid dependent
Cardiac disease
Chronic liver disease
Chronic medical condition that may affect fetal growth due to utero-placental insufficiency
Diabetes that requires oral medication or insulin
Gastroschisis in current pregnancy
Heart disease – New York Heart Association class III or IV or arrhythmia
Hemoglobinopathies, including sickle cell disease, not sickle cell trait
Hypertension
History of fertility drugs and treatment
HIV Positive
Kidney disease such as pyelonephritis, glomerulonephritis, lupus, or persistent protein in the urine
Maternal blood clotting disorder (Antiphospholipid Syndrome, Factor V Leiden mutation, Antithrombin III deficiency, Protein C/Protein S deficiency, etc.)
Obesity (BMI greater than 30)
Renal disease
Rh sensitization (titers greater than 1/8)
Seizure disorders
Sickle cell disease (SS) NOT sickle cell trait (AS, SC, etc)
Subchorionic or placental hematoma (known)
Systemic lupus
Systemic malignancy
Syphilis, untreated
Thrombophilia - hereditary and acquired such as Factor V Leiden Mutation
Poorly controlled hyperthyroidism
Tuberculosis
Vaginal bleeding

*Risk Factors are continued on next page . . . . .*

*Risk Factors continued . . . . .*

**OB-11.1 Risk Factors continued . . .**

Patients who have at least one of the following risk factors are classified as having a high-risk pregnancy.

<b>HIGH RISK PREGNANCY – Risk Factors</b>
<b>Current Pregnancy Related Risk Factors</b>
Abdominal pain
Abruptio placenta
Antepartum hemorrhage
Breech presentation without mention of version
Conception with assisted reproductive technologies
Excessive fetal growth
Fetal indications/diagnosed fetal anomaly/abnormality
Gestational diabetes
Grand multiparity
Known chromosomal abnormalities
RH Isoimmunization / Alloimmunization
Multiple gestation
No prenatal care prior to 28 weeks
Oligohydramnios
Placenta previa and vasa previa
IUGR
Polyhydramnios
Postmaturity
Pre-eclampsia, eclampsia, PIH
Pregnancy related complications during current pregnancy
Premature rupture of membranes and/or premature labor with estimated fetal weight of $\geq 2000$ grams
Single umbilical artery
Threatened abortion
<b>Previous Pregnancy Related Risk Factors</b>
Pregnancy-related complications during a previous pregnancy
History of two or more miscarriages (less than 20 weeks)
History of late fetal death (greater than or equal to 20 weeks)
Two or more elective terminations of pregnancy
Prior NICU infant (NICU Level III, or greater than 24 hours)
Two or more low birth weight infants
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)
Multiple pregnancies (twins or greater)
Chromosomal abnormalities with previous pregnancy

## **OB-11.2 Imaging**

1.	<p>Perform <u>one</u> ultrasound in the first trimester to establish dates, and report <u>one</u> of the following:</p> <ul style="list-style-type: none"><li>• CPT<sup>®</sup>76801 [plus CPT<sup>®</sup>76802 if more than one fetus] if a complete ultrasound has not yet been performed, or</li><li>• CPT<sup>®</sup>76813 if between 11 0/7 to 13 6/7 weeks gestation and fetal nuchal translucency scan is being performed, or</li><li>• CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816 if a complete ultrasound was done previously, and CPT<sup>®</sup>76817 for a transvaginal ultrasound if indicated</li></ul>
2.	<p><b>CPT<sup>®</sup>76811</b> can be approved when <u>all of the following</u> criteria are met:</p> <ul style="list-style-type: none"><li>• Pregnancy diagnosed as High Risk per <b><u>OB-11.1</u></b>.</li><li>• Ordered by a Specialist (MFM, Perinatology, Radiology) <b><u>or</u></b> if an OB is ordering CPT<sup>®</sup>76811 and the facility is privileged to perform.</li><li>• The patient's gestation is 16 weeks or greater.</li><li>• There is no prior approval for a CPT<sup>®</sup>76811 for the current pregnancy.</li></ul>
3.	<p>Perform one fetal anatomic scan at 16 weeks or greater. See: <b><u>OB-5~Fetal Anatomic Scan</u></b></p>

### **OB-11.3 Follow-Up Studies**

<b>Follow-up Imaging for High Risk Pregnancy</b>	
1.	Ultrasound for fetal growth (CPT <sup>®</sup> 76815 or CPT <sup>®</sup> 76816) every 2 to 4 weeks starting after performance of the fetal anatomic scan at 16-20 weeks.
2.	Follow-up biophysical profile (BPP) or NST studies: <ul style="list-style-type: none"><li>• Weekly BPP (CPT<sup>®</sup>76818 or CPT<sup>®</sup>76819; CPT<sup>®</sup>76815 AFI); or</li><li>• NST starting at 32 weeks</li></ul>
3.	Earlier surveillance studies starting at 26 weeks or as described in the particular guideline can be considered for the following: <ul style="list-style-type: none"><li>• Multiple risk factors</li><li>• Collagen vascular disease (such as Antiphospholipid Syndrome)</li><li>• Steroid-dependent or poorly controlled asthma</li><li>• Impaired maternal renal function</li><li>• Maternal heart disease</li><li>• IUGR (see <b><u>OB-8~Fetal Growth Problems</u></b>)</li></ul>

## **OB-11.4 SPECIAL CONSIDERATIONS**

**Diabetes, hypertension, and single umbilical artery** are high risk conditions that require additional imaging. The tables in the following sections address these high risk conditions.

### **OB-11.4.1 Diabetes**

<b>DIABETES: Maternal Diet Controlled</b>			
<b>Test</b>	<b>When</b>	<b>Frequency</b>	<b>Codes</b>
Fetal anatomic scan	16 to 20 weeks***	Once	CPT®76805 CPT®76811
Ultrasound (for fetal growth)	Starting at 35 weeks	Every 2 to 4 weeks	CPT®76816*
Biophysical Profile* (BPP) or NST**	Starting at 35 weeks	Up to 2 times per week	CPT®76818 or CPT®76819 (BPP) CPT®59025 (NST)*
<b>Maternal diet-controlled diabetes</b> refers to patients that have a diagnosis of any type of diabetes, but require no medication for their diabetes.			
*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 MedSolutions for any health plan.			
***If there has not been a prior anatomical scan, this can be done at greater than 20 weeks.			

