MetroPlusHealth

Policy and Procedure

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1. POLICY DESCRIPTION:

Metroplus covers infertility treatment with a stepwise approach. The exact details are tailored for each couple. Treatment starts with the steps that are the simplest, safest, least uncomfortable, least invasive, and least expensive. Step 1 is to try patient-directed (e.g., lifestyle changes or timed intercourse). Should that fail, patients usually move to the intermediate level (e.g., clomiphene citrate [CC] plus intrauterine insemination [IUI]).

If intermediatelevel treatment fails, or can't be used, MetroPlus will also cover high level treatment for MetroPlus Gold and GoldCare I & II only (e.g., gonadotropin injections plus IUI, in vitro fertilization [IVF]). IVF is not a covered benefit for MarketPlace, SHOP, and Essential lines of business.

2. RESPONSIBLE PARTIES:

Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting.

3. DEFINITIONS:

- **Infertility**
  - **Basic Definition**
    - **Male-**inability to impregnate a woman. Factors which may impact male fertility include the number of sperm, the histology (shape) of the sperm, the motility of the sperm, and other genetic defects of the sperm
      - **Mild male infertility:** For this policy, male fertility with sperm count > 10 million
      - **Severe male infertility**: For this policy, male infertility with sperm count < 1 million
    - **Female-** Inability to conceive
  - **Functional Definition:** failure to establish a pregnancy after unprotected sexual intercourse or therapeutic donor insemination
    - For a woman under the age of 35, the trial should last 12 months
    - For a woman 35 years old or older, the definition is met after six (6) months.
    - **Severe male infertility**, for this policy, is said to be present when any of the following are found in semen analysis
      - Unprocessed semen has <10 million total mobile sperm/cubic centimeter (CC)
      - Processed semen has<3 million total sperm
      - 2 unprocessed semen specimen show ≤4% Kruger normal forms
    - Earlier evaluation and treatment may be warranted based on a member's medical history or physical findings (See also IX)
    - **Unexplained infertility**-for the purposes of this policy, unexplained infertility meets both:
      - Infertility that persists after lifestyle changes (see below)
      - No alternative explanation of infertility is found following routine evaluation
- **Lifestyle changes** : avoiding behavior that lowers fertility. This includes not smoking, not concuming alcohol, not using other recreational drugs. Lifestyle changes may also include having intercourse during periods of maximum fertility.

- **Sperm:** Reproductive cells, manufactured by a man's testes (testicles). Usually a sperm cell in semen fertilizes an egg. Alternatively, testicular aspiration (see below) may be necessary.
- **Semen**: Male reproductive fluid. Normally, sperm moves through the spermatic cord to the prostate gland. In the prostate glad, sperm is activated and additional fluid added to produce semen. Semen may be ejaculated directly into a woman's vagina during intercourse as part of Step 1. As part of higher levels of infertility treatment, a man may masturbate into a tube and this semen is used (see AI, IUI, and IVF).
- **Testicular aspiration**-Removing sperm directly from the testicle with a needle or other device (see ICSI below)
- **Microepididymal Sperm Aspiration (MESA)-**a male infertility procedure. An incision is made in the scrotum. The epididymis (and organ near the testicle) is exposed and sperm removed from epidymus for ICSI (below)
- **Testicular Excisional Sperm Extraction (TESE)-** a male infertility procedure. An incision is made into the scrotum and the testicle is exposed. An excision is then made into the testicle and a small part is removed so that the sperm can be removed, processed and often used for ICSI (see below).
- **Percutaneous Testicular Sperm Aspiration (TEFNA)** a male infertility procedure. A needle is inserted through the scrotum into the testicle. A small amout of testicular tissue is aspirated through the needle and taken to the lab. In the lab, sperm is isolated and used for IVF (below)
- **Artificial Insemination (AI)**- Semen is collected outside of the vagina and then instilled into the woman. IVI and IUI (below) are forms of AI.
- **Intravaginal Insemination**: Semen is collected outside of the vagina and then instilled into the vagina
- **IUI** - Intrauterine insemination: a clinician inserts a fine catheter through the cervix into the uterus to deposit a semen sample directly into the uterus.
  - **Natural IUI also known as natural cycle IUI or unmedicated IUI**: IUI without fertility medication
  - **Medicated IUI also known as Ovarian Stimulation IUI or OS IUI**: IUI used in conjunction with medication to induce ovulation and/or prepare the endometrium
- **ART (Assisted Reproductive Technology)-**Fertility treatment where both the egg (ovum) and sperm are handled in the lab
- **IVF** - In Vitro Fertilization is an assisted reproductive technology (ART). Eggs are extracted from the biological mother. The egg is then fertilized, outside of the woman's body in a laboratory. There are two basic types of IVF:

  - **Conventional insemination.** During conventional insemination, healthy sperm and mature eggs are mixed and incubated overnight
  - **Intracytoplasmic sperm injection (ICSI).** In ICSI, a single healthy sperm is injected directly into each mature egg. ICSI may be used when there is a problem with semen or if fertilization attempts during prior IVF cycles failed.

- **Reciprocal IVF-**A method of fertility used by lesbian couples: the oocytes from one woman are extracted, fertilized in vitro with donated sperm, then implanted into the uterus of the other female partner
- **Freeze all cycle-**Eggs and sperm are harvested and combined to form embryos, all of which are saved (none are implanted promptly)
- **Embryo Banking-**Undergoing multiple successive freeze all cycles.
- **Long term cryopreservation**
  - **Basic definition**- Storing oocytes (eggs), sperm or embryos for use in the distant future
  - **Functional Definition-**Preserving oocytes, sperm or embryos for more than 9 months since ending the last unsuccessful IVF cycle or more than 36 months after the most recent pregnancy
- **Sterilization**-Intentionally destroying fertility, usually by surgically removal or destruction of part of the fallopian tubes (female) or spermatic cord (male).
- **Iatrogenic infertility** –
  - **Basic definition**- Infertility caused by surgery, radiation, chemotherapy or other medical treatment.
  - **Gender affirming (“Transgender”) surgery** is considered a form of iatrogenic infertility under NY State guidelines
  - **Functional Definition:** Infertility that is a side effect of therapy. For this policy we do not include voluntary sterilization. Gender affirming surgery is considered iatrogenic infertility as the surgery is intended to treat gender dysphoria and sterility is a side effect. Note: MetroPlus Health Plan covers standard fertility preservation services when future medical treatment will directly or indirectly lead to iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm.
- **Female Menopause-**
  - **Basic Definition:** A woman with ovaries has permanently lost the ability to produce eggs
  - **Functional Definition:** A woman has 6 months without a menstrual period and hormone levels that we expect to see in a menopausal woman. For

straightforward cases , menopausal women have FSH (follicular stimulating hormone) levels that are markedly higher than levels in pre-menopausal women for at least 6 months. If fertility treatment is desired and the question of menopause is not straightforward, treatment coverage will be considered after medical review.

- **Iatrogenic menopause, including surgical menopause:** Menopause brought on by medical intervention, including surgical removal of the ovaries
- **Premature menopause:** Menopause that occurs in a woman under the age of 40. For this policy, we exclude iatrogenic menopause from the definition of premature menopause
- **Secondary menopause:** menopause that occurs in a woman with normal, functional ovaries but the hormones that stimulate the ovaries are not working normally. Usually, these women have a problem with the pituitary gland
- **Natural menopause:** any female menopause that is not iatrogenic, secondary, or premature

