MetroPlusHealth **Policy and Procedure**

Title: Infertility Services	Division: Medical Management Department: Utilization Management
Approval Date: 1/1/2020	LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Gold Care I&II, QHP, Essential, HARP
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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.

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

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.

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

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

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 ≥ 15mm
   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:

   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

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)

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

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

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

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

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

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

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
CPT	**Description**	**Auth Required**
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

S0126	Injection, follitropin alfa, 75 IU	N
S0128	Injection, follitropin beta, 75 IU	N
S0132	Injection, ganirelix acetate, 250 mcg	N
S3655	Antisperm antibodies test (immunobead)	N
S4011	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
S4015	Complete in vitro fertilization cycle, not otherwise specified, case rate	Y
S4016	Frozen in vitro fertilization cycle, case rate	Y
S4017	Incomplete cycle, treatment cancelled prior to stimulation, case rate	Y

IX. APPLICABLE DIAGNOSIS CODES:

CODE	Description

X. REFERENCES:

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XI. REVISION LOG:

REVISIONS	DATE
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Medical Guideline Disclaimer:

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