



Northern Virginia
 Physicians to Women, Ltd
 Obstetricians & Gynecologists

Chromosome Testing Options

A list of your testing options for pregnancy and pre-pregnancy planning.

Patients: Should you have questions; our doctors will review the testing listed below during your genetic counseling visit. **Please contact your insurance plan after selecting a test to understand coverage and benefits. If your insurance tells you precertification is required, notify our billing staff immediately so that we may begin the process. Some insurance plans take several days to make their determination, failure to notify us may result in delayed testing.**

Noninvasive Screening

	Is Pre-Cert Required ?	What Are My Ins. Benefits ?
<p><u>Cell Free Fetal DNA</u> – Not done earlier than 10 weeks <input type="checkbox"/></p> <p>CPT CODE 81420</p> <p>Offered to those 35 years or older. Screening for sono markers, other positive testing, previous affected child, parent with translocation.</p> <p>Screens for Trisomy 21 (>99% accurate)</p> <p>Trisomy 18 (97% accurate)</p> <p>Trisomy 13 (91% accurate)</p> <p>Sex chromosome anomalies (91% accurate)</p> <p>For patients less than 35 poor Positive Predictive value</p>	_____	_____
<p><u>Nuchal Translucency</u> - Done between 11 3/7 and 13 6/7 weeks <input type="checkbox"/></p> <p>Sonogram CPT: 76813</p> <p>Lab CPT codes 84163, 82397, 76813</p> <p>Appropriate for low risk patients</p> <p>Combines ultrasound of fetal neck skin Thickness with blood test for levels of certain markers</p> <p>90% detection rate of Trisomy 21 & 18</p> <p>5% false positive</p> <p>Some labs will also include Trisomy 13</p> <p>Can do with twins</p>	_____	_____

MISCELLANEOUS TESTING OPTIONS

The ideal time for all carrier testing is pre-conception.

Is Pre-Cert
Required ?

What Are My
Ins. Benefits ?

ForeSight or Inheritest Carrier Screening

CPT codes – Refer to Lab Pamphlet

Carrier screening can help determine whether you carry inherited health conditions that you might pass on to a child.

I have personally explained the above testing options to the patient or the patients' designated decision maker.

Physician Signature

Date

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. In the event that my health plan determines a test not to be "not payable", I will be responsible for the complete charge and agree to pay the cost of all testing I have accepted. I understand that it is my responsibility to contact my insurance and become familiar with my benefits.

Patient Signature

Date

If you decline the above testing, please sign below.

Patient Signature

Date