



**INFERTILITY DIAGNOSIS AND TREATMENT/  
ASSISTED REPRODUCTION/ARTIFICIAL CONCEPTION\***

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**Status:** Current

**I. BACKGROUND**

**Infertility** is the inability to achieve a pregnancy after 12 months of unprotected intercourse (after 6 months if the female partner is over age 35). Primary infertility is the term used to describe a couple that has never been able to conceive a pregnancy, after at least 1 year (6 months) of unprotected intercourse. The term secondary infertility describes couples who have previously been pregnant at least once, but have not been able to achieve another pregnancy.

**Assisted reproduction or artificial conception procedures** are not a covered benefit because they are not medically necessary for the health of the patient, nor do they correct the underlying cause of the infertility.

Some types of assisted reproduction are:

- Artificial insemination (AI)
- In-vitro fertilization (IVF)
- Gamete intra-fallopian tube transfer (GIFT)
- Zygote intra-fallopian tube transfer (ZIFT)

Other assisted reproduction technologies may be used or developed; none are a covered benefit.

**II. COVERAGE**

Specific information regarding Medicaid is discussed below.

**A. Infertility**

**1. Limits/Indications:**

**a. Diagnostic Services:**

Diagnostic evaluation of infertility is a covered benefit if the procedure has been determined to be appropriate and medically necessary to diagnose the underlying cause of infertility. Examples of covered diagnostic procedures include:



- 1 Female:
  - Hysterosalpingogram;
  - Huhners' test;
  - Endometrial biopsy
  - Diagnostic Laparoscopy or Hysteroscopy.
- 2 Male:
  - Hormone evaluation;
  - Semen analysis;
  - Hamster egg penetration assay.

**b. Treatment:**

Infertility treatment is a covered benefit if the member is diagnosed as infertile, and has not had an elective sterilization. Covered treatment procedures include:

- 1 Female
  - Laparoscopy for surgical intervention;
  - Tuboplasty for scarring/blockage (tuboplasty for the reversal of elective sterilization is not covered);
  - Chemotherapeutic (drug) intervention.
- 2 Male:
  - Varicocelectomy;
  - Testicular hypothermia device (see policy: *Durable Medical Equipment*);
  - Endocrine management.

The individual on whom the procedure is being performed must be a member to be eligible for coverage. For example, coverage for semen analysis, would require that the male is a member of Priority Health.

**B. Assisted reproduction or artificial conception procedures:** All services and supplies related to assisted reproduction or artificial conception are excluded from coverage. Some examples of this exclusion are:

1. Any service done in preparation for the assisted reproduction procedure or done to determine optimal timing of the procedure (e.g., lab work, ultrasounds).
2. Any concomitant procedure or service done with the assisted reproduction (e.g. laparoscopy).
3. Any post-operative or follow-up service or procedure (e.g. testing to determine success of procedure, such as ultrasonography).



**SPECIAL NOTES:**

Maternity care for a pregnancy resulting from infertility treatment is covered if the woman is a member.

**Medicaid members:** The Medicaid Certificate of Coverage (COC) states that all services and supplies relating to treatments for infertility including, among other things, artificial insemination, in-vitro fertilization, embryo or ovum transfer procedures, any other assisted reproduction procedure, fees to a surrogate parent, prescription drugs designed to achieve pregnancy, ultrasounds for egg harvest and services to reverse voluntary sterilizations are **not a covered benefit**. Diagnostic services are covered as described in the COC Section 7, #24.

**III. MEDICAL NECESSITY REVIEW:**

Required     Not required     Not Applicable

**IV. APPLICATION TO PRODUCTS:**

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- ❖ **HMO/EPO:** *This policy applies to insured HMO/EPO plans.*
- ❖ **POS:** *This policy applies to insured POS plans.*
- ❖ **PPO:** *This policy applies to insured PPO plans.*
- ❖ **ASO:** *For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.*
- ❖ **INDIVIDUAL:** *For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.*
- ❖ **MEDICARE:** *Coverage is determined by the Centers for Medicare and Medicaid Services (CMS).*
- ❖ **MEDICAID:** *Coverage is determined by the Michigan Medicaid Provider Manual and the Michigan Medicaid Fee Schedule at: [http://www.michigan.gov/mdch/0,1607,7-132-2945\\_42542\\_42543\\_42546\\_42551-159815--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html).*
- ❖ **MICHILD:** *For MICHILD members, this policy will apply unless MICHILD certificate of coverage limits or extends coverage.*



**V. CODING INFORMATION:**

**ICD-9 Codes that may apply** (*List should not be considered inclusive*):

- \*606.0 Azoospermia
- \*606.1 Oligospermia
- \*606.8 Infertility due to extratesticular causes
- \*606.9 Unspecified male infertility
  
- \*628.0 Female infertility associated with anovulation
- \*628.1 Female infertility of pituitary-hypothalamic origin
- \*628.2 Female infertility of tubal origin
- \*628.3 Female infertility of uterine origin
- \*628.4 Female infertility of cervical or vaginal origin
- \*628.8 Female infertility of other specified origin
- \*628.9 Female infertility of unspecified origin
  
- V26.21 Fertility testing
- \*V26.29 Procreation management; Other investigation and testing
- V26.8 Other specified procreative management
- V26.9 Unspecified procreative management

*All procedures billed with these \*diagnoses may be subject to the plans Fertility benefit limitations including but not limited to:*

- Anesthesia
- Medication
- Imaging
- Lab/Path
- Physician Services
- Therapy
- Office Visits
- Surgery

