

Medical Coverage Policy | Infertility Services Mandate



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OVERVIEW

The policy addresses medical necessity criteria and coverage guidelines related to the treatment of female infertility using assisted reproductive technology such as artificial intrauterine insemination (IUI) or in vitro fertilization (IVF). While IUI is addressed in this policy, this service is not impacted by benefit limits or the prior authorization process. However, the member must meet eligibility criteria for coverage of IUI.

For the purpose of this policy a cycle starts with the initiation of medication to stimulate ovulation and ends with either pregnancy confirmation or failure to conceive.

Testing for Infertility

Testing to determine the diagnosis of infertility is a covered service and not applicable to the infertility benefit in this policy.

Note: Due to recent changes in the member's benefit, please contact Customer Service at the number on the back of the member's ID card to validate benefits. The correct benefit may not be reflected in the member's Benefit Booklet, Evidence of Coverage, or Subscriber Agreement.

MEDICAL CRITERIA

Multiple embryo transfer (MET) in vitro fertilization is medically necessary when one of the following criteria is met:

- Members less than 35 years of age who have diminished ovarian reserve or have had an unsuccessful Single Embryo Transfer (SET).
- Members (any age) who have undergone 2 unsuccessful Single Embryo Transfers - IVF treatment cycles using donor eggs
- Members who are 35 years old and prior to 38th birthday after either:
 - had an unsuccessful first treatment cycle using their own fresh or frozen embryo, OR
 - had a prior successful IVF treatment cycle followed by a one failed SET
- Members ages 38 years and older undergoing IVF treatment

After 4 IVF cycles (SET or MET) that do not result in pregnancy and delivery, the requesting physician must provide the following information for review to determine if further cycles will be approved:

- Documentation regarding the number and type of all past IVF/IUI attempts.
- Details of a revised IVF methodology and the predicted success rate supported by literature statements of using the revised IVF methodology.
- Documentation that the patient has been informed of the predicted success rate and accepts the proposed services.

Members not in active infertility treatment, undergoing medical treatment that may result in infertility:

Retrieval and cryopreservation of eggs, embryos and sperm are covered when documentation confirms that member, who is not in active treatment for infertility, will be undergoing medical treatment (e.g., chemotherapy, radiation therapy) that is likely to result in infertility. Note: Fees associated with storage are not covered.

PRIOR AUTHORIZATION

Prior authorization is required for BlueCHIP for Medicare and recommended for Commercial products for in vitro fertilization cycle only. No prior authorization is needed for any cycle in which IUI only is rendered.

POLICY STATEMENT

Infertility treatment services (IUI and IVF [SET or MET]) are covered for members that meet eligibility criteria. For members that do not meet the following eligibility criteria, services will be denied as not covered as these services would be considered a non-covered benefit.

In addition to meeting eligibility criteria, IVF with MET is medically necessary when the medical criteria above is met. Services not meeting the criteria are not medically necessary as there is no peer review literature or studies that support the use of MET over SET in those instances.

Eligibility Criteria

1. A female member must have a documented inability to conceive after a period of 1 year of unprotected intercourse with exposure to sperm or 6 months if 35 years or older.

Note: For a member who has miscarried, the duration of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1-year or 6-month period above, as applicable.

For female members without male partners or without exposure to sperm, infertility is determined based on the inability to conceive after 6 artificial insemination (AI) (intra-cervical insemination or IUI cycles performed by a qualified specialist using donor sperm). AI cycles with donor sperm are not a covered benefit because the diagnosis of infertility cannot be established until the cycles are completed. The 6 failed cycles must include the following number of documented failed medicated assisted IUI cycles to qualify for IVF services:

Female members younger than 35 years old: 3 medicated IUI cycles

Female members 35-39 years old: 2 medicated IUI cycles

Female members older than 40: no medicated IUI cycles are required

2. The male and female members attempting to conceive must be presumably healthy without a history of past sterilization (or reversal).
3. For female members, a postmenopausal state must not be the cause of infertility, unless the member is under age 43 and had premature ovarian failure.

IVF services after 4 unsuccessful cycles, not using a different technique, would be considered not medically necessary as there is no peer-reviewed literature to support the continued success of further attempts.

