

**Subject: Infertility Services- Connecticut****Definition:**

Infertility is the condition of an individual who is unable to conceive or produce conception during a period of one year (if the female is age 35 years or younger), or during a period of 6 months (if the female is over age 35).

- For purposes of meeting Harvard Pilgrim Health Care (HPHC) criteria, if a woman conceives but is unable to carry the pregnancy to live birth, the period of time spent attempting to conceive prior to achieving that pregnancy is included in the calculation of the one year (for females age 35 or younger) or 6-month (for females over age 35 years) period described above.

For women without male partners or exposure to sperm, infertility is the inability to conceive after 6 cycles of Artificial Insemination or Intrauterine Insemination performed by a qualified specialist using normal quality Donor Sperm.

- These 6 cycles (including Donor Sperm) are not covered by HPHC as a diagnosis of infertility cannot be established until after the AI/IUI cycles have been completed.

**Authorization:**

Prior authorization is required for the following infertility services provided to members enrolled in Core (HMO, POS and PPO) products:

- Artificial Insemination (AI)/ Intrauterine Insemination (IUI)
- Collection, storage, cryopreservation, and banking of sperm, eggs (oocytes), or embryos
- Donor Eggs
- Donor sperm
- Embryo Transfer
- Frozen Embryo Transfer (FET)
- Gamete Intra-Fallopian Transfer (GIFT)
- Intra-Cytoplasmic Sperm Injection (ICSI)
- In-Vitro fertilization (IVF) including conversion from IUI to an IVF cycle
- Microsurgical Epididymal Sperm Aspiration (MESA)
- Single Embryo Transfer (SET)
- Testicular Sperm Extraction (TESE)
- Zygote intra-fallopian transfer (ZIFT)

Prior authorization is also required for out-of-network Assisted Hatching services provided to members enrolled in PPO/POS products.

**In-network providers should submit authorization requests on HPHC's Infertility Services Precert and IVF Cycle Summary forms. Forms can be found on HPHC's Provider Site:**

**<https://www.harvardpilgrim.org>**

**Policy and Coverage Criteria:**

Harvard Pilgrim Health Care (HPHC) Infertility benefits include coverage for non-experimental infertility services that are medically necessary to diagnose and/or treat medical infertility when such treatment is reasonably likely

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(i.e. with greater than 5% probability) to result in viable offspring. Covered services include, but are not limited to:

- Specialist consultation (PCP referral required for HMO members)
- Diagnostic services (e.g. lab work, hysterosalpingograms, laparoscopies, ultrasound) that are medically necessary to assess infertility.
- Infertility services and procedures (i.e., Ovulation Induction, Intrauterine Insemination, Uterine Embryo Leverage, Frozen Embryo Transfer, Gamete Intra-Fallopian Transfer, Zygote Intra-Fallopian Transfer, In-Vitro fertilization, and Low Tubal Ovum Transfer)
- Medically necessary prescription drugs.
  - Self-administered drugs including ovulatory injections (e.g., HCG) are covered only for members with HPHC prescription drug coverage, who are in an active, authorized cycle of infertility treatment.

**Covered infertility treatment or procedures must be performed at facilities that conform to standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility.**

HPHC considers the individual's medical history when making coverage determinations, and generally does not authorize infertility treatment or related services for members in whom fertility is not naturally expected and who do not meet our general eligibility criteria.

Coverage for medically necessary Infertility services is limited to the following maximum benefit cycles:

- Coverage for Ovulation Induction is limited to a benefit maximum of 4 cycles.
- Coverage for Intrauterine Insemination (IUI) services is limited to a benefit maximum of 3 cycles.
- Coverage for IVF services (including in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer or low tubal ovum transfer) is limited to a benefit maximum of 2 cycles.
  - HPHC covers no more than 2 embryo implantations per cycle; each such fertilization or transfer shall be credited toward such maximum as one cycle.

Infertility Services are authorized for eligible members who meet applicable General Eligibility Criteria and relevant Service-Specific criteria (listed below).

