OBSTETRICAL INDUCTION OF LABOR

Protocol: OBG033
Effective Date: September 1, 2018

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INSTRUCTIONS FOR USE
This protocol provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee's document (e.g., Certificate of Coverage (COC) or Evidence of Coverage (EOC)) may differ greatly. In the event of a conflict, the enrollee's specific benefit document supersedes this protocol. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this Protocol. Other Protocols, Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Protocols, Policies and Guidelines as necessary. This protocol is provided for informational purposes. It does not constitute medical advice. This policy does not govern Medicare Group Retiree members.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

COMMERCIAL, MEDICAID AND MEDICARE COVERAGE RATIONALE

MCG™ Guidelines 22nd edition
Referenced in Vaginal Delivery S-1180

Induction of Labor Portion of the MCG is as follows:
Induction of labor is indicated for 1 or more of the following:
  • Late-term gestation (41 0/7 weeks or beyond)
  • Chorioamnionitis
  • Fetal demise
  • Fetal compromise as indicated by 1 or more of the following:
    o Intrauterine growth restriction
    o Isoimmunization
    o Oligohydramnios
    o Fetal compromise indicated by other significant finding (specify)
• Premature rupture of membranes (34 weeks or beyond)
• Premature rupture of the membranes at term (37 weeks or beyond)
• Maternal comorbidity as indicated by **1 or more** of the following:
  o Antiphospholipid syndrome
  o Cardiac disease
  o Cholestasis of pregnancy
  o Pulmonary disease
  o Maternal comorbidity indicated by other significant disease or finding (specify)
• Eclampsia
• Delivery planned due to preeclampsia with severe features (ie, severe preeclampsia) indicated by **ALL** of the following:
  o Severe preeclampsia present as indicated by **1 or more** of the following:
    ▪ SBP greater than or equal to 160 mm Hg or DBP greater than or equal to 110 mm Hg on 2 occasions at least 4 hours apart while patient is at bed rest (unless antihypertensive therapy is initiated before this time)
    ▪ Platelet count less than 100,000/mm$^3$ (100 x10$^9$/L)
    ▪ Impaired liver function as indicated by **1 or more** of the following:
      ▫ Elevation of liver enzymes (eg, SGOT, SGPT) to twice normal concentration
      ▫ Severe persistent right upper quadrant or epigastric pain unresponsive to medication and not accounted for by alternative diagnosis
    ▪ Progressive renal insufficiency indicated by **1 or more** of the following:
      ▫ Serum creatinine concentration greater than 1.1 mg/dL (97 micromoles/L)
      ▫ Doubling (from baseline) of serum creatinine concentration in absence of other renal disease
      ▫ Pulmonary edema
      ▫ Cerebral or visual symptoms (eg, headache, altered mental status, changes in vision)
  o Delivery indicated due to **1 or more** of the following:
    ▪ Gestational age of 34 0/7 weeks or more
    ▪ Maternal indication for delivery at less than 34 0/7 weeks of gestation indicated by **1 or more** of the following:
      ▫ Persistent epigastric or right upper quadrant pain
      ▫ Premature rupture of membranes
      ▫ Recurrent severe hypertension
      ▫ Recurrent or persistent signs or symptoms of severe preeclampsia
    ▪ Suspected abruptio placentae
    ▪ Fetal indication for delivery at less than 34 0/7 weeks of gestation indicated by **1 or more** of the following:
      ▫ Severe fetal growth restriction (estimate of fetal weight less than the 5th percentile)
      ▫ Persistent oligohydramnios (maximum vertical pocket less than 2 cm)
      ▫ Biophysical profile of 4 out of 10 or less on at least 2 occasions 6 hours apart
      ▫ Reversed end-diastolic flow on umbilical artery Doppler studies
      ▫ Recurrent variable or late decelerations during nonstress test
      ▫ Nonviable fetus (eg, 23 to 24 weeks of gestation or less)
      ▫ Fetal death
• Delivery planned due to nonsevere preeclampsia indicated by **ALL** of the following:
  o Nonsevere preeclampsia present as indicated by **ALL** of the following:
- Woman at 20 or more weeks of gestation
- New-onset SBP greater than or equal to 140 mm Hg but less than 160 mm Hg or DBP greater than or equal to 90 mm Hg but less than 110 mm Hg on 2 occasions at least 4 hours apart
- Proteinuric present as indicated by **1 or more** of the following:
  - Urinary protein excretion greater than or equal to 300 mg per 24-hour collection (or this amount extrapolated from a shorter timed collection)
  - Protein/creatinine ratio greater than or equal to 0.3 (measured in mg/dL)
- Delivery indicated due to **1 or more** of the following:
  - Gestational age of 37 0/7 weeks or more
  - Gestational age of 34 0/7 weeks to 36 6/7 weeks and **1 or more** of the following:
    - Progressive labor or rupture of membranes
    - Abnormal biophysical profile
    - Suspected abruptio placentae
    - Ultrasound estimate of fetal weight less than 5th percentile
    - Other indication for preterm delivery
- Delivery planned due to gestational because of **1 or more** of the following:
  - Delivery indicated because gestational age of 37 0/7 weeks or more has been reached
  - Gestational age of 34 0/7 weeks to 36 6/7 weeks for which delivery is indicated because of **1 or more** of the following:
    - Progressive labor or rupture of membranes
    - Abnormal biophysical profile
    - Suspected abruptio placentae
    - Ultrasound estimate of fetal weight less than 5th percentile
    - Other indication for preterm delivery
- Elective induction preferred (ie, versus awaiting spontaneous labor) and appropriate as indicated by **ALL** of the following:
  - Adequate fetal lung maturity or course of antenatal corticosteroids administered
  - Sufficient gestational age indicated by **1 or more** of the following:
    - Fetal or maternal complication warrants delivery prior to 39 0/7 weeks’ gestation
    - Singleton pregnancy of at least 39 0/7 weeks of gestation
    - Dichorionic-diamniotic twins of at least 34 0/7 weeks’ gestation
    - Monochorionic-monoamniotic twins of at least 32 0/7 weeks’ gestation
    - Higher-order pregnancy (ie beyond twin)

