

MedStar Health, Inc.

POLICY AND PROCEDURE MANUAL

Policy Number: PA.018.MH
Last Review Date: 05/11/2017
Effective Date: 07/01/2017

PA.018.MH – Infertility- Treatment

This policy applies to the following lines of business:

- ✓ MedStar Employee (Select)
- ✓ MedStar CareFirst PPO
- ✓ MedStar MA – DSNP – CSNP (Not Covered)

MedStar Health considers **Infertility Treatment** medically necessary for the following indications:

1. Criteria for Eligibility of Members for Treatment
 - Member treated must have an established diagnosis of infertility
 - Females must be premenopausal and reasonably expect fertility as a natural state or if menopausal, should have experienced it at an early age.

Note: MedStar Health allows for the use of donor egg and sperm. However, the procurement of the donor egg and sperm are not covered.

2. Treatment of Infertility
 - Basic Treatment

Once infertility has been established and, depending on the member's unique medical situation, the following treatments may be considered medically necessary:

- (1) Human chorionic gonadotropin
 - (2) Low dose glucocorticoids (dexamethasone or prednisone)
 - (3) Dopamine agonists (ie Bromocriptine)
 - (4) Therapeutic operative Laparoscopy
 - (5) Endometriosis or periaidnexal adhesions (treatment of)
 - (6) Ovarian wedge resection
 - (7) Salpingo oviolysis
 - (8) Terminal salpingostomy
 - (9) Fimbrioplasty
- Assisted Reproductive Technology (ART)
These services are frequently excluded from coverage, specifically so, when any ART or related treatments are classified as experimental, investigative or innovative by the American Society of Reproductive Medicine and the American College of Obstetrics and Gynecology.
 - Services are only covered if the member's benefit plan identifies them as covered services. These services include:
 - (1) Artificial Insemination (AI) for female infertility

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- (2) Artificial Insemination for male infertility
- (3) in Vitro Fertilization (IVF)

Benefits of IVF are available only as specified in the member contract or benefit rider. These may include:

- Monitoring and/or stimulation of ovulation
- Oocyte retrieval
- Lab studies
- Embryo assessment and transfer
- Luteal phase support

All services received as part of an IVF procedure are considered under the same benefit as the IVF procedure, i.e. drugs, labs, pathology and surgical procedures.

Limitations

- Normal physiological causes of infertility such as menopause
- Infertility resulting from voluntary sterilization

Benefits for **Artificial Insemination (AI)** and **In Vitro Fertilization (IVF)** are combined and limited to four attempts per year and six attempts per lifetime. Coverage for infertility benefits includes injectibles drugs and allows for the use of donor egg and sperm. The procurement and donor egg and sperm are not covered.

The following treatments are not covered:

- Reversal of sterilization
- Administration of Tamoxifen, Cyclofenil, Pulsatile Administration of Human Menopausal Gonadotropins (hMG)

ART is contraindicated in the following situations:

- Severe Endometriosis (Stage IV)
- Pregnancy
- Unexplained Uterine Bleeding
- Presence of Venereal Disease or AIDS
- Tubal Obstructions
- Infections such as Acute Cervicitis, Salpingo-oophoritis, Prostatitis, Epididymitis

Limitations include modifications of the IVF Procedure such as:

- Gamete Intrafallopian Transfer (GIFT)
- Zygote Intrafallopian Transfer (ZIFT)
- Pronuclear Stage Transfer (PROST)
- Tubal Embryo Stage Transfer (TEST)
 - 1) Sperm or Oocyte Donation and all Aspects of Storage

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- 2) Cryopreservation, Thawing and Storage of Embryos
- 3) Coculture of Embryos

Note: Embryo donation for substitute motherhood or surrogacy, reversal of voluntary sterilization or cryopreservation of eggs or any other related experimental procedures are not recognized as medically necessary procedures by MedStar Health.

