

DSHS Grand Rounds

May 2

**Reducing
Non-Medically
Necessary Deliveries
before 39 Weeks**



Logistics

Registration through TRAIN at:

<https://tx.train.org>

For additional guidance on registration please contact Annette Lara,
CE.Service@dshs.state.tx.us or (512) 776-3567

Slides and recorded webinar available on Grand Rounds website at:

<http://extra.dshs.state.tx.us/grandrounds>

Questions?

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Disclosure to the Learner

Requirement of Learner

Participants requesting continuing education contact hours or a certificate of attendance must register in TRAIN, attend the entire session, and complete the online evaluation within two weeks of the presentation.

Commercial Support

This educational activity received no commercial support.

Disclosure of Financial Conflict of Interest

The speakers and planning committee have no relevant financial relationships to disclose.

Non-Endorsement Statement

Accredited status does not imply endorsement by Department of State Health Services – Continuing Education Services, Texas Medical Association, or American Nurses Credentialing Center of any commercial products displayed in conjunction with an activity.

Introductions



David Lakey, MD,
DSHS Commissioner
is pleased to introduce today's
DSHS Grand Rounds speakers.

Reducing Non-Medically Necessary Deliveries before 39 Weeks



Eugene C. Toy, MD
Vice Chair of Academic Affairs
Department of Ob/Gyn
Methodist Hospital, Houston
John S. Dunn, Sr. Academic Chief of Ob/Gyn
St. Joseph Medical Center, Houston



Paula J. Efird, RNC-OB, BSN
Director of Maternal Fetal Services
St. Joseph Medical Center, Houston

Acknowledgments

- Texas DSHS
- Texas HHSC and TMHP
- Texas Association of Ob/Gyn
- Texas District XI of ACOG
- St Joseph Medical Center, Houston
 - Special thanks to Pat Mathews, CEO and Tina Coker, CNO
- March of Dimes
 - Texas Chapter and Big 5 Project

Objectives

- **Objective #1** – Demonstrate understanding of the national and state trends in preterm birth, low birth weight and how they may be impacted by less than 39 week deliveries.
- **Objective #2** – Describe the new Medicaid reimbursement policy for delivery prior to 39 weeks and the clinical reasons that policy was implemented.
- **Objective #3** – Recognize the clinical implications of elective delivery by induction or cesarean-section prior to 39 weeks.

Objectives (cont.)

- **Objective #4** –Support individualized medical decision-making of providers regarding medical conditions that would warrant delivery prior to 39 weeks.
- **Objective #5**– Describe resources to be able to implement processes in provider's practices and hospitals to reduce non-medically indicated (NMI) deliveries less than 39 weeks.
- **Objective #6**– Effectively negotiate with and educate patients who desire elective birth at less than 39 weeks.

Disclaimer

- We have made every effort to be accurate; however, we don't speak for Texas Health and Human Services Commission (HHSC), Texas Medicaid and Healthcare Partnership (TMHP), or the Office of the Inspector General (OIG)
- Please consult the appropriate bulletins or communications

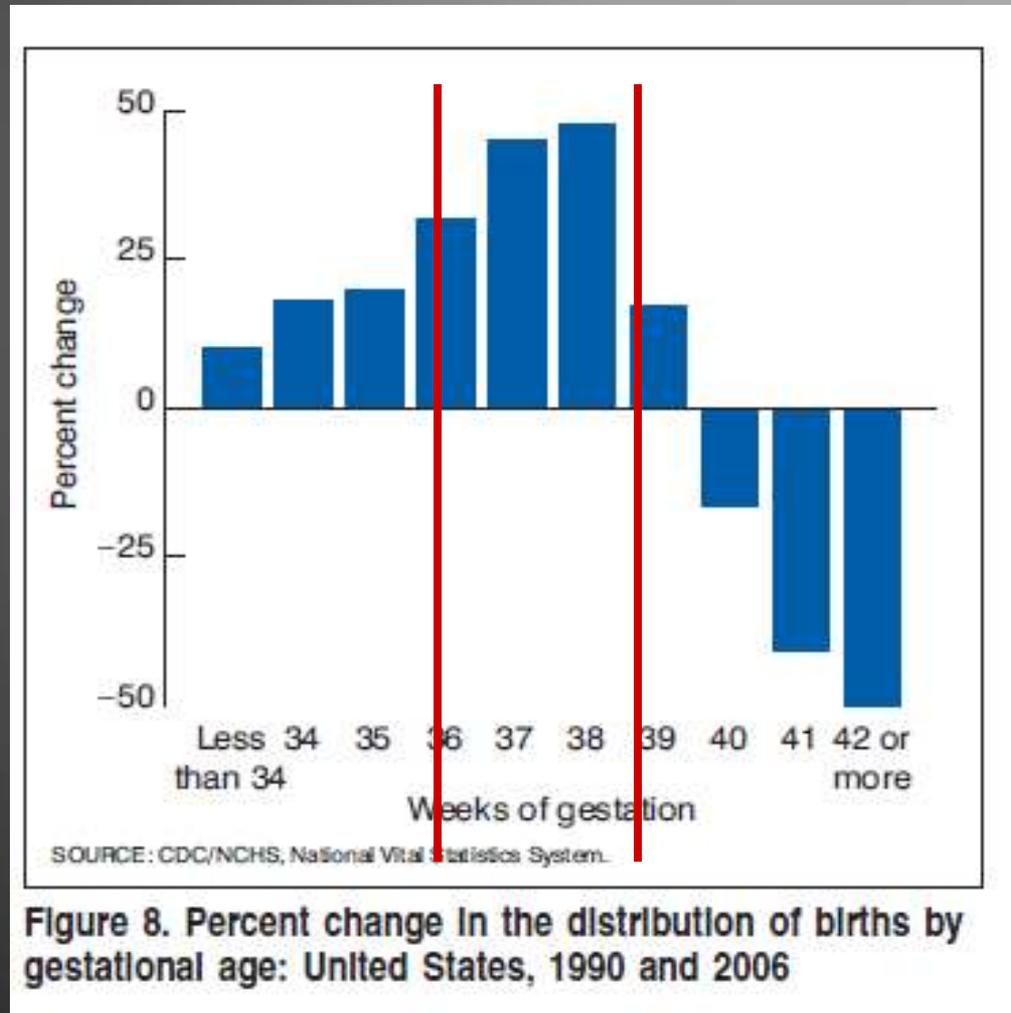
Terminology

- Term: 37–42 weeks
- Late Preterm: 34w0d–36w 6d
- Early Term: 37w0d–38w 6d
- **KEY: Early Term is from 37w0d to 38w6d**

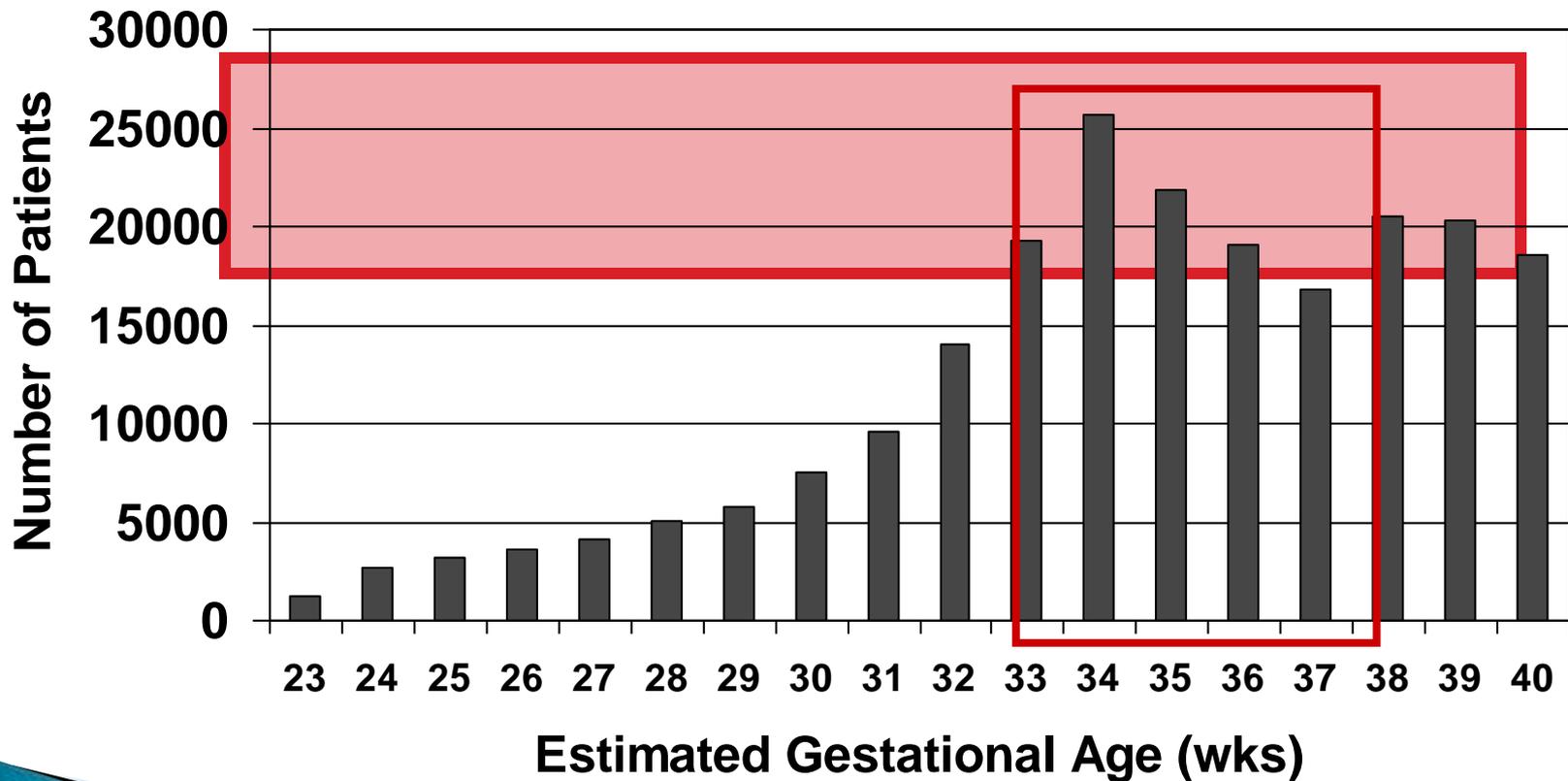
Gestational Age Outcomes

- Until recently, we thought **term** neonates (37 weeks) did as well as 38, or 39 or 40 weeks
- We thought all “**term**” were the same
- Hence, previously no special designation for “**early term**”

Percent change in gestational age distribution in US (1990–2006)



Late-preterm and near-term infants occupy most NICU beds



Clark R et al. Pediatrix Database. 2005.

