Anthem

Clinical UM Guideline

Subject: Maternity Ultrasound in the Outpatient Setting
Guideline #: CG-MED-42
Status: Reviewed

Publish Date: 01/03/2024
Last Review Date: 11/09/2023

Description

This document addresses the use of maternity ultrasound in the outpatient setting. This document does not address nuchal translucency.

Note: Please see the following related document for additional information:

- RAD.00038 Use of 3-D, 4-D or 5-D Ultrasound in Maternity Care

Clinical Indications

Medically Necessary:

Maternity ultrasound is considered **medically necessary** for *any* of the following:

- Routine anatomy screen and dating:
  - One ultrasound of a pregnant uterus per member, per routine course of care;
  - Estimate gestational age for individuals with uncertain clinical dates.
- Known or suspected abnormality of maternal reproductive structure:
  - Clinical suspicion of cervical insufficiency (for example, abnormal cervix on physical examination, maternal history of second trimester pregnancy loss, prior cervical surgery, and diethylstilbestrol [DES] exposure);
  - To assess cervical length in the second or third trimester in individuals with a history of one or more pregnancy losses in the second or early third trimester or in individuals who have had preterm labor in the current pregnancy or in multi-fetal pregnancies;
  - Provide guidance for cervical cerclage placement;
  - Confirm suspected anatomical uterine abnormality, including fibroid uterus;
  - Localization of intrauterine device (IUD);
  - Evaluate a pelvic mass that has been detected clinically.
- Known or suspected abnormality of fetus:
  - Assess significant discrepancy between uterine size and dates;
  - Follow-up for observation of identified fetal or cord anomaly;
  - Evaluate suspected fetal growth abnormality (either growth restriction or macrosomia), and to follow proven or suspected intrauterine growth restriction;
  - Confirm suspected or follow confirmed diagnosis of polyhydramnios or oligohydramnios;
  - Estimate fetal weight or presentation in premature rupture of membranes or preterm labor;
  - Confirm suspected multiple gestation;
  - Serial evaluation of fetal growth in multi-fetal pregnancy. The most relevant clinical information is obtained when serial exams are done at least three weeks apart, beginning no earlier than 18 weeks gestation. In the case of monochorionic twins, one scan per two weeks in the third trimester is considered medically necessary;
  - For twin-twin transfusion syndrome, one scan per week and serial exams, more than once per week, beginning once the diagnosis of monochorionic twins or twin-twin transfusion is made;
  - Confirm suspected abnormal fetal position or presentation;
  - As an adjunct to external version from breech to vertex presentation;
  - A known or suspected exposure to Zika virus.
- Known or suspected abnormality of placenta:
  - Assess placental location associated with vaginal bleeding;
  - Suspected abruptio placenta;
  - Follow-up of subchorionic hematoma;
  - Suspected abnormal placental attachment (placenta accreta);
  - Suspected retained placenta or products of conception.
- Fetal viability or well-being:
  - Evaluate for threatened, incomplete, or missed abortion;
  - Evaluation of decreased fetal movement;
  - Non-reassuring fetal heart rate monitoring;
  - Suspected fetal death;
  - Assess amniotic fluid volume in post-term gestation.
- Other high risk conditions:
  - Assess vaginal bleeding of undetermined etiology;
  - Assess abdominal or pelvic pain of undetermined etiology;
  - Evaluation of fetal condition in late registrants for prenatal care;
  - History of unexplained fetal demise in a previous pregnancy;
  - Assess the fetus in cases with maternal risk factors such as family history of congenital abnormalities, chronic systemic disease (including but not limited to, hypertension, diabetes or sickle cell disease), preeclampsia, substance abuse or hyperemesis gravidarum;
  - Assessment of fetus after abnormal serum Alpha Fetal Protein (AFP), serum screen or multiple analyte serum screen, or cell-free fetal deoxyribonucleic acid (DNA) screening for aneuploidy;
  - Suspected ectopic pregnancy or hydatidiform mole, and to follow hydatidiform mole;
  - Assess the fetus in cases of Rhesus (Rh) isoimmunization and other causes of fetal hydrops;
  - Provide guidance for other testing, such as amniocentesis, chorionic villus sampling, and cordocentesis or procedures such as intrauterine blood transfusions or other in-utero fetal therapeutic procedures.

Not Medically Necessary:

Maternity ultrasound is considered **not medically necessary** for:

- Assessment of fetal well being, in the absence of the signs, symptoms, or conditions listed above;
- Only sex determination of the fetus;
- Providing a keepsake picture of the baby for the parents.