**End of MCG**

A mature fetal lung test result before 39 weeks of gestation, in the absence of appropriate clinical circumstances, is not an indication for delivery and would therefore be **not medically necessary**.

**Contraindications for Induction of Labor**

The individual patient and clinical situation should be considered in determining when induction of labor is **contraindicated**. Generally, the contraindications to labor induction are the same as those for spontaneous labor and vaginal delivery. They include, but are not limited to, the following situations:

- Vasa previa or complete placenta previa
- Transverse fetal lie
- Umbilical cord prolapse
- Previous classical cesarean delivery
- Active genital herpes infection
- Previous myomectomy entering the endometrial cavity

Induction of Labor for Type 2 or GDMA1 (see definition below) diabetic members is not medically necessary in the absence of other indications.

Medicare does not have a National Coverage Determination or a Local Coverage Determination for obstetric induction of labor (Accessed July 2018).


603.4 Maternity Care
Early Induction of Labor (EIOL)
The American Congress of Obstetricians and Gynecologists (ACOG) issued a Revision of Labor Induction Guidelines in July 2009, citing, “The rate of labor induction in the US has more than doubled since 1990. In 2006, more than 22% (roughly one out of every five) of all pregnant women had their labor induced.” The revision further states, “… the ACOG recommendations say the gestational age of the fetus should be determined to be at least 39 weeks or that fetal lung maturity must be established before induction.”

Research shows that early elective induction (<39 weeks gestation) has no medical benefit and may be associated with risks to both the mother and infant. Based upon these recommendations, the DHCFP will require prior authorization for hospital admissions for EIOL prior to 39 weeks to determine medical necessity.

For Medicare and Medicaid Determinations Related to States Outside of Nevada:
Please review Local Coverage Determinations that apply to other states outside of Nevada.
http://www.cms.hhs.gov/mcd/search

Important Note: Please also review local carrier Web sites in addition to the Medicare Coverage database on the Centers for Medicare and Medicaid Services’ Website.

BACKGROUND
The goal of induction of labor is to achieve vaginal delivery by stimulating uterine contractions before the spontaneous onset of labor. Generally, induction of labor has merit as a therapeutic option when the benefits of expeditious delivery outweigh the risks of continuing the pregnancy. The benefits of labor induction must be weighed against the potential maternal and fetal risks associated with this procedure.

Methods used for induction of labor include the administration of oxytocin, membrane stripping, amniotomy, nipple stimulation and the administration of prostaglandin E analogues.
Gestational Diabetes Definitions:

- GDMA1 - abnormal oral glucose tolerance test (OGTT), but normal blood glucose levels during fasting and two hours after meals; diet modification is sufficient to control glucose levels.
- GDMA2: abnormal OGTT compounded by abnormal glucose levels during fasting and/or after meals; additional therapy with insulin or other medications is required.

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

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<tr>
<th>CPT® Codes</th>
<th>Description</th>
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<tr>
<td>59200</td>
<td>Insertion of cervical dilator (e.g., laminaria, prostaglandin) (separate procedure)</td>
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<tr>
<td>59400</td>
<td>Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care</td>
</tr>
<tr>
<td>59510</td>
<td>Routine obstetric care including antepartum care, cesarean delivery, and postpartum care</td>
</tr>
<tr>
<td>59610</td>
<td>Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery</td>
</tr>
<tr>
<td>59618</td>
<td>Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery</td>
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REFERENCES


Dare MR, Middleton P, Crowther CA, Flenady VJ, Varatharaju B. Planned early birth versus expectant management (waiting) for prelabour rupture of membranes at term (37 weeks or more). Cochrane Database of Systematic Reviews 2006, Issue 1. Art. No.: CD005302. DOI: 10.1002/14651858.CD005302.pub2. (Level III)


The foregoing Health Plan of Nevada/Sierra Health & Life Health Operations protocol has been adopted from an existing UnitedHealthcare coverage determination guideline that was researched, developed and approved by the UnitedHealthcare Coverage Determination Committee.