Donor Eggs and Sperm

Egg Bank

Donor Eggs (gametes) are covered when the member meets the criteria for infertility services. If obtained through an egg bank, reimbursement is provided for the cost of the eggs. Most egg banks do not accept any insurance. In these instances the member will be responsible for submitting the claim to BCBSRI for reimbursement and the claim will be processed at the member's in-network benefit. Additional services related to the implantation of the embryo are covered and will be billed by the facility and provider performing the implantation services. Most infertility providers will assist the member in seeking out an Egg Bank.

Claim form for Member submitted claims



MLTI-162159 Donor
Egg & Sperm Reimbur

Egg Donation Facilitation Agency

Services obtained from an egg donation facilitation agency are not covered as these charges are not related to the egg donation. These agencies will facilitate the contractual agreements between the member and the Egg Donor. In addition, these agencies will refer both parties to reputable fertility attorneys who will draft, review, and finalize the egg donation contract. Some of these agencies will also cover transportation costs for the donor which is a not a covered service. Once the donor is identified, all services related to egg retrieval including medication are covered. Egg retrieval and other services related to the implantation will be billed by the participating facility that is providing the implantation.

Donor Sperm

Donor Sperm is covered and can be obtained from a sperm bank or know donor. Services related to the procurement of the sperm are covered. Fees associated with collection and finding a donor are not covered.

The following services are not covered:

- Freezing and storage of blood, gametes, sperm, embryos, or other tissues for future use
- Reversal of voluntary sterilization
- Infertility treatment for an individual that previously had a voluntary sterilization procedure
- Women who meet the definition of normal menopause
- Surrogate parenting

Previous Sterilization

There is contract exclusion for infertility services provided to a person who previously had a sterilization procedure. If one spouse has had a sterilization procedure, it is presumed that the other spouse is not considered infertile. This is the basis for a contractual exclusion of infertility services. In such a case, it is presumed that the sterilization procedure is the cause of the inability to conceive or sustain a pregnancy, whether or not there has been a procedure to reverse the sterilization. The sterilization procedure will also be presumed to be the cause of the inability to conceive or sustain a pregnancy in cases where the individual seeking infertility services also has a disorder that is felt to cause such inability to conceive or sustain a pregnancy.

Exception:

Only in cases where there is medical certainty that a prior sterilization procedure is in no manner related to the present inability to conceive or sustain pregnancy will it be determined that the contractual exclusion is not applicable.

Clinician review required:

Requests for infertility services for a married individual who has undergone a previous sterilization procedure or whose partner has undergone a previous sterilization procedure will undergo review by a clinician.

A determination that the contractual exclusion does apply (i.e., that inability may be related to a previous sterilization procedure) is an administrative denial even though it is based upon clinician review. Such denials are not medical necessity determinations.

Normal Menopause

BCBSRI considers normal menopause to be exclusionary. Amenorrhea and an elevated *follicle stimulating* hormone (FSH) after age 42 is considered to be equivalent to normal menopause. Menopause occurring prior to age 42 is not considered normal menopause, as defined in this policy.

COVERAGE

Benefits may vary between groups/contracts. Please refer to the appropriate Evidence of Coverage, Subscriber Agreement, or Benefit Booklet for applicable Infertility Services coverage.

Many BCBSRI plans have yearly benefit limits of 3 IVF attempts in a 12-month period and a lifetime maximum of 8 IVF attempts not resulting in a successful pregnancy.

Note: Due to recent changes in the member's benefit, please contact Customer Service at the number on the back of the member's ID card to validate benefits. The correct benefit may not be reflected in the member's Benefit Booklet, Evidence of Coverage, or Subscriber Agreement.

BACKGROUND

Effective January 1, 2014, Qualified Health Plans were required to cover Essential Health Benefits (EHBs), as defined in Section 1302(b) of the Patient Protection and Affordable Care Act. As groups renewed in 2014, most benefit plans were updated to include these EHBs (some exceptions may apply to certain large groups; consult your Subscriber Agreement for details).

Infertility treatment is included in the Rhode Island Benchmark Plan that defines the EHBs for RI QHPs. Federal mandates regarding EHBs supersede RI state mandates with regards to removing any annual and lifetime dollar limits.