*Diabetes continued next page . . . .*

## **OB-11.4 SPECIAL CONSIDERATIONS**

### **OB-11.4.1 Diabetes *continued . . .***

<b>DIABETES: Maternal Non-Diet-Controlled</b>			
<b>Test</b>	<b>When</b>	<b>Frequency</b>	<b>Codes</b>
Fetal anatomic scan	16 to 20 weeks***	Once	CPT®76805 CPT®76811
Fetal echo	22-26 weeks	Once	
Biophysical Profile (BPP) or NST*	If complicated by additional high risk factors, perform between 26 & 28 weeks	Weekly	CPT®76818 or CPT®76819 (BPP) CPT®59025 (NST)*
Ultrasound (for fetal growth)	Starting at 28 weeks	Every 2 to 4 weeks	CPT®76816*
Biophysical Profile* (BPP) or NST**	Starting at 32 weeks	Up to 2 times/week	CPT®76818 or CPT®76819 (BPP) CPT®59025 (NST)*
Umbilical artery Doppler (if IUGR diagnosed)	Upon diagnosis of IUGR	Weekly	CPT®76820
<p><b>Maternal non-diet-controlled diabetes</b> refers to patients that have any type of diabetes, and their diabetes requires medication. This includes Type 2 diabetes on diabetic medication, gestational diabetes on diabetic medication, insulin dependent diabetes [IDDM].</p>			
<p>For a poorly controlled diabetic, a <b>repeat fetal echocardiogram</b> may be considered at 32-36 weeks gestation to evaluate for diabetic associated septal hyperplasia.</p>			
<p>*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 MedSolutions for any health plan.            ***If there has not been a prior anatomical scan, this can be done at greater than 20 weeks.</p>			

## **OB-11.4 SPECIAL CONSIDERATIONS**

### **OB-11.4.2 Hypertension**

<b>HYPERTENSIVE DISORDERS IMAGING</b>	
<b>Maternal chronic hypertension <u>not on</u> prescribed HTN medication:</b>	
One US at 16-20 weeks; and one US at 30-34 weeks only	CPT <sup>®</sup> 76816
<b>Maternal chronic hypertension <u>on</u> prescribed HTN medication:</b>	
One US at 16-20 weeks; and US every 2 to 4 weeks	CPT <sup>®</sup> 76816
Starting at 32 weeks, weekly biophysical profile (BPP) or NST*	CPT <sup>®</sup> 76818 or CPT <sup>®</sup> 76819
If diagnosed IUGR, weekly umbilical artery Doppler	CPT <sup>®</sup> 76820
<b>Maternal chronic hypertension <u>on</u> prescribed HTN medication <u>PLUS</u> other risk factors:</b>	
Starting at 26-28 weeks, weekly biophysical profile (BPP) or NST*	CPT <sup>®</sup> 76818 or CPT <sup>®</sup> 76819
<b>Maternal pregnancy-induced hypertension (PIH, preeclampsia, toxemia):</b>	
US every 2 to 4 weeks starting at time of diagnosis	CPT <sup>®</sup> 76815 or CPT <sup>®</sup> 76816
Weekly BPP or NST* starting at time of diagnosis	CPT <sup>®</sup> 76818 or CPT <sup>®</sup> 76819
Weekly umbilical artery Doppler	CPT <sup>®</sup> 76820
<b>If IUGR or oligohydramnios is present:</b>	
Twice weekly BPP or NST*	CPT <sup>®</sup> 76818 or CPT <sup>®</sup> 76819
Twice weekly umbilical artery Doppler	CPT <sup>®</sup> 76820
MCA Doppler (CPT <sup>®</sup> 76821) may be a more useful test in SGA/IUGR fetuses detected after 32 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/IUGR fetus with normal umbilical artery Doppler.	
*NST (CPT <sup>®</sup> 59025) is not currently prior authorized by MedSolutions for any health plan	

## **OB-11.4 SPECIAL CONSIDERATIONS**

### **OB-11.4.3 Single Umbilical Artery**

<b>SINGLE UMBILICAL ARTERY</b>	
Detailed anatomic ultrasound at 16 weeks or greater	CPT <sup>®</sup> 76811
Fetal echocardiogram at 22-24 weeks	CPT <sup>®</sup> 76825 and/or CPT <sup>®</sup> 76827 and/or CPT <sup>®</sup> 93325
Follow-up ultrasound to evaluate fetal growth at 28-32 weeks and then every 2 to 4 weeks	CPT <sup>®</sup> 76816

### **References**

1. ACOG Practice Bulletin No.30: *Gestational Diabetes*. Reaffirmed 2008 *Diabetes Care* 2007 July; 30(Supplement 2)
2. ACOG Practice Bulletin No.101: *Ultrasonography in pregnancy*. February 2009
3. ACOG Practice Bulletin No. 132: *Antiphospholipid Syndrome*. December 2012.
4. ACOG Practice Bulletin No. 125: *Chronic Hypertension in Pregnancy*. February 2012.
5. ACOG Practice Bulletin No. 9: *Antepartum Fetal Surveillance*. October 1999.
6. ACOG Practice Bulletin No. 137: *Gestational Diabetes Mellitus*. August 2013.
7. ACOG Practice Bulletin No. 33: *Diagnosis and Management of Preeclampsia and Eclampsia*. January 2002.
8. ACOG Practice Bulletin No. 78: *Hemoglobinopathies in Pregnancy*. January 2007.
9. ACOG Practice Bulletin No. 124: *Inherited Thrombophilia in Pregnancy*. September 2011.

**OB-12~History of Infertility**

**OB-12.1 History of Infertility in Prior Pregnancy**

- ✓ Ultrasound imaging is supported if there is a history of infertility treatment (CPT<sup>®</sup>76801 [plus CPT<sup>®</sup>76802 if more than one fetus] if a complete ultrasound has not yet been performed, CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816 if a complete ultrasound was done previously, and/or CPT<sup>®</sup>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-11.2**

**OB-13~History of Pregnancy Loss**

**OB-13.1: History of Pregnancy Loss**

**History of Two or More Pregnancy Losses at Less than 14 Weeks:**

Ultrasound is supported:

- CPT<sup>®</sup>76801 [plus CPT<sup>®</sup>76802 if more than one fetus];
- If a complete ultrasound has not yet been performed, CPT<sup>®</sup>76815; or
- CPT<sup>®</sup>76816 if a complete ultrasound was done previously; and/or
- CPT<sup>®</sup>76817 for a transvaginal ultrasound

**History of One or More Pregnancy Losses at 20 Weeks or Greater:**

Ultrasound is supported:

- CPT<sup>®</sup>76805 [plus CPT<sup>®</sup>76810 if more than one fetus];
- If a complete ultrasound has not yet been performed, CPT<sup>®</sup>76815; or
- CPT<sup>®</sup>76816 if a complete ultrasound was done previously; and/or
- CPT<sup>®</sup>76817 for a transvaginal ultrasound

**Reference**

1. ACOG Practice Bulletin No. 102. *Management of Stillbirth*. March 2009.

**OB-14~Incompetent Cervix/Preterm Labor/Preterm Delivery**

**OB-14.1 Incompetent Cervix**

1.	Ultrasound is supported at 16 to 18 weeks for known or suspected incompetent cervix in order to evaluate cervical length: (CPT <sup>®</sup> 76805 [plus CPT <sup>®</sup> 76810 if more than one fetus] if a complete ultrasound has not yet been performed during this pregnancy, CPT <sup>®</sup> 76816 if a complete ultrasound was done previously, and/or CPT <sup>®</sup> 76817 for a transvaginal ultrasound). Ultrasound can be used earlier if there are known risk factors.
2.	<p>Ultrasound (CPT<sup>®</sup>76816 and/or CPT<sup>®</sup>76817) can be performed every 2 to 4 weeks, starting at 16-18 weeks for the following:</p> <ul style="list-style-type: none"> <li>• Precipitous delivery</li> <li>• Surgical trauma to cervix (e.g. conization [CKC—cold-knife conization] or Loop Electrosurgical Excision Procedure [LEEP])</li> <li>• Overdilation of cervix during a termination of pregnancy</li> <li>• Cervical obstetrical laceration from a previous delivery</li> <li>• Preterm labor with current pregnancy</li> <li>• Personal history of incompetent cervix</li> <li>• Personal history of preterm delivery</li> <li>• Personal history of preterm labor with preterm delivery</li> <li>• Personal history of premature rupture of membranes</li> <li>• Cerclage in place in current or past pregnancy</li> <li>• Presence of uterine anomaly</li> <li>• Current pregnancy is twins, triplets, or other multiple gestation</li> <li>• Shorten cervix (25-30mm prior to 32-35 weeks gestation)</li> </ul>
3.	If funneling or abnormally shorten cervix less than 25 mm <32-35 weeks gestation is found, ultrasound (CPT <sup>®</sup> 76816 and/or CPT <sup>®</sup> 76817) can be performed weekly

**OB-14.2 Personal History of Preterm Delivery**

- ✓ For individuals with a history of preterm delivery, use ultrasound guidelines above in: **OB-14.1 Incompetent Cervix.**

**References**

1. ACOG Practice Bulletin No.48: *Cervical Insufficiency*. Reaffirmed 2008
2. ACOG Practice Bulletin No. 127: *Management of Preterm Labor*. June 2012.

**OBSTETRICAL ULTRASOUND IMAGING GUIDELINES**

**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<sup>®</sup> 76801 if a complete ultrasound has not yet been performed, CPT<sup>®</sup> 76815 or CPT<sup>®</sup> 76816 if a complete ultrasound was done previously, and/or CPT<sup>®</sup> 76817 for a transvaginal ultrasound)

**OBSTETRICAL ULTRASOUND IMAGING GUIDELINES**

**OB-16~MACROSOMIA**

See **OB-8~Fetal Growth Problems**

## OBSTETRICAL ULTRASOUND IMAGING GUIDELINES

### **OB-17~Multiple Pregnancies**

#### **OB-17.1 Multiple Pregnancies**

##### **For Suspected multiple pregnancies:**

Ultrasound is appropriate to confirm **suspected** multiple pregnancy (CPT<sup>®</sup>76801 or CPT<sup>®</sup>76805 if a complete ultrasound has not yet been performed during this pregnancy, CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816 if a complete ultrasound was done previously, and/or CPT<sup>®</sup>76817 for a transvaginal ultrasound)

##### **For Known multiple pregnancies:**

Follow-up ultrasounds for all **known** multiple pregnancies (CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816 and/or CPT<sup>®</sup>76817):

1.
  - Ultrasound (CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816 and CPT<sup>®</sup>76817) every 2 to 4 weeks to assess fetal growth starting at 16 weeks gestation
  - Transvaginal ultrasound (CPT<sup>®</sup>76817) every 2-4 weeks to assess cervical length
  - Weekly BPP (CPT<sup>®</sup>76818 or CPT<sup>®</sup>76819) or NST starting at 24 weeks
    - Twice weekly BPP can be considered in rare clinical circumstances. These requests will be forwarded for Medical Director review.
  - If IUGR is diagnosed, weekly umbilical artery Doppler (CPT<sup>®</sup>76820)

2. In addition to the imaging listed above, diamniotic-monochorionic or monoamniotic-monochorionic twins also receive:

- Weekly or twice weekly fetal middle cerebral artery (MCA) Doppler (CPT<sup>®</sup>76821) starting at 28 weeks
- If Twin to Twin Transfusion syndrome is suspected due to one twin failing to grow compared with the other twin, daily evaluation (CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816, and/or CPT<sup>®</sup>76818 or CPT<sup>®</sup>76819) and/or umbilical artery Doppler (CPT<sup>®</sup>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<sup>®</sup>76816) every 2 to 4 weeks, AND umbilical artery Doppler (CPT<sup>®</sup>78620) weekly
- Daily fetal testing may be indicated if umbilical Doppler is abnormal. These requests will be forwarded for Medical Director review.

NOTE: Monitoring of monochorionic twin gestations for both TTTS and TAPS should be performed every 2-3 weeks beginning at 16 weeks of gestation and continuing until delivery.

3. Triplets or higher Multiple Pregnancy receive same imaging as diamniotic-monochorionic and monoamniotic-monochorionic twins. These requests will be forwarded for Medical Director review.

#### **Reference**

1. ACOG Practice Bulletin No. 56: *Multiple Gestation: Complicated Twin, Triplet, and High Order Multi-Fetal Pregnancy*. October 2004.

