Fertility Preservation for Iatrogenic Infertility

Guideline Number: CDG.039.02
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Instructions for Use

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Related Commercial Policies

- Infertility Diagnosis and Treatment
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Coverage Rationale

Indications for Coverage

Certain plans may include coverage for fertility preservation. Refer to the member specific benefit plan document to determine if this coverage applies.

Fertility Preservation for Iatrogenic Infertility

Benefits are available for fertility preservation for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer. Services include the following procedures, when provided by or under the care or supervision of a Physician:

- Collection of sperm
- Cryo-preservation of sperm
- Ovarian stimulation, retrieval of eggs and fertilization
- Oocyte cryo-preservation
- Embryo cryo-preservation

Benefits for medications related to the treatment of fertility preservation are considered under the Outpatient Prescription Drug benefit or under the Pharmaceutical Products. Check the member specific benefit plan document for inclusion or exclusion.

For medical necessity criteria, refer to the Fertility Solutions Medical Necessity Clinical Guideline: Infertility.

Coverage Limitations and Exclusions

- Benefits are not available for embryo transfer
- Benefits are not available for long-term storage costs (greater than one year)
- Benefits are further limited to one cycle of fertility preservation for Iatrogenic Infertility per covered person during the entire period of time he or she is enrolled for coverage under the policy

Documentation Requirements

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

CPT/HCPCS Codes*	Required Clinical Information
Fertility Preservation for Iatrogenic Infertility	
58970, 89250, 89251, 89253, 89254, 89258, 89259, 89260, 89261, 89264, 89268, 89272, 89280, 89281, 89337, 89342, 89343, 89346, S4011, S4022, S4030, S4031	Medical notes documenting the following, when applicable: • Initial history and physical • All clinical notes including rationale for proposed treatment plan • All ovarian stimulation sheets for timed intercourse, IUI, and/or IVF cycles • All embryology reports • All operative reports • Laboratory report FSH, AMH, estradiol, and any other pertinent information • Ultrasound report antral follicle count and any other pertinent information • HSG report • Semen analysis

**For code descriptions, see the Applicable Codes section.*

Definitions

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

Iatrogenic Infertility: An impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

Medically Necessary: Health care services that are all of the following as determined by us or our designee:
- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on your ID card. They are also available to Physicians and other health care professionals on UHCprovider.com.

Physician: Any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Coding Clarification: Claims must be submitted with Diagnosis code Z31.84 in order for the benefit to apply.

CPT Code	Description
58970	Follicle puncture for oocyte retrieval, any method
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
89253	Assisted embryo hatching, microtechniques (any method)
89254	Oocyte identification from follicular fluid
89258	Cryopreservation; embryo
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 oocyte(s)/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
89337	Cryopreservation, mature oocyte(s)
89342	Storage, (per year); embryo(s)
89343	Storage, (per year); sperm/semen
89346	Storage, (per year); oocyte(s)

HCPCS Code	Description
S0122	Injection, menotropins, 75 IU
S0126	Injection, follitropin alfa, 75 IU
S0128	Injection, follitropin beta, 75 IU
S0132	Injection, ganirelix acetate 250 mcg
S4011	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
S4022	Assisted oocyte fertilization, case rate
S4027	Storage of previously frozen embryos

HCPCS Code	Description
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
J0725	Injection, chorionic gonadotropin, per 1,000 USP units
J3355	Injection, urofollitropin, 75 IU

Diagnosis Code	Description
Z31.84	Encounter for fertility preservation procedure

References

American Society for Reproductive Medicine. Fertility preservation in patients undergoing gonadotoxic therapy or gonadectomy: a committee opinion. December 2019.

UnitedHealthcare Insurance Company Generic Certificate of Coverage 2018.

Guideline History/Revision Information

Date	Summary of Changes
09/01/2021	**Coverage Rationale** • Added instruction to refer to the *Fertility Solutions Medical Necessity Clinical Guideline: Infertility* for medical necessity criteria ***Coverage Limitations and Exclusions*** • Added language to indicate benefits are limited to one cycle of fertility preservation for Iatrogenic Infertility per covered person during the entire period of time he or she is enrolled for coverage under the policy **Supporting Information** • Archived previous policy version CDG.039.01

Instructions for Use

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

This Coverage Determination Guideline may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Coverage Determination Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.