KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

Clinical Review Criteria
Fertility Services

Criteria

For Medicare Members

Source	Policy
CMS Coverage Manuals	None
National Coverage Determinations (NCD)	None
Local Coverage Determinations (LCD)	None
Local Coverage Article	None

Non-Medicare Members

Referrals to Reproductive Endocrinology and Infertility (REI) specialists and associated services are not covered as a base benefit and are only eligible for coverage when the member has a sterility and infertility (SI) rider or other evidence of coverage in their contract. **When a Sterility/Infertility (SI) rider is present, initial consultation with an REI specialist is covered without additional criteria review. However, tests and procedures are subject to clinical criteria (as elaborated below).**

Please note that individual riders/contracts may vary in benefit design either excluding or waiving criteria for some services. These may include, but are not limited to, fertility-promoting medications, medications for erectile dysfunction, artificial insemination, in vitro fertilization, long-term cryopreservation, surrogacy services and tubal reanastomosis. The member's rider/contract should be reviewed before making a final coverage determination and supersedes clinical review criteria.

Reproductive services are also subject to lifetime coverage limits which vary by rider/contract and service category.

Exclusions

Unless otherwise stated in the members rider/contract, the following services are not covered

- Reproductive services after voluntary sterilization of a male or female partner (e.g., tubal ligation, vasectomy), including tubal reanastomosis, vas reanastomosis, sperm extraction, artificial insemination and in vitro fertilization
- Long-term cryopreservation (i.e., apart from real-time efforts to conceive)
- Costs related to donor genetic material used for artificial insemination or invitro fertilization
- Services for the purpose of surrogacy
- Routine use of pre-implantation genetic testing (with IVF); medical necessity criteria for pre-implantation genetic testing can be found in a separate clinical criteria - see PGD criteria here

The following services are subject to clinical review criteria unless the services have been specifically excluded or the criteria has been waived in the member's rider/contract.

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Definition of Infertility	The definition of infertility is used to determine eligibility for infertility workup (e.g., diagnostic laboratory or imaging studies) apart from other reproductive services enumerated below. Based on Kaiser Permanente policy, a member is considered infertile if they are unable to conceive or produce conception: • Inability to achieve conception after frequent unprotected heterosexual intercourse lasting 12 months for members under 35 years of age or 6 months for members 35 years of age and older • Inability to achieve conception after 6 cycles of artificial insemination (of which at least 3 cycles must be medically supervised) for members under 35 years of age or 3 cycles of medically supervised artificial insemination for members 35 years of age and older • A member is not considered “infertile” if they have had a voluntary sterilization (e.g., tubal ligation, vasectomy) **Some members may be eligible for reproductive services without meeting the definition of infertility. Please refer to specific criteria listed below.*
Pharmaceutical Therapy to Promote Fertility	• Both oral and injectable medications to promote ovulation for the purpose of fertility require evidence of coverage (SI rider or contract language) and are covered under the pharmacy benefit subject to any applicable prior auth requirements. • Medications for erectile dysfunction are not covered under this policy but may or may not be covered under the pharmacy benefit subject to any applicable prior auth requirements.
Artificial insemination (AI)	AI including intravaginal, intracervical, and intrauterine insemination techniques and associated medications, laboratory, imaging, and procedure codes may be covered for the purpose of conception. This includes hysterosalpingogram that would confirm tubal patency necessary for the success of such techniques. Members are eligible for coverage when they have a SI rider that does not specifically exclude these services, have not exceeded their lifetime maximum and meet **ONE OR MORE** of the following criteria: • Natal female member without a male partner (applies to single members and same-sex female couples) • Natal female member’s male partner is unable to participate in natural insemination due to a physical condition. Erectile dysfunction responsive to medical therapy is excluded even when such medication is not a covered benefit. • Inability to achieve conception after frequent unprotected heterosexual intercourse lasting 12 months for members under 35 years of age or 6 months for members 35 years of age and older • Documentation of an infectious disease that would make unprotected heterosexual intercourse unsafe according to the medical opinion of the member’s treating clinician • Documentation of a heritable genetic trait in the male partner (such as an autosomal dominant trait in the male or co-occurrence of an autosomal recessive trait in both partners)

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	would jeopardize the future health of naturally inseminated offspring according to the medical opinion of the member's treating clinician and the member intends to use donor genetic material that does not pose the same risk
In Vitro Fertilization (IVF)	IVF techniques including egg retrieval, fertilization, short-term storage, implantation and associated medications, laboratory, imaging, and procedure codes are eligible for coverage when the member has an SI rider that does not specifically exclude these services, has not exceeded their lifetime maximum and meets **ONE OR MORE** of the following criteria: • Inability to achieve conception after frequent unprotected heterosexual intercourse lasting 12 months for members under 35 years of age or 6 months for members 35 years of age and older • Presence of previously diagnosed male-factor infertility that is reasonably expected to prevent conception (with heterosexual intercourse or artificial insemination). Mild to moderately reduced sperm count and/or motility are not included. • Inability to achieve conception after 6 cycles of artificial insemination (of which at least 3 cycles must be medically supervised) for members under 35 years of age or 3 cycles of medically supervised artificial insemination for members 35 years of age and older • Presence of previously diagnosed female factor infertility that is reasonably expected to prevent conception with heterosexual intercourse or artificial insemination (e.g., fallopian tubes are not patent) • Member has coverage and meets criteria for Preimplantation Genetic Testing
Surgical Procedures of the Fallopian Tube(s) to Promote Fertility	Surgical therapy of the fallopian tube(s) to promote fertility may be covered when the patient has an SI rider or evidence of coverage in their contract and meets **ALL** of the following criteria: • Member meets the definition of infertility above • Imaging (HSG) confirms scarring of the fallopian tube(s) or the patient has undergone prior surgery of the fallopian tube(s) not for the purpose of voluntary sterilization (e.g. ectopic tubal pregnancy) • The member intends to become pregnant once tubal patency is re-established • The member has not had a voluntary tubal ligation for the purpose of sterilization

If requesting these services, please send the following documentation to support medical necessity:

• Last 6 months of clinical notes from requesting provider &/or specialist

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, Kaiser Permanente will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background

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Infertility is a common problem. According to the Centers for Disease Control and Prevention (CDC), about 10 percent of U.S. women ages 15 through 44 years have difficulty getting pregnant or staying pregnant.[1]

Both women and men can have problems that cause infertility. About one-third of infertility cases can be connected to the woman. Another third of the cases of infertility can be connected to the man. In the remainder of instances, a cause can't be found.

Applicable Codes

Member contracts differ in health plan benefits. Always consult the patient's Evidence of Coverage or call Kaiser Permanente Member Services at 1-888-901-4636 (TTY 711), Monday through Friday, 8 a.m. to 5 p.m. to determine coverage for a specific medical service.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT® or HCPC Codes	Description
Diagnostic services to Evaluate Potential Infertility	
54500	Biopsy of testis, needle (separate procedure)
54505	Biopsy of testis, incisional (separate procedure)
54800	Biopsy of epididymis, needle
55200	Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)
55300	Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral
55550	Laparoscopy, surgical, with ligation of spermatic veins for varicocele
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography
58345	Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography
58350	Chromotubation of oviduct, including materials
58540	Hysteroplasty, repair of uterine anomaly (Strassman type)
58560	Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58740	Lysis of adhesions (salpingolysis, ovariolysis)
58752	Tubouterine implantation
58770	Salpingostomy (salpingoneostomy)
58920	Wedge resection or bisection of ovary, unilateral or bilateral
74740	Hysterosalpingography, radiological supervision and interpretation
76831	Saline infusion sonohysterography (SIS), including color flow Doppler, when performed
89300	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)
89310	Semen analysis; motility and count (not including Huhner test)
89320	Semen analysis; volume, count, motility, and differential
89321	Semen analysis; sperm presence and motility of sperm, if performed
89322	Semen analysis; volume, count, motility, and differential using strict morphologic criteria (eg, Kruger)
89325	Sperm antibodies
89329	Sperm evaluation; hamster penetration test
89330	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test
89331	Sperm evaluation, for retrograde ejaculation, urine (sperm concentration, motility, and morphology, as indicated)
G0027	Semen analysis; presence and/or motility of sperm excluding Huhner
Q0115	Postcoital direct, qualitative examinations of vaginal or cervical mucous
S3655	Antisperm antibodies test (immunobead)

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

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CPT® or HCPC Codes	Description
Intrauterine Insemination (ICI/IUI)	
58321	Artificial insemination; intra-cervical
58322	Artificial insemination; intra-uterine
58323	Sperm washing for artificial insemination
89260	Sperm isolation; simple prep (eg, sperm wash and swim-up) for insemination or diagnosis with semen analysis
89261	Sperm isolation; complex prep (eg, Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis
89268	Insemination of oocytes
S4035	Stimulated intrauterine insemination (IUI), case rate
Advanced Reproductive/Fertilization Services (IVF)	
58970	Follicle puncture for oocyte retrieval, any method
58974	Embryo transfer, intrauterine
76948	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation
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
89255	Preparation of embryo for transfer (any method)
89257	Sperm identification from aspiration (other than seminal fluid)
89258	Cryopreservation; embryo(s)
89259	Cryopreservation; sperm
89264	Sperm identification from testis tissue, fresh or cryopreserved
89272	Extended culture of oocyte(s)/embryo(s), 4-7 days
89335	Cryopreservation, reproductive tissue, testicular
89337	Cryopreservation, mature oocyte(s)
89342	Storage (per year); embryo(s)
89343	Storage (per year); sperm/semen
89344	Storage (per year); reproductive tissue, testicular/ovarian
89346	Storage (per year); oocyte(s)
89352	Thawing of cryopreserved; embryo(s)
89353	Thawing of cryopreserved; sperm/semen, each aliquot
89354	Thawing of cryopreserved; reproductive tissue, testicular/ovarian
89356	Thawing of cryopreserved; oocytes, each aliquot
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, case rate
S4016	Frozen in vitro fertilization cycle, case rate
S4017	Incomplete cycle, treatment cancelled prior to stimulation, case rate
S4018	Frozen embryo transfer procedure cancelled before transfer, case rate
S4020	In vitro fertilization procedure cancelled before aspiration, case rate
S4021	In vitro fertilization procedure cancelled after aspiration, case rate
S4027	Storage of previously frozen embryos
S4028	Microsurgical epididymal sperm aspiration (MESA)
S4030	Sperm procurement and cryopreservation services; initial visit
S4031	Sperm procurement and cryopreservation services; subsequent visit
S4037	Cryopreserved embryo transfer, case rate
S4040	Monitoring and storage of cryopreserved embryos, per 30 days
Zygote Intra-Fallopian Transfer (ZIFT)	
58976	Gamete, zygote, or embryo intrafallopian transfer, any method
S4014	Complete cycle, zygote intrafallopian transfer (ZIFT), case rate
Gamete Intra-Fallopian Transfer (GIFT)	
S4013	Complete cycle, gamete intrafallopian transfer (GIFT), case rate
Intracytoplasmic Sperm Injection (ICSI); or Ovum Microsurgery	

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55870	Electroejaculation
89280	Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes
89281	Assisted oocyte fertilization, microtechnique; greater than 10 oocytes
Sterilization Reversal Services	
55400	Vasovasostomy, vasovasorrhaphy
58750	Tubotubal anastomosis
58760	Fimbrioplasty
58672	Laparoscopy, surgical; with fimbrioplasty
58673	Laparoscopy, surgical; with salpingostomy (salpingoneostomy)

Considered Not Covered:

CPT® or HCPC Codes	Description
S4023	Donor egg cycle, incomplete, case rate
S4025	Donor services for in vitro fertilization (sperm or embryo), case rate
S4026	Procurement of donor sperm from sperm bank

****To verify authorization requirements for a specific code by plan type, please use the **Pre-authorization Code Check**.

Creation Date	Review Date	Date Last Revised
1/25/2019	02/05/2019[MPC], 01/07/2020[MPC], 01/05/2021[MPC], 01/04/2022[MPC], 01/10/2023[MPC]	08/22/2023

[MDCRPC] Medical Director Clinical Review and Policy Committee

[MPC] Medical Policy Committee

Revision History	Description
02/05/2019	MPC approved to adopt coverage for KP I&F and SBG plans
06/04/2019	Added SEIU has no requirements regarding: age, duration of time, or gender per SEIU contract
05/05/2020	Information regarding the SI-AO rider for SIEU cryopreservation (Effective 8/1/2020) was added
01/04/2022	Added definition of infertility from KP policy document. Listed groups that are no longer requiring a diagnosis of infertility for members to access benefit as of 01/01/2022.
12/16/2022	Updated criteria to include indication for, *"A member is not considered "infertile" if they have had a voluntary sterilization."*
06/06/2023	MPC approved to adopt the proposed changes to Fertility Services criteria definition of infertility with additional indications for AI and IVF. Renamed title of criteria to "Fertility Services" (formerly Infertility Services). Requires 60-day notice, effective 11/1/2023.
8/22/2023	Updated applicable codes

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