

Clinical Policy: Non-Medically Indicated (Elective) Early Delivery Before 39 Weeks Gestational Age

Reference Number: HNCA.CP.MP.502

Last Review Date: 6/23

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

The American College of Obstetrics and Gynecology (ACOG), the Society for Maternal-Fetal Medicine and other evidence based sources consider the practice of non-medically indicated elective deliveries performed prior to 39 weeks gestation may cause unjustified fetal and maternal risk. According to the ACOG, indications for induction of labor are not absolute but should take into account maternal and fetal conditions, gestational age, cervical status, and other factors. Early induction of labor or cesarean delivery (C-section) should not be considered for maternal request, availability of effective pain management, provider convenience, or facility scheduling.

Policy/Criteria

- I. It is the policy of Health Net of California that elective delivery performed prior to 39 weeks gestation is not medically necessary unless there is a maternal and/or fetal complication such as those identified in the ACOG Committee Opinion Number 764 (2019) and Number 831 (2021). Complications include the following (please see the actual committee opinion for more detail):
 - A. Placenta or uterine issues such as:
 - 1.Placenta previa
 - 2.Suspected accrete, increta or percreta
 - 3.Vasa previa
 - 4.Prior classical cesarean delivery
 - 5.Prior myomectomy requiring C section
 - 6.Previous uterine rupture
 - B. Fetal conditions such as:
 - 1.Oligohydramnios
 - 2.Polyhydramnios
 - 3.Growth restriction
 - 4.Multiple gestation
 - 5.Alloimmunization of pregnancy with known or suspected fetal effects
 - C. Maternal conditions such as:
 - 1.Hypertensive disorders of pregnancy, including preeclampsia, eclampsia, gestational hypertension, or complicated chronic hypertension
 - 2.Diabetes (pre-gestational and gestational)
 - 3.HIV
 - 4.Intrahepatic cholestasis of pregnancy
 - D. Obstetric conditions such as:

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1. Preterm premature rupture of membranes (PROM)
2. PROM
3. Previous stillborn

Background

In 2019, the American College of Obstetricians and the Society for Maternal-Fetal Medicine updated the Committee Opinion on Non-medically Indicated Early-Term Deliveries, Number 764 (replacing the Committee opinion 560 from April 2013) and the Committee Opinion on Avoidance of Non-medically Indicated Early Term Delivery and Associated Neonatal Morbidity Number 765 (replacing the Committee opinion 561 from April 2013). An interim update (number 818) was also published in February 2021 that replaces the committee opinion 764 from February 2019. ACOG also issued a practice bulletin - ACOG Committee Opinion Number 831 Medically Indicated Late-Preterm and Early Term Deliveries in 2021. Both entities have long discouraged non-indicated delivery before 39 weeks of gestation. There are greater reported rates of morbidity and mortality among neonates and infants delivered during the early-term period compared with those delivered at 39 and 40 weeks of gestation. Maternal complications can also occur, such as increased risk of infection and postpartum hemorrhage due to prolonged labor, increased risk of C-sections which often results in repeat C-sections in subsequent pregnancies and increased use of instruments such as forceps or vacuum during delivery. The ACOG and SMFM have also stated that a mature fetal lung maturity profile is not an indication for delivery in the absence of other clinical indications.

Neonatal morbidities associated with early term delivery include the following:

- Respiratory distress syndrome
- Transient tachypnea of the newborn
- Pneumonia
- Ventilator use
- Respiratory failure
- Neonatal intensive care unit admission
- Hypoglycemia
- 5 minute Apgar score less than 7
- Neonatal mortality

A number of studies noted the association with adverse outcomes. A retrospective cohort study (Hibbard et al 2010) by the Consortium on Safe Labor, which included 233,844 births, found that among all infants delivered at 37 weeks of gestation, regardless of indication, there were higher rates of respiratory failure compared with infants delivered at 39 weeks of gestation. In addition, higher rates of respiratory distress syndrome, transient tachypnea of the newborn, pneumonia, and surfactant and oscillator use were reported for infants delivered at 37 weeks of gestation compared with those delivered at 39 weeks of gestation. Slightly higher rates of respiratory failure were reported for infants delivered at 38 weeks of gestation versus 39 weeks of gestation; however, the differences did not reach statistical significance and there was no commonly reported difference in any other measure of respiratory morbidity between these two groups.

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Tita et al 2009 reported similar outcomes in a secondary analysis of data from the Eunice Kennedy Shriver NICHD, neonates delivered during the early-term period by cesarean delivery, in the absence of indications for delivery, were associated with a higher risk of a composite outcome of neonatal respiratory and nonrespiratory morbidities compared with neonates delivered at 39 weeks of gestation. These findings also suggest that scheduled cesarean delivery even a day before 39 weeks of gestation should be avoided.