Coding

The following codes for treatments and procedures applicable to this guideline are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

When services are Medically Necessary for routine anatomy screen and dating when criteria are met:

CPT	
76801-76802	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks, 0 days), transabdominal approach; single or first gestation/each additional gestation [includes codes 76801, 76802]
76805-76810	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> 14 weeks 0 days), transabdominal approach; single or first gestation/each additional gestation [includes codes 76805, 76810]
76811-76812	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation/each additional gestation [includes codes 76811, 76812]
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses
76816	Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal

ICD-10 Diagnosis	
	For any of the diagnosis codes listed below for abnormalities and high-risk conditions, and including the following:
Z34.00-Z34.93	Encounter for supervision of normal pregnancy [codes 76801, 76805, when criteria are met]
Z36.0-Z36.9	Encounter for antenatal screening of mother

When services may be Medically Necessary when criteria are met for known or suspected abnormality of maternal reproductive structure, fetus, or placenta, or fetal viability or other high-risk conditions:
For the procedure codes listed above for the following diagnoses

ICD-10 Diagnosis	
A92.5	Zika virus disease
D25.0-D25.9	Leiomyoma of uterus
O00.00-O00.91	Ectopic pregnancy
O01.0-O01.9	Hydatidiform mole
O02.0-O02.9	Other abnormal products of conception
O03.4	Incomplete spontaneous abortion without complication
O03.9	Complete or unspecified spontaneous abortion without complication
O07.4	Failed attempted termination of pregnancy without complication
O09.00-O09.03	Supervision of pregnancy with history of infertility
O09.10-O09.13	Supervision of pregnancy with history of ectopic pregnancy
O09.A0-O09.A3	Supervision of pregnancy with history of molar pregnancy
O09.211-O09.219	Supervision of pregnancy with history of pre-term labor
O09.291-O09.299	Supervision of pregnancy with other poor reproductive or obstetric history
O09.30-O09.33	Supervision of pregnancy with insufficient antenatal care
O09.511-O09.529	Supervision of elderly primigravida and multigravida
O09.811-O09.93	Supervision of other or unspecified high risk pregnancy
O10.011-O10.019	Pre-existing essential hypertension complicating pregnancy
O10.111-O10.119	Pre-existing hypertensive heart disease complicating pregnancy
O10.211-O10.219	Pre-existing hypertensive chronic kidney disease complicating pregnancy
O10.311-O10.319	Pre-existing hypertensive heart and chronic kidney disease complicating pregnancy
O10.411-O10.419	Pre-existing secondary hypertension complicating pregnancy
O10.911-O10.919	Unspecified pre-existing hypertension complicating pregnancy
O11.1-O11.3	Pre-existing hypertension with pre-eclampsia; first, second or third trimester
O11.9	Pre-existing hypertension with pre-eclampsia; unspecified trimester
O14.00-O14.03	Mild to moderate pre-eclampsia; unspecified, second or third trimester
O14.10-O14.13	Severe pre-eclampsia; unspecified, second or third trimester
O14.20-O14.23	HELLP syndrome; unspecified, second or third trimester
O14.90-O14.93	Unspecified pre-eclampsia; unspecified, second or third trimester
O16.1-O16.3	Unspecified maternal hypertension; first, second or third trimester
O16.9	Unspecified maternal hypertension; unspecified trimester
O20.0-O20.9	Hemorrhage in early pregnancy
O21.0-O21.9	Excessive vomiting in pregnancy
O24.011-O24.019	Pre-existing diabetes mellitus, type 1, in pregnancy
O24.111-O24.119	Pre-existing diabetes mellitus, type 2, in pregnancy
O24.311-O24.319	Unspecified pre-existing diabetes mellitus in pregnancy
O24.410-O24.419	Gestational diabetes mellitus in pregnancy
O24.811-O24.819	Other pre-existing diabetes mellitus in pregnancy

