

## Clinical Policy: Fetal Surgery in Utero for Prenatally Diagnosed Malformations

Reference Number: CP.MP.129

Date of Last Revision: 07/22

[Coding Implications](#)

[Revision Log](#)

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### Description

This policy describes the medical necessity requirements for performing fetal surgery. This becomes an option when it is predicted that there will be severe disability, or if it is predicted that the fetus will not live long enough to survive delivery or after birth.<sup>8</sup> Therefore, surgical intervention during pregnancy on the fetus is meant to correct problems that would be too advanced to correct after birth.

### Policy/Criteria

- I. It is the policy of health plans affiliated with Centene Corporation® that in-utero fetal surgery (IUFS) is **medically necessary** for any of the following:
  - A. Sacrococcygeal teratoma (SCT): SCT resection or a minimally invasive approach;
  - B. Lower urinary tract obstruction without multiple fetal anomalies or chromosomal abnormalities: urinary decompression via vesico-amniotic shunting;
  - C. Congenital pulmonary airway malformation (CPAM) and extralobar bronchopulmonary sequestration (BPS), with high risk tumors: resection of malformed pulmonary tissue, or placement of a thoraco-amniotic shunt;
  - D. Placement of a thoraco-amniotic shunt for pleural effusion with or without secondary fetal hydrops;
  - E. Twin-twin transfusion syndrome (TTTS): treatment approach is dependent on Quintero stage, maternal signs and symptoms, gestational age and the availability of requisite technical expertise and include either:
    1. Amnioreduction; or
    2. Fetoscopic laser ablation, with or without amnioreduction when pregnancy is between 16 and 26 weeks gestation;
  - F. Twin-reversed-arterial-perfusion sequence (TRAP): ablation of anastomotic vessels of the acardiac twin (laser, radiofrequency ablation);
  - G. Myelomeningocele: repair when all of the following criteria are met:
    1. Singleton pregnancy;
    2. Upper boundary of myelomeningocele located between T1 and S1;
    3. Evidence of hindbrain herniation;
    4. Gestational age 19.0 to < 26 weeks;
    5. Normal fetal karyotype;
    6. None of the following:
      - a. Severe kyphosis;
      - b. Risk of preterm birth (e.g., short cervix or previous preterm birth);
      - c. Placental abruption;
      - d. Maternal body mass index of  $\geq 35$ ;
      - e. Previous hysterotomy in the active uterine segment.

- II.** It is the policy of health plans affiliated with Centene Corporation that all repeat utero fetal surgery procedures require secondary review.
- III.** It is the policy of health plans affiliated with Centene Corporation that current evidence does not support the use of utero fetal surgery for any of the following indications:
- A.** Open or endoscopic fetal surgery for congenital diaphragmatic hernia (CDH), including temporary tracheal occlusion;
  - B.** Surgery for heart block, pulmonary valve, or aortic obstruction;
  - C.** Tracheal atresia or stenosis;
  - D.** Cleft lip and palate;
  - E.** In-utero stem cell transplantation;
  - F.** In-utero gene therapy;
  - G.** Amnioexchange procedure for gastroschisis.

## **Background**

### *Maternal–Fetal Surgery*

Maternal–fetal surgery is a major procedure for the mother and her fetus, and it has significant implications and complications that could occur acutely, postoperatively, for the duration of the pregnancy, and in subsequent pregnancies. For the fetus, safety and effectiveness are variable, and depend on the specific procedure, the reasons for the procedure, and the gestational age and condition of the fetus. Often babies who have been operated on in this manner are born pre-term. Therefore, it should only be offered at facilities with the expertise, multidisciplinary teams, services, and facilities to provide the intensive care required for these patients.<sup>8</sup>

Fetal surgery approaches can be divided into two categories:

- Open fetal surgery is considered when the fetal condition is life threatening, and the intervention is felt to be the only option for fetal survival. A hysterotomy is performed, the fetus is partially removed to expose the area that needs surgery, the fetal abnormality is corrected, and the fetus is returned to the uterus where it continues to develop until delivery.
- Fetoscopic surgery employs minimally invasive techniques and uses small fiberoptic telescopes and instruments to enter the uterus through small surgical openings to correct congenital malformations without major incisions or removing the fetus from the womb. This interim procedure is less traumatic, reduces the chances of preterm labor, and allows the fetus to remain in utero until it has matured enough to survive delivery and neonatal surgical procedures.