1. The member is an individual in whom fertility would naturally be expected, and has a documented history of Infertility (as defined above).
2. Documentation of Ovarian Reserve Assessment (i.e., results of a day 3 Follicle-Stimulating Hormone [FSH] test and Estradiol levels) obtained within the past year is submitted.
  - For women aged 40 and older, documentation of adequate ovarian reserve, confirmed by ANY of the following is required:
    - Clomiphene Citrate Challenge Test (CCCT) performed within the past 6 months with BOTH:
      - Day 3 and Day 10 FSH levels less than 15 milli international units per milliliter (mIU/ml) and
      - Day 3 Estradiol level less than 100 picograms per milliliter (pg/ml)
    - CCCT performed within the past 12 months with ALL:
      - Day 3 and Day 10 FSH levels less than 15mIU/ml and
      - Day 3 Estradiol level <100 pg/ml and
      - Day 3 FSH level <15 mIU/ml and
      - Day 3 Estradiol level <100 pg/m within the past 6 months

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- Normal Anti-Mullerian Hormone (AMH) level, and documentation confirming the member is unable to take (or tolerate) Clomid.

**Women over age 40 with ANY history of Day 3 or Day 10 FSH >15 remain eligible for coverage of the transfer of frozen embryos created prior to the abnormal test finding, but are not eligible for ANY further assisted reproduction treatments.**

3. Documentation confirms adequate ovarian response to stimulation (i.e., 2 follicles >12 mm diameter for IUI, or at least 3 follicles >12 mm diameter for IVF) to any monitored, medicated-stimulated infertility treatments provided within the past six months.
4. The female member’s Body Mass Index (BMI) is submitted with the request for infertility services.
  - If reported BMI is 30 or higher, the patient must be counseled to lose weight prior to approval of coverage of infertility services, and educated about the adverse effects of an elevated BMI (e.g., impact on fertility and fertility treatment success, obstetrical risks including diabetes and hypertension, potential anesthesia complications, poorer fetal outcomes).
  - If reported BMI is 35 or higher, there must also be documentation of a nutrition consult within the past 6 months, including documented history of previous weight loss attempts.
5. If there is a male partner, results of a semen analysis performed within the past year, are submitted prior to the initial approval of infertility services, and demonstrate normal fertility threshold.
  - If the initial semen analysis is abnormal, a second sample (obtained within the past year) must be submitted; if the second sample is abnormal, the REI specialist may request a urology consult for further evaluation.
  - If the male partner has undergone vasectomy reversal, results of 2 consecutive semen analyses performed within 3 months of the initial request for infertility services must be submitted and demonstrate a normal fertility threshold. The couple must also meet Service-Specific Criteria for Reversal of Prior Sterilization.
6. There is a greater than 5% probability, based on the individual woman’s clinical history (including diagnosis, menopausal status, response to and outcomes of previous infertility treatment) that infertility treatment using the member’s own eggs will result in a live birth.
  - For women with a diagnosis of premature ovarian failure (POF), premature diminished ovarian reserve, or premature menopause, there must be evidence that, absent such a diagnosis, the member would be an individual in whom fertility would naturally be expected, and infertility treatment would have greater than 5% probability of success.

**Service-Specific Criteria**

Service	Criteria
<p><b>Artificial Insemination (AI)</b></p> <p><b>Intrauterine Insemination (IUI)</b></p> <p><b>Coverage for IUI is limited to a maximum of 3 cycles.</b></p>	<p>Authorized (within benefit limits described above) when General Eligibility Criteria are met, and there is documentation of:</p> <ol style="list-style-type: none"> <li>1. Hysterosalpingogram, laparoscopic chromotubation with hysteroscopy, or definitive sonohysterosalpingogram (e.g., FemVue, HyCoSy) <u>within the past 4 years</u> confirming the presence of all the following:               <ul style="list-style-type: none"> <li>• At least one patent Fallopian tube</li> <li>• Normal ipsilateral ovary</li> <li>• Normal endometrial cavity</li> </ul> </li> </ol>

