MASSACHUSETTS

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Medical Policy

Acute and Maintenance Tocolysis

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Policy Number: 518

BCBSA Reference Number: 5.01.07

Related Policies

- Progesterone Therapy as a Technique to Reduce Preterm Birth in High-Risk Pregnancies, #552

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity
Medicare HMO Blue[SM] and Medicare PPO Blue[SM] Members

Acute tocolytic therapy with calcium channel blockers, magnesium sulfate, prostaglandin inhibitors, and parenteral terbutaline may be **MEDICALLY NECESSARY** for the induction of tocolysis in patients with preterm (<37 weeks' gestational age) labor.

Maintenance (beyond 48-72 hours) tocolytic therapy administered via home infusion with any medication is **INVESTIGATIONAL**.

Authorization Information

Commercial Members: Managed Care (HMO and POS)

- Prior authorization is required for acute tocolytic therapy in an ***inpatient*** setting.
- Prior authorization is **NOT** required for acute tocolytic therapy in an ***outpatient*** hospital setting (i.e., observation).

Commercial Members: PPO, and Indemnity

- Prior authorization is required for acute tocolytic therapy in an ***inpatient*** setting.
- Prior authorization is **NOT** required for acute tocolytic therapy in an ***outpatient*** hospital setting (i.e., observation).

Medicare Members: HMO Blue[SM]

- Prior authorization is required for acute tocolytic therapy in an ***inpatient*** setting.
- Prior authorization is **NOT** required for acute tocolytic therapy in an ***outpatient*** hospital setting (i.e., observation).

Medicare Members: PPO Blue[SM]

- Prior authorization is required for acute tocolytic therapy in an ***inpatient*** setting.

- Prior authorization is **NOT** required for acute tocolytic therapy in an ***outpatient*** hospital setting (i.e., observation).

CPT Codes / HCPCS Codes / ICD-9 Codes

The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member. A draft of future ICD-10 Coding related to this document, as it might look today, is included below for your reference.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

CPT Codes

There is no specific CPT code for this service.

HCPCS Codes

HCPCS codes:	Code Description
J3105	Injection, terbutaline sulfate, up to 1 mg
J3475	Injection, magnesium sulfate, per 500 mg
S9349	Home infusion therapy, tocolytic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

ICD-9 Diagnosis Coding

ICD-9-CM diagnosis codes:	Code Description
644.00	Threatened premature labor, unspecified as to episode of care or not applicable
644.03	Threatened premature labor, antepartum condition or complication

ICD-9 Procedure Codes

When the following ICD 9 procedure codes are associated with the service(s) described in this document coverage for the service(s) is aligned with the policy statement.

ICD-9-CM procedure codes:	Code Description
99.29	Injection or infusion of other therapeutic or prophylactic substance

ICD-10-CM Diagnosis Coding

ICD-10-CM diagnosis codes:	Code Description
O60.00	Preterm labor without delivery, unspecified trimester
O60.02	Preterm labor without delivery, second trimester
O60.03	Preterm labor without delivery, third trimester

ICD-10-PCS Diagnosis Coding

ICD-10-PCS diagnosis codes:	Code Description

3E033GC	Introduction of Other Therapeutic Substance into Peripheral Vein, Percutaneous Approach
3E043GC	Introduction of Other Therapeutic Substance into Central Vein, Percutaneous Approach

Description

Tocolysis refers to the suppression of preterm labor to delay delivery. General indications for tocolysis include continued regular uterine contractions associated with cervical changes in a pregnant woman at less than 37 weeks' gestation. Successful delay of preterm delivery allows further fetal development and precludes the complications of preterm delivery, especially neonatal respiratory distress syndrome. If successful acute tocolysis is achieved, patients may continue to receive pharmacologic therapy for maintenance.

A variety of agents have been used for tocolysis. The only FDA-approved tocolytic drug is ritodrine, a beta-sympathomimetic. Ritodrine is no longer available in the United States and thus only off-label medications are available. Terbutaline, also a beta-sympathomimetic, is an alternative to ritodrine, for acute and maintenance tocolysis. Other tocolytic drugs include calcium channel blockers (e.g., nifedipine), magnesium sulfate, oxytocin receptor antagonists (e.g., atosiban), prostaglandin inhibitors (e.g., indomethacin), and nitrates (e.g., nitroglycerin).

Summary

There is sufficient evidence that the commonly used tocolytic agents presented here are effective at inducing tocolysis in patients with preterm labor or threatened preterm labor. Thus, these agents are considered medically necessary for the acute prevention of preterm delivery. There are data suggesting that oral terbutaline is associated with more adverse events than parenteral terbutaline for acute tocolysis. Each medication has a different risk/benefit profile, and there is no clear first-line tocolytic agent. There are fewer studies on medications to maintain tocolysis. The available evidence does not suggest that maintenance tocolysis improves health outcomes, and therefore maintenance tocolysis is considered investigational.

Policy History

Date	Action
7/2014	Updated Coding section with ICD10 procedure and diagnosis codes, effective 10/2015.
12/2013	New references from BCBSA National medical policy.
11/2011- 4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
12/1/2011	BCBSA National medical policy review. Changes to policy statements.
9/2011	Reviewed - Medical Policy Group - Urology and Obstetrics/Gynecology. No changes to policy statements.
9/1/2011	BCBSA National medical policy review. Changes to policy statements.
4/4/2011	BCBSA National medical policy review. Changes to policy statements.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines

References

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