### *Sacroccygeal germ cell tumors*

The prenatal diagnosis of sacroccygeal teratoma (SCT) typically occurs during the second trimester during routine sonography. Prenatal diagnosis and close monitoring have improved outcomes for fetal SCT, but overall perinatal mortality remains high. The major goal is to identify fetuses at increased risk of fetal demise because of hydrops fetalis and intervene as appropriate. Hydrops fetalis is a condition of excess fluid accumulation in the fetus that results in significant fetal demise and neonatal mortality. Criteria for open fetal surgery varies, but most centers include fetuses with high-risk SCT and hydrops that have developed at a gestational age too early for appropriate delivery and neonatal care. Type III or IV Altman type tumors, severe

placentomegaly, cervical shortening, and maternal medical issues are all contraindications for open fetal surgery for SCT.<sup>9</sup>

*Lower Urinary Tract Obstruction*

The prenatal diagnosis of lower urinary tract obstructions typically occurs during the first or second trimester during routine sonography. Outcomes range from clinically insignificant to in-utero fetal demise. Vesicoamniotic shunts can be a temporizing measure and provide a survival advantage in a select cohort of fetuses with urinary tract obstruction.<sup>19</sup>

*Congenital pulmonary airway malformation (CPAM)*

CPAM is one of the most common lung lesions diagnosed prenatally, although the birth prevalence is quite low. Prenatal diagnosis is typically made by ultrasonography. CPAMs presenting prenatally are classified as macrocystic or microcystic based on ultrasound appearance. Approximately 50% of the masses resolve before delivery, while the remainder persists until delivery. Hydrops can develop with either micro or macrocystic lesions due to compression of lymphatic structures or due to hemodynamic alterations from vena cava obstruction or cardiac displacement/compression.

The presence of hydrops is a sign for impending fetal demise (risk of death approaches 100% in the absence of intervention), and thus it is an indication for fetal intervention. For hydropic fetuses over 32 to 34 weeks of gestation, early delivery with immediate postnatal resection is a reasonable option. Ex utero intrapartum therapy (EXIT) has been used to stabilize fetuses with large lesions expected to have difficulty breathing at delivery. In EXIT, the fetus is partially delivered and intubated without clamping the umbilical cord. Uteroplacental blood flow and gas exchange are maintained by using inhalational agents to provide uterine relaxation and amnioinfusion to maintain uterine volume. This provides time for resection of the lung mass prior to complete delivery of the infant. For hydropic fetuses between 20 and 32 weeks of gestation, the choice of the best invasive approach depends on the type of anomaly (macro-versus microcystic). Drainage procedures are used for CPAMS with dominant cysts, while solid masses are treated by resection or ablation.<sup>10</sup>

*Twin-twin transfusion syndrome (TTTS)*

TTTS occurs in approximately 10–15% of monochorionic–diamniotic twin pregnancies and results from the presence of arteriovenous anastomoses in a monochorionic placenta. In the affected pregnancy, there is an imbalance in the fetal–placental circulations, whereby one twin transfuses the other. It usually presents in the second trimester. Once the diagnosis of TTTS has been made, the prognosis depends on gestational age and severity of the syndrome. Staging is commonly performed via the Quintero staging system, and treatment is by laser coagulation or amnioreduction, often in collaboration with an expert in TTTS diagnosis and management.<sup>18</sup>

*Twin reversed arterial perfusion (TRAP)*

TRAP sequence is a rare unique serious complication of monochorionic twin pregnancy in which a twin with an absent or a nonfunctioning heart (“acardiac twin”) is perfused by its co-twin (“pump twin”) via placental arterial anastomoses. The acardiac twin usually has a poorly developed heart, upper body, and head. The pump twin is at risk of heart failure and problems related to preterm birth. Current treatment modalities target occlusion of the umbilical cord of

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the acardiac twin and include laser coagulation, bipolar cord coagulation, and radiofrequency ablation.<sup>12</sup>

#### *Myelomeningocele*

Per the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal–Fetal Medicine (SMFM), open maternal–fetal surgery for myelomeningocele repair has shown improvement in pediatric outcomes, but poses procedure-associated maternal and fetal risks. According to ACOG and SMFM recommendations for myelomeningocele repair, women who meet specific criteria for in utero repair should be counseled about all management options, including open maternal-fetal surgery. A referral for additional assessment and consultation to a fetal therapy center should be completed for candidates interested in fetal myelomeningocele repair. These centers have the expertise, resources, and multi-disciplinary team to provide the information and intensive care needed for patients choosing to undergo open maternal-fetal surgery.<sup>8</sup>

