Policy Number: CP-IFP21-011A

Effective Date: January 1,2024

Infertility Diagnosis

The purpose of this policy is to provide clarity and specificity for Infertility Diagnosis coverage. *UCare covers services to diagnose infertility. These include office visits, consultations, procedures, and tests needed to diagnose infertility.*

Some of the listed services may also be used for treatment. *Treatment of infertility is* ***not*** *a covered benefit.*

DISCLAIMER

Coverage Policies are developed to assist in identifying coverage for UCare benefits under UCare's health plans. They are intended to serve only as a general reference regarding UCare's administration of health benefits and are not intended to address all issues related to coverage for health services provided to UCare members.

These services may or may not be covered by all UCare products (refer to product section of individual coverage policy for product-specific detail). Providers are encouraged to have their UCare patient refer to their UCare plan documents (Evidence of Coverage/Member Handbook/Member Contract) for specific coverage information. If there is a conflict between a coverage policy and the UCare plan documents, the UCare plan documents prevail.

Coverage Policies do not constitute medical advice. Providers are responsible for submission of accurate and compliant claims.

PRODUCT SUMMARY

This coverage policy applies to the following UCare products:

UCare Product	Applies To
UCare Individual & Family Plans (IFP), UCare IFP with M Health Fairview	✓
UCare Medicare Plans, UCare Medicare with M Health Fairview & North Memorial Health, UCare Advocate Plus (HMO I-SNP), EssentiaCare	
UCare's Minnesota Senior Health Options (MSHO) (HMO D-SNP)	
UCare Connect + Medicare (HMO D-SNP)	
UCare Connect (SNBC)	
Prepaid Medical Assistance Program (PMAP), MinnesotaCare	
Minnesota Senior Care Plus (MSC+)	

Benefit category:

Infertility Diagnosis

Definitions and summary

Services received during an office visit may be covered under another benefit in the Contract. These categories include laboratory and diagnostic imaging, outpatient surgical. The most appropriate benefit in the Contract will apply for each service received.

*State law requires that services from network and non-network providers to **diagnose** infertility be covered at the same benefit level.*

- **Infertility:** is defined as the inability to conceive after one year (or longer) of unprotected sex.
    - *Because fertility in women is known to decline steadily with age, some providers evaluate and treat women aged 35 years or older after 6 months of unprotected sex.*
    - Infertility can be due to either male or female factors.
- **Secondary infertility**: Infertility in which one or more pregnancies have occurred before the present condition of infertility.

Coverage policy

Covered

Professional services necessary to diagnose infertility and related tests, facility charges, and laboratory work, including but not limited to diagnostic radiology, laboratory services, semen analysis, and diagnostic ultrasounds related to covered services.

Tests for diagnosing male infertility
A general physical exam and specific diagnostic fertility tests may include:

- **Semen analysis.** A lab test to analyze a semen specimen. Urine may be tested for the presence of sperm.
- **Hormone testing.** Blood test to determine the level of testosterone and other male hormones.
- **Testicular biopsy.** A testicular biopsy may be performed to identify abnormalities contributing to infertility. *This procedure can also be done to retrieve sperm for non-covered assisted reproductive techniques, such as IVF.*
- **Imaging.** Imaging studies such as transrectal or scrotal ultrasound, or a test of the vas deferens (vasography) may be performed.

Tests for diagnosing female infertility
A general physical exam, including a regular gynecological exam and specific diagnostic fertility tests may include:

- **Ovulation testing.** A blood test to measure hormone levels to determine ovulation.
- **Hysterosalpingography.** Hysterosalpingography evaluates the condition of the uterus and fallopian tubes and looks for blockages or other problems. X-ray contrast is injected into the uterus, and an X-ray is taken to determine if the cavity is normal and to see if the fluid spills out of the fallopian tubes.
- **Ovarian reserve testing.** Determines the quantity of the eggs available for ovulation. This approach often begins with hormone testing early in the menstrual cycle.
- **Other hormone testing.** Other hormone tests check levels of ovulatory hormones, as well as pituitary hormones that control reproductive processes.
- **Imaging tests.** Pelvic ultrasound looks for uterine or ovarian disease. Sometimes a *sonohysterogram*, or saline infusion sonogram is used to see details inside the uterus that are not seen on a regular ultrasound.

