NO. 91163

INFERTILITY DIAGNOSIS AND TREATMENT/ ASSISTED REPRODUCTION

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Policy scope: This policy addresses the evaluation and treatment of infertility, including diagnostic services, management of underlying causes, and services related to assisted reproduction and fertility preservation

Related policies:

- Genetics: Counseling, Testing, Screening No. 91540
- Recurrent Pregnancy Loss No. 91156

I. MEDICAL NECESSITY CRITERIA

A. Establishment of Infertility Diagnosis

Inclusions

1. Priority Health may consider a member infertile when one of the following criteria is met:

    a. The inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.
    b. The need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner.
    c. Female member with sperm exposure
        i. Failure to achieve pregnancy after 12 months of regular, unprotected intercourse when the female member is younger than 35 years of age.
        ii. Failure to achieve pregnancy after 6 months of regular, unprotected intercourse when the female member is 35 years of age or older.
    d. Female member without sperm exposure
        i. Failure to achieve pregnancy following a sufficient number of therapeutic donor insemination cycles in accordance with current ASRM clinical practice guidelines (typically after 6 unsuccessful cycles).

Note: Nothing in this definition shall be used to deny or delay treatment to any individual, regardless of relationship status or sexual orientation.

Limitations

The following limitations apply:

1. Meeting the definition of infertility does not guarantee benefit eligibility. Coverage, quantity limits, frequency limits, and applicable exclusions may vary by product, group, rider, and line of business. Please refer to a member's plan documents, including riders if available, for specific pharmacy or medical benefits availability and the terms and conditions of coverage.

B. Infertility Diagnostic and Treatment Services

Benefit Requirement

Diagnostic testing and treatment services for the evaluation and management of infertility are eligible for coverage only when the member's benefit plan includes reproductive services benefits. Coverage is limited to services used to establish the cause of infertility and to treat an underlying medical condition contributing to infertility. Benefits vary by product, employer group, and plan design.

1. **Diagnostic Testing Services:**

1.A. Female Factor Diagnostic Testing Services

Inclusions

Priority Health may consider the following diagnostic services medically necessary for an individual that meets the definition of infertility, as outlines in Section I, when specifically indicated and performed to establish the etiology of infertility:

a. **Clinical Evaluation**
   - **i.** Comprehensive reproductive, medical, surgical, family, and menstrual history
   - **ii.** Physical examination

b. **Laboratory Tests**
   - **i.** Endocrine evaluation, including the following:
     - **a)** Follicle-stimulating hormone (FSH)
     - **b)** Luteinizing hormone (LH) when clinically indicated (e.g., suspected ovulatory dysfunction or PCOS)
     - **c)** Estradiol (E2)
     - **d)** Progesterone
     - **e)** Testosterone (T) when clinically indicated (e.g., suspected hyperandrogenism or PCOS)
     - **f)** Prolactin (PRL) when clinically indicated (e.g., ovulatory disorder, galactorrhea or a pituitary tumor)
     - **g)** Thyroid-stimulating hormone (TSH) when clinically indicated (member has symptoms of thyroid disease)
   - **ii.** Ovarian reserve assessment when clinical indicated including:
     - **a)** Anti-Müllerian hormone (AMH)
     - **b)** Cycle Day 3 FSH testing

c. **Imaging and Diagnostic Procedures**
   - **i.** Pelvic ultrasound
   - **ii.** Transvaginal ultrasound (TVUS)
   - **iii.** Saline infusion sonohysterography (SIS)
   - **iv.** Hysterosalpingography (HSG)
   - **v.** Hysterosalpingo-Contrast Sonography (HyCoSy)
   - **vi.** Diagnostic hysteroscopy when clinically indicated

vii. Diagnostic laparoscopy with or without chromotubation when clinically indicated (e.g., evaluation of pelvic pathology, tubal disease, or endometriosis).
viii. Antral follicle count (AFC) by ultrasonography

Exclusions

The following are not medically necessary when performed solely as routine infertility screening without specific clinical indications:

a. Endometrial biopsy for routine infertility evaluation
b. Routine thrombophilia testing including but not limited to:
    i. Prothrombin (Factor II) mutation testing
    ii. Factor V Leiden mutation testing
c. Routine immunologic testing, including but not limited to:
    i. Antiphospholipid antibody panels
    ii. Reproductive immunophenotyping
    iii. Natural killer cell testing
    iv. Cytokine testing
d. Routine postcoital testing
e. Endometrial receptivity testing (e.g., Endometrial Receptivity Analysis [ERA])
f. Vaginal microbiome testing
g. Routine serum inhibin B testing
h. Routine prolactin test in the absence of clinical findings suggestive of ovulatory dysfunction, galactorrhea or pituitary disease
i. Routine thyroid function testing in the absence of signs, symptoms, or clinical suspicion of thyroid disease
j. Experimental, investigational, or unproven infertility diagnostic tests, including tests not supported by current ASRM, ACOG, or other generally accepted infertility evaluation guidelines

Limitations

The following limitations apply:

a. Diagnostic testing must be clinically appropriate and directed toward identifying or confirming the cause of infertility
b. Meeting medical necessity criteria does not guarantee benefit eligibility. Coverage, quantity limits, frequency limits, and applicable exclusions may vary by product, group, rider, and line of business. Please refer to a member's plan documents, including riders if available, for specific pharmacy or medical benefits availability and the terms and conditions of coverage.

