Medica Central Coverage Policy

Policy Name:	**Infertility Services**
Effective Date:	**11/01/2025**

Important Information – Please Read Before Using This Policy

These services may or may not be covered by all Medica Central plans. Coverage is subject to requirements in applicable federal or state laws. Please refer to the member's plan document for other specific coverage information. If there is a difference between this general information and the member's plan document, the member's plan document will be used to determine coverage. With respect to Medicare, Medicaid, and other government programs, this policy will apply unless these programs require different coverage.

Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions may call the Provider Service Center. Please use the Quick Reference Guide on the Provider Communications page for the appropriate phone number. https://mo-central.medica.com/Providers/SSM-employee-health-plan-for-IL-MO-OK-providers

Medica Central coverage policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care, and treatment.

Coverage Policy

Infertility is a disease, condition, or status characterized by any of the following:

- The inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.
- The need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy.
- In patients having regular, unprotected intercourse and without any known etiology for either partner suggestive of impaired reproductive ability, evaluation should be initiated at 12 months when the female partner is under 35 years of age and at 6 months when the female partner is 35 years of age or older. (American Society for Reproductive Medicine [ASRM], 2023)

Once an individual meets the definition of infertility as outlined in the benefit plan or as listed above, the following services associated with establishing the etiology of infertility are generally covered under the medical benefits of the infertility plan option when available.

If benefit coverage is available, covered services may consist of infertility diagnostics, or infertility diagnostics AND treatment as described below:

A. Diagnostic Testing to Establish the Etiology of Infertility

The following services are considered medically necessary when performed solely to establish the underlying etiology of infertility:

- **Evaluation of the female factor**
  1. History and physical examination
  2. Laboratory tests: thyroid stimulating hormone (TSH), prolactin, follicle stimulating hormone

     (FSH), luteinizing hormone (LH), estradiol, progesterone
  3. Ultrasound of the pelvis to assess pelvic organs/structures
  4. Hysteroscopy
  5. Hysterosalpingography
  6. Sonohysterography
  7. Diagnostic laparoscopy with or without chromotubation
  8. Ovarian reserve testing using anti-mullerian hormone (AMH) level, cycle day 3 FSH, ultrasonography for antral follicle assessment, or clomiphene challenge test when ANY of the following criteria is met:
     a. Women over age 35
     b. Family history of early menopause
     c. Single ovary or history of previous ovarian surgery, chemotherapy, or pelvic radiation therapy
     d. Unexplained infertility
     e. Previous poor response to gonadotropin stimulation
     f. Planning treatment with assisted reproductive technologies, e.g., in-vitro fertilization (IVF)
- **Evaluation of the male factor**
  1. History and physical examination
  2. Semen analysis: two specimens at least one month apart, to evaluate semen volume, concentration, motility, pH, fructose, leukocyte count, microbiology, and morphology
  3. Additional laboratory tests: endocrine evaluation (including FSH, total and free testosterone, prolactin, LH, TSH), antisperm antibodies, post-ejaculatory urinalysis
  4. Transrectal ultrasound (TRUS), scrotal ultrasound
  5. Vasography and testicular biopsy in individuals with azoospermia
  6. Scrotal exploration
  7. Testicular biopsy

B. Treatment of Infertility

If benefit coverage for infertility treatment is available, the following treatment services may be considered medically necessary:

- **Female infertility treatment services:**
  1. FDA-approved ovulation induction medications
  2. Ovulation monitoring studies such as ultrasound and endocrine evaluation

3. Tubal recanalization, fluoroscopic/hysteroscopic selective tube cannulation, tuboplasty, salpingostomy, fimbrioplasty, tubal anastomosis, and salpingectomy (NOTE: Procedures performed to reverse female voluntary sterilization are not covered, even if benefits are available for infertility treatment.)
4. Surgical laparoscopy, therapeutic hysteroscopy, cervical recanalization, lysis of adhesions, myomectomy, removal of tumors and cysts, septate uterus repair, ovarian wedge resection, ovarian drilling

If Assisted Reproductive Technology (ART) benefit coverage for infertility treatment is available, the following treatment services may be considered medically necessary:

5. In vitro fertilization with embryo transfer (IVF-ET), in vitro with elective single embryo transfer (eSET), tubal embryo transfer (TET), low tubal ovum transfer (LTOT), pronuclear stage transfer (PROST), or natural cycle IVF, and associated services, including the following: ovulation induction, oocyte retrieval, sperm preparation and washing, associated laboratory tests and ultrasounds, mock embryo transfer/uterine sounding, embryo assessment and transfer, and embryologist services
6. Assisted embryo hatching for women with ANY of the following criteria:
    a. Individuals 38 years of age or older
    b. Elevated day-3 FSH
    c. Increased zona thickness on microscopy
    d. Three or more IVF-attempt failures related to failed implantation
7. Intracytoplasmic sperm injection (ICSI) and associated services, including sperm extraction and retrieval procedures

