

Clinical Policy: FEHB Infertility Coverage



Reference Number: QCP.CP.027

Last Review Date: 10-7-25

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See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

This policy describes Infertility coverage under the Federal Employees Health Benefit Program. Diagnosis, evaluation, and treatment of infertility is covered except for services listed in the Not Covered section of this document.

Policy/Criteria

- I. It is the policy of QualChoice Health for FEHB members that infertility is medically necessary for the following indications:
 - a. Infertility includes all services rendered on behalf of an enrollee that are intended to learn why there is a delay in conception or to increase the likelihood of conception
- II. All services related to infertility treatment require pre-authorization.
 - a. If you are receiving services from an in-network provider, that provider is responsible for obtaining pre-authorization.
 - b. If you are receiving services from an out-of-network provider, you are responsible for all pre-authorizations
- III. The Federal Employees Health Benefit Program covers services related to the diagnosis, evaluation, and treatment of infertility, including intra-vaginal insemination, including:
 - a. Artificial insemination (AI)
 - b. Intrauterine insemination (IUI)
 - c. Intravaginal insemination (IVI)
 - d. Intracervical insemination (ICI)
 - e. Infertility services after voluntary sterilization
 - f. Cost of Donor Sperm
 - g. Cost of Donor Egg
- IV. The category of infertility includes all services rendered to any enrollee which are intended to ascertain the cause of failure to conceive and carry a baby to term and all services which are intended to treat any cause of failure or delay in conceiving a baby or failure to carry that baby to term.
- V. Among plans administered by QualChoice, the FEHBP program is unique in offering broad coverage for the diagnosis and treatment of infertility.

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- VI. Most diagnostic and treatment services are covered (see below for the exceptions)
- VII. The FEHB program does not cover the following services related to infertility:
 - a. In Vitro Fertilization
 - b. Embryo Transfer
 - c. Gamete Intrafallopian (GIFT)
 - d. Zygote Intra-Fallopian (ZIFT)
 - e. Intracytoplasmic sperm injection (ICSI)

Note: Fertility preservation treatment is limited to people facing iatrogenic infertility. Storage is limited to one (1) year and benefits are limited to one cycle of fertility preservation per covered person during the entire period the member is enrolled with QualChoice.

Note: All infertility testing, fertility drugs, preservation and treatment related services require preauthorization.

Note: The category of infertility includes all services rendered to any enrollee which are intended to ascertain the cause of failure to conceive and carry a baby to full term and all services which are intended to treat any cause of failure or delay in conceiving a baby or failure to carry that baby to term

Background

National Institutes of Health infertility guidelines recommend initiating infertility investigations for heterosexual couples when conception has not occurred after 12 months of regular, unprotected intercourse (for women under 35) or 6 months (for women 35 and older). For other individuals or those with known issues like irregular periods, expedited evaluation is advised. The process involves a comprehensive workup including medical history, physical exams, semen analysis, ovarian reserve assessment, and imaging tests to diagnose causes ranging from ovulation disorders to tubal or uterine factors

Coding Implications

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CPT® Codes	CPT Codes that Support Medical Necessity
58321	Artificial insemination; intra-cervical
58322	Artificial insemination; intra-uterine

HCCPS Codes	Description
S4023	Donor egg cycle, incomplete, case rate
S4026	Procurement of donor sperm from sperm bank
S4035	Stimulated intrauterine insemination (IUI), case rate

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code requiring an additional character

ICD-10-CM Code	Description

Reviews, Revisions, and Approvals	Date	Approval Date
Annual Review	10-7-25	

References

1. American College of Obstetricians and Gynecologists Committee on Gynecologic Practice and Practice Committee. Female age-related fertility decline. Committee Opinion No. 589. Fertil Steril. 2014;101(3):633 to 634. doi:10.1016/j.fertnstert.2013.12.03
2. 2 Practice Committee of the American Society for Reproductive Medicine. Diagnostic evaluation of the infertile male: a committee opinion. Fertil Steril. 2015;103(3):e18 to e25. doi:10.1016/j.fertnstert.2014.12.103
3. Practice Committee of the American Society for Reproductive Medicine. Effectiveness and treatment for unexplained infertility. Fertil Steril. 2006;86(5 Suppl 1):S111 to S11
4. doi:10.1016/j.fertnstert.2006.07.1475 Practice Committee of the American Society for Reproductive Medicine. Evaluation and treatment of recurrent pregnancy loss: a committee opinion. Fertil Steril. 2012;98(5):1103 to 1111. doi:10.1016/j.fertnstert.2012.06.048
5. Practice Committees of the American Society for Reproductive Medicine and the Society for Assisted Reproductive Technology. Electronic address: asrm@asrm.org. Intracytoplasmic sperm injection (ICSI) for non-male factor indications: a committee opinion. Fertil Steril. 2020;114(2):239 to 245. doi:10.1016/j.fertnstert.2020.05.032
6. Practice Committee of the American Society for Reproductive Medicine. Electronic address: ASRM@asrm.org; Practice Committee of the American Society for Reproductive Medicine. Removal of myomas in asymptomatic patients to improve fertility and/or reduce miscarriage rate: a guideline. Fertil Steril. 2017;108(3):416 to 425. doi:10.1016/j.fertnstert.2017.06.034

7. Practice Committee of the American Society for Reproductive Medicine. Electronic address: asrm@asrm.org; Practice Committee of the American Society for Reproductive Medicine. Testing and interpreting measures of ovarian reserve: a committee opinion. Fertil Steril. 2020;114(6):1151 to 1157. doi:10.1016/j.fertnstert.2020.09.134
8. Practice Committee of the American Society for Reproductive Medicine. Electronic address: ASRM@asrm.org. Role of tubal surgery in the era of assisted reproductive technology: a committee opinion. Fertil Steril. 2021;115(5):1143 to 1150. doi:10.1016/j.fertnstert.2021.01.051

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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