

Fertility Preservation for Iatrogenic Infertility

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[Instructions for Use](#)

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Related Policies

- [Infertility Diagnosis and Treatment](#)
- [Preimplantation Genetic Testing \(PGT\) and Related Services](#)

Related Optum Clinical Guideline

- [Fertility Solutions Medical Necessity Clinical Guideline: Infertility](#)

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.

Coverage Limitations and Exclusions

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

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.

Required Clinical Information

Fertility Preservation for Iatrogenic Infertility

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

Definitions

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

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.

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.

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

Prior Authorization Requirements

Prior authorization is required in all sites of service.

Notes:

- Participating providers in the office setting: Prior authorization is required for services performed in the office of a participating provider.
- Non-participating/out-of-network providers in the office setting: Prior authorization is not required but is encouraged for out-of-network services. If prior authorization is not obtained, Oxford will review for out-of-network benefits and medical necessity after the service is rendered.

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 policy 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 may apply.

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

CPT Code	Description
58321	Artificial insemination; intra-cervical
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)

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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

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
S4022	Assisted oocyte fertilization, case rate
S4027	Storage of previously frozen embryos
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

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Medical Technology Assessment Committee. [CDG.039.01]

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

Policy History/Revision Information

Date	Summary of Changes
01/01/2022	<ul style="list-style-type: none"> New Clinical Policy

Instructions for Use

This Clinical Policy provides assistance in interpreting UnitedHealthcare Oxford 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 policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare Oxford reserves the right to modify its Policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice.

The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual[®] criteria, to assist us in administering health benefits. UnitedHealthcare Oxford Clinical Policies 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.