

<b>Title: Infertility Services</b>	<b>Division: Medical Management</b> <b>Department: Utilization Management</b>
<b>Approval Date: 1/1/2020</b>	<b>LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&amp;II, QHP, Essential, HARP</b>
<b>Effective Date: 1/1/2020</b>	<b>Policy Number: UM-MP271</b>
<b>Review Date: 8/27/2025</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 1 of 19</b>

### A. POLICY DESCRIPTION:

We cover services for the diagnosis and treatment (medical and surgical) of infertility. Basic services will be provided to a member who is an appropriate candidate for infertility treatment. If basic infertility services do not result in pregnancy, we cover comprehensive infertility services. Gold and GoldCare 1&2 cover for IUI and IVF. QHP, and Essential lines of business do not cover IVF. All other lines of business do not cover IUI or IVF.

An individual may also be eligible for fertility coverage if they are unable to conceive due to their sexual orientation or gender identity, in accordance with their coverage policy.

### B. RESPONSIBLE PARTIES:

Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting.

### C. DEFINITIONS:

1. Assisted hatching – A procedure intended to assist with embryo implantation in the uterus by making a small hole in the zona pellucida, the embryo’s “shell.”
2. Assisted reproductive technology (ART) – Fertility treatment where both egg and sperm and handled in the lab.
3. Artificial insemination – Sperm collected outside of the vagina is later instilled into the female patient. IUI and IVF are forms of artificial insemination.
4. Clomiphene citrate (CC) – A medication used to stimulate growth of ovarian follicles and initiate ovulation; can be taken orally.
5. Clomiphene + Intrauterine insemination (CC/IUI) – The combined use of clomiphene and IUI is a first-line treatment. Medicated IUI may use this medication or others for ovarian stimulation.
6. Cryopreservation – A process of preserving cells or tissues by cooling samples to very low temperatures. May be used for embryos, oocytes, or sperm during IVF or in preparation for iatrogenic infertility.
7. Embryo banking – Undergoing multiple successive freeze-all cycles.
8. Embryo transfer – The fertilized egg, or embryo, is placed in the uterus.
9. Frozen embryo transfer – Thawing a previously frozen embryo and transferring it to the uterus.
10. Single embryo transfer – Transferring one embryo during a treatment cycle.
11. Single thawed elective embryo transfer (STEET or SET/FET) – Thawing a single, previously frozen embryo and transferring it to the uterus.
12. Freeze-all cycle – Eggs and sperm are collected and combined to form embryos, all of which are saved.

<b>Title: Infertility Services</b>	<b>Division: Medical Management</b> <b>Department: Utilization Management</b>
<b>Approval Date: 1/1/2020</b>	<b>LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&amp;II, QHP, Essential, HARP</b>
<b>Effective Date: 1/1/2020</b>	<b>Policy Number: UM-MP271</b>
<b>Review Date: 8/27/2025</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 2 of 19</b>

13. Infertility - A disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after twelve months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female thirty-five years of age or older. Earlier evaluation and treatment may be warranted based on an individual's medical history or physical findings
14. Iatrogenic infertility – Infertility that is a side-effect of therapy, such as chemotherapy, radiation or surgery. For this policy, we do not include voluntary sterilization. MetroPlus Health Plan covers standard fertility preservation services when future medical treatment will directly or indirectly lead to iatrogenic infertility. Gender-affirming surgery is considered iatrogenic infertility since the intent of this surgery is to treat gender dysphoria and the sterility is a side-effect. Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm.
15. Intravaginal insemination – Semen, which has been collected outside of intercourse, is instilled into the vagina using a syringe.
16. Intrauterine insemination (IUI) – Semen, which has been collected outside of intercourse, is injected into the uterus by a clinician.
17. In Vitro fertilization (IVF) – An assisted reproductive technology, where eggs are extracted from the ovaries and then fertilized in a laboratory setting.
  - a. NYS law defines an IVF “cycle” to mean all treatment that starts when preparatory medications are administered for ovarian stimulation for oocyte retrieval with the *intent* of undergoing IVF using a fresh embryo or frozen embryo transfer. Cycles begun in this manner that fail at some point are counted towards the three-cycle limit.
  - b. The retrieval of oocytes, creation and freezing of embryos, and the planned and impending first implantation of those frozen embryo(s) when part of an insured's IVF treatment plan counts as one cycle toward the three-cycle limit on IVF coverage.
  - c. A frozen embryo transfer cycle done without oocyte retrieval counts towards the three-cycle limit on IVF coverage.
18. Conventional Insemination – Sperm and mature eggs are mixed and incubated overnight.
19. Intracytoplasmic sperm injection (ICSI) – a single, healthy sperm is injected directly into a mature egg. ICSI may be used when there is a problem with semen fertilizing eggs or if fertilization attempts during prior IVF cycles have failed.
20. Lifestyle changes / noninvasive therapy – Behaviors that may augment fertility, including having intercourse during periods of maximum fertility. This often includes scheduling intercourse starting up to five days prior to anticipated ovulation and extending through

