IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

Property of ConnectiCare, Inc. All rights reserved. The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies (LMRP). All coding and web site links are accurate at time of publication.

Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility</td>
<td>“Infertility” is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after twelve (12) months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female thirty-five (35) years of age or older. Earlier evaluation and treatment may be warranted based on a member’s medical history or physical findings (Section 4: IVF for Women without Male Partners or Exposure to Sperm)</td>
</tr>
<tr>
<td>Iatrogenic infertility</td>
<td>An impairment of fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes</td>
</tr>
<tr>
<td>IUI</td>
<td>Intrauterine insemination (IUI) is a fertility treatment in which a fine catheter is inserted through the cervix into the uterus to deposit a sperm sample directly into the uterus.</td>
</tr>
</tbody>
</table>
**Medical Policy Criteria: Infertility**

**Commercial**

<table>
<thead>
<tr>
<th>IVF</th>
<th>In Vitro Fertilization (IVF) is an assisted reproductive technology (ART). IVF is the process of fertilization by extracting eggs, retrieving a sperm sample, and then manually combining an egg and sperm in a laboratory dish. The embryo(s) is then transferred to the uterus.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cycle</td>
<td>A “cycle” is defined as either all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in-vitro fertilization using a fresh embryo transfer; or medications are administered for endometrial preparation with the intent of undergoing in-vitro fertilization using a frozen embryo transfer.</td>
</tr>
</tbody>
</table>

**Connecticut State Limitations:**

A. Ovulation induction limited to four cycles;

B. Intrauterine Insemination (IUI) limited to three cycles;

C. In-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) or low tubal ovum transfer limited to two cycles, with not more than two embryo implantations per cycle, for, provided each such fertilization or transfer shall be credited toward such maximum as one cycle; (IVF Cycles are defined as induction of ovulation induction and considered complete at oocyte retrieval).

D. Limit coverage for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer to those individuals who have been unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures covered under such policy. Nothing in this subdivision shall be construed to deny the coverage required by this section to any individual who foregoes a particular infertility treatment or procedure if the individual's physician determines that such treatment or procedure is likely to be unsuccessful;

E. Requires that covered infertility treatment or procedures be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility;

**Massachusetts State Limitations:**

A. Insurers that provide pregnancy-related benefits must cover diagnostics and treatment for infertility, including artificial insemination, IVF, GIFT, egg or sperm procurement processing, sperm or egg banking, ICSI, and ZIFT.

B. IVF can only be covered if patient is unsuccessful achieving pregnancy with less expensive treatment options covered by the plan.

C. IVF procedure must be performed at a fertility clinic or medical facility that conforms to standards and guidelines set by the American Society for Reproductive Medicine (ASRM) or the American College of Obstetricians and Gynecologists.

D. The following procedures identified in the mandate as exempt:
   - Sterilization procedures or reversals (vasectomy or tubal ligation)
   - Surrogacy

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Medical Policy Criteria: Infertility
(Commercial)

- Experimental fertility treatments
- Egg freezing

E. Medically necessary prescription drugs
   - Self-administered drugs including ovulatory injections (e.g., HCG) are covered only for members with prescription drug coverage, who are in an active, authorized cycle of infertility treatment

Guideline
Section 1: General Indications for Initial and Continuation of Infertility Treatment Coverage
The below general infertility criteria are to be met for consideration of treatment:
- Prognosis for conception must be ≥ 5%; AND
- No evidence of significant diminished ovarian reserve. Markers of significant diminished ovarian reserve include but are not limited to (one or more of the following within the previous 6 months):
  - FSH level ≥ 15 mIU/ml if ≥35 years of age; OR
  - FSH level ≥ 20 mIU/ml if < 35 years of age; OR
  - AMH level < 0.3 ng/ml; OR
  - Antral follicle count < 7(ASTM (a)); AND
- If there has been monitored, medicated-stimulated infertility treatment within the previous 6 months it must demonstrate adequate ovarian response to stimulation.
  Examples include but are not limited to:
  - 1 follicle ≥ 15 mm diameter for IUI
  - Minimum of 1 follicle ≥15 mm diameter for ART

The general infertility surgery criteria as listed below are to be met for consideration of treatment:
- Pelvic pain that is not responsive to conservative management; OR
- Presence of a pelvic mass for which gynecologic diagnosis warrants surgical intervention; OR
- As an alternative treatment modality to the Assisted Reproductive Technologies (ART) particularly for individuals who are averse to pursuing ART for religious, social or financial concerns.

