Clinical Policy: Fetal Surveillance

Reference Number: WNC.CP.225 Coding Implications
Last Review Date: Revision Log

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

Note: 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.

Description[1]

This policy details the medical necessity criteria for Fetal Surveillance.

Policy/Criteria[1]

I. It is the policy of WellCare of North Carolina® that Fetal Surveillance is covered as follows:

- **A. Medically Necessary Ultrasound** – Covered when used as a diagnostic tool for the following conditions:
  1. Abnormality in pregnancy such as, **but** not limited to:
     - a. suspected ectopic pregnancy
     - b. suspected hydatidiform mole
     - c. threatened or missed abortion
     - d. congenital malformations, fetal or maternal
     - e. polyhydramnios/oligohydramnios
     - f. placenta previa
     - g. abrupto placenta
     - h. vaginal bleeding
  2. A medical condition threatening the fetus and/or delivery such as, **but** not limited to:
     - i. suspected abnormal presentation
     - j. suspected multiple gestation
     - k. significant difference between the size of the uterus and the time the fetus has been in the womb
     - l. elevated maternal serum alpha-fetoprotein
     - m. suspected genetic abnormality due to abnormal maternal serum screening (QUAD Screen) or maternal age greater than 35.
     - n. suspected fetal death
     - o. suspected anatomical abnormality of the uterus
     - p. maternal risk factors such as family history of congenital abnormalities, chronic systemic disease (hypertension, diabetes, sickle cell disease), or substance abuse
     - q. suspected fetal growth abnormality, either growth retardation or macrosomia

3. Confirmation of the estimated date of conception when the clinical history and examination are not certain. In general, a single ultrasound performed prior to 20 weeks' gestation is sufficient for this purpose.
4. Follow-up ultrasounds may be medically necessary if the study will be used to alter or confirm a treatment plan.
5. Umbilical artery Doppler velocimetry is considered medically necessary in evaluating pregnancies complicated by intra-uterine growth restriction, oligohydramnios, and/or discordant twins
6. Middle cerebral artery Doppler velocimetry is considered medically necessary for evaluation of suspected fetal anemia in conditions such as isoimmunization and parvovirus B-19 infection.

B. Fetal Contraction Stress Testing – Covered only for **high-risk pregnancies** including, **but** not limited, to the following:

1. Anti-phospholipid syndrome
2. Hyperthyroidism (poorly controlled)
3. Hemoglobinopathies (hemoglobin SS, SC, or S-thalassemia)
4. Cyanotic heart disease
5. Pregestational diabetes
6. Hypertensive disorders
7. Pregnancy-induced hypertension
8. Decreased fetal movement
9. Oligohydramnios
10. Polyhydramnios
11. Intrauterine growth restriction
12. Post-term pregnancy(greater than 41 weeks' gestation)
13. Isoimmunization (moderate to severe
14. Previous fetal demise (unexplained or recurrent risk)
15. Multiple gestation (with significant growth discrepancy)

C. Fetal Non-Stress Testing – Covered for a **high-risk pregnancy** when:

1. Pregnancy is at least at a gestation of 23 weeks, **AND**
2. There is a high risk that the fetus' health could be compromised because of **ONE** of the following conditions, including **BUT** not limited to:
    a. Maternal conditions associated with uteroplacental compromise:
        i. diabetes mellitus (pre-existing or pregnancy related)
        ii. underlying maternal hypertension
        iii. pregnancy-induced hypertension
        iv. anti-phospholipid syndrome
        v. hyperthyroidism (poorly controlled)
        vi. hemoglobinopathies (hemoglobin SS, SC, or S-thalassemia)
        vii. cyanotic heart disease
        viii. isoimmunization (moderate to severe)
        ix. previous fetal demise (unexplained or recurrent risk)
    b. Fetal conditions associated with uteroplacental compromise:

i. fetal distress, identified by clinical history or examination
ii. poor fetal growth
iii. decreased fetal movement
iv. oligohydramnios
v. polyhydramnios
vi. preterm premature rupture of membranes
vii. intrauterine growth restriction
viii. post-term pregnancy(greater than 41 weeks' gestation)
ix. multifetal gestation (with significant growth discrepancy)
x. known fetal anomaly

c. Other suspected causes of fetal distress

3. Up to three fetal non-stress tests are covered in a 280-day period or 40 weeks. Medical necessity for additional non-stress tests during a pregnancy is indicated by the presence of a high-risk diagnosis on the claim. All non-stress tests must be medically necessary. Claim diagnoses will be reviewed for high-risk pregnancy.