1.B. Male Factor Diagnostic Testing Services

Inclusions

Priority Health may consider the following diagnostic services medically necessary when performed to establish the etiology of infertility:

- **a. Clinical Evaluation**
  - **i.** Comprehensive reproductive, medical, surgical, and family history
  - **ii.** Physical examination

- **b. Laboratory Tests**
  - **i.** Semen Analysis
    - **1)** Evaluation of:
      - **a.** Semen volume
      - **b.** pH
      - **c.** Sperm concentration
      - **d.** Total sperm number
      - **e.** Total motility
      - f. Progressive motility
      - **g.** Vitality
      - **h.** Sperm morphology
    - **2)** Additional semen testing when clinically indicated:
      - **a.** Fructose
      - **b.** Leukocyte count
    - **3)** Repeat semen analysis for the following indications:
      - **a.** First semen analysis is abnormal; or
      - **b.** Gross spermatozoa deficiency detected (azoospermia or severe oligozoospermia)

  - **ii.** Endocrine evaluation when clinically indicated, including:
    - **1)** Follicle-stimulating hormone (FSH)
    - **2)** Luteinizing hormone (LH)
    - **3)** Total testosterone
    - **4)** Free testosterone
    - **5)** Prolactin
    - **6)** Thyroid-stimulating hormone (TSH)
  - **iii.** Antisperm antibody testing when clinically indicated
  - **iv.** Post-ejaculatory urinalysis when clinically indicated

c. **Imaging and Diagnostic Procedures**
    i. Scrotal ultrasound
    ii. Transrectal ultrasound (TRUS)
    iii. Testicular biopsy when clinically indicated (e.g., azoospermia or suspected obstructive pathology)
    iv. Vasography when clinically indicated and performed in conjunction with surgical evaluation of suspected obstructive azoospermia

Exclusions

The following are considered not medically necessary for routine infertility evaluation:

a. Repeat semen analysis when first test indicates that all semen parameters are within reference range
b. Computer-assisted sperm analysis
c. Sperm deoxyribonucleic acid (DNA) fragmentation testing
d. Sperm capacitation testing
e. Hyaluronan binding assays
f. Reactive oxygen species testing
g. Sperm acrosome reaction testing
h. Routine antisperm antibody testing
i. Routine sperm aneuploid testing
j. Routine sperm RNA testing
k. Routine seminal plasma biomarker testing
l. Hamster penetration testing
m. Routine thrombophilia testing including but not limited to:
    i. Prothrombin, (Factor II) mutation testing
    ii. Factor V Leiden mutation testing
n. Experimental, investigational, or unproven male infertility diagnostic tests, including but not limited to tests not supported by current AUA, ASRM, or other generally accepted infertility evaluation guidelines

Limitations

The following limitations apply:

a. Diagnostic testing must be clinically appropriate and directed toward identifying or confirming the underlying cause of infertility.
b. Genetic testing must be supported by clinical findings and consistent with generally accepted infertility guidelines.

c. Meeting medical necessity criteria does not guarantee benefit eligibility. Coverage, quantity limits, frequency limits, and applicable exclusions may vary by product, group, rider, and line of business. Please refer to a member's plan documents, including riders if available, for specific pharmacy or medical benefits availability and the terms and conditions of coverage.

2. Treatment of Infertility Services

2.A. Treatment of Underlying Causes of Female Infertility

Inclusions

Priority Health may consider treatment services directed at correcting an underlying medical condition causing infertility medically necessary when:

a. The member meets the definition of infertility, as outlined in Section I; and
b. The treatment is intended to restore, preserve, or improve reproductive function; and
c. The treatment is clinically appropriate for the identified cause of infertility; and
d. The treatment is supported by current evidence-based clinical guidelines

1. Examples of treatment services include, but are not limited to:

- **Medical Treatments**
  - Ovulation induction medications, adjunctive medications and ovulation monitoring studies (e.g., ultrasound and endocrine labs)
  - Timed intercourse with oral ovulation agents for ovulation induction
  - Timed intercourse with oral and injectable medications for ovulation induction