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Service	Criteria
	<p>2. Spontaneous ovulation or normal ovarian reserve testing</p> <p>3. Any of the following:</p> <ul style="list-style-type: none"> <li>• Unexplained infertility</li> <li>• Polycystic Ovary Syndrome (PCOS), anovulation, or oligoovulation</li> <li>• Mild to moderate endometriosis</li> <li>• Cervical factors</li> <li>• Mild to moderate male factor infertility <ul style="list-style-type: none"> <li>○ There must be documentation confirming infertility cannot be improved through standard conservative treatment.</li> </ul> </li> <li>• Use of stored sperm from male members who, subsequent to active infertility treatment, required sperm banking/storage as a result of medical treatment (e.g., cancer treatment) likely to cause infertility.</li> </ul> <p>Results of prior IUI cycles must be submitted with each request, and demonstrate ALL the following:</p> <ol style="list-style-type: none"> <li>1. Adequate ovarian response to stimulation (i.e. at least 2 follicles &gt;12 mm diameter for any monitored IUI using standard medication doses);</li> <li>2. Adequate fresh semen and post wash semen parameters in order to continue with IUI.</li> </ol>
<p><b>IUI After IVF</b></p> <p><b>Coverage for IUI is limited to a benefit maximum of 3 cycles.</b></p>	<p>In the absence of an intervening live birth, subsequent IUI cycles are not authorized for members who have unsuccessfully undergone IVF for infertility treatment when further IVF cycles do not meet HPHC medical necessity criteria.</p> <ul style="list-style-type: none"> <li>• IUI after IUI-to-IVF conversion for hyperstimulation may be authorized if the stimulation that was initially given is reduced.</li> <li>• IUI after IVF/ICSI/Preimplantation Genetic Testing (PGT) may be authorized for couples with a male genetic disorder who opt to use donor sperm after IVF/ICSI/PGT if the female member meets IUI criteria.</li> </ul>
<p><b>Conversion from IUI to IVF</b></p>	<p>Authorized when the current IUI cycle has resulted in ALL:</p> <ol style="list-style-type: none"> <li>1. Estradiol level of <math>\geq 800</math> pg/ml; AND</li> <li>2. Production of at least 5 follicles &gt;12 mm in diameter.</li> </ol>
<p><b>In Vitro Fertilization</b></p> <p><b>Coverage for IVF services is limited to a benefit maximum of 2 cycles.</b></p> <p><b>HPHC does not deny coverage for medically necessary IVF services for any member who foregoes a particular infertility treatment or</b></p>	<p>Results of prior IUI cycles must be submitted with each IVF request (initial and subsequent requests).</p> <p>Results must demonstrate an adequate response to each cycle (i.e., at least 3 follicles &gt;12 mm diameter for IVF, and adequate embryo numbers and quality for transfer), and adequate fresh semen and post wash semen parameters.</p> <ul style="list-style-type: none"> <li>• In addition, there must be documentation confirming the female member requesting IVF has undergone hysterosalpingogram,</li> </ul>

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Service	Criteria
<p><b>procedure if her physician determines that such treatment or procedure is likely to be unsuccessful.</b></p>	<p>sonohistogram, sonohysterosalpingogram (e.g., FemVue, HyCoSy), <b>or</b> hysteroscopy (to establish uterine contours) within the past 4 years.</p> <ul style="list-style-type: none"> <li>• Members &lt; 35 years of age are required to have SET during the first two IVF treatment cycles with more than one top-quality embryo available for transfer;</li> <li>• Members 35 to 38 years of age are required to have SET for the first IVF cycle if there is more than one top-quality embryo available for transfer from a fresh cycle, OR 1 top-quality frozen embryo after thawing;</li> <li>• Members &lt;38 years of age with a documented live birth from IVF treatment are required to have SET for one treatment/cycle if there are more than one top-quality embryos available from a fresh cycle, OR 1 top-quality frozen embryo after thawing;</li> <li>• Members 38 years of age and older undergoing authorized IVF cycles are NOT required to undergo SET as the risk for multiples is low.</li> </ul> <p>IVF services are authorized when relevant General Eligibility Criteria (above) are met, and there is documentation confirming ANY of the following:</p> <ul style="list-style-type: none"> <li>• History of failed medicated IUI cycles when IUI criteria (above) have been met;</li> <li>• Female member with bilateral Fallopian tube absence (excluding prior elective sterilization) or bilateral Fallopian tube obstruction due to prior tubal disease with history of failed conventional therapy;</li> <li>• Female member with severe endometriosis and history of failed medical and surgical therapy;</li> <li>• Male member with severe male factor infertility has been evaluated by a urologist who confirms condition cannot be improved by standard conservative treatment(s), and cannot be addressed via IUI.</li> </ul>
<p><b>IVF for Women Without Male Partners or Exposure to Sperm</b></p> <p><b>Coverage for IVF services is limited to a benefit maximum of 2 cycles.</b></p>	<p>Documentation confirms a female without a male partner or exposure to sperm has failed 6 consecutive AI/IUI cycles using normal donor sperm.</p> <p>The female must also meet Service-Specific Criteria for IVF including documentation of a history of failed medicated IUI cycles.</p> <p>Age-related embryo transfer requirements outlined in the Service-specific criteria for IVF also apply</p>
<p><b>Gamete Intrafallopian Transfer (GIFT)</b></p>	<p>Authorized for members who have one normal patent Fallopian tube, <u>and</u> meet IVF criteria (above).</p>