<b>Title: Infertility Services</b>	<b>Division: Medical Management</b> <b>Department: Utilization Management</b>
<b>Approval Date: 1/1/2020</b>	<b>LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&amp;II, QHP, Essential, HARP</b>
<b>Effective Date: 1/1/2020</b>	<b>Policy Number: UM-MP271</b>
<b>Review Date: 8/27/2025</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 3 of 19</b>

ovulation. Additionally, avoiding behaviors known to decrease fertility, such as use of cannabis, ethanol, tobacco, or other recreational drugs, may augment fertility.

21. Long-term cryopreservation – Storing eggs, embryos, or sperm for more than 9 months after the last unsuccessful IVF cycle, or for more than 36 months after the most recent pregnancy.
22. Male infertility - There are several causes of male infertility, including low sperm count, or absence of sperm, or poor sperm morphology or motility.
23. Mild male infertility - sperm concentration between 10M and 15M sperm/mL and/or motility is between 30% to 40%, or at least 5M motile sperm.
24. Moderate male infertility - sperm concentration between 5M to 10M sperm/mL and motility is between 25% to 30%, or at least 1M motile sperm.
25. Severe male infertility - sperm concentration is less than 5M/mL, or less than 1M motile sperm.
26. Menopause (female) – When a woman has permanently lost the ability to create mature follicles and conceive naturally. Functional definition – A time 12 months after a woman’s last menstrual period, accompanied by hormone concentrations (e.g., FSH) in a range expected in menopausal women. If the diagnosis of menopause remains in doubt, treatment coverage will be considered after medical review.
27. Iatrogenic menopause – menopause brought on by a medical intervention, such as surgical removal of ovaries.
28. Premature menopause – Occurs in women < 40 yrs old. Iatrogenic menopause is excluded from this definition.
29. Secondary menopause – The absence of previously regular menses for 6 months or 3 menstrual cycles, and may result from problems in the ovaries, pituitary gland, or uterus.
30. Natural menopause – menopause which is not iatrogenic, premature, or secondary.
31. Microepididymal sperm aspiration (MESA) – A surgical procedure to obtain sperm from men.
32. Percutaneous testicular sperm extraction (PESA) – A surgical procedure extracting sperm from the epididymis in men.
33. Pre-implantation genetic testing (PGT) – A fertilized embryo is tested for genetic abnormalities prior to transfer.
34. Reciprocal IVF – An infertility method used by a female couple where an embryo from one woman is transferred to the other woman. This procedure is not covered by MetroPlus Health.
35. Semen – Sperm in the carrier fluid, which is produced by seminal vesicles and the prostate to help transport sperm to meet the egg.
36. Sperm - Reproductive cells made by men.
37. Sterilization – Intentionally destroying fertility, usually via surgery.

<b>Title: Infertility Services</b>	<b>Division: Medical Management</b> <b>Department: Utilization Management</b>
<b>Approval Date: 1/1/2020</b>	<b>LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&amp;II, QHP, Essential, HARP</b>
<b>Effective Date: 1/1/2020</b>	<b>Policy Number: UM-MP271</b>
<b>Review Date: 8/27/2025</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 4 of 19</b>

- 38.** Testicular aspiration – A surgical procedure to extract sperm.
- 39.** Testicular excisional sperm extraction (TESA) – A surgical procedure extracting sperm from the testes in men.
- 40.** Treatment cycle – The law defines a “cycle” as all treatment that begins when preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing IVF using a fresh embryo transfer, OR Medications are administered for endometrial preparation with the intent of undergoing IVF using a frozen embryo transfer. Collecting and freezing oocytes or sperm in anticipation of iatrogenic infertility is not considered the start of a treatment cycle.

#### **D. PROCEDURE:**

##### I. Covered Services

- A. Basic Infertility Services are covered if medically necessary for all lines of business. Services include:
  - a. Initial history and physical examination
  - b. Laboratory evaluation
  - c. Evaluation of ovulatory function (FSH testing)
  - d. Endometrial biopsy
  - e. Hysterosalpingogram
  - f. Pelvic ultrasound
  - g. Postcoital test
  - h. Semen collection and analysis
  - i. Sono-histogram
  - j. Testis biopsy
  - k. Additional tests may be covered if the tests are determined to be medically necessary.
  
