Clinical Policy Title: Transvaginal and transabdominal ultrasound

Clinical Policy Number: CCP.1116

Effective Date: September 1, 2015
Initial Review Date: June 17, 2015
Most Recent Review Date: August 7, 2018
Next Review Date: August 2019

Policy contains:
- Transvaginal ultrasound.
- Transabdominal ultrasound.
- Ultrasound.

Related policies:
- CCP.1191 Prenatal obstetrical ultrasound
- CCP.1242 Zika virus

ABOUT THIS POLICY: Select Health of South Carolina has developed clinical policies to assist with making coverage determinations. Select Health of South Carolina’s clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of “medically necessary,” and the specific facts of the particular situation are considered by Select Health of South Carolina when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. Select Health of South Carolina’s clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. Select Health of South Carolina’s clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, Select Health of South Carolina will update its clinical policies as necessary. Select Health of South Carolina’s clinical policies are not guarantees of payment.

Coverage policy

Select Health of South Carolina considers the use of either transvaginal ultrasound or transabdominal ultrasound to be clinically proven and, therefore, medically necessary for the following clinical indications (American College of Obstetricians and Gynecologists, 2018a-b, 2017a-d; American College of Radiology, 2018, 2017a-b, 2014a-c, 2013; American Institute of Ultrasound in Medicine, 2017a-b, 2015):

- Confirmation of the presence of an intrauterine pregnancy.
- Evaluation of a suspected ectopic pregnancy.
- Estimation of gestational (menstrual) age.
- Confirmation of fetal cardiac activity.
- Imaging as an adjunct to chorionic villus sampling and embryo transfer and localization, and removal of an intrauterine device.
- Assessing for certain fetal anomalies, such as anencephaly, in high-risk patients.
- Evaluation of pelvic masses and/or uterine abnormalities.
- Measuring the nuchal translucency when part of a screening program for fetal aneuploidy.
• Evaluation of suspected hydatidiform mole.
• Follow-up evaluation of a fetal anomaly.
• Evaluation of fetal anatomy.
• Evaluation of fetal growth.
• Evaluation of abnormal vaginal bleeding.
• Evaluation of abdominal or pelvic pain.
• Evaluation of cervical insufficiency.
• Evaluation of endometrial thickness.
• Adjunct to cervical cerclage placement.
• Determination of fetal presentation.
• Diagnosis or evaluation of suspected multiple gestation.
• Adjunct to amniocentesis or other procedure.
• Adjunct to follicle puncture for egg retrieval for in vitro fertilization (in vitro fertilization).
• Adjunct to ovarian cyst puncture and/or aspiration.
• Adjunct to embryo transfer in “fresh” in vitro fertilization cycle, cryopreservation and/or egg donation.
• Adjunct to sonohysterography.
• Evaluation of cervical length.
• Evaluation of significant discrepancy between uterine size and clinical dates.
• Evaluation of pelvic mass.
• Suspected fetal death.
• Suspected uterine abnormality.
• Suspected amniotic fluid abnormalities.
• Suspected placental abruption.
• Adjunct to external cephalic version.
• Evaluation of premature rupture of membranes and/or premature labor.
• Evaluation of abnormal biochemical markers.

Select Health of South Carolina considers the combined use of transabdominal ultrasound and transvaginal ultrasound to be clinically proven and, therefore, medically necessary when either study is insufficient to provide adequate diagnosis.

Limitations:

All other uses of transvaginal ultrasound and transabdominal ultrasound are not medically necessary, including but not limited to:
• Screening for ovarian cancer with or without serum marker CA-125 in asymptomatic women in the absence of heritable disease (Moyer, 2012).
• Screening for endometrial cancer in asymptomatic women in the absence of heritable disease (National Cancer Institute, 2018; Meyer, 2009).
• Determination of gender of fetus.
• Use of three-dimensional or four-dimensional ultrasounds.