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<p><b>Zygote intrafallopian transfer (ZIFT)</b></p> <p><b>Coverage for IVF services is limited to a benefit maximum of 2 cycles.</b></p> <p><b>HPHC does not deny coverage for medically necessary IVF services for any member who foregoes a particular infertility treatment or procedure if her physician determines that such treatment or procedure is likely to be unsuccessful.</b></p>	
<p><b>Donor Egg (Donor Oocyte)</b></p> <p><b>Non-medical services related to donor egg procurement (e.g., finder fees, broker fees, legal fees) are not covered.</b></p>	<p>Donor egg procedures are authorized when General Eligibility Criteria (above) are met, and there is documentation of ANY of the following:</p> <ul style="list-style-type: none"> <li>• Congenital or surgical absence of ovaries</li> <li>• Premature ovarian failure or premature menopause in women under age 40 years</li> <li>• Premature diminished ovarian reserve (i.e., FSH <math>\geq</math>15 in women under age 40 years)</li> <li>• Inadequate ovarian response (i.e., fewer than 3 follicles &gt;12 mm diameter), or inadequate embryo numbers and quality, during authorized IVF cycles within the prior 6 months.</li> </ul> <p>When donor egg criteria are met, a donor egg cycle is authorized for up to 6 months.</p> <ul style="list-style-type: none"> <li>• A SET is required for members &lt; 35 years of age for the first two approved donor egg IVF treatment cycles with more than one top-quality embryo available for transfer;</li> <li>• If the donor egg procedure is not performed within 6 months, the member must be reevaluated and continue to meet HPHC criteria for infertility services and donor egg procedures before additional services are authorized.</li> </ul> <p>For female members (embryo recipients) without HPHC prescription drug coverage, coverage for the egg donor is limited to monitoring (up to egg retrieval), and the egg retrieval procedure.</p> <ul style="list-style-type: none"> <li>• For embryo recipients with HPHC prescription drug coverage, medications to stimulate the donor's ovaries, and to induce ovulation, are covered.</li> </ul> <p>After proceeding to a donor egg cycle, further IVF cycles using the member's eggs are not authorized.</p>
<p><b>Intracytoplasmic Sperm Injection (ICSI)</b></p>	<p>Authorized (in conjunction with IVF) to treat sperm-related infertility problems in the male partner when the use of ICSI is expected (with a greater than 5% probability) to result in a live birth, and there is</p>

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<b>ICSI is not authorized for any IVF cycle involving use of donor sperm, or solely to perform Preimplantation Genetic Testing (PGT) when HPHC's PGT criteria are not met.</b>	documentation of ANY of the following: <ul style="list-style-type: none"> <li>Severe male factor infertility that cannot be overcome by IVF</li> <li>Less than 50% fertilization (for mature eggs) on a prior IVF cycle with drop insemination</li> <li>Obstruction of the male reproductive tract unrelated to prior sterilization or sterilization reversal, and not amenable to repair (necessitating sperm retrieval via Microsurgical Epididymal Sperm Aspiration)</li> <li>Nonobstructive azospermia (necessitating sperm retrieval via Testicular Sperm Extraction)</li> </ul>
<b>Assisted Hatching (AH)</b>	Authorized as part of an IVF or Frozen Embryo Transfer (FET) procedure when documentation confirms ANY of the following: <ul style="list-style-type: none"> <li>Failed IVF cycles that produced 3 or more morphologically high quality embryos, with failure to implant after embryo transfer; OR</li> <li>Prior pregnancy resulting from IVF that required assisted hatching;</li> <li>Planned transfer of a frozen-thawed embryo.</li> </ul>
<b>Donor Sperm</b>	Normal quality donor sperm is authorized when documentation (by ANY of the following) confirms male factor infertility: <ul style="list-style-type: none"> <li>Bilateral congenital absence of vas deferens (BCAVD)</li> <li>Non-obstructive Azoospermia confirmed through MESA/TESE results</li> <li>Previous radiation or chemotherapy treatment resulting in abnormal semen analyses</li> <li>Two or more abnormal semen analyses at least 30 days apart</li> <li>Inadequate fertilization rates despite use of ICSI</li> </ul> <p>Normal quality donor sperm may also be authorized <u>in lieu of Preimplantation Genetic Testing (PGT)</u> for couples who meet HPHC's PGT Medical Review Criteria due to the male partner's genetic abnormality. A diagnosis of infertility is not required if PGT criteria are met.</p>
<b>Microsurgical Epididymal Sperm Aspiration (MESA)</b>	Authorized for male members with documented congenital absence or obstruction, or traumatic obstruction, of the vas deferens. <ul style="list-style-type: none"> <li>Excludes obstruction resulting from prior sterilization or sterilization reversal procedures.</li> </ul>
<b>Testicular Sperm Extraction (TESE)</b> <b>Micro-TESE</b>	Authorized when documentation confirms a male member has documented non-obstructive azoospermia, or has failed a prior MESA procedure.
<b>Sperm Collection and Cryopreservation including up to one year of storage</b>	Authorized for male members when documentation confirms ANY of the following: <ul style="list-style-type: none"> <li>Need for frozen back-up sperm because of unreliable ability to produce adequate or useful sperm on the day of ovulation;</li> <li>Sperm was recovered through MESA or TESE;</li> </ul>