- **Hysteroscopy.** A hysteroscopy looks for uterine disease. During the procedure a thin, lighted device is inserted through the cervix into the uterus to view any potential abnormalities.
- **Laparoscopy.** A thin viewing device (laparoscope) is inserted into the abdomen to examine the fallopian tubes, ovaries, and uterus. It can be used to diagnose endometriosis, scarring, blockages, irregularities of the fallopian tubes, or abnormalities in the ovaries and uterus that interfere with fertility.

Not Covered

Once a diagnosis of infertility has been established, **all** services necessary to treat infertility are **not** covered. These include:

- Office visits and consultations
- Laboratory tests and diagnostic imaging tests (once diagnosis of infertility is made)
- Surrogate pregnancy and related obstetric /maternity benefits
- Sperm, ova or embryo acquisition, retrieval, or storage
- Reversal of sterilization
- Assisted reproduction including
    - artificial insemination (AI),
    - intrauterine insemination (IUI),
    - gamete intrafallopian tube transfer (GIFT),
    - zygote intrafallopian tube transfer (ZIFT),
    - intracytoplasmic sperm injection (ICSI),
    - in-vitro fertilization (IVF), and all related charges,
    - preimplantation genetic screening (PGS) and preimplantation genetic diagnosis (PGD)
- All oral and/or injectable drugs used to treat infertility, including, but not limited to:
    - Clomiphene (Clomid)
    - Human chorionic gonadotropin (hCG), such as Novarel, Ovidrel, Pregnyl, Profasi.
    - Follicle-stimulating hormone (FSH), such as Bravelle, Fertinex, Follistim, Gonal-F.
    - Human menopausal gonadotropin (hMG), such as Menopur, Metrodin, Pergonal, Repronex.
    - Gonadotropin-releasing hormone (GnRH), such as Factrel, Lutrepulse.
    - Gonadotropin-releasing hormone agonist (GnRH agonist), such as Lupron, Synarel, Zoladex.
    - Gonadotropin-releasing hormone antagonist (GnRH antagonist), such as Antagon, Cetrotide.

CPT/ HCPCS/ICD-10 Codes		
*Note: If available, codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. This list may not be all-inclusive.		
CPT®, HCPCS or ICD-10 CODES	**Modifier**	**Narrative Description**
58350		Chromotubation of oviduct, including materials
58770		Salpingostomy, Salpingoneostomy
76948		Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation
84830		Ovulation tests, by visual color comparison methods for human luteinizing hormone
89257		Sperm identification from aspiration (other than seminal fluid)
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
89329		Sperm evaluation; hamster penetration test
89331		Sperm evaluation, for retrograde ejaculation, urine (sperm concentration, motility, and morphology, as indicated)
Q0115		Postcoital direct, qualitative examinations of vaginal or cervical mucous
S3655		Antisperm antibodies test (immunobead)
58345		Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography

*CPT is a registered trademark of the American Medical Association.

Prior authorization
Not required

Related policies and documentation	
References to other policies or documentation that may be relevant to this policy	
Policy Number	**Policy Description**
None	

References and source documents
Links to the UCare contracts, Center for Medicare and Medicaid Services (CMS), MHCP, Minnesota statute and other relevant documents used to create this policy
Individual and Family Plan (IFP) member contract:
Minnesota Statute (62Q.14) regarding Restrictions on Enrollee Services:
Individual and Family Plan (IFP) Formulary

Coverage policy development and revision history		
Version	**Date**	**Note(s)**
V1	Oct. 1, 2021	New policy; original effective date
	Dec.14, 2021	Annual review; no changes
	Nov. 30, 2022	Annual review; no changes
	Oct. 18, 2023	Annual Review: No substantive changes