- B. Comprehensive infertility services are only covered if medically necessary for all Commercial lines of business. These services include:
  - a. Artificial insemination
  - b. Hysteroscopy
  - c. Laparoscopy
  - d. Laparotomy
  - e. Ovulation induction and monitoring
  - f. Pelvic ultrasound

<b>Title: Infertility Services</b>	<b>Division: Medical Management</b> <b>Department: Utilization Management</b>
<b>Approval Date: 1/1/2020</b>	<b>LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&amp;II, QHP, Essential, HARP</b>
<b>Effective Date: 1/1/2020</b>	<b>Policy Number: UM-MP271</b>
<b>Review Date: 8/27/2025</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 5 of 19</b>

C. Advanced infertility services are only covered for the MetroPlus Gold and GoldCare lines of business. These services include

- a. Cryopreservation and storage of embryos in connection with in vitro fertilization
- b. Sperm collection and storage costs in connection with in vitro fertilization
- c. Three (3) cycles per lifetime of in vitro fertilization

### II. Medically necessary/covered infertility treatment

A. Basic infertility services to determine the cause and treatment of infertility for those with:

- a. Premature infertility –
  - i. Age < 35 yrs. and failure to conceive within 12 months OR
  - ii. Age > 35 and failure to conceive within 6 months
  - iii. Age > 40 may indicate immediate evaluation for infertility
- b. Iatrogenic infertility, caused by
  - i. Chemotherapy
  - ii. Gender-affirming treatment
  - iii. Radiation exposure/treatments
  - iv. Other medical treatments
  - v. Other surgery (including oophorectomy)
- c. Secondary infertility - functioning ovaries with hormone problem (e.g., pituitary)
- d. Excluded – Basic infertility services are not medically necessary-not covered for:
  - i. Patient had voluntary sterilization.
  - ii. 40+yrs old with natural menopause
  - iii. FSH > 30mIU/mL

III. IUI – Intrauterine Insemination, whether Natural (without the use of ovarian stimulating medication) or Medicated (with the use of ovarian stimulating medication). NYS guidance provides for Unlimited Intrauterine Insemination (IUI) for members who meet the clinical definition of infertility. IUI is medically necessary for:

- a. Women who are not excluded for basic infertility services.
- b. Women who have failed trial of noninvasive therapy (+/- clomiphene).
  - i. Documentation of failed noninvasive therapy is required
  - ii. This trial of noninvasive therapy counts as part of meeting the time-definition of infertility (e.g.: 12 months for women under 35, 6 months for women older than 35)
- c. Normal ovarian reserve – FSH testing
- d. Women <40yo are assumed to have normal reserve
- e. Women >40yo, cycle day 3: FSH <15mIU/mL and Estradiol <80 pg/mL

<b>Title: Infertility Services</b>	<b>Division: Medical Management</b> <b>Department: Utilization Management</b>
<b>Approval Date: 1/1/2020</b>	<b>LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&amp;II, QHP, Essential, HARP</b>
<b>Effective Date: 1/1/2020</b>	<b>Policy Number: UM-MP271</b>
<b>Review Date: 8/27/2025</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 6 of 19</b>

- f. Women 42+yo, cycle day one: FSH <17mIU/mL
- g. Women without a male partner, who have stored sperm
- h. Women with any of the following:
  - i. Cervical scarring (or other barrier to sperm entering, often from surgery)
  - ii. Mild to moderate male infertility (medicated IUI)
  - iii. Minimal to mild endometriosis
  - iv. Polycystic ovary syndrome (PCOS), anovulation, oligoovulation
- i. Excluded – IUI is not medically necessary / not approvable for (see below-patients may need to skip directly to IVF):
  - i. >1 insemination per cycle
  - ii. Bilateral fallopian tube obstruction
  - iii. Moderate to severe endometriosis, unless previously treated with documentation of at least 1 uncompromised fallopian tube
  - iv. Recurrent loss of the most recent 3 pregnancies
  - v. Severe male infertility without use of donor sperm
  - vi. Converting IVF to IUI when at least 3 follicles are  $\geq 15$ mm
  - vii. Women who were denied or failed IVF are not covered for IUI

IV. IVF – In Vitro Fertilization. All frozen embryos must be used before another cycle of IVF (beginning with sperm and egg) will be approved. A lifetime maximum of three cycles of IVF will be covered. IVF is medically necessary for:

- a. Women/couples who are infertile but maintain ovarian reserve as above
- b. Uterus has been evaluated within the past year and is capable of maintaining a pregnancy
- c. And ONE of these criteria:
  - I. 3 consecutively failed IUI cycles (unless medically indicated to go directly to IVF)
  - II. Bilateral fallopian tube absence or obstruction
  - III. Decreased ovarian reserve
  - IV. Moderate to Severe endometriosis which has failed conventional therapy
  - V. Women without a male partner, who have stored sperm, and otherwise meet IVF criteria
  - VI. Male with severe infertility, which cannot be improved