In the absence of other infertility factors or recurrence of disease additional infertility treatment is not indicated following infertility surgery for 12 months for individuals <35 and 6 months for individuals ≥ 35 years of age.

Infertility treatment is warranted when an infertility factor has been identified. This would include but is not limited to:
- Two abnormal semen analyses (abnormal count and/or motility), ovulatory dysfunction; compromise of the fallopian tubes; documented untreated or recurrent endometriosis; sexual dysfunction; abnormalities of the cervix or uterus that may interfere with conception.

Treatment is not indicated in the setting of using autologous oocytes in females’ ≥44 years of age.

Poor Prognosis and Futility
Examples where continued treatment may be futile: (ASRM, 2006)
- Markedly elevated FSH levels
  - ≥20 for women < 40
  - ≥ 15 for women ≥ 40
- FSH levels should be evaluated in the context of other markers of ovarian
reserve, such as AMH, AFC and response to prior ovarian stimulation
  • In the absence of a history of prior ovarian stimulation, a cycle of ART may be
    considered, especially in women age <35.
  • Lack of viable spermatozoa
  • Ovarian failure where a couple is attempting conception with their own gametes
  • Numerous ART cycles without adequate egg production, fertilization and/or embryo
    development

Section 2: Artificial Insemination (IUI)
A. Medical Necessity Criteria
IUI may be authorized when the definition of infertility is met (see definitions above) and
(Section 4: IVF for Women without Male Partners or Exposure to Sperm) and there is
documentation of the following:

1. Hysterosalpingography (hysterosalpingogram (HSG) or sonohysterosalpingogram) to
   screen for tubal occlusion; or Hysteroscopy, salpingoscopy (falloscopy), hydrotubation
   where clinically indicated; or Laparoscopy and chromotubation (contrast dye) to
   assess tubal and other pelvic pathology, and to follow-up on hysterosalpingography
   abnormalities, within the past 2 years confirming the presence of all the following:
   • At least one patent Fallopian tube
   • Normal endometrial cavity

2. Normal ovarian reserve testing (FSH Level)

3. Any of the following:
   • Unexplained infertility
   • Polycystic Ovary Syndrome (PCOS), anovulation, or oligoovulation
   • Minimal or mild endometriosis
   • Cervical factors
   • Mild to moderate male factor infertility *
   • 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.

4. If prior IUI, results must be submitted with each request, and demonstrate ALL the
   following:
   • Adequate ovarian response to stimulation (i.e. at least 2 follicles >12 mm diameter for
     any monitored IUI using standard medication doses);
   • Adequate fresh semen and post wash semen parameters in order to continue with IUI.

B. Intra-uterine (IUI) Without Medication
Natural IUI, defined as IUI without medication, for a woman who has a diagnosis of infertility
may be covered when the member has documented acceptable ovarian reserve as defined
above under General Indications for Initial and Continuation of Infertility Treatment
Coverage AND the Member must meet one of the following:

• The woman has a history of one or more cervical surgical procedures or conization
  procedures that is considered a factor in the woman’s infertility
• The woman has a diagnosis of vaginismus
• Use of therapeutic donor insemination

C. Intra-uterine (IUI) With Medication
Medicated IUI, defined as IUI with medication, for a woman who has a diagnosis of infertility
may be covered when the member has documented acceptable ovarian reserve as defined
above under General Indications for Initial and Continuation of Infertility Treatment Coverage AND the Member must meet one of the following:

- Unexplained infertility
- Mild - moderate male factor infertility (see Male Infertility section)
- Minimal or mild endometriosis
- Unilateral tubal factor infertility absent any compromise of the patent fallopian tube
- Polycystic Ovary Syndrome (PCOS), anovulation, or oligoovulation