§ 27-20-20 Coverage for infertility. – (a) Any nonprofit medical service contract, plan, or insurance policies delivered, issued for delivery, or renewed in this state, except contracts providing supplemental coverage to Medicare or other governmental programs, which includes pregnancy related benefits shall provide coverage for the medically necessary expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25) and forty-two (42) years. To the extent that a nonprofit medical service corporation provides reimbursement for a test or procedure used in the diagnosis or treatment of conditions other than infertility, those tests and procedures shall not be excluded from reimbursement when provided attendant to the diagnosis and treatment of infertility for women between the ages of twenty-five (25) and forty-two (42) years. Provided, that subscriber copayment, not to exceed twenty percent (20%), may be required for those programs and/or procedures the sole purpose of which is the treatment of infertility.

(b) For the purposes of this section, "infertility" means the condition of an otherwise presumably healthy married individual who is unable to conceive or sustain a pregnancy during a period of one year.

(c) The health insurance contract may limit coverage to a lifetime cap of one hundred thousand dollars (\$100,000).

Definitions:

Artificial Intrauterine Insemination (IUI) – Artificial insemination by IUI process bypasses the cervix, allowing the sperm to target the ova without being slowed or stopped by the lower portions of the reproductive tract. For this reason, ICI (intracervical insemination) is rarely used. When IUI is used in conjunction with ultrasound to track follicular development, the procedure can be timed to maximize the chances for getting pregnant. Fertility drugs may also be used.

Assisted Hatching – One key component of a successful attempt at in vitro fertilization is implantation of the embryo in the uterus. Although the exact steps in implantation are poorly understood, one critical component is thought to be the normal rupture of the surrounding zona pellucida with escape of the developing embryo, termed hatching. It is hypothesized that during the in vitro component of the in vitro

fertilization, the zona pellucida becomes hardened, thus impairing the hatching process. Alternatively, some embryos may have some inherent inability to induce thinning of the zona pellucida before hatching. In either case, mechanical disruption of the zona pellucida (i.e., assisted hatching) has been proposed as a mechanism to improve implantation rates.

Randomized controlled trials (RCTs) and meta-analyses of these trials have not found that assisted hatching significantly improves the live birth rate compared to a control intervention. Meta-analyses of heterogeneous studies have found that the clinical pregnancy rate is improved with assisted hatching.

Blastocyst Transfer – This refers to the extended culture of oocytes/embryos, i.e., for greater than 4 days. The rationale behind blastocyst transfer is that embryos progressing to the blastocyst stage have a much greater chance of implanting successfully in the uterus and resulting in an ongoing pregnancy. Due to the higher probability of implantation, it is thought that fewer blastocysts can be transferred, ultimately resulting in a decreased incidence of triplets and higher-order pregnancies.

According to evidence from RCTs, observational studies and meta-analyses of published studies, blastocyst transfer results in higher live birth rates compared to cleavage stage transfer. Based on evidence from RCTs of a higher live birth rate than cleavage-stage embryo transfer, as well as on supportive clinical input, blastocyst transfer may be considered medically necessary.

Cryopreservation of Ovarian Tissue – Cryopreservation of ovarian tissue or an entire ovary with subsequent auto- or heterotopic transplant has been investigated as a technique to sustain the reproductive function of women or children who are faced with sterilizing procedures, such as chemotherapy, radiation therapy, or surgery, frequently due to malignant diseases. A variety of articles have focused on the technical feasibility of such an option. There are a few individual case reports of return of ovarian function using this technique. (9, 10) There are also several case series describing live births using cryopreserved ovarian tissue. (11-13) However, in general, the technique is not standardized and has not been sufficiently studied to determine the success rate. (14, 15) In 2011, Johnson and Patrizio commented on whole ovary freezing as a technique of fertility preservation in women with disease or disease treatment that threaten their reproductive tract function. (16) They concluded, “Although theoretically optimal from the point of view of maximal follicle protection and preservation, the risks and difficulties involved in whole ovary freezing limit this technique to experimental situations.”

This technique has not been standardized, and there is insufficient published data that cryopreservation of ovarian tissue is an effective and safe reproductive technique.