V. Additional Covered Services:

- a. Assisted hatching – women >38 yo with either:

<b>Title: Infertility Services</b>	<b>Division: Medical Management</b> <b>Department: Utilization Management</b>
<b>Approval Date: 1/1/2020</b>	<b>LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&amp;II, QHP, Essential, HARP</b>
<b>Effective Date: 1/1/2020</b>	<b>Policy Number: UM-MP271</b>
<b>Review Date: 8/27/2025</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 7 of 19</b>

- i. Prior IVF cycles that produced 3+ high-quality embryos which failed to implant after each was transferred
  - ii. Prior successful pregnancy that required assisted hatching
  - iii. NOT covered for embryos having undergone pre-genetic testing, since the zona pellucida has already been pierced for this test
- b. Cryopreservation of embryos when:
  - i. Mother is infertile or iatrogenically infertile
  - ii. Part of an IVF cycle where at least one embryo was transferred, and others were stored for use during another menstrual cycle
  - iii. Embryos were generated as part of freeze-all cycle
  - iv. Freeze-all cycles and embryo banking - one member of a couple is scheduled for iatrogenic sterilization or other DNA disrupting procedure (e.g., chemotherapy, radiation therapy with large dose gonadal exposure)
- c. Intracytoplasmic sperm injection (ICSI) when:
  - i. Azo or oligospermia, obstructive or non-obstructive
  - ii. Cryopreserved oocytes are used
  - iii. Lower than expected or failed fertilization previously occurred with conventional insemination
  - iv. Severe male infertility
- d. Long-term cryopreservation of oocyte or sperm – when oocyte or sperm was recovered prior to iatrogenic infertility, stored per year.
- e. Use of Donor Sperm (MetroPlus Health covers the use of donor sperm, not the procurement of donor sperm) in cases where:
  - i. Male partner’s serious genetic disorder poses a high risk to the embryo (the disorder must be stated in the request)
  - ii. Male is HIV+ and the female is not
  - iii. Male has severe infertility, which cannot be improved
- f. Covered services for Male Infertility
  - i. Microepididymal Sperm Aspiration (MESA) for documented absence or obstruction of the vas deferens.
  - ii. Percutaneous Testicular Sperm Aspiration (TEFNA) for nonobstructive azoospermia or spinal cord disease/injury resulting in inability to ejaculate
  - iii. Testicular Excisional Sperm Extraction (TESE) for nonobstructive azoospermia or spinal cord disease/injury resulting in inability to ejaculate.

### VI. Non-Covered Procedures

<b>Title: Infertility Services</b>	<b>Division: Medical Management</b> <b>Department: Utilization Management</b>
<b>Approval Date: 1/1/2020</b>	<b>LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&amp;II, QHP, Essential, HARP</b>
<b>Effective Date: 1/1/2020</b>	<b>Policy Number: UM-MP271</b>
<b>Review Date: 8/27/2025</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 8 of 19</b>

1. All experimental/investigational procedures and treatments for the diagnosis and treatment of infertility are determined in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine
2. ART/Infertility services for members when clinical documentation confirms an individual or couple are using illicit substances or abusing substances known to interfere with fertility or fetal development (e.g. marijuana, opiates, cocaine, tobacco or alcohol)
3. Chromosome studies of a donor (sperm or egg – different from PGT of embryo)
4. Coculture of embryos
5. Direct intraperitoneal insemination (DIPI)
6. Egg harvesting, or other infertility treatment performed during an operation not related to an infertility diagnosis
7. Embryo toxic factor test (ETFL)
8. Gamete intrafallopian tube transfers (GIFT) or zygote intrafallopian tube transfers (ZIFT)
9. Genetic engineering
10. Gender selection
11. Human zona binding assay (hemizona test)
12. Infertility services in cases in which normal embryos have been or will be discarded because of gender selection
13. Infertility treatment when infertility is the result of a non-reversed or unsuccessful reversal of a voluntary sterilization
14. Infertility treatment if, based on the member's individual medical history, they have < 5% chance of a birth outcome
15. In vitro maturation of eggs
16. Monitoring of non-authorized IUI cycles
17. Ovarian or testicular tissue cryopreservation
18. Ovarian Reserve Assessment results (Clomiphene Citrate Challenge Test (CCCT))
19. Ovulation kits
20. Peritoneal ovum and sperm transfer (POST)
21. Reciprocal IVF
22. Serum anti-sperm antibody testing
23. Sperm acrosome reaction test
24. Storage of cryopreserved reproductive materials (i.e., embryos, oocytes, or sperm)  
(Note: Storage is only covered for ova/sperm for iatrogenic infertility)
25. Surrogacy (Note: Maternity service benefits may be available for members acting as surrogate mothers)

