Clinical Policy: FEHB Infertility Coverage

Reference Number: QCP.CP.027

Coding Implications

Last Review Date: 4/26

Revision Log

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 within the background information section of this document.

Diagnostic infertility services to determine the cause of infertility and treatment are covered only when specific coverage is provided under the terms of a member/enrollee's benefit plan. *All coverage, including of a partner's infertility, if applicable, is subject to the terms and conditions of the plan*. The following discussion is applicable only to members/enrollees whose Plan covers infertility services.

For the purpose of this policy, those with a female reproductive system, infertility is defined as the failure to achieve a successful pregnancy during a period of one year if under the age of 35, during a period of six months if they are 35 years or older, or more immediately if age 40 and over. [39]

Assisted Reproductive Technologies (ART) encompass a variety of clinical treatments and laboratory procedures, which include the handling of human oocytes, sperm, or embryos with the intent of establishing pregnancy.

> *For consideration of Food and Drug Administration (FDA) approved medications such as clomiphene, aromatase inhibitors, estrogens, corticosteroids, aprogestins, metformin, and prolactin inhibitors, gonadotropin releasing hormone (GnRH) agonists, gonadotropins, and GnRH antagonists, antiestrogens, carbergoline, thyroid replacement, androgens, GnRH, see CP.PHAR.131 Infertility and Fertility Preservation and/or other applicable pharmacy policy.*

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*

Policy/Criteria

I. It is the policy of QualChoice that Assisted Reproductive Technology (ART) is **medically necessary** for the following indications when the basic and treatment-specific criteria in **A** and **B** are met.

Authorized infertility benefits are covered based on the member/enrollee's benefit plan contract. Refer to benefit guidelines for coverage limitations.

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

A. Basic criteria, meets all the following:
   1. There is no untreatable anatomic cause of infertility and modifiable causes of infertility not addressed within this policy have been considered and modified if possible;
   2. There is documentation of an inability to conceive during a period of 12 months of cycles exposed to sperm (including intrauterine insemination (IUI)), or six months for those with female reproductive systems ≥ age 35;
   3. For those with female reproductive systems ≥ age 40 attempting conception using their own oocytes, documentation that the treating provider has evaluated age, infertility risk factors, measure of ovarian reserve, prior treatment and response, and considers use of the member/enrollee's own oocytes a viable strategy for attempting conception;
   4. Infertility is unrelated to voluntary sterilization or failed reversal of voluntary sterilization of either partner.

***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*

B. Treatment-specific criteria:
   1. Artificial Insemination (intracervical insemination (ICI)/intrauterine insemination (IUI)), meets the following:
      a. Unilateral or bilateral tubal patency, and one of the following:
         i. Mild male reproductive system factor infertility;
         ii. Cervical factors (e.g.: stenosis, chronic cervicitis);
         iii. Ovulatory dysfunction treated with medications such as clomiphene;
         iv. Unexplained infertility;
         v. Sperm antibodies;
         vi. Endometriosis;

vii. Utilization of cryopreserved sperm obtained for the purpose of fertility preservation before commencing non-elective medical or surgical treatment likely to cause infertility;
viii. One of the following factors, which doesn't require the inability to conceive over six to 12 months as described in I.A.2:
   1) Unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psychosexual problem and are using partner or donor sperm;
   2) Couples in which the partner with a male reproductive system is HIV positive or have a diagnosis of retrograde ejaculation and undergoing sperm washing;
   3) Member/enrollee's with a female reproductive system and without a partner with a male reproductive system who are using donor sperm.

2. Donor egg cycle, member/enrollee has a female reproductive system and meets one of the following:
   a. Congenital or surgical absence of ovaries;
   b. Primary ovarian insufficiency (menopause before age 40);
   c. Diminished ovarian reserve;
   d. Ovarian failure following radiation or chemotherapy;
   e. Previously failed IVF in those with a female reproductive system age $\geq$40;
   f. Gonadal dysgenesis including Turner Syndrome;
   g. High risk of transmitting genetic disorder from those with a female reproductive system;
   h. Hypergonadotropic hypogonadism.

