PriorityHealth

MEDICAL POLICY
No. 91163-R8

INFERTILITY DIAGNOSIS AND TREATMENT/ ASSISTED REPRODUCTION/ARTIFICIAL CONCEPTION

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Date of Origin: July 7, 1989	**Status: Current**

Clarifications:

- Reworded initial reference to SPECIAL NOTES section for Medicaid and Health Michigan plan members.
- I B: Inserted qualifier, “Unless provided by plan amendment, . . .”

I. COVERAGE

See SPECIAL NOTES section below for specific information regarding Medicaid and Healthy Michigan plan members.

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. Gonadotropin-releasing hormone (GnRH) antagonists
d. GnRH agonists

2. Male:
   - Varicocelectomy;
   - Testicular hypothermia device (see policy: *Durable Medical Equipment #91110*);
   - 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**: Unless provided by plan amendment, all services and supplies related to assisted reproduction or artificial conception are excluded from coverage. Some examples of this exclusion are:

- Any service done in preparation for the assisted reproduction procedure or done to determine optimal timing of the procedure (e.g., lab work, ultrasounds).
- Immunological testing (e.g., antiprothrombin antibodies, embryotoxicity assay, circulating natural killer cell measurement, antiphospholipid antibodies, reproductive immunophenotype [RIP], cytokine assay and Th1/Th2 cytokine ratio)
- Any concomitant procedure or service done with the assisted reproduction (e.g. laparoscopy)
- Any post-operative or follow-up service or procedure (e.g. testing to determine success of procedure, such as ultrasonography).

C. For specific coverage regarding pre-implantation genetic diagnosis (PGD), please refer to the Genetics*: Counseling, Testing and Screening medical policy #91540*.

SPECIAL NOTES:

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

See also *policy 91393 Sperm Oocyte Retrieval Storage*.

Medicaid/Healthy Michigan Plan members: The Medicaid and Healthy Michigan Plan Certificates of Coverage (COC) state 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, harvest preservation and storage of eggs or sperm and services to reverse voluntary sterilizations are **not a covered benefit**. Diagnostic services are covered as described in the Medicaid COC Section 5.B. (16), and the Healthy Michigan Plan COC Section 6.B. (14).

II. MEDICAL NECESSITY REVIEW

☐ Required ☒ Not Required ☐ Not Applicable

III. 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. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.***
- **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); if a coverage determination has not been adopted by CMS, this policy applies.***
- **MEDICAID/HEALTHY MICHIGAN PLAN:** ***For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.***

IV. 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.

V. CODING INFORMATION

A. Infertility:

ICD-10 Codes that apply to this policy:

N46.01 – N46.9	Male infertility
N97.0 – N97.9	Female infertility
Z31.41	Encounter for fertility testing
Z31.49	Encounter for other procreative 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 (*no active NDC for this code)*

  J3355 Injection, urofollotropin, 75IU

  S0126 Injection, follitropin alfa, 75 IU

S0128 Injection, follitropin beta, 75 IU

- Radiology
  - 74740 Hysterosalpingography, radiological supervision and interpretation
  - 74742 Transcervical catheterization of fallopian tube, radiological supervision and interpretation
  - 74440 Vasography, vesiculography, or epididymography, 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 (e.g., 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/Medicine Services

- Office Visits

- Surgery
  - 52010 Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service
  - 52402 Cystourethroscopy with transurethral resection or incision of ejaculatory ducts
  - 54692 Laparoscopy, surgical; orchiopexy for intra-abdominal testis
  - 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
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography
58345	Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography
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 (*not covered for Medicaid)*
58752	Tubouterine implantation (*not covered for Medicaid)*
58760	Fimbrioplasty (*not covered for Medicaid)*
58673	Laparoscopy, surgical; with salpingostomy (salpingoneostomy)
58679	Unlisted laparoscopy procedure, oviduct, ovary *(Explanatory notes must accompany claim)*
58752	Tubouterine implantation (*not covered for Medicaid)*
58760	Fimbrioplasty (*not covered for Medicaid)*
58770	Salpingostomy (salpingoneostomy)
58999	Unlisted procedure, female genital system (nonobstetrical)

B. Assisted reproduction or artificial conception procedures

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

(Check plan rules for any coverage exceptions)

ICD-10 Codes that are required for billing these services:

Z31.81	Encounter for male factor infertility in female patient
Z31.83	Encounter for assisted reproductive fertility procedure cycle
Z31.89	Encounter for other procreative management
Z31.9	Encounter for procreative management, unspecified
Z52.810	Egg (Oocyte) donor under age 35, anonymous recipient
Z52.811	Egg (Oocyte) donor under age 35, designated recipient
Z52.812	Egg (Oocyte) donor age 35 and over, anonymous recipient
Z52.813	Egg (Oocyte) donor age 35 and over, designated recipient
Z52.819	Egg (Oocyte) donor, unspecified

CPT/HCPCS Codes:

All procedures billed with the diagnoses above will be denied as not covered (unless plan specifies coverage), including but not limited to:

- Anesthesia
- Medication
- Radiology
- Lab/Path

Code	Description
80414	Chorionic gonadotropin stimulation panel; testosterone response This panel must include the following: Testosterone (84403 x 2 on 3 pooled blood samples)
80415	Chorionic gonadotropin stimulation panel; estradiol response This panel must include the following: Estradiol (82670 x 2 on 3 pooled blood samples)
80426	Gonadotropin releasing hormone stimulation panel This panel must include the following: Follicle stimulating hormone (FSH) (83001 x 4) Luteinizing hormone (LH) (83002 x 4)
82626	Dehydroepiandrosterone (DHEA)
82627	Dehydroepiandrosterone-sulfate (DHEA-S)
82670	Estradiol
82671	Estrogens; fractionated
82672	Estrogens; total
82679	Estrone
82757	Fructose, semen
83001	Gonadotropin; follicle stimulating hormone (FSH)
83002	Gonadotropin; luteinizing hormone (LH)
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 (e.g., sperm wash and swim-up) for insemination or diagnosis with semen analysis
89261	Sperm isolation; complex prep (e.g., 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
89335	Cryopreservation, reproductive tissue, testicular
89337	Cryopreservation, mature oocyte(s)
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

- Physician Services
- Office Visits
- Surgery/Procedures
  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

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

Z31.0 Encounter for reversal of previous sterilization
Z31.7 Encounter for procreative management and counseling for gestational carrier
Z31.42 Aftercare following sterilization reversal
Z31.84 Encounter for fertility preservation procedure

*The following services are **not covered** regardless of diagnosis billed:*

0058T Cryopreservation; reproductive tissue, ovarian
0357T Cryopreservation; immature oocyte(s)

55400 Vasovasostomy, vasovasorrhaphy
55870 Electroejaculation
58750 Tubotubal anastomosis

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

Aetna Clinical Policy Bulletin, Infertility @ http://www.aetna.com/cpb/medical/data/300_399/0327.html (Retrieved April 9, 2015 , March 4, 2016 , March 13, 2017, March 28, 2018 & March 12, 2019)

Cigna Medical Coverage Policy #0089, Infertility Services @ https://cignaforhcp.cigna.com/web/public/resourcesGuest/resourcesearch (Retrieved April 9, 2015, March 4, 2016, March 13, 2017, March 28, 2018, and March 12, 2019)

Seshadri S(1), Sunkara SK. Natural killer cells in female infertility and recurrent miscarriage: a systematic review and meta-analysis. Hum Reprod Update. 2014 May-Jun;20(3):429-38.

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