Clinical Policy: Ultrasound in Pregnancy

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Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy outlines the medical necessity criteria for ultrasound use in pregnancy. Ultrasound is the most common fetal imaging tool used today. Ultrasound is accurate at determining gestational age, fetal number, viability, and placental location and is necessary for many diagnostic purposes in obstetrics. The determination of the time and type of ultrasound should allow for a specific clinical question(s) to be answered. Ultrasound exams should be conducted only when indicated and must be appropriately documented.

Policy/Criteria

It is the policy of Coordinated Care Corporation, in accordance with the Revised Code of Washington (RCW), that the following ultrasounds during pregnancy are considered medically necessary when the associated conditions are met:

I. One standard *first trimester ultrasound (76801)* is allowed per pregnancy to establish viability, gestational age, and determine if singleton or multiple births.

Subsequent standard first trimester ultrasounds are considered **not medically necessary** as a limited or follow-up ultrasound assessment (76815 or 76816) should be sufficient to provide a re-examination of suspected concerns.

II. One standard *second trimester ultrasound (76805)* is allowed per pregnancy for fetal morphology.

Subsequent standard second or third trimester ultrasounds are considered **not medically necessary** as a limited or follow-up ultrasound assessment (76815 or 76816) should be sufficient to provide a re-examination of suspected concerns.

III. One *detailed anatomic ultrasound (76811)* is allowed per pregnancy when performed to evaluate for suspected anomaly based on history, laboratory abnormalities, or clinical evaluation; or when there are suspicious results from a limited or standard ultrasound. Further indications include the possibility of fetal growth restriction and multifetal gestation. This ultrasound must be billed with an appropriate high risk diagnosis code from the table below.

A second detailed anatomic ultrasound is considered **medically necessary** if a new maternal fetal medicine specialist group is taking over care, a second opinion is required, or the patient has been transferred to a tertiary care center in anticipation of delivery of an anomalous fetus requiring specialized neonatal care.

Further anatomic ultrasounds are considered **not medically necessary** as there is inadequate evidence of the clinical utility of multiple detailed fetal anatomic examinations.

IV. *Transvaginal ultrasounds (TVU)* are considered **medically necessary** when conducted in the first trimester for the same indications as a standard first trimester ultrasound, and later in pregnancy to assess cervical length, location of the placenta in women with placenta previa, or after an inconclusive transabdominal ultrasound. Cervical length screening is conducted for women with a history of preterm labor or to monitor a shortened cervix based on Table 1 below. Up to 13 transvaginal ultrasounds are allowed per pregnancy.

Table 1: Berghella approach to TVU measurement of cervical length for screening singleton gestations

Past pregnancy history	TVU cervical length screening	Frequency	Maximum # of TVU
Prior preterm birth 14 to 27 weeks	Start at 14 weeks and end at 24 weeks	Every 2 weeks as long as cervix is at least 30 mm*	11
Prior preterm birth 28 to 36 weeks	Start at 16 weeks and end at 24 weeks	Every 2 weeks as long as cervix is at least 30 mm*	9
No prior preterm birth	One exam between 18 and 24 weeks	Once	1

* Increase frequency to weekly in women with TVU cervical length of 26 to 29 mm, through 24 weeks. If ≤25 mm before 24 weeks, consider cerclage.

V. 3D and 4D ultrasounds are considered **not medically necessary**. Studies lack sufficient evidence that they alter management over two-dimensional ultrasound in a fashion that improves outcomes.

The following additional procedures are considered **not medically necessary**:

- Ultrasounds performed solely to determine the sex of the fetus or to provide parents with photographs of the fetus;
- Scans for growth evaluation performed less than 2 weeks apart;
- Ultrasound to confirm pregnancy in the absence of other indications;
- A follow-up ultrasound in the first trimester in the absence of pain or bleeding.

Classifications of fetal ultrasounds include:

I. Standard First Trimester Ultrasound - 76801

A standard first trimester ultrasound is performed before 14 weeks and 0 days of gestation. It can be performed transabdominally, transvaginally, or transperineally. When performed transvaginally, CPT 76817 should be used. It includes an evaluation of the presence, size, location, and number of gestational sac(s); and an evaluation of the gestational sac(s).