MFM Network Study– NEJM 2009

- Large research study with 19 hospitals and 24,000 patients
- > 1 / 3 of babies delivered by cesarean w/o a medical reason before 39 weeks
 - Infants born at 38 weeks: 50% greater chance of NICU admission
 - Those delivered at 37 weeks: 2x as likely to enter NICU
 - The gestational age with the lowest risk for neonatal problems: 39 weeks or 40 weeks

Tita, et al., NEJM, Jan 2009

The NEW ENGLAND JOURNAL *of* MEDICINE

ESTABLISHED IN 1812

JANUARY 8, 2009

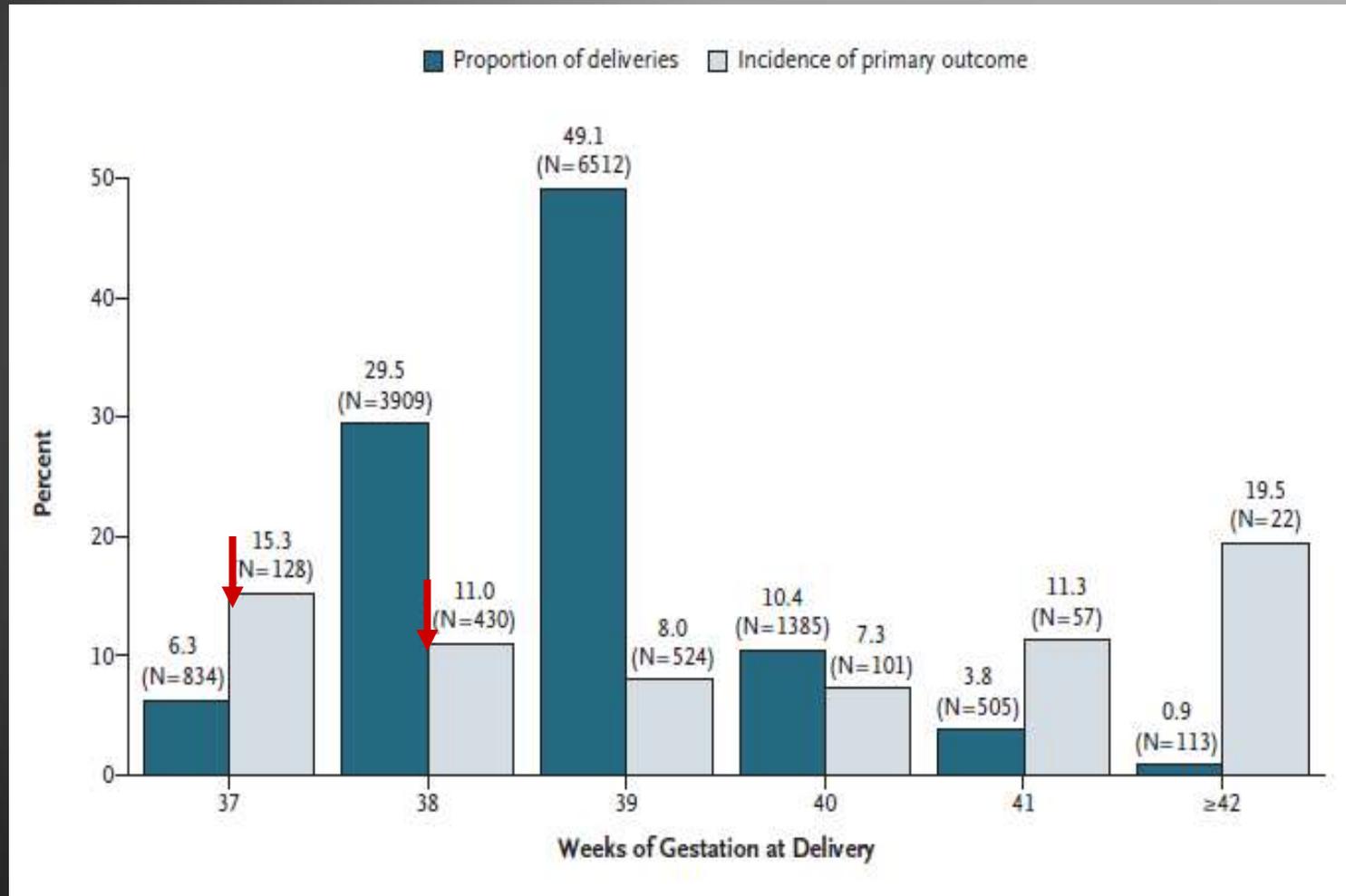
VOL. 360 NO. 2

Timing of Elective Repeat Cesarean Delivery at Term and Neonatal Outcomes

Alan T.N. Tita, M.D., Ph.D., Mark B. Landon, M.D., Catherine Y. Spong, M.D., Yinglei Lai, Ph.D., Kenneth J. Leveno, M.D., Michael W. Varner, M.D., Atef H. Moawad, M.D., Steve N. Caritis, M.D., Paul J. Meis, M.D., Ronald J. Wapner, M.D., Yoram Sorokin, M.D., Menachem Miodovnik, M.D., Marshall Carpenter, M.D., Alan M. Peaceman, M.D., Mary J. O'Sullivan, M.D., Baha M. Sibai, M.D., Oded Langer, M.D., John M. Thorp, M.D., Susan M. Ramin, M.D., and Brian M. Mercer, M.D., for the Eunice Kennedy Shriver NICHD Maternal-Fetal Medicine Units Network*

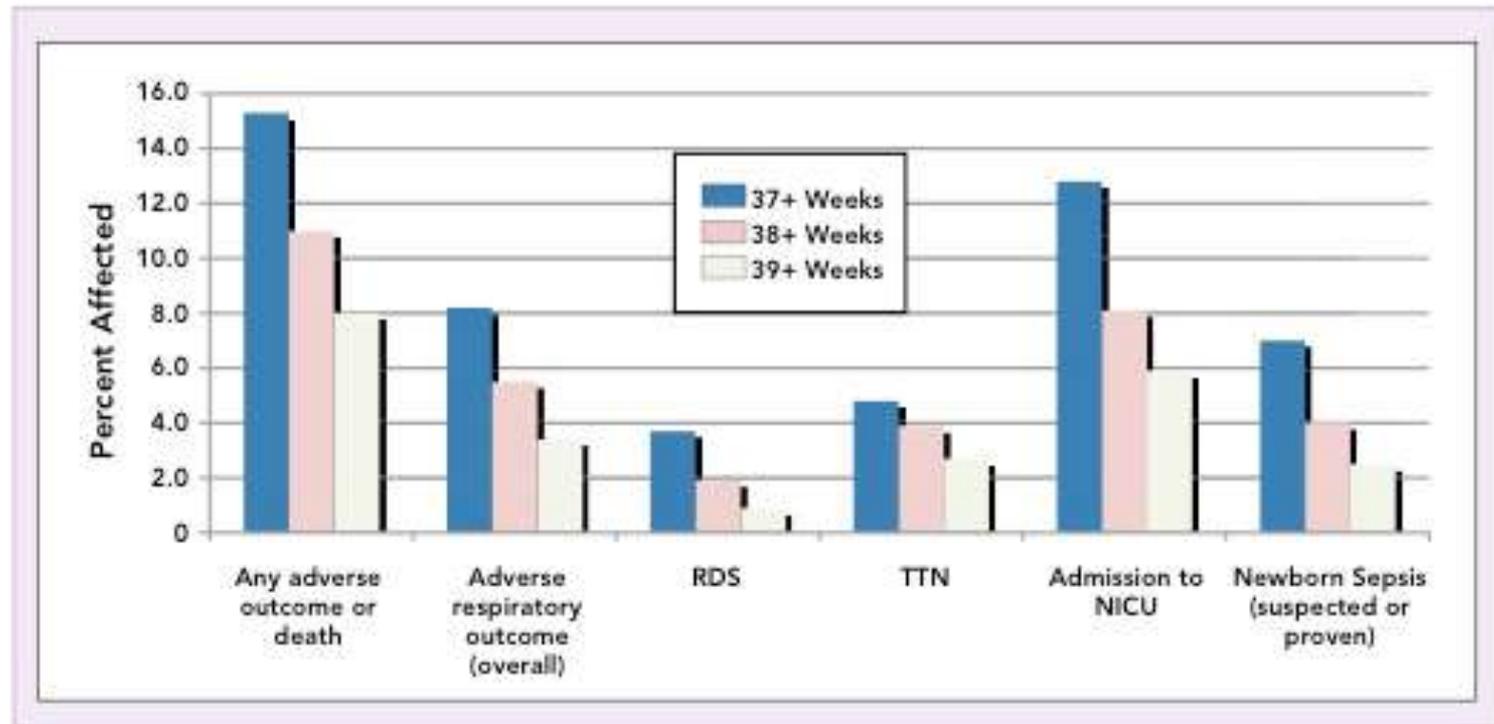
ABSTRACT

Timing of elective repeat cesarean delivery at term and neonatal outcomes



Tita ATN, Landon MB, Spong CY, et al. NEJM 2009.