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	<ul style="list-style-type: none"> <li>• Member is undergoing medical treatment (e.g., cancer treatment) that is likely to result in infertility. <ul style="list-style-type: none"> <li>○ Members who are undergoing medical treatment that is likely to result in infertility, and are not in active treatment for infertility, are not required to meet General Eligibility Criteria for Infertility Services.</li> </ul> </li> </ul>
<p><b>Cryopreservation of Eggs and/or Embryos including retrieval and up to one year of storage</b></p>	<p><u>For women in active (authorized) infertility treatment:</u> Authorized for any embryos remaining after an authorized IVF cycle.</p> <ul style="list-style-type: none"> <li>• Cryopreserved embryos must be used before additional (fresh) IVF cycles using the member's or a donor's eggs are authorized if: <ul style="list-style-type: none"> <li>○ A woman up to age 35 years has 2 or more cryopreserved embryos; or</li> <li>○ A woman age 35 years or older has 4 or more cryopreserved embryos.</li> </ul> </li> </ul> <p>Requests for authorization of a Frozen Embryo Transfer_(FET) cycle must meet General Eligibility Criteria (above) at the time of the request for the FET.</p> <p><b>NOTE: HPHC will also cover cryopreservation, and up to one year of storage, of mature eggs from an authorized IVF cycle when there is an unexpected lack of sperm for fertilization.</b></p> <p><u>For women who are not in active infertility treatment:</u> Authorized when documentation confirming the female member will be undergoing medical treatment (e.g., chemotherapy, radiation therapy) that is likely to result in infertility.</p> <ul style="list-style-type: none"> <li>• The member is not required to meet HPHC's General Eligibility Criteria for Infertility Services.</li> </ul> <p><u>For all women and/or couples who are requesting fertilization of eggs and cryopreservation of embryos, but not in active infertility treatment,:</u></p> <ul style="list-style-type: none"> <li>• Results of ovarian testing, and the male partner's semen analysis, must be submitted to assess the likelihood of embryo creation.</li> </ul>
<p><b>Cryopreservation of Eggs or Sperm (including retrieval and up to one year of storage) for Members Undergoing Gender Reassignment Treatment</b></p>	<p>Covered when documentation confirms a member with Gender Dysphoria will be undergoing covered Gender Reassignment treatment that is likely to result in infertility.</p> <ul style="list-style-type: none"> <li>• Documentation must confirm that member and provider(s) have discussed the impact of Gender Reassignment treatment on fertility and family planning.</li> </ul>
<p><b>Reversal of Prior Sterilization</b></p>	<p>Authorized for members who have undergone previous sterilization procedures (e.g., tubal ligation or vasectomy) and subsequent surgical reversal only when documentation confirms ALL the</p>