D. Intrauterine insemination (IUI) is not indicated in any one of the following situations:

- >1 insemination per cycle
- Severe male factor infertility (< 1 million motile sperm after sperm preparation) (without use of donor sperm)
- Bilateral tubal factor infertility
- Moderate or severe endometriosis unless treatment has previously been rendered and there is documentation of at least one uncompromised fallopian tube
- Recurrent pregnancy loss
- In the setting of ART in any the following situations:
  - To convert an ART cycle to IUI when at least 3 follicles ≥15 mm in diameter are present (particularly in the setting of diminished ovarian reserve or on the 2nd or greater ART cycle when maximal dosage of gonadotropins is being used)
  - Following an ART cycle that fails to result in conception due to poor ovarian response or poor-quality oocytes or embryos; OR
  - Following ≥ 2 ART cycles that have failed to result in a conception despite good quality oocytes or embryos.

E. IUI after IVF

- 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 medical necessity criteria.
- Women who have been denied or failed ART services are generally not appropriate candidates for IUI cycles. Exceptions based upon an individual’s medical history will be considered.
- IUI after IUI-to-IVF conversion for hyperstimulation may be authorized if the stimulation that was initially given is reduced.
- 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.

F. Conversion from IUI to IVF/Hyperstimulation

Authorized when the current IUI cycle has resulted in ALL:

- Estradiol level of ≥800 pg/ml; AND
- Production of at least 5 follicles >12 mm in diameter.
- Age<40, AND
- Has benefit for IVF available

Section 3: Assisted Reproductive Technology (ART) (May not be covered for all plans)

Coverage for IVF services is limited to a benefit maximum of 2 cycles in the State of Connecticut. CCI 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.

A. Medical Necessity Criteria

IVF services are authorized when the relevant infertility eligibility criteria are met, and there is documentation confirming ANY of the following:

- Unexplained infertility
- Diminished ovarian reserve (not due to age)
- Ovulatory dysfunction
  - When ovulation induction has not resulted in conception
  - Poor response to ovulation induction
  - Hyper-response to ovulation induction; hyper-response can convert to IVF
- History of failed medicated IUI cycles when IUI criteria (above) have been met (Results of prior IUI cycles must be submitted with each IVF request [initial and subsequent requests]). (Note: 3 IUIs before IVF [unless medically necessary indicated to go straight to IVF]).
- 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;
- Female member with severe endometriosis and history of failed medical and surgical therapy;
- 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.

B. IVF Protocol

Members must meet above medical necessity criteria

- For members <35 years of age
  - 1st IVF treatment cycle: SET (single embryo transfer) is required.
    - If no top-quality embryos after thawing, then two or more embryos of any quality may be transferred.
  - 2nd IVF treatment cycle and subsequent IVF treatment cycles:
    - STEET (single thawed elective embryo transfer; a.k.a SET/FET- SINGLE EMBRYO TRANSFER- FROZEN EMBRYO TRANSFER) is required if member has one or more embryos frozen
      - If there are no top-quality embryos after thawing, then two embryos of any quality may be transferred
    - Fresh IVF cycle with SET if no frozen embryos available
      - If there are no top-quality embryos is after thawing, then two embryos of any quality may be transferred
  - For all treatment cycles, all normal frozen embryos must be used before another fresh cycle may be approved.
- For members 35-38 years of age:
  - 1st IVF treatment cycle: SET is required.
    - If only one top quality embryo is available, then two embryos of any quality may be transferred.
  - 2nd and subsequent IVF treatment cycles do not need to be SET or STEET
  - For all treatment cycles, all normal frozen embryos must be used before
another fresh cycle may be approved.

- For members <38 years of age and had successful IVF treatment cycle (i.e. had a live birth from that IVF treatment)
  - 1st IVF treatment cycle:
    - STEET is required if member has one or more embryos frozen
      - If there are no top-quality embryos after thawing, then two embryos of any quality may be transferred
    - Fresh IVF cycle with SET if no frozen embryos available
      - If no top-quality embryo is available, then two embryos of any quality may be transferred.
  - 2nd and subsequent IVF treatment cycles do not need to be SET or STEET
  - For all treatment cycles, all normal frozen embryos must be used before another fresh cycle may be approved.

