Preimplantation Genetic Testing (PGT) and Related Services

Guideline Number: CDG.040.02
Effective Date: August 1, 2021

Instructions for Use

Table of Contents Page

Related Commercial Policies

- Fertility Preservation for Iatrogenic Infertility
- Infertility Diagnosis and Treatment
- Infertility Services
- Preimplantation Genetic Testing

Related Optum Clinical Guideline

- Fertility Solutions Medical Necessity Clinical Guideline: Infertility

Coverage Rationale

Indications for Coverage

Certain plans may include coverage for:

- Preimplantation genetic testing
- PGT-M or PGT-SR. PGT-M or PGT-SR as it may be considered a covered expense if the fetus is at risk for a genetic disorder

Refer to the member specific benefit plan document to determine if the coverage applies.

Preimplantation Genetic Testing (PGT) and Related Services

Preimplantation Genetic Testing (PGT) performed to identify and to prevent genetic medical conditions from being passed onto offspring. To be eligible for benefits the following must be met:

- PGT must be ordered by a Physician after genetic counseling
- The genetic medical condition, if passed onto offspring, would result in significant health problems or severe disability and be caused by a single gene (detectable by PGT-M) or structural changes of a parents' chromosome (detectable by PGT-SR)
- Benefits are limited to PGT for the specific genetic disorder and the following related services when provided by or under the supervision of a Physician:
  - Ovulation induction (or controlled ovarian stimulation)
  - Egg retrieval, fertilization and embryo culture
  - Embryo biopsy
  - Embryo transfer
  - Cryo-preservation and short-term embryo storage (less than one year)

Refer to the Medical Policy titled Preimplantation Genetic Testing for additional information.

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

Coverage Limitations and Exclusions

- Benefits are not available for long-term storage costs (greater than one year)

- Benefits are not available for Preimplantation Genetic Testing – Aneuploidy (PGT-A)

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
Preimplantation Genetic Testing	
81228 81229 81479	Medical notes documenting the following, when applicable: • Family history information related to the condition for which the member is being tested • Genetic testing results supporting the family history concerns [i.e., confirmation that the condition(s) being assessed for actually exist] • Genetic counseling documentation (if available)
Related Services	
58970, 58974, 76948, 89250, 89251, 89253, 89254, 89255, 89258, 89260, 89261, 89264, 89268, 89272, 89280, 89281, 89290, 89291, 89342, 89257, 89352, S4011, S4015, S4016, S4022, S4037	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.

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.

Preimplantation Genetic Testing (PGT): A test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. These include:

- PGT-M - for monogenic disorder (formerly single-gene PGD).
- PGT-SR - for structural rearrangements (formerly chromosomal PGD).

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.

CPT Code	Description
58970	Follicle puncture for oocyte retrieval, any method
58974	Embryo transfer, intrauterine
76948	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation
81228	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants (e.g., bacterial artificial chromosome [BAC] or oligo-based comparative genomic hybridization [CGH] microarray analysis)
81229	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities
81479	Unlisted molecular pathology procedure
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
89254	Oocyte identification from follicular fluid
89255	Preparation of embryo for transfer (any method)
89258	Cryopreservation; embryo(s)
89260	Sperm isolation: simple prep (sperm wash and swim-up) for insemination or diagnosis
89261	Sperm isolation: complex prep (Percoll gradient,albumin gradient) for insemination or diagnosis
89264	Sperm indentification from testis tissue, fresh or cyropreserved
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
89290	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos
89291	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos

CPT Code	Description
89342	Storage (per year); embryo(s)
89257	Sperm Identification from aspiration (other then seminal fluid)
89352	Thawing of cryopreserved: embryos(s)

HCPCS Code	Description
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
S4015	Complete in vitro fertilization cycle, not otherwise specified
S4016	Frozen in vitro fertilization cycle, case rate
S4022	Assisted oocyte fertilization, case rate
S4037	Cryopreserved embryo transfer, case rate

References

Society for Assisted Reproductive Technology and American Society for Reproductive Medicine. Preimplantation genetic testing: a practice committee opinion. Fertil Steril. 2008 Nov; 90(5 Suppl):S136-43.

UnitedHealthcare Insurance Company Generic Certificate of Coverage 2018.

Guideline History/Revision Information

Date	Summary of Changes
08/01/2021	Coverage Rationale • Added instruction to refer to the *Fertility Solutions Medical Necessity Clinical Guideline: Infertility* for medical necessity criteria Supporting Information • Archived previous policy version CDG.040.01

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.