**OBSTETRICAL ULTRASOUND IMAGING GUIDELINES**

**OB-18~Pelvic Mass or Neoplasm**

See: **OB-27~Uterine Anomalies or Abnormalities**

**OBSTETRICAL ULTRASOUND IMAGING GUIDELINES**

**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.	Twice weekly BPP (CPT <sup>®</sup> 76818 or CPT <sup>®</sup> 76819) and/or NST after 40 weeks gestation
2.	Follow-up ultrasound (CPT <sup>®</sup> 76816) every 2 weeks (after 40 weeks gestation) to evaluate fetal growth
3.	<ul style="list-style-type: none"><li>• CPT<sup>®</sup>76815 may be approved if ordered at 40 weeks or greater to evaluate amniotic fluid index (AFI).</li><li>• A BPP (CPT<sup>®</sup>76818 or CPT<sup>®</sup>76819) should not be approved in addition to CPT<sup>®</sup>76815 if the request is ONLY to evaluate AFI.</li></ul>

**Practice Note**

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

**OB-21~Preterm/Premature Rupture of Membranes**

See also: **OB-4~Amniotic Fluid Abnormalities**

**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.

**OB-21.2 Premature Rupture of Membranes (PROM)**

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

**Reference**

1. ACOG Practice Bulletin No. 80. *Premature Rupture of Membranes*. April 2007.

**OB-22~Second Trimester Screening**

**OB-22.1 Second Trimester Screening**

**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 <sup>®</sup> 76805) (to examine fetal anatomy) between 16 and 20 weeks.
2.	If the quad screening is abnormal, an ultrasound (CPT <sup>®</sup> 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 3.) and 4.) dimeric inhibin-A.

Providers often wait for the results of the quad screen before ordering CPT<sup>®</sup> 76805. If the quad screen is abnormal, they may request CPT<sup>®</sup>76811 in lieu of CPT<sup>®</sup>76805.

**References**

1. ACOG Practice Bulletin No. 77: Screening for Fetal Chromosomal Abnormalities, 2007.
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:

Testing should begin either at 32 weeks gestation or one week before the previous pregnancy loss:

- Weekly ultrasound (CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816)
- Weekly CST or BPP (CPT<sup>®</sup>76818 or CPT<sup>®</sup>76819)

Women **at risk** for still birth may have the following:

- Fetal anatomic scan at 16 weeks or greater (CPT<sup>®</sup>76805 or if criteria met in **OB-5.1**—CPT<sup>®</sup>76811)
- Ultrasound (CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816) every 2 to 4 weeks to assess fetal growth starting at 32 weeks
- If IUGR diagnosed, then see **Known IUGR** section in: **OB-8~Fetal Growth Problems**
- Weekly BPP (CPT<sup>®</sup>76818 or CPT<sup>®</sup>76819) or NST starting at 32 weeks

## **OB-23.2 Risk Factors**

See <b><u>OB-11~High Risk Pregnancy</u></b>
History of stillbirth
Obesity (BMI >30)
Age >35 years old
History of IUGR or Current IUGR (See <b><u>OB-8~Fetal Growth Problems</u></b> )
Infections (Listeria, syphilis, streptococcus, Parvovirus B-19 (Fifth Disease) See: <b><u>OB-3~Alloimmunization/Fetal Anemia</u></b>
Maternal hypertension (see <b><u>OB-11~High Risk Pregnancy</u></b> )
Multiple pregnancy (see <b><u>OB-17~Multiple Pregnancies</u></b> )
Diabetes (see <b><u>OB-1~High Risk Pregnancy</u></b> )
Chromosome abnormalities
Gastroschisis
Systemic lupus
Renal disease
Thyroid disease

### **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.
2.	For suspected breach position, imaging is indicated after 35 weeks. The following may be approved for these indications: <ul style="list-style-type: none"><li>• One ultrasound (CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816)</li><li>• Biophysical Profile (BPP)(CPT<sup>®</sup>76818 or CPT<sup>®</sup>76819), if not already performed</li><li>• Fetal anatomic scan (CPT<sup>®</sup> 76805 or CPT<sup>®</sup> 76811), if not already performed</li></ul>

## OBSTETRICAL ULTRASOUND IMAGING GUIDELINES

### **OB-25~Uncertain Dates**

#### **OB-25.1 Uncertain Dates**

✓ A positive pregnancy test is required.

1.	The <b>low risk pregnancy</b> that has no other indications for ultrasound should have a fetal anatomic ultrasound (CPT <sup>®</sup> 76805) performed between 16 weeks or greater. The timing can be determined by fundal height. (See: <b><u>OB-5~Fetal Anatomic Scan</u></b> ).
2.	If the mother has had <b><u>irregular menstrual periods</u></b> in the year prior to the current pregnancy, then one ultrasound can be performed to confirm dates (CPT <sup>®</sup> 76801 [plus CPT <sup>®</sup> 76802 if more than one fetus] if a complete ultrasound has not yet been performed. CPT <sup>®</sup> 76815 or CPT <sup>®</sup> 76816 if a complete ultrasound was done previously and was inconclusive for confirming pregnancy dates, and/or CPT <sup>®</sup> 76817 for a transvaginal ultrasound)
3.	<p>If there are <b><u>maternal risk factors</u></b> present, (see <b><u>OB-11~High Risk Pregnancy</u></b>), such that knowing the EDC is critical to managing the pregnancy, one ultrasound can be performed to confirm dates:</p> <ul style="list-style-type: none"><li>• (CPT<sup>®</sup>76801 [plus CPT<sup>®</sup>76802 if more than one fetus] if a complete ultrasound has not yet been performed</li><li>• CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816 if a complete ultrasound was done previously and was inconclusive for confirming pregnancy dates, and/or CPT<sup>®</sup>76817 for a transvaginal ultrasound)</li></ul> <p>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 intrauterine growth restriction (IUGR), known or suspected oligohydramnios or polyhydramnios, etc.</p>
4.	<p>If mother has had a <b><u>previous Cesarean section</u></b>, one ultrasound can be performed to confirm dates:</p> <ul style="list-style-type: none"><li>• (CPT<sup>®</sup>76801 [plus CPT<sup>®</sup>76802 if more than one fetus] if a complete ultrasound has not yet been performed</li><li>• CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816 if a complete ultrasound was done previously and was inconclusive for confirming pregnancy dates, and/or CPT<sup>®</sup>76817 for a transvaginal ultrasound)</li></ul>

#### **References**

1. ACOG Practice Bulletin No.101: *Ultrasonography in pregnancy*. February 2009
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

**OB-26~Unequal Fundal Size and Dates**

**OB-26.1 Unequal Fundal Size and Dates**

Unequal fundal size is defined as either more than or less than a 3 week difference in fundal height and gestational age at **16 weeks gestation or greater**.