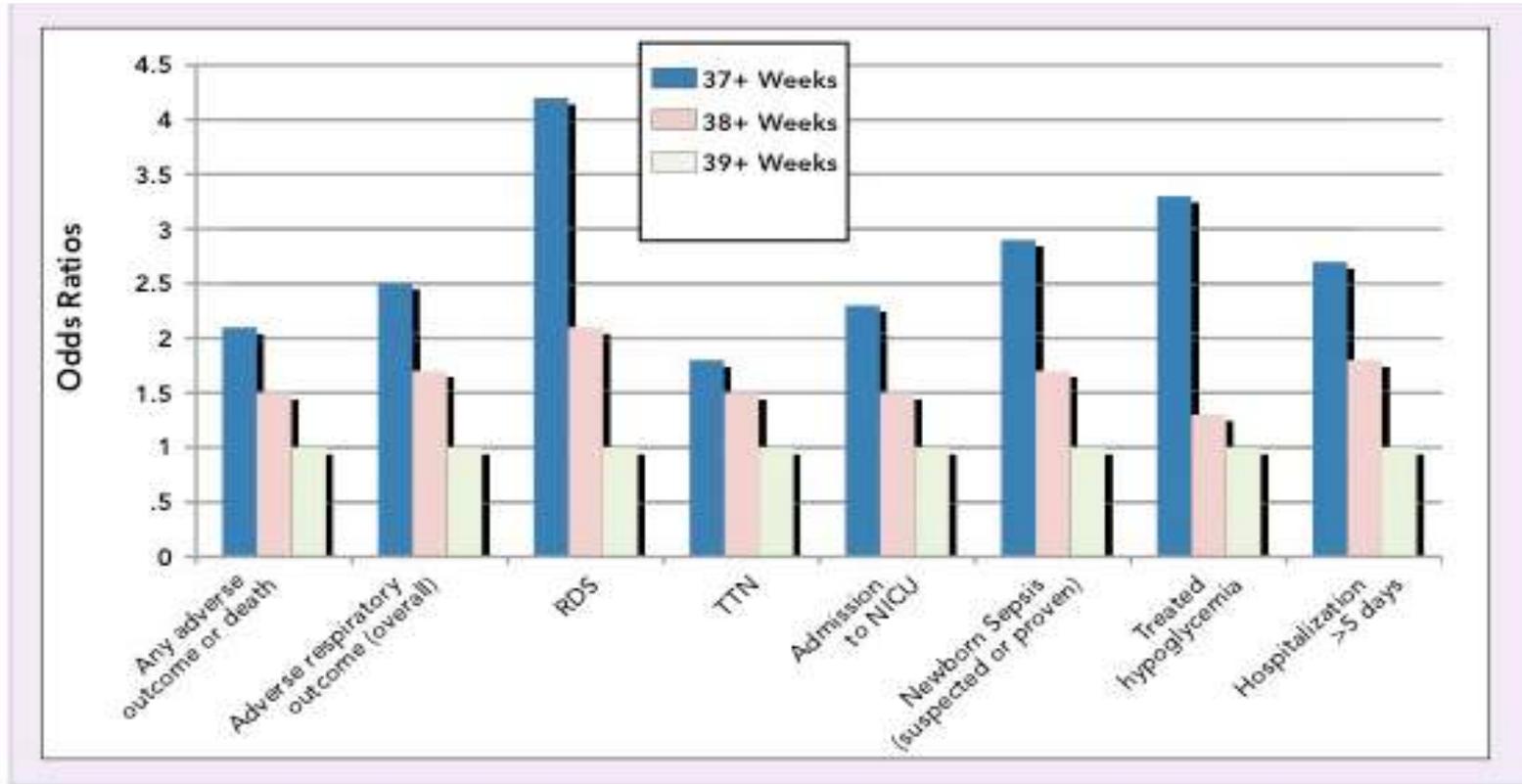
Adverse Neonatal Outcomes According to Completed Week of Gestation at Delivery: **Absolute Risk**



Adapted from Tita AT, et al. NEJM 2009;360:111

Courtesy of March of Dimes

Adverse Neonatal Outcomes According to Completed Week of Gestation at Delivery: Odds Ratios



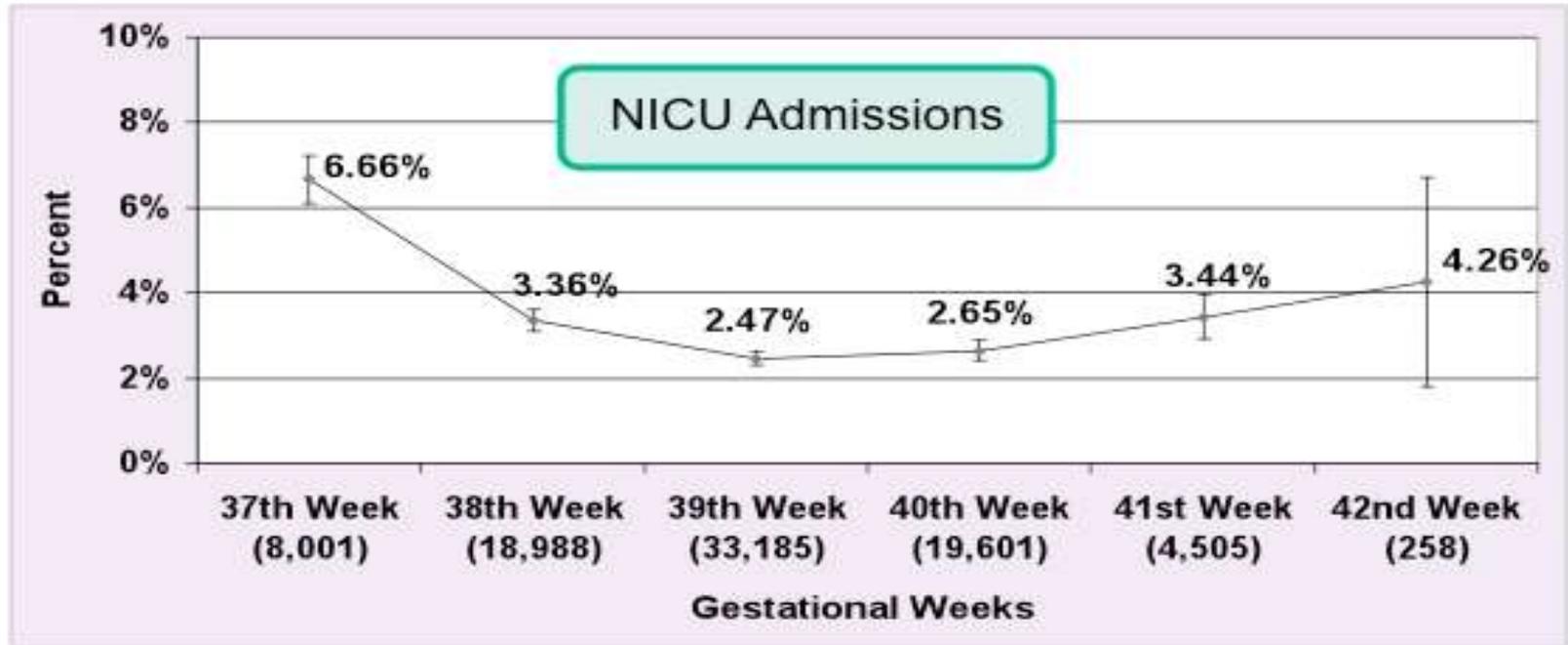
Adapted from Tita AT, et al. NEJM 2009;360:111

Courtesy of March of Dimes

MFM Network Study (NEJM 2009)

- This remains the best, most comprehensive study on the subject
- Numerous other studies confirm these findings

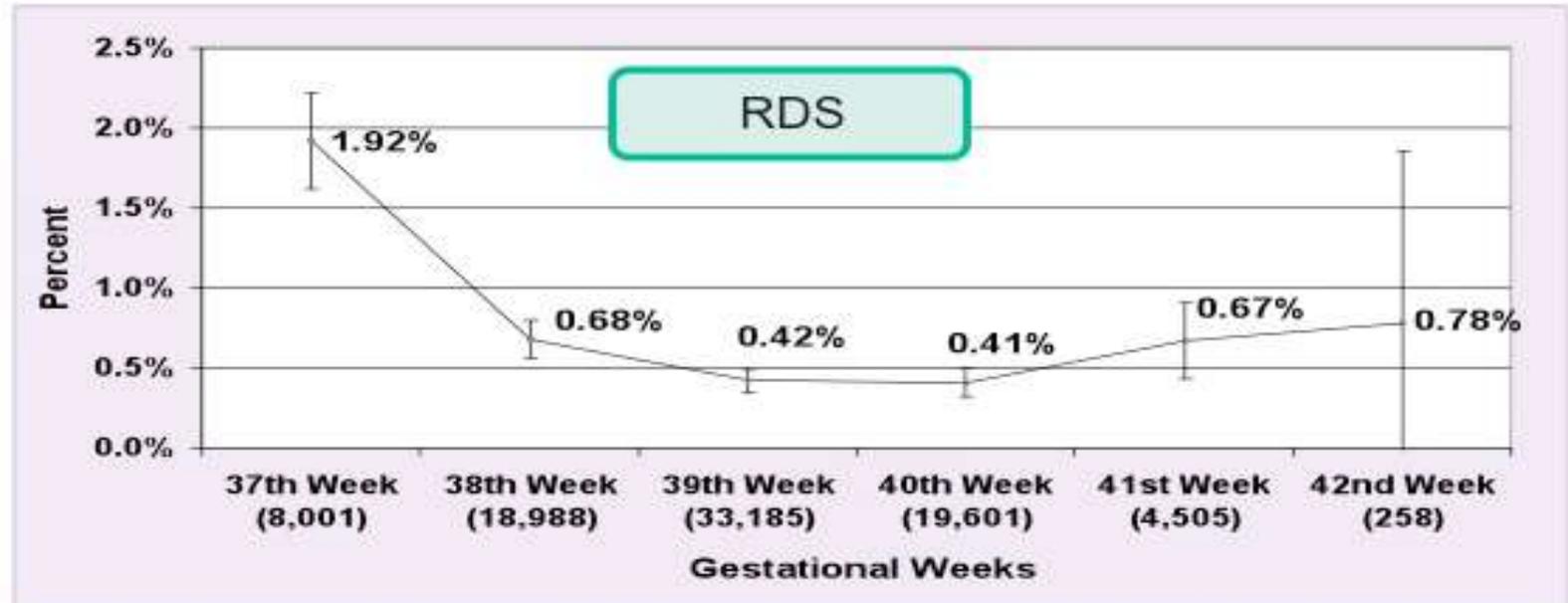
NICU Admissions by Weeks Gestation Deliveries Without Complications, 2000–2003