<b>Title: Infertility Services</b>	<b>Division: Medical Management</b> <b>Department: Utilization Management</b>
<b>Approval Date: 1/1/2020</b>	<b>LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&amp;II, QHP, Essential, HARP</b>
<b>Effective Date: 1/1/2020</b>	<b>Policy Number: UM-MP271</b>
<b>Review Date: 8/27/2025</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 9 of 19</b>

26. Treatments requested solely for the convenience, lifestyle, personal or religious preference of the member in the absence of medical necessity
27. Treatment to reverse voluntary sterilization, i.e. MESA/TESE, for a member who has undergone prior sterilization
28. Additional Non-covered codes
  - a. 58976 - Gamete, zygote, or embryo intrafallopian transfer, any method 89398 - Unlisted reproductive medicine laboratory procedure
  - b. S4025 - Donor services for in vitro fertilization (sperm or embryo), case rate  
S4026 - Procurement of donor sperm from sperm bank
  - c. S4030 - Sperm procurement and cryopreservation services; initial visit S4031 - Sperm procurement and cryopreservation services; subsequent visit

### VII NYS Guidance and Limitations:

- Every large group contract that provides medical, major medical or similar comprehensive-type coverage shall provide coverage for three cycles of in-vitro fertilization (IVF) used in the treatment of infertility.
- Unlimited intrauterine insemination (IUI) for members who meet the clinical definition of infertility (Note: Clinical evidence suggests that greater than 6 IUI cycles is unlikely to yield positive results.)
- Coverage for prescription drugs is limited to medications approved by the Food and Drug Administration for use in the diagnosis and treatment of infertility (**bromocriptine, clomiphene citrate, letrozole, and tamoxifen.**) The cost of those FDA- approved drugs is considered part of the covered procedure.
- The identification of the required training, experience and other standards for health care providers for the provision of procedures and treatments for the diagnosis and treatment of infertility determined in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine.
- The determination of appropriate medical candidates by the treating physician in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and/or the American Society for Reproductive Medicine.
- Insurers may not place dollar limits on IVF coverage.
- IVF services are subject to deductible, copayment and coinsurance guidelines.
- Insurers may limit coverage to three IVF cycles over the life of the insured. Insurers may not count cycles paid by the insured out-of-pocket or cycles covered by other issuers

<b>Title: Infertility Services</b>	<b>Division: Medical Management</b> <b>Department: Utilization Management</b>
<b>Approval Date: 1/1/2020</b>	<b>LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&amp;II, QHP, Essential, HARP</b>
<b>Effective Date: 1/1/2020</b>	<b>Policy Number: UM-MP271</b>
<b>Review Date: 8/27/2025</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 10 of 19</b>

toward the three-cycle limit. A cycle that was begun, but not completed, counts toward the three-cycle limit.

- Cycles completed before January 1, 2020 do not count as part of the three cycle limit.
- Insurers may not place age restrictions on IVF or fertility preservation coverage.
- Insurers are not required to cover IVF for persons who have undergone voluntary sterilization procedures.
- Insurers may limit coverage to in-network providers for those services that are available in network.
- Insurers may require prior authorization for IVF procedures.
- Insurers may review requests for IVF for medical necessity. Insurers are prohibited from discrimination based on the expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life or other health conditions, or personal characteristics including age, sex, sexual orientation, marital status or gender identity.
- Gender affirming surgery as a treatment for gender dysphoria is considered iatrogenic infertility. Oocyte or sperm cryopreservation is covered for patients about to undergo surgical castration or oophorectomy as part of gender affirming surgery.
- After insurance coverage terminates, the insurer is no longer responsible for costs of cryopreservation. If a patient joins a new plan after oocytes, sperm or embryos have already been preserved, the insurer assumes responsibility for the new, ongoing costs of cryopreservation.

### VIII APPLICABLE PROCEDURE CODES:

CPT	Description	Auth Required
<b>0058T</b>	Cryopreservation; reproductive tissue, ovarian	Y
<b>52402</b>	Cystourethroscopy with transurethral resection or incision of ejaculatory ducts	N
<b>54500</b>	Biopsy of testis, needle (separate procedure)	N
<b>54505</b>	Biopsy of testis, incisional (separate procedure)	N
<b>55300</b>	Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral	N

<b>Title: Infertility Services</b>	<b>Division: Medical Management</b> <b>Department: Utilization Management</b>
<b>Approval Date: 1/1/2020</b>	<b>LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&amp;II, QHP, Essential, HARP</b>
<b>Effective Date: 1/1/2020</b>	<b>Policy Number: UM-MP271</b>
<b>Review Date: 8/27/2025</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 11 of 19</b>