1.	One ultrasound can be performed at 16 weeks or greater, CPT <sup>®</sup> 76805 if complete US has not been performed or CPT <sup>®</sup> 76815 or CPT <sup>®</sup> 76816 if complete ultrasound has been done previously
2.	Also see <b><u>OB-17~Multiple Pregnancies</u></b>
3.	See <b><u>OB-25~Uncertain Dates</u></b>

## OBSTETRICAL ULTRASOUND IMAGING GUIDELINES

### **OB-27~Uterine Anomalies or Adnexal/Pelvic Masses**

#### **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 <sup>®</sup> 76801 [plus 76802 if more than one fetus] if a complete ultrasound has not yet been performed, or CPT <sup>®</sup> 76815 or CPT <sup>®</sup> 76816 if a complete ultrasound was done previously, and/or CPT <sup>®</sup> 76817 for a transvaginal ultrasound.
3.	Second or third trimester: CPT <sup>®</sup> 76805 [plus 76810 if more than one fetus] if a complete ultrasound has not yet been performed, or CPT <sup>®</sup> 76815 or CPT <sup>®</sup> 76816 if a complete ultrasound was done previously.
4.	Large Leiomyomata (fibroid) - Large fibroid defined as over 600 cm <sup>3</sup> <ul style="list-style-type: none"><li>• Fetal anatomic scan at 16-20 weeks gestation (CPT<sup>®</sup>76805 or if meets criteria in <b><u>OB-3.8</u></b> — CPT<sup>®</sup> 76811)</li><li>• Transvaginal ultrasound (CPT<sup>®</sup>76817) if pre-term labor or incompetent cervix is of concern. If follow-up of cervical length is needed, see: <b><u>OB-14~Incompetent Cervix/Preterm Delivery</u></b></li><li>• Ultrasound (CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816) may be considered at 28-30 weeks and a repeat ultrasound at 34-36 weeks gestation. If IUGR is present then proceed with monitoring per guidelines.</li></ul>
5.	If advanced imaging is requested, <b>send for MD review.</b>

#### **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 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 cm<sup>3</sup>) 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 cm<sup>3</sup> 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.

## **Reference**

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.

<b>OB-28~Vaginal Bleeding</b>
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See: **OB-1~Abdominal Trauma or Pain**

**OB-28.1 Vaginal Bleeding - First Trimester**

<b>For Vaginal Bleeding and/or Abdominal/Pelvic Cramping/Pain:</b>	
1.	CPT <sup>®</sup> 76801 and/or CPT <sup>®</sup> 76817 may be performed when medically indicated
2.	CPT <sup>®</sup> 76815 or CPT <sup>®</sup> 76816 and/or CPT <sup>®</sup> 76817 may be performed when medically indicated, IF a complete US has previously been performed.
3.	When CPT <sup>®</sup> 76815 or CPT <sup>®</sup> 76816 and/or CPT <sup>®</sup> 76817 have been done prior to having a 76801 performed initially, request should be sent to MD review.
<b>For Ectopic Pregnancy: (Signs and symptoms of ectopic pregnancy include pain and/or bleeding)</b>	
1.	Ultrasound can be performed (CPT <sup>®</sup> 76801 and/or CPT <sup>®</sup> 76817) as the initial US
2.	If a complete ultrasound has previously been performed, then use CPT <sup>®</sup> 76815 or CPT <sup>®</sup> 76816 and/or CPT <sup>®</sup> 76817. <ul style="list-style-type: none"> <li>• When CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816 and/or CPT<sup>®</sup>76817 have been performed prior to having had a CPT<sup>®</sup>76801, the request for CPT<sup>®</sup>76801 will be forwarded to Medical Director review.</li> </ul>
3.	If patient has a history of ectopic pregnancy without pain and without bleeding with an hCG >1500, ultrasound can be performed (CPT <sup>®</sup> 76801 and/or CPT <sup>®</sup> 76817) to confirm an intrauterine pregnancy
4.	If ectopic pregnancy is being treated non-surgically with methytrexate, imaging may be required per the <b><u>OB-1~Abdominal Pain or</u></b> Trauma or the imaging guidelines above for ectopic pregnancy.

*Continued next pages . . . .*

**OB-28.1 Vaginal Bleeding - First Trimester *Continued* . . . .**

<b>For Spontaneous Abortion:</b>	
1.	<p>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), CPT<sup>®</sup>76801 [plus CPT<sup>®</sup>76802 if more than one fetus] if a complete ultrasound has not yet been performed, CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816 if a complete ultrasound was done previously, and/or CPT<sup>®</sup>76817 for a transvaginal ultrasound)</p> <ul style="list-style-type: none"><li>• Repeat ultrasound (CPT<sup>®</sup>76815, or CPT<sup>®</sup>76816, and/or CPT<sup>®</sup>76817) is appropriate in the setting of rising or non-falling serum hCG levels at weekly intervals.</li><li>• Ultrasound imaging can be repeated earlier than seven days if there are new symptoms.</li></ul>
2.	<p>For <u>complete spontaneous abortion</u>, ultrasound is generally not indicated if there is no pain, no ongoing bleeding, and hCG levels are decreasing</p>
<b>For Hydatidiform Mole:</b>	
<p>Ultrasound can be performed for diagnosis of <u>hydatidiform mole</u> CPT<sup>®</sup>76801 [plus CPT<sup>®</sup>76802 if more than one fetus] if a complete ultrasound has not yet been performed, CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816 if a complete ultrasound was done previously, and/or 76817 for a transvaginal ultrasound.</p> <p>Following treatment with D &amp; C and/or methotrexate, serial serum hCG values are measured until they become negative.</p> <ul style="list-style-type: none"><li>• Ultrasound may be necessary for follow-up (CPT<sup>®</sup>76815, or CPT<sup>®</sup>76816, and/or CPT<sup>®</sup>76817) if hCG titers are not decreasing as expected, are increasing following treatment, or if there is onset of pain despite falling hCG titers.</li></ul>	
<b>For Subchorionic Hematoma or Placental Hematoma:</b>	
1.	<p>Ultrasound can be performed for follow-up of a known <u>subchorionic hematoma or placental hematoma</u> (CPT<sup>®</sup>76815, or CPT<sup>®</sup>76816, and/or CPT<sup>®</sup>76817) if the last ultrasound was performed greater than seven days ago.</p>
2.	<p>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.</p>
3.	<p>No further ultrasound is needed if the follow-up ultrasound 7 days following the hemorrhage shows that the hemorrhage has resolved, or there is no further cramping and/or bleeding, and the fetus is growing as determined by size equal dates.</p>