- **"Male Menopause"-**This concept is less precisely defined. It is a form of secondary menopause (see above), with lower testorerone production and less sperm production, associated with lower levels of stimulation from the pituitary gland. Male menopause usually occurs naturally with aging. The onset of male menopause is more gradual than the onset of female menopause.
- **Treatment Cycle** – The law defines "cycle" to mean all treatment that starts when preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing IVF using a fresh embryo transfer or medications are administered for endometrial preparation with the intent of undergoing IVF using a frozen embryo transfer. Either one counts as the start of a treatment cycle. Collecting and freezing oocytes or sperm in anticipation of iatrogenic infertility is not considered the start of a treatment cycle. Unless otherwise specified, for this policy, "cycle" referes to a treatment cycle, not a menstrual cycle.
- **Clomiphene citrate [CC]** – A medicine used to stimulate the ovaries to produce eggs. (Ovulation Stimulator; Selective Estrogen Receptor Modulator or SERM)
- **Clomiphene plus IUI [CC/IUI]** — The combination of CC and IUI. CC/IUI is generally the first line treatment for unexplained infertility. CC/IUI usually works. CC/IUI rarely results in multiple gestations (twins, triplets…). The medicine can be taken by mouth. CC/IUI is relatively simple, safe, inexpensive, and it can be done without extensive medical testing beyond the standard infertility evaluation.
- **Pre-implantation Genetic Testing (PGT)-** An egg is fertilized with sperm in the laboratory and begins to grow into an embryo. Before the embryo is implanted into the uterus, the embryo is tested for genetic diseases.

- **Assisted Hatching-**A small hole is made in the zona pellucida before implanting the embryo. (The zona pellucida is the "shell" surrounding the embryo, i.e. the fertilized egg)
- **Embryo Transfer-**Taking an embryo created in the laboratory and implanting it into the woman's uterus
  - **Single Embryo Transfer (SET)-**Implanting one embryo during this treatment cycle
  - **Frozen Embryo Transfer (FET)-**thawing a previously frozen embryo and implanting it
  - **Single Thawed Elective Embryo Transfer (STEET or SET/FET)-**thawing a single previously frozen embryo and then implanting it

4. Covered Services

Basic infertility services:	**Comprehensive infertility services:**
• Initial evaluation • Semen collection and analysis • Laboratory evaluation • Evaluation of ovulatory function • Postcoital test • Endometrial biopsy • Pelvic ultrasound • Hysterosalpingogram • Sono-hystogram • Testis biopsy • Blood tests; and • Medically appropriate treatment of ovulatory dysfunction Note: Additional tests may be Covered if the tests are determined to be Medically Necessary.	• Ovulation induction and monitoring • Pelvic ultrasound • Artificial insemination • Hysteroscopy • Laparoscopy • Laparotomy **Advanced infertility services:** • Three (3) cycles per lifetime of in vitro fertilization • Sperm collection and storage costs in connection with in vitro fertilization • Cryopreservation and storage of embryos in connection with in vitro fertilization •

5. Policy:

Menopause

Menopause

a. **Natural Menopause** does not meet the definition of infertility. Donor embryo services not allowed for members after natural menopause

b. **Secondary Menopause** is normally treated by addressing the underlying hormone problems. For patients with secondary menopause, prior authorization would be required before M+ would cover IVF, IUI, egg retrieval or testicular aspiration.

Treatment of Infertility

IUI

A. Noninvasive therapy—MetroPlus requires documentation that a couple has tried noninvasive therapy before invasive (IUI, IVF see below) therapy can be approved.
  - **a.** Trial of noninvasive therapy counts as part meeting the functional definition of infertility: at least 12 months for a woman under 35 and 6 months for older women (see above)
  - **b.** The trial should include fertility counseling, avoiding fertility inhibiting agents (e.g. ethanol, nicotine), timed intercourse and, where appropriate, fertility medication (e.g. clomiphene) with timed intercourse.
  - **c.** Women without a male partner may start fertility treatment with donor sperm and IVI

