



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

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Date of Origin: July 7, 1989

Status: Current

Summary of Changes

Clarifications:

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Deletions:

- Pg 2, Section II, A, 1, b, Chemotherapeutic (drug) intervention removed

Additions:

- Pg 2, Section II, A, 1, b, Chemotherapeutic (drug) intervention replaced with:

Pharmacologic* intervention is limited to the following:

- a. Ovulatory stimulating drugs
- b. Gonadotrophin stimulating drugs
- c. GnRH antagonists
- d. GnRH agonists

*The medications listed above may not be covered for members without pharmacy benefit plans; in addition, some pharmacy benefit plans may exclude or limit coverage of some or all of these medications. Please check benefit plan descriptions and formularies for details on which specific medications are covered if any.

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);
- Pharmacologic* intervention is limited to the following:
 - a. Ovulatory stimulating drugs
 - b. Gonadotrophin stimulating drugs
 - c. GnRH antagonists
 - d. GnRH agonists

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.

*The medications listed above may not be covered for members without pharmacy benefit plans; in addition, some pharmacy benefit plans may exclude or limit coverage of some or all of these medications. Please check benefit plan descriptions and formularies for details on which specific medications are covered if any.

- 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, #21.

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:** *For Medicaid members, this policy will apply.*
- ❖ **MICHILD:** *For MICHILD members, this policy will apply unless MICHILD certificate of coverage limits or extends coverage.*

V. CODING INFORMATION

A. Infertility:

ICD-9 Codes that may apply:

- *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

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

*All procedures billed with the *diagnoses above may be subject to the plan’s Fertility benefit limitations, including but not limited to:*

- Anesthesia
- DME

- E1399 Durable medical equipment, miscellaneous – *if billed for testicular hypothermia device (Explanatory notes must accompany claim)*
- Medication
 - J0725 Injection, Chorionic Gonadotropin, Per 1,000 Usp Units
 - J1620 Injection, Gonadorelin Hydrochloride, Per 100 Mcg
 - J3355 Injection, urofollotropin, 75IU
 - Radiology
 - 74740 Hysterosalpingography, radiological supervision and interpretation
 - 74742 Transcervical catheterization of fallopian tube, radiological supervision and interpretation
 - Lab/Path
 - 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
 - 89322 Semen analysis; volume, count, motility, and differential using strict morphologic criteria (eg, Kruger)
 - 89325 Sperm antibodies
 - 89329 Sperm evaluation; hamster penetration test
 - 89330 Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test
 - 89331 Sperm evaluation, for retrograde ejaculation, urine (sperm concentration, motility, and morphology, as indicated)
 - 89398 Unlisted reproductive medicine laboratory procedure (*Explanatory notes must accompany claim*)
 - G0027 Semen analysis; presence and/or motility of sperm excluding huhner -
 - Q0115 Post-coital direct, qualitative examinations of vaginal or cervical mucous
 - Physician Services
 - Office Visits
 - Surgery
 - 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 (*Explanatory notes must accompany claim*)
- 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 (*Explanatory notes must accompany claim*)
- 58750 Tubotubal anastomosis
- 58752 Tubouterine implantation
- 58760 Fimbrioplasty
- 58999 Unlisted procedure, female genital system (nonobstetrical)

B. Assisted reproduction or artificial conception procedures**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
- V26.82 Encounter for fertility preservation procedure

- 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

CPT/HCPCS Codes:

All procedures billed with the diagnoses above will be denied as not covered, including but not limited to:

- Anesthesia
- Medication
- Radiology
- Lab/Path
- Physician Services
- Office Visits

▪ Surgery

The following services are not covered regardless of dx billed:

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
89255	Preparation of embryo for transfer (any method)
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
89264	Sperm identification from testis tissue, fresh or cryopreserved
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
89335	Cryopreservation, reproductive tissue, testicular
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
S0122	Injection, menotropins, 75 IU
S0126	Injection, follitropin alfa, 75 IU
S0128	Injection, follitropin beta, 75 IU

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
S4013	Complete cycle, gamete intrafallopian transfer (GIFT), case rate
S4014	Complete cycle, zygote intrafallopian transfer (ZIFT), case rate
S4015	Complete in vitro fertilization cycle, not otherwise specified, case rate
S4016	Frozen in vitro fertilization cycle, case rate
S4017	Incomplete cycle, treatment cancelled prior to stimulation, case rate
S4018	Frozen embryo transfer procedure cancelled before transfer, case rate
S4020	In vitro fertilization procedure cancelled before aspiration, case rate
S4021	In vitro fertilization procedure cancelled after aspiration, case rate
S4022	Assisted oocyte fertilization, case rate
S4023	Donor egg cycle, incomplete, case rate
S4025	Donor services for in vitro fertilization (sperm or embryo), case rate
S4026	Procurement of donor sperm from sperm bank
S4027	Storage of previously frozen embryos
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
S4037	Cryopreserved embryo transfer, case rate
S4040	Monitoring and storage of cryopreserved embryos, per 30 days
S4042	Management of ovulation induction (interpretation of diagnostic tests and studies, nonface-to-face medical management of the patient), per cycle

VI. REFERENCES:

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