Society for Maternal•Fetal Medicine
High-risk pregnancy experts

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

DATE

ADDRESS

To Whom It May Concern:

On behalf of the Society for Maternal-Fetal Medicine (SMFM), and the American College of Obstetricians and Gynecologists (ACOG), we draw your attention to your proposal to reduce reimbursement for transvaginal ultrasound when assessing second-trimester cervical length, as reported with CPT code 76817 if this code is reported during the same session as a transabdominal ultrasound. As the medical professional society responsible for developing guidelines and providing clinical best practices for high-risk pregnant women, we respectfully disagree and ask that you **reverse this policy**.

Founded in 1977 to give Maternal-Fetal Medicine (MFM) physicians and scientists a place to share knowledge, research and clinical best practices, SMFM is at the forefront of treating high-risk pregnancy, including women with a history of pre-term birth. We work to optimize the health of both mothers and their children. SMFM Consult series #40 published in September 2016 recommends routine transvaginal cervical length screening for women in singleton pregnancy and history of prior spontaneous preterm birth (GRADE 1A)[1]. SMFM also views the implementation of universal cervical length screening in patients without prior history of preterm birth to be reasonable. There are interventions that will improve outcome if universal cervical screening is adopted, such as using progesterone prophylaxis for short cervix, even with no prior preterm birth.[2]

There are evidence and published guidance from the professional societies' recommendations and best practices, stating that "transvaginal ultrasound cervical length (TVU CL) assessment is a safe, acceptable, reproducible, and accurate screening test, with potentially widespread availability.[3] This guidance, published in 2013, demonstrates the necessity for cervical length screening and recommends that code 76817, *Ultrasound, pregnant uterus, real time with image documentation, transvaginal,* be reimbursed at 100% whether done alone or with abdominal scanning such as fetal anatomy survey. Each scanning approach has individual work effort and skill that are independent from each other. In fact, the multiple procedure payment reduction proposed by the Centers for Medicare and Medicaid Services[4] excluded obstetrical ultrasound codes because the work effort is not significantly decreased when more than one procedure is done on the same day, particularly when accessed with a different approach or different body part.

The 2003 clinical vignette that was used when 76817 was created was:

> *"A 31-year-old female in her second pregnancy presents. Her first pregnancy was complicated by preterm rupture of the membranes at 28 weeks gestation. A fetal scan for anatomy was performed at 18 weeks and was normal. She is seen at 22 weeks of pregnancy for transvaginal ultrasound determination of cervical length and determination of the presence of cervical funneling."*

The vignette did not exclude the performance of abdominal and vaginal scanning on the same day. In fact, doing both studies on the same day when indicated is more convenient for patients, and will improve compliance and safety.

Additionally, the 2017 ACOG Coding manual[5] states that the work associated with 76817 includes:

- *Proper positioning and draping of patient*
- *Evaluation may include the following elements;*
- *Evaluation of embryo(s) and gestational sac(s)*
- *Evaluation of maternal uterus, adnexa, and/or cervix*
- *Completion of ultrasound report*

Evaluation of the cervix should suffice as often the uterus and adnexa are not visualized vaginally with advancing gestation. This is still consist with the description and work associated with 76817.

The American Medical Association's CPT manual describes 76817 as: *Ultrasound, pregnant uterus, real time with image documentation, transvaginal,* and notes that "if transvaginal examination is done in addition to transabdominal obstetrical ultrasound exam, use 76817 **in addition to appropriate transabdominal exam code**."[6] It specifically states that when both transvaginal and transabdominal approaches are required to adequately view the structures, it is appropriate to code both approaches.

Finally, the cost of furnishing a transvaginal ultrasound has actually increased recently due to the increased cost of the supplies needed to furnish the service. In particular, growing concerns about potential human papillomavirus transmission[7] has resulted in the recommendation to use sonicated hydrogen peroxide high level disinfection along with viral barrier probe covers. This has increased the cost of providing the service associated with 76817 compared to what was originally submitted when this CPT code was created.

In conclusion, there is no justification to decrease reimbursement by 50% if the elements of 76817 are obtained. Thank you for your attention to this matter as we look forward to working with you to resolve this issue.

Sincerely,

1. Society for Maternal-Fetal Medicine (SMFM) Consult Series #40: The role of routine cervical length screening in selected high- and low-risk women for preterm birth prevention. September 2016.
2. Society for Maternal-Fetal Medicine, with the assistance of Andrew Helfgott. Coding and billing for transvaginal ultrasound to assess second-trimester cervical length. Contemporary OB-GYN, June 1, 2013.
3. Society for Maternal-Fetal Medicine Publications Committee – SMFM Statement. The choice of progestogen for the prevention of preterm birth in women with singleton pregnancy and prior preterm birth. March 2017.
4. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1104OTN.pdf
5. ACOG. OB/GYN Coding manual. Components of Correct procedural Coding, 2017
6. American Medical Association. CPT 2017.
7. Combs CA, Fishman A. A proposal to reduce the risk of transmission of human papilloma virus via transvaginal ultrasound. Am J Obstet Gynecol 215:63-67, 2016.