Alternative covered services:

• Organ-specific diagnostic procedures such as cystoscopy, hysteroscopy, anoscopy, or sigmoidoscopy.
• With the diagnostic exception of possible or known pregnancy:
  – Plain radiographs of the abdomen and/or pelvis.
  – Organ-specific radiographs with contrast (including air insufflation) such as cystography or hysterosalpingography.
  – Computed tomography of the abdomen with or without contrast.
  – Computed tomography of the pelvis with or without contrast.
  – Magnetic resonance imaging of the abdomen.
  – Magnetic resonance imaging of the pelvis.

Background

Transabdominal ultrasound images the pelvic organs through the anterior abdominal wall in the supra-pubic region (Moorthy, 2000). It requires a distended urinary bladder and uses lower sonographic frequencies to overcome the longer distance between the transducer and deep pelvic organs (i.e., the reproductive organs), which can degrade image quality. An anterior approach may create acoustic shadowing that can limit adequate visualization of some structures.

Transvaginal ultrasound was developed to overcome the limitations of an anterior approach (Moorthy, 2000). A transducer inserted in the vagina achieves closer proximity to deep pelvic structures to provide superior imaging quality and to facilitate aspiration and biopsy procedures and exenterative procedures. It also avoids the discomfort of a full urinary bladder. Prudent practice may require a chaperone for transvaginal ultrasound procedures, as well as specialized training and materials to perform.

Searches

Select Health of South Carolina searched PubMed and the databases of:
• UK National Health Services Centre for Reviews and Dissemination.
• Agency for Healthcare Research and Quality’s National Guideline Clearinghouse and other evidence-based practice centers.
• The Centers for Medicare & Medicaid Services.

We conducted searches on June 13, 2018. Search terms were: “Ultrasonography, Doppler” (MeSH), “Ultrasonography, Interventional” (MeSH), “Ultrasonography, Prenatal” (MeSH), and free text terms “transvaginal,” “transabdominal,” “ultrasound,” and “endovaginal sonography.”
We included:

- **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.
- **Guidelines** based on systematic reviews.
- **Economic analyses**, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

**Findings**

Transvaginal ultrasound and transabdominal ultrasound performed alone or in combination are established diagnostic imaging modalities for multiple clinical indications. Transvaginal ultrasound and transabdominal ultrasound in combination is generally indicated when either study is insufficient to provide adequate diagnosis. In addition, limited evidence suggests transvaginal ultrasound and transabdominal ultrasound in combination may reduce overall investigative cost and surgical delay in the diagnosis of appendicitis and can facilitate chorionic villus sampling (Bondi, 2012; Bertucci, 2011).

**Screening gynecological cancers:**

The United States Preventive Services Task Force does not recommend screening for ovarian cancer in asymptomatic women, as there is no evidence of benefit (Moyer, 2012). This recommendation does not apply to women with known genetic mutations that increase their risk for ovarian cancer.

The Prostate, Lung, Colon and Ovarian multicenter randomized controlled trial considered data from the first four annual screens and found 60 of the 89 invasive ovarian or peritoneal cancers diagnosed were screen-detected (Partridge, 2009). The positive-predictive value and cancer (diagnostic) yield per 10,000 women screened on the combination of tests were similar across screening rounds (positive predictive value range 1.0 to 1.3 percent, cancer yield 4.7 to 6.2); however, the biopsy (surgery) rate among screen positives decreased from 34 percent at T0 to 15 to 20 percent at T1-T3. The overall ratio of surgeries to screen-detected cancers was 19.5:1, and 72 percent of screen-detected cases were late stage (III/IV). The authors concluded that through four screening rounds, the ratio of surgeries to screen-detected cancers was high, and most cases were late stage. However, the effect of screening on mortality is unknown.

