



MEDICAL COVERAGE POLICY

SERVICE: Fetal Surgery

Policy Number: 258

Effective Date: 04/01/2025

Last Review: 03/10/2025

Next Review: 03/10/2026

Important note: Unless otherwise indicated, medical policies will apply to all lines of business.

Medical necessity as defined by this policy does not ensure the benefit is covered. This medical policy does not replace existing federal or state rules and regulations for the applicable service or supply. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan documents. See the member plan specific benefit plan document for a complete description of plan benefits, exclusions, limitations, and conditions of coverage. In the event of a discrepancy, the plan document always supersedes the information in this policy.

SERVICE: Fetal Surgery

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.

Note: Unless otherwise indicated (see below), this policy will apply to all lines of business.

For Medicare plans, please refer to appropriate Medicare NCD (National Coverage Determination) or LCD (Local Coverage Determination). Medicare NCD or LCD specific InterQual criteria may be used when available. If there are no applicable NCD or LCD criteria, use the criteria set forth below.

For Medicaid plans, please confirm coverage as outlined in the [Texas Medicaid Provider Procedures Manual | TMHP](#) (TMPPM). If there are no applicable criteria to guide medical necessity decision making in the TMPPM, use the criteria set forth below.

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

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

BSWHP 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



MEDICAL COVERAGE POLICY

SERVICE: Fetal Surgery

Policy Number: 258

Effective Date: 04/01/2025

Last Review: 03/10/2025

Next Review: 03/10/2026

- Treatment of amniotic band syndrome
- Treatment of aqueductal stenosis (i.e., hydrocephalus)
- 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

BACKGROUND:

With significant advances in imaging, instrumentation, and surgical techniques intrauterine fetal surgery has emerged as a viable option to post-natal repair. Currently, the potential indications remain limited to conditions that interfere with the development of fetal organs and threaten fetal survival.

Fetal surgery requires a multidisciplinary team (e.g., pediatric surgeons, perinatal obstetricians, sonographers, echocardiographers, neonatologists, intensive care specialists, geneticists, ethicists, neonatal, and obstetric nurses)—with the availability of Level III NICU and high level obstetric care.

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.

CODES:

Important note: 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.

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 Codes Not Covered	



MEDICAL COVERAGE POLICY

SERVICE: Fetal Surgery

Policy Number: 258

Effective Date: 04/01/2025

Last Review: 03/10/2025

Next Review: 03/10/2026

HCPCS Codes	<p>S2401 - Repair, urinary tract obstruction in the fetus, procedure performed in-utero</p> <p>S2402 - Repair, congenital cystic adenomatoid malformation in the fetus, procedure performed in-utero</p> <p>S2403 - Repair, extralobar pulmonary sequestration in the fetus, procedure performed in-utero</p> <p>S2404 - Repair, myelomeningocele in the fetus, procedure performed in-utero</p> <p>S2405 - Repair of sacrococcygeal teratoma in the fetus, procedure performed in-utero</p> <p>S2409 - Repair, congenital malformation of fetus, procedure performed in-utero, not otherwise classified</p> <p>S2411 - Fetoscopic laser therapy for treatment of twin-to-twin transfusion syndrome</p>
HCPCS Not Covered	S2400 - Repair, congenital diaphragmatic hernia in the fetus using temporary tracheal occlusion, procedure performed in-utero
ICD-10 Codes	<p>O33.7xx0 - Maternal care for disproportion due to other fetal deformities, not applicable or unspecified</p> <p>O33.7xxx - Maternal care for disproportion due to other fetal deformities, fetus x</p> <p>O36.21x0 - Maternal care for hydrops fetalis, first trimester, not applicable or unspecified</p> <p>O36.21xx - Maternal care for hydrops fetalis, first trimester, fetus x</p> <p>O36.22x0 - Maternal care for hydrops fetalis, second trimester, not applicable or unspecified</p> <p>O36.23x0 - Maternal care for hydrops fetalis, third trimester, not applicable or unspecified</p> <p>O36.23xx - Maternal care for hydrops fetalis, third trimester, fetus x</p> <p>O43.021 Fetus-to-fetus placental transfusion syndrome, first trimester</p> <p>O43.022 Fetus-to-fetus placental transfusion syndrome, second trimester</p> <p>O43.023 Fetus-to-fetus placental transfusion syndrome, third trimester</p> <p>O43.029 Fetus-to-fetus placental transfusion syndrome, unspecified trimester</p>
ICD-10 Codes Not Covered	

POLICY HISTORY:

Status	Date	Action
New	10/17/2019	New policy
Reviewed	06/25/2020	Added language for use across all LOBs
Reviewed	05/27/2021	No changes
Reviewed	05/26/2022	Added S2411 to code list
Reviewed	05/25/2023	No changes
Reviewed	05/13/2024	Formatting changes, added hyperlinks to TMPPM, beginning and ending note sections updated to align with CMS requirements and business entity changes
Reviewed	03/10/2025	Updated background information, ending note section updated to align with business entity changes.



MEDICAL COVERAGE POLICY

SERVICE: Fetal Surgery

Policy Number: 258

Effective Date: 04/01/2025

Last Review: 03/10/2025

Next Review: 03/10/2026

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. BSWHP 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 BSWHP 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.

Note:

Health Maintenance Organization (HMO) products are offered through Scott and White Health Plan dba Baylor Scott & White Health Plan, and Scott & White Care Plans dba Baylor Scott & White Care Plan. Insured PPO and EPO products are offered through Baylor Scott & White Insurance Company. Scott and White Health Plan dba Baylor Scott & White Health Plan serves as a third-party administrator for self-funded employer-sponsored plans. Baylor Scott & White Care Plan and Baylor Scott & White Insurance Company are wholly owned subsidiaries of Scott and White Health Plan. These companies are referred to collectively in this document as Baylor Scott & White Health Plan.

RightCare STAR Medicaid is offered through Scott and White Health Plan in the Central Texas Medicaid Rural Service Area (MRSA); FirstCare STAR is offered through SHA LLC dba FirstCare Health Plans (FirstCare) in the Lubbock and West MRSA; and FirstCare CHIP is offered through FirstCare in the Lubbock Service Area.