3. TESE, micro-TESE and epididymal sperm extraction for those with a male reproductive system with obstructive or non-obstructive azoospermia.

4. Donor sperm, meets one of the following:
   a. Partner with male reproductive system has bilateral congenital absence of the vas deferens (BCAVD);
   b. Partner with male reproductive system has ejaculatory dysfunction;
   c. Partner with male reproductive system has obstructive azoospermia, severe oligozoospermia, or other significant sperm or seminal fluid abnormalities;
   d. Those with a female reproductive system without a partner with a male reproductive system;
   e. High risk of transmitting an infectious disease from partner with a male reproductive system (such as HIV);
   f. High risk of transmitting a genetic disorder in the partner with a male reproductive system to the offspring;
   g. Partner with male reproductive system has non-obstructive azoospermia confirmed through MESA/TESA;
   h. Couples who are incompatible for red cell antigens (e.g., D, Kell) associated with hemolytic disease of the newborn and with a history of a severely affected infant;

i. Partner with male reproductive system has had previous radiation or chemotherapy resulting in abnormal semen analysis;
j. Partner with male reproductive system has had two abnormal semen analyses (by Krüger or WHO classification) at least 30 days apart;
k. Failure of at least three cycles IVF or ICSI.

5. Cryopreservation of sperm: Short term storage of sperm for one year for member/enrollee with a male reproductive system already in active infertility treatment who has undergone an approved MESA or TESE procedure.

   ***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.*

6. Cryopreservation of mature oocytes: Short-term storage for one year.

   ***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.*

II. It is the policy of QualChoice that ART is **not medically necessary** for the following indications:

A. Any experimental infertility procedure;
B. Surrogacy;
C. Reversal of voluntary sterilization;
D. Commercially available over-the-counter home test kits, including but not limited to ovulation prediction and pregnancy test kits;
E. Infertility treatment needed as a result of prior voluntary sterilization or unsuccessful sterilization reversal procedure;
F. A partner's infertility services when the partner is not a member/enrollee, unless mandated by benefits;
G. Those with a female reproductive system who are ≤ 54 years of age and are menopausal (unless using a donor egg for premature diminished ovarian reserve or premature ovarian failure);
H. Those with a female reproductive system who are > 55 years of age;
I. Sex selection, chromosomal studies of donor sperm or egg.

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

Non-covered Services:
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)

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 2018, 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	CPT Codes that Support Medical Necessity
58321	Artificial insemination; intra-cervical
58322	Artificial insemination; intra-uterine
58323	Sperm washing for artificial insemination
58970	Follicle puncture for oocyte retrieval, any method
89257	Sperm identification from aspiration (other than seminal fluid)
89258	Cryopreservation; embryo(s)
89259	Cryopreservation; sperm
89260	Sperm isolation; simple prep (eg, sperm wash and swim-up) for insemination or diagnosis with semen analysis
89261	Sperm isolation; complex prep (eg, Percoll gradient, albumin gradient for insemination or diagnosis with semen analysis
89264	Sperm identification from testis tissue, fresh or cryopreserved
89268	Insemination of oocytes
89337	Cryopreservation, mature oocyte(s)
89352	Thawing of cryopreserved; embryo(s)
89353	Thawing of cryopreserved; sperm/semen, each aliquot
89356	Thawing of cryopreserved; oocytes, each aliquot

HCPCS Codes	Description
S4022	Assisted oocyte fertilization, case rate
S4023	Donor egg cycle, incomplete, case rate
S4025	Donor services for in vitro fertilization (sperm or embryo), case rate
S4026	Procurement of donor sperm from sperm bank
S4028	Microsurgical epididymal sperm aspiration (MESA)
S4035	Stimulated intrauterine insemination (IUI), case rate

Reviews, Revisions, and Approvals	Date	Approval Date
Annual Review	10/07/ 2025	10/25
Ad hoc Review, updated to criteria from Centene cp.mp.55 for covered benefits, restructured benefit language to introduction and background information. Updated coding lists from cp.mp.55 for covered services	04/17/ 2026	4/226

References

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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.

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.