<b>55530</b>	Excision of varicocele or ligation of spermatic veins for varicocele; (separate procedure)	N
<b>55535</b>	Excision of varicocele or ligation of spermatic veins for varicocele; abdominal approach	N
<b>55550</b>	Laparoscopy, surgical, with ligation of spermatic veins for varicocele	N
<b>55870</b>	Electroejaculation	N
<b>58140</b>	Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; abdominal approach	N
<b>58145</b>	Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; vaginal approach	N
<b>58146</b>	Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g, abdominal approach	N
<b>58321</b>	Artificial insemination; intra-cervical	Y
<b>CPT</b>	<b>Description</b>	<b>Auth Required</b>
<b>58322</b>	Artificial insemination; intra-uterine	Y
<b>58323</b>	Sperm washing for artificial insemination	Y
<b>58340</b>	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingogra	N
<b>58345</b>	Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography	N
<b>58350</b>	Chromotubation of oviduct, including materials	N
<b>58545</b>	Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 g or less and/or removal of surface myomas	N
<b>58546</b>	Laparoscopy, surgical, myomectomy, excision; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g	N
<b>58555</b>	Hysteroscopy, diagnostic (separate procedure)	N

<b>Title: Infertility Services</b>	<b>Division: Medical Management</b> <b>Department: Utilization Management</b>
<b>Approval Date: 1/1/2020</b>	<b>LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&amp;II, QHP, Essential, HARP</b>
<b>Effective Date: 1/1/2020</b>	<b>Policy Number: UM-MP271</b>
<b>Review Date: 8/27/2025</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 12 of 19</b>

<b>58559</b>	Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)	N
<b>58660</b>	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)	N
<b>58662</b>	Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method	N
<b>58670</b>	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	N
<b>58672</b>	Laparoscopy, surgical; with fimbrioplasty	N
<b>58673</b>	Laparoscopy, surgical; with salpingostomy (salpingoneostomy)	N
<b>58740</b>	Lysis of adhesions (salpingolysis, ovariolysis)	N
<b>58752</b>	Lysis of adhesions (salpingolysis, ovariolysis)	N
<b>58760</b>	Fimbrioplasty	N
<b>CPT</b>	<b>Description</b>	<b>Auth Required</b>
<b>58770</b>	Salpingostomy (salpingoneostomy)	N
<b>58800</b>	Drainage of ovarian cyst(s), unilateral or bilateral (separate procedure); vaginal approach	N
<b>58805</b>	Drainage of ovarian cyst(s), unilateral or bilateral (separate procedure); abdominal approach	N
<b>58920</b>	Wedge resection or bisection of ovary, unilateral or bilateral	N
<b>58970</b>	Follicle puncture for oocyte retrieval, any method	N
<b>58974</b>	Embryo transfer, intrauterine	Y
<b>80415</b>	Chorionic gonadotropin stimulation panel; estradiol response This panel must include the following: Estradiol (82670 x 2 on 3 pooled blood samples)	<u>N1</u>
<b>80426</b>	Gonadotropin releasing hormone stimulation panel This panel must include the following: Follicle stimulating hormone (FSH) (83001 x 4) Luteinizing hormone (LH) (83002 x 4)	N

<b>Title: Infertility Services</b>	<b>Division: Medical Management</b> <b>Department: Utilization Management</b>
<b>Approval Date: 1/1/2020</b>	<b>LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&amp;II, QHP, Essential, HARP</b>
<b>Effective Date: 1/1/2020</b>	<b>Policy Number: UM-MP271</b>
<b>Review Date: 8/27/2025</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 13 of 19</b>

<b>81224</b>	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)	Y
<b>82397</b>	Chemiluminescent assay	Y
<b>82670</b>	Estradiol	N
<b>83001</b>	Gonadotropin; follicle stimulating hormone (FSH)	N
<b>83002</b>	Gonadotropin; luteinizing hormone (LH)	N
<b>83498</b>	Hydroxyprogesterone, 17-d	N
<b>83520</b>	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; quantitative, not otherwise specified	Y
<b>84144</b>	Progesterone	N
<b>84146</b>	Prolactin	N
<b>CPT</b>	<b>Description</b>	<b>Auth Required</b>
<b>84402</b>	Testosterone; free	N
<b>84403</b>	Testosterone; total	N
<b>84443</b>	Thyroid stimulating hormone (TSH)	N
<b>84830</b>	Ovulation tests, by visual color comparison methods for human luteinizing hormone	N
<b>89250</b>	Culture of oocyte(s)/embryo(s), less than 4 days;	Y
<b>89251</b>	Culture of oocyte(s)/embryo(s), less than 4 days; with co-culture of oocyte(s)/embryos	Y
<b>89253</b>	Assisted embryo hatching, microtechniques (any method)	Y
<b>89254</b>	Oocyte identification from follicular fluid	N
<b>89255</b>	Preparation of embryo for transfer (any method)	Y

<b>Title: Infertility Services</b>	<b>Division: Medical Management</b> <b>Department: Utilization Management</b>
<b>Approval Date: 1/1/2020</b>	<b>LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&amp;II, QHP, Essential, HARP</b>
<b>Effective Date: 1/1/2020</b>	<b>Policy Number: UM-MP271</b>
<b>Review Date: 8/27/2025</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 14 of 19</b>

<b>89257</b>	Sperm identification from aspiration (other than seminal fluid)	N
<b>89258</b>	Cryopreservation; embryo(s)	Y
<b>89259</b>	Cryopreservation; sperm	Y
<b>89260</b>	Cryopreservation; sperm	Y
<b>89261</b>	Sperm isolation; complex prep (eg, Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis	N
<b>89264</b>	Sperm identification from testis tissue, fresh or cryopreserved	N
<b>89268</b>	Insemination of oocytes	Y
<b>89272</b>	Extended culture of oocyte(s)/embryo(s), 4-7 days	Y
<b>89280</b>	Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes	Y
<b>CPT</b>	<b>Description</b>	<b>Auth Required</b>
<b>89281</b>	Assisted oocyte fertilization, microtechnique; greater than 10 oocytes	Y
<b>89290</b>	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos	N
<b>89291</b>	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos	N
<b>89300</b>	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)	N
<b>89310</b>	Semen analysis; motility and count (not including Huhner test)	N
<b>89320</b>	Semen analysis; volume, count, motility, and differential	N
<b>89321</b>	Semen analysis; sperm presence and motility of sperm, if performed	N
<b>89322</b>	Semen analysis; volume, count, motility, and differential using strict morphologic criteria (eg, Kruger)	N
<b>89325</b>	Sperm antibodies	N

<b>Title: Infertility Services</b>	<b>Division: Medical Management</b> <b>Department: Utilization Management</b>
<b>Approval Date: 1/1/2020</b>	<b>LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&amp;II, QHP, Essential, HARP</b>
<b>Effective Date: 1/1/2020</b>	<b>Policy Number: UM-MP271</b>
<b>Review Date: 8/27/2025</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 15 of 19</b>

CPT	Description	Auth Required
89330	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test	N
89331	Sperm evaluation, for retrograde ejaculation, urine (sperm concentration, motility, and morphology, as indicated)	N
89335	Cryopreservation, reproductive tissue, testicular	Y
89337	Cryopreservation, mature oocyte(s)	Y
89342	Storage (per year); embryo(s)	Y
89343	Storage (per year); sperm/semen	Y
89344	Storage (per year); reproductive tissue, testicular/ovarian	Y
89346	Storage (per year); oocyte(s)	Y
89352	Thawing of cryopreserved; embryo(s)	Y
89353	Thawing of cryopreserved; sperm/semen, each aliquot	Y
89354	Thawing of cryopreserved; reproductive tissue, testicular/ovarian	Y
89356	Thawing of cryopreserved; oocytes, each aliquot	Y
89398	Unlisted reproductive medicine laboratory procedure	Y
J0725	Injection, chorionic gonadotropin, per 1,000 USP units	N
J3355	Injection, urofollitropin, 75 IU	N
S0122	Injection, menotropins, 75 IU	N

<b>Title: Infertility Services</b>	<b>Division: Medical Management</b> <b>Department: Utilization Management</b>
<b>Approval Date: 1/1/2020</b>	<b>LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&amp;II, QHP, Essential, HARP</b>
<b>Effective Date: 1/1/2020</b>	<b>Policy Number: UM-MP271</b>
<b>Review Date: 8/27/2025</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 16 of 19</b>

<b>S0126</b>	Injection, follitropin alfa, 75 IU	N
<b>S0128</b>	Injection, follitropin beta, 75 IU	N
<b>S0132</b>	Injection, ganirelix acetate, 250 mcg	N
<b>S3655</b>	Antisperm antibodies test (immunobead)	N
<b>S4011</b>	In vitro fertilization; including but not limited to identification and incubation of mature oocytes, fertilization with sperm, incubation of embryo(s), and subsequent visualization for determination of development	Y
<b>S4015</b>	Complete in vitro fertilization cycle, not otherwise specified, case rate	Y
<b>S4016</b>	Frozen in vitro fertilization cycle, case rate	Y
<b>S4017</b>	Incomplete cycle, treatment cancelled prior to stimulation, case rate	Y

