

Guidelines on cervical length screening and progesterone treatment

In our continuing efforts to improve pregnancy outcomes and prevent preterm birth (PTB), we are reminding you of our endorsement of the American College of Obstetricians and Gynecologists (ACOG) and Society for Maternal Fetal Medicine (SMFM) guidelines on cervical length (CL) screening and progesterone treatment.¹

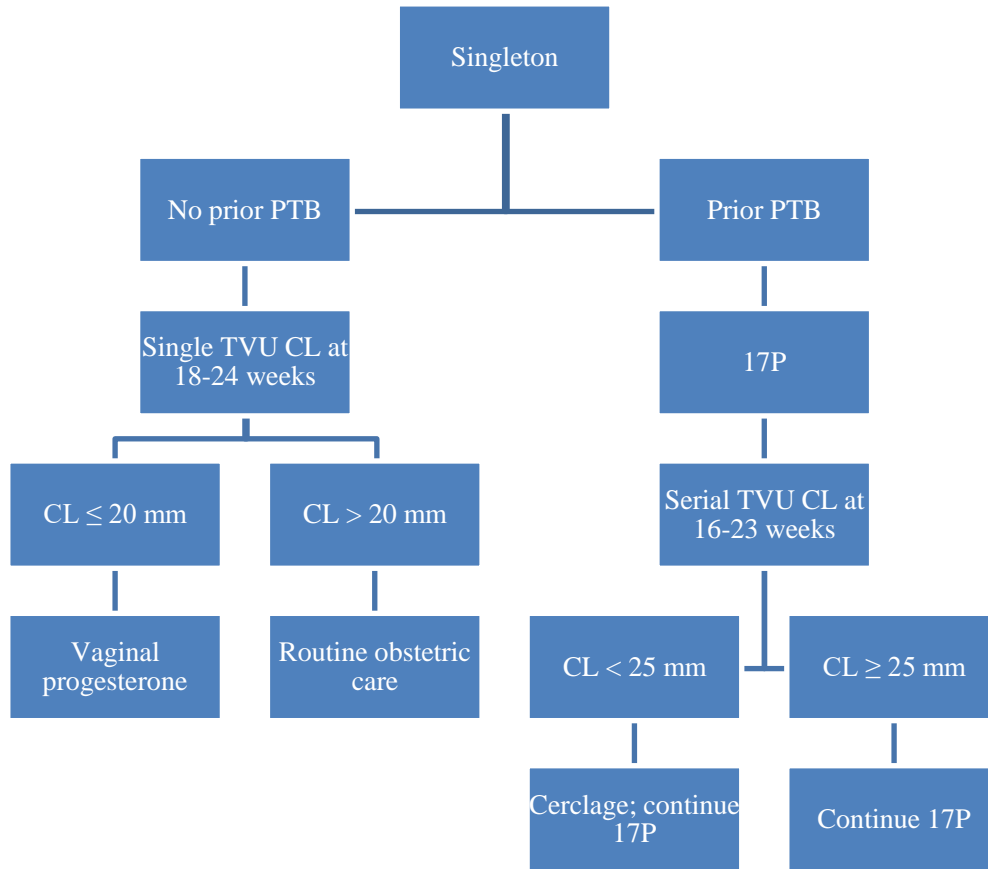
As you know, the risk factor most consistently predictive of PTB is a prior preterm birth.² Women with this risk factor are currently treated with alpha-hydroxyprogesterone caproate (17P) by intramuscular injection weekly from 16 to 36 weeks; however, less than 10% of spontaneous PTB occurs in women with a prior history.

We have a tremendous opportunity to address this by screening CL and treating with progesterone. Shortened CL before 24 weeks is now recognized to be a second strongly predictive risk factor for PTB in singleton pregnancies.³ Using this evidence-based strategy, we can improve our efforts by identifying and treating at risk women who might not be otherwise identified.

ACOG and SMFM have collaborated to promote an algorithm to aid in this endeavor. UniCare Health Plan of West Virginia, Inc. endorses this strategy of CL screening and treating with progesterone.⁴ We support universal CL screening at 18 to 24 weeks.⁵ CL screening by ultrasound is considered the gold standard and makes other measuring methods and devices medically unnecessary.⁶

On the next page is the algorithm. We encourage you to obtain a CL measurement with your patient's 18- to 24-week ultrasound as shown on the algorithm. If, in addition to an abdominal scan, a vaginal approach is necessary to obtain this measurement, please add modifier 52 to the vaginal ultrasound billing code. Diagnosis codes such as Z36.86 and O09.21-O09.219 are the most appropriate. We believe this will help you continue to provide high quality, evidence-based prenatal care to your patients.⁷

We thank you for your care of our members.



The above algorithm is based on the ACOG recommendation referenced in footnote 1.

1. Society for Maternal-Fetal Medicine Publications Committee with the assistance of Vincenzo Berghella, MD, Progesterone and preterm birth prevention: translating clinical trials data into clinical practice, *Am J Obstet Gynecol* 2012;206:376-386.
2. J.D Iams, R.L. Goldenberg, P.J. Meis, et al., The length of the cervix and the risk of spontaneous premature delivery, *N Engl J Med* 1996;334:567-572.
3. S.S. Hassan, R. Romero, D. Vidyadhari, et al., Vaginal progesterone reduces the rate of preterm birth in women with a sonographic short cervix: a multi-center, randomized, double-blind, placebo-controlled study, *Ultrasound Obstet Gynecol* 2011;38:18-31.
4. S. Campbell, Universal cervical length screening and vaginal progesterone prevents early preterm births, reduces neonatal morbidity and is cost saving: doing nothing is no longer an option, *Ultrasound Obstet Gynecol* 2011;38:1-9.
5. ACOG/SMFM letter to Secretary Burwell, 2014.
6. American Institute of Ultrasound in Medicine, AIUM practice guideline for the performance of obstetric ultrasound examinations, *J Ultrasound Med* 2013;32:1083-1101. doi:10.7863/ultra.32.6.1083.
7. R. Romero, K. Nicolaides, A. Conde-Agudelo, et al., Vaginal progesterone in women with an asymptomatic sonographic short cervix in the midtrimester decreases preterm delivery and neonatal morbidity: a systematic review and meta-analysis of individual patient data, *Am J Obstet Gynecol* 2012;206:124.e1-19.