Infertility Treatment Services
Medical Policy

File Name: Infertility Treatment Services
File Code: 4.01.VT201
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Description/Summary

Infertility is the condition of an individual who is unable to conceive or produce conception. This may be related to biological female factors (i.e., pelvic adhesions, ovarian dysfunction, endometriosis, prior tubal ligation, etc.), biological male factors (i.e., abnormalities in sperm production, function or transport, prior vasectomy, etc.), a combination of both biological male and biological female factors, and unknown causes.

Definitions

Gender Descriptions:
The term biological female used in this policy refers to members with two X chromosomes (or no Y chromosome) and includes members with gender identities other than female.

The term biological male used in this policy refers to members with XY chromosomes and includes members with gender identities other than male.

In this policy, the terms biological female and biological male are used to clarify the reproductive capacity of the member and are not meant to exclude members with other gender identities/expressions.

Artificial means of conception- This includes any means of attempting pregnancy that does not involve sexual intercourse.

Artificial Insemination (AI) – Is an artificial means of conception, a procedure when viable sperm (from a biological female's partner or donor) is mechanically injected into the vagina, cervix or uterus for the purpose of producing a pregnancy.

Gamete Intra-fallopian Transfer (GIFT) – Is a procedure in which unfertilized eggs and sperm are placed together in the biological female's fallopian tubes, with fertilization

taking place in the tube instead of a laboratory dish.

In Vitro Fertilization (IVF) - In vitro fertilization (IVF) is a method of assisted reproduction that involves combining an egg with sperm in a laboratory dish. If the egg fertilizes and begins cell division, the resulting embryo is transferred into the biological female’s uterus with the intention to implant in the uterine lining and further develop. IVF bypasses the fallopian tubes and is usually the treatment choice for biological females who have badly damaged or absent tubes.

Zygote Intra-fallopian Transfer (ZIFT) - In ZIFT an egg is fertilized in the laboratory and the zygote is transferred to the fallopian tube at the pronuclear stage before cell division takes place. The eggs are retrieved and fertilized on one day and the embryo is transferred the following day.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.

Attachment I- CPT®/ HCPCS coding table & Instructions

Coverage is subjected to the provisions and limitations specified in the plan documents.

Diagnostic testing and evaluation for infertility are not subject to the provisions of this policy.

Services may be eligible for benefits as outlined in the remainder of this policy and in accordance with the criteria below.

ALL of the following criteria must be met for consideration of coverage:

1. Infertility diagnosis has been established by one of the following:

    - For purposes of this policy, a member is considered infertile if they are unable to conceive or produce conception after 1 year of egg-sperm contact when the biological female attempting conception is under 35 years of age, **or** after 6 months of egg-sperm contact when the biological female attempting conception is 35 years of age or older. Egg-sperm contact can be achieved by frequent sexual intercourse or through monthly cycles of timed sperm insemination (intrauterine, intracervical, or intravaginal). This definition applies to all individuals regardless of sexual orientation or the presence or availability of a reproductive partner; **OR**
    - Infertility may also be established by the demonstration of a disease of the reproductive tract such that timed egg-sperm contact would be ineffective; **OR**
    - With Medical Director review, a medically diagnosed condition that establishes the inability to conceive; i.e.

- Partner has had vasectomy, regardless of member's infertility status; **OR**
- Vasectomy reversal and six months unprotected intercourse, without a successful pregnancy; **OR**
- If member has had a child previously through IUI or IVF after diagnosis of infertility, there is no waiting period to be approved for additional infertility benefits.

2. Biological female less than 44 years of age at time of service
   - (exception: < = 49 years for drugs and/or donor gamete)

3. All services must be conducted in accordance with guidelines established by the American Society for Reproductive Medicine (ASRM).

The following services are eligible when the above criteria are met and the member has seen a Blue Cross VT Plan in-network reproductive endocrinology or infertility specialist:

- Artificial Insemination with donor sperm (AI);
- Assisted Hatching;
- Cryopreservation; oocyte(s);
- Intra-cystoplasmic sperm injection (ICSI);
- Intrauterine Insemination (IUI);
- In Vitro Fertilization (IVF), including donor oocyte fertilization, up to 4 cycles;
- Pharmaceuticals associated with a covered service;
- Pre-implantation genetic diagnosis (PGD) for single cell disorders;
- Ovulation induction, with or without IUI, for unexplained infertility, biological male factor infertility or anovulatory infertility;
- Oocyte and sperm storage;
- Oocyte stimulation and retrieval.

With medical director review, a medically diagnosed condition that establishes a need for preconception genetic testing of the embryo according to the Blue Cross Blue Shield Association BCBSA medical policy will meet the criteria for medical necessity of the IVF services.