B. IUI may be authorized for Women without a male partner or for women who meet the definition of infertility (see above) AND have
  1. Normal ovarian reserve testing (FSH Level) AND
  2. Failure of noninvasive therapy (see above)
  3. Any of the following:
     - **a.** Unexplained infertility
     - **b.** Polycystic Ovary Syndrome (PCOS), anovulation, or oligoovulation
     - **c.** Minimal or mild endometriosis
     - **d.** Cervical scarring (often from surgery) or other barrier to sperm entering uterus from the vagina
     - **e.** mild to moderate male infertility
     - **f.** Use of stored sperm from male members
  4. If the woman had prior IUI, the request for additional IUI should include demonstration of **both**
     - a. Adequate ovarian response to stimulation (i.e. at least 2 follicles >12 mm diameter for any monitored IUI using standard medication doses)
     - b. Adequate Adequate fresh semen and post wash semen parameters in order to continue with IUI
  5. **Natural IUI** May be covered when the couple is “infertile” (see above) and
     - a. the woman has acceptable ovarian reserve.
     - b. Initially, women <40yo are assumed to have adequate ovarian reserve.

c. The American Society of Reproductive Medicine recommends against using natural IUI at a treatment for male infertility. Payment for natural IUI as a treatment for male infertility requires prior authorization

d. For women ≥ 40 years of age: FSH level which is < 15mIU/mIU/ml on cycle day 3 and the day 3 Estradiol level is < 80 pg/mL

AND ANY ONE of the following applies

- The woman has a history of one or more cervical surgical procedures or conization procedures that is considered a factor in the woman's infertility
  The woman has a diagnosis of vaginismus

6. **Medicated IUI:** May be covered for an infertile couple when both a and b below are met:
   a. the woman has adequate ovarian reserve
   b. 40 and 41 years of age: FSH level which is < 15mIU/mIU/ml on Cycle day 3 and the day 3 Estradiol level is < 80 pg/mLAge> 42 years of age: FSH level which is < 17 mIU/ml on Cycle dayOne of the following
      1. Mild–moderate male factor infertility
      2. Minimal or mild endometriosis
      3. Polycystic Ovary Syndrome (PCOS), anovulation, or oligoovulation
   c. As there is no good evidence that aromatase inhibitors or gonatropins are more effective than clomaphine, medication costs of aromatase inhibitors or gonadotropins require prior authorization. Exogenous HCG injections, where indicated, would be covered.

7. (IUI) is not indicated in any one of the following situations:
   a. >1 insemination per cycle
   b. Severe male factor infertility \ (without use of donor sperm)
   c. Bilateral tubal factor infertility
   d. Moderate or severe endometriosis unless treatment has previously been rendered and there is documentation of at least one uncompromised fallopian tube
   e. Recurrent loss of the most recent three pregnancies
   f. In the setting of IVF ART in any of the following situations:
      1. To convert an ART cycle to IUI when at least 3 follicles ≥15 mm in diameter are present
      2. Women who have been denied or failed ART services are generally not appropriate candidates for IUI cycles

8. **IUI after IVF.** In the absence of an intervening pregnancy, IUI after IVF requires prior authorization.
9. **Converting IUI to IVF** covered when the current ICI cycle has resulted in all of the following:
    a. Estradiol level >800pg/ml
    b. Production of at least 5 follicles > 12mm in diameter
    c. IVF is a covered benefit for MetroPlus Gold and GoldCare I & II only

1. **Eligibility** The couple must be infertile, as defined above. Additionally, at least one of the following conditions must be documented:
    a. 3 consecutive failed IUI cycles
    b. Female with bilateral fallopian tube absence/obstruction. (Prior sterilization does not qualify)
    c. Female with severe endometriosis which has failed conventional therapy
    d. Male with severe male infertility (defined above) which has been evaluated and can not be improved. (prior sterilization does not qualify)
    e. A maximum of three (3) IVF cycles will be covered. (This is a lifetime limt. The limit only applies to cycles that were paid for by MetroPlus. See item 8 of "NYS Guidance and Limitations" below)
2. **Frozen Embryos created prior to MetroPlus coverage**: MetroPlus will cover embryo transfer when
    a. Uterine cavity has been evaluated in the past year and found to be capable of maintaining a pregnancy
    b. The mother is fertile, as defined above
3. **Covered IVF when the female is <35 years of age**
    a. 1st IVF: Single embryo transfer (SET) is covered.
    b. Subsequent IVF:
        a. SET Approved if a top quality frozen embryo is available after thawing
        b. If there are no top quality embryos available after thawing, then transfer of two embryos will be covered
        c. Fresh IVF cycle with SET is approved if no frozen embryos are available
        d. All frozen embryos must be used before another cycle of IVF (beginning with egg and sperm) will be approved

