Geisinger

Geisinger Health Plan Policies and Procedure Manual

Policy: MP059

Section: Medical Benefit Policy

Subject: Fetal Surgery

Applicable Lines of Business

Commercial	X	CHIP	X
Medicare	X	ACA	X
Medicaid	X		

I. Policy: Fetal Surgery

II. Purpose/Objective:
To provide a policy of coverage regarding Fetal Surgery

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

DESCRIPTION:
Fetal surgery involves opening the uterus (either by traditional cesarean surgical incision or through single or multiple fetoscopic port incisions), surgically correcting a fetal abnormality, then returning the fetus to the uterus and closing the uterus.

INDICATIONS: REQUIRES PRIOR MEDICAL DIRECTOR OR DESIGNEE AUTHORIZATION
The Plan will cover intrauterine fetal surgery (IUFS) for the following indications:

- Congenital cystic adenomatoid malformations
- Urinary tract obstruction
- Hydronephrosis
- Acardiac twins
- High risk sacrococcygeal teratomas (SCT)
- Twin reversed arterial perfusion
- Myelomeningocele repair
- Fetal cord ligation for twin to twin transfusion*
  *only in the event of 100% predicted infant mortality without intervention

The Plan will cover fetoscopic endoluminal tracheal occlusion (FETO) for the intrauterine treatment of congenital diaphragmatic hernia (CDH) when the following criteria are met:

- Diagnosis of CDH is made before 30 weeks of gestation
- Severe pulmonary hypoplasia defined as a quotient of the observed-to-expected lung-to-head ratios of less than 25.0%
- Absence of other known major structural defects

LIMITATIONS:
Requests for in utero fetal surgery for indications not listed in this policy will be reviewed on a per-case basis, utilizing current published peer-reviewed medical literature and assessments by currently contracted technology assessment vendors.

EXCUSIONS:
The Plan does **NOT** provide coverage for in utero stem cell transplantation and in utero gene therapy because it is considered to be **experimental, investigational or unproven**. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of these procedures on health outcomes.

Medicaid Business Segment:
Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH: Fetal surgery
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements

59072 Fetal umbilical cord occlusion, including ultrasound guidance
59074 Fetal fluid drainage (e.g., vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance
59076 Fetal shunt placement, including ultrasound guidance
S2400 Repair, congenital diaphragmatic hernia in the fetus using temporary tracheal occlusion, procedure performed in utero
S2401 Repair, urinary tract obstruction in the fetus, procedure performed in utero
S2402 Repair, congenital cystic adenomatoid malformation in the fetus, procedure performed in utero

S2403 Repair, extralobar pulmonary sequestration in the fetus, performed in utero
S2404 Repair, myelomeningocele in the fetus, procedure performed in utero
S2405 Repair of sacrococcygeal teratoma in the fetus, procedure performed in utero
S2409 Repair, congenital malformation of fetus, procedure performed in utero, not otherwise classified
S2411 Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome
S2400 Repair, congenital diaphragmatic hernia in the fetus using temporary tracheal occlusion, procedure performed in utero

Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL

LINE OF BUSINESS:

Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

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This policy will be revised as necessary and reviewed no less than annually.

Devised: 10/98

Revised: 4/99, 7/02, 7/03 (add limitation); 8/04, 8/14(added indication); 7/16 (add indications); 8/18 (added indication); 8/21 (add gene therapy exclusion); 8/22 (add Indication FETO for CDH)

Reviewed: 8/05; 8/06; 8/07, 9/08, 9/09, 7/10, 8/11, 8/12, 8/13, 8/15, 7/17. 8/19, 8/20, 8/23, 8/24

CMS UM Oversight Committee Approval: 12/23; 11/8/24

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at https://www.geisinger.org/health-plan/providers/ghp-clinical-policies

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.