Cryopreservation of Oocytes – Cryopreservation of oocytes was originally investigated primarily as an alternative to embryo cryopreservation due to ethical or religious reasons. More recently, it has been examined as a fertility preservation option for reproductive-age women undergoing cancer treatment, both single women and those who do not want the option of embryo cryopreservation. The mature oocyte is very fragile due to its large size, high water content, and chromosomal arrangement. For example, the mature oocyte is arrested in meiosis, and as such, the chromosomes are lined up in a meiotic spindle. This spindle apparatus is easily damaged both in freezing and thawing. Survival after thawing may also be associated with sublethal damage, which may further impact on the quality of the subsequent embryo. Moreover, due to the large amount of water, when the oocyte is frozen, ice crystals can form that can damage the integrity of the cell. To reduce or prevent ice crystals, oocytes are dehydrated using cryoprotectants, which replace the water in the cell. The most common method of freezing oocytes is a controlled-rate slow-cooling method. A newer technique involves a flash-freezing process known as vitrification. This technique is faster, yet requires a higher concentration of cryoprotectants.

There are insufficient published data on the safety and efficacy of cryopreservation of oocytes; data are only available from select clinical settings and select populations.

Cryopreservation of Testicular Tissue – Testicular sperm extraction refers to the collection of sperm from testicular tissue in men with azoospermia. Extraction of testicular sperm may be performed at the time of a diagnostic biopsy or performed as a subsequent procedure, specifically for the collection of spermatozoa. The spermatozoa may be isolated immediately and a portion used for an intracytoplasmic sperm injection (ICSI) procedure at the time of oocyte retrieval from the partner, with the remainder cryopreserved. Alternatively, the entire tissue sample can be cryopreserved with portion thawed and sperm isolation performed at subsequent ICSI cycles. This technique appears to be a well-established component of the overall ICSI procedure; cryopreservation of either the isolated sperm or the tissue sample eliminates the need for multiple biopsies to obtain fresh tissue in the event of a failed initial ICSI cycle. (32) However, a unique application of cryopreservation of testicular tissue is its use to potentially preserve the reproductive capacity in prepubertal boys undergoing cancer chemotherapy; the typical cryopreservation of an ejaculate is not an option in these patients. It is hoped that re-implantation of the frozen-thawed testicular stem cells will re-initiate spermatogenesis, or alternatively, spermatogenesis could be attempted in vitro, using frozen-thaw spermatogonia. While these strategies have been explored in animals, there are inadequate human studies. (33, 34) Cryopreservation of testicular tissue in adult men with ozoospermia is a well-established component of the ICSI procedure.

Embryo Co-Culture – In routine IVF procedures, the embryo is transferred to the uterus on day 2 or 3 of development, when it has between 4 and 8 cells. However, with this approach the implantation rate is estimated to be between 5% and 30%, potentially related to the fact that under normal conditions the embryo reaches the uterus at a blastocyst stage of development. Embryo co-culture techniques, used successfully in domestic animals, represent an effort to improve the culture media for embryos such that a greater proportion of embryos will reach the blastocyst stage, in hopes of improving the implantation and pregnancy rate. In addition, if co-culture results in a higher implantation rate, fewer embryos could be transferred at each cycle, resulting in a decreased incidence of multiple pregnancies. A variety of co-culture techniques have been investigated, involving the use of feeder cell layers derived from a range of tissues, including the use of human reproductive tissues (i.e., oviducts) to non-human cells (i.e., fetal bovine uterine or oviduct cells) to established cell lines (i.e., Vero cells or bovine kidney cells). However, no standardized method of co-culture has emerged, and no controlled trials have evaluated an improved implantation or pregnancy rate associated with co-culture. (3-8) For example, Wetzels and colleagues reported on a study that randomized IVF treatments to include co-culture with human fibroblasts or no culture. (8) Patients in the 2 groups were stratified according to age (older or younger than 36 years) and prior IVF attempts (yes vs. no). The authors reported that fibroblast co-culture did not affect the implantation or the pregnancy rate. Updated literature reviews did not identify any additional published studies that would prompt reconsideration of the relevant policy statement. There is a lack of controlled trials demonstrating improved outcomes with co-culture, and no standardized method of co-culture has emerged in the literature.