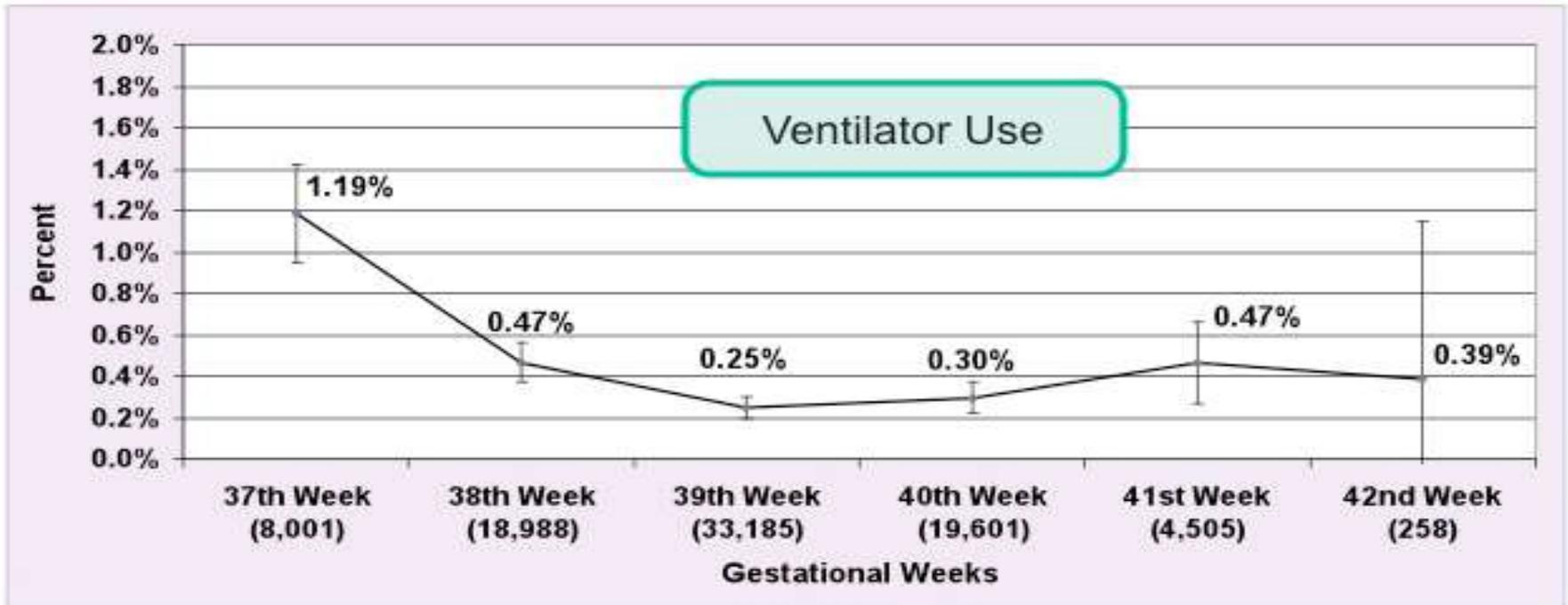
Oshiro et al. Obstet Gynecol 2009;113:804-811.

Courtesy of March of Dimes

RDS by Weeks Gestation Deliveries Without Complications, 2000–2003



Ventilator Usage by Weeks Gestation Deliveries Without Complications, 2000–2003



Oshiro et al. Obstet Gynecol 2009;113:804-811.

Courtesy of March of Dimes

Quality Marker

- The Joint Commission, CMS, Agency for Healthcare Research and Quality, National Quality Forum, and many insurers have listed early term NMI deliveries as a perinatal quality measure.
- Increasingly, hospitals and doctors are being scrutinized regarding this area.



NQMC National Quality Measures Clearinghouse

- Home
- Measures
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 - By Domain
 - NQF-Endorsed Measures
 - Measure Initiatives
 - Measures in Progress
 - Measure Index
 - Measure Archive
 - Measures Most Viewed
 - Related NGC Guidelines
- Expert Commentaries

Measure Summary

Title

Perinatal care: percentage of patients with **elective** vaginal deliveries or **elective** cesarean sections at greater than or equal to 37 and less than 39 weeks o

Source(s)

Specifications manual for Joint Commission National Quality Core Measures [Version 2010A2]. Oakbrook Terrace (IL): The Joint Commission; 2010 Jan. 335 p.

Jump To

Measure Classification

Related Content

- Measure Domain
- Brief Abstract
- Evidence Supporting the Measure
- Evidence Supporting Need for the Measure
- State of Use of the Measure
- Application of Measure in its Current Use
- Institute of Medicine (IOM) Healthcare Quality Report Categories
- Data Collection for the Measure
- Computation of the Measure
- Evaluation of Measure Properties
- Identifying Information
- Disclaimer

Perinatal care: percentage of patients with elective vaginal deliveries or elective cesarean sections 37 to less than 39 weeks of gestation.

Leap Frog Group

- www.leapfroggroup.org/tooearlydeliveries
- Nonprofit organization, publishes hospitals' self-reported numbers of NMI early deliveries
- Advises patients to find hospitals with the lowest rates

Too Many Babies Are Delivered Too Early: Hospitals Should Just Say No

By **BOHNIIE ROCHMAN** Monday, January 31, 2011 | **102 COMMENTS**

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You're Kidding! Medical Clown Increases Pregnancy Rates with IVF



Related Topics: babies, C-section, early elective delivery, hospitals, Love & Family, Pregnancy, scheduling delivery

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Pregnancy lasts 40 weeks for a reason. At 35 weeks, a baby's brain tips the scales at

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For the past decade, [Tuesday's Children](#) has been committed to serving all those directly impacted by September 11, 2001.

Join us and make a **promise to never forget** those left behind that day.



Patience, Mom: More Hospitals Say No to Scheduled Delivery Before 39 Weeks

By **BONNIE ROCHMAN** Friday, August 26, 2011 | [5 Comments](#)

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The Healthland Podcast: Dictators, Corporal Punishment and Supermoms

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Patient Pressures

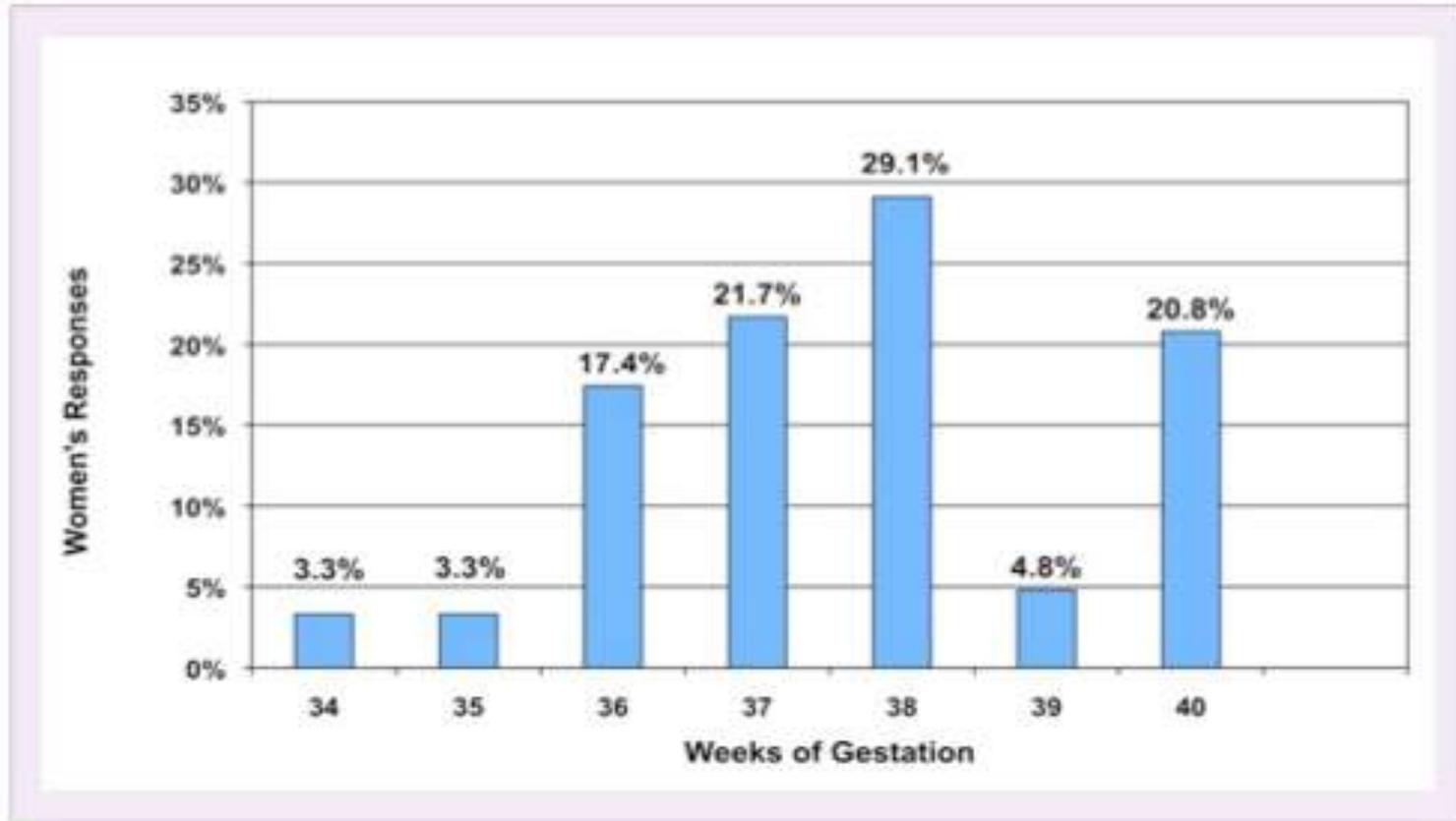
Women's Perceptions Regarding the Safety of Births at Various Gestational Ages