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	<p>following:</p> <ol style="list-style-type: none"> <li>1. The member/couple meets all applicable medical necessity criteria in this policy;</li> <li>2. The member has undergone a successful reversal procedure, and infertility is independent of the previous sterilization procedure;</li> <li>3. The successful reversal procedure has been followed by at least 6 months of attempting natural conception;</li> <li>4. There is documentation of either: <ul style="list-style-type: none"> <li>• For males, two consecutive semen analyses within 3 months of the request for infertility services demonstrating a normal fertility threshold (as noted in General Eligibility Criteria) and continued success of the reversal;</li> <li>• For females, post-surgery hysterosalpingogram (HSG) or chromotubation demonstrate unilateral or bilateral free spill tubal patency, and results of an HSG or chromotubation performed within the six months of the request for infertility services demonstrate that post-operative scarring and tubal blockage have not occurred.</li> </ul> </li> </ol>
<p><b>Surrogacy/Gestational Carriers</b></p> <p><b>HPHC does not cover:</b></p> <ul style="list-style-type: none"> <li>▪ <b>Use of donor egg with a gestational carrier as the HPHC member is not treated in this situation; or</b></li> <li>▪ <b>Cost(s) of implantation or other services (e.g., transfer, pre-pregnancy costs, cryopreservation of embryos) provided to a gestational carrier, regardless of whether or not the gestational carrier is an HPHC member.</b></li> </ul>	<p>One cycle of oocyte stimulation, retrieval, and fertilization is authorized for female members who:</p> <ul style="list-style-type: none"> <li>• Meet General Eligibility Criteria for Infertility Services, but are unable to carry a pregnancy due to an uncorrectable structural uterine abnormality or a life-threatening condition that precludes a safe pregnancy; AND</li> <li>• Are using their own oocytes and self-paying for a gestational carrier.</li> </ul>

**Exclusions:**

Harvard Pilgrim Health Care (HPHC) does not cover Infertility Services when criteria above are not met.

In addition, HPHC does not cover Infertility services for ANY of the following:

- Members without HPHC Infertility benefits
- Members are not medically infertile unless the member meets other HPHC criteria (e.g., PGT, sperm/egg banking and storage for a member who is undergoing medical treatment that is likely to result in infertility)
- Individuals who are not members (including partners, dependents, or other third parties), or services in which the member is not treated, or is not the intended recipient of the infertility services
- Infertility services (including but not limited to consultations, labs, radiology studies, infertility drugs, ART cycles, and other services to assess and/or treat infertility in a member or a member’s partner) requested

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as a result of a prior voluntary sterilization or unsuccessful sterilization reversal procedure unless there is documentation that infertility criteria are met

- Infertility services requested to treat effects that are due to natural aging, or for women who are menopausal
- Donor sperm:
  - In the absence of documented male factor infertility, or for genetic sperm defects in the male partner when the male partner is not an HPHC member
  - In the absence of a male partner
  - When the male partner has undergone vasectomy reversal and fails to meet the medical necessity criteria for infertility services for males with prior vasectomy with reversal
- Chromosome studies of a donor (sperm or egg)
- Infertility services in cases in which normal embryos have been or will be discarded because of gender selection
- ICSI for any IVF cycle involving use of donor sperm
- Any Advanced Reproductive Technology requested solely for PGT (e.g., IVF, ICSI) when PGT is not a covered benefit, or PGT criteria (above) are not met.
  - When PGT is not covered or not authorized, medically necessary Infertility services (including IVF and ICSI) may be authorized for members with Infertility benefits if service-specific criteria (above) are met.
- Treatments requested solely for the convenience, lifestyle, personal or religious preference of the member in the absence of medical necessity
- Treatment to reverse voluntary sterilization, or MESA/TESE, for a member who has undergone prior sterilization
- Supplies that may be purchased without a physician’s written order (e.g., ovulation test kits)
- Monitoring of non-authorized IUI cycles
- Services related to achieving pregnancy through a surrogate or gestational carrier except as described above
- Implantation or other services provided to a gestational carrier, including, but not limited to transfer, impending pregnancy costs or cryopreservation of embryos, whether or not the gestational carrier is an HPHC member
- Use of donor egg with gestational carrier even when the surrogate is a member of the health plan
- Charges for the storage of eggs, sperm or embryos that remain in storage after the completion of an approved series of infertility cycles, or more than 1 year after the cryopreservation (whichever is shorter)
- Service fees, charges or compensation for the recruitment of egg donors. (This exclusion does not include the charges related to the medical procedure of removing an egg for the purpose of donation when the recipient is a member of the Plan.)
- Infertility services when clinical documentation confirms an individual or couple are using illicit substances or abusing substances known to negatively interfere with fertility or fetal development (e.g. marijuana, opiates, cocaine, or alcohol).
  - Results of serum or urine drug screening may be requested before infertility services are authorized.