Indications for a first trimester ultrasound include, but are not limited to, the following:

- To confirm an intrauterine pregnancy
- To evaluate a suspected ectopic pregnancy

- To evaluate vaginal bleeding
- To evaluate pelvic pain
- To estimate gestational age
- To diagnose or evaluate multiple gestations
- To confirm cardiac activity
- As adjunct to chorionic villus sampling, embryo transfer, or localization and removal of an intrauterine device
- To assess for certain fetal anomalies, such as anencephaly, in high risk patients
- To evaluate maternal pelvic or adnexal masses or uterine abnormalities
- To screen for fetal aneuploidy (nuchal translucency) when a part of aneuploidy screening
- To evaluate suspected hydatidiform mole

II. Standard Second or Third Trimester Ultrasound - 76805

A standard ultrasound in the second or third trimester involves an evaluation of fetal presentation and number, amniotic fluid volume, cardiac activity, placental position, fetal biometry, and an anatomic survey.

Indications for a standard second or third trimester ultrasound include, but are not limited to, the following**:**

- Screening for fetal anomalies
- Evaluation of fetal anatomy
- Estimation of gestational age
- Evaluation of fetal growth
- Evaluation of vaginal bleeding
- Evaluation of cervical insufficiency
- Evaluation of abdominal or pelvic pain
- Determination of fetal presentation
- Evaluation of suspected multiple gestation
- Adjunct to amniocentesis or other procedure
- Evaluation of discrepancy between uterine size and clinical dates
- Evaluation of pelvic mass
- Examination of suspected hydatidiform mole
- Adjunct to cervical cerclage placement
- Evaluation of suspected ectopic pregnancy
- Evaluation of suspected fetal death
- Evaluation of suspected uterine abnormality
- Evaluation of fetal well-being
- Evaluation of suspected amniotic fluid abnormalities
- Evaluation of suspected placental abruption
- Adjunct to external cephalic version
- Evaluation of prelabor rupture of membranes or premature labor
- Evaluation for abnormal biochemical markers
- Follow-up evaluation of a fetal anomaly
- Follow-up evaluation of placental location for suspected placenta previa

- Evaluation with a history of previous congenital anomaly
- Evaluation of fetal condition in late registrants for prenatal care
- Assessment for findings that may increase the risk of aneuploidy

III. Detailed Anatomic Ultrasound - 76811

A detailed anatomic ultrasound is performed when there is an increased risk of an anomaly based on the history, laboratory abnormalities, or the results of the limited or standard ultrasound.

IV. Other Ultrasounds – 76817

A transvaginal ultrasound of a pregnant uterus can be performed in the first trimester of pregnancy and later in a pregnancy to evaluate cervical length and the position of the placenta relative to the internal cervical os. When this exam is done in the first trimester, the same indications for a standard first trimester ultrasound, 76801, apply.

Background

The Routine Antenatal Diagnostic Imaging with Ultrasound (RADIUS) trial showed that routine ultrasound screening of a low risk population did not lead to improved perinatal outcomes. This was a practice based, multi-center randomized trial. There were no significant differences in birth weight or preterm delivery rates.[11]

Ultrasound is used most often in pregnancy for the estimation of gestational age.[5] It has been shown that the use of multiple biometric parameters can allow for accuracy to within three to four days in a mid-trimester study (14 to 22 weeks). Accurate dating of a pregnancy is crucial as many important decisions might be made based on this date, such as whether or not to resuscitate an infant delivered prematurely, when to give antenatal steroids, when to electively deliver a term infant, and when to induce for post-dates.[9]

Pregnancy dating with a first trimester or mid-trimester ultrasound will reduce the number of misdated pregnancies and subsequent unnecessary inductions for post-dates pregnancies. Third trimester ultrasounds for pregnancy dating are much less dependable.

Ultrasound is a helpful tool for the evaluation of fetal growth in at-risk pregnancies and the diagnosis of a small-for-gestational age baby (SGA). Those SGA babies with actual chronic hypoxemia and/or malnutrition can be termed growth restricted (FGR) if it is suspected that their growth has been less than optimal.