- **Male infertility treatment services:**

1. Pharmacologic treatment of endocrinopathies including hypogonadotropic hypogonadism with FDA-approved drugs such as human chorionic gonadotropins, human menopausal gonadotropin or pulsatile gonadotropin-releasing hormone, corticosteroids, and androgens
2. Surgical/microsurgical reconstruction or repair of the vas and/or epididymis or other epididymis surgery, such as vasovasostomy, epididymovasostomy, and epididymectomy (NOTE: Procedures performed to reverse voluntary male sterilization are not covered, even if benefits are available for infertility treatment.)
3. Transurethral resection of the ejaculatory ducts (TURED) for the treatment of ejaculatory duct obstruction
4. Repair of varicocele, excision of tumors (e.g., epididymal), testicular biopsy, orchiopexy, spermatic vein ligation, and excision of spermatocele
5. Seminal tract washout

If Assisted Reproductive Technology (ART) benefit coverage for infertility treatment is available, the following treatment services may be considered medically necessary:

6. Sperm extraction and retrieval procedures such as: electroejaculation, microsurgical epididymal sperm aspiration (MESA), testicular sperm aspiration (TESA), testicular fine needle aspiration (TEFNA), testicular sperm extraction

(TESE), microscopic-TESE, percutaneous epididymal sperm aspiration (PESA), vasal sperm aspiration, and seminal vesicle sperm aspiration

C. Cryopreservation Services

Coverage of cryopreservation services varies across plans and may be governed by state mandates. The applicable member coverage document should be reviewed to determine what coverage, if any, is available. If benefit coverage for cryopreservation, ART and/or related services are available and there is no state mandate requiring coverage of more extensive fertility preservation services, the following apply:

- Cryopreservation, storage and thawing of EITHER of the following is considered **medically necessary**:
  1. Embryos, only while the individual is currently under covered active infertility treatment
  2. Mature oocyte(s), only while the individual is currently under covered active infertility treatment and when BOTH of the following criteria are met:
     a. A covered IVF cycle using fresh oocyte(s) for fertilization
     b. An inability to obtain viable sperm for oocyte fertilization at the time of oocyte retrieval
- Each of the following services is considered **not medically necessary**:
  1. Embryos when not undergoing covered active infertility treatment
  2. Sperm
  3. Oocytes for any indication other than listed above
  4. Cryopreservation of immature oocytes, including in vitro maturation
  5. Retrieval, cryopreservation, storage, thawing, and re-transplantation of testicular reproductive tissue
  6. Retrieval, cryopreservation, storage, thawing, and re-transplantation of ovarian reproductive tissue (Unless applicable state mandate requires coverage for fertility preservation.)

D. Not Medically Necessary Infertility Services or Tests

- Services not listed above are considered not medically necessary and therefore **NOT COVERED**, including but are not limited to the following:
  1. Acupuncture
  2. Hyperbaric oxygen therapy for IVF and/or treatment of male factor infertility
  3. Intravaginal culture of oocytes (e.g., INVOcell)
  4. Immunological testing (e.g., antiprothrombin antibodies, embryotoxicity assay, circulating natural killer cell measurement, antiphospholipid antibodies, reproductive immunophenotype [RIP], T1 and T2 Helper ratios)
  5. Co-culturing of embryos/oocytes (i.e., culture of oocyte(s), embryo(s), less than 4 days with co-culture)
  6. Computer-assisted sperm motion analysis
  7. Direct intraperitoneal insemination, intrafollicular insemination, fallopian tube sperm transfusion

8. Endometrial receptivity testing (e.g., Endometrial Function Test ™ [EFT ®], integrin testing, Beta-3 integrin test, E-tegrity ® , endometrial receptivity array [ERA])
9. Fine needle aspiration mapping
10. Hemizona test
11. Hyaluronan binding assay (HBA)
12. Serum inhibin B
13. Sperm viability test (e.g., hypo-osmotic swelling test), when performed as a diagnostic test
14. The use of sperm precursors (i.e., round or elongated spermatid nuclei, immature sperm) in the treatment of infertility
15. Sperm-capacitation assessment (e.g., Cap-Score™ Assay [Androvia LifeSciences, Mountainside, New Jersey])
16. Manual soft tissue therapy for the treatment of pelvic adhesions (WURN Technique ® , Clear Passage Therapy)
17. Laser-assisted necrotic blastomere removal from cryopreserved embryos
18. Reactive oxygen species testing (ROS)
19. Time-lapse monitoring/imaging of embryos (e.g., EmbryoScope, Eeva™ Test)
20. Vaginal microbiome testing (e.g., SmartJane ™ screening test [Biome, Inc])
21. Saline-air infused sono-hysterosalpingogram (e.g., femVue ® [Femasys, Inc.])