- Members 38 years of age and older undergoing IVF treatment do not need to attempt a SET or STEET as their risk of multiple births is low.
  - Max of 2 embryos per transfer.
  - For all treatment cycles, all normal frozen embryos must be used before another fresh cycle may be approved.

C. Frozen Embryo Transfers (FET)

Members seeking coverage for FET must meet the definition of infertility and expect fertility as a natural state.

- It is clinically appropriate and cost effective to utilize all appropriate frozen embryos for transfer prior to another fresh ART cycle. Fresh oocyte retrievals are not indicated when frozen oocytes or embryos are available and appropriate for transfer.
  - See IVF criteria above for # of embryos allowed per transfer.

- For members with frozen embryos created in an IVF cycle not initially approved by ConnectiCare, the following criteria must be met before embryo transfer may be approved:
  - Uterine cavity evaluation completed within the last year
  - Diagnosis of infertility from treating provider
  - Fertility is naturally expected for member

D. Embryo Banking

There is no evidence in the medical literature to support the practice of repeated ART cycles for the purpose of accumulating (banking) embryos for later use (egg retrievals without a fresh or frozen embryo transfer) with the exception of freeze all cycles for medical necessity.

E. Freeze-All Cycles

An ART cycle, when it is known at the initiation of a cycle that none of the resulting embryos will be transferred immediately and/or the intent is to cryopreserve all of the embryos for future use, will be covered only if one of the following is met:

- Member has no prior history of sterilization, in the presence or absence of ongoing infertility care, when the Member requires medical treatment that may render them sterile. A letter of medical necessity from the treating physician is required. For example, the Member has been diagnosed with cancer and will be undergoing chemotherapy and/or radiation that will likely result in infertility.
- Member is approved by ConnectiCare for preimplantation genetic testing (PGT) with IVF.
- Member is eligible for coverage of an IVF cycle based on the definitions and criteria outlined in this guideline and is privately paying for PGT.
  - IVF/PGT testing for gender selection is a benefit exclusion.
Medical Policy Criteria: Infertility (Commercial)

- The Member’s progesterone concentration (P4) is > 1ng/mL at the time of administration of hCG trigger injection
- Management of Ovarian Hyperstimulation Syndrome
- The first embryo transfer performed within 60 days of a freeze all cycle will be considered a continuation of the freeze-all cycle (both require authorization).

F. Assisted Hatching (AH)
Authorized as part of an IVF or Frozen Embryo Transfer (FET) procedure when documentation confirms either of the following:

- Failed IVF cycles that produced 3 or more morphologically high-quality embryos, with failure to implant after embryo transfer
- Prior pregnancy resulting from IVF that required assisted hatching

Non-covered services include but are not limited to the following:
- Assisted hatching if PGT is done, as PGT process includes opening the zona (See Preimplantation Genetic Testing below)

G. ICSI - Intracytoplasmic Sperm Injection (ICSI)
- Authorized (in conjunction with IVF) to treat sperm-related infertility problems in the male partner (see Male Infertility section) when the use of ICSI is expected (with a greater than 5% probability) to result in a live birth, and there is documentation of ANY of the following:
  - Severe male factor infertility that cannot be overcome by IVF based on semen analysis reports performed within the last 3 months; any:
    - At least 2 unprocessed semen analyses show <10 million total motile sperm, OR
    - At least 2 processed semen analyses show ≤3 million total motile sperm, OR
    - At least 2 unprocessed semen analyses show ≤ 4% strict Kruger normal forms.
  - ICSI is covered when reduced fertilization on a prior IVF cycle using non-donor sperm if the rate of fertilization on the prior cycle is less than 40% fertilization with the standard insemination of mature eggs.
  - 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)
  - Nonobstructive azoospermia (necessitating sperm retrieval via Testicular Sperm Extraction)
  
  ICSI is not authorized for any IVF cycle involving use of donor sperm, or solely to perform Preimplantation Genetic Testing (PGT) when PGT has not been authorized. (See also Preimplantation Genetic Testing below)
  
  ICSI is covered on the day of IVF egg retrieval if the post processing semen (severe male factor infertility results above must be met) analysis of non-donor non-frozen sperm on that day meets the ICSI coverage criteria noted immediately above. Retrospective authorizations will be allowed.
  