O24.911-O24.919	Unspecified diabetes mellitus in pregnancy
O26.20-O26.23	Pregnancy care for patient with recurrent pregnancy loss
O26.30-O26.33	Retained intrauterine contraceptive device in pregnancy
O26.841-O26.849	Uterine size-date discrepancy complicating pregnancy
O26.851-O26.859	Spotting complicating pregnancy
O26.872-O26.879	Cervical shortening
O30.001-O30.93	Multiple gestation
O31.00X0-O31.8X99	Complications specific to multiple gestation
O32.0XX0-O32.9XX9	Maternal care for malpresentation of fetus
O33.0-O33.9	Maternal care for disproportion
O34.00-O34.93	Maternal care for abnormality of pelvic organs
O35.00X0-O35.9XX9	Maternal care for known or suspected fetal abnormality and damage
O36.0110-O36.0999	Maternal care for anti-D [Rh] antibodies
O36.20X0-O36.23X9	Maternal care for hydrops fetalis
O36.4XX0-O36.4XX9	Maternal care for intrauterine death
O36.5110-O36.5999	Maternal care for known or suspected poor fetal growth
O36.60X0-O36.63X9	Maternal care for excessive fetal growth
O36.70X0-O36.73X9	Maternal care for viable fetus in abdominal pregnancy
O36.80X0-O36.80X9	Pregnancy with inconclusive fetal viability
O36.8120-O36.8199	Decreased fetal movements
O36.8310-O36.8399	Maternal care for abnormalities of the fetal heart rate or rhythm
O36.8910-O36.8999	Maternal care for other specified fetal problems
O36.90X0-O36.93X9	Maternal care for fetal problem, unspecified
O40.1XX0-O40.9XX9	Polyhydramnios
O41.00X0-O41.93X9	Other disorders of amniotic fluid and membranes
O42.00-O42.92	Premature rupture of membranes
O43.021-O43.029	Fetus-to-fetus placental transfusion syndrome
O43.101-O43.199	Malformation of placenta
O43.211-O43.93	Morbidly adherent placenta, other/unspecified placental disorder
O44.00-O44.53	Placenta previa
O45.001-O45.93	Premature separation of placenta (abruptio placentae)
O46.001-O46.93	Antepartum hemorrhage
O47.00-O47.9	False labor
O48.0-O48.1	Late pregnancy
O60.00-O60.03	Preterm labor without delivery
O73.0-O73.1	Retained placenta and membranes, without hemorrhage
O76	Abnormality in fetal heart rate and rhythm complicating labor and delivery
O98.111-O98.119	Syphilis complicating pregnancy
O99.210-O99.213	Obesity complicating pregnancy
O99.310-O99.313	Alcohol use complicating pregnancy
O99.320-O99.323	Drug use complicating pregnancy
O99.330-O99.333	Smoking (tobacco) complicating pregnancy
O99.810	Abnormal glucose complicating pregnancy
O99.891	Other specified diseases and conditions complicating pregnancy
Q51.21-Q51.28	Other doubling of uterus
Z20.821	Contact with and (suspected) exposure to Zika virus

When services are Not Medically Necessary:
For the procedure and diagnosis codes listed above when criteria are not met or for all other diagnoses not listed; or when the code describes a procedure or situation designated in the Clinical Indications section as not medically necessary.

Discussion/General Information

Ultrasound imaging, also called ultrasound scanning or sonography, is a method of obtaining images of internal organs by sending high-frequency sound waves into the body. The sound wave echoes are recorded and displayed as a real-time visual image. No ionizing radiation (x-ray) is used in ultrasound imaging. Ultrasound during pregnancy is used to assess the uterus, umbilical cord and placenta, as well as fetal anatomy and well-being. Ultrasound imaging can be used after delivery to evaluate abnormalities of the reproductive and adjacent structures.

The American College of Obstetricians and Gynecologists (ACOG) 2018 Practice Bulletin Ultrasound in Pregnancy lists the following recommendations:

The following conclusions are based on good and consistent evidence (Level A):

- At various gestational ages, ultrasound examination is an accurate method of determining gestational age, fetal number, viability, and placental location, and it is recommended for all pregnant patients.

The following conclusions are based on limited or inconsistent evidence (Level B):

- Assessment of chorionicity is most accurate early in pregnancy and, because of the increased rate of complications associated with monochorionicity, determination of chorionicity by the late first trimester or early second trimester is important for counseling and caring for women with multifetal pregnancies.
- An abnormal finding on second-trimester ultrasonography that identifies a major congenital anomaly significantly increases the risk of genetic abnormality and warrants further counseling, including the discussion of various prenatal testing strategies.
- When a growth disturbance is suspected clinically or there is a medical or obstetric condition that increases the risk of a growth disturbance, ultrasonography is the modality of choice to identify abnormal fetal growth.