**Coding:**

**Codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible.**

CPT® Codes	Description
<b>89250</b>	Culture of oocyte(s)/embryo(s), less than 4 days
<b>89251</b>	Culture of oocyte(s)/embryo(s), less than 4 days; with co-culture of oocyte(s)/embryos

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<b>89253</b>	Assisted embryo hatching, microtechniques (any method)
<b>89254</b>	Oocyte identification from follicular fluid
<b>89255</b>	Preparation of embryo for transfer (any method)
<b>89258</b>	Cryopreservation; embryo(s)
<b>89259</b>	Cryopreservation; sperm
<b>89343</b>	Storage (per year); sperm/semen
<b>89346</b>	Storage (per year): oocyte(s)
<b>89352</b>	Thawing of cryopreserved; embryo(s)

<b>HCPCS Codes</b>	<b>Description</b>
<b>S4011</b>	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
<b>S4013</b>	Complete cycle, gamete intrafallopian transfer (GIFT), case rate
<b>S4014</b>	Complete cycle, zygote intrafallopian transfer (ZIFT), case rate
<b>S4015</b>	Complete in vitro fertilization cycle, not otherwise specified, case rate
<b>S4016</b>	Frozen in vitro fertilization cycle, case rate
<b>S4017</b>	Incomplete cycle, treatment cancelled prior to stimulation, case rate
<b>S4018</b>	Frozen embryo transfer procedure cancelled before transfer, case rate
<b>S4020</b>	In vitro fertilization procedure cancelled before aspiration, case rate
<b>S4021</b>	In vitro fertilization procedure cancelled after aspiration, case rate
<b>S4022</b>	Assisted oocyte fertilization, case rate
<b>S4026</b>	Procurement of donor sperm from sperm bank
<b>S4028</b>	Microsurgical epididymal sperm aspiration (MESA)

### State Mandate Information

<b>State/Mandate</b>	<b>Members Covered</b>
<b>Connecticut</b> <ul style="list-style-type: none"> <li>• <b>Bill No. 508 / Public Act No. 05-196</b></li> <li>• <b>Connecticut State Mandate: Sec. 38a-536.</b></li> </ul>	Members enrolled through CT employer groups in CT HMO (Open Access), PPO, and HDHP products.
<b>Massachusetts:</b> <b>176G §4 211 CMR 37.00</b>	All MA residents enrolled through Fully Insured Employer groups.  Please see Infertility Services Medical Review Criteria for UM and coverage information.
<b>Maine</b>	No mandate.
<b>New Hampshire</b>	No mandate.

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#### Infertility Services- Connecticut

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[https://www.asrm.org/uploadedFiles/ASRM\\_Content/News\\_and\\_Publications/Practice\\_Guidelines/Committee\\_Opinions/Definitions\\_of\\_infertility.pdf](https://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Committee_Opinions/Definitions_of_infertility.pdf)

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### Summary of Changes

Date	Revisions
<b>9/17</b>	Background updated
<b>9/28/16</b>	Added requirements for SET
<b>4/27/16</b>	Revise footnote re: cryopreservation and storage. (Approved off-line 5/2/16) Clarify that, for women without male partners or exposure to sperm seeking authorization for IVF, documentation must confirm failure after 6 <u>consecutive</u> AI/IUI cycles using normal donor sperm.
<b>4/13/16</b>	Added footnote clarifying coverage of cryopreserved eggs, sperm and embryos
<b>2/24/16</b>	Minor updates for compliance. Added age-related criteria for Ovarian Reserve Assessment
<b>10/28/15</b>	Removed language related to age and lifetime maximums; effective 1/1/16
<b>5/27/15</b>	Removed requirement that member to be treated must have maintained coverage under their HPHC policy for at least twelve months.
<b>3/11/15</b>	Clarify coverage for cryopreservation services for members undergoing Gender Reassignment treatment that is likely to render them infertile.
<b>2/25/15</b>	Language changes for clarity. Add criteria re: cryopreservation of eggs or sperm for members undergoing GRS. Clarify coverage for ART when PGT is excluded or not covered. Add mandate summary.

**Approved by UMCP: 9/13/17**

**Reviewed/Revised: 2/15, 3/15, 10/15; 2/16; 5/16; 9/16; 9/17**

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