Clinical Policy: Infertility Diagnosis & Treatment

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Document: BI057:00

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) Medical plans administered by QualChoice generally cover a limited diagnostic work-up for infertility, which is designed to screen for basic problems that might cause infertility. This benefit is limited to a maximum of one each of the following tests per lifetime for infertility diagnosis:
   a) Semen analysis
   b) Pelvic ultrasound
   c) Hormone levels
   d) Hysterosalpingogram
   e) Post-coital test
   f) Endometrial biopsy
2) Any other service required for the diagnosis or treatment of infertility, or of any associated disease whose manifestation is infertility, is not covered.
3) Some QualChoice administered plans, especially self-insured plans, offer somewhat broader coverage for infertility. For further information on such coverage:
   a) If you are enrolled in the Federal Employees Health Benefit Program, please see medical policy 244 that deals with the infertility coverage in that plan.
   b) Consult your plan's coverage documents; or
   c) View a summary description of your plan at www.qualchoice.com ; or
   d) Call our Customer Service line.

Medical Statement

1) For instructions regarding administration of the FEHBP infertility benefit, please go to medical policy BI244.
2) 2)QualChoice covers a limited diagnostic work-up for infertility, which is designed to screen for basic problems that might cause infertility. This benefit is limited to a maximum of one each of the following tests per lifetime:
    i) Semen analysis
    ii) Pelvic ultrasound
    iii) Hormone levels
    iv) Hysterosalpingogram (Exception: HSG is allowed three months after placement of Essure permanent contraceptive device to ensure appropriate placement, even in women who have had a previous HSG)
    v) Post-coital test
    vi) Endometrial biopsy
3) Any other services required for the diagnosis or treatment of infertility, or of any associated disease whose predominant manifestation is infertility, is not covered. Claims for non-covered services will result in the return of an EOB indicating no member financial responsibility. If the physician and patient agree on a course of diagnosis and treatment of infertility that is not covered, the physician should obtain a procedure-specific acknowledgement of financial responsibility from the patient before performing any tests or procedures.
4) QualChoice will not cover services for treatment of infertility such as: artificial insemination, in-vitro fertilization, fertility drugs, sonograms, SCORIF (Stimulated Cycle Oocyte Retrieval Intravaginal Fertilization), IVC (intravaginal culture), GIFT or other infertility procedures.
5) QualChoice will not cover any medications, procedures, or other services for treatment of infertility, no matter whether diagnostic or therapeutic, or whether by natural, artificial, mechanical, pharmacological or other means. QualChoice will not cover the treatment of any disease whose only significant manifestation is infertility. QualChoice will also not cover services to alter, restore or promote function or structural anatomy of any reproductive organs for the predominant purpose of restoring fertility.
6) Diagnostic procedures or tests performed after a diagnosis of infertility has been confirmed will not be covered.
7) Diagnostic procedures or tests that are related to the treatment of infertility will not be covered. Repetitive diagnostic testing to confirm the effectiveness of fertility medications will not be covered. Testing of a pregnancy resulting from infertility treatment to assure the number, location and viability of embryos is also not covered.

Codes Used In This BI:

58321	artificial insemination – cervix
58322	artificial insemination – uterus
58323	sperm washing
58340	HSG
58345	Hydrotubation
58350	Chromotubation
58559	Hysteroscopy lysis of adhesions
58560	" division of septum
58565	
58660	Laparoscopic Lysis of adhesions
58662	Laparoscopic fulgurate adhesions
58672	Laparoscopic fimbrioplasty
58673	" salpingostomy
58679	Unlisted
58740	Lysis of adhesions
58750	tubotubal anastomosis
58752	tubo-uterine anastomosis
58760	Fimbrioplasty
58770	Salpingostomy
58970	IVF oocyte retrieval
58974	IVF embryo transfer
58976	IVF – GIFT
58999	unlisted female genital
59866	multifetal pregnancy reduction
74740	HSG (radiology charge)
76831	Sonohysterography
82670	Estradiol; total (*code revised eff 01-01-2021*)
83001	Gonadotropin (FSH)
83002	Gonadotropin (LH)
89250	culture of oocyte
89251	culture of embryo
89253	assisted embryo hatching
89254	oocyte identification, follicle
89255	prep of embryo for transfer
89257	sperm ident from aspirate
89258	cryopreservation of embryos
89259	cryopreservation of sperm
89260	sperm isolation
89261	complex sperm preparation
89264	sperm from testicle tissue

89268	insemination of oocytes
89272	extended culture of oocytes
89280	assisted oocyte fertilization
89281	>10
89290	biopsy oocyte polar body
89291	>5
89300	Semen Analysis (incl Huhner)
89310	" (no Huhner)
89320	Semen Analysis, Complete
89321	Semen Analysis, presence or motility
89325	Sperm Antibodies
89329	Sperm Evaluation, lamster ovum penetration
89330	" , cervix mucus penetration
89335	cryopreservation of testis
89342	storage – embryos
89343	storage – sperm
89344	storage - reproductive tissue
89346	storage – oocytes
89352	thaw embryos
89353	thaw sperm
89354	thaw reproductive tissue
89356	thaw oocytes
A4264	Perm implantable contraceptive device
J3355	Inj urofollitropin
S0122	Inj menotropins
S0126	Inj follitropin alfa
S0128	Inj follitropin beta
S4011	IVF Package
S4013	Compl GIFT Case Rate
S4014	Compl ZIFT Case Rate
S4015	Compl IVF Nos Case Rate
S4016	Frozen IVF Case Rate
S4017	IVF Canc A Stim Case Rate
S4018	F EMB Trns Canc Case Rate
S4020	INF Canc A Aspir Case Rate
S4021	IVF Canc P Aspir Case Rate
S4022	Asst Oocyte Fert Case Rate
S4023	Incompl Donor Egg Case Rate
S4025	Donor Serv IVF Case Rate
S4026	Procure Donor Sperm
S4027	Store Prev Froz Embryos

S4028	Microsurg Epi Sperm Asp
S4030	Sperm Pricure Init Visit
S4031	Sperm Pricure Subs Visit
S4035	Stimulated IUI Case Rate
S4037	Cryo Embryo Transf Case Rate
S4040	Monit Store Cryo Embryo 30 d

Limits
Intentially left empty

Reference
Intentially left empty

Addendum

Application to Products
This policy applies to all health plans and products administered by QualChoice, both those insured by QualChoice and those that are self-funded by the sponsoring employer, unless there is indication in this policy otherwise or a stated exclusion in your medical plan booklet. Consult the individual plan sponsor Summary Plan Description (SPD) for self-insured plans or the specific Evidence of Coverage (EOC) or Certificate of Coverage (COC) for those plans or products insured by QualChoice. In the event of a discrepancy between this policy and a self-insured customer's SPD or the specific QualChoice EOC or COC, the SPD, EOC, or COC, as applicable, will prevail. State and federal mandates will be followed as they apply.

For coverage statements appropriate to the Federal Employees Health Benefit Program, see medical policy BI244.

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