Payment Policy: Infertility Diagnosis and Treatment

Reference Number: QCP.PP.015
Last Review Date: 10-7-25

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that a limited diagnostic work-up for infertility is medically necessary and 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

iv) Hysterosalpingogram 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)

D. Post-coital test
E. Endometrial biopsy

II. Any other service required for the diagnosis or treatment of infertility, or of any associated disease whose manifestation is infertility, is not covered.

III. 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 clinical policy QCP.CP.027 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.

IV. Claims for noncovered services will result in the return of an Explanation of Benefits (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.

V. 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.

VI. 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.

VII. Diagnostic procedures or tests performed after a diagnosis of infertility has been confirmed will not be covered.

VIII. 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.

Background

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
58323	sperm washing
58340	HSG
58559	Hysteroscopy lysis of adhesions
58560	Hysteroscopy div/rescj Intrauterine Septum
58565	Hysteroscopy BI Tube Occlusion w perm implnts
74740	HSG (radiology charge)
76856	Ultrasound pelvic non-obstetric real -time image complete
83001	Gonadotropin (FSH)
83002	Gonadotropin (LH)
89257	sperm ident from aspirate
89264	sperm from testicle tissue
89290	biopsy oocyte polar body
89291	Biopsy oocyte micrtotq> 5 embry
89300	Semen Analysis (incl Huhner)
89310	Semen Analysis; motility and count (no Huhner)

89320	Semen Analysis, Complete
89321	Semen Analysis, presence or motility
89325	Sperm Antibodies
89329	Sperm Evaluation, lamster ovum penetration
89330	SPERM EVALUATION CERVICAL MUCOUS PENETRATION

HCPCS Codes	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.2013.12.032
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 S114. doi:10.1016/j.fertnstert.2006.07.1475

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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage

decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.