## OB-28.2 Vaginal Bleeding – Second and Third Trimesters

<b>Vaginal Bleeding and/or Abdominal/Pelvic Cramping/Pain</b>	
1.	CPT <sup>®</sup> 76815 or 76816 and/or 76817
<b>Hydatidiform Mole</b>	
<p>Ultrasound can be performed for diagnosis of <u>hydatidiform mole</u> CPT<sup>®</sup>76801 [plus CPT<sup>®</sup>76802 if more than one fetus] if a complete ultrasound has not yet been performed, CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816 if a complete ultrasound was done previously, and/or CPT<sup>®</sup>76817 for a transvaginal ultrasound</p> <p>Following treatment with D &amp; C and/or methotrexate, serial serum hCG values are measured until they become negative.</p> <ul style="list-style-type: none"><li>• Ultrasound may be necessary for follow-up (CPT<sup>®</sup>76815, or CPT<sup>®</sup>76816, and/or CPT<sup>®</sup>76817) if hCG titers are not decreasing as expected, are increasing following treatment, or if there is onset of pain despite falling hCG titers.</li></ul>	
<b>For Subchorionic Hematoma or Placental Hematoma</b>	
1.	Ultrasound can be performed for follow-up of a known <u>subchorionic hematoma or placental hematoma</u> (CPT <sup>®</sup> 76815, or CPT <sup>®</sup> 76816, and/or CPT <sup>®</sup> 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.
<b>For Suspected Abruptio Placentae</b>	
1.	Ultrasound is appropriate for <b>suspected</b> <u>abruptio placentae</u> (CPT <sup>®</sup> 76805 [plus CPT <sup>®</sup> 76810 if more than one fetus] if a complete ultrasound has not yet been performed during this pregnancy, CPT <sup>®</sup> 76815 or CPT <sup>®</sup> 76816 if a complete ultrasound was done previously, and/or CPT <sup>®</sup> 76817 for a transvaginal ultrasound)
2.	Ultrasound is appropriate to follow-up a <b>known</b> <u>abruption</u> (CPT <sup>®</sup> 76815, CPT <sup>®</sup> 76816, and/or CPT <sup>®</sup> 76817). <ul style="list-style-type: none"><li>• 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</li></ul>

*Continued next pages . . . .*

**OB-28.2 Vaginal Bleeding – Second and Third Trimesters Continued . . . .**

<b>For Placenta Previa</b>	
1.	For <b>suspected placenta previa</b> , Ultrasound can be performed (CPT <sup>®</sup> 76805 [plus CPT <sup>®</sup> 76810 if more than one fetus] if a complete ultrasound has not yet been performed during this pregnancy, CPT <sup>®</sup> 76815 or CPT <sup>®</sup> 76816 if a complete ultrasound was done previously, and/or CPT <sup>®</sup> 76817 for a transvaginal ultrasound)
2.	<p>For <b>known placenta previa</b>, one routine follow-up ultrasound can be performed at 28-32 weeks (CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816). If placenta previa is still present, one follow-up ultrasound (CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816) can be performed at 35-37 weeks. Amniocentesis is no longer required or recommended for lung maturity (ACOG Committee Opinion #560 May 2013)</p> <p>“Amniocentesis for the determination of fetal lung maturity in well-dated pregnancies generally should not be used to determine timing of delivery”.</p> <ul style="list-style-type: none"><li>• Follow-up ultrasound can be performed at any time if bleeding occurs (CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816)</li></ul>

**OB-29~Vasa Previa**

**OB-29.1 Vasa Previa – Imaging**

Vasa previa: Fetal blood vessels within the placenta or the umbilical cord that cross, or are in close proximity to, the internal opening of the cervix.

- ✓ Ultrasound (CPT<sup>®</sup>76817 and/or CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816) every 2 to 4 weeks to assess cervical length starting at 28 weeks
- ✓ Amniocentesis is no longer required or recommended for lung maturity.  
(ACOG Committee Opinion #560 May 2013)  
“Amniocentesis for the determination of fetal lung maturity in well-dated pregnancies generally should not be used to determine timing of delivery”.

**OBSTETRICAL ULTRASOUND IMAGING GUIDELINES**

**OB-30~Procedure Coding Basics for Established Pregnancy**

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**OBUS-30~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-30.1 OB Ultrasound Code Selection**

- ✓ It is not appropriate to report non-obstetrical pelvic ultrasound procedure codes (CPT<sup>®</sup>76830, CPT<sup>®</sup>76856, and CPT<sup>®</sup>76857) if pregnancy is suspected or diagnosed.
- ✓ The CPT<sup>®</sup> code series, 76801-76815, contains what are considered the “normal OB codes”.
- ✓ **The OB ultrasound CPT<sup>®</sup> codes should be selected based on the following:**
  - **The length of gestation:**
    - CPT<sup>®</sup>76801 and CPT<sup>®</sup>76802 are reported for complete studies performed during the first trimester (<14 weeks).
    - CPT<sup>®</sup>76801 and CPT<sup>®</sup>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<sup>®</sup>76805 and CPT<sup>®</sup>76810 are used to report complete studies performed during the second and third trimester.
    - CPT<sup>®</sup>76805 and CPT<sup>®</sup>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<sup>®</sup>76802, CPT<sup>®</sup>76810, CPT<sup>®</sup>76812, and CPT<sup>®</sup>76814 are “add-on” codes used to report each additional fetus.
  - **The imaging approach:**
    - CPT<sup>®</sup>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<sup>®</sup>76815 and CPT<sup>®</sup>78616 are used to report limited or follow-up studies.
  - **Whether a detailed fetal anatomic evaluation is performed:**
    - CPT<sup>®</sup>76811 and CPT<sup>®</sup>78612 describe an extensive fetal ultrasound evaluation and detailed anatomic survey and are used only when the study includes this service.
    - CPT<sup>®</sup>76812 is an add-on for each additional fetus.
    - Any follow-up ultrasound for CPT<sup>®</sup>76811 should be coded as CPT<sup>®</sup>76816

### **OB-30.2 Required Elements for First Trimester OB Ultrasound**

- ✓ A complete first trimester transabdominal ultrasound (CPT<sup>®</sup>76801 and CPT<sup>®</sup>76802) is defined in CPT<sup>®</sup> 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 and placental anatomic structure
  - Qualitative assessment of amniotic fluid volume/gestational sac shape
  - Examination of maternal uterus and adnexa
- ✓ It may not be possible to visualize the placenta during the early weeks of pregnancy. CPT<sup>®</sup>76801 and/or CPT<sup>®</sup>76802 may still be appropriately billed if the report documentation indicates placental anatomic structure could not be evaluated due to gestational age.
- ✓ CPT<sup>®</sup>76802 is an ‘add-on’ code used with the ‘primary procedure’ CPT<sup>®</sup>76801 to report each additional gestation.
- ✓ CPT<sup>®</sup>76801 and CPT<sup>®</sup>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. Follow-up studies to CPT<sup>®</sup>76801 and CPT<sup>®</sup>76802 should be reported as CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816.