4. **Women >35 years old with a previous successful (live birth) IVF cycle**
    a. 1st IVF cycle following the live birth
        i. STEET is covered if member has available frozen embryos\

- **ii.** If no top quality embryos are available after thawing, M+ will cover multiple transfers

b. Subsequent IVF cycles: MetroPlus will cover any number of embryo transfers
c. For first or subsequent embryo implantations, MetroPlus will cover a fresh IVF cycle (starting with egg and sperm retrieval) only if no frozen embryos are available

5. **Freeze all cycles and embryo banking** are not covered unless one member of the couple is scheduled to undergo iatrogenic sterilization or other DNA disrupting procedure (e.g. chemotherapy, radiation therapy with large dose of gonadal radiation)
6. **Long term cryopreservation of oocyte or sperm** is only covered when the oocyte or sperm was recovered prior to iatrogenic infertility and the member has not had natural menopause.
7. **Assisted hatching**-A additional charge for assisted hatching is not covered for implanting an embryo which has undergone PGT, since the zonal pellucida was pierced as part of the PGT. Assisted hatching will be covered for women>38 years old if either of the following conditions is met:
   a. Prior failed IVF cycles that produced 3 or more high quality embryos with failure to implant after each embryo transfer
   b. A prior successful pregnancy that required assisted hatching
8. **ICSI** (Intracytoplasmic sperm injection) is covered when it's use has a >5% probability of resulting in a live birth and at least one of the following criteria is met:
   a. Severe male infertility (defined above)
   b. Prior IVF produced <40% fertilization (egg became an embryo)
   c. Obstruction of the male reproductive tract, not amenable to operative correction and unrelated to prior sterilization
   d. Nonobstructive azoospermia
9. **Cryopreservation of embryos** is covered when:
   a. The mother is fertile or iatrogenically infertile
   b. As part of an IVF cycle where at least one embryo was implanted and the other embryos are stored for use in another menstrual cycle OR when embryos were generated as part of a covered freeze all cycle.
10. **IVF using donor sperm for women without a fertile male partner.** The costs of donor sperm are not covered. Costs of other fertility procedures will be covered if:
    a. there have been 6 consecutive AI/IUI cycles using donor sperm, without an intervening pregnancy

   b. woman meets all other IVF guidelines above
   c. The "Use of donor sperm" criteria are met

11. **Male Infertilty Services:**
    a. **Microepidymal sperm aspiration (MESA)** is covered only when there is documented absence or obstruction of the vas deferens
    b. **Testicular excisional sperm extraction (TESE**) is covered for non-obstructive azoospermia or for spinal cord disease or injury resulting in inability to ejaculate
    c. **Percutaneous Testicular Sperm Aspiration (TEFNA)** is covered for non-obstructive azoospermia or for spinal cord disease or injury resulting in inability to ejaculate

Use of Donor Sperm

1. **Use of Donor Sperm:** The costs of procurement of sperm are not covered. MetroPlus will not cover any fertility procedure if either partner has undergone a sterilization procedure. Otherwise , for a female member, MetroPlus will cover fertility procedures using donor sperm, rather than the male partner's sperm, when any of the following conditions are met:
   a. There is high risk of transmitting the male partner's serious genetic disorder to the embryo (The disorder must be stated in the request)
   b. The male is HIV+ and the female is not
   c. The male partner has severe infertility

NYS Guidance and Limitations:

NYS Guidance and Limitations:

1. Every large group contract that provides medical, major medical or similar comprehensive-type coverage shall provide coverage for three cycles of in-vitro fertilization (IVF) used in the treatment of infertility
2. Unlimited intrauterine insemination (IUI) for members who meet the clinical definition of infertility (Note: Clinical evidence suggests that greater than 6 IUI cycles is unlikely to yield positive results)
3. Coverage for prescription drugs is limited to medications approved by the federal Food and Drug Administration for use in the diagnosis and treatment of infertility. The cost of those FDA approved drugs is considered part of the covered procedure.
4. The identification of the required training, experience and other standards for health care providers for the provision of procedures and treatments for the diagnosis and treatment of infertility determined in accordance with the standards and guidelines established and adopted by the American College of

Obstetricians and Gynecologists and the American Society for Reproductive Medicine

5. The determination of appropriate medical candidates by the treating physician in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and/or the American Society for Reproductive Medicine
6. Insurers may not place dollar limits of IVF coverage
7. IVF services are subject to deductible, copayment and coinsurance guidelines
8. Insurers may limit coverage to three IVF cycles over the life of the insured. Insurers may not count cylces paid by the insured out-of-pocket or cycles covered by other issuers toward the three cycle limit. A cycle that was begun, but not completed, counts toward the three cycle limit.
9. Cycles completed before January 1, 2020 do not count as part of the three cycle limit.
10. Insurers may not place age restrictions on IVF or fertility preservation coverage
11. Insurers are not required to cover IVF for persons who have undergone voluntary sterilization procedures
12. Insurers may limit coverage to in network providers for those services that are available in network.
13. Insureres may require prior authorization for IVF procedures
14. Insurers may review requests for IVF for medical necessity. Insurers are prohibited from discrimination based on the expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life or other health conditions, or personal characteristics including age, sex, sexual orientatiuon, marital status or gender identity.
15. Gener affirming surgery as a treatment for gender dysphoria is considered iatrogenic infertility. Oocyte or sperm cryopreservation is covered for patients about to about to undergo surgical castration or oophorectomy as part of gender affirming surgery.
16. After insurance coverage terminates, the insurer is no longer responsible for costs of cryopreservation. If a patient joins a new plan after oocytes, sperm or embryos have already been preserved, the insurer assumes reonsibility for the new, ongoing costs of cryopreservation.

Non-covered procedures includes:

A partial list of non-covered procedures includes but is not limited to:

1. Infertility treatment if, based on the member's individual medical history, they have < 5% chance of a birth outcome

2. ART/Infertility services for members when clinical documentation confirms an individual or couple are using illicit substances or abusing substances known to negatively interfere with fertility or fetal development (e.g. marijuana, opiates, cocaine, tobacco or alcohol)
3. Infertility treatment when infertility is the result of a non-reversed or unsuccessful reversal of a voluntary sterilization
4. Ovarian Reserve Assessment results (Clomiphene Citrate Challenge Test (CCCT))
5. Selective fetal reduction without known disorders that are non-compatible with life
6. Gender selection
7. Human zona binding assay (hemizona test)
8. Serum anti-sperm antibody testing
9. Sperm acrosome reaction test
10. Co-culture of embryos
11. Embryo toxic factor test (ETFL)
12. Ovulation kits
13. In vitro maturation of eggs
14. Direct intraperitoneal insemination (DIPI)
15. Peritoneal ovum and sperm transfer (POST)
16. Genetic engineering
17. Egg harvesting, or other infertility treatment performed during an operation not related to an infertility diagnosis
18. Chromosome studies of a donor (sperm or egg)
19. Infertility services in cases in which normal embryos have been or will be discarded because of gender selection
20. ICSI for any IVF cycle involving use of donor sperm
21. Treatments requested solely for the convenience, lifestyle, personal or religious preference of the member in the absence of medical necessity
22. Treatment to reverse voluntary sterilization, i.e. MESA/TESE, for a member who has undergone prior sterilization
23. Monitoring of non-authorized IUI cycles
24. Reciprocal IVF
25. Oocyte, ovarian or testicular tissue cryopreservation
26. Storage of cryopreserved reproductive materials (i.e., embryos, oocytes, or sperm) (Note: Storage is only covered for ova/sperm for iatrogenic infertility)
27. Gamete intrafallopian tube transfers (GIFT) or zygote intrafallopian tube transfers (ZIFT)
28. Surrogacy (Note: Maternity service benefits may be available for members acting as surrogate mothers)

