

## Clinical Policy: Elective Deliveries Before 39 Weeks Gestational Age

Reference Number: TX.CP.MP.513

Last Review Date: 10/19

[Coding Implications](#)

[Revision Log](#)

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

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### Description

Multiple recent studies indicate that elective deliveries <39 weeks carry significant increased risk for the baby compared to infants born between 39 and 41 weeks. The risk is highest for scheduled pre-labor cesarean sections at 37 weeks gestation, but is significant for all subgroups examined. Even babies delivered at 38 4/7 to 38 6/7 weeks have higher risk of complications than those delivered after 39 weeks:

- Increased NICU admissions
- Increased transient tachypnea of the newborn
- Increased respiratory distress syndrome
- Increased ventilator support
- Increased suspected or proven sepsis
- Increased newborn feeding problems and other transition issues

In addition, preliminary data indicates these risks are not diminished despite amniocentesis documenting a mature lung profile. A mature lung profile does not necessarily lessen the risk of morbidity.

This policy applies to the following products: STAR, STAR Health, STAR Kids, STAR+PLUS, CHIP and CHIP Perinate.

### Policy/Criteria

- I. It is the policy of Superior HealthPlan that delivery before 39 weeks gestational age may be **medically necessary** for the following indications:
- A. Placental abruption, placenta previa, or unspecified antenatal hemorrhage
  - B. Fetal demise or fetal demise in prior pregnancy
  - C. Rupture of membranes prior to labor (term or preterm)
  - D. Gestational hypertension, preeclampsia, eclampsia, or chronic hypertension
  - E. Preexisting diabetes or gestational diabetes
  - F. Renal disease
  - G. Maternal coagulation defects in pregnancy (includes anti-phospholipid syndrome)
  - H. Liver diseases (including cholestasis of pregnancy)
  - I. Cardiovascular diseases (congenital and other)
  - J. HIV (human immunodeficiency virus) infection
  - K. Intrauterine growth restriction, oligohydramnios, polyhydramnios, fetal distress, or abnormal fetal heart rate
  - L. Isoimmunization (Rh and other) or fetal-maternal hemorrhage
  - M. Fetal malformation, chromosomal abnormality, or suspected fetal injury.

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Note: This list of indications does not set a standard of care for who should or should not have an elective delivery prior to 39 weeks gestation. For example, women with diet-controlled gestational diabetes generally should not be induced prior to 39 or even 40 weeks unless complications are present.

- II.** It is the policy of Superior HealthPlan that any services at the delivering facility for the mother and baby will be denied if medical necessity is not met for the elective delivery, including any NICU admission. In addition, the professional fees for the delivering physician will be denied as well.

Note: This will not affect the payment of any professionals other than the delivering physician or any facility authorizations other than the delivering facility.

#### Background

According to the American College of Obstetricians and Gynecologists (ACOG), the indications for delivery prior to 39 weeks gestation are not absolute, but should take into account maternal and fetal conditions, gestational age, cervical status and other factors. Furthermore, “labor can be induced for logistical or psychosocial indications, but gestation should be  $\geq 39$  weeks or a mature fetal lung test should be established. A mature fetal lung test result before 39 weeks of gestation, in the absence of appropriate clinical circumstances, is not an indication for delivery” because a mature fetal lung test does not mean the baby will not experience breathing difficulties after birth.

The *Guidelines for Perinatal Care*, 8th Edition similarly advise against elective cesarean deliveries until 39 weeks.

Rates of labor induction have increased dramatically, from 9% in 1989 to 21.2% in 2004. Much of this rise has been attributed to an increase in elective inductions. Data from the Hospital Corporation of America showed that 44% of deliveries at term in 2007 were scheduled cesarean sections or inductions and that 71% of these were elective. Deliveries between 37 and 38 weeks gestation have increased dramatically in the period 1990 through 2006 and account for approximately 17.5% of live births in the United States.

The concomitant rise in deliveries between 37 and 39 weeks has been associated with an increase in obstetrical interventions such as induction of labor and cesarean sections.

The rise of induction of labor is present in all racial groups with the highest increase in Non-Hispanic whites. Most concerning is that a large proportion of these early term births, regardless of race/ethnicity, may be due to scheduled, non-medically indicated interventions.

Non-medically indicated (elective) deliveries described above are either induced and/or done by scheduled cesarean section and indicate that physician decisions may, in part, be driving higher rates of early elective deliveries. In addition, it has been suggested that women may not have an accurate perception of the benefits of carrying a baby to term.

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#### Appendix

##### Definitions:

- **Early term deliveries** – the delivery of infants who are born between 37 0/7 through 38 6/7 weeks gestation.
- **Elective induction of labor** – the induction of labor without an accepted medical or obstetrical indication before the spontaneous onset of labor or rupture of membranes.
- **Elective cesarean section** – scheduled primary or repeat cesarean section without an accepted medical or obstetrical indication before the spontaneous onset of labor or rupture of membranes.
- **Gestational weeks** – often grouped into categories:
  - Late preterm is defined as the period from 34 0/7 to 36 6/7 weeks gestation.
  - Early term is defined as the period from 37 0/7 to 38 6/7 weeks gestation.
- **Scheduled** – a planned induction or cesarean section that is scheduled for either elective or non-elective/medically indicated reasons.

#### Coding Implications

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.

CPT® Codes	Description
N/A	

HCPCS Codes	Description
N/A	

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	02/12	02/12
Removed work process and imbedded under attachment. Work Process change to include infants NOT admitted to the NICU but delivered prior to	02/15	02/15

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Reviews, Revisions, and Approvals	Date	Approval Date
39 weeks gestational age due to C-section or induction of labor. Signature page updated.		
Removed post term pregnancy under policy criteria. Work process attachment removed. Updated references.	01/16	01/16
Removed product regional references. Updated references and signatories.	01/17	01/17
Added Star Kids under products. Added ACOG reference on induction of labor and updated TMPPM reference.	12/17	12/17
Annual Review. Updated references, signatories, and review date. Deleted revision history prior to 2014. Grammatical edits.	12/18	12/18
Updated to new template from TX.UM.13 (TX.CP.MP.513 nomenclature implementation 10/1/19). Updated references.	10/19	10/19

### References

1. Texas Medicaid Provider Procedure Manual, 4.1.3 *Elective Deliveries Prior to 39 weeks*, September 2019.
2. MCAH- Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks: Main E, Oshiro B, Chagolla B, Bingham D, Dang-Kilduff L, and Kowalewski L. Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age. (California Maternal Quality Care Collaborative Toolkit to Transform Maternity Care) Developed under contract #08-85012 with the California Department of Public Health; Maternal, Child and Adolescent Health Division; First edition published by March of Dimes, July 2010.
3. The American College of Obstetricians and Gynecologists. (2009), *Induction of Labor*. ACOG Practice Bulletin Number 107.
4. American Academy of Pediatrics and American College of Obstetricians and Gynecologists. Guidelines for perinatal care: Eighth edition. September 2017.

### **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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage

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decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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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