The American College of Obstetricians and Gynecologists (ACOG) does not yet recommend the use of three- or four-dimensional ultrasound as a replacement for any necessary two-dimensional study. ACOG states, “the technical advantages of three-dimensional ultrasonography include its ability to acquire and manipulate an infinite number of planes and to display ultrasound planes traditionally inaccessible by two-dimensional ultrasonography. Despite these technical advantages, proof of a clinical advantage of three-dimensional ultrasonography in prenatal diagnosis in general still is lacking.”[5]

The Society of Maternal Fetal Medicine specifically addresses what is often considered a level II screening ultrasound or routine ultrasound, stating:

> "CPT 76811 is not intended to be the routine scan performed for all pregnancies. Rather, it is intended for a known or suspected fetal anatomic or genetic abnormality (i.e., previous anomalous fetus, abnormal scan this pregnancy, etc.). Thus, the performance of CPT 76811 is expected to be rare outside of referral practices with special expertise in the identification of, and counseling about, fetal anomalies.
>
> It is felt by all organizations involved in the codes development and description that only one medically indicated CPT 76811 per pregnancy, per practice is appropriate. Once this detailed fetal anatomical exam (76811) is done, a second one should not be performed unless there are extenuating circumstances with a new diagnosis. It is appropriate to use CPT 76811 when a patient is seen by another maternal-fetal medicine specialist practice, for example, for a second opinion on a fetal anomaly, or if the patient is referred to a tertiary center in anticipation of delivering an anomalous fetus at a hospital with specialized neonatal capabilities.
>
> Follow-up ultrasound for CPT 76811 should be CPT 76816 when doing a focused assessment of fetal size by measuring the BPD [biparietal diameter], abdominal circumference, femur length, or other appropriate measurements, OR a detailed re-examination of a specific organ or system known or suspected to be abnormal. CPT 76805 would be used for a fetal maternal evaluation of the number of fetuses, amniotic/chorionic sacs, survey of intracranial, spinal, and abdominal anatomy, evaluation of a 4-chamber heart view, assessment of the umbilical cord insertion site, assessment of amniotic fluid volume, and evaluation of maternal adnexa when visible when appropriate."[4]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2021, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes that may be Medically Necessary

CPT Codes	Description
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 day), transabdominal approach; single or first gestation
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (≥14 weeks 0 day), transabdominal approach; single or first gestation

CPT Codes	Description
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation
76815	Ultrasound, pregnant uterus, real time with image documentation, limited, 1 or more fetuses
76816	Ultrasound, pregnancy uterus, real time with image documentation, follow-up, transabdominal approach, per fetus
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal

CPT Codes considered Not Medically Necessary:

CPT Codes	Description
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post-processing under concurrent supervision; not requiring image post-processing on an independent workstation
76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post-processing under concurrent supervision; requiring image post-processing on an independent workstation

ICD-10 Diagnosis Codes that Support Medical Necessity for First Detailed Fetal Ultrasound

ICD-10-CM Code	Description
B06.00 – B06.9	Rubella
B50.0 – B54	Malaria
B97.6	Parvovirus as the cause of diseases classified elsewhere
E66.01	Morbid (severe) obesity due to excess calories
O09.511 – O09.519	Supervision of elderly primigravida
O09.521 – O09.529	Supervision of elderly multigravida
O09.811 – O09.819	Supervision of pregnancy resulting from assisted reproductive technology
O24.011 – O24.019, O24.111 – O24.119, O24.311 – O24.319, O24.811 – O24.819, O24.911 – O24.919	Diabetes mellitus in pregnancy
O28.3	Abnormal ultrasonic finding on antenatal screening of mother
O28.5	Abnormal chromosomal and genetic finding on antenatal screening of mother
O30.001 – O30.099	Twin pregnancy
O30.101 – O30.199	Triplet pregnancy
O30.201 – O30.299	Quadruplet pregnancy
O30.801 – O30.899	Other specified multiple gestation