### IX. APPLICABLE DIAGNOSIS CODES:

CODE	Description

### X. REFERENCES:

1. Cedars M. Evaluation of female fertility – AMH and ovarian reserve testing. J Clin Endocrinol Metab 2022;107:1510-1519 Centers for Disease Control and Prevention (CDC). What is Assisted Reproductive Technology? Last accessed 8/12/25 and available at: <https://www.cdc.gov/art/index.html>
2. Committee on Ethics, American College of Obstetricians and Gynecologists. Multifetal Pregnancy Reduction – Committee Opinion No 719. 2017;1-6 Accessed 8/12/25 and available at: <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/09/multifetal-pregnancy->

<b>Title: Infertility Services</b>	<b>Division: Medical Management</b> <b>Department: Utilization Management</b>
<b>Approval Date: 1/1/2020</b>	<b>LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&amp;II, QHP, Essential, HARP</b>
<b>Effective Date: 1/1/2020</b>	<b>Policy Number: UM-MP271</b>
<b>Review Date: 8/27/2025</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 17 of 19</b>

[reduction](#)

3. Coward RM, Mills JN A. Step-by-step guide to office-based sperm retrieval for obstructive azoospermia. *Transl Androl Urol* 2017;6: 730-744.
4. Flannigan R, Bach PV, Schlegel PN. Microdissection testicular sperm extraction. *Trans Androl Urol* 2017;6: 745-752.
5. New York State Department of Financial Services. IVF and Fertility Preservation Law Q&A Guidance. (Part L of Chapter 57 of the Laws of 2019) Accessed 7/6/23 and available at:  
[https://www.dfs.ny.gov/apps\\_and\\_licensing/health\\_insurers/ivf\\_fertility\\_preservation\\_law\\_qa\\_guidance](https://www.dfs.ny.gov/apps_and_licensing/health_insurers/ivf_fertility_preservation_law_qa_guidance).
6. NY State Department of Financial Services, Insurance Circular Letter No. 3 (2021), Health Insurance Coverage of Infertility Treatments Regardless of Sexual Orientation or Gender Identity  
[https://www.dfs.ny.gov/industry\\_guidance/circular\\_letters/cl2021\\_03](https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2021_03)
7. [New York State Medicaid Update - June 2019 Volume 35 - Number 7](#)
8. [https://www.health.ny.gov/health\\_care/medicaid/program/update/2019/2019-06.htm#:~:text=top%20of%20page%7C-,Medicaid%20Coverage%20of%20Limited%20Infertility%20Benefit,through%2044%20years%20of%20age](https://www.health.ny.gov/health_care/medicaid/program/update/2019/2019-06.htm#:~:text=top%20of%20page%7C-,Medicaid%20Coverage%20of%20Limited%20Infertility%20Benefit,through%2044%20years%20of%20age)
9. Practice Committee of the American Society for Reproductive Medicine. Evidence-based treatments for couples with unexplained infertility: a guideline. *Fertil Steril* 2020; 113: 305-322.
10. Practice Committee of the American Society for Reproductive Medicine. Intracytoplasmic sperm injection (ICSI) for non-male factor indications: a committee opinion. *Fertil Steril* 2020; 114: 239-245.

<b>Title: Infertility Services</b>	<b>Division: Medical Management Department: Utilization Management</b>
<b>Approval Date: 1/1/2020</b>	<b>LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&amp;II, QHP, Essential, HARP</b>
<b>Effective Date: 1/1/2020</b>	<b>Policy Number: UM-MP271</b>
<b>Review Date: 8/27/2025</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 18 of 19</b>

11. Practice Committee of the American Society for Reproductive Medicine.

Optimizing natural fertility: A committee opinion. Fertil Steril 2022; 117:

53-63

**XI. REVISION LOG:**

<b>REVISIONS</b>	<b>DATE</b>
Creation date	1/1/2020
Revised	10/2/2020
Revised	12/15/2020
Annual Review	6/27/2022
Annual Review	7/25/2023
Annual Review	8/27/2025

**Approved:**

**Date:**

**Approved:**

**Date:**

**David Ackman, MD  
VP Medical Director**

**Sanjiv Shah, MD  
Chief Medical Officer**

<b>Title: Infertility Services</b>	<b>Division: Medical Management</b> <b>Department: Utilization Management</b>
<b>Approval Date: 1/1/2020</b>	<b>LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&amp;II, QHP, Essential, HARP</b>
<b>Effective Date: 1/1/2020</b>	<b>Policy Number: UM-MP271</b>
<b>Review Date: 8/27/2025</b>	<b>Cross Reference Number:</b>
<b>Retired Date:</b>	<b>Page 19 of 19</b>

**Medical Guideline Disclaimer:**

Property of Metro Plus Health Plan. All rights reserved. The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, MetroPlus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and or paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members.

All coding and website links are accurate at time of publication.