D. Fetal Biophysical Profiles (BPP) – Covered during pregnancy when:
1. Pregnancy is at least at a gestation of 26 weeks, **AND**
2. There is a high risk that the fetus' health could be compromised because of **one** of the following conditions, including but not limited to:
   a. inconclusive Non-Stress testing (Non-Reactive) **OR**
   b. indications listed for Non-Stress Test above
3. Allowed to be performed on each fetus. The diagnosis must support the number of units billed.

E. Fetal Echocardiography – Covered as a diagnostic tool for a fetus at high risk for congenital heart disease:
1. Suspected congenital heart disease based on Obstetrical screening
2. Elevated risk for congenital heart disease based on fetal risk factors (e.g., abnormal nuchal thickness, chromosomal abnormality, other fetal structural abnormalities)
3. Elevated risk for congenital heart disease based on maternal risk factors (e.g., pre-gestational diabetes, fetal teratogen exposure)
4. Elevated risk for congenital heart disease based on family risk factors (e.g., previous child with congenital heart disease, first degree relative with congenital heart disease)
5. Elevated risk for acquired fetal heart disease (e.g., maternal autoimmune disease, maternal infectious exposure, maternal non-infectious illness).
6. Allowed twice in a 280-day period. Claims submitted for testing that exceeds this limit will be reviewed for medical necessity.

F. Amniocentesis – Covered for the following clinical indications:
1. To diagnose or determine the severity of neural tube defect

2. In pregnancy where the mother will be 35 years of age or older at the expected time of delivery or will be 32 years of age or older in a dichorionic twin gestation
3. When a previous pregnancy resulted in the birth of a child with chromosomal or genetic abnormality or major malformations
4. When a chromosomal or genetic abnormality is known to exist in either parent
5. When a history of chromosomal or genetic abnormality is present in a blood relative
6. Abnormal maternal serum screening or fetal ultrasound
7. Where there is history of three or more spontaneous abortions in this relationship or in a previous mating of either partner
8. Other conditions associated with increased risk for fetal aneuploidy such as first trimester thickened nuchal translucency.
9. When the fetus is at increased risk for a detectable metabolism error
10. For fetal sex determination in pregnancies at risk for an X-linked hereditary disorder such as, **BUT** not limited to the following:
    a. hemophilia
    b. mental retardation
    c. hydrocephalus
    d. Duchenne's muscular dystrophy
11. To diagnose and monitor Rh incompatibility
12. To gauge fetal lung maturity when early delivery is anticipated
13. To control polyhydramnios (reduction amniocentesis)

G. Chorionic Villus Sampling – Covered for the following clinical indications:

1. In pregnancy where the mother will be 35 years of age or older at the expected time of delivery or will be 32 years of age or older in a dichorionic twin gestation.
2. When a previous pregnancy resulted in the birth of a child with chromosomal or genetic abnormality or major malformations.
3. When a chromosomal or genetic abnormality is known to exist in either parent.
4. When a history of chromosomal or genetic abnormality is present in a blood relative.
5. When there is history of three or more spontaneous abortions in this relationship or in a previous mating of either partner.
6. Abnormal fetal ultrasound.
7. Other conditions associated with increased risk for fetal aneuploidy such as first trimester thickened nuchal translucency.
8. When the fetus is at increased risk for metabolism error, detectable in vitro.
9. For fetal sex determination in pregnancies at risk for an X-linked hereditary disorder such as, **BUT** not limited to the following:
    a. hemophilia.
    b. mental retardation.
    c. Hydrocephalus.
    d. Duchenne's muscular dystrophy.

H. **Cordocentesis** – Covered for the following indications:
1. Suspected chromosome abnormality when rapid diagnosis will influence management.
2. Suspected fetal hematologic abnormality when confirmation will influence management.