ICD-10-CM Code	Description
O31.10x0 - O31.23x9	Continuing pregnancy after spontaneous abortion / intrauterine death of one fetus or more
O33.6XX0 -O33.6XX9	Maternal care for disproportion due to hydrocephalic fetus
O33.7XX0 - O33.7XX9	Maternal care for disproportion due to other fetal deformities
O35.00X0 – O35.09X9	Maternal care for (suspected) central nervous system malformation in fetus
O35.10X0 – O35.19X9	Maternal care for (suspected) chromosomal abnormality in fetus
O35.20X0 – O35.29X9	Maternal care for (suspected) hereditary disease in fetus
O35.30X0 – O35.39X9	Maternal care for (suspected) damage to fetus from viral disease in mother
O35.40X0 – O35.49X9	Maternal care for (suspected) damage to fetus from alcohol
O35.50X0 – O35.59X9	Maternal care for (suspected) damage to fetus by drugs
O35.60X0 – O35.69X9	Maternal care for (suspected) damage to fetus by radiation
O35.80X0 – O35.89X9	Maternal care for other (suspected) fetal abnormality and damage
O35.90X0 – O35.99X9	Maternal care for (suspected) fetal abnormality and damage, unspecified
O35.AXX0 - O35.AXX9	Maternal care for other (suspected) fetal abnormality and damage, fetal facial anomalies
O35.BXX0 - O35.BXX9	Maternal care for other (suspected) fetal abnormality and damage, fetal cardiac anomalies
O35.CXX0 - O35.CXX9	Maternal care for other (suspected) fetal abnormality and damage, fetal pulmonary anomalies
O35.DXX0 - O35.DXX9	Maternal care for other (suspected) fetal abnormality and damage, fetal gastrointestinal anomalies
O35.EXX0 - O35.EXX9	Maternal care for other (suspected) fetal abnormality and damage, fetal genitourinary anomalies
O35.FXX0 - O35.FXX9	Maternal care for other (suspected) fetal abnormality and damage, fetal musculoskeletal anomalies of trunk
O35.GXX0 - O35.GXX9	Maternal care for other (suspected) fetal abnormality and damage, fetal upper extremities anomalies
O35.HXX0 - O35.HXX9	Maternal care for other (suspected) fetal abnormality and damage, fetal lower extremities anomalies
O36.011+ - O36.099+	Maternal care for rhesus isoimmunization
O36.111+ - O36.199+	Maternal care for other isoimmunization
O36.511+ - O36.599+	Maternal care for other known or suspected poor fetal growth
O40.1xx+ - O40.9xx+	Polyhydramnios
O41.00x+ - O41.03x+	Oligohydramnios
O69.81x+ - O69.89x+	Labor and delivery complicated by other cord complications
O71.9	Obstetric trauma, unspecified
O76	Abnormality in fetal heart rate and rhythm complicating labor and delivery

ICD-10-CM Code	Description
O98.311 – O98.319, O98.411 – O98.419, O98.511 – O98.519, O98.611 – O98.619, O98.711 – O98.719, O98.811 – O98.819	Other maternal infectious and parasitic diseases complicating pregnancy
O99.310-O99.313	Alcohol use complicating pregnancy
O99.320 – O99.323	Drug use complicating pregnancy
O99.411 – O99.419	Diseases of the circulatory system complicating pregnancy
Q00.0 – Q99.9	Personal history of congenital abnormality that is potentially detectable by prenatal ultrasound
R93.5	Abnormal findings on diagnostic imaging of other abdominal regions, including retroperitoneum
R93.811-R93.89	Abnormal findings on diagnostic imaging of other specified body structures
Z68.35 – Z68.45	Body mass index [BMI] 35.0 – 70 or greater, adult
Z82.71-Z82.79	Family history of congenital malformations, deformations and chromosomal abonormalities
Z87.71-Z87.798	Personal history of (corrected) congenital malformations

Table 5: ICD-10 Diagnosis Codes that Support Medical Necessity for TVU

ICD-10-CM Code	Description
O09.211-O09.219	Supervision of pregnancy with history of pre-term labor
O26.872-O26.879	Maternal Care for Cervical Shortening
O34.30-O34.33	Maternal Care for Cervical Incompetence
Z87.51	Personal history of pre-term labor

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy created & reviewed by Obstetrical specialist	01/11	01/11
Reviewed with no changes Obstetrical specialist reviewed	02/12	03/12
Reviewed with no changes	04/13	05/13
Nuchal translucency removed. Divided criteria into first and second trimester. Added indications for transvaginal ultrasound. Obstetrical specialist reviewed	05/14	08/14
Reformatted policy. Added ICD-9 and ICD-10 codes for when a standard ultrasound would be appropriate. Obstetrical specialist reviewed. Removed prior authorization language	08/15	08/15
Removed ICD-9 codes	11/15	
Added follow-up ultrasound as an alternative in Policy/Criteria sections I and II	02/16	
Reviewed with no criteria changes.	08/16	08/16