*Robert L. Goldenberg, MD, Elizabeth M. McClure, MEd, Anand Bhattacharya, MHS,
Tina D. Groat, MD, MBA, and Pamela J. Stahl*

VOL. 114, NO. 6, DECEMBER 2009

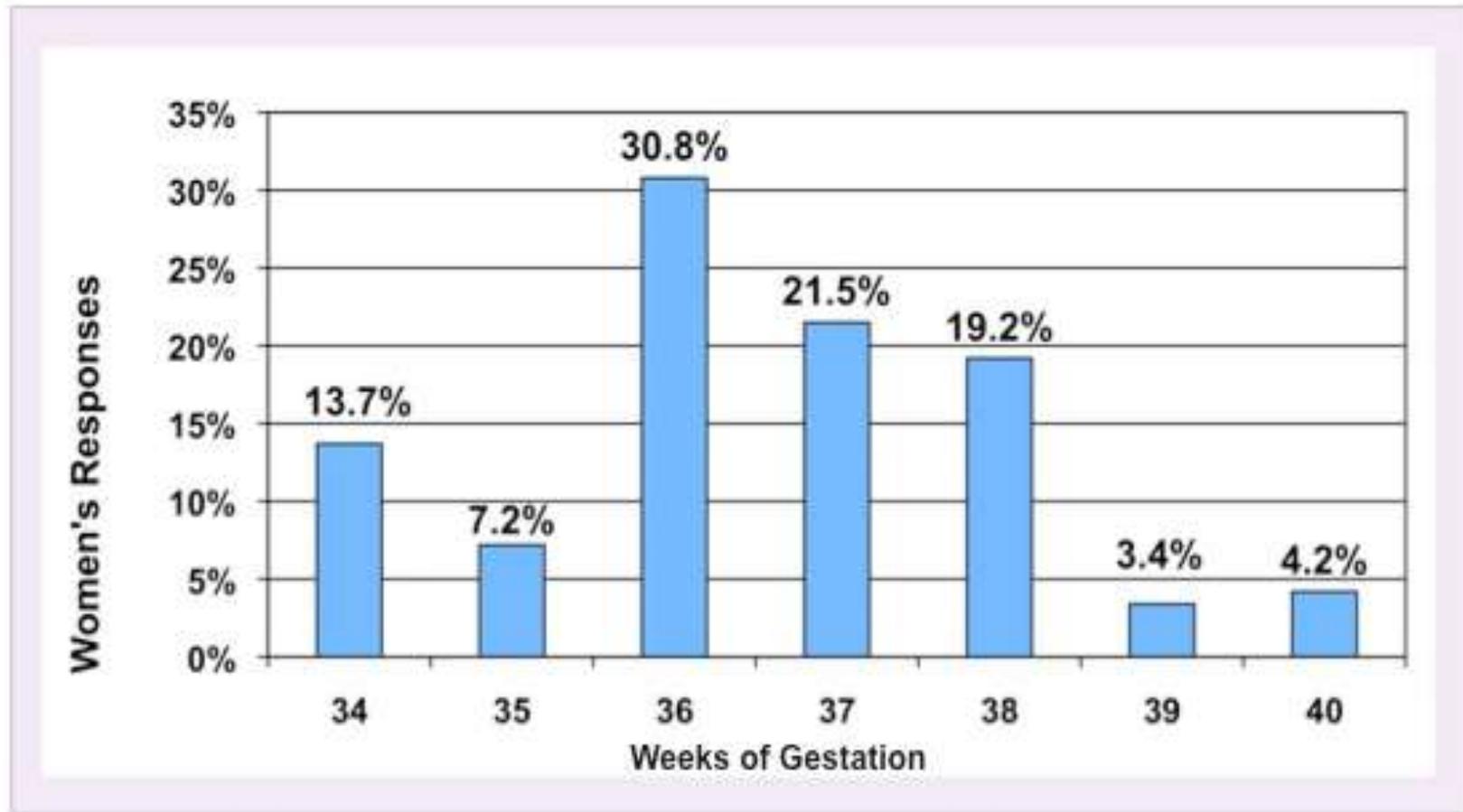
OBSTETRICS & GYNECOLOGY

The Gestational Age at Which Women Considered a Baby to Be Full Term



Goldenberg et al., Ob Gyn 2009

The Gestational Age at Which Women Considered it Safe to Deliver



Goldenberg et al., Ob Gyn 2009

Factors Driving NMI Deliveries

- **Patient Factors**

- Scheduling
- Discomfort of pregnancy
- Perception of safety

- **Provider Factors**

- Controlling timing of deliveries
- Reimbursement issues
- Logistics

House Bill 1983

- ORIGINAL BILL: Medicaid not pay for elective deliveries < 39 wks
 - Govt would determine **what is 39 weeks**, and **what is a valid medical indication**
- REVISED BILL:
 - Directs HHSC (Texas Medicaid) to develop cost-cutting for elective deliveries < 39 weeks
 - Hospitals and doctors **collaborate** to develop quality initiatives to reduce non-medically indicated (NMI) deliveries < 39 weeks

AN ACT

1
2 relating to certain childbirths occurring before the 39th week of
3 gestation.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

5 SECTION 1. Subchapter B, Chapter 32, Human Resources Code,
6 is amended by adding Section 32.0313 to read as follows:

7 Sec. 32.0313. INDUCED DELIVERIES OR CESAREAN SECTIONS
8 BEFORE 39TH WEEK. (a) The department shall achieve cost savings
9 with improved outcomes by adopting and implementing quality
10 initiatives that are evidence-based, tested, and fully consistent
11 with established standards of clinical care and that are designed
12 to reduce the number of elective or nonmedically indicated induced
13 deliveries or cesarean sections performed at a hospital on a
14 medical assistance recipient before the 39th week of gestation.

15 (b) The department shall coordinate with physicians,
16 hospitals, managed care organizations, and the department's
17 billing contractor for the medical assistance program to develop a
18 process for collecting information regarding the number of induced
19 deliveries and cesarean sections described by Subsection (a) that
20 occur during prescribed periods.

21 SECTION 2. Subchapter A, Chapter 241, Health and Safety
22 Code, is amended by adding Section 241.007 to read as follows:

23 Sec. 241.007. INDUCED DELIVERIES OR CESAREAN SECTIONS
24 BEFORE 39TH WEEK. A hospital that provides obstetrical services

H.B. No. 1983

1 shall collaborate with physicians providing services at the
2 hospital to develop quality initiatives to reduce the number of
3 elective or nonmedically indicated induced deliveries or cesarean
4 sections performed at the hospital on a woman before the 39th week
5 of gestation.

6 SECTION 3. (a) The Health and Human Services Commission
7 shall conduct a study to assess the effects of the quality
8 initiatives adopted under Section 32.0313, Human Resources Code, as
9 added by this Act, and Section 241.007, Health and Safety Code, as
10 added by this Act, on infant health and frequency of infant
11 admissions to neonatal intensive care units and hospital
12 readmissions for mothers and infants.

13 (b) Not later than December 1, 2012, the Health and Human
14 Services Commission shall submit a written report containing the
15 findings of the study conducted under this section together with
16 the commission's recommendations to the standing committees of the
17 senate and house of representatives having primary jurisdiction
18 over public health.

19 SECTION 4. If before implementing any provision of this Act
20 a state agency determines that a waiver or authorization from a
21 federal agency is necessary for implementation of that provision,
22 the agency affected by the provision shall request the waiver or
23 authorization and may delay implementing that provision until the
24 waiver or authorization is granted.