- **Surgical Treatments**
  - Tubal disease
    - Tubal recanalization
    - Tuboplasty/fimbrioplasty/neosalpingostomy (for scarring/blockage)
    - Salpingectomy for hydrosalpinx
    - Salpingostomy
  - Uterine cavity disorders
    - Myomectomy (e.g., fibroids contributing to infertility)
    - Uterine septum resection

        - Adhesiolysis (Lysis of intrauterine adhesions)
        - Polypectomy
    - Ovarian/Pelvic factors
        - Ovarian cystectomy
        - Lysis of pelvic adhesions
        - Treatment of endometriosis
        - Ovarian drilling/wedge resection
    - Therapeutic hysteroscopy

Exclusions

The following are not medically necessary:

a. Treatment of infertility that is directly related to a voluntary sterilization procedure
b. Services performed to reverse a voluntary sterilization procedure (e.g., Tuboplasty)
c. Treatment that is experimental, investigational, or unproven for infertility
d. Services performed solely to enhance fertility in the absence of an infertility diagnosis

Limitations

The following limitations apply:

a. Services must be directed toward treatment of a documented infertility related medical condition.
b. Services must be consistent with generally accepted standards of
c. reproductive medicine and performed by appropriately qualified providers
d. The individual receiving the treatment or service must be a covered PH member and otherwise to be eligible under the applicable benefit plan. For example, coverage for semen analysis would require that they are a member of Priority Health.
e. Meeting medical necessity criteria does not guarantee benefit eligibility. Coverage, quantity limits, frequency limits, and applicable exclusions may vary by product, group, rider, and line of business. Please refer to a member's plan documents, including riders if available, for specific pharmacy or medical benefits availability and the terms and conditions of coverage.
f. Pharmacologic intervention: Limitations may apply. Pharmacy benefits may vary by product and line of business. Please check benefit plan descriptions and formularies for details on which specific medications are covered if any. The medications may not be covered for members without pharmacy benefit plans; in

addition, some pharmacy benefit plans may exclude or limit coverage of some or all of these medications.

2.B. Treatment of Underlying Causes of Male Infertility

Inclusions

Priority Health may consider treatment of male factor infertility medically necessary when:

a. The member meets the definition of infertility, as outlined in Section I; and
b. Diagnostic evaluation demonstrates an identifiable male factor contributing to infertility; and
c. The treatment is intended to improve, restore, or preserve reproductive function; and
d. The treatment is supported by current evidence-based clinical guidelines.

1. **Examples of treatment services include, but are not limited to:**

- **Medical Treatments**
  - Treatment of endocrine disorders affecting fertility
  - Medical treatment of hypogonadotropic hypogonadism
  - Pharmacologic management of hyperprolactinemia when clinically indicated
  - Gonadotropin therapy when clinically indicated for hypogonadotropic hypogonadism

- **Surgical Treatments**
  - Varicocelectomy when clinically indicated (e.g., palpable Grade I, II, or III varicocele and abnormal semen parameters)
  - Surgical repair of ejaculatory duct obstruction
  - Epididymovasostomy
  - Epididymal reconstruction
  - Surgical correction of obstructive azoospermia
  - Orchiopexy when clinically indicated
  - Excision of lesions affecting reproductive function

Exclusions

The following are not medically necessary:

a. Treatment of infertility that is directly related to a voluntary sterilization procedure
b. Services performed to reverse voluntary sterilization procedures including vasovasostomy or vasoepididymostomy performed solely to restore fertility
c. Experimental, investigational, or unproven therapies for infertility
d. Services performed solely to enhance fertility in the absence of an infertility diagnosis

Limitations

The following limitations apply:

a. Services must be directed toward treatment of a diagnosed male factor infertility condition
b. Pharmacy coverage may vary by product, group, rider, and line of business
d. Meeting medical necessity criteria does not guarantee benefit eligibility. Coverage, quantity limits, frequency limits, and applicable exclusions may vary by product, group, rider, and line of business. Please refer to a member's plan documents, including riders if available, for specific pharmacy or medical benefits availability and the terms and conditions of coverage.

C. Assisted Reproductive Technology (ART)

Benefit Requirement

Care and services related to Assisted Reproductive Technologies (ART) and Artificial Insemination are eligible for coverage **only when the member's benefit plan includes a specific infertility rider, assisted reproductive technologies (ART) benefit, or other supplemental reproductive services benefit.** Benefits for ART services vary by product, employer, group, benefit plan, rider, and line of business. Please refer to a member's plan documents, including riders if available, for specific pharmacy or medical benefits availability and the terms and conditions of coverage.

When an applicable ART benefit is present, coverage determinations are subject to the medical necessity criteria, terms, limitations, exclusions, and benefit provisions. Meeting medical necessity criteria does not guarantee benefit eligibility.

