



MEDICAL COVERAGE POLICY

SERVICE: Fetal Surgery

Policy Number: 258

Effective Date: 08/01/2020

Last Review: 06/25/2020

Next Review Date: 06/25/2021

Important note:

Unless otherwise indicated, this policy will apply to all lines of business.

Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

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PRIOR AUTHORIZATION: Certain procedures require PRIOR AUTHORIZATION.

POLICY: Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for coverage details.

For Medicare plans, please refer to appropriate Medicare LCD (Local Coverage Determination). If there is no applicable LCD, use the criteria set forth below.

For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid TMPPM.

SWHP/FirstCare may consider in-utero fetal surgery medically necessary for any of the following indications:

1. Ablation of anastomotic vessels in acardiac twins;
2. Fetoscopic occlusion of anastomotic vessels in early, severe twin-twin transfusion, e.g. twin reversed arterial perfusion (TRAP);
3. Insertion of pleuro-amniotic shunt for fetal pleural effusion;
4. Fetal vesico-amniotic shunt procedures for fetal urinary-tract obstruction
5. Removal of sacrococcygeal teratoma;
6. Repair of myelomeningocele;
7. Resection of malformed pulmonary tissue:
 - Congenital cystic adenomatoid malformation; or
 - Extralobar pulmonary sequestration;

SWHP/FirstCare considers the following applications of in-utero fetal surgery experimental, investigational and unproven because its effectiveness for these indications has not been established:

- Fetal aortic valvuloplasty;
- Treatment of congenital diaphragmatic hernia;
- Shunting for the treatment of fetal cerebral ventriculomegaly;
- Treatment of amniotic band syndrome;
- Treatment of aqueductal stenosis (i.e., hydrocephalus);



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- Treatment of cleft lip and/or cleft palate;
- Treatment of congenital heart disease (e.g. mitral valve dysplasia);
- Treatment of fetal hydronephrosis;
- Treatment of gastroschisis.
- In-utero stem cell transplantation and in-utero gene therapy
- All other applications of in-utero surgery

OVERVIEW:

Intrauterine fetal surgery involves accessing the fetus through the uterine wall using either an open or a minimally invasive endoscopic technique, surgically correcting the fetal abnormality and closing the uterus to permit completion of gestational development until delivery. Intrauterine fetal surgery includes a broad range of highly complex surgical interventions to repair birth defects in the uterus.

MANDATES: None

CODES:

Important note:

CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

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| CPT Codes: | 59072 Fetal umbilical cord occlusion, including ultrasound guidance 59074 Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance 59076 Fetal shunt placement, including ultrasound guidance 59897 Unlisted fetal invasive procedure, including ultrasound guidance, when performed |
| CPT Not Covered: | |
| HCPCS Codes: | 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, procedure 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 |
| HCPCS Not Covered | S2400 Repair, congenital diaphragmatic hernia in the fetus using temporary tracheal occlusion, procedure performed in-utero |
| ICD10 codes: | O33.7xx0 Maternal care for disproportion due to other fetal deformities, not applicable or unspecified O33.7xxx Maternal care for disproportion due to other fetal deformities, fetus x O36.21x0 Maternal care for hydrops fetalis, first trimester, not applicable or unspecified O36.21xx Maternal care for hydrops fetalis, first trimester, fetus x O36.22x0 Maternal care for hydrops fetalis, second trimester, not applicable or |



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| | unspecified O36.23x0 Maternal care for hydrops fetalis, third trimester, not applicable or unspecified O36.23xx Maternal care for hydrops fetalis, third trimester, fetus x O43.021 Fetus-to-fetus placental transfusion syndrome, first trimester O43.022 Fetus-to-fetus placental transfusion syndrome, second trimester O43.023 Fetus-to-fetus placental transfusion syndrome, third trimester O43.029 Fetus-to-fetus placental transfusion syndrome, unspecified trimester |
| ICD10 Not covered: | |

CMS:

POLICY HISTORY:

| Status | Date | Action |
|----------|------------|--|
| New | 10/17/2019 | New policy |
| Reviewed | 06/25/2020 | Added language for use across all LOBs |

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. SWHP will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to SWHP so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

1. American Pediatric Surgical Association (APSA). Fetal diagnosis and therapy. Reference Handbook for Pediatric Surgeons. 2nd Ed. <http://www.eapsa.org/>. Published April 2019.
2. UpToDate, Inc. Congenital anomalies of the intrathoracic airways and tracheoesophageal fistula. <http://www.uptodate.com>. Updated July 2019.
3. UpToDate, Inc. Congenital diaphragmatic hernia: prenatal issues. <http://www.uptodate.com>. Updated July 2019
4. UpToDate, Inc. Open neural tube defects: risk factors, prenatal screening and diagnosis, and pregnancy management. <http://www.uptodate.com>. Updated July 2019.
5. Wójcicki P, Drozdowski P. In-utero surgery – current state of the art: part I. Med Sci Monit. 2010;16(11):RA237-RA244.
6. Wójcicki P, Drozdowski P, Wójcicka K. In-utero surgery – current state of the art: part II. Med Sci Monit. 2011;17(12):RA262-RA270.