### **OB-30.3 Required Elements for Second or Third Trimester OB Ultrasound**

- ✓ A complete second or third trimester transabdominal ultrasound (CPT<sup>®</sup>76805 and CPT<sup>®</sup>76810) is defined in CPT<sup>®</sup> as including the following elements:
  - Determination of the number of fetuses and amniotic/chorionic sacs
  - Measurements appropriate for gestation (≥14 weeks)
  - Survey of intracranial/spinal/abdominal anatomy
  - Four-chambered heart
  - Umbilical cord insertion site
  - Placenta location
  - Amniotic fluid assessment
  - Examination of maternal adnexa, when visible
- ✓ CPT<sup>®</sup>76810 is an ‘add-on’ code used with the ‘primary procedure’ CPT<sup>®</sup>76805 to report each additional gestation.
- ✓ CPT<sup>®</sup>76805 and CPT<sup>®</sup>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<sup>®</sup>76805 and CPT<sup>®</sup>76810 should be coded as CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816.

## **OB-30.4 Required Elements for Fetal Anatomic Evaluation OB Ultrasound**

- ✓ Performance of the specialized fetal anatomic evaluation (CPT<sup>®</sup>76811 and CPT<sup>®</sup>76812) should be limited to those with special skills to perform this study, such as Maternal Fetal Medicine specialists, Perinatologists, and Radiologists.
- ✓ CPT<sup>®</sup>76811 and CPT<sup>®</sup>76812 are defined in CPT<sup>®</sup> as including all of the requirements listed for CPT<sup>®</sup>76805 and CPT<sup>®</sup>76810. In addition, the report must document detailed anatomic evaluation of the following elements:
  - Fetal brain/ventricles
  - Face
  - Heart/outflow tracts and chest anatomy
  - Abdominal organ-specific anatomy
  - Number/length/architecture of limbs
  - Detailed evaluation of the umbilical cord and placenta
  - Other fetal anatomy as clinically indicated
- ✓ CPT<sup>®</sup>76812 is an ‘add-on’ code used with the ‘primary procedure’ CPT<sup>®</sup>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<sup>®</sup>76811 per pregnancy, per practice (per NPI) is appropriate.\* Follow-up studies should be coded as CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816

\*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](http://www.askleslie.net/rads/White_Paper_on_Ultrasound_Code_76811.pdf). Accessed September 22, 2009

## **OB-30.5 Fetal Nuchal Translucency**

- ✓ CPT<sup>®</sup>76813 and CPT<sup>®</sup>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.
  - Performed only once during a pregnancy during 11 0/7 to 13 6/7 weeks gestation
  - The sonographer performing the study and the physician interpreting the study must be credentialed by the Maternal Fetal Medicine Foundation through their Nuchal Translucency Quality Review Program (NTQR).
  - CPT<sup>®</sup>76814 is an add-on for each additional fetus.
  - Summary of the Society for Maternal Fetal Medicine's White Paper on Nuchal Translucency Billing 2006/2007:

“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.”

[http://www.ntqr.org/SM/Newsletters/NTEXaminer\\_1.htm](http://www.ntqr.org/SM/Newsletters/NTEXaminer_1.htm), November 10, 2006. Accessed September 30, 2010

<b>Criteria for Nuchal Translucency (NT) Measurement By: Steven L. Warsof, MD</b>	
<b>Prof. Ob-Gyn, Eastern Virginia Medical School - Director, Center for Advanced Fetal Therapy</b>	
1.	CRL between 44-84mm, abnormal nuchal translucency is $\geq 2.5$ mm. Criteria by the Fetal Medicine Foundation
2.	Margins of NT edges are clear <ul style="list-style-type: none"><li>a. Clear image</li><li>b. Angle of insonation is perpendicular to NT space</li><li>c. Clear NT lines</li></ul>
3.	Fetus in Mid Sagittal plane <ul style="list-style-type: none"><li>a. Midsagittal view of fetal spine seen in cervical &amp; thoracic region</li><li>b. Tip of nose seen in fetal profile</li><li>c. Third &amp; fourth ventricle seen in CNS</li><li>d. Should not see ribs, stomach or heart</li></ul>
4.	Fetus occupies majority of image <ul style="list-style-type: none"><li>a. Image predominately filled by fetal head neck and thorax</li><li>b. The fetus should occupy &gt;50% of image</li></ul>
5.	Fetal head in neutral position <ul style="list-style-type: none"><li>a. Amniotic fluid seen between chin and chest</li><li>b. Angle &lt;90 degrees</li></ul>
6.	Fetus observed away from amnion
7.	Measurement <ul style="list-style-type: none"><li>a. Use the + calipers</li><li>b. Place crosshairs on the inner edge, but not in the clear space</li><li>c. Measurement is perpendicular to long axis of the fetus</li><li>d. Measure at the widest space and use largest of 3 technically correct measurements</li></ul>

### **From the ACR Coding Archives 2007:**

If a nuchal translucency measurement is requested in the first trimester in addition to a complete ultrasound (CPT<sup>®</sup>76801, CPT<sup>®</sup>76802) or a limited ultrasound (CPT<sup>®</sup>76815), it would be appropriate to code for both the nuchal translucency study (CPT<sup>®</sup>76813 or CPT<sup>®</sup>76814) and the first trimester or limited ultrasound procedure. As noted in the CPT<sup>®</sup> code application, the nuchal translucency measurement codes are used to describe a more detailed evaluation of specific embryonic structures than is required by either code CPT<sup>®</sup>76801, CPT<sup>®</sup>76802 or CPT<sup>®</sup>76815. Follow-up studies to CPT<sup>®</sup>76813 and CPT<sup>®</sup>76814 should be coded as CPT<sup>®</sup>76815 or CPT<sup>®</sup>76816.