Fertility Treatment

Once the condition of infertility or recurrent pregnancy loss has been established fertility services typically include artificial intrauterine insemination, and assisted reproductive technology (ART) services such as in vitro fertilization, including assisted oocyte fertilization, also known as intra-cytoplasmic sperm injection, frozen/cryo embryo transfer, preimplantation genetic testing, zygote intra-fallopian transfer and gamete intra-fallopian transfer, donor oocyte procedures, and assisted embryo hatching.

In Vitro Fertilization (IVF) – In vitro fertilization is a method of assisted reproduction that involves combining an egg with sperm in a laboratory dish. If the egg fertilizes and begins cell division, the resulting embryo is transferred into the woman's uterus where it will hopefully implant in the uterine lining and further develop. IVF bypasses the fallopian tubes and is usually the treatment choice for women who have badly damaged or absent tubes.

Services received as part of an IVF procedure may include office visits, drugs, lab and pathology, surgical procedures, etc. Mechanically assisted fertilization (MAF) may be performed as part of an IVF procedure.

Such procedures include Zona “drilling” or (PZD) where the zona pellucida of the oocyte is mechanically interrupted so as to assist sperm entry, and intracytoplasmic sperm injection.

Modifications of the IVF procedure include such procedures as GIFT (gamete intrafallopian transfer), ZIFT (zygote intrafallopian transfer), PROST (pronuclear stage transfer), TEST (tubal embryo stage transfer), and TET (tubal embryo transfer). While many of the services received during these procedures are similar to IVF, in GIFT, eggs and sperm are transferred to the fallopian tube where fertilization occurs. In ZIFT, PROST, TEST, and TET, fertilized embryos are transferred at various stages of development into the fallopian tube, either from the fimbrial end via laparoscopy or through catheterization of the uterine end, the latter with or without ultrasound guidance.

A typical IVF may consist of the steps noted below, all of which take place during one menstrual cycle:

1. **Controlled ovarian hyperstimulation.**
Fertility drugs are administered to the women to stimulate the ovaries so that multiple follicles and eggs develop. In a normal cycle, the ovaries typically make and release only one egg.
2. **Egg retrieval.**
The eggs are typically removed from the ovaries in an outpatient surgical setting. The fertility doctor uses a needle passed through the vagina under ultrasound guidance to aspirate the fluid from the follicles and pull out the egg.
3. **In vitro fertilization.**
The eggs are placed with sperm in the laboratory dish, or the embryologist may use a procedure known as intracytoplasmic sperm injection (ICSI) in which one sperm is injected directly into the egg for fertilization.
4. **Uterine embryo transfer.**
The embryos are transferred into the woman's uterus using a tiny catheter and ultrasound guidance.
5. **Monitoring and support.**
The fertility specialists will monitor the woman to check blood levels to assess the quality of the uterine lining. If the woman gets pregnant, she will have an ultrasound two weeks after a positive result to check for the fetal heartbeat.

IVF Cycle Timeline – Below is an outline of a typical IVF cycle outline:

- Birth control pills (approx. 14-21 days)
- Medication to stimulate ovulation (approx. 12-15 days)
- Baseline ultrasound; stimulation (approx. 10-12 days);
- Trigger shot; egg retrieval (36-37 hours after trigger shot);
- Embryo transfer (3-5 days after retrieval);
- Pregnancy test (14 days after retrieval);
- Ultrasounds 1st – approx. 6 ½-7 weeks pregnant, 2nd – approx. 7 ½-8 ½ weeks pregnant
- Release to OB at 8-10 weeks pregnant

Intracytoplasmic Sperm Injection (ICSI) for male factor infertility – ICSI is performed in cases of male factor infertility when either insufficient numbers of sperm, abnormal morphology, or poor motility preclude unassisted in vitro fertilization. Using ICSI, fertilization rates of up to 76% have been reported, considerably

better than the competing technique of sub-zonal insemination (up to 18%), in which sperm are injected into the perivitelline space (as opposed to into the oocyte itself), and by definition better than the negligible to absent fertilization rates seen in patients with male factor infertility. Fertilization rates represent an intermediate outcome; the final outcome is the number of pregnancies per initiated cycle or per embryo transfer, reported in the largest series as 44.7% and 49.6%, respectively. (26-30) These rates are very competitive with those of the standard in vitro fertilization. A 2012 committee opinion of the American Society of Reproductive Medicine and Society for Assisted Reproductive Technology stated that ICSI is a safe and effective treatment for male factor infertility. (31) The document also stated that ICSI for unexplained fertility, low oocyte yield and advanced maternal age does not improve clinical outcomes. The opinion included a statement that ICSI may be beneficial for patients undergoing *in vitro* fertilization with preimplantation genetic testing, *in vitro* matured oocytes and cryopreserved oocytes.

