

Clinical Policy: Elective Deliveries Before 39 Weeks Gestational Age

Reference Number: MS.CP.MP.17
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See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Multiple recent studies indicate that elective deliveries before 39 weeks gestational age carry significant increased risk for the baby with no known benefit to the mother. 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 (TTN)
- Increased respiratory distress syndrome (RDS)
- Increased ventilator support
- Increased suspected or proven sepsis
- Increased newborn feeding problems and other transition issues

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

Policy/Criteria

1. It is the policy of the Plan that delivery before 39 weeks gestational age **is medically necessary** when meeting one of the following criteria:

- Placenta previa, accrete, or abruption
- Thrombophilia or an occurrence of maternal coagulation defects
- Fetal demise in prior pregnancy
- Non-reassuring fetal status or fetal compromise
- Premature rupture of membranes
- Complicated chronic or gestational hypertension
- Preeclampsia
- Eclampsia
- Poorly controlled diabetes mellitus (pre-gestational or gestational)
- Renal disease
- Liver disease
- Cardiovascular diseases
- HIV infection
- Intrauterine Growth Restriction (IUGR)
- Oligohydramnios
- Polyhydramnios

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- Fetal malformation
- Isoimmunization
- Prior myomectomy
- Multiple gestations
- Chorioamnionitis
- Classical or vertical uterine incision from prior cesarean delivery
- Pulmonary disease
- Malignancy
- Other conditions documented as medically necessary by attending practitioner

Note: This list of indications does not set a standard of care for who should or should not be electively delivered 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. Likewise most centers recommend a scheduled cesarean delivery prior to 39 weeks for women with a prior vertical uterine incision.

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

2. The Plan does not cover non-medically necessary early elective deliveries, prior to 39 weeks gestational age including, but not limited to, the following:

- Maternal request
- Convenience of the member or family
- Maternal exhaustion or discomforts
- Availability of effective pain management
- Provider convenience
- Facility scheduling
- Suspected macrosomia with documented pulmonary maturity with no other medical indication
- Well-controlled diabetes
- History of rapid deliveries
- Long distance between member and treating facility
- Adoption

Background

According to the American College of Obstetricians and Gynecologists, 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 ≥ 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.

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The *Guidelines for Perinatal Care*, 6th 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.

Multiple recent studies indicate that elective deliveries before 39 weeks carry significant increased risk for the baby. 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.

| Reviews, Revisions, and Approvals | Date | Approval Date |
|---|-----------|---------------|
| New Policy. | 7/12/16 | 7/12/16 |
| Added the sentence Nurses may approve 3 days for a vaginal delivery and 5 days for a cesarean delivery. | 2/23/17 | 2/23/17 |
| Annual review; updated references. | 7/10/17 | 7/10/17 |
| Annual review. | 7/10/18 | 7/10/18 |
| Annual review; converted to a Clinical Policy. | 3/15/19 | 5/16/19 |
| Annual review. | 2/18/2020 | 2/20/2020 |

Bibliography

1. Mississippi Division of Medicaid Administrative Code
2. American College of Obstetricians and Gynecologists (ACOG)
3. Guidelines for Perinatal Care, 6th edition
4. Hospital Corporation of America
5. 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)

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a thorough review and consideration of generally accepted standards of medical practice, peer-reviewed medical literature, government agency/program approval status and other indicia of medical necessity.

The purpose of this clinical policy is to provide a guide to medical necessity. Benefit determinations should be based in all cases on the applicable contract provisions governing plan benefits (“Benefit Plan Contract”) and applicable state and federal requirements, as well as applicable plan-level administrative policies and procedures. To the extent there are any conflicts between this Clinical Policy and the Benefit Plan Contract provisions, the Benefit Plan Contract provisions will control.

Clinical policies are intended to be reflective of current scientific research and clinical thinking. This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding results. 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.

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