

Policy: MP059

Section: Medical Benefit Policy

Subject: Fetal Surgery

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

Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

- (i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- (ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
- (iii) The service or benefit 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 fetal surgery 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

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.

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

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)

Reviewed: 8/05; 8/06; 8/07, 9/08, 9/09, 7/10, 8/11, 8/12, 8/13, 8/15, 7/17