29. All experimental/investigational procedures and treatments are not covered for the diagnosis and treatment of infertility as determined in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine

30. Additional Non-covered codes:

58976 - Gamete, zygote, or embryo intrafallopian transfer, any method
89398 - Unlisted reproductive medicine laboratory procedure
S4025 - Donor services for in vitro fertilization (sperm or embryo), case rate
S4026 - Procurement of donor sperm from sperm bank
S4030 - Sperm procurement and cryopreservation services; initial visit
S4031 - Sperm procurement and cryopreservation services; subsequent visit

6. APPLICABLE PROCEDURE CODES:

CPT	Description	Auth Required
0058T	Cryopreservation; reproductive tissue, ovarian	Y
52402	Cystourethroscopy with transurethral resection or incision of ejaculatory ducts	N
54500	Biopsy of testis, needle (separate procedure)	N
54505	Biopsy of testis, incisional (separate procedure)	N
55300	Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral	N
55530	Excision of varicocele or ligation of spermatic veins for varicocele; (separate procedure)	N
55535	Excision of varicocele or ligation of spermatic veins for varicocele; abdominal approach	N
55550	Laparoscopy, surgical, with ligation of spermatic veins for varicocele	N
55870	Electroejaculation	N
58140	Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; abdominal approach	N
58145	Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; vaginal approach	N

CPT	Description	Auth Required
58146	Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g, abdominal approach	N
58321	Artificial insemination; intra-cervical	Y
58322	Artificial insemination; intra-uterine	Y
58323	Sperm washing for artificial insemination	Y
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingogra	N
58345	Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography	N
58350	Chromotubation of oviduct, including materials	N
58545	Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 g or less and/or removal of surface myomas	N
58546	Laparoscopy, surgical, myomectomy, excision; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g	N
58555	Hysteroscopy, diagnostic (separate procedure)	N
58559	Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)	N
58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)	N
58662	Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method	N
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	N
58672	Laparoscopy, surgical; with fimbrioplasty	N
58673	Laparoscopy, surgical; with salpingostomy (salpingoneostomy)	N
58740	Lysis of adhesions (salpingolysis, ovariolysis)	N
58752	Lysis of adhesions (salpingolysis, ovariolysis)	N
58760	Fimbrioplasty	N
58770	Salpingostomy (salpingoneostomy)	N
58800	Drainage of ovarian cyst(s), unilateral or bilateral (separate procedure); vaginal approach	N
58805	Drainage of ovarian cyst(s), unilateral or bilateral (separate procedure); abdominal approach	N
58920	Wedge resection or bisection of ovary, unilateral or bilateral	N

CPT	Description	Auth Required
58970	Follicle puncture for oocyte retrieval, any method	N
58974	Embryo transfer, intrauterine	Y
80415	Chorionic gonadotropin stimulation panel; estradiol response This panel must include the following: Estradiol (82670 x 2 on 3 pooled blood samples)	N
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)	N
81224	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)	Y
82397	Chemiluminescent assay	Y
82670	Estradiol	N
83001	Gonadotropin; follicle stimulating hormone (FSH)	N
83002	Gonadotropin; luteinizing hormone (LH)	N
83498	Hydroxyprogesterone, 17-d	N
83520	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, not otherwise specified	Y
84144	Progesterone	N
84146	Prolactin	N
84402	Testosterone; free	N
84403	Testosterone; total	N
84443	Thyroid stimulating hormone (TSH)	N
84830	Ovulation tests, by visual color comparison methods for human luteinizing hormone	N
89250	Culture of oocyte(s)/embryo(s), less than 4 days;	Y
89251	Culture of oocyte(s)/embryo(s), less than 4 days; with co-culture of oocyte(s)/embryos	Y
89253	Assisted embryo hatching, microtechniques (any method)	Y
89254	Oocyte identification from follicular fluid	N
89255	Preparation of embryo for transfer (any method)	Y
89257	Sperm identification from aspiration (other than seminal fluid)	N
89258	Cryopreservation; embryo(s)	Y
89259	Cryopreservation; sperm	Y
89260	Cryopreservation; sperm	Y