The following conclusion and recommendation are based primarily on consensus and expert opinion (Level C):

- In the absence of specific indications, the optimal time for a single ultrasound examination is at 18–22 weeks of gestation.
- In the obese patient, expectations regarding visualization of fetal anatomy should be tempered.
- Subtle second-trimester ultrasound markers should be interpreted in the context of a background risk based on the patient's age, history, genetic screening, and serum screening results.

- The benefits and limitations of ultrasonography should be discussed with all patients.

The American College of Radiology (ACR), the American Institute of Ultrasound in Medicine (AIUM), ACOG, the Society for Maternal Fetal Medicine (SMFM), and the Society of Radiologists in Ultrasound (SRU) practice parameter (2018) notes:

> A standard obstetrical ultrasound examination in the first trimester includes evaluation of the presence, size, location, and number of gestational sac(s). The gestational sac is examined for the presence of yolk sac and embryo/fetus (a fetus is generally defined as greater than or equal to 10 weeks gestational age). When an embryo/fetus is detected, it should be measured, and the cardiac activity should be recorded by 2-D video clip or M-mode. The routine use of pulsed Doppler ultrasound to either document or "listen" to embryonic/fetal cardiac activity is discouraged. The uterus, cervix, adnexa, and cul-de-sac region should be examined.
>
> An obstetrical ultrasound in the second or third trimester includes an evaluation of fetal number, cardiac activity, presentation, amniotic fluid volume, placental position, fetal biometry, and an anatomic survey. The maternal cervix and adnexa should be examined.

Zika virus was first reported in South America in May 2015 and since that time has now appeared in the United States. In 2016, ACOG and the SMFM released a practice advisory regarding the current information and recommendations regarding the Zika virus. The recommendations are based on limited data. In October 2017, ACOG and SMFM released an updated version of the practice advisory based upon updated Centers for Disease Control and Prevention (CDC) recommendations and recently published guidance. Recommendations for the management of a pregnant individuals with suspected Zika virus infection include:

- For pregnant women with laboratory evidence of Zika infection, ultrasound to evaluate for fetal abnormalities consistent with congenital Zika virus syndrome is recommended.
  Importantly:
- Ultrasound examinations can be used to assess fetal anatomy, particularly neuroanatomy, and to monitor growth. Specific findings associated with congenital Zika syndrome include intracranial calcifications, microcephaly, ventriculomegaly, arthrogryposis; abnormalities of the corpus callosum, cerebrum, cerebellum, and eyes; and other brain abnormalities.
- Ultrasound examinations, particularly if obtained soon after onset of infection, may not identify prenatal features of congenital Zika syndrome and structural manifestations can be identified at later points in pregnancy. Ultrasound abnormalities have been detected in the fetus from 2 to 29 weeks after symptom onset, and therefore, insufficient data are available to define the optimal timing between exposure and initial sonographic screening.
- Previously, CDC recommended serial ultrasounds every 3-4 weeks for women with laboratory evidence of Zika virus infection based on existing fetal growth monitoring for other maternal conditions (e.g., hypertension or diabetes). However, there are no data specific to congenital Zika virus infection to guide recommendations for timing of serial ultrasounds; ob-gyns and other obstetric providers may consider extending the time interval between ultrasounds in accordance with patient preferences and clinical judgement.
- If maternal testing does not suggest infection, patients should receive the same ultrasound screening as any other pregnant woman as part of standard routine prenatal care.

The 2021 CDC guideline on the treatment of sexually transmitted infections includes management recommendations for individuals who are diagnosed with syphilis in the second half of pregnancy. In addition to treatment, these individuals should undergo a sonographic fetal evaluation to evaluate for signs of fetal or placental syphilis.

While there is no reliable evidence to support ultrasounds performed during pregnancy will harm a fetus, there is general agreement that the casual use of ultrasonography during pregnancy should be avoided (ACOG, 2018). The 2018 ACR/AIUM/ACOG/SMFM/SRU practice parameter notes "Obstetrical ultrasound should be performed only when there is a valid medical reason, and the lowest possible ultrasonic exposure settings should be used to gain the necessary diagnostic information."

Definitions

Ultrasound: A screening or diagnostic technique in which very high frequency sound waves are passed into the body, and the reflected echoes are detected and analyzed to build a picture of the internal organs or of a single fetus or multiple fetuses in the uterus.

