Medical Necessity Guidelines: Fetal Surgery

Effective: July 25, 2018

Prior Authorization Required
If REQUIRED, submit supporting clinical documentation pertinent to service request.

Applies to:
COMMERCIAL Products
☒ Tufts Health Plan Commercial products; Fax: 617.972.9409
☒ Tufts Health Freedom Plan products; Fax: 617.972.9409
• CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products
☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 781.393.2607
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products
• Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan
  SCO Prior Authorization List
• Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred
  HMO Prior Authorization and Inpatient Notification List

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

OVERVIEW
Maternal-fetal surgery is used to correct certain malformations of the fetus that interfere with organ development and are associated with a poor postnatal prognosis. Prenatal or in utero fetal surgery typically involves opening the gravid uterus, by cesarean surgical incision or minimally invasive laparoscopic technique, to surgically correct the abnormality. The fetus is returned to the uterus followed by uterine closure to permit completion of gestational development1,6.

There are several conditions that can be treated with fetal surgery:
• Sacrococcygeal teratoma (SCT): A tumor that develops at the base of the coccyx (tailbone). It is seen in 1 in every 35,000 live births, and is the most common tumor in the newborn. These tumors are usually non-malignant when diagnosed after birth and, after treatment, full recovery is likely.
• Congenital diaphragmatic hernia (CDH): Congenital means born with, diaphragm is the breathing muscle that separates the chest cavity from the abdominal cavity; therefore congenital diaphragmatic hernia is the absence of the diaphragm, or a hole in the diaphragm. As a result, the contents of the abdomen, including the stomach, intestines, liver, and spleen may go through the hole and into the chest. The contents prevent the normal development of the lung (pulmonary hypoplasia) on that side, and may affect the growth of the other lung. After birth the infant will have difficulty breathing if the lungs are not developed enough.
• Myelomeningocele: A severe form of spina bifida. This neurological condition can cause a portion of the spinal cord and the surrounding structures to develop outside, instead of inside, the body. These babies typically have weakness and loss of sensation below the defect. Problems with bowel and bladder function are also common. A majority of babies with myelomeningocele will also have hydrocephalus, a condition that causes the fluid inside of the head to build up, causing pressure inside of the head to increase and the skull bones to expand to a larger than normal size.
• Twin-twin transfusion syndrome (TTTS): A problem involving the placenta in a twin pregnancy. It can occur when the twins are identical and share a placenta (monochorionic). Almost all identical twins exchange blood across the placenta, although usually the exchange is balanced. In TTTS,
the blood connections in the placenta are abnormal and the blood passes unequally between the two fetuses. One fetus, the donor twin, pumps blood to the other fetus, the recipient twin. Without intervention, the recipient twin receives too much blood and may develop fluid overload, heart failure and die and the donor twin may die from not having enough blood, or severe anemia.

- Congenital cystic adenomatoid malformation (CCAM): A benign (non-cancerous) mass of abnormal lung tissue, located usually on one section (lobe) of the lung. This condition is caused by overgrowth of abnormal lung tissue that may form fluid filled cysts. The tissue does not function as normal lung tissue. There are effectively two types of CCAMs. Type I is distinguished by one or more large cysts. Type II has both solid regions and cysts.

**CLINICAL COVERAGE CRITERIA**

- 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>
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<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>
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<tr>
<td>S2402</td>
<td>Repair, congenital cystic adenomatoid malformation in the fetus, procedure performed in utero</td>
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<tr>
<td>S2403</td>
<td>Repair, extralobar pulmonary sequestration in the fetus, procedure performed in utero</td>
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<tr>
<td>S2404</td>
<td>Repair, myelomeningocele in the fetus, procedure performed in utero</td>
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<tr>
<td>S2405</td>
<td>Repair of sacrococcygeal teratoma in the fetus, procedure performed in utero</td>
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<tr>
<td>S2409</td>
<td>Repair, congenital malformation of fetus, procedure performed in utero, not otherwise classified</td>
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<tr>
<td>S2411</td>
<td>Fetoscopic laser therapy for treatment of twin-to-twin transfusion (please refer to separate clinical criteria for TTTS)</td>
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**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
October, 2018: Template and disclaimer updated

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.

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.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline 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.