



## Infertility Services

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P&P # C.6.12

### Policy

The Medical Management Department performs claim review for services related to reproduction and/or infertility. Authorization or denial is based on policy and individual certificate language.

Reproductive and/or infertility services which are not for treatment of illness or injury (i.e. which are for the purpose of achieving pregnancy) are excluded in most of the health plans. The diagnosis of infertility alone does not constitute an illness: therefore, limited services are covered for preliminary evaluation of infertility, but not for the treatment of infertility. Once an individual begins infertility treatment, no additional evaluation services will be covered for either partner.

This Medical Policy does not constitute medical advice. When deciding coverage, the enrollee's specific plan document must be referenced. The terms of an enrollee's plan document (Certificate of Coverage (COC) or Summary Plan Description (SPD)) may differ from this Medical Policy. In the event of a conflict, the enrollee's specific benefit plan document supersedes this Medical Policy. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements, and the plan benefit coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. Quartz reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

### Procedure

#### A. Documentation Required:

To facilitate the authorization process referral requests must include the following:

1. How diagnosis of infertility was made
2. Statement if previous treatment of infertility has been performed
3. Necessity of requested testing for the workup of infertility
4. Previous workup of infertility if performed

#### B. Criteria for Medical Necessity:

Evaluation for infertility is considered medically necessary if **ALL** the following criteria are met:

1. Criteria for infertility are met as stated in the definitions; **AND**
2. The individual **or** their spouse/partner has not begun treatment for infertility with the following exception:
  - a. Women who have used ovulation induction medication for treatment of amenorrhea or oligomenorrhea who have not previously undergone anatomic imaging studies listed below under 2b-2f, OR
  - b. Women who are not in heterosexual relationship who have undergone medically supervised donor insemination. NOTE: donor insemination is not a covered benefit.

The following workup of **women** is considered medically necessary for evaluation of infertility

1. History and physical exam
2. Studies/procedures when clinically indicated:
  - a. Hysterosalpingogram (HSG) or sonohysterosalpingogram

- b. Pelvic or transvaginal ultrasound
- c. Sonohysterogram
- d. Diagnostic hysteroscopy if needed to further evaluate an abnormal finding on imaging studies
- e. Laparoscopy and contrast dye if tubal and other pelvic pathology is suspected based on symptoms or abnormal HSG or sonogram
- f. MRI of head or pituitary if prolactin is elevated

The following workup of **men** is considered medically necessary for evaluation of infertility:

1. History and physical exam including urological exam
2. Studies/procedures when clinically indicated:
  - a. Semen analysis
  - b. Post-ejaculatory urinalysis
  - c. Transrectal ultrasonography of the prostate, seminal vesicles, and ejaculatory duct may be indicated for evaluation of ejaculatory duct obstruction in men with azoospermia or oligospermia, palpable vasa, and low ejaculate volumes.
  - d. Cultures of urine, sperm and prostatic secretions
  - e. Scrotal ultrasound may be indicated to evaluate a suspected testicular mass;
  - f. MRI of head or pituitary if prolactin is elevated

The following tests and treatments are generally considered as not a covered benefit. Check member's certificate of coverage for exclusions:

1. Diagnostic services and procedures related to the reversal of voluntary sterilization procedures (e.g. tuboplasty and vasoplasty).
2. The following procedures when performed solely for the treatment of infertility:
  - a. Hysteroscopic adhesiolysis for women with amenorrhea related to uterine adhesions
  - b. Removal of myomas, uterine septa, cysts, ovarian tumors and polyps
  - c. Open or laparoscopic cystectomy for women with ovarian endometriomas
  - d. Ovarian wedge resection
  - e. Varicocelectomy for men
3. Purchase of donor sperm and or storage of sperm
4. Purchase of donor eggs and any associated charges
5. Cryopreservation or storage of cryopreserved embryos
6. Frozen embryo transfers
7. Home ovulation prediction kits
8. Artificial insemination
9. In Vitro Fertilization with Embryo Transfer (IVF-ET)
10. Gamete Intrafallopian Transfer (GIFT)
11. Intracytoplasmic Sperm Injection (ICSI)
12. Microscopic Testicular Sperm Extraction (TESE)
13. Tubal Embryo Transfer (TET)
14. Epididymal sperm aspiration and cryopreservation

**C. Tests and Treatments Considered Not Medically Necessary:** *(Not all inclusive)*

1. Endometrial biopsy for evaluation of luteal phase defect
2. Tubal Embryo Transfer (TET)
3. Epididymal sperm aspiration and cryopreservation

**REFERENCES:**

American College of Obstetricians and Gynecologists (ACOG) and American Society for Reproductive Medicine. ACOG Committee Opinion Number 781. Infertility workup for the women's health specialist. *Obstetrics & Gynecology*. 2019;133(6):e377-384.

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