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Allowed up to 6 TVU per pregnancy and added ICD-10 codes indicating when > 6 TVUs are appropriate	11/16	
Added to ICD-10 code list for standard ultrasounds: O02.0 – O02.9, O03.9, O28.0 – O28.9, Z32.01	01/17	
Removed ICD-10 code tables for 76801 and 76805, and 76817 No diagnosis code limitations in place for these codes. 76817 frequency over time changed to 12 from 6	05/17	
Added that transperineal u/s can be appropriate for a standard first trimester ultrasound scan per updated ACOG guidelines. Added "possibility of fetal growth restriction and multifetal gestation" to indications for detailed ultrasound in section III. Added "as an adjunct to embryo transfer" as an indication for standard first trimester ultrasound in "classifications of fetal ultrasound" section I. Added "The maternal cervix and adnexa are examined as clinically appropriate and when feasible" to description of standard second or third trimester ultrasound in "classifications of fetal ultrasound" section II. Minor wording clarifications made to criteria throughout policy to ensure consistency with latest ACOG practice bulletin for US in Pregnancy, No. 175.	08/17	08/17
Removed – in the primary diagnosis position from section III as this is not a requirement for the edit.	12/17	
Added code range O30.801 – O30.899 to Table 4. References reviewed and updated.	06/18	06/18
Annual review. Added O28.3, O28.5, O99.310 – O99.313. Expanded code range of R93.811 – R93.89	05/19	06/19
References reviewed and updated. Reviewed by specialist.	05/20	06/20
Per 10/1/20 ICD-10 code updates, code set Z68.35 – Z68.45 was revised changing parenthesis around BMI to brackets with no change to code descriptor. Removed "member" from I.A and replaced "member" with "member/enrollee" in all instances	10/20	
Section IV.Table 1, revised note * Increase frequency to weekly in women with TVU cervical length of 25 to 29 mm, to 26 to 29mm and changed "If < 25 mm before 24 weeks…" to < = 25mm; edited maximum # TVU to 11 for prior preterm birth at 14-27 weeks, and 9 for prior preterm birth at 28 to 36 weeks. Changed total number of allowed TVUS per pregnancy to 13. Removed "experimental" from section V. Changed "review date" in the header to "date of last revision" and "date" in the revision log header to "revision date." References reviewed and updated.	06/21	06/21
Updated policy to reflect updates to WAC 246-680-020. Assigned new policy number and added language to indicate this version of the policy applies to Ambetter from Coordinated Care, only.	06/22	06/22

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Annual review. Minor rewording in Description, in Table 1 under Criteria IV., and in Criteria V. Added Classifications of Fetal Ultrasounds. Background updated with no impact on criteria. Updated Table 4 Coding description. The following retired code ranges were removed: O35.0XX0 through O35.0XX9 and O35.1XX0 through O35.1XX9. The following code ranges were added: O35.00X0 through O35.00X9, O35.01X0 through O35.01X9, O35.02X0 through O35.02X9, O35.03X0 through O35.03X9, O35.04X0 through O35.04X9, O35.05X0 through O35.05X9, O35.06X0 through O35.06X9, O35.07X0 through O35.07X9, O35.08X0 through O35.08X9, O35.09X0 through O35.09X9, O35.10X0 through O35.10X9, O35.11X0 through O35.11X9, O35.12X0 through O35.12X9, O35.13X0 through O35.13X9, O35.14X0 through O35.14X9, O35.15X0 through O35.15X9, O35.19X0 through O35.19X9, O35.AXX0 through O35.AXX9, O35.BXX0 through O35.BXX9, O35.CXX0 through O35.CXX9, O35.DXX0 through O35.DXX9, O35.EXX0 through O35.EXX9, O35.FXX0 through O35.FXX9, O35.GXX0 through O35.GXX9, O35.HXX0 through O35.HXX9. References reviewed and updated.	04/23	05/23