25 SECTION 5. This Act takes effect September 1, 2011.

How to Access Bill

- <http://www.legis.state.tx.us/tlodocs/82R/billtext/pdf/HB01983F.pdf#navpanes=0>

HB 1983 Implementation

- Effective Oct 1, 2011 Texas Medicaid requires providers to use CPT modifier for deliveries
- Texas Medicaid can require repayment for any NMI deliveries < 39 wks

Texas Medicaid and Healthcare Partnership Updates

- Implementation date delayed to Oct 1, 2011
- Medicaid and managed care Medicaid
- Three modifiers (-U1, -U2, -U3)



CPT coding changes

- For OB deliveries codes (all vaginal del and cesareans): 59409, 59410, 59414, 59515, 59612, 59614, 59620, 59622, etc. require modifier:
 - -U1 medically necessary prior to 39 weeks (or spontaneous labor)
 - -U2 Delivery at 39 weeks or later
 - -U3 non-medically necessary delivery < 39 weeks
- For more info, call TMHP Contact Center 800-925-9126

Medicaid Managed Care

- MCO policies will mirror Medicaid
- MCOs are subject to HB 1983 as well
- Same modifier system

Nonpayment



- For any OB Delivery code without a modifier
 - Example: 59414 (cesarean) = **payment denied**
- Any delivery code with “-U3” modifier
 - Example: 59409-U3 (NMI, <39 weeks) = **payment denied**

Retrospective Review

- Records subject to retrospective review
- NMI deliveries or fail to meet criteria based on medical record review subject to recoupment
- Recoupment may apply to all delivery services including:
 - Additional physician fees and hospital fees, and if baby went to NICU (those fees too)

Retrospective Review



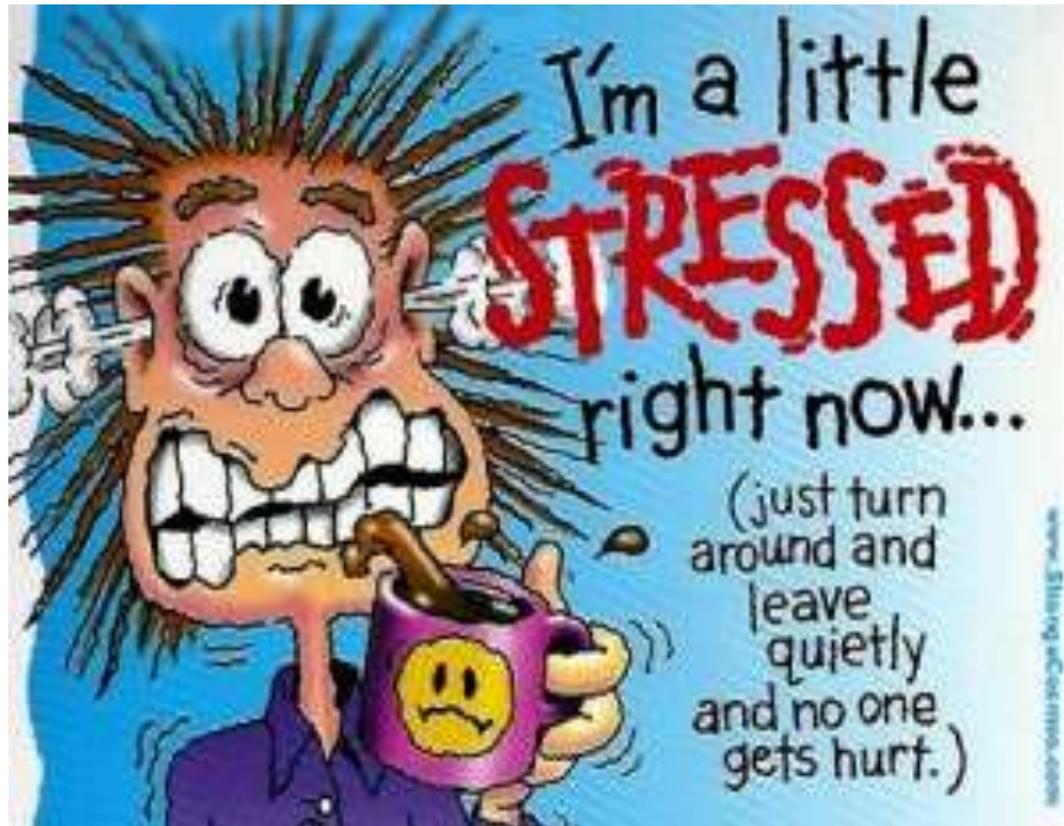
- **Performed by Office of the Inspector General (OIG)**
- “Doing right thing” is not enough, **MUST** be documented properly
- **More stringent standards**
 - Legibility
 - Clear medical indication
 - Clear gestational age

Recoupment



- May apply to all services related to the delivery including
 - Physician fees
 - Hospital fees
 - NICU fees

How Should Doctors & Hospitals Respond?



Ideal Solution

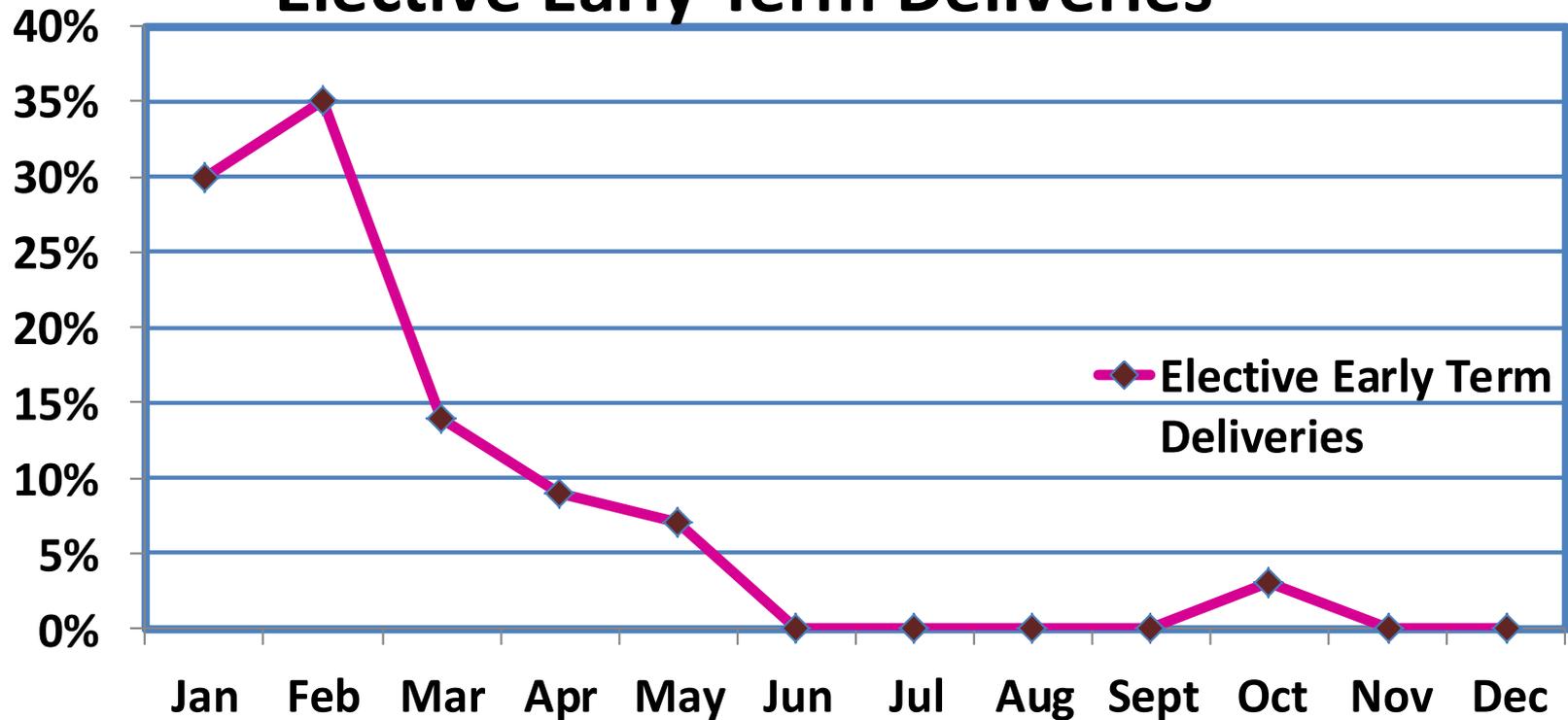
- **Construct a process to reduce NMI deliveries less than 39 weeks to zero**
- **Hospitals collaborate with physicians**
- **Standardized consistent scheduling process with user-friendly, timely appeal**
- **Clear criteria for scheduler and physician office**
- **Flexible process to avoid unintended adverse outcomes**

One Hospital's Experience



Percent of Early Term (37⁰/₇ through 38⁶/₇ weeks gestation) Scheduled Singleton Deliveries that Are Elective – St. Joseph Medical Center

Elective Early Term Deliveries



An elective delivery is non-medically indicated. Measure 5 is a process measure defined in the toolkit.



Recommended “Hard Stop” Policy

- **Physician office fills out scheduling form for ALL deliveries**
- **Scheduling form: Gestational age based on EDD, dating criteria, medical necessity**
- **Scheduling office inspects for completeness**
- **Scheduling office uses EDD rather than EGA (OB wheels are inaccurate)**
- **If no medical reason & <39 wks, physician office contacted to see if medical indication**

Recommended “Hard Stop” Policy

- If no medical reason, delivery cannot be scheduled **UNLESS** within 7 days of EDD
- If physician states there is a medical reason but not on list, referred to Physician Director for “real time” discussion
- Best practice = discussion in same day
- Deliveries monitored by peer review

Important Step – “The List”

- The List of Medical Indications
- We strongly advocated for local hospitals and physicians to determine their own lists
- Should be largely based on ACOG recommendations with reasonable add-ons
- Should be **evidence-based MEDICAL** indications (not social or convenience)