The Society of Gynecologic Oncologists recommends that symptomatic women (i.e., bloating, pelvic pain, abdominal pain, dysphagia, or early satiety) see a gynecologist if symptoms persist for more than three weeks (Foundation for Women’s Cancer Network, 2007). If there is suspicion of cancer, the clinician may choose to perform a transvaginal ultrasound for signs of ovarian malignancy.
Lacey (2006) found that stratifying women into risk groups based on family history slightly enhanced the positive predictive value of a combined CA-125 and transvaginal ultrasound-based screening approach. Whether screening for ovarian cancer with or without serum marker CA-125 and transvaginal ultrasound proves to be efficacious, cost-effective, or clinically useful in screened populations awaits the results of the Prostate, Lung, Colon and Ovarian and other cancer screening studies. Prostate, Lung, Colon and Ovarian study participants are being followed and additional data will be collected through 2015.

The National Cancer Institute (2018) found insufficient evidence to establish whether a decrease in mortality from endometrial cancer occurs with screening asymptomatic women by transvaginal ultrasound. The risks associated with false-positive test results include anxiety and additional diagnostic testing and surgery. In addition, ultrasound may miss many endometrial cancers.

According to Meyer (2009), approximately 2 percent to 5 percent of endometrial cancers may be due to an inherited susceptibility. Lynch syndrome (also known as hereditary non-polyposis colorectal cancer syndrome) accounts for the majority of inherited cases. Current gynecologic cancer screening guidelines for women with Lynch syndrome include annual endometrial sampling and transvaginal ultrasound beginning at age 30 to 35 years. Diagnosing endometrial cancer patients with Lynch syndrome has important clinical implications for the individual and family members, and screening for endometrial cancer with transvaginal ultrasound in this cohort can decrease the likelihood of developing additional cancers.

**Policy updates:**

We identified five new systematic reviews and meta-analyses (Nisenblat, 2016; Ezebialu, 2015; Polena, 2015; Ruiter, 2015; Teixeira, 2015) and one evidence-based practice guideline from the Society of Obstetricians and Gynaecologists of Canada (Carranza-Mamane, 2015) for this policy update. The new information confirms a role for transvaginal ultrasound in the non-invasive assessment of: uterine disorders such as endometriosis and uterine fibroids (Nisenblat, 2016; Carranza-Mamane, 2015); obstetrical complications such as vasa previa and pre-induction cervical ripening (Ezebialu, 2015; Ruiter, 2015); and potentially life-threatening gynecological emergencies (Polena, 2015). For embryonic transfer, ultrasound and clinical touch have similar effects on obstetrical outcomes, and both would be acceptable means of guiding the procedure (Teixeira, 2015). Ultimately, the choice of diagnostic tool would depend on several factors, for example, clinical circumstances, available technology, clinician training, and patient preferences. These findings would not change previous findings; therefore, no changes to the policy are warranted.

In 2017, we found no new information that would materially change previous findings. No policy changes are warranted.

In 2018, we updated several professional guidelines (American College of Obstetricians and
Gynecologists, 2018a and b, 2017a, b, c, and d; American College of Radiology, 2018, 2017a and b; American Institute of Ultrasound in Medicine, 2017a and b). No policy changes are warranted at this time.

Policy ID changed from CP# 13.01.02 to CCP.1116.

Summary of clinical evidence:

<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
</tr>
</thead>
</table>
| Nisenblat (2016) | **Key points:**  
  - Systematic review and meta-analysis of 49 cross-sectional studies and randomized controlled trials (4,807 total women) representing: pelvic endometriosis (13 studies); endometrioma (10 studies), and deeply infiltrating endometriosis (15 studies), and 33 studies of endometriosis at specific anatomical sites.  
  - Overall quality: low.  
  - No imaging modality was able to detect overall pelvic endometriosis with sufficient accuracy to replace surgery.  
  - For endometrioma, transvaginal ultrasound had sufficiently high specificity such that a positive test would rule in pathology.  
  - For deeply infiltrating endometriosis, transvaginal ultrasound could be used clinically to identify additional anatomical sites versus magnetic resonance imaging and facilitate preoperative planning.  
  - Transvaginal ultrasound, transrectal ultrasound, and magnetic resonance imaging accurately mapped rectosigmoid endometriosis.  
  - Insufficient evidence to assess diagnostic role of advanced imaging modalities (e.g., transvaginal ultrasound with bowel preparation or rectal water contrast, 3.0T magnetic resonance imaging or multi-detector computed tomography with enema).  
  - Future well-designed comparative diagnostic studies are needed. |
| Carranza-Mamane (2015) for the Society of Obstetricians and Gynaecologists of Canada | **Key points:**  
  - Adequately evaluate and classify fibroids using transvaginal ultrasound, hysteroscopy, hysterosonography, or magnetic resonance imaging, particularly those impinging on the endometrial cavity (III-A).  
  - Preoperatively assess submucosal fibroids for fibroid size and location within the uterine cavity, the degree of invasion of the cavity, and thickness of residual myometrium to the serosa. Combinations of hysteroscopy and either transvaginal ultrasound or hysterosonography are the modalities of choice (III-B). |
| Ezebialu (2015) | **Key points:**  
  - Systematic review and meta-analysis of two randomized controlled trials (234 total women) comparing Bishop score (standard digital vaginal assessment) and transvaginal ultrasound.  
  - Overall quality: moderate.  
  - Results did not demonstrate superiority of one method over the other. Perinatal |
<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transvaginal ultrasound was associated with an increased need for misoprostol for cervical ripening, but both methods could be complementary. Choice of method may depend on environment and availability (i.e., transvaginal ultrasound).</td>
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<tr>
<td>Adequately powered randomized controlled trials of transvaginal ultrasound, Bishop score, and other methods are needed.</td>
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<td></td>
<td>Polena (2015)</td>
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<tr>
<td><strong>Non-invasive assessment of potentially life-threatening gynecological emergencies</strong></td>
<td><strong>Key points:</strong></td>
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<tr>
<td></td>
<td>• Systematic review of 45 diagnostic efficacy studies (6,885 women) for four major emergencies: complicated (ruptured) ectopic pregnancy, complicated pelvic inflammatory disease, adnexal torsion, and hemoperitoneum.</td>
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<tr>
<td></td>
<td>• Overall quality: low to moderate with a high degree of spectrum bias. Mostly retrospective, single-center studies.</td>
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<td>• Overall transvaginal ultrasound was most often studied (20/45 studies) and had highest diagnostic performance (both high sensitivity and high specificity) in the emergency setting compared with medical history, clinical exam, and biological tests.</td>
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<td></td>
<td>• Further studies needed to assess implementation and impact on health outcomes, used alone or in combination.</td>
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<tr>
<td></td>
<td>Ruiter (2015)</td>
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<tr>
<td><strong>Diagnosis of vasa previa</strong></td>
<td><strong>Key points:</strong></td>
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<tr>
<td></td>
<td>• Systematic review of two prospective (33,795 total women) and six retrospective (442,633 women) cohort studies. Four of eight studies used transvaginal ultrasound for primary evaluation; four studies used transabdominal ultrasound initially and transvaginal ultrasound when vasa previa was suspected.</td>
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<td>• Overall quality: low in retrospective studies, moderate in prospective studies.</td>
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<td></td>
<td>• Retrospective studies: prenatal detection rates varied from 53% (10/19) to 100% (138 cases of vasa previa).</td>
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<td>• Prospective studies (11 cases of vasa previa): transvaginal ultrasound color Doppler detected all cases of vasa previa (sensitivity 100%, specificity 99.0 to 99.8%).</td>
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<td></td>
<td>• Future studies needed to inform decision on the effectiveness of routine or targeted prenatal screening for vasa previa.</td>
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<td>Teixeira (2015)</td>
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<tr>
<td><strong>Ultrasound-guided embryo transfer</strong></td>
<td><strong>Key points:</strong></td>
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<td></td>
<td>• Systematic review of 21 randomized controlled trials: ultrasound guidance vs. clinical touch (17 randomized controlled trials), transvaginal ultrasound guidance versus transabdominal ultrasound (three randomized controlled trials), and hysterosonometry before embryo transfer vs. ultrasound guidance (one randomized controlled trial).</td>
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<td>• Evidence suggests a modest benefit of using ultrasound guidance over clinical touch during embryo transfer; the increased cost and need to change the catheter type may affect choice. Results inconclusive.</td>
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<td>American College of Radiologists Appropriateness Criteria: Abnormal vaginal bleeding (2014)</td>
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<td><strong>Key points:</strong></td>
<td>• Transvaginal ultrasound is generally the initial imaging procedure of choice for evaluating abnormal vaginal bleeding due to ability to depict endometrial pathology and its widespread availability, excellent safety profile, and cost effectiveness.</td>
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<tr>
<td>Citation</td>
<td>Content, Methods, Recommendations</td>
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<td>Transabdominal ultrasound often performed in conjunction with transvaginal ultrasound, and both are complementary.</td>
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<td>Transabdominal ultrasound offers a wider field of view, increased depth of penetration, ability to evaluate adjacent organs, and is helpful for evaluating a markedly enlarged fibroid uterus, especially if there is extrapelvic extension of subserosal or pedunculated fibroids.</td>
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<tr>
<td>Optimal evaluation of the endometrium generally requires transvaginal ultrasound, which allows for higher-resolution imaging. If the transvaginal probe cannot be tolerated, as is often the case in a prepubertal or virginal patient, transabdominal ultrasound using the urinary bladder as an acoustic window becomes essential.</td>
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<tr>
<td>Moyer (2012) for the U.S. Preventive Services Task Force Screening for ovarian cancer</td>
<td><strong>Key points:</strong></td>
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<tr>
<td></td>
<td>• Ovarian cancer screening in asymptomatic women is not recommended.</td>
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<td>• Women with known genetic mutations that increase their risk for ovarian cancer (for example, BRCA mutations) are not included in this recommendation.</td>
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<tr>
<td>American College of Radiologists Appropriateness Criteria: Multiple gestations (2011)</td>
<td><strong>Key points:</strong></td>
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<tr>
<td></td>
<td>• Transabdominal ultrasound or transvaginal ultrasound is safe and appropriate for patients with suspected multiple gestation pregnancy or in patients who have already been diagnosed with twins.</td>
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<td></td>
<td>• The discussion section refers to the superior accuracy of transvaginal ultrasound for measuring cervical length and predicting preterm birth in twin pregnancies.</td>
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<tr>
<td>American Institute of Ultrasound in Medicine Practice Guideline for the Performance of Sonohysterography (2011)</td>
<td><strong>Key points:</strong></td>
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<td></td>
<td>• Preliminary endovaginal sonography (transvaginal ultrasound) with measurements of the endometrium and evaluation of the uterus, ovaries, and pelvic free fluid should be performed before sonohysterography.</td>
</tr>
<tr>
<td>American College of Obstetricians and Gynecologists Practice Bulletin No. 101 (2009) Ultrasoundography in pregnancy</td>
<td><strong>Key points:</strong></td>
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<tr>
<td></td>
<td>• Consider transvaginal ultrasound or “transperitoneal” ultrasound if the cervix appears shortened.</td>
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<td>• Does not recommend routine cervical length assessment in low-risk pregnancies because of the lack of evidence supporting this application, other than a demonstrated association between short cervix and preterm delivery.</td>
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<td>• Serial assessment of cervical length may benefit certain women at high risk of preterm birth.</td>
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<td>Partridge (2009) Prostate, Lung, Colon and Ovarian cancer study</td>
<td><strong>Key points:</strong></td>
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<tr>
<td></td>
<td>• Multicenter randomized controlled trial of ovarian cancer screening with transvaginal ultrasound and CA-125.</td>
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<td></td>
<td>• Among 34,261 women, data from the first four annual screens found surgical intervention for screen-detected cancers was high, and most cases were late stage. The effect of screening on mortality is unknown.</td>
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</tbody>
</table>
Key points:

- Transvaginal ultrasound may distinguish a suspected mass from fluid and feces within the normal rectosigmoid.
- Transvaginal ultrasound or transabdominal ultrasound follicle puncture for retrieving eggs for in vitro fertilization is appropriate in the following circumstances:
  - The patient has undergone comprehensive sonographic evaluation of the pelvis within four to six months prior to the start of hormonal stimulation of the ovaries.
  - Real-time continuous guidance is available, and the image demonstrates a safe approach for the needle path.
  - The ovaries can be brought in close proximity to the ultrasound transducer, thus avoiding the puncture of vital structures (e.g., bowel and blood vessels).
- Transvaginal ultrasound or transabdominal ultrasound ovarian cyst puncture and aspiration is appropriate in patients who have been diagnosed with a persistent ovarian cyst and who meet the following criteria:
  - Failed resolution of the cyst following observation and/or hormonal manipulation.
  - The cyst is unilocular and thin-walled without internal excrescences or septations.
  - Real-time continuous guidance is available, and the image demonstrates a safe approach for the needle path.
  - The cyst can be brought in close proximity to the ultrasound transducer, thus avoiding the puncture of vital structures (e.g., bowel and blood vessels).
- Embryo transfer: Ultrasound-assisted embryo transfer is appropriate in patients undergoing a “fresh” in vitro fertilization cycle or following embryo cryopreservation or embryo/egg donation. If an abdominal ultrasound examination is performed, the bladder should be full to facilitate visualization of the endometrium and the transfer catheter.
- Transabdominal ultrasound or transvaginal ultrasound in the first 10 weeks of pregnancy may be performed; transvaginal ultrasound preferred.