There are data indicating that intracytoplasmic sperm injection for male factor infertility has a relatively high rate of successful pregnancy.

Intracytoplasmic sperm injection has a relatively high rate of successful live births for treatment of male factor infertility due to low sperm count and/or impaired sperm motility. ICSI for male factor infertility and cryopreservation of testicular tissue in adult men with azoospermia as part of an ICSI injection procedure received support from clinical reviewers. These techniques may be considered medically necessary.

The evidence is insufficient to permit conclusions concerning the effectiveness of the following reproductive techniques: assisted hatching; co-culture of embryos; cryopreservation of ovarian tissue or oocytes; cryopreservation of testicular tissue in prepubertal boys; and storage and thawing of ovarian tissue, oocytes, or testicular tissue. For these procedures, there is a lack of published data on live birth rates, the incidence of multiples and neonatal and child outcomes, compared to established reproductive techniques. Therefore, these procedures are considered not medically necessary

Single Embryo Transfer – the transfer of a single embryo at either the cleavage stage (day 2 or 3 after an egg retrieval) or blastocyst stage (day 5 or 6 after an egg retrieval), that is selected from a larger number of available embryos. This is the best way to reduce the health risks of multiple gestations.

In a clinical based study A total of 886,686 fresh, nondonor cycles reported to the National Assisted Reproductive Technology Surveillance System during 1999–2010, of which 17,166 met criteria for elective single Embryo Transfer (ET). The main measure of the study was to determine the rates of elective single ET and good perinatal outcome (term, singleton infant with normal birth weight). In 2010, elective single ET comprised 5.6% of all fresh transfers, representing an eightfold increase since publication of first guidelines in 2004 recommending elective single ET. Compared with other ETs, elective single ETs were nearly twice as likely to result in a good perinatal outcome (37.1% vs. 18.9%, respectively). Among women using elective single ET, those aged <35 and 35–37 years had a good perinatal outcome (40.2% and 32.5%, respectively). In multivariable, log-binomial analyses, factors positively associated with a good perinatal outcome included male factor infertility, day 5 ET, and having ≥ 3 supernumerary embryos for cryopreservation. Between 1999 and 2010, national rates of elective single ET increased. Given the frequency of good perinatal outcomes among women aged 35–37 years, guidelines for elective single ET could be expanded to include patients in this age group with favorable prognoses.

Surrogate – An embryo is placed in the womb of a woman other than the member, and the “surrogate” (not the member) carries the baby. In the case of a surrogate, the embryo does not come from the female member’s egg, so the baby is not biologically related to the member. A gestational surrogate is a variation where the egg is donated from one woman other than the member and the embryo is placed into a different woman that is not the member or the egg donor. A usual surrogate is the egg donor and then carries the pregnancy.

CODING

BlueCHIP for Medicare and Commercial Products

The following infertility/in vitro fertilization services CPT Codes are covered under the member's infertility benefit when the benefit and medical necessity criteria are met:

58970	Follicle puncture for oocyte retrieval, any method
58974	Embryo transfer, intrauterine
58976	Gamete, zygote or embryo intrafallopian transfer, any method
76948	Ultrasonic Guidance for aspiration of ova, imaging supervision and interpretation
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) embryo(s)
89253	Assisted embryo hatching, microtechniques (any method)
89254	Oocyte identification from follicular fluid
89280	Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes
89281	Assisted oocyte fertilization, microtechnique; greater than 10 oocytes
89255	Preparation of embryo for transfer (any method)
89268	Insemination of oocytes
89272	Extended culture of oocyte(s)/embryo(s), 4-7 days
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
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
S4025	Donor services for in vitro fertilization (sperm or embryo), case rate
S4017	Incomplete cycle, treatment cancelled prior to stimulation, case rate
S4018	Frozen embryo transfer procedure cancelled before transfer, case rate (NSR)
S4023	Donor egg cycle, incomplete, case rate
S4042	Management of ovulation induction (interpretation of diagnostic tests and studies, non-face-to-face medical management of the patient), per cycle

Note: BCBSRI-participating facilities primarily use "S" codes when reporting infertility/in vitro fertilization services.