Inclusions

General Requirement

Priority Health may consider Assisted Reproductive Technology (ART) medically necessary when:

1. The member has a documented diagnosis of infertility; **and**
2. The member has an applicable infertility rider, employer group benefit, or supplemental fertility benefit; **and**
3. ART services are being performed in accordance with the member's benefit plan; **and**
4. The requested ART service is clinically appropriate and consistent with current evidence-based reproductive medicine guidelines.

When covered under the member's ART benefit, medically necessary services may include the assisted reproduction procedure and related services required to perform and support the covered treatment cycle, including pre-treatment evaluation, cycle monitoring, laboratory testing, imaging studies, medical management, and post-procedure follow-up services when performed in accordance with the member's benefit plan.

Examples of assisted reproductive technology services may include:

- **Artificial Insemination**
  - Intravaginal insemination (IVI)
  - Intracervical insemination (ICI)
  - Intrauterine insemination (IUI)

- **Advanced Reproductive Technologies**
  - In vitro fertilization (IVF)
  - Intracytoplasmic sperm injection (ICSI)
  - Embryo transfer
  - Frozen embryo transfer
  - Assisted hatching
  - Gamete intrafallopian transfer (GIFT)
  - Zygote intrafallopian transfer (ZIFT)
  - Related laboratory services necessary to perform a covered ART cycle

- **Donor Services**
  - Coverage for donor sperm, donor oocytes, donor embryos, gestational carrier services, or related services is determined according to benefit plan, applicable riders, and benefit provisions.

Exclusions

Unless specifically included under the member's benefit plan, the following are not medically necessary or are benefit exclusions:

1. Assisted reproductive technology **(**ART) services for members without an infertility benefit rider or supplemental fertility benefit
2. Services performed to reverse voluntary sterilization
3. ART or other fertility treatment when infertility is solely attributable to a prior voluntary sterilization procedure
4. Retrieval, storage, banking, or preservation of sperm, oocytes, embryos, ovarian tissue, or testicular tissue, except where specifically covered by a fertility preservation benefit
5. Experimental, investigational, or unproven reproductive technologies
6. Services performed solely to enhance fertility in the absence of a diagnosis of infertility
7. Surrogacy-related expenses, agency fees, legal fees, and non-medical donor expenses

Limitations

The following limitations apply:

1. Specific ART-related services, including cycle monitoring, laboratory testing, imaging, immunologic testing, concomitant procedures, and post-procedure follow-up services, may be subject to additional benefit restrictions, exclusions, or rider-specific provisions
2. Coverage may be subject to cycle limits, age limitations, lifetime maximums, dollar maximums, quantity limits, network requirements, and prior authorization requirements
3. Meeting medical necessity criteria does not guarantee benefit eligibility. Benefit coverage, eligible procedures, covered medications, quantity limits, and frequency limits vary by product, employer group, rider, and line of business. Please refer to a member's plan documents, including riders if available, for specific pharmacy or medical benefits availability and the terms and conditions of coverage.

D. Sperm and Oocyte Retrieval and Storage

Exclusions

1. All services for retrieval, preservation, storage or thawing of semen, oocytes, or ovaries are not covered benefit.
2. The retrieval and storage of semen, oocytes or ovarian tissue prior to cancer treatment are not a covered benefit.

E. Pre-Implantation Genetic Diagnosis (PGD)

1. Please refer to Priority Health's medical policy: *Genetics: Counseling, Testing, Screening* *No. 91540*

II. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COVERAGE DETERMINATION

Any applicable federal or state mandates will take precedence over this medical coverage policy.

Medicare: Refer to the CMS Online Manual System (IOMs) and Transmittals.
For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to CMS Medicare Coverage Database.

The information below is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. MAC jurisdiction for purposes of local coverage determinations is governed by the geographic service area where the Medicare Advantage plan is contracted to provide the service. Please refer to the Medicare Coverage Database website for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

National Coverage Determinations (NCDs)	
N/A	
Local Coverage Determinations (LCDs)	
CGS Administrators, LLC	N/A
First Coast Service Options, Inc.	N/A
Wellpoint Federal (formerly National Government Services, Inc.)	N/A
Noridian Healthcare Solutions	N/A
Novitas Solutions, Inc.	N/A
Palmetto GBA	N/A
WPS Insurance Corporation	N/A

III. BACKGROUND

For the intent of this section, the terms *female* and *male refer* to sex assigned at birth and are not used solely to describe reproductive anatomy and clinical evaluation pathways. Definitions of infertility contained in this section are for informational purposes and do not determine medical necessity, eligibility, or coverage. Please refer to the member's specific plan documents and any applicable riders for benefit coverage.