  ICSI is also clinically indicated when fertilizing previously frozen oocytes. Exposure to cryoprotectants often lead to the hardening of the zona.

H. Pre-implantation Genetic Testing
- Meets ART criteria above
Medical Policy Criteria: Infertility
(Commercial)

- At least 1 of the following is present:
  - Both partners are known carriers of a single gene autosomal recessive disorder
  - One partner is known to have a balanced translocation
  - One partner has a single gene autosomal dominant disorder
  - One partner is a known carrier of an x-linked disorder
  - Testing is being conducted to determine the sex of an embryo, when there is a documented history of an x-linked disorder and decisions regarding management can be made on the basis of sex alone

- Must meet all of the following:
  - A specific mutation, or set of mutations, has been identified, that specifically identifies the genetic disorder with a high degree of reliability
  - The genetic disorder is associated with severe disability or has a lethal natural history
  - Testing is accompanied by genetic counseling

PGT Limitations/Exclusions
- Based upon the Connecticare member documents, pre-implantation genetic testing is only covered if performed in conjunction with pre-authorized Advanced Reproductive Technology
- Pre-implantation genetic testing is not considered medically necessary for any of the following:
  - The selection of embryos with specific HLA typing to provide a match for a member in need of an allogenic transplant
  - The selection of embryos with the sole purpose of determining the gender of the resultant offspring.

I. Cryopreservation of Embryos
- For women in active (authorized) infertility treatment cryopreservation for any embryos remaining after an authorized IVF cycle.
  - Storage remains non-covered
- Cryopreserved embryos must be used before additional (fresh) IVF cycles using the member’s or a donor’s eggs are authorized.
- If member meets criteria for 2 embryo transfers and only one embryo is available, then a fresh IVF cycle may be authorized if benefit is available.
- Requests for authorization of a Frozen Embryo Transfer (FET) cycle must meet Infertility criteria (above) at the time of the request for the FET.
- Limitations - ConnectiCare will not cover the following:
  - Long-term sperm, oocyte or embryo storage
  - Sperm cryopreservation as a routine procedure for sperm backup in the absence of a confirmed physical or psychological diagnosis requiring cryopreservation.
  - An ART cycle when it is known at the initiation of a cycle that none of the resulting embryos will be transferred during the same cycle, and/or the intent is to cryopreserve all of the embryos for future use, except as outlined above. (see Freeze-All Cycles Section E above)
Section 4: IVF for Women without Male Partners or Exposure to Sperm

- Documentation confirms a female without a male partner or exposure to sperm has failed 6 consecutive AI/IUI cycles using normal donor sperm. (Note: Costs of donor sperm, and IUIs to demonstrate infertility are not covered)
- The female must also meet Service-Specific Criteria for IVF including documentation of a history of failed medicated IUI cycles. Age-related embryo transfer requirements outlined in the Service specific criteria for IVF also apply.

Section 5: Donor Services

A. Donor Egg (Donor Oocyte)

Non-medical services related to donor egg/embryo or sperm procurement (e.g., finder fees, broker fees, legal fees, medications, donor screening, donor testing, and oocyte retrievals) are not covered.

Use of Donor egg during infertility procedures is a covered benefit when infertility criteria are met, and there is documentation of ANY of the following:

- Congenital or surgical absence of ovaries
- Premature ovarian failure or premature menopause in women under age 40 years
- Premature diminished ovarian reserve (i.e., FSH ≥15 in women under age 40 years
- Inadequate ovarian response (i.e., fewer than 3 follicles >12 mm diameter), or inadequate embryo numbers and quality, during authorized IVF cycles within the prior 6 months. (Note: When donor egg criteria are met, a donor egg cycle is authorized for up to 6 months)
- A SET is required for members < 35 years of age for the first approved donor egg IVF treatment cycles with more than one top-quality embryo available for transfer
- If the donor egg procedure is not performed within 6 months, the member must be reevaluated and continue to meet ConnectiCare criteria for infertility services and donor egg procedures before additional services are authorized.