References

Peer Reviewed Publications:

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2. Kenkhuis MJA, Bakker M, Bardi F, ET AL. Effectiveness of 12-13-week scan for early diagnosis of fetal congenital anomalies in the cell-free DNA era. Ultrasound Obstet Gynecol. 2018; 51(4):463-469.
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Government Agency, Medical Society, and Other Authoritative Publications:

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   - Antepartum Fetal surveillance. ACOG Practice Bulletin Number 229. June 2021.
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   - Postpartum hemorrhage. ACOG Practice Bulletin Number 183, October 2017.
   - Screening for Fetal Aneuploidy. ACOG Practice Bulletin 163. Reaffirmed 2018.
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9. AIUM. Official Statements. Available at: https://www.aium.org/resources/official-statements. Accessed on September 20, 2023.
    - Limited obstetrical ultrasound examination. Reapproved June 16, 2020.
    - Prudent use and safety diagnostic ultrasound in pregnancy. Approved May 19, 2020.
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    - AIUM Practice Parameter for the Performance of Detailed Second- and Third-Trimester Diagnostic Obstetric Ultrasound Examinations. November 17, 2019.
    - AIUM Practice Parameter for the Performance of Detailed Diagnostic Obstetric Ultrasound Examinations Between 12 Weeks 0 Days and 13 Weeks 6 Days. August 27, 2020.
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Websites for Additional Information

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History

Status	Date	Action
Reviewed	11/09/2023	Medical Policy & Technology Assessment Committee (MPTAC) review. Updated References sections.
Revised	11/10/2022	MPTAC review. Replaced term “women” with “individual” within clinical indications. Updated Discussion and References section. Updated Coding section; added ICD-10-CM code ranges O98.111-O98.119, O99.310-O99.313, O99.320-O99.323, O99.330-O99.333.
	09/28/2022	Updated Coding section with 10/01/2022 ICD-10-CM changes; added O35.00X0-O35.9XX9 replacing O35.0XX0-O35.9XX9.
Reviewed	11/11/2021	MPTAC review. Updated References section. Reformatted Coding section.
Reviewed	11/05/2020	MPTAC review. Updated References and Websites for additional information sections. Reformatted Coding section.
	10/01/2020	Updated Coding section with 10/01/2020 ICD-10-CM changes; added O99.891; removed Q51.20 deleted 09/30/2020.
	04/01/2020	Updated Coding section; corrected ICD-10 diagnosis code O41.00X0.

Revised	11/07/2019	MPTAC review. Updated grammar in medically necessary statement regarding maternal risk factors from “including but not limited to, hypertension, diabetes, sickle cell disease preeclampsia), substance abuse, or hyperemesis gravidarum” to “including but not limited to, hypertension, diabetes or sickle cell disease), preeclampsia, substance abuse or hyperemesis gravidarum”. Updated Discussion, References and Websites for Additional Information sections.
	10/01/2019	Updated Coding section to add ICD-10-CM diagnosis codes O09.00-O09.03, O09.811-O09.829.
Reviewed	01/24/2019	MPTAC review. Updated Discussion/General Information, References and Websites for Additional Information sections. Updated Coding section with additional diagnosis codes D25.0-D25.9, O26.872-O26.879, O99.210-O99.213, O99.810.
	09/20/2018	Updated Coding section with 10/01/2018 ICD-10-CM diagnosis code changes; added Q51.20-Q51.28, Z20.821.
	04/25/2018	Updated Coding section to include ICD-10-CM diagnosis codes Z36.0-Z36.9.
Reviewed	02/27/2018	MPTAC review. The document header wording updated from “Current Effective Date” to “Publish Date.” Updated Discussion/General Information, References and Websites for Additional Information sections.
	10/01/2017	Updated Coding section with 10/01/2017 ICD-10-CM diagnosis code changes.
Revised	02/02/2017	MPTAC review. Added medically necessary indication when there is a known or suspected exposure to the Zika virus to the Clinical Indications section. Added Websites for Additional Information section. Updated Discussion/General Information, Coding and Reference sections.
	10/01/2016	Updated Coding section with 10/01/2016 ICD-10-CM diagnosis code changes.
Reviewed	02/04/2016	MPTAC review. Updated Discussion/General Information and Reference sections. Removed ICD-9 codes from Coding section.
Reviewed	02/05/2015	MPTAC review. Updated Coding, Description, Discussion/General Information, and References.
Revised	02/13/2014	MPTAC review. Addition of “cell-free fetal deoxyribonucleic acid (DNA) screening for aneuploidy” to Medically Necessary Statement. Clarification to Not Medically Necessary Statement. Updated References.
New	02/14/2013	MPTAC review. Initial document development.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to adopt a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan’s or line of business’s members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.