Geisinger

Geisinger Health Plan

FEHP Benefit Document

Subject: Infertility Coverage

I. Policy: FEHP Infertility Coverage

II. Purpose/Objective: To outline the benefit for FEHP Infertility Coverage

III. Responsibility:

A. Medical Directors
B. Medical Management
C. GHP Account Executive Service Specialists

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

The term **biological female** used in this document refers to members with two X chromosomes and includes members with sex identities other than female.

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

In this document, 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 sex identities/expressions.

The term **infertility** used in this document, is a person unable to conceive or produce conception after one year of egg-sperm contact when the individual attempting conception is under the age of 35, or after six months egg-sperm contact when the individual attempting conception is 35 years of age or older. Infertility may be due to natural dysfunction

(congenital), as a sequelae of another physical condition or disease (secondary), or as a result of surgery, radiation, chemotherapy, sex transition or other medical treatment affecting reproductive organs or processes (iatrogentic).

CRITERIA FOR COVERAGE:

Coverage for the following services related to a person unable to conceive or produce conception after one year of egg-sperm contact when the female attempting conception is less than or equal to 35 years of age, or after six months egg-sperm contact when the female attempting conception is 35 years of age or older may be considered medically necessary.

Diagnosis and Evaluation Services – the following do not require prior authorization

- History & Physical
- Sperm function tests
- Hysterosalpingogram
- Hysteroscopy
- Sonohysterogram
- Prediction of Ovarian Reserve Hormone Evaluation
- Evaluation of folliculogenesis
- Endometrial biopsy
- Diagnostic laparoscopy
- Follow-up Conference

Other Covered Services

- Ovarian transposition (oophoropexy);
- Radiation (gonadal) shielding;
- Conservative gynecologic surgery including but not limited to the following:
- Radical trachelectomy in early stage cervical cancer (i.e., stage IA2 to IB cervical cancer with diameter <2 cm and invasion <10 mm);
- Ovarian cystectomy for early-stage ovarian cancer

The following services REQUIRE PRIOR AUTHORIZATION

Member is responsible for the cost once the member's enrollment terminates or reaches the six attempts per year benefit.

Fertility Services

Coverage for members with congenital infertility, undergoing sex transformation, or a treatment that is expected to render them permanently infertile (excluding voluntary sterilization):

- Ovarian stimulation, retrieval of eggs (prior to age 45) and fertilization limited to two (2) attempts.
- Oocyte cryo-preservation limited to 24 months. Coverage is only applicable while the member is actively enrolled with GHP.
- Sperm collection (prior to age 45) and storage limited to 24 months. Coverage is only applicable while the member is actively enrolled with GHP.
- Three cycles of IVF (drugs and service) with egg or embryo cryopreservation is covered for congenital infertility
- One cycle of IVF (drugs and service) with egg or embryo cryopreservation is covered in the case of fertility preservation due to iatrogenic infertility or sex transformation

Pharmacologic Agents to Treat Infertility – please refer to associated Pharmaceutical policies

Electroejaculation

Electroejaculation is covered

Intravaginal insemination (IVI), Intrauterine insemination (IUI), Intracervical insemination (ICI)

IVI, IUI, and ICI with or without medication is covered for otherwise healthy biological female members. IUI, IVI and ICI is covered for the time period that fertility is naturally expected. Services will no longer be covered for members clinically determined to have less than 5% chance for a live birth (for example: after a member has done and failed to deliver with IVF).

Cryopreservation (Fertility Preservation)

Covered services for members who are naturally able to conceive but undergoing radiation, pharmacological treatment, surgical treatment or chemotherapy that is expected to render them permanently infertile:

- Ovarian stimulation, retrieval of eggs (prior to age 45) and fertilization limited to two (2) attempts.
- Oocyte cryo-preservation limited to 24 months. Coverage is only applicable while the member is actively enrolled with GHP.
- Sperm collection (prior to age 45) and storage limited to 24 months. Coverage is only applicable while the member is actively enrolled with GHP.
- Artificial insemination: Intravaginal insemination (IVI), Intrauterine insemination (IUI), Intracervical insemination (ICI)
- Three cycles of IVF with egg or embryo cryopreservation. In-vitro fertilization is covered only in the case of fertility preservation due to iatrogenic infertility

EXCLUSIONS: The following services are considered non-covered:

- Reversal of voluntary sterilization
- Assisted reproductive technology (ART) other than IVF noted above. e.g., Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT).
- Cryopreservation of embryos or eggs for reciprocal IVF
- Sperm storage/banking for members requesting this service for convenience or “back-up” for a fresh specimen.
- Elective egg/sperm cryopreservation for fertility preservation due to natural aging or menopause.
- Storage of cryopreserved sperm, eggs for more than 24 months
- Selective fetal reduction
- sex selection
- Frozen embryo Transfer
- Human zona binding assay (hemizona test)
- Serum anti-sperm antibody testing
- Sperm acrosome reaction test
- Sperm DNA fragmentation assays
- Advanced Sperm Selection Techniques (i.e. PICSI, Zeta potential, sorting by X or Y chromosome, magnetic activating cell sorting, etc.)
- Sperm hyperactivation processing/techniques
- Co-culture of embryos
- Embryo toxic factor test (ETFL) or Natural killer cell assay
- IVIG (Intravenous Immunoglobulin)
- Granulocyte Colony Stimulating Factor (G-CSF)
- Intralipid infusion
- Ovulation kits
- Post-coital testing
- Artificial oocyte activation
- In vitro maturation of eggs
- Direct intraperitoneal insemination (DIPI)
- Peritoneal ovum and sperm transfer (POST)
- Genetic engineering
- Endometrial Scratching
- Embryo Glue (hyaluronic acid)
- human chorionic gonadotropin (hCG) infusion into the uterine cavity
- uterine artery vasodilation (i.e. sildenafil)
- Ovarian tissue cryopreservation and transplantation procedures
- Reimplantation or grafting of human testicular tissue
- Donor sperm
- Donor egg

CODING ASSOCIATED WITH: Iatrogenic Fertility Preservation

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

00840 Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified
49320 Diagnostic laparoscopy
51596 Ovarian cystectomy for early-stage ovarian cancer
55400 Reversal of voluntary sterilization
55870 Electroejaculation
57531 Radical trachelectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling biopsy, with or without removal of tube(s), with or without removal of ovary(s)
58100 Endometrial biopsy
58321 Artificial insemination, intra-cervical
58322 intrauterine
58323 Sperm washing for artificial insemination
58340 Hysterosalpingogram
58555 Hysteroscopy
58750 tubotubal anastomosis
58825 Transposition, ovary(s)
59866 Multifetal pregnancy reduction(s) (MPR)
58920 Ovarian transposition (oophoropexy)
58970 Follicle Puncture for oocyte retrieval, any method
58974 Embryo transfer, intrauterine
58976 Gamete, zygote or embryo intrafallopian transfer, any method
76831 Sonohysterogram
76856 Ultrasound, pelvic (nonobstetric), real time with image documentation; complete
76948 Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation
77334 Treatment devices, design and construction, complex (irregular blocks, special shields, compensators, wedges, molds or casts)
82670 Estradiol
83001 Gonadotropin; follicle stimulating hormone (FSH)
83002 Gonadotropin; luteinizing hormone (LH)
84144 Progesterone
84702 Gonadotropin; chorionic (hCG); quantitative
86357 Embryo toxic factor test (ETFL) or Natural killer cell assay
89250 Culture of oocyte(s)/embryo(s), less than 4 days
89251 Culture of oocyte(s)/embryo(s), less than 4 days; with co-culture of oocyte(s)/embryos
89254 Oocyte identification from follicular fluid
89258 Cryopreservation, embryo(s) (freezing services, not storage)
89259 Cryopreservation; sperm
89260 Sperm isolation; simple prep (e.g., sperm wash and swim-up) for insemination or diagnosis with semen analysis
89261 Sperm isolation; complex prep (e.g., Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis
89264 Sperm identification from testis tissue, fresh or cryopreserved
89268 Insemination of oocytes
89272 Extended culture of oocytes/embryo(s), 4-7 days
89280 Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes
89281 Assisted oocyte fertilization, microtechnique; greater than 10 oocytes
89320 Semen analysis; volume, count motility and differential
89325 Serum anti-sperm antibody testing
89335 Cryopreservation, reproductive tissue, testicular
89337 Cryopreservation, mature oocyte(s)
89343 Storage, (per year); sperm/semen
89346 Storage, (per year); oocyte(s
89352 Thawing of cryopreserved; embryo(s)
89353 Thawing of cryopreserved; sperm/semen, each aliquot

89354 Ovarian tissue cryopreservation and transplantation procedures
99000 Handling and/or conveyance of specimen for transfer from office to a laboratory
99001 Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory (distance may be indicated)
99070 Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)
99078 Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services in a group setting (eg, prenatal, obesity, or diabetic instructions)
99199 Unlisted special service, procedure or report
0058T Cryopreservation; reproductive tissue, ovarian
S4026 Donor sperm
S4030 Sperm procurement and cryopreservation services; initial visit
S4031 Sperm procurement and cryopreservation services; subsequent visit
S4040 Monitoring and storage of cryopreserved embryos, per 30 days
S8055 Ultrasound guidance for multifetal pregnancy reduction(s), technical component

Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL

LINE OF BUSINESS: FEHP

Devised: 08/22

Revised: 5/23, 7/23 (remove dollar cap, revise from 3 cycles to six); 10/23 (revise from six cycles to three, clarify IVF benefit); 7/25 (revise language)

Reviewed: 1/25

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at https://www.geisinger.org/health-plan/providers/ghp-clinical-policies

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.