Clark et al 2009 looked at a cohort of planned term deliveries (defined as deliveries not initiated by labor or ruptured membranes) during a 3-month period in 27 hospitals across the United States, neonatal intensive care unit (NICU) admission rates were higher among neonates delivered in the early-term period (2). A comparison of NICU admission rates for neonates delivered at 37 weeks of gestation or 38 weeks of gestation with those for neonates delivered at 39 weeks of gestation revealed that 31% of 17,794 deliveries had no medical indication. Admission to the NICU, which can be dependent on a variety of factors, was required for 17.8% of infants delivered without medical indication at 37 weeks of gestation and for 8% delivered without medical indication at 38 weeks of gestation, compared with 4.6% of infants delivered at 39 weeks of gestation or beyond ($P < .001$ for deliveries at 38 weeks of gestation and 39 weeks of gestation).

In addition to immediate adverse perinatal outcomes, multiple studies have shown increased rates of adverse long-term infant outcomes associated with late-preterm and early-term delivery compared with full-term delivery such as increased hospitalization, cognitive issues and school related problems but further research in this area is needed .

There have been increasing efforts to reduce the incidence of elective induction or C-section prior to 39 weeks. Multiple national quality organizations have identified elective deliveries prior to 39 weeks as key quality indicators for obstetric hospital care. Groups include the Joint Commission (TJC), National Quality Forum (NQF), the American Board of Internal Medicine (Choosing Wisely) and The Leapfrog Group (LFG), identified elective deliveries prior to 39 weeks (induction of labor and cesarean section) as a key quality indicator for obstetric hospital care.

In order to support hospitals in eliminating non-medically indicated deliveries before 39 weeks, March of Dimes, California Maternal Quality Care Collaborative (CMQCC), and the California Department of Health, Maternal Child and Adolescent Health Division collaborated on the development of a quality improvement toolkit entitled “Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age; Quality Improvement Toolkit that contains comprehensive literature review about the importance of eliminating elective deliveries before 39 weeks, an implementation guide for hospitals, quality improvement processes and clinical and patient education tools. Examples of best practices are also included.

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The February 2021 interim update (number 818) by ACOG and Society for Maternal-Fetal Medicine includes updates and highlights (or removed as necessary) reflecting limited, focused changes in delivery timing recommendations, around fetal growth restrictions and intrahepatic cholestasis of pregnancy. A link to this document can be found in the References section.

The June 2021 interim update (number 831) by ACOG and Society for Maternal-Fetal Medicine includes updates and highlights (or removed as necessary) to reflect a limited focused change in delivery timing recommendations around preterm prelabor rupture of membranes.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2015, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

ICD-10-CM Diagnosis Codes (may not be an all inclusive list)

ICD-10-CM Code	Description
O10	Pre-existing hypertension complicating pregnancy, childbirth and the puerperium
O11	Pre-existing hypertension with pre-eclampsia
O12	Gestational [pregnancy-induced] edema and proteinuria without hypertension
O13	Gestational [pregnancy-induced] hypertension without significant proteinuria
O14	Pre-eclampsia
O15	Eclampsia
O16	Unspecified maternal hypertension
O24	Diabetes mellitus in pregnancy, childbirth, and the puerperium
O26.6	Liver and biliary tract disorders in pregnancy, childbirth and the puerperium
O28	Abnormal findings on antenatal screening of mother
O30	Multiple gestation
O31	Complications specific to multiple gestation
O32	Maternal care for malpresentation of fetus
O33	Maternal care for disproportion
O34	Maternal care for abnormality of pelvic organs
O35	Maternal care for known or suspected fetal abnormality and damage
O36	Maternal care for other fetal problems

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ICD-10-CM Code	Description
O40	Polyhydramnios
O41	Other disorders of amniotic fluid and membranes
O42	Premature rupture of membranes
O43	Placental disorders
O44	Placenta previa
O45	Premature separation of placenta [abruptio placentae]
Z3A.0	Weeks of gestation of pregnancy, unspecified or less than 10 weeks
Z3A.1	Weeks of gestation of pregnancy, weeks 10 - 19
Z3A.2	Weeks of gestation of pregnancy, weeks 20 - 29
Z3A.3	Weeks of gestation of pregnancy, weeks 30 - 39

Reviews, Revisions, and Approvals	Date	Approval Date
Initial Policy annual review	6/11	6/11
Broadened scope of policy to include both induction of labor and cesarean delivery and revised title to reflect both Added examples of potential diagnoses for early elective deliveries and ICD-10 codes	6/17	6/17
Update with no changes	6/18	6/18
Added information from the ACOG committee opinions (#764 and #765) updated in 2019 to include additional obstetric conditions that may be considered for delivery before 39 weeks of gestation; updated background, references and codes	6/19	6/19
Update no changes	6/20	6/20
Added link to updated ACOG Committee Opinion 818 with revisions to delivery timing recommendations, fetal growth restriction and intrahepatic cholestasis of pregnancy	6/21	6/21
Added link to updated ACOG Committee Opinion 831 with revisions to delivery timing recommendations, fetal growth restriction and intrahepatic cholestasis of pregnancy	6/22	6/22
Reviewed with no changes, updated references	6/23	6/23

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Accessed: February 2022

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.



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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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