Scheduled Delivery Order Form

Patient Information					
Last Name		First Name		Birth Date	Social Security
Street Address			Apt #	City	State/Zip
Home Phone			Work/Other Phone		
Physician			Date of Procedure		GBS <input type="checkbox"/> Positive <input type="checkbox"/> Negative Gravid/Para
Primary Insurance Information			Secondary Insurance		
Insurance Co. Name		Insurance Co. Phone		Insurance Co. Name	
Policy #		Insured's Name/Relation to patient		Policy #	
Insured SS#		Insured DOB		Insured SS#	
Insured DOB			Insured DOB		
Cesarean Delivery			Induction		
Procedure Time: _____			Procedure <input type="checkbox"/> Pitocin Induction		
Diagnosis with ICD9 Code			Time Slot <input type="checkbox"/> 0400 <input type="checkbox"/> 0500 <input type="checkbox"/> 0600 <input type="checkbox"/> 0800 <input type="checkbox"/> 0900 <input type="checkbox"/> 1000 <input type="checkbox"/> 1900		
Procedure with CPT Code			<input type="checkbox"/> Misoprostol <input type="checkbox"/> Cervidil		
<input type="checkbox"/> 2000 <input type="checkbox"/> 2100 <input type="checkbox"/> 1400 <input type="checkbox"/> 1500 <input type="checkbox"/> 1700 <input type="checkbox"/> 1800					
Routine Labs			Dating (MUST FILL OUT COMPLETELY)		
<input type="checkbox"/> CBC <input type="checkbox"/> Type and Screen <input type="checkbox"/> RPR <input type="checkbox"/> Urinalysis <input type="checkbox"/> Hepatitis B <input type="checkbox"/> HIV <input type="checkbox"/> Other: _____			EDD: _____ Gestational age at time of induction (week/day): _____ EDD Based on: <input type="checkbox"/> US < 20 wks <input type="checkbox"/> Doppler FHT + for 30 wks <input type="checkbox"/> +HCG for 35 wks <input type="checkbox"/> Other dating criteria: _____		
Physician Signature: _____ Date: _____			<input type="checkbox"/> Fetal Lung Maturity Test result: _____ Date: _____		
Obstetric and Medical Conditions					
INDICATION					
Obstetric and Medical Conditions (OK if <39 weeks)					
<i>(need to deliver <39 weeks dependent on severity of condition)</i>					
<input type="checkbox"/> Abruptio	<input type="checkbox"/> Heart disease				
<input type="checkbox"/> Previa	<input type="checkbox"/> Liver disease (e.g. cholestasis of preg.)				
<input type="checkbox"/> Preeclampsia	<input type="checkbox"/> Chronic HTN				
<input type="checkbox"/> Gestational HTN	<input type="checkbox"/> Diabetes (Type I or II)				
<input type="checkbox"/> GDM with Insulin	<input type="checkbox"/> Renal disease				
<input type="checkbox"/> ≥41 + 0 weeks	<input type="checkbox"/> Coag/Thrombophilia				
<input type="checkbox"/> PROM	<input type="checkbox"/> Pulmonary disease				
<input type="checkbox"/> Fetal Demise (current)	<input type="checkbox"/> HIV infection				
<input type="checkbox"/> Fetal Demise (prior)	<input type="checkbox"/> Other (needs Dept chair approval)				
<input type="checkbox"/> Oligohydramnios	Perinatology consult obtained and agrees with plan. _____ (Consultants Name)				
<input type="checkbox"/> Polyhydramnios					
<input type="checkbox"/> IUGR					
<input type="checkbox"/> Non-reassuring fetal status					
<input type="checkbox"/> Isoimmunization					
<input type="checkbox"/> Fetal malformation					
<input type="checkbox"/> Twin with Complication					
			Scheduled C/S (>39 wks) <input type="checkbox"/> Prior C/S <input type="checkbox"/> Prior classical C/S <input type="checkbox"/> Prior myomectomy (may be earlier with fetal lung maturity test) <input type="checkbox"/> Breech presentation <input type="checkbox"/> Other malpresentation <input type="checkbox"/> Patient choice <input type="checkbox"/> Other: _____ <input type="checkbox"/> Twin w/o complication (ok ≥38 wks)		
			Elective Induction (>39 wks) <input type="checkbox"/> Patient choice/social <input type="checkbox"/> Macrosomia <input type="checkbox"/> Distance <input type="checkbox"/> Other: _____		



Courtesy of St. Joseph Medical Center, Houston

Dating Criteria Important



Cervidil

1800

Dating (MUST FILL OUT COMPLETELY)

EDD:

Gestational age at time of induction
(week/day) :

EDD Based on : US < 20 wks Doppler FHT + for 30 wks

+HCG for 36 wks

Other dating criteria:

By ACOG Guidelines, women should be 39 wks or greater before initiating an elective (no indication) delivery. ACOG also states that a mature fetal lung test in the absence of clinical indication is not considered an indication for delivery

Fetal Lung Maturity Test result : _____ Date: _____

Use Template as a “95% guide”



Obstetric and Medical Conditions

INDICATION

Obstetric and Medical Conditions (OK if <39 weeks)

(need to deliver <39 weeks dependent on severity of condition)

- Abruptio
- Previa
- Preeclampsia
- Gestational HTN
- GDM with Insulin
- ≥41 + 0 weeks
- PROM
- Fetal Demise (current)
- Fetal Demise (prior)
- Oligohydramnios
- Polyhydramnios
- IUGR
- Non-reassuring fetal status
- Isoimmunization
- Fetal malformation
- Twin with Complication

- Heart disease
- Liver disease (e.g. cholestasis of preg.)
- Chronic HTN
- Diabetes (Type I or II)
- Renal disease
- Coag/Thrombophilia
- Pulmonary disease
- HIV infection
- Other (needs Dept chair approval)

Perinatology consult obtained
and agrees with plan.

(Consultants Name)

Scheduled C/S (≥39 wks)

- Prior C/S
- Prior classical C/S
- Prior myomectomy
(may be earlier with fetal lung maturity test)
- Breech presentation
- Other malpresentation
- Patient choice
- Other: _____
- Twin w/o complication
(ok ≥38 wks)

Okay <
39 wks

Elective Induction (≥39 wks)

- Patient choice/social
- Macrosomia
- Distance
- Other: _____

Dos and Don'ts (TAOG)

- Do document gestational age (use EDD)
- Do use earlier US vs. later US to support dates
- Do make sure non-medically deliveries are within 7 days of EDD (39 weeks)
- Do document in medical record legibly
 - Gestational age and EDD
 - Indication: Clear and legible medical indication

Advice to Hospitals (TAOG)

- Do set up policy and guidelines, “hard stop” in scheduling
- Don’t assume physician notices and education will be sufficient
- Do track deliveries, monitor documentation
- Do consider pre-printed form for physicians to write in:
 - Gestational Age ___ weeks (EDD: _____)
 - Indication for delivery: _____

Example Case A

- 22 year old G1 P0 at 38w1d arrives in active labor in the hospital, and delivers vaginally.
- How should the delivery be coded?

Example Case A (Answer)

- 22 year old G1 P0 at 38w1d arrives in active labor in the hospital, and delivers vaginally.
- How should the delivery be coded?
- Vaginal delivery code: 59409
- Medically necessary (labor): -U1
- Coded as: 59409-U1

Documentation for Case A

- Inadequate documentation (and potentially subject to recoupment):

*“22 y/o G1P0 admitted and delivered.”
(gestational age , medical necessity not documented)*

- Better documentation:

*“22 y/o G1P0 at **38 1/7 wks** admitted **in labor**, delivered.”*

Example Case B

- 26 year old G2 P1 at 39w3d had repeat cesarean performed.
- How should the delivery be coded?

Example Case B (Answer)

- 26 year old G2 P1 at 39w 3d had repeat cesarean.
- Cesarean delivery code: 59414
- At or greater than 39 weeks: -U2
- Coded as: 59414-U2

Documentation for Case B

- Inadequate documentation (possibly subject to recoupment):

“26 y/o G2P1 delivered.”

(gestational age not documented; route of delivery not documented)

- Adequate documentation:

“26 y/o G2P1 at 39 3/7 wks had repeat cesarean delivery.”

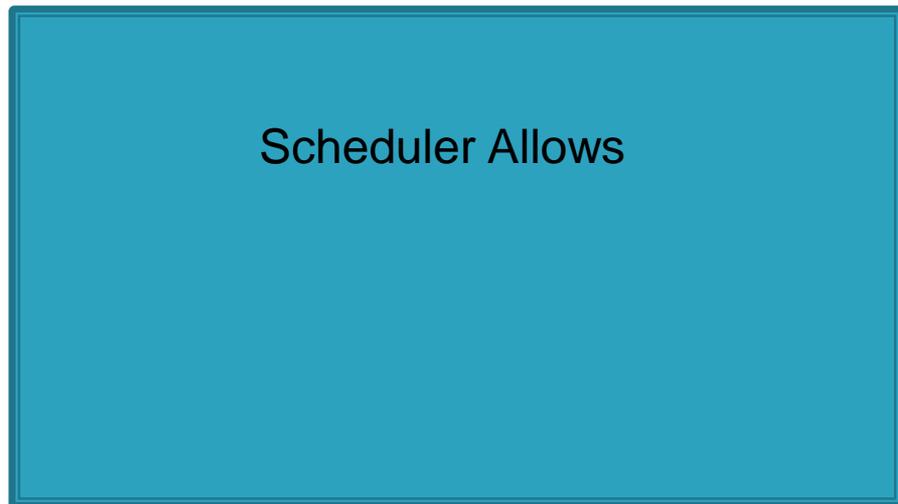
Determination of Medical Necessity



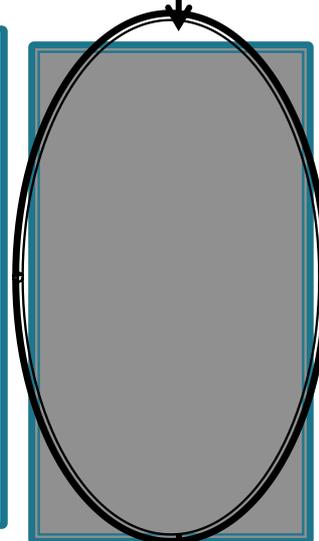
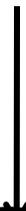
- Determined at the hospital level
- Physicians & hospitals collaborate
- Flexibility to evaluate individual pts
- No “all-inclusive list”
- Hospital’s process should be able to withstand scrutiny