Infertility
Infertility is a disease of the reproductive system characterized by the inability to achieve a successful pregnancy. The American Society of Reproductive Medicine's (ASRM) defines infertility as "the inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors" (American Society for Reproductive Medicine

[ASRM], 2023). ASRM further recognizes infertility as including situations in which an individual requires medical intervention, including the use of donor gametes, or donor embryos, to achieve pregnancy (Practice Committee of ASRM, 2023). The World Health Organization (WHO) defines infertility as a disease of the male or female reproductive system characterized by failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse (WHO, 2025). The American College of Obsterics & Gynecology defines infertility as failure to achieve pregnancy within 12 months of unprotected intercourse or therapeutic donor insemination in women younger than 35 years or within 6 months in women older than 35 years (American College of Obsterics & Gynecology [ACOG], 2019).

Infertility affects both females and males and may result from a wide range of reproductive, endocrine, genetic, structural, environmental, and lifestyle factors. Female infertility may be associated with ovulatory disorders, diminished ovarian reservice, tubal disease, endometriosis, uterine abnormalities, and endocrine disorders.
Male infertility may result from abnormalities in spermatogenesis, sperm transport, hormonal dysfunction, genetic disorders, or obstructive conditions affecting semen delivery (WHO, 2025; AUA/ARSM, 2024).

ASRM states that in the absence of exigent history or physical findings, evaluation should be initiated after 12 months of unsuccessful attempts to conceive in females younger than 35 years of age and after 6 months in females aged 35 years and older. Earlier evaluation may be appropriate when clinical conditions known to impair fertility are present or suspected (ASRM, 2021).

Diagnostic Evaluation of Infertility

Female Factor Evaluation
The evaluation of female infertility begins with a comprehensive medical, reproductive, menstrual, surgical, family, and social history, accompanied by a focused physical examination ASRM, ACOG, WHO, and National Institute for Health and Care Excellence (NICE) recommend that diagnostic testing be individualized and guided by clinical findings rather than performed as routine screening (ACOG, 2019; ASRM, 2021; WHO, 2025; National Institute for Health and Care Excellence [NICE], 2026).

Assessment commonly includes evaluation of ovarian reserve, ovulatory function, and structural abnormalities of the reproductive tract. Hormonal testing may include follicle-stimulating hormone (FSH), luteinizing hormone (LH), estradiol, progesterone, prolactin, thyroid-stimulating hormone (TSH), testosterone, and anti-Müllerian hormone (AMH) when clinically indicated. WHO recommends the use of AMH, antral follicle count (AFC), or day-2/day-3 FSH testing when assessment of ovarian reserve is clinically warranted. Mid-luteal progesterone measurement may be used to confirm ovulation (WHO, 2025).

Imaging studies are frequently used to evaluate uterine anatomy, ovarian pathology, and tubal patency. Commonly utilized modalities include pelvic ultrasound, transvaginal ultrasound, saline infusion sonohysterography (SIS), hysterosalpingography (HSG), hysterosalpingo-contrast sonography (HyCoSy), hysteroscopy, and laparoscopy when clinically indicated for suspected pelvic pathology, tubal disease, or endometriosis (ACOG, 2019; ASRM, 2021).

Current guidelines do not support routine use of several tests previously incorporated into infertility evaluations. ASRM, WHO, and NICE generally discourage routine use of thrombophilia testing, immunologic testing, endometrial receptivity testing, routine endometrial biopsy, routine postcoital testing, and other adjunctive testing in the absence of specific clinical indications, as evidence has not demonstrated consistent improvement in fertility outcomes (ASRM, 2021; WHO, 2025; NICE, 2026).

Male Factor Evaluation

Male factor infertility contributes to approximately one-half of infertility cases and should be evaluated concurrently with female factor infertility whenever possible. The American Urological Association (AUA) and ASRM recommend a comprehensive reproductive history, physical examination, and at least one semen analysis as the cornerstone of initial male infertility evaluation (AUA/ASRM, 2024).

Semen analysis assesses sperm concentration, total sperm count, motility, morphology, vitality, semen volume, and pH. Additional endocrine testing, including FSH, LH, testosterone, prolactin, and TSH, may be indicated when hormonal abnormalities are suspected. Genetic testing, including karyotype analysis, Y-chromosome microdeletion testing, and CFTR mutation testing, may be appropriate in selected patients with severe oligospermia, azoospermia, or suspected genetic etiologies (AUA/ASRM, 2024).

The AUA, ASRM, and NICE do not recommend routine use of advanced sperm function testing, sperm DNA fragmentation testing, antisperm antibody testing, sperm capacitation testing, sperm aneuploidy testing, or other specialized assays as part of the standard infertility evaluation in most patients because evidence supporting routine clinical use remains limited (AUA/ASRM, 2024; NICE, 2026).

Treatment of Underlying Causes of Infertility

Treatment of infertility is directed toward correction or management of the underlying cause whenever possible. Selection of therapy is individualized and based upon age, duration of infertility, identified etiology, reproductive goals, and overall prognosis (ASRM, 2021; WHO, 2025).

Female Infertility Treatments

Female infertility treatment may include pharmacologic ovulation induction, monitoring of ovulatory response, surgical correction of structural abnormalities, treatment of

endometriosis, repair of tubal disease, and management of endocrine disorders that impair fertility. Surgical interventions may include hysteroscopic polypectomy, lysis of intrauterine adhesions, septum resection, myomectomy, treatment of hydrosalpinx, salpingostomy, tubal reconstructive procedures, and laparoscopic treatment of endometriosis when clinically indicated (ACOG, 2020; ASRM, 2021).

Male Infertility Treatments

Treatment of male infertility may include management of endocrine disorders, medical treatment of hypogonadotropic hypogonadism, pharmacologic treatment of hyperprolactinemia, gonadotropin therapy, and surgical correction of identifiable reproductive tract abnormalities. Procedures such as varicocelectomy, repair of obstructive azoospermia, orchiopexy, and surgical correction of ejaculatory duct obstruction may improve fertility in appropriately selected patients (AUA/ASRM, 2024).

Assisted Reproductive Technology (ART)

Assisted reproductive technology (ART) encompasses procedures in which oocytes, sperm, or embryos are manipulated to establish pregnancy. These technologies are frequently utilized when infertility persists despite treatment of underlying causes or when specific fertility factors significantly reduce the likelihood of spontaneous conception. ART may be used for male factor infertility, female factor infertility, unexplained infertility, genetic indications, or situations requiring donor gametes or donor embryos (American Society for Reproductive Medicine [ASRM], 2025; Practice Committee of ASRM, 2023).

ART includes procedures such as intrauterine insemination (IUI), in vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI), embryo transfer, frozen embryo transfer (FET), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT). Although IVF and related technologies represent the most commonly performed ART procedures today, treatment selection is individualized based on the underlying cause of infertility, age, prognosis, and reproductive goals (ASRM, 2025).

Intrauterine insemination (IUI) is a procedure that bypasses the cervix and places sperm directly into the uterus around the time of ovulation. IUI is most commonly used for mild male factor infertility, (e.g., low sperm count, decreased sperm motility), cervical factor infertility, ovulatory disorders, unexplained infertility, or when donor sperm is utilized. The procedure is often combined with ovulation induction medications to improve the likelihood of conception (Practice Committee of ASRM, 2025).

In Vitro Fertilization (IVF) is the most commonly performed ART procedure. IVF involves controlled ovarian stimulation, oocyte retrieval, fertilization of eggs with sperm in a laboratory setting, embryo culture, and embryo transfer. Additional embryos may be cryopreserved for future use. IVF may be used in cases of tubal factor infertility, severe endometriosis, diminished ovarian reserve, male factor infertility, unexplained infertility,

or when donor gametes are required ((Practice Committee of ASRM 2025; Practice Committee of ARSM, 2021).

Intracytoplasmic Sperm Injection (ICSI) is a specialized laboratory technique performed as part of an IVF cycle in which a single sperm is injected directly into the cytoplasm of a mature oocyte to facilitate fertilization. ICSI is most commonly utilized for severe male factor infertility, including severe oligospermia, azoospermia requiring surgical sperm retrieval, impaired sperm motility, or previous failed fertilization during conventional IVF. ASRM notes that routine use of ICSI for non-male factor infertility has not consistently demonstrated improved live birth outcomes compared with conventional IVF (Practice Committees of ASRM and SART, 2020).

Embryo Transfer (ET) is the process of placing one or more embryos into the uterine cavity following IVF. Embryo transfer may occur several days after fertilization, typically during either the cleavage stage or blastocyst stage of embryo development. Current reproductive medicine practices emphasize individualized embryo transfer strategies and the use of single embryo transfer when appropriate to reduce the risk of multiple gestations while maintaining favorable pregnancy outcomes (Practice Committee of ASRM and SART, 2021).

Frozen Embryo Transfer (FET) involves thawing and transferring previously cryopreserved embryos into the uterus during a subsequent treatment cycle. Advances in embryo vitrification techniques have improved embryo survival rates and reproductive outcomes following thawing. FET allows utilization of embryos from a prior IVF cycle without requiring repeat ovarian stimulation and oocyte retrieval procedures (ARSM ,2025)

Gamete Intrafallopian Transfer (GIFT) is similar to IVF, but the oocytes and sperm are transferred into the fallopian tubes rather than the uterus, allowing fertilization to occur within the body rather than in the laboratory. Because the procedure requires laparoscopy and at least one functional fallopian tube, its utilization has declined significantly with advances in IVF success rates. GIFT may be considered only in select clinical circumstances (ASRM, 2025).

Zygote Intrafallopian Transfer (ZIFT) combines elements of both IVF and GIFT. Fertilization occurs in the laboratory as in conventional IVF; however, the resulting zygote is transferred into the fallopian tube rather than directly into the uterus. Similar to GIFT, the procedure requires laparoscopy and at least one functional fallopian tube. Due to the invasive nature of the procedure and the effectiveness of modern IVF protocols, ZIFT is now infrequently performed (ASRM, 2025).

Donor Gametes and Donor Embryos may be utilized when pregnancy cannot be achieved using an individual's own gametes or when there is a significant risk of transmitting a genetic disorder. Donor sperm may be used with therapeutic insemination

or IVF, while donor oocytes and donor embryos are generally utilized within IVF treatment cycles. ASRM recognizes the use of donor gametes and donor embryos as established reproductive treatment options for appropriately selected individuals and couples (Practice Committee of ASRM, 2023).

ASRM guidance supports the use of ART when clinically appropriate and emphasizes individualized treatment planning, evidence-based patient selection, embryo transfer practices intended to minimize multiple gestations, and adherence to established laboratory and clinical standards to optimize reproductive outcomes while reducing treatment-related complications (Practice Committee of ASRM and SART, 2021; ASRM, 2025).

Fertility Preservation

Fertility preservation refers to interventions intended to preserve reproductive potential before medical treatments or conditions that may impair fertility. Professional society guidelines support discussion of fertility preservation options for individuals undergoing potentially gonadotoxic therapies such as chemotherapy, radiation therapy, or other medical treatments associated with loss of reproductive function (ASCO, 2025; ASRM, 2026).

IV. GUIDELINES / POSITION STATEMENTS

Medical/Professional Society	Guideline
American College of Obstetricians and Gynecologists (ACOG)	Infertility Workup for the Women's Health Specialist- ACOG Committee Opinion Summary, Number 781 (2019) Preimplantation Genetic Testing- ACOG Committee Opinion, Number 799 (2020; Reaffirmed 2025) The Use of Hysteroscopy for the Diagnosis and Treatment of Intrauterine Pathology- ACOG Committee Opinion, Number 800 (2020; Reaffirmed 2025)
Practice Committee of the American Society for Reproductive Medicine (ASRM) and Society for Assisted Reproductive Technology (SART)	The International Glossary on Infertility and Fertility Care (2025) Definition of Infertility: A Committee Opinion (2023) Fertility treatment when the prognosis is very poor or futile: an Ethics Committee opinion (2024)

	Fertility evaluation of infertile women: a committee opinion (2021) In vitro maturation: a committee opinion (2021) Guidance on the limits to the number of embryos to transfer: a committee opinion (2021) Intracytoplasmic sperm injection (ICSI) for non–male factor indications: a committee opinion (2020) Fertility preservation in patients with medical indications: a committee opinion (2026) Evidence-based outcomes after oocyte cryopreservation for donor oocyte in vitro fertilization and planned oocyte cryopreservation: a guideline (2021)
American Urological Association (AUA)/American Society for Reproductive Medicine (ASRM)	Diagnosis and Treatment of Infertility in Men: AUA/ASRM Guideline - American Urological Association (2020, Amended 2024)
National Institute for Health and Care Excellence (NICE)	NICE Guideline NG257: Fertility Problems: Assessment and Treatment (2026)
American Society of Clinical Oncology (ASCO)	Fertility Preservation in People with Cancer: ASCO Guideline Update (2025)
World Health Organization (WHO)	Infertility (2025) Guideline for the prevention, diagnosis and treatment of infertility (2025)

V. REGULATORY (US FOOD AND DRUG ADMINISTRATION)

See U.S. Food & Drug Administration (FDA) Medical Device Databases for the most current information.

VI. CODING

Coding Note

Inclusion of a code in this section does not guarantee coverage or reimbursement. Coverage is subject to the member's benefit plan, applicable infertility rider, supplemental reproductive services benefit, medical necessity criteria, exclusions, limitations, and prior authorization requirements.

ICD-10 Codes that may support medical necessity

A. Infertility Diagnosis and Diagnostic Testing:

ICD-10 Codes that apply to this policy:

N46.01 – N46.9	Male infertility
N97.0 – N97.9	Female infertility

All procedures billed with the diagnoses above may be subject to the plan's Fertility benefit limitations, including but not limited to:

Applicable to Female and/or Male Evaluation

CPT/HCPCS Codes (*List should not be considered inclusive*):

- **Laboratory/Pathology**

80414	Chorionic gonadotropin stimulation panel; testosterone response This panel must include the following: Testosterone (84403 x 2 on 3 pooled blood samples)
80415	Chorionic gonadotropin stimulation panel; estradiol response This panel must include the following: Estradiol (82670 x 2 on 3 pooled blood samples)
80426	Gonadotropin releasing hormone stimulation panel- This panel must include the following: Follicle stimulating hormone (FSH) (83001 x 4) Luteinizing hormone (LH) (83002 x 4)
82626	Dehydroepiandrosterone (DHEA)
82627	Dehydroepiandrosterone-sulfate (DHEA-S)
82670	Estradiol
82671	Estrogens; fractionated
82672	Estrogens; total
82679	Estrone
82681	Estradiol; free, direct measurement
82757	Fructose, semen
83001	Gonadotropin; follicle stimulating hormone (FSH)
83002	Gonadotropin; luteinizing hormone (LH)
81015	Urinalysis; microscopic only

82397 Chemiluminescent assay
89398 Unlisted reproductive medicine laboratory procedure (*Explanatory notes must accompany claim)*

Q0115 Post-coital direct, qualitative examinations of vaginal or cervical mucous

Female Factor Diagnostic Testing

- **Radiology**

74740 Hysterosalpingography, radiological supervision and interpretation
74742 Transcervical catheterization of fallopian tube, radiological supervision and interpretation

76830 Ultrasound, transvaginal
76856 Ultrasound, pelvic (nonobstetric), real time with image documentation; complete
76857 Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)
76948 Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation

- **Surgery/Procedures**

58100 Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)
58110 Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure
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

Male Factor Diagnostic Testing

- **Laboratory/Pathology**

0255U Andrology (infertility), sperm-capacitation assessment of ganglioside GM1 distribution patterns, fluorescence microscopy, fresh or frozen specimen, reported as percentage of capacitated sperm and probability of generating a pregnancy score

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; complete (volume, count, motility, and differential)
89321 Semen analysis, presence and/or motility of sperm
89322 Semen analysis; volume, count, motility, and differential using strict morphologic criteria (e.g., 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)
89398 Unlisted reproductive medicine laboratory procedure (*Explanatory notes must accompany claim)*
G0027 Semen analysis; presence and/or motility of sperm excluding huhner

- **Radiology**

74440 Vasography, vesiculography, or epididymography, radiological supervision and interpretation
76870 Ultrasound, scrotum and contents
76872 Ultrasound, transrectal;

- **Surgery/Procedures**

52010 Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service
55300 Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral

B. Treatment of Underlying Causes of Infertility

Treatment of Underlying Causes of Female Infertility

- **Medications**

J0725 Injection, Chorionic Gonadotropin, Per 1,000 Usp Units
J1620 Injection, Gonadorelin Hydrochloride, Per 100 Mcg (*no active NDC for this code)*
J1950 Injection, leuprolide acetate (for depot suspension), per 3.75 mg
J3355 Injection, urofollotropin, 75 IU
S0126 Injection, follitropin alfa, 75 IU
S0128 Injection, follitropin beta, 75 IU

- **Surgery/Procedures**

57292 Construction of artificial vagina; with graft
58540 Hysteroplasty, repair of uterine anomaly (Strassman type)

58558 Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C
58559 Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)
58560 Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)
58561 Hysteroscopy, surgical; with removal of leiomyomata
58578 Unlisted laparoscopy procedure, uterus (*Explanatory notes must accompany claim)*
58660 Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)
58662 Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method
58672 Laparoscopy, surgical; with fimbrioplasty
58673 Laparoscopy, surgical; with salpingostomy (salpingoneostomy)
58679 Unlisted laparoscopy procedure, oviduct, ovary (*Explanatory notes must accompany claim)*
58700 Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58740 Lysis of adhesions (salpingolysis, ovariolysis)
58752 Tubouterine implantation
58760 Fimbrioplasty
58770 Salpingostomy (salpingoneostomy)
58800 Drainage of ovarian cyst(s), unilateral or bilateral (separate procedure); vaginal approach
58805 Drainage of ovarian cyst(s), unilateral or bilateral (separate procedure); abdominal approach
58920 Wedge resection or bisection of ovary, unilateral or bilateral
58925 Ovarian cystectomy, unilateral or bilateral
58999 Unlisted procedure, female genital system (nonobstetrical)

Treatment of Underlying Causes of Male Infertility

- **DME**

E1399 Durable medical equipment, miscellaneous – *if billed for testicular hypothermia device (Explanatory notes must accompany claim)*

- **Surgery/Procedures**

52402 Cystourethroscopy with transurethral resection or incision of ejaculatory ducts
54692 Laparoscopy, surgical; orchiopexy for intra-abdominal testis
54900 Epididymovasostomy, anastomosis of epididymis to vas deferens; unilateral
54901 Epididymovasostomy, anastomosis of epididymis to vas deferens;

bilateral

55200 Vasotomy, cannulization with or without incision of vas, unilateral or bilateral (separate procedure)

55550 Laparoscopy, surgical, with