IEHP UM Subcommittee Approved Authorization Guideline			
Guideline	Fetal Non-Stress Testing	**Guideline #**	UM_GYN 02
		Original Effective Date	11/10/2021
Section	Gynecology/Obstetrics	**Revision Date**	

COVERAGE POLICY

This policy describes indications for Inland Empire Health Plan's (IEHP's) coverage of antepartum fetal non-stress testing (NST) in the outpatient setting.

COVERAGE LIMITATIONS AND EXCLUSIONS

IEHP will cover antepartum fetal NST in the outpatient setting in accordance with Table 1 presented below ("Additional Information" section). Table 1 describes the clinical factors that would be indications for antepartum fetal NST; it also suggests the gestational age at which NSTs can begin and the frequency with which they should be performed.

ADDITIONAL INFORMATION

Source: American College of Obstetricians and Gynecologists (June 2021). "Indications for Outpatient Antenatal Fetal Surveillance." Committee Opinion Number 828.

Factor			Suggested Gestational Age to begin Antenatal Fetal Surveillance	Suggested Frequency of Antenatal Fetal Surveillance
Fetal				
	Growth restriction[1]	Umbilical artery dopplers (UAD): normal or with elevated impedance to flow in umbilical artery with diastolic flow present; with normal amniotic fluid index (AFI) and no other concurrent maternal or fetal conditions	At diagnosis[2]	Once or twice weekly
		UAD: absent end-diastolic velocity or concurrent	At diagnosis[2]	Twice weekly[3] or consider

		conditions (oligohydramnios, maternal comorbidity [e.g., preeclampsia, chronic hypertension])		inpatient management
		UAD: reversed end-diastolic velocity	At diagnosis[2]	Inpatient management[3]
	Multiple gestation			
		Twins, uncomplicated dichorionic	36 0/7 weeks	Weekly
		Twins, dichorionic, complicated by maternal or fetal disorders, such as fetal growth restriction	At diagnosis[2]	Individualized
		Twins, uncomplicated monochorionic-diamniotic	32 0/7 weeks[4]	Weekly
		Twins, complicated monochorionic-diamniotic (i.e., twin-twin transfusion syndrome)	Individualized	Individualized
		Twins, monoamniotic	Individualized	Individualized
		Triplets and higher order multiples	Individualized	Individualized
	Decreased fetal movement		At diagnosis[3]	Once[5]
	Fetal anomalies and aneuploidy		Individualized	Individualized
Maternal				
	Hypertension, chronic			
		Controlled with medications	32 0/7 weeks	Weekly
		Poorly controlled or with associated medical conditions	At diagnosis[2]	Individualized
	Gestational hypertension/preeclampsia			
		Without severe features	At diagnosis[2,3]	Twice weekly

		With severe features	At diagnosis[2,3]	Daily
	Diabetes			
		Gestational, controlled on medications without other comorbidities	32 0/7 weeks	Once or twice weekly
		Gestational, poorly controlled	32 0/7 weeks	Twice weekly
		Pregestational	32 0/7 weeks[6]	Twice weekly
	Systemic lupus erythematosus	Uncomplicated	By 32 0/7 weeks	Weekly
		Complicated[7]	At diagnosis[2]	Individualized
	Antiphospholipid syndrome		By 32 0/7 weeks[8]	Twice weekly
	Sickle cell disease			
		Uncomplicated	32 0/7 weeks	Once or twice weekly
		Complicated[9]	At diagnosis[2]	Individualized
		Hemoglobinopathies other than sickle cell disease	Individualized	Individualized
	Renal disease (creatinine greater than 1.4 mg/dL)		32 0/7 weeks	Once or twice weekly
	Thyroid disorders, poorly controlled		Individualized	Individualized
	In vitro fertilization		36 0/7 weeks	Weekly
	Substance use			
		Alcohol, 5 or more drinks per week	36 0/7 weeks	Weekly
		Polysubstance use	Individualized	Individualized
	Pre-pregnancy body mass index (BMI)			
		Pre-pregnancy BMI 35.0-39.9 kg/m^2	37 0/7 weeks	Weekly
		Pre-pregnancy BMI 40 kg/m2 or above	34 0/7 weeks	Weekly
	Maternal age older than 35 years		Individualized[10]	Individualized
Obstetric				
	Previous stillbirth			
		At or after 32 0/7 weeks	32 0/7 weeks[11]	Once or twice weekly
		Before 32 0/7 weeks of gestation	Individualized	Individualized
	History of other adverse pregnancy outcomes in immediately preceding			

	pregnancy			
		Previous fetal growth restriction requiring preterm delivery	32 0/7 weeks	Weekly
		Previous preeclampsia requiring preterm delivery	32 0/7 weeks	Weekly
	Cholestasis		At diagnosis[2]	Once or twice weekly
	Late term		41 0/7 weeks	Once or twice weekly
	Abnormal serum markers[12]			
		Pregnancy-associated plasma protein A (PAPP-A) less than or equal to the fifth percentile (0.4 multiples of the median – MoM)	36 0/7 weeks	Weekly
		Second-trimester inhibin A equal to or greater than 2.0 MoM	36 0/7 weeks	Weekly
Placental				
	Chronic placental abruption[13]		At diagnosis[2]	Once or twice weekly
	Vasa previa		Individualized	Individualized
	Velamentous cord insertion		36 0/7 weeks	Weekly
	Single umbilical artery		36 0/7 weeks	Weekly
	Isolated oligohydramnios (single deepest vertical pocked less than 2 cm)		At diagnosis[2,3]	Once or twice weekly
	Polyhydramnios, moderate to severe (deepest vertical pocket equal to or greater than 12 cm or AFI equal to or greater than 30 cm)		32 0/7 – 34/07 weeks[14]	Once or twice weekly

The guidance offered in this table should be construed only as suggestions, not mandates. Ultimately, individualization about if and when to offer antenatal fetal surveillance is advised.

[1]Estimated fetal weight or abdominal circumference less than that 10th percentile.

[2]Or at a gestational age when delivery would be considered because of abnormal test results.

[3]If not delivered.

[4]In addition to routine surveillance for TTTS and other monochorionic twin complications.

[5]Repeat if decreased fetal movement recurs.
[6]Or earlier for poor glycemic control or end organ damage.
[7]Such as active lupus nephritis, recent lupus flare, antiphospholipid antibodies with prior fetal loss, anti-RO/SSA or anti-La/SSB antibodies, or thrombosis.
[8]Individualize, take into consideration obstetric history, number of positive antibodies, and current pregnancy complications.
[9]Such as maternal hypertension, vaso-occlusive crisis, placental insufficiency, fetal growth restriction.
[10]Based on cumulative risk when present with other factors.
[11]Or starting 1-2 weeks before the gestational age of the previous stillbirth.
[12]If serum screening for aneuploidy is performed, the results may be considered in determining whether antenatal fetal surveillance should be performed.
[13]In individuals who are candidates for outpatient management.
[14]Or at diagnosis if diagnosed after 32 0/7 – 34 0/7 weeks.

CLINICAL/REGULATORY RESOURCE

Not applicable.

DEFINITION OF TERMS

Antenatal fetal surveillance (in the case of this guideline, **fetal** NST) is performed to reduce the risk of stillbirth. As with all testing and interventions, shared decision making between the pregnant individual and the clinician is critically important when considering or offering antenatal fetal surveillance for individuals with pregnancies at high risk for stillbirth or with multiple comorbidities that increase the risk of stillbirth.

REFERENCES

American College of Obstetricians and Gynecologists (June 2021). “Indications for Outpatient Antenatal Fetal Surveillance.” Committee Opinion Number 828.

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