Clinical Policy: PPO Infertility Treatment

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CPT Codes: 58321-58323, 58750, 58752, 58760, 58770, 58970, 58974, 58976
Document: BI331:00

Public Statement

Effective Date:

a) This policy will apply to all services performed on or after the above revision date which will become the new effective date.
b) For all services referred to in this policy that were performed before the revision date, contact customer service for the rules that would apply.

1. If your plan documents cover in vitro fertilization, the following criteria must be met:
   a) The patient is the Certificate Holder or the Certificate Holder's spouse; and
   b) The member meets the medical criteria below in the Medical Statement; and
   c) IVF procedures are performed at a facility licensed by the Arkansas Department of Health as an in vitro fertilization clinic, or if such licensed clinic is unavailable, in a clinic elsewhere which is approved by QualChoice.

2. The lifetime maximum benefits available under this Certificate for all approved in vitro fertilization services, including all drug therapy, and any other service related to infertility shall not exceed one cycle.
   a) One cycle ends when a diagnosis of pregnancy is made, regardless of the final outcome of that pregnancy.

3. In vitro fertilization benefits are not available to either the husband or the wife, whether covered under this Certificate or not, when either one of the Spouses has previously undergone a voluntary sterilization.

Medical Statement

1. In vitro fertilization, for members whose plan covers it, is covered only for members who meet the following criteria:
   a) The patient and the patient's spouse have a history of unexplained infertility of at least two (2) years duration; or
   b) The infertility is associated with one or more of the following medical conditions:
      i) Endometriosis;
      ii) Exposure in utero to Diethylstilbestrol (DES);
      iii) Blockage of or removal of one or both fallopian tubes not a result of voluntary sterilization;

c) Abnormal male factors contributing to such infertility not a result of voluntary sterilization.
d) The patient's oocytes must be fertilized with the sperm of the patient's spouse when any fertilization procedures are performed.
e) In vitro fertilization procedures must be performed at a facility licensed by the Arkansas Department of Health as an in vitro fertilization clinic, or if such licensed clinic is unavailable, in a clinic elsewhere which is approved by QualChoice.

2. In vitro fertilization is limited to a lifetime maximum of one cycle, not to exceed one year.
   a) The cycle includes but is not limited to all diagnostic testing, medications required for ovarian stimulation or other purposes related to IVF, retrieval of eggs, insemination, and embryo transfer.
   b) Cryopreservation of oocytes and sperm are covered for the duration of the cycle.
   c) The cycle ends with a diagnosis of pregnancy.

Codes Used In This BI:

58321	Artificial Insemination – Cervix
58322	Artificial Insemination – Uterus
58323	Sperm Washing
58750	Tubotubal Anastomosis
58752	Tubo-Uterine Anastomosis
58760	Fimbrioplasty
58770	Salpingostomy
58970	IVF Oocyte Retrieval
58974	IVF Embryo Transfer
58976	IVF – GIFT

Limits

1. Services related to the reversal of any sterilization procedure regardless of the reason are not covered.

2. Services related to the removal of an intrauterine contraceptive device (IUD) are not covered.

Application to Products

This policy applies to all health plans administered by QualChoice Life and Health PPO product.

Changes: QualChoice reserves the right to alter, amend, change or supplement benefit interpretations as needed.