CPT	Description	Auth Required
89261	Sperm isolation; complex prep (eg, Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis	N
89264	Sperm identification from testis tissue, fresh or cryopreserved	N
89268	Insemination of oocytes	Y
89272	Extended culture of oocyte(s)/embryo(s), 4-7 days	Y
89280	Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes	Y
89281	Assisted oocyte fertilization, microtechnique; greater than 10 oocytes	Y
89290	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos	N
89291	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos	N
89300	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)	N
89310	Semen analysis; motility and count (not including Huhner test)	N
89320	Semen analysis; volume, count, motility, and differential	N
89321	Semen analysis; sperm presence and motility of sperm, if performed	N
89322	Semen analysis; volume, count, motility, and differential using strict morphologic criteria (eg, Kruger)	N
89325	Sperm antibodies	N
89329	Sperm evaluation; hamster penetration test	N
89330	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test	N
89331	Sperm evaluation, for retrograde ejaculation, urine (sperm concentration, motility, and morphology, as indicated)	N
89335	Cryopreservation, reproductive tissue, testicular	Y
89337	Cryopreservation, mature oocyte(s)	Y
89342	Storage (per year); embryo(s)	Y
89343	Storage (per year); sperm/semen	Y
89344	Storage (per year); reproductive tissue, testicular/ovarian	Y
89346	Storage (per year); oocyte(s)	Y
89352	Thawing of cryopreserved; embryo(s)	Y
89353	Thawing of cryopreserved; sperm/semen, each aliquot	Y
89354	Thawing of cryopreserved; reproductive tissue, testicular/ovarian	Y
89356	Thawing of cryopreserved; oocytes, each aliquot	Y

CPT	Description	Auth Required
89398	Unlisted reproductive medicine laboratory procedure	Y
J0725	Injection, chorionic gonadotropin, per 1,000 USP units	N
J3355	Injection, urofollitropin, 75 IU	N
S0122	Injection, menotropins, 75 IU	N
S0126	Injection, follitropin alfa, 75 IU	N
S0128	Injection, follitropin beta, 75 IU	N
S0132	Injection, ganirelix acetate, 250 mcg	N
S3655	Antisperm antibodies test (immunobead)	N
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	Y
S4015	Complete in vitro fertilization cycle, not otherwise specified, case rate	Y
S4016	Frozen in vitro fertilization cycle, case rate	Y
S4017	Incomplete cycle, treatment cancelled prior to stimulation, case rate	Y

For review with Benefit Coder

- S4011-S4989 Infertility Services Temporary National Codes
- S4028 Microsurgical epididymal sperm aspiration (MESA)
- S4020 In vitro fertilization procedure cancelled before aspiration, case rate
- S4021 In vitro fertilization procedure cancelled after aspiration, case rate
- S4015 Complete in vitro fertilization cycle, not otherwise specified, case rate
- S4018 Frozen embryo transfer procedure cancelled before transfer, case rate

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8. REVISION LOG:

REVISIONS	DATE
Creation date	1/1/2020
Revised	10/2/2020
Revised	12/15/2020
Annual Review	6/27/2022

Approved: Date:	Approved: Date:
Glendon Henry	
Glendon Henry , MD Senior Medical Director	Sanjiv Shah, MD Chief Medical Officer

Medical Guideline Disclaimer:

Property of Metro Plus Health Plan. All rights reserved. The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered andor paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements

of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members.
All coding and website links are accurate at time of publication.
MetroPlus Health Plan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.