Clinical Medical Policy

Obstetrical Ultrasounds- # 045

Last reviewed: 12/10/25

Application

Application of this Medical Policy applies to:
RIte Care (MED), Rhody Health Partners (RHP), Rhody Health Expansion (RHE), Children with Special Health Care Needs (CSN), Substitute Care (SUB), Commercial (HBE), INTEGRITY for Duals (FIDE), Duals CONNECT (CO-DSNP)
Application Excluded for:
Extended Family Planning (EFP)

Medicare Distinction

For INTEGRITY for Duals (FIDE) and Duals CONNECT (CO-DSNP) members: Neighborhood Health Plan of Rhode Island (Neighborhood) uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations, including medical necessity. Coverage determinations are based on applicable National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and other Medicare guidelines.

For FIDE Members: In the absence of an applicable or incomplete NCD, LCD, or other Medicare guidelines OR if available Medicare coverage guidance is not met, then Neighborhood will apply coverage guidance from the Rhode Island Executive Office of Health & Human Services (EOHHS), or other widely used treatment guidelines with peer-reviewed scientific evidence, such as InterQual® and/or internal Clinical Medical Policies as a means of secondary coverage through the member's Medicaid benefit.

For CO-DSNP Members: In the absence of an applicable or incomplete NCD, LCD, or other Medicare guidelines, then Neighborhood will apply coverage guidance from other widely used treatment guidelines with peer-reviewed scientific evidence, such as InterQual® and/or internal Clinical Medical Policies.

Description

Ultrasound examination is an accurate method of determining gestational age, fetal number, viability, and placental location. Gestational age is most accurately determined in the first half of the pregnancy. Ultrasonography can be used in the diagnosis of many major fetal anomalies. Ultrasonography is safe for the fetus when used appropriately. Obstetrical ultrasound may also be considered necessary for many conditions of pregnancy.

Coverage Determination

- Neighborhood will reimburse for up to three (3) routine ultrasounds during each pregnancy.

- Additional ultrasounds will be reimbursed only when a diagnosis or condition is suspected that represents an abnormality of pregnancy or represents a threat to the fetus or the delivery.

- Until clinical evidence shows a clear advantage to conventional two-dimensional ultrasonography, three-dimensional ultrasonography is not considered a required modality at this time.

Criteria

ONE of the following clinical situations of pregnancy must be present for more than three (3) obstetrical ultrasounds to be approved during pregnancy:

Indications for First- Trimester Ultrasonography

- ☐ To confirm the presence of an intrauterine pregnancy
- ☐ To evaluate a suspected ectopic pregnancy
- ☐ To evaluate vaginal bleeding
- ☐ To evaluate pelvic pain
- ☐ To estimate gestational age
- ☐ To diagnosis or evaluate multiple gestations
- ☐ To confirm fetal 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 patients at high risk
- ☐ To evaluate maternal pelvic or adnexal masses or uterine abnormalities
- ☐ To screen for fetal aneuploidy
- ☐ To evaluate suspected hydatidiform mole

Indications for Second and Third Trimester Ultrasonography

- ☐ Estimation of gestational age
- ☐ Evaluation of fetal growth
- ☐ Evaluation of vaginal bleeding
- ☐ Evaluation of cervical insufficiency
- ☐ Evaluation of a pelvic mass
- ☐ Evaluation of suspected fetal death
- ☐ Evaluation of abdominal or pelvic pain
- ☐ Determination of fetal presentation
- ☐ Adjunct to cervical cerclage placement
- ☐ Evaluation of suspected multiple gestation
- ☐ Evaluation of fetal well-being
- ☐ Adjunct to external cephalic version
- ☐ Evaluation of suspected ectopic pregnancy
- ☐ Examination of suspected hydatidiform mole

- ☐ Adjunct to amniocentesis or other procedure
- ☐ Significant discrepancy between uterine size and clinical dates
- ☐ Evaluation of suspected uterine abnormality
- ☐ Evaluation of suspected amniotic fluid abnormalities
- ☐ Evaluation of suspected placental abruption
- ☐ Evaluation for premature 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 for those with a history of previous congenital anomaly
- ☐ Evaluation of fetal condition in late registrants for prenatal care
- ☐ To assess findings that my increase the risk of aneuploidy

Exclusions and Limitations

There is no coverage for:

1. Routine ultrasound to determine the gender of the fetus in the absence of a concern about a gender-related genetic disorder, OR
2. Ultrasound for a "picture" of the fetus.

References:

- Overview of ultrasound examination in obstetrics and gynecology. Author Thomas D Shipp, MD. Literature review current through: Oct 2021. | This topic last updated: Sep 8, 2021. UpToDate Accessed 11/30/2021.
- Ultrasonography in Pregnancy. ACOG Practice Bulletin, No. 101, February 2009 (Reaffirmed 2016).

Authorization Request Forms

Access prior authorization request forms by visiting Neighborhood's website at www.nhpri.org.

1. Click on Providers
2. Click on Provider Resources
3. Click on Forms
4. Click on "Click here for a list of prior authorization request forms" – forms are listed alphabetically.

A phone messaging system is in place for requests/inquiries both during and outside of business hours.

Providers can call 1-800-963-1001 for assistance.

Covered Codes: For information on coding, please reference the Authorization Quick Reference Guide.

CMP Cross Reference:

Created	11/10/09
Annual Review Month	November
Review Dates	5/21/13, 5/20/14, 7/7/15, 5/4/16, 6/20/17, 11/9/18, 12/4/19, 12/9/20, 12/8/21, 12/7/22, 12/6/23, 12/11/24, 12/10/25
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CMC Review Dates	12/06/11, 5/21/13, 5/20/14, 7/7/15, 5/17/16, 7/11/17, 11/14/18 12/4/19, 12/9/20, 12/8/21, 12/7/22, 12/6/23, 12/11/24, 12/10/25
Medical Director Approval Dates	11/10/09, 11/9/10, 12/28/11, 6/27/13, 6/20/14, 7/14/15, 5/28/16, 7/17/17, 11/14/18/12/4/19, 12/9/20, 12/8/21, 12/7/22, 12/6/23, 12/10/2512/11/24
Effective Date	6/20/14, 7/14/15, 6/1/16, 7/1/16, 7/17/17, 11/14/18, 12/4/19, 12/9/20, 12/8/21, 12/7/22, 12/6/23, 12/11/24, 12/10/25

Neighborhood reviews clinical medical policies on an annual basis.

Disclaimer:

Neighborhood has developed medical policies to assist us in administering health benefits. This medical policy is made available to you for informational purposes only and does not constitute medical advice. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Members should always consult their physician before making any decisions about medical care. Treating providers are solely responsible for medical advice and treatment of members. Benefits and eligibility are determined by the member's coverage plan; a member's coverage plan will supersede the provisions of this medical policy. For information on member-specific benefits, call member services. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to review and revise this policy for any reason and at any time, with or without notice.