References

1. Alldred SK, Takwoingi Y, Guo B, et al. First and second trimester serum tests with and without first trimester ultrasound tests for Down's syndrome screening. *Cochrane Database Syst Rev*. 2017;3(3):CD012599. Published 2017 Mar 15. doi:10.1002/14651858.CD012599
2. American Academy of Pediatrics and American College of Obstetricians and Gynecologists (ACOG). *Guidelines for Perinatal Care* – Eighth Edition. 2017. https://www.acog.org/-/media/project/acog/acogorg/clinical/files/ebook/guidelines-for-perinatal-care.pdf. Accessed February 24, 2023.
3. Fetal Growth Restriction: ACOG Practice Bulletin, Number 227. *Obstet Gynecol*. 2021;137(2):e16 to e28. doi: 10.1097/AOG.0000000000004251
4. American College of Obstetricians and Gynecologists' Committee on Practice Bulletins—Obstetrics; Committee on Genetics; Society for Maternal-Fetal Medicine. Screening for Fetal Chromosomal Abnormalities: ACOG Practice Bulletin, Number 226. *Obstet Gynecol*. 2020;136(4):e48 to e69. doi:10.1097/AOG.0000000000004084
5. American College of Obstetricians and Gynecologists'—Committee on Practice Bulletins—Obstetrics and the American Institute of Ultrasound in Medicine. Ultrasound in Pregnancy. No. 175. Published December 2016. (reaffirmed 2022). Accessed February 2, 2023.
6. AIUM-ACR-ACOG-SMFM-SRU Practice Parameter for the Performance of Standard Diagnostic Obstetric Ultrasound Examinations. *J Ultrasound Med.* 2018;37(11):E13 to E24. doi:10.1002/jum.14831
7. Berghella V. Short cervix before 24 weeks: Screening and management in singleton pregnancies. UpToDate website. www.uptodate.com. Published January 09, 2023. Accessed February 20, 2023.

8. Bricker L, Medley N, Pratt JJ. Routine ultrasound in late pregnancy (after 24 weeks' gestation). *Cochrane Database Syst Rev*. 2015;2015(6):CD001451. Published 2015 Jun 29. doi:10.1002/14651858.CD001451.pub4
9. Caradeaux J, Eixarch E, Mazarico E, Basuki TR, Gratacos E, Figueras F. Longitudinal growth assessment for the prediction of adverse perinatal outcome in fetuses suspected to be small-for-gestational age. *Ultrasound Obstet Gynecol*. 2018;52(3):325 to 331. doi:10.1002/uog.18824
10. Caughey AB, Nicholson JM, and Washington AE. First- vs. second-trimester ultrasound: the effect on pregnancy dating and perinatal outcomes. *Am J Obstet Gynecol* 2008;198(6):703.e1 to 703.e6. doi:10.1016/j.ajog.2008.03.034
11. Ewigman BG, Crane JP, Frigoletto FD, LeFevre ML, Bain RP, McNellis D.N. Effect of prenatal ultrasound screening on perinatal outcome. RADIUS Study Group.*N Engl J Med*. 1993;329(12):821-827. doi:10.1056/NEJM19930916329120.
12. Malone FD, Canick JA, Ball RH, et al. First-trimester or second-trimester screening, or both, for Down's syndrome. *N Engl J Med* 2005;353(19):2001 to 2011. doi:10.1056/NEJMoa043693
13. Wax J, Minkoff H, Johnson A, et al. Consensus report on the detailed fetal anatomic ultrasound examination: indications, components, and qualifications. *J Ultrasound Med*. 2014;33(2):189 to 95. doi: 10.7863/ultra.33.2.189
14. Whitworth M, Bricker L, Mullan C. Ultrasound for fetal assessment in early pregnancy. *Cochrane Database Syst Rev.* 2015;2015(7):CD007058. Published 2015 Jul 14. doi: 10.1002/14651858.CD007058.pub3
15. Zhang J, Merialdi M, Platt LD, Kramer MS. Defining normal and abnormal fetal growth: promises and challenges. Am *J Obstet Gynecol*. 2010;202(6):522 to 528. doi:10.1016/j.ajog.2009.10.889
16. American College of Obstetricians and Gynecologists' Committee on Practice Bulletins—Obstetrics. Prediction and Prevention of Spontaneous Preterm Birth: ACOG Practice Bulletin, Number 234. *Obstet Gynecol.* 2021;138(2):e65 to e90. doi:10.1097/AOG.0000000000004479.
17. Washington State Administrative Code (WAC) 246-680-020, effective July 1, 2022. WAC 246-680-020: Accessed April 9, 2023.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollee. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.