Key points:

- Consensus statement recommendations:
- Women who have symptoms — specifically bloating, pelvic, or abdominal pain; difficulty eating or feeling full quickly; and urinary frequency and urgency — should see a gynecologist if symptoms are new and persist for more than three weeks.
- If suspicion of cancer, the clinician may perform a transvaginal ultrasound to check the ovaries.
- Testing for CA-125 levels should be considered.

- Committee Opinion No. 716: The role of the obstetrician-gynecologist in the early detection of epithelial ovarian cancer in women at average risk. Obstet Gynecol. 2017; 130(3): e146-e149. DOI: 10.1097/aog.0000000000002299.(c)


- ACR-AIUM-SPR-SRU practice parameter for the performance of an ultrasound examination of the abdomen and/or retroperitoneum. Res. 27. Revised 2017.(b)


- Practice parameter for the performance of sonohysterography (2015).
- Practice parameter for the performance of an ultrasound examination of the abdomen and/or retroperitoneum (2017).(a)
- practice parameter for ultrasonography in reproductive medicine (2017).(b)


Peer-reviewed references:


Centers for Medicare & Medicaid Services National Coverage Determinations:


Local Coverage Determinations:

L37636 Nonobstetric Pelvic Ultrasound.

L34577 Retroperitoneal Ultrasound.

Commonly submitted codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
<td>76813</td>
<td>Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation</td>
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<tr>
<td>76814</td>
<td>Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation</td>
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<tr>
<td>76830</td>
<td>Ultrasound, transvaginal</td>
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<tr>
<td>CPT Code</td>
<td>Description</td>
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<tr>
<td>76856</td>
<td>Ultrasound, pelvic (nonobstetric), real time with image documentation; complete</td>
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<tr>
<td>76945</td>
<td>Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation</td>
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<tr>
<td>78657</td>
<td>Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or followup</td>
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<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
<td>O35.1XXO – O35.1XX9</td>
<td>Maternal care for (suspected) chromosomal abnormality in fetus</td>
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<tr>
<td>O09.51</td>
<td>Supervision of elderly primigravida and multigravida</td>
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<table>
<thead>
<tr>
<th>HCPCS Level II Code</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
<td>N/A</td>
<td>No Applicable Codes</td>
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