**Any services billed with the following diagnoses are not covered:**

- V26.0 Tuboplasty or vasoplasty after previous sterilization
- V26.1 Artificial insemination
- V26.81 Encounter for assisted reproductive fertility procedure cycle
  
- V59.70 Egg (oocyte) (ovum) donor, unspecified
- V59.71 Egg (oocyte) (ovum) donor, under age 35, anonymous recipient
- V59.72 Egg (oocyte) (ovum) donor, under age 35, designated recipient
- V59.73 Egg (oocyte) (ovum) donor, age 35 and over, anonymous recipient
- V59.74 Egg (oocyte) (ovum) donor, age 35 and over, designated recipient
- V59.8 Other specified organ or tissue

**CPT/HCPCS Codes** (*List should not be considered inclusive*):

- 54692 Laparoscopy, surgical; orchiopexy for intra-abdominal testis  
55866 Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing  
54900 Epididymovasostomy, anastomosis of epididymis to vas deferens; unilateral  
54901 Epididymovasostomy, anastomosis of epididymis to vas deferens; bilateral  
55200 Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)  
55300 Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral  
58100 Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)  
58110 Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure 58350)  
Chromotubation of oviduct, including materials  
58578 Unlisted laparoscopy procedure, uterus  
58660 Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)  
58662 Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method  
58672 Laparoscopy, surgical; with fimbrioplasty  
58673 Laparoscopy, surgical; with salpingostomy (salpingoneostomy)  
58679 Unlisted laparoscopy procedure, oviduct, ovary  
58750 Tubotubal anastomosis  
58752 Tubouterine implantation  
58760 Fimbrioplasty  
58999 Unlisted procedure, female genital system (nonobstetrical)  
59100 Hysterotomy, abdominal (eg, for hydatidiform mole, abortion)  
  
74740 Hysterosalpingography, radiological supervision and interpretation  
74742 Transcervical catheterization of fallopian tube, radiological supervision and interpretation  
  
89300 Semen analysis; presence and/or motility of sperm including Huhner test (post coital)  
89310 Semen analysis; motility and count (not including Huhner test)  
89320 Semen analysis; complete (volume, count, motility, and differential)  
89321 Semen analysis, presence and/or motility of sperm  
89325 Sperm antibodies  
89329 Sperm evaluation; hamster penetration test  
89330 Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test  
G0027 Semen analysis; presence and/or motility of sperm excluding huhner (Priority Medicare Advantage only)  
Q0115 Post-coital direct, qualitative examinations of vaginal or cervical mucous  
J0725 Injection, Chorionic Gonadotropin, Per 1,000 Usp Units



J1620 Injection, Gonadorelin Hydrochloride, Per 100 Mcg  
J3355 Injection, urofollotropin, 75IU  
E1399 Durable medical equipment, miscellaneous (Explanatory notes must accompany claim)

**The following services are not covered:**

0058T Cryopreservation; reproductive tissue, ovarian  
0059T Cryopreservation; oocyte(s)  
0087T Sperm evaluation, Hyaluronan sperm binding test

55870 Electroejaculation  
58321 Artificial insemination; intra-cervical  
58322 Artificial insemination; intra-uterine  
58323 Sperm washing for artificial insemination  
58970 Follicle puncture for oocyte retrieval, any method  
58974 Embryo transfer, intrauterine  
58976 Gamete, zygote, or embryo intrafallopian transfer, any method

89250 Culture of oocyte(s)/embryo(s), less than 4 days;  
89251 Culture of oocyte(s)/embryo(s), less than 4 days; with co-culture of oocyte(s)/embryos

89253 Assisted embryo hatching, microtechniques (any method)  
89254 Oocyte identification from follicular fluid  
89257 Sperm identification from aspiration (other than seminal fluid)  
89258 Cryopreservation; embryo(s)  
89259 Cryopreservation; sperm  
89260 Sperm isolation; simple prep (eg, sperm wash and swim-up) for insemination or diagnosis with semen analysis  
89261 Sperm isolation; complex prep (eg, Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis  
89268 Insemination of oocytes  
89272 Extended culture of oocyte(s)/embryo(s), 4-7 days  
89280 Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes  
89281 Assisted oocyte fertilization, microtechnique; greater than 10 oocytes  
89290 Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos  
89291 Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos

89342 Storage, (per year); embryo(s)  
89343 Storage, (per year); sperm/semen  
89344 Storage, (per year); reproductive tissue, testicular/ovarian  
89346 Storage, (per year); oocyte(s)  
89352 Thawing of cryopreserved; embryo(s)  
89353 Thawing of cryopreserved; sperm/semen, each aliquot  
89354 Thawing of cryopreserved; reproductive tissue, testicular/ovarian  
89356 Thawing of cryopreserved; oocytes, each aliquot



G0027	Semen analysis; presence and/or motility of sperm excluding hühner
S4011	In vitro fertilization; including but not limited to identification and incubation of mature oocytes, fertilization with sperm, incubation of embryo(s), and subsequent visualization for determination of development
S4022	Assisted oocyte fertilization, case rate
S4025	Donor services for in vitro fertilization (sperm or embryo), case rate
S4026	Procurement of donor sperm from sperm bank
S4028	Microsurgical epididymal sperm aspiration (MESA)
S4030	Sperm procurement and cryopreservation services; initial visit
S4031	Sperm procurement and cryopreservation services; subsequent visit
S4035	Stimulated intrauterine insemination (IUI), case rate
S4042	Management of ovulation induction (interpretation of diagnostic tests and studies, nonface-to-face medical management of the patient), per cycle

## **VI. REFERENCES:**

### **AMA CPT Copyright Statement:**

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