I. **Fetal Fibronectin Testing** – Covered when **ALL** of the following criteria are met:
1. Amniotic membranes are intact; **AND**
2. Cervical dilation is minimal (less than 3 cm); **AND**
3. Sampling is performed between 22 weeks, 0 days and 34 weeks, 6 days of gestation.

II. It is the policy of WellCare of North Carolina® that Fetal Surveillance is **NOT COVERED** as follows:

A. **Ultrasound** - Not covered when:
1. It is a screening test used in the absence of medical indications or predisposing factors; **OR**
2. It is used solely to determine the sex of the fetus.

B. **Fetal Echocardiography** – Not covered when:
1. It is used for routine screening for congenital heart disease in the absence of risk factors; **OR**
2. The pregnancy is low risk and there are normal anatomic findings on ultrasound examination; **OR**
3. Premature contractions are occasional and without sustained tachycardia or signs of dysfunction or distress; **OR**
4. A non-cardiovascular system abnormality is present, but evaluation of the cardiovascular system will not alter either obstetrical decision making or fetal outcome.

C. **Amniocentesis** - Not covered when it is performed for the following reasons:
1. Sex determination, in the absence of a documented risk of an X-linked disorder, **OR**
2. Routine screening, in the absence of risk factors

Background[1]

Fetal surveillance testing may be necessary to ensure that the fetus is developing normally. The predominant goal of antepartum fetal testing is to lower perinatal morbidity and mortality rates. Fetal testing should not begin until interventions can be undertaken.

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 2024, 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	Description
59000	Amniocentesis; diagnostic
59001	Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)
59012	Cordocentesis (intrauterine), any method
59015	Chorionic villus sampling, any method
59020	Fetal contraction stress test
59025	Fetal non-stress test
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation
76802	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation
76810	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; each additional gestation
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation
76812	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation
76813	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation
76814	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation (List separately in addition to code for primary procedure)

CPT®* Codes	Description
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (e.g., fetal heartbeat, 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 (e.g., 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
76818	Fetal biophysical profile; with non-stress testing
76819	Fetal biophysical profile; without non-stress testing
76820	Doppler velocimetry, fetal; umbilical artery
76821	Doppler velocimetry, fetal; middle cerebral artery
76825	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording;
76826	Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; follow-up or repeat study
76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete
76828	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; follow-up or repeat study
76945	Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation
76946	Ultrasonic guidance for amniocentesis, imaging supervision and interpretation
82143	Amniotic fluid scan (spectrophotometric)
82731	Fetal fibronectin, cervicovaginal secretions, semi-quantitative
82963	Glucosidase, beta
83661	Fetal lung maturity assessment; lecithin sphingomyelin (L/S) ratio
83662	Fetal lung maturity assessment; foam stability test
83663	Fetal lung maturity assessment; fluorescence polarization
83664	Fetal lung maturity assessment; lamellar body density
84081	Phosphatidylglycerol
88235	Tissue culture for non-neoplastic disorders; amniotic fluid or chorionic villus cells
88267	Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, 1 karyotype, with banding
88269	Chromosome analysis, in situ for amniotic fluid cells, count cells from 6-12 colonies, 1 karyotype, with banding
93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	04/21	05/21
Reviewed CPT and ICD-10-CM codes.	09/21	11/21
Annual Review. Reviewed CPT and ICD-10-CM codes.	09/22	09/22
NCHC verbiage removed from NC Guidance Verbiage	04/23	04/23
Annual Review. CPT and ICD-10-CM codes reviewed.	08/23	08/23
Annual Review. CPT codes reviewed. Removed ICD-10 diagnosis table. Removed "Medicaid and health choice" verbiage from References.		

References

1. State of North Carolina Medicaid Clinical Coverage Policy No: 1E-4 Fetal Surveillance. Program Specific Clinical Coverage Policies | NC Medicaid(ncdhhs.gov). Published June 1, 2023. Accessed June 3, 2024.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay

the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
   Unlisted Procedure or Service
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
   HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

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/enrollees. 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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers,

members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.