Policy:	**202306-CSTM**	**Initial Effective Date:**	**01/01/2024**
SUBJECT:	**Infertility Services**	**Annual Review Date:**	**10/16/2024**
		Last Revised Date:	**10/16/2024**

Prior approval is required for some or all procedure codes listed in this Corporate Medical Policy.

Definition: Infertility is defined as not being able to conceive after 1 year of unprotected sex when the individual with female reproductive organs is under 35 years of age, 6 months of unprotected sex for an individual with female reproductive organs aged 35 years and older, or 12 months of attempts of artificial insemination. (6 months for individuals 35 years of age and older) Infertility may also be defined by demonstration of a disease or condition of the reproductive tract such that unprotected sex or artificial insemination would be ineffective. There are many approaches to management of infertility, including traditional fertility treatments such as artificial insemination. Options for use of artificial insemination include intrauterine insemination (IUI), intracervical insemination (ICI), and intravaginal insemination (IVI). Treatment may be permitted based on medical history or diagnostic testing.

Medical Necessity: The Company considers the following infertility services to be **medically necessary** and eligible for reimbursement:

- Diagnosis and treatment of involuntary infertility;
- Therapeutic injection of drugs[†] or hormones[†];
- Artificial insemination, including the following;
    - Intrauterine insemination (IUI);
    - Intracervical insemination (ICI);
    - Intravaginal insemination (IVI);
- Sperm preparation/washing for artificial insemination;

[†]Please consult plan documents for details regarding pharmacy coverage.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member, and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results, and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply, and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

NOTE: After reviewing the relevant documentation, the Company reserves the right to apply this policy to the service, or procedure, supply, product, or accommodation performed or furnished regardless of how the service, or procedure, supply, product, or accommodation was coded by the Provider.

Approval or clearance by the U.S. Food and Drug Administration alone is not a basis for coverage.

Coverage may differ for Medicare Advantage plan members; please see any applicable national and/or local coverage determinations for details. This information may be available at the Centers for Medicare & Medicaid Services (CMS) website.

Sources of Information:

- Chambers GM, Harrison C, Raymer J, Petersen Raymer AK, Britt H, Chapman M, … Norman RJ. (2019). Infertility management in women and men attending primary care-patient characteristics, management actions and referrals. *Hum Reprod*, *34*(11):2173–2183.
- Salem W. (2024). Assisted reproductive technology: Pregnancy and maternal outcomes. Lockwood CJ and Barbieri RL, eds. UpToDate. Waltham, MA: UpToDate Inc. http://www.uptodate.com. Accessed on October 15, 2024.

Applicable Code(s):	
CPT:	**58321, 58322, 58323, 89259, 89260, 89261, 89343, 89353,**
HCPCS:	**G0027, J0725, J3355, S0122, S0126, S0128, S0132, S4026, S4028, S4030, S4031, S4035, S4042**
ICD10 Procedure Codes:	**3E0P7LZ, 8E0VX63**