Clearly Medically Necessary

Ex: Hypertension

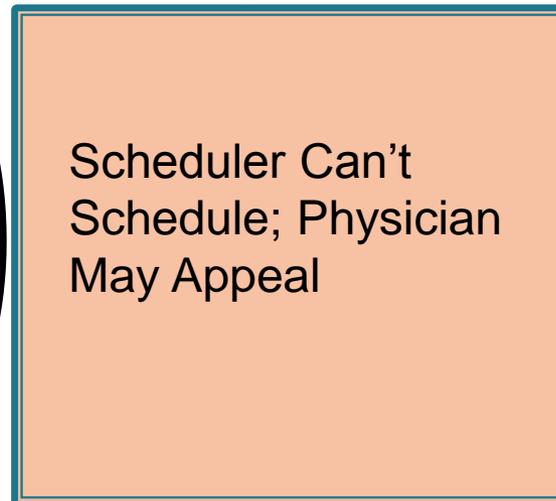


Gray Zone



Clearly No Medical Necessity

Ex: Pt's mother in town



Discuss with Physician Director

Example C

- 27 y.o. G1 P0 at 37w2d is referred to the L&D area for elevated blood pressure. The urine protein is negative. The BP as measured by L&D nurses: 130/86 and 134/82.
 - The L&D nurse is concerned that the BP doesn't meet medical indication.
- What should the L&D nurse do?

Example C (Answer)

- **L&D nurse should consult up Chain of Command**
 - **L&D Nurse should consult charge nurse**
- **If charge nurse does not have clear guidelines, then charge nurse should consult L&D Nursing Director**

Example C: L&D Nursing Director

- Option 1: May choose to ask for office records to be faxed (documentation)
 - If office records show hypertension (ex: BP 144/94), then delivery can be allowed
- Option 2: May choose to consult with Physician Director
 - Physician director may ask for more information, or have discussion with requesting doctor

Example C (Wrong Approaches)

- Nursing needs to be careful not to make “medical decisions”
- Ex 1: L&D Nurse calls Requesting Doctor, unilateral decision: **“Because BP’s normal, induction not allowed”**
- Ex 2: L&D Nursing Director sends patient home to follow back up with doctor, calls doctor and says: **“Policy says: BP normal = pt must go home”**

Example D

- 32 y.o. G2 P1 at 38w2d is seen in the OB Triage area for contractions. Hx: Prior low transverse cesarean x 1.
 - FHR tracing: 140 bpm and normal. Contractions: every 5 minutes.
 - Cervix: closed and long.
 - Pt's physician wants to perform a repeat cesarean.
- What should the L&D nurse do?

Example D (Answer)

- **L&D nurse should consult up Chain of Command**
 - **Ex: L&D Nurse consults charge nurse**

- **Charge nurse assessment:**
 - **Strength and frequency of contractions**
 - **Consult hospital guidelines**

Example D: L&D Charge Nurse

- **Hospital Guideline:**
 - **Prior low transverse cesarean x1 without medical indication are delivered at 39 weeks or beyond**
- **This patient's cervix closed/long**
- **L&D Nurse makes own nursing assessment:**
"Pt at 38w 2d, prior LT cesarean x 1, having UC's, not in labor"

Example D: L&D Charge Nurse

- **Answer: Consult Physician Director (or Nursing Director)**
- **Reason: There may be extenuating circumstances**
 - **How painful are UC's?**
 - **Rural hospital –pt lives far away? Need to call in anesthesia, OR staff (time delay = medical danger in uterine rupture)?**
 - **Medical determination based on individual pt circumstances & particular community/hospital**

Documentation

- Documentation– discussion with Physician Director and basis of decision
- Example: “Per Physician Director, because of strong regular UC’s and concern about possible uterine rupture, repeat cesarean for this pt at 38w3d to be performed.”
- Avoid “arguing in chart” – “I wanted to induce this pt at 38 weeks due to concern about fetal well being, but I was over–ruled by Physician Director and Hospital”

Guidelines for Nurses



- Gestational Age is a complicated clinical assessment (not for nurses to argue with physicians)
- Medical necessity can be complex
- Discussion about Gestational Age & Medical Necessity should be handled between Physician Director & Requesting Doctor

Abuses

- Abuses of scheduling by doctors should be handled by peer review
- Judging the “gray zone” can be tricky
- In general, medical necessity is determined by evidence based indication
 - Flexibility
 - Individualizing
 - Common sense

Physician Leadership

- Success needs strong physician leadership
- Good listening & communication skills
- Put the patient's interest as #1
- Deal with situations respectfully and consistently
- Be open to new information, new literature

Discussion with Patient

- Empathy with patient
- Outline developmental progress of infant
- Describe potential medical issues of delivery less than 39 weeks
 - Longer hospital stay
 - NICU stay
 - Sepsis
 - Hypoglycemia



Script

- *“Ms. G, I know how uncomfortable these last weeks of pregnancy are...”*
- *“I can imagine how hard it is to get any sleep...”*
- *“These last days of pregnancy are important for your baby’s development”*
- *“We know that babies delivered more than 1 week before due date have a higher chance for neonatal ICU care...”*



Dangers of Overly Strict Policy

- Potential for increased adverse events
 - Such as stillbirths
- Overly–strict hospital policy that uses Indication List as “The Law”
- Overly–strict Physician Director who isn’t open to various circumstances



Neonatal Outcomes After Implementation of Guidelines Limiting Elective Delivery Before 39 Weeks of Gestation

Deborah B. Ehrenthal, MD, Matthew K. Hoffman, MD, MPH, Xiaozhang Jiang, MD, MS, and Gordon Ostrum, MD

OBJECTIVE: To evaluate the association of a new institutional policy limiting elective delivery before 39 weeks of gestation with neonatal outcomes at a large community-based academic center.

METHODS: A retrospective cohort study was conducted to estimate the effect of the policy on neonatal outcomes using a before and after design. All term singleton deliveries 2 years before and 2 years after policy enforcement were included. Clinical data from the electronic hospital obstetric records were used to identify outcomes and relevant covariates. Multivariable logistic regression was used to account for independent effects of changes in characteristics and comorbidities of the women in the cohorts before and after implementation.

RESULTS: We identified 12,015 singleton live births before and 12,013 after policy implementation. The overall percentage of deliveries occurring before 39 weeks of gestation fell from 33.1% to 26.4% ($P < .001$); the greatest difference was for women undergoing repeat cesarean delivery or induction of labor. Admission to the neonatal intensive care unit (NICU) also decreased significantly; before the intervention, there were 1,116 admissions (9.29% of term live births), whereas after, there were 1,027 (8.55% of term live births) and this difference was significant ($P = .044$). However, an 11% increased odds of birth weight greater than 4,000 g (adjusted odds ratio 1.11; 95% confidence interval [CI] 1.01–1.22) and an

increase in stillbirths at 37 and 38 weeks, from 2.5 to 9.1 per 10,000 term pregnancies (relative risk 3.67, 95% CI 1.02–13.15, $P = .032$), were detected.

CONCLUSION: A policy limiting elective delivery before 39 weeks of gestation was followed by changes in the timing of term deliveries. This was associated with a small reduction in NICU admissions; however, macrosomia and stillbirth increased.

(*Obstet Gynecol* 2011;118:1047–55)

DOI: 10.1097/AOG.0b013e3182319c58

LEVEL OF EVIDENCE: III

The gestational age distribution of live births in the United States has declined over recent years resulting in an average gestational age of 39 weeks.^{1,2} Much of the shift has been attributed to the more active role of the obstetrician in the early initiation of the parturition process through induction of labor or timing of planned cesarean deliveries.^{2,3} Although such strategies lead to improved outcomes among women with growth-restricted fetuses and other appropriate indications, there is substantial evidence that a portion of induced labors is not medically indicated according to the American College of Obstetricians and Gynecologists guidelines, and many elective deliveries are initiated before 39 weeks.^{4,5}

Danger of increased stillbirths if policy is too strict

Conclusions

- NMI Deliveries <39 weeks associated with neonatal complications, NICU admissions
- NMI Deliveries <39 weeks a Quality Measure
- Hard Stop **with judgment, being reasonable & flexible**
- **Physician-Led, Collaborative Implementation best for success**

Conclusions (cont.)

- **HB1 983 directed Medicaid to implement quality initiatives to reduce deliveries < 39 weeks without medical indication**
- **Medicaid deliveries after Oct 1, 2011 need code modifier (U1, U2, U3)**
- **Records are subject to retrospective review, recoupment of payment**
- **Education of patient is key**

Resources

- **March of Dimes Toolkit**
 - http://www.marchofdimes.com/professionals/medicalresources_39weeks.html
- **Texas Association of Ob/Gyn & Texas District of ACOG Toolkit**
 - <http://www.txobgyn.org>
- **TAOG Grand Rounds Speakers via March of Dimes Grant**
 - Physicians available to visit hospitals at no cost

Questions and Answers



Evelyn Delgado
Assistant Commissioner for Family
and Community Health Services

Remote sites can send in questions by typing in the *GoToWebinar* chat box or email GrandRounds@dshs.state.tx.us.

For those in K-100, please come down to the microphone on the left side of the auditorium to ask your questions.

Next Grand Rounds Presentation

May 9

Sexual Predators: Implications for State Hospital Services

**Presenters from North Texas State
Hospital:**

**James (Jim) Smith, LCSW, DCSW,
Superintendent; Stacey Shipley, PsyD, Dir. of
Psychology; Thomas Mareth, MD, Clinical Dir.
for Psychiatric Services; Jeff Bearden, LCSW,
Dir. of Forensic Psychiatric Programs**