For female members (embryo recipients) without ConnectiCare prescription drug coverage, coverage for the egg donor is limited to monitoring (up to egg retrieval), and the egg retrieval procedure.

- Services after oocyte retrieval from donor such as fertilization and transfer are covered when authorized.
- Limitations:
  - Infertility treatment when the infertile Member is not the recipient of said services (e.g., donor egg in conjunction with gestational carrier).
  - Medications that are directly related to a stimulated ART cycle for anonymous or designated donors unless medication is for the member.
  - After proceeding to a donor egg cycle, further IVF cycles using the member’s eggs are not covered.

B. Donor Sperm

Use of donor sperm of normal quality is authorized when documentation (by ANY of the following) confirms male factor infertility:

- Bilateral congenital absence of vas deferens (BCAVD)
- Non-obstructive Azoospermia confirmed through MESA/TESE results
- Previous radiation or chemotherapy treatment resulting in abnormal semen analyses
Medical Policy Criteria: Infertility (Commercial)

- Two or more abnormal semen analyses at least 30 days apart
- A high risk of transmitting the male partner’s genetic disorder to the offspring
- HIV+ male partner

In order to receive coverage for infertility services, male members must meet **either** of the following criteria based on semen analysis reports performed within the last 3 months:
- At least 2 unprocessed/processed semen analyses show <10 million total motile sperm,
- At least 2 unprocessed semen analyses show ≤ 2% strict Kruger normal forms.

Non-covered services include but are not limited to the following:
- Donor sperm without documented biological male factor infertility proven with 2 abnormal semen analyses with the same defect
- Donor sperm for biological males with genetic sperm defects
- For biological females without a biological male partner.
- The cost of donor sperm, IUI, ART, and related services, if the male partner has a history of prior vasectomy with no subsequent successful vasectomy reversal procedure.
- Cost of procurement of Donor Sperm

**Section 6: Fertility Preservation**

No infertility workup is required for coverage

Covered services for members undergoing chemotherapy that is expected to render them permanently infertile (excluding voluntary sterilization) are as follows:
- Up to 2 cycles of IVF; if the member is <44 years of age, she must have ovarian reserve testing. If testing demonstrates diminished ovarian reserve is present, then IVF cycle is not covered
- Sperm collection
- Frozen embryo transfer is covered when transferred back to member.

Non-covered services include but are not limited to the following:
- Cryopreservation of embryos or eggs for fertility preservation purposes other than chemotherapy or other treatments that may render an individual infertile.
- Cryopreservation of embryos or eggs for reciprocal IVF
- Sperm storage/banking for males requesting this service for convenience or “back-up” for a fresh specimen.
- Storage of cryopreserved sperm, eggs or embryos

**Section 7: Male Infertility**

A. Male Factor Infertility:

- **Mild Male Factor:** abnormalities in the semen analysis where the sperm concentration is ≥10 million/ml but <15 million/ml and/or progressive motility is ≥ 30% but < 40%
- **Moderate Male Factor:** abnormalities in the semen analysis where the sperm concentration is ≥5 million/ml but < 10 million/ml and/or progressive motility is ≥ 25% but <30%.
- **Severe Male Factor:** abnormalities in the semen analysis where the sperm concentration is <5 million/ml or sperm preparation techniques result in a sperm concentration of < 1 million motile sperm/ml.
- Isolated teratospermia is considered a male factor when there is <2% normal morphology on at least two semen analyses 1-4 weeks apart
B. Microepididymal Sperm Aspiration (MESA)
   - Covered only for congenital absence or congenital obstruction of the vas deferens (typically diagnosed by the absence of fructose in semen) and confirmed by exam.

C. Microdissection- Testicular Excisional Sperm Extraction (TESE)
   - Covered for non-obstructive azoospermia and spinal cord injury resulting in inability to ejaculate.