Surrogate Motherhood Exclusions: All services and supplies associated with surrogate motherhood of a member acting as a surrogate mother, including, but not limited to, all services and supplies related to the following:

- Pre-pregnancy evaluations
- Conception
- Prenatal care
- Perinatal care
- Postnatal care

Background

The American Society for Reproductive Medicine defines infertility as the result of a disease (an interruption, cessation, or disorder of body functions, systems or organs) of the male or female reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery.

The Centers for Disease Control and Prevention (CDC) defines assisted reproductive technology (ART) as all fertility treatments in which both eggs and sperm are handled (as outlined in the 1992 Fertility Clinic Success Rate and Certification Act). ART procedures involve surgically removing eggs from a woman's ovaries, combining them with sperm in the laboratory, and returning them to the woman's body or donating them to another woman.

The CDC reports about 6% of married women 15-44 years of age in the United States are unable to get pregnant after one year of unprotected sex. Fertility is known to decline with age, smoking, excessive alcohol use, extreme weight gain or loss, and excessive stress.

Codes:

The codes for infertility services are only covered under the provision of a member's specific benefit plan/rider.

ICD-10 Codes

N97.9	Female infertility, unspecified
N97.8	Female infertility of other origin
N97.2	Female infertility of uterine origin

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N97.0	Female infertility associated with anovulation
N97.1	Female infertility of tubal origin
N46.9	Male infertility, unspecified
N46.8	Other male infertility
N46.1	Oligospermia

CPT Codes *(List should not be inclusive)*

84702	Gonadotropin, chorionic (hCG); quantitative
84703	Gonadotropin, chorionic (hCG); qualitative
80426	Chorionic gonadotropin stimulation panel; estradiol response This panel must include the following: Estradiol (82670 x 2 on three pooled blood samples)
81224	Gonadotropin releasing hormone stimulation panel This panel must include the following: Follicle stimulating hormone (FSH) (83001 x 4) Luteinizing hormone (LH) (83002 x 4)
83001	Gonadotropin; follicle stimulating hormone (FSH)
83002	Gonadotropin; luteinizing hormone (LH)
J1094	Injection, dexamethasone acetate, 1 mg
J1100	Injection, dexamethasone sodium phosphate, 1 mg
J8540	Dexamethasone, oral, 0.25 mg
J7512	Prednisone, immediate release or delayed release, oral, 1 mg
49321	Laparoscopy, surgical; with biopsy (single or multiple)
49322	Laparoscopy, surgical; with aspiration of cavity or cyst (eg ovarian cyst) (single or multiple)
54692	Laparoscopy, surgical; orchiopexy for intra-abdominal testis
58545	Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 g or less and/or removal of surface myomas
58546	Laparoscopy, surgical, myomectomy, excision; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g
58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58662	Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method
58672	Laparoscopy, surgical; with fimbrioplasty
58673	Laparoscopy, surgical; with salpingostomy (salpingoneostomy)

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58920	Wedge resection or bisection of ovary, unilateral or bilateral
58740	Lysis of adhesions (salpingolysis, ovariolysis)
58770	Salpingostomy (salpingoneostomy)
58760	Fimbrioplasty
58321	Artificial insemination; intra-cervical
58322	Artificial insemination; intra-uterine
58323	Sperm washing for artificial insemination
58970	Follicle puncture for oocyte retrieval, any method
58976	Gamete, zygote, or embryo intrafallopian transfer, any method
58974	Embryo transfer, intrauterine
89253	Assisted embryo hatching, microtechniques (any method)
89250	Culture of oocyte(s)/embryo(s), less than 4 days
89254	Oocyte identification from follicular fluid
89255	Preparation of embryo transfer (any method)
89251	Culture of oocyte(s)/embryo(s), less than 4 days; with co-culture of oocyte(s)/embryos
89280	Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes
89272	Extended culture of oocyte(s)/embryo(s), 4-7 days
89290	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos
89291	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos
89281	Assisted oocyte fertilization, microtechnique, greater than 10 oocytes
89268	Insemination of oocytes
89352	Thawing of cryopreserved; embryo(s)

References

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Disclaimer:

MedStar Health medical payment and prior authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. The policies constitute only the reimbursement and coverage guidelines of MedStar Health and its affiliated managed care entities. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies.

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