Quick Reference

Inpatient Quality Indicator 21 (IQI 21)
Cesarean Delivery Rate, Uncomplicated (CES)

Texas Children's® Health Plan

There is a rising call-to-action in the U.S. to address high rates of uncomplicated C-section, meaning those performed on low-risk women in the absence of a hysterotomy procedure, abnormal presentation, preterm delivery, fetal death, multiple gestation, or breech presentation. Still, uncomplicated C-section rates in Texas remain over 30%.[1]

The Texas Health and Human Services Commission has prioritized uncomplicated C-section rates as part of the Quality of Care reporting and as a STAR Pay for Quality measure beginning in MY 2022.[1]

Why it matters

Cesarean delivery is the most frequent surgical procedure performed in the U.S. Nationally, the procedure accounts for 1-in-3 births. Cesarean delivery is a potentially lifesaving intervention that is necessary in some cases to protect the lives and health of the mother and newborn. Compared with vaginal delivery, however, the procedure is associated with a higher risk of various maternal complications, such as maternal infection and subsequent pregnancy complications, and a higher likelihood of re-hospitalization within 6 weeks of delivery. Furthermore, the likelihood of maternal morbidity increases for mothers who repeatedly undergo cesarean delivery.

According to the World Health Organization, cesarean delivery rates above 10% to 15% are generally not associated with improvements in maternal, neonatal, and infant mortality rates.[2]

Measure Description

Cesarean deliveries without a hysterotomy procedure per 1,000 deliveries. This excludes deliveries with complications, like abnormal presentation, preterm delivery, fetal death, multiple gestation, or breech presentation.[3]

Best Practices:

The goal of this measure is to ensure that C-sections are decreased and averted in the absence of known high-risk situations. Therefore, best practices are offered to support alternatives to C-sections in low-risk deliveries.

Prenatal Period:

- Educate patients and their partners on safe labor guidelines and risks of caesarean section during the prenatal period.
- Encourage patients to avoid excessive weight gain during pregnancy.
- If a baby is breech at about 36 weeks of pregnancy, consider offering external cephalic version.
- Encourage the use of continuous labor support, such as labor doula care.

First Stage of Labor:

- A prolonged latent phase (greater than 20 hours in nulliparous women and 14 hours in multiparous women) should not in and of itself be an indication for cesarean delivery.
- Slow but progressive labor in the first stage of labor should not be an indication for cesarean delivery.
- Considering cervical dilation of 6cm as the start of active phase labor.
- Encourage patients to stay upright and move around in the first stage of labor especially before the use of epidural pain relief.

Second Stage of Labor:

- Cesarean should only be done for poor progress in active labor (6cm cervical dilation) if: 1) membranes are broken and there have been 4 hours of contractions with no progress; or 2) synthetic oxytocin has been used for 6 hours with no progress.
- Before diagnosing arrest of labor in the second stage, if the maternal and fetal conditions permit, allow for at least 2 hours of pushing in multiparous women or 3 hours of pushing in nulliparous women. Longer durations may be appropriate on an individualized basis as long as labor is progressing.

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Induction of Labor:
- Avoid induction of labor before 41 0/7 weeks of gestation unless indicated by maternal and fetal medical conditions.
- Use cervical ripening methods when inducing labor in women with an unfavorable cervix.
- If maternal and fetal status allow, allowing prolonged latent phase labor (up to 24 hours or longer) and require Oxytocin be administered for at least 12-18 hours after membrane rupture before deeming the induction a failure.

Eligible Population:
Members are included in this measure when they have discharge codes for a birth or delivery. The rate is calculated by identifying cesarean deliveries **without** a hysterotomy procedure. Members with complications are excluded from this measure (see below).

Discharges with an ICD-10-CM diagnosis code for birth delivery outcome:

ICD10	Z37.0, Z37.1, Z37.2, Z37.3, Z37.4, Z37.50, Z37.51, Z37.52, Z37.53, Z37.54, Z37.59, Z37.60, Z37.61, Z37.62, Z37.63, Z37.64, Z37.69, Z37.7, Z37.9

Exclude discharges:
• with any listed ICD-10-CM diagnosis code for abnormal presentation, preterm delivery, fetal death, multiple gestation, or breech presentation. See the AHRQ Inpatient Quality Indicators Appendix A for a complete list of ICD-10-CM codes.

• with a principal ICD-10-CM diagnosis code assigned to Newborns & Other Neonates with Conditions Originating in Perinatal Period. See the AHRQ Inpatient Quality Indicators Appendix B for a complete list of ICD-10-CM codes.

Low-risk Cesarean deliveries are identified by any listed ICD-10-PCS procedure code for Cesarean Delivery: 10D00Z0, 10D00Z1, 10D00Z2
AND
without any listed ICD-10-PCS procedure code for hysterotomy: 10A00ZZ, 10A04ZZ, 10A03ZZ

[1] https://www.hhs.texas.gov/sites/default/files/documents/eqro-annual-tech-report-contract-yr-2022.pdf
[2] Sakai-Bizmark, Rie MD. "Evaluation of Hospital Cesarean Delivery–Related Profits and Rates in the United States." The Journal of the American Medical Association (JAMA), 2021, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2777679
[3] https://qualityindicators.ahrq.gov/Downloads/Modules/IQI/V2023/TechSpecs/IQI_21_Cesarean_Delivery_Rate_Uncomplicated.pdf