

Evidence Based Guideline

Fetal Fibronectin

File Name: fetal_fibronectin
Guideline Number: EBG.OBGYN3014
Origination: 07/1996
Last Review: 12/2006

Active guideline, no longer scheduled for routine literature review.

Description of Procedure or Service

The Fetal Fibronectin test is a diagnostic method of detecting potential premature labor. The test, similar to a Pap smear, may be performed in a doctor's office anytime between the 24th and 34th week of [gestation](#). It measures a protein found in the amniotic fluid and membranes (the sac of water surrounding the [fetus](#)). This protein, fetal fibronectin, serves as an adhesive substance and helps the fertilized egg attach to the wall of the uterus. Changes in this protein level are monitored to detect the onset of labor.

Evidence Based Guideline for Fetal Fibronectin

Fetal fibronectin testing may be appropriate when the following medical criteria are met:

- ◆ in women between 24 and 34 weeks of pregnancy, and
- ◆ who are likely to be hospitalized with symptoms suggestive of [preterm labor](#), and
- ◆ who have singleton (one [fetus](#)) or twin gestations, and
- ◆ who have intact amniotic membranes, and
- ◆ whose cervix is dilated less than 3 centimeters.

Medical Evidence regarding Fetal Fibronectin indicates it is not recommended in the following situations:

The fetal fibronectin test is not recommended for the following conditions:

- ◆ in women carrying a single [fetus](#) with no risk factors for preterm birth and without symptoms of [preterm labor](#), seen during routine pregnancy monitoring
- ◆ in women with high risk characteristics for preterm birth, without symptoms of [preterm labor](#), being seen for high risk clinical monitoring
- ◆ in women at term, with or without intact membranes, being considered for labor induction
- ◆ in women with triplet or higher-order gestations (carrying more than 2 [fetuses](#)) whether or not they are experiencing symptoms suggestive of [preterm labor](#)

Policy: Fetal Fibronectin

Benefits Application

Please refer to certificate for availability of benefit. This guideline relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore certificate language should be reviewed before applying the terms of the policy.

Any member who is pregnant is eligible to have access to the Member Health PartnershipsSM – Pregnancy program. This program provides up-to-date information on pregnancy, labor and delivery options and costs, newborn care, and choosing a pediatrician, car seat and day-care with access to one-on-one health coaching from a pregnancy case manager.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable codes: 82731

Medical Term Definitions

Fetus

pertains to a developing unborn infant while in the uterus, from the 9th week following conception until birth.

Gestation

length of time fetus has been in the mother's womb; from conception until birth.

Preterm labor

regular contractions associated with cervical change before the completion of 37 weeks of gestation.

Scientific Background and Reference Sources

From original policy entitled: Fetal Fibronectin

Plan Consultant 7/96

Blue Cross and Blue Shield Association "TEC Bulletin", June 25, 1997

From policy entitled: Preventing Premature Labor and Delivery

Specialty Matched Consultant Advisory Panel - 11/1999

Medical Policy Advisory Group - 12/2/1999

ECRI Executive Briefing No. 91 - July 2000

Specialty Matched Consultant Advisory Panel - 9/2001

BCBSA Medical Policy Reference Manual, 07/12/02; 4.01.09

BCBSA Medical Policy Reference Manual, 07/12/02; 5.01.07

BCBSA Medical Policy Reference Manual, 10/8/02; 2.04.11

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BCBSA Medical Policy Reference Manual, 12/18/02; 2.04.03

Specialty Matched Consultant Advisory Panel - 8/2003

BCBSA Medical Policy Reference Manual, 12/17/03; 4.01.16

BCBSA Medical Policy Reference Manual, [Electronic Version]. 5.01.07, 12/17/03.

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.04.03, 2/25/04.

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.04.11, 2/25/04.

BCBSA Medical Policy Reference Manual [Electronic Version]. 4.01.09, 2/25/04.

Meis PJ, Klebanoff M, Thom E et al. Prevention of recurrent preterm delivery by 17 alpha-hydroxyprogesterone caproate. N Eng J Med 2003;348(24):2379-85.

da Fonseca EB, Bittar RE, Carvalho MH et al. Prophylactic administration of progesterone by vaginal suppository to reduce the incidence of spontaneous preterm birth in women at increased risk: a randomized placebo-controlled double-blind study. Am J Obstet Gynecol 2003;188(2):419-24.

American College of Obstetricians and Gynecologists. ACOG Committee Opinion No. 291. Use of Progesterone to Reduce Preterm Birth. Obstet Gynecol 2003;102:1115-6

Specialty Matched Consultant Advisory Panel - 12/2004.

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.04.03, 12/14/05.

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.04.11, 3/7/06.

BCBSA Medical Policy Reference Manual [Electronic Version]. 4.01.09, 12/14/05.

BCBSA Medical Policy Reference Manual [Electronic Version]. 4.04.16, 12/14/05.

Specialty Matched Consultant Advisory Panel - 12/13/2006

For Evidence Based Guideline entitled: Fetal Fibronectin

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.04.03, "No further scheduled review".

Policy Implementation/Update Information

From Original Policy entitled: Fetal Fibronectin

7/96 Original Policy issued

10/97 Revised: Based on BCBS National Association TEC report, Changes policy from investigational for all indications to medically necessary only when certain criteria are met. Changes from local policy to national.

3/99 Reaffirmed by MPAG

From Policy entitled: Preventing Premature Labor and Delivery

5/99 Reformatted, changed descriptions of procedures or services, added Medical term definitions. Combined Fetal Fibronectin, Salivary Estriol test, Home Uterine Monitoring, and Portable Pump for the administration of Terbutaline into one policy and renamed policy Preventing Premature Labor and Delivery.

12/99 Approved by Medical Policy Advisory Group

10/00 System coding changes.

2/01 Added new source to Scientific Background and Reference Sources

Policy: Fetal Fibronectin

- 9/01 Specialty Matched Consultant Advisory Panel review. No change in criteria.
- 10/01 Coding format changes.
- 12/03 Specialty Matched Consultant Advisory Panel review 8/2003. Under "When Fetal Fibronectin is covered", third bullet changed to "who have singleton (one fetus) or twin gestations"; fourth bullet changed "cervical" membranes to "amniotic" membranes. Under "When Fetal Fibronectin is not covered", last bullet changed to "in women with triplet or higher-order gestations (carrying more than 2 fetuses)....". Benefits Application and Billing/Coding sections revised.
- 1/6/2005 Specialty Matched Consultant Advisory Panel review - 12/9/04. Added Section re: Progesterone Therapy in High Risk Pregnancies. Reference sources added.
- 1/17/07 Specialty Matched Consultant Advisory Panel review - 12/13/06. Under Section II - Progesterone Therapy in High Risk Pregnancies, second paragraph, added "by a health care professional" to the following sentence: " Administration of 17 alpha-hydroxyprogesterone caproate or vaginal suppositories in the home setting *by a health professional* is considered not medically necessary." Reference sources added. Added CPT code 90772 to the "Billing /Coding" section. Deleted CPT code 90782 from "Billing /Coding" section. No other changes.

For Evidence Based Guideline entitled: Fetal Fibronectin

- 1/12/09 Section I: Fetal Fibronectin removed from policy entitled: Preventing Premature Labor and Delivery and changed to Evidence Based Guideline entitled Fetal Fibronectin with status of: "Active guideline, no longer scheduled for routine literature review."

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.