When a service is considered a benefit exclusion and therefore not covered

- Vasovasostomy or vasovasorrhaphy
- Donor or surrogate medical care, expenses and specimens.
- Gamete Intra-fallopian Transfer (GIFT)
- Zygote Intra-fallopian Transfer (ZIFT)

Reference Resources:

1. Practice Committee of the American Society of Reproductive Medicine Fertility and

Sterility (2020). *Definitions of Infertility and Recurrent Pregnancy Loss*. 90, Suppl: 3, S60.

Document Precedence

Blue Cross and Blue Shield of Vermont (Blue Cross VT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, Blue Cross VT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, Blue Cross VT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Infertility benefits are limited to a lifetime maximum of $15,000.00. Any member responsibility relative to eligible services, such as deductibles and copays, coinsurance, does not apply to the benefit maximum.

Prior approval is required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered compete, see policy guidelines above.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group,

benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

01/2020	New policy
09/2020	Added code 89354 to coding table requiring prior approval.
01/2021	Deleted code 0058T effective 01/01/2021
11/2022	Policy reviewed. Updated language in the infertility diagnosis section of the medical policy to further define when a person is considered infertile criteria. References updated.
10/2023	Policy reviewed. No changes to policy statement.
12/2024	Policy reviewed. Language change to "biological female" and "biological male" to clarify reproductive capacity across different gender identities/expressions. No changes to policy statement criteria or intent. Formatting changes for clarity and consistency.
04/2025	Policy reviewed. No changes to policy statement.
04/2026	Policy reviewed. No changes to policy statement.

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by Blue Cross VT Medical Directors

Tom Weigel, MD, MBA
Vice President and Chief Medical Officer

Attachment I

CPT®/ HCPCS coding table & Instructions

Code Type	Number	Description
The following codes will be considered medically necessary when applicable criteria have been met & Prior Approval has been obtained.		
CPT®	58321	Artificial insemination; intra-cervical
CPT®	58322	Artificial insemination; intra-uterine
CPT®	58323	Sperm washing for artificial insemination
CPT®	58672	Laparoscopy, surgical; with fimbrioplasty
CPT®	58673	Laparoscopy, surgical; with salpingostomy (salpingoneostomy)
CPT®	58760	Fimbrioplasty
CPT®	58770	Salpingostomy
CPT®	58970	Follicle puncture for oocyte retrieval, any method
CPT®	58974	Embryo transfer, intrauterine
CPT®	76948	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation
CPT®	89250	Culture of oocyte(s)/embryo(s), less than 4 days;
CPT®	89251	Culture of oocyte(s)/embryo(s), less than 4 days; with c-culture of oocyte(s)/ embryo(s)
CPT®	89253	Assisted embryo hatching, microtechniques (any method)
CPT®	89254	Oocyte identification from follicular fluid
CPT®	89255	Preparation of embryo for transfer (any method)
CPT®	89257	Sperm identification from aspiration (other than seminal fluid)
CPT®	89258	Cryopreservation; embryo(s)
CPT®	89259	Cryopreservation; sperm
CPT®	89260	Sperm isolation; simple prep (eg, sperm wash and swim-up) for insemination or diagnosis with semen analysis
CPT®	89261	Sperm isolation; complex prep (eg, Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis
CPT®	89268	Insemination of oocytes
CPT®	89280	Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes
CPT®	89281	Assisted oocyte fertilization, microtechnique; greater than 10 oocytes

CPT®	89290	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre- implantation genetic diagnosis); less than or equal to 5 embryos
CPT®	89291	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre- implantation genetic diagnosis); greater than 5 embryos
CPT®	89337	Cryopreservation, mature oocyte(s)
CPT®	89342	Storage (per year); embryo(s)
CPT®	89343	Storage (per year); sperm/semen
CPT®	89352	Thawing of cryopreserved; embryo(s)
CPT®	89353	Thawing of cryopreserved; sperm/semen, each aliquot
CPT®	89354	Thawing of cryopreserved; reproductive tissue, testicular/ovarian
HCPCS	J0725	Injection, chorionic gonadotropin, per 1,000 USP units
HCPCS	J3355	Injection, urofollitropin, 75 IU
HCPCS	S0122	Injection, menotropins, 75 IU
HCPCS	S0126	Injection, follitropin alfa, 75 IU
HCPCS	S0128	Injection, follitropin beta, 75 IU
The Following Codes will be Considered Benefit Exclusions and Therefore Non-Covered.		
CPT®	55400	Vasovasostomy, vasovasorrhaphy
CPT®	58976	Gamete, zygote or embryo intrafallopian transfer, any method
HCPCS	S4013	Complete cycle, gamete intrafallopian transfer (GIFT)
HCPCS	S4014	Complete cycle, zygote intrafallopian transfer (ZIFT)