- In addition, all of these services are **NOT COVERED** OR **REIMBURSABLE**:
  1. Services associated with the reversal of voluntary sterilization
  2. Infertility services when the infertility is caused by or related to voluntary sterilization
  3. Donor charges, fees and services, including services associated with donor sperm and donor oocytes
  4. Infertility services rendered to a surrogate and surrogate fees regardless of whether the member is acting as a surrogate for another individual or seeks the assistance of another individual to act as their surrogate
  5. Commercially available over-the-counter home ovulation prediction test kits
  6. Home pregnancy test kits

Description

Definition of Infertility

Infertility is a disease, condition or status characterized by the need for medical intervention to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This includes, for example, the need for an individual, regardless of relationship status, sexual orientation, or gender identity, to use donor gametes or embryos in order to achieve a successful pregnancy resulting in delivery. (American Society of Reproductive Medicine [ASRM], 2023). Evaluation and treatment may be warranted based on medical history and physical findings and is reasonable after six months for women over the age of 35 years

(ASRM, 2021; ACOG, 2019, American Urological Association/ASRM, 2020). For woman over the age of 40 more immediate evaluation and treatment may be considered (ASRM, 2021). In addition, the inability of a woman to achieve conception after six trials of medically supervised artificial insemination over a one-year period may necessitate evaluation for infertility. Infertility can affect one or both reproductive partners. Some underlying factors are reversible through medical intervention; the major underlying causes of infertility include: ovulatory, tubal, cervical, uterine/endometrial, and male partner factors.

Diagnostic Testing To Establish the Etiology of Infertility

Formal evaluation of infertility is generally initiated in women attempting pregnancy who fail to conceive after one year or more of regular, unprotected intercourse. However, there are an increasing number of women over the age of 35 who are seeking infertility services. Since reproductive potential decreases in the early to mid-thirties, for this age group formal evaluation typically begins earlier. For couples over age 35 it is generally recommended that infertility testing begins after 6 months of unsuccessful attempts at conception (ASRM, 2023; ACOG, 2014; Williams, Elam, 2007; Institute for Clinical Systems Improvement [ICSI], 2004). In some cases, an evaluation may be warranted prior to one year if there is a known male infertility risk factor such as bilateral cryptorchidism or known female risk factor (AUA, 2021). The preliminary approach to infertility typically begins with the evaluation of ovulatory, tubal, and male factors, and involves physical examination, laboratory studies and diagnostic testing. Other potential contributing causes that may be explored include genetic factors and immunological factors.

Treatment of Female Infertility Factors

Treatment of infertility typically begins with the confirmed diagnosis of infertility. Treatment is determined by the specific diagnosis and may involve oral or injectable medication, surgery, assisted reproductive technologies, or a combination of these. Infertility may be the result of endometriosis, tubal factors, uterine and endometrial factors, cervical factors, ovulatory factors, or from unexplained factors. Pharmacologic and other medical treatment is typically attempted before more invasive interventions are sought.

Definition of Assistive Reproduction Technology (ART)

All treatments or procedures that include the handling of human eggs, sperm, and/or embryos to help a patient become pregnant. ART includes, but is not limited to, gamete intrafallopian transfer (GIFT), uterine embryo lavage, embryo transfer, artificial insemination (AI), intrauterine insemination (IUI), intracervical insemination (ICI), intravaginal insemination (IVI), in vitro fertilization (IVF), pronuclear state transfer (PROST), tubal embryo transfer (TET), zygote intrafallopian transfer (ZIFT), low tubal ovum transfer, intracytoplasmic sperm injection (ICSI), cryopreservation (e.g., egg, embryo, sperm), and other third party-assisted ART methods (e.g., sperm donation, egg donation, Traditional Surrogates and Gestational Carriers, embryo donation).

Cryopreservation

Cryopreservation may be employed as a method to preserve fertility or as part of assisted reproductive technologies. In general, preservation of fertility is considered not medically necessary. When employed as part of assisted reproductive technologies cryopreservation of some reproductive cells/tissue have been proven safe and effective, although some remain under investigation. Cryopreservation, storage and thawing of testicular tissue is considered unproven in the treatment of infertility (ASRM, 2014). Cryopreservation of sperm and embryos are well-established services and have been proven safe and effective; cryopreservation of mature oocytes is no longer considered investigational. The ASRM reaffirmed a 2013 practice committee guideline (ASRM, 2021) for mature oocyte

cryopreservation. This document was endorsed by the American College of Obstetricians and Gynecologists (ACOG) Committee on Gynecological Practice. Within the guidelines the ASRM notes limited data exists evaluating the effect of duration of storage on oocyte cryopreservation as well as clinical outcomes and that success rates may not be generalizable. Although success rates generally decline with increased maternal age, there are no comparative trials evaluating success of cryopreserved versus fresh oocytes by age. Furthermore, whether or not the incidence of anomalies and developmental abnormalities of children born from cryopreserved oocytes is similar to those born from cryopreserved embryos has not been firmly established. Nevertheless, although the data is very limited, oocyte cryopreservation may be recommended, with appropriate counseling, for couples pursuing IVF with insufficient sperm on the day of retrieval (e.g., severe oligospermia, azoospermia) and for individuals undergoing chemotherapy or other gonadotoxic therapies.

Prior Authorization

Prior authorization may be required for certain drugs for treatment of infertility. Refer to member's formulary for prior authorization information. Prior authorization is not applicable for other services. Claims for other services are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Coding Considerations

Use the current applicable CPT/HCPCS code(s). The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.

Original Effective Date: 11/01/2025
Re-Review Date(s):
Administrative Update: