Medical Necessity Guidelines: Fetal Surgery

Effective: July 25, 2018

临床验证和前授权要求

覆盖指南，无需前授权

<table>
<thead>
<tr>
<th>应用于：</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Tufts Health Plan Commercial Plans products; Fax: 617.972.9409</td>
</tr>
<tr>
<td>☒ Tufts Health Direct – Health Connector; Fax: 888.415.9055</td>
</tr>
<tr>
<td>☒ Tufts Health Together – A MassHealth Plan; Fax: 888.415.9055</td>
</tr>
<tr>
<td>☐ Tufts Health Unify – OneCare Plan; Fax: 781.393.2607</td>
</tr>
<tr>
<td>☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404</td>
</tr>
<tr>
<td>☒ Tufts Health Freedom Plan products; Fax: 617.972.9409</td>
</tr>
</tbody>
</table>

注：虽然您可能不是需要获取授权的医疗提供者，但作为支付条件，您需要确保已经获取授权。

概览

围产期胎儿手术用于纠正胎儿期影响器官发育并伴有不良后遗症的某些畸形。该手术通常涉及剖宫产，在子宫内进行手术。围产期胎儿手术通常涉及剖宫产，通过剖宫术或微创腹腔镜技术，对胎儿进行手术。胎儿被送回子宫，然后进行子宫缝合，以允许完成妊娠期发育。

有几种情况可以采用胎儿手术：

- 可切除性尾骨肿瘤（SCT）：一种发生在尾骨（尾骨）基部的肿瘤。它在每年35,000名活产婴儿中可见一次，是新生儿最常见的肿瘤。这些肿瘤通常在诊断后非恶性，治疗后完全恢复的可能性很高。
- 先天性膈疝（CDH）：先天性意味着出生时带有的，膈是分隔胸腔和腹腔的呼吸肌肉；因此先天性膈疝是指膈的缺失，或者一个在膈上的洞。结果，腹部的器官，包括胃、肠、肝和脾，可能会通过孔进入胸腔。这些器官阻碍了肺（肺发育不全）的正常发育，可能会影响另一侧肺的发育。出生后，婴儿可能由于肺发育不良而难以呼吸。
- 脊髓裂（MMC）：一种严重的脊柱裂。这种神经系统疾病可导致的一部分脊髓和周围结构在出生时显示在体外，而不是体内。这些婴儿通常有虚弱和感觉障碍。问题与肠道和膀胱功能也有关。大多数有MMC的婴儿也将有脑积水，一种引起头部内压力增加，造成头骨扩大以适应大于正常大小的疾病。
- 双胎输血综合征（TTTS）：一种发生在双胞胎妊娠中涉及胎盘的疾病。它可能发生于双胞胎是同卵双胞胎时。几乎所有的同卵双胞胎都会通过胎盘交换血液，虽然通常交换是平衡的。在TTTS中，血液在胎盘的连接处异常，血液在两者之间不平均流动。一个胎儿，先胎，将血液泵入另一个胎儿，后胎。如果没有干预，后胎会得到太多血液，可能引起液体过载、心力衰竭和死亡，而先胎可能因为没有足够的血液，或严重的贫血而死亡。
- 先天性囊性腺瘤样畸形（CCAM）：一种良性（非癌性）异常肺组织，位于肺的一个部分（叶）中。这种情况是由于异常肺组织的过度生长，可能会形成充满液体的囊肿。这些组织不具有正常肺组织的功能。CCAM有两种类型。类型I由一个或更多大的囊肿组成。类型II有固体区域和囊肿。
COVERAGE GUIDELINES

- Tufts Health Plan does not generally cover procedures that are considered investigational. Fetal surgery typically falls under this definition and is not a covered benefit unless there is substantial evidence demonstrating that the intervention is efficacious and the benefits clearly outweigh the risks. This scientific evidence must be published by recognized peer review journals and within the standards of coverage for Tufts Health Plan and the Member's individual plan.
- All requests for fetal surgery require a letter of medical necessity and a treatment plan from the pediatric surgeon.

LIMITATIONS

None

CODES

The following HCPCS codes require prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S2400</td>
<td>Repair, congenital diaphragmatic hernia in the fetus using temporary tracheal occlusion, procedure performed in utero</td>
</tr>
<tr>
<td>S2401</td>
<td>Repair, urinary tract obstruction in the fetus, procedure performed in utero</td>
</tr>
<tr>
<td>S2402</td>
<td>Repair, congenital cystic adenomatoid malformation in the fetus, procedure performed in utero</td>
</tr>
<tr>
<td>S2403</td>
<td>Repair, extralobar pulmonary sequestration in the fetus, procedure performed in utero</td>
</tr>
<tr>
<td>S2404</td>
<td>Repair, myelomeningocele in the fetus, procedure performed in utero</td>
</tr>
<tr>
<td>S2405</td>
<td>Repair of sacrococcygeal teratoma in the fetus, procedure performed in utero</td>
</tr>
<tr>
<td>S2409</td>
<td>Repair, congenital malformation of fetus, procedure performed in utero, not otherwise classified</td>
</tr>
<tr>
<td>S2411</td>
<td>Fetoscopic laser therapy for treatment of twin-to-twin transfusion (please refer to separate clinical criteria for TTTS)</td>
</tr>
</tbody>
</table>

REFERENCES


APPROVAL HISTORY

- February 15, 2007: Reviewed by the Medical Affairs Medical Policy Committee
- November 28, 2007: Reviewed and renewed without changes
- December 17, 2008: Reviewed and renewed without changes
- December 16, 2009: Reviewed and no changes made
- November 28, 2012: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), renewed without changes
- October 9, 2013: Reviewed by IMPAC, renewed without changes.
- October 8, 2014: Reviewed by IMPAC, renewed without changes.
• September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
• November 16, 2015: Reviewed by IMPAC, renewed without changes
• November 9, 2016: Reviewed by IMPAC, renewed without changes
• April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
• October 11, 2017: Reviewed by IMPAC, renewed without changes
• July 25, 2018: Reviewed by IMPAC, renewed without changes

**BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION**

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Medical Necessity Guidelines apply to the fully insured Commercial and Medicaid products when Tufts Health Plan conducts utilization review unless otherwise noted in this guideline or in the Member's benefit document, and may apply to Tufts Health Unify to the same extent as Tufts Health Together. This guideline does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options or to certain delegated service arrangements. For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates or other requirements will take precedence. For CareLink℠ Members, Cigna conducts utilization review so Cigna’s medical necessity guidelines, rather than these guidelines, will apply.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of these guidelines is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.