## **OB-30.6 Limited and Follow-Up Studies**

- ✓ **CPT<sup>®</sup>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 76815)
  - Reported only once, regardless of the number of fetuses, and only once per date of service
  - CPT<sup>®</sup>76815 should never be reported with complete studies CPT<sup>®</sup>76801/76802 and CPT<sup>®</sup>76805/76810.
- ✓ **CPT<sup>®</sup>76816** describes a **follow-up** study designed to reassess fetal size or re-evaluate one or more abnormalities previously revealed on ultrasound.
  - CPT<sup>®</sup>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<sup>®</sup>76816 and CPT<sup>®</sup>76816-59.
  - CPT<sup>®</sup>76816 should never be reported with complete studies CPT<sup>®</sup>76801, CPT<sup>®</sup>76802 and CPT<sup>®</sup>76805, CPT<sup>®</sup>76810.

## **OBUS-30.7 Obstetric Transvaginal Ultrasound**

- ✓ **CPT<sup>®</sup>76817** is used to report an obstetrical transvaginal ultrasound.
- ✓ CPT<sup>®</sup>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.

## **OBUS-30.8 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 >22 weeks; should NOT be performed prior to the time when the fetus would be viable outside of the uterus**).
  - The following parameters are evaluated:
    - Fetal breathing movements
    - Gross fetal body movements
    - Fetal tone
    - Qualitative amniotic fluid volume (AVF)
    - Reactive FHR (non-stress testing portion)
  - **CPT<sup>®</sup>76818** includes non-stress testing.
  - **CPT<sup>®</sup>76819** does not include the non-stress testing portion.
  - **NOTE:** If non-stress testing is performed without BPP, the appropriate code to use is CPT<sup>®</sup>59025 (Fetal non-stress test). CPT<sup>®</sup>59025 should not be reported with codes CPT<sup>®</sup>76818 or CPT<sup>®</sup>76819.
  - **Although obstetrical ultrasound (CPT<sup>®</sup> codes 76805/76810/76815/76816/76820) and BPP (CPT<sup>®</sup>76818 and CPT<sup>®</sup>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.

### **OB-30.9 Fetal Doppler**

- ✓ **CPT<sup>®</sup>76820** describes Doppler velocimetry of the umbilical artery.
  - Performed >22 weeks gestation
  - Utilized for known IUGR and known oligohydramnios
  - Its use to predict preeclampsia, and stillbirth is considered investigational.
- ✓ **CPT<sup>®</sup>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 and Twin anemia polycythemia sequence.
  - Its use in the diagnosis of fetal anemia due to causes such as, fetomaternal hemorrhage, and non-immune hydrops (other than Parvo) has yet to be determined.\*
- ✓ MCA Doppler may be a useful test in SGA/IUGR fetuses detected after 32 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/IUGR fetus with normal umbilical artery Doppler (see: **OB-General Guidelines**)

\**Obstetrics and Gynecology* 2008;112:145-157

### **OB-30.10 Duplex Scan (Uterine Artery)**

There is currently insufficient data to generate appropriateness criteria for uterine artery Doppler (CPT<sup>®</sup>93975, CPT<sup>®</sup>93976), and this procedure should be considered investigational at this time. The evidence does not currently support routine screening with uterine artery Doppler in any patient group. There are no standards for study technique, gestational age, and abnormal test thresholds. Furthermore, there are no published randomized studies that assess the use of uterine artery Doppler in first trimester pregnancies or in high-risk pregnancies

- ✓ **CPT<sup>®</sup>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.
- ✓ **CPT<sup>®</sup>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<sup>®</sup>93976** is used to report a **fetal umbilical-placental flow study**.

### **OB-30.11 Fetal Echocardiography**

- ✓ It is inappropriate to report codes CPT<sup>®</sup>76825 – CPT<sup>®</sup>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<sup>®</sup>76825** describes fetal echocardiography, real time with image documentation (2D), with or without M-mode recording
- ✓ **CPT<sup>®</sup>76826:**
  - is a follow-up or repeat fetal echocardiogram
  - should never be billed with CPT<sup>®</sup>76825
  - should never be billed more than once on any date of service
- ✓ **CPT<sup>®</sup>76827** describes a complete Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display
- ✓ **CPT<sup>®</sup>76828:** is a follow up or repeat Doppler fetal echocardiogram
- ✓ **CPT<sup>®</sup>93325** is used to report color mapping in conjunction with fetal echocardiography procedures CPT<sup>®</sup>76825 – CPT<sup>®</sup>76828.

## **OB-30.12 3D and 4D RENDERING**

### **3D Ultrasound**

- ✓ 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 (2009) 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 (2009) 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 IUGR.

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 IUGR. 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**

1. Lee W, Deter R, Sangi-Haghpeykar H, Yeo L, Romero R. Prospective validation of fetal weight estimation using fractional limb volume. *Ultrasound Obstet Gynecol*. 2013 Feb;41(2):198-203.
2. *Obstetrics and Gynecology* 2008; 112:145-157
3. ACOG Practice Bulletin No.101: *Ultrasonography in pregnancy*. February 2009

### **OB-30.13 Codes for Selected Obstetrical Procedures**

- ✓ Amniocentesis: CPT<sup>®</sup>59000 and CPT<sup>®</sup>76946 (for ultrasound guidance)
- ✓ Amniocentesis, therapeutic amniotic fluid reduction: CPT<sup>®</sup>59001 (includes ultrasound guidance)
- ✓ Transabdominal amnioinfusion: CPT<sup>®</sup>59070 (includes ultrasound guidance)
- ✓ Umbilical Cord Occlusion: CPT<sup>®</sup>59072 (includes ultrasound guidance)
- ✓ Fetal Fluid Aspiration: CPT<sup>®</sup>59074 (includes ultrasound guidance)
- ✓ Fetal Shunt Placement: CPT<sup>®</sup>59076 (includes ultrasound guidance)
- ✓ Unlisted fetal invasive procedure, including ultrasound guidance: CPT<sup>®</sup>59897

### **OB-30.14 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 MRI is reported with pelvis codes (CPT<sup>®</sup>72195-CPT<sup>®</sup>72197), not abdomen codes.
- ✓ “MRI of the pelvis is used to examine and diagnose the contents of the pelvis; in this case the contents of the pelvis are a fetus.” *Clinical Examples in Radiology*, (Fall 2006).

**OB-31~High Risk Medications and Substances**

**Specific drugs that qualify as risk factors in High Risk Pregnancy and qualify as medical indications for Fetal Anatomic Scan (CPT®76805) and Specialized Fetal Anatomic Scan (CPT®76811):**

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