#### Coding Implications

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| CPT® Codes | Description                                                                        |
|------------|------------------------------------------------------------------------------------|
| 59001      | Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance) |
| 59076      | Fetal shunt placement, including ultrasound guidance                               |
| 59897      | Unlisted fetal invasive procedure, including ultrasound guidance, when performed   |

| HCPCS Codes | Description                                                                                     |
|-------------|-------------------------------------------------------------------------------------------------|
| 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 |
| S2411       | Fetoscopic laser therapy for treatment of twin-to-twin transfusion                              |

#### ICD-10-CM Diagnosis Codes that Support Coverage Criteria

| ICD 10 CM Code | Description                                   |
|----------------|-----------------------------------------------|
| D43.4          | Neoplasm of uncertain behavior of spinal cord |

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| ICD 10 CM Code            | Description                                                        |
|---------------------------|--------------------------------------------------------------------|
| O30.021 through O30.029   | Conjoined twin pregnancy [twin reversed arterial perfusion (TRAP)] |
| O31.031 through O31.039   | Twin pregnancy, monochorionic/diamniotic                           |
| O35.0XX0 through O35.9XX9 | Maternal care for known or suspected fetal abnormality and damage  |
| O36.20X0 through O36.23X9 | Maternal care for hydrops fetalis                                  |
| O43.021 through O43.029   | Fetus-to-fetus placental transfusion syndrome                      |
| Q05.0 through Q05.9       | Spina Bifida                                                       |
| Q33.0                     | Congenital cystic lung                                             |
| Q33.2                     | Sequestration of lung                                              |
| Q33.3                     | Agenesis of lung                                                   |
| Q33.6                     | Congenital hypoplasia and dysplasia of lung                        |
| Q34.0 through Q34.9       | Other congenital malformations of respiratory system               |
| Q62.31 through Q62.39     | Other obstructive defects of renal pelvis and ureter               |
| Q64.2                     | Congenital posterior urethral valves                               |
| Q64.31 through Q64.39     | Other atresia and stenosis of urethra and bladder neck             |
| Q89.4                     | Conjoined twins                                                    |
| Q89.8                     | Other specified congenital malformations                           |

| Reviews, Revisions, and Approvals                                                                                                                                                                                                                                                                                                                                                                                                                                       | Revision Date | Approval Date |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------|
| Policy adopted from HN NMP344 Fetal Surgery in Utero for Prenatally Diagnosed Malformations.                                                                                                                                                                                                                                                                                                                                                                            | 09/16         | 10/16         |
| Removed gestational age requirements from sections: IA.1, treatment of sacrococcygeal teratoma and IA.3 congenital pulmonary airway malformation or bronchopulmonary sequestration.<br>Removed specific criteria from IA.2, Vesico-amniotic shunting as a treatment of lower urinary tract obstruction to allow procedure per the discretion of the treating surgeon.<br>Updated background with more recent recommendations from ACOG committee opinion. Code updates. | 09/17         | 10/17         |
| Reworded section I.A# 1-5 for clarification. Removed EXIT procedure from I.A. as the procedure is an “ex utero procedure.” Updated background information. Removed I.B, to defer to the discretion of the treating surgeon. References reviewed and updated.                                                                                                                                                                                                            | 08/18         | 08/18         |
| Myelomeningocele repair: clarified that “no history of previous hysterotomy in the active uterine segment should be “history of previous hysterotomy in the active uterine segment.                                                                                                                                                                                                                                                                                     | 10/18         |               |

| Reviews, Revisions, and Approvals                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Revision Date | Approval Date |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------|
| SCT: removed requirement for hydrops and included option for minimally invasive approach. CPAM/BPS: removed requirement for hydrops. Specialist review.                                                                                                                                                                                                                                                                                                                                                                                                                                | 08/19         | 08/19         |
| References reviewed and updated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 07/20         | 07/20         |
| Annual review. References reviewed and updated. Coding reviewed. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” Replaced all instance of “member” with “member/enrollee.” Added, “D. Placement of a thoraco-amniotic shunt for pleural effusion with or without secondary fetal hydrops,” to criteria set I. Added criteria set, “II. It is the policy of health plans affiliated with Centene Corporation that all repeat utero fetal surgery procedures require secondary review.” Reviewed by specialist. | 07/21         | 07/21         |
| Annual review. Description updated with no impact on criteria. Background updated with no impact on criteria. References reviewed and updated.                                                                                                                                                                                                                                                                                                                                                                                                                                         | 07/22         | 07/22         |

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### **Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical

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**Note: For Medicaid members/enrollees**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members/enrollees**, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria



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set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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