The following codes are male infertility services and no preauthorization is needed. Services are covered under the members infertility benefit:

55870	Electroejaculation
58321	Artificial insemination; intra-cervical
58322	Artificial insemination; intra-uterine
58323	Sperm washing for artificial insemination
89257	Sperm identification from aspiration (other than seminal fluid)
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
S3655	Antisperm antibodies test (immunobead)
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

The following codes for tests and procedures are non-covered:

Note: For members undergoing medical treatment that may result in infertility, all of the codes are covered except for CPT code for storage.

0058T Cryopreservation; reproductive tissue, ovarian
0059T Cryopreservation;oocyte(s)
55400 Vasovasostomy, vasovasorrhaphy NOTE: If 55400 Vasovasostomy/vasovasorrhaphy is performed for other than reversal of sterilization, it may be reviewed by a clinician.
88240 Cryopreservation, freezing and storage of cells, each cell line
88241 Thawing and expansion of frozen cells, each aliquot
89258 Cryopreservation; embryo(s)
89259 Cryopreservation; sperm
89290 Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis PGD); less than or equal to 5 embryos
89291 Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis PGD); 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
89337 Cryopreservation, mature oocyte(s)
89354 Thawing of cryopreserved; reproductive tissue; testicular/ovarian
89356 Thawing of cryopreserved; oocytes, each aliquot
S4027 Storage of previously frozen embryos
S4040 Monitoring and storage of cryopreserved embryos, per 30

The following codes are covered but not separately reimbursed:

89352 Thawing of cryopreserved; embryo(s)
89353 Thawing of cryopreserved; sperm/semen, each aliquot
S4037 Cryopreserved embryo transfer, case rate

The following services may also be used for the diagnostic evaluation of infertility and therefore not considered part of the infertility benefit. These services are covered under the applicable benefit.

55200 Vasotomy, cannulization with or without incision of Vas, unilateral or bilateral (separate procedure) (surgery)
58750 Tubotubal anastomosis
88349 Electron microscopy; scanning (lab)
89300 Semen analysis; presence and/or motility of sperm including Huhner test (post coital) (lab)
89310 Semen analysis; motility and count (not including Huhner test) (lab)
89320 Semen analysis; complete (volume, count, motility and differential) (lab)
89321 Semen analysis, presence and/or motility of sperm
89322 Semen analysis: volume, count, and differential using strict morphologic criteria (e.g.,Kruger) (lab)
89325 Sperm antibodies (lab)
89329 Sperm evaluation; hamster penetration test (lab)
89330 Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test (lab)
89331 Sperm evaluation; for retrograde ejaculation,urine (sperm concentration,motility, and morphology as indicated) (lab)
58350 Chromotubation of oviduct, including materials

Providers filing for sperm evaluation, hyaluronan binding assay should file the following unlisted CPT Category I code:

89398 Unlisted reproductive medicine laboratory procedure

Note: Since there is no applicable CPT code for TESE (testicular sperm extraction) or TESA (testicular sperm aspiration), MESA (maximum entropy spectral estimation) claims will be submitted with an unlisted code and the claim will follow the standard unlisted procedure format.

RELATED POLICIES

None

PUBLISHED

Provider Update, March 2017
Provider Update, June 2016
Provider Update, March 2016
Provider Update, August 2015
Provider Update, November 2013
Provider Update, April 2012
Provider Update, March 2011
Provider Update, August 2010

REFERENCES

1. Rhode Island General Law (RIGL) 27-20-20: Coverage for Infertility. <http://www.rilin.state.ri.us/Statutes/TITLE27/27-20/27-20-20.HTM>
2. Physician Expense for Surgery, Childbirth, and Treatment for Infertility. Section 20-1. Rev. 1, 10-01-03) B3-2005.l. Treatment for Infertility. <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>
3. Blackwell, R. et al. American Journal of Obstetrics & Gynecology. 182 (4): 891-895, April 2000. <Http://pt.wkhealth.com/pt/re/ajog/abstract.00000447-200004000->

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