



ANTENATAL FETAL TESTING CLINICAL PRACTICE GUIDELINES*

SUBJECT: Indications for Antenatal Fetal Testing

The following conditions qualify for Antenatal Fetal Testing and DO NOT require pre-authorization:

Advancing Maternal Age (>35 at EDD)
Asthma, Active
Antiphospholipid Antibody Syndrome/+ACLA/LAC
Autoimmune Disorders (ITP, others).
Chronic lung disease
Chronic Renal Disease
Decreased Fetal Movements
Hemoglobinopathies, such as Sickle Cell Disease
Hypertensive Disorders/ Chronic high blood pressure/GHTN
Hyperthyroidism/hypothyroidism
Inpatient PROM
Insulin and non-insulin dependent diabetes mellitus and gestational diabetes mellitus
Intrauterine Growth Retardation/SGA/FGFR
Isoimmunization (Rh sensitization/Anti D, C, E anti-Kell, anti M and others)
MSQS elevations (unexplained)
Maternal Heart Disease (>II AHA)
Maternal Cyanotic Heart Disease
Maternal Drug Use
Maternal Trauma
Multiple Gestations
Oligohydramnios
Placenta previa with bleeding
Placental separation
Polyhydramnios
Postdates at 40-41 weeks gestation (NST and AFI)
Postdates at 41-42 weeks gestation (twice weekly NST and AFI)
Preeclampsia
Premature labor
Previous unexplained fetal demise/previous stillbirth
System Lupus Erythematosus
Thrombophilia disorders

Limitations and other provisions:

1. Coverage for antenatal testing for indications other than those mentioned above require pre-authorization.
2. In general with most at-risk pregnancies, testing usually begins by 30-32 weeks of gestation. In pregnancies with multiple or particularly worrisome high-risk conditions (such as insulin requiring diabetics, SGA, oligohydramnios, complex thrombophilias, preeclampsia among others), testing can begin as early as 26-28 weeks with approval.

3. The frequency for repeating the testing is every 7 days. Patients with insulin requiring diabetes, SGA, oligohydramnios, severe polyhydramnios, complex thrombophilias, chronic abruption, preeclampsia and postdates will require testing q 3 to 4 days. Testing may be repeated at more frequent intervals with pre-authorization if clinical deterioration occurs, or the high-risk condition dictates. I/P with pPROM or placental previa or separation will undergo daily NST's.

4. Modified BPP is the preferred method (NST/AFI-limited ultrasound). BPP will be performed if NST is nonreactive or is inconclusive or if FHR decelerations are present. CST will be performed if NST and /or BPP are not conclusive.

5. For IUGR, we will also perform weekly UA Doppler study (it does not require preauthorization).

6. For Isoimmunization /fetal anemia, we will also perform weekly UA Doppler and Middle Cerebral Artery Peak Systolic Velocity examinations (it does not require preauthorization).

Selected References

ACOG Technical Bulletin #9, October 1999, Antenatal Testing Indications

ACOG Technical Bulletin #55, September 2004, Management of Post term Pregnancy

Clinical Obstetrics and Gynecology: A Critique of Fetal Surveillance Tests, 45(4), 2002:973-1068.

Creasy/Resnik: Maternal Fetal Medicine, 5th Edition, Chapters 20, 21, 28-30

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