Subject: Infertility - Therapeutic*

Effective Date: May 28, 2002

Department(s): Utilization Management

Policy: Therapeutic management of infertility is a covered benefit under QualCare, Inc., if specified by the Plan design.

Coverage of females under this policy is limited to those 45 years of age or younger.

Objective: To ensure proper and consistent reimbursement and to delineate criteria for coverage of elements of the management of a specific type of medical problem.

Definitions:

A. For the purposes of this Policy and Procedure, the term “infertility” shall mean one of the following:

1. the inability to impregnate another person;
   \[\text{OR}\]
2. the inability of an opposite-sex couple to achieve conception after one year of unprotected intercourse; or, if the female is over the age of 35 years, after six months of unprotected intercourse;
   \[\text{OR}\]
3. the inability to carry a pregnancy to live birth;
   \[\text{OR}\]
4. The inability of a woman to achieve conception after six trials of medically supervised artificial insemination over a one-year period.
B. A “cycle” shall mean an ovulatory interval that includes at least one completed egg retrieval.

ICD-9 Codes Commonly Indicating Infertility include but are not limited to the following:

Female:

- **614.1, N70.11-N70.13** Chronic salpingitis and oophoritis
- **617.0-617.9; N80-N80.9** Endometriosis
- **614.6, N73.6** Pelvic peritoneal adhesions, female
- **614.9, N73.5, N73.9** Unspecified inflammatory disease of female pelvic organs and tissues
- **218.0-218.2, 218.9, D25.0 D25.2, D25.9** Uterine Leiomyoma
- **253.1, E22.1, E22.8, E22.9** Other and Unspecified Anterior Pituitary Hyperfunction
- **253.2, E23.0** Panhypopituitarism
- **253.4, E23.6** Other Anterior Pituitary Disorders
- **253.8, E24.1** Other Disorders of the Pituitary and Other Syndromes
- **256.0-256.2, E28.0, E28.1, E28.8, E89.40, E89.41** Ovarian Dysfunction
- **256.31, 256.39, E28.310, E28.319, E28.39** Other Ovarian Failure
- **256.4, E28.2** Polycystic Ovarian Disease
259.9, E34.9  Other Endocrine Disorders

628.0, N97.0  Infertility, Female, Associated with Anovulation

628.1, E23.0  Infertility, Female, of Pituitary/Hypothalamic Origin

628.2, N97.1  Infertility, Female, of Tubal Origin

628.3, N97.2  Infertility, Female, of Uterine Origin

628.4, N97.8  Infertility, Female, of Cervical or Vaginal Origin

628.8  Infertility, Female, of Other Specified Origin

628.9, N97.9  Infertility, Female, of Other Unspecified Origin

Male:

606  Infertility, Male

606.0, N46.021-N46.025

N46.029  Azoospermia

606.1, N46.11,

N46.121-N46.125, N46.129  Oligospermia

606.8, N46.029  Infertility Due to Extratesticular Causes

606.9, N46.8 , N46.9  Male Infertility, Unspecified

Procedure:  1. Coverage includes, but is not limited to, the following therapeutic services related to infertility:

a. in the female
1. medications, including ovulatory stimulation and/or induction
2. surgery
  ♦ hysteroscopy
    58558 – with polypectomy
    58559 – with lysis of adhesions
    58560 – with division or resection of intrauterine septum
    58561 – with removal of leiomyomata
  ♦ laparoscopy
    49322 – with aspiration of cavity or cyst
    58660 – with lysis of adhesions
    58661 – with removal of adnexal structures (partial or total)
    58662 – with excision of lesions
  ♦ vaginal surgery
    57130 – excision of vaginal septum
  ♦ drainage
    58820 – ovarian abscess, vaginal approach
    58822 – ovarian abscess, abdominal approach
    58800 – ovarian cyst, unilateral or bilateral, vaginal approach
    58805 – ovarian cyst, unilateral or bilateral, abdominal approach
    58823 – pelvic abscess, transvaginal, transrectal, percutaneous
  ♦ ovarian
    58920 – wedge resection or bisection, unilateral or bilateral
3. in vitro fertilization (IVF)*
   58970 – follicle puncture for oocyte retrieval
4. embryo transfer*
   58974 – embryo transfer, intrauterine
5. artificial insemination
   58321 – intra-cervical
   58322 – intra-uterine
   58323 – sperm washing
6. gamete intra-fallopian transfer (GIFT)*
   zygote intra-fallopian transfer (ZIFT)*
58976 – GIFT or ZIFT
7. intracytoplasmic sperm injection (ICSI)*
   89252 – assisted oocyte fertilization, microtechnique (any method)
8. four completed egg retrievals* per lifetime of the covered female.
9. anesthesia
   00840 – anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified

b. in the male
1. varicocele repair
   55530 – Excision of varicocele or ligation of spermatic veins for varicocele
   55535 – Excision of varicocele or ligation of spermatic veins for varicocele, abdominal approach
   55550 – Laparoscopy, surgical, with ligation of spermatic veins for varicocele
2. correction of ejaculatory system problems, except for reversal of voluntary sterilization procedures
3. repair of epididymis
   54860 – epididymectomy, unilateral
   54861 – epididymectomy, bilateral
   54900 – epididymovasostomy, unilateral
   54901 – epididymovasostomy, bilateral
4. repair of vas deferens
   55400 – vasovasostomy, vasovasorrhaphy
5. testicular surgery
   54640 – orchiopexy, inguinal approach, with or without hernia repair
   54650 – orchiopexy, abdominal approach, for intra-abdominal testis

2. Coverage for in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) shall be limited to a member who
a. has used all reasonable, less expensive and medically appropriate treatments and is still unable to become pregnant or carry a pregnancy AND
b. has not reached the limit of four completed egg retrievals

3. GIFT, ZIFT, ICSI, and IVF services provided under this Policy and Procedure shall be performed at facilities that conform to standards established by the American Society for Reproductive Medicine (ASRM) or the American College of Obstetricians and Gynecologists.

4. To be reimbursed, services indicated by the asterisk (*), covered under this Policy and Procedure, must be received from Board Certified or Board Eligible Reproductive Endocrinologists who are members of the Society of Assisted Reproductive Technology (SART).

5. For infertility laboratory work, only services performed at embryology laboratories which are SART and ASRM/CAP certified (or if a New York laboratory, which are NY State certified IVF laboratories) will be reimbursed.

6. Medical expenses of egg and sperm donors in connection with the management of infertility are covered to the extent that benefits remain and are available under the recipient’s Plan.

7. The following infertility services are not covered:
   a. reversal of voluntary sterilization procedures:
      ♦ reversal of vasectomy or tubal ligation
      ♦ infertility services provided to members who have had sterilization procedures;

   7. The following infertility services are not covered (continued):
      b. cryopreservation of eggs;
      c. psychiatric sex therapy;
      d. surrogacy;
e. home ovulation, pregnancy or sperm testing supplies;

f. mock transfers;

g. more than four lifetime egg retrievals

h. more than one attempt of cryopreserved embryo transfer per egg retrieval;

i. maintenance/storage of frozen embryos, eggs or semen;

j. more than five attempts at artificial insemination;

k. provision of infertility services to members without documented impairment of fertility;

l. provision of infertility services to non-members.

8. Dollar limits may be specified by the individual Plan.

9. Drug treatment in connection with this Policy and Procedure is covered under the Plan’s pharmacy benefit, if one is part of the Plan, and may be subject to separate dollar limits.

References


State of New Jersey, 209th Legislature, S-1076/A-1862, signed by Acting Governor Donald T. DiFrancesco, August 31, 2001

State of New Jersey Department of Banking and Insurance, Bulletin No. 02-09, Compliance with Mandated Infertility Benefit (P.L. 2001, c. 236), May 9, 2002

*Consistent with Summary Plan Description (SPD). When there is discordance between this policy and the SPD, the provisions of the SPD prevail.*