Section 8: Limitations/Exclusions

Non-covered tests/procedures include but are not limited to the following:

- Infertility treatment if, based on the member’s individual medical history they have < 5% chance of a birth outcome
- ART/Infertility services for Members 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, tobacco or alcohol)
- Infertility treatment, when infertility is the result of a non-reversed or unsuccessful reversal of a voluntary sterilization
- Ovarian Reserve Assessment results (Clomiphene Citrate Challenge Test (CCCT))
- Selective fetal reduction without known disorders that are non-compatible with life
- Sperm DNA integrity/fragmentation tests [e.g., sperm chromatin structure assay (SCSA), single-cell gel electrophoresis assay (Comet), deoxynucleotidyl transferase-mediated dUTP nick end labeling assay (TUNEL), sperm chromatin dispersion (SCD) or Sperm DNA Decondensation™ Test (SDD)]
- Sperm wash without approved cycle
- Laboratory tests for cycle monitoring when IUI or IVF cycle has not been approved.
- Infertility treatment when medically contraindicated (e.g. uterine or tubal abnormalities
- Gender selection
- Human zona binding assay (hemizona test)
- Serum anti-sperm antibody testing
- Sperm acrosome reaction test
- Co-culture of embryos
- Embryo toxic factor test (ETFL)
- Ovulation kits
- Post-coital testing
- In vitro maturation of eggs
- Direct intraperitoneal insemination (DIPI)
- Peritoneal ovum and sperm transfer (POST)
- Genetic engineering
- Egg harvesting, or other infertility treatment performed during an operation not related to an infertility diagnosis.
- 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
- 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, i.e. MESA/TESE, for a member who has undergone prior sterilization
- Monitoring of non-authorized IUI cycles
- Oocyte, ovarian or testicular tissue cryopreservation
- Storage of cryopreserved reproductive materials (i.e., embryos, oocytes, or sperm)
- All experimental/investigational procedures and treatments are not covered for the diagnosis and treatment of infertility as determined in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine.

**Coding Criteria:**

To access the codes, please download the policy and click on the links below

<table>
<thead>
<tr>
<th>Applicable CPT Codes</th>
</tr>
</thead>
</table>

**References**

**State Mandate Information**

Connecticut Bill No. 508 / Public Act No. 05-196
Connecticut State Mandate: Sec. 38a-536.
Massachusetts: 176G §4 211 CMR 37.00


Published jointly by the Practice Committees of the American Society for Reproductive Medicine


### Revision History

<table>
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| 08/14/2020 | Infertility Definition updated  
Added Section 1: General Indications for Initial and Continuation of Infertility Treatment Coverage  
Added sonohysterosalpingogram as a covered screening option for tubal occlusion.  
Enhanced male factor infertility definition (i.e., mild, moderate and severe factor parameters).  
Clarified that the first embryo transfer performed within 60 days of a freeze all cycle will be considered a continuation of the freeze-all cycle.  
Clarified that ICSI is also clinically indicated when fertilizing previously frozen oocytes.  
Clarified that IUIs to demonstrate infertility are not covered for women without male partners or exposure to sperm  
Noncovered additions to Limitations/Exclusions:  
a. Sperm DNA integrity/fragmentation tests [e.g., sperm chromatin structure assay (SCSA), single-cell gel electrophoresis assay (Comet), deoxynucleotidyl transferase-mediated dUTP nick end labeling assay (TUNEL), sperm chromatin dispersion (SCD) or Sperm DNA Decondensation™ Test (SDD)]  
b. Sperm wash without approved cycle  
c. Laboratory tests for cycle monitoring when IUI or IVF cycle has not been approved  
d. Infertility treatment when medically contraindicated (e.g. uterine or tubal abnormalities) |
| 02/14/2020 | Merged pre-implantation genetic testing criteria into policy. Clarified semen analysis must be current; within past 3 months. |
| 11/18/2019 | Clarified Experimental and Investigational treatment definition  
Added iatrogenic infertility definition  
Updated Cycle definition |
| 08/16/2019 | Removed PGD or PGS reference from document and replaced with PGT  
Freeze All Cycles section updated:  
2<sup>nd</sup> bullet removed “diagnosis” and replaced with “testing”.  
3<sup>rd</sup> bullet removed....” (preimplantation genetic screening) for the reason of aneuploidy in the setting of multiple spontaneous abortions of uncertain etiology.”  
Added IVF/PGT testing for gender selection is a benefit exclusion |
| 4/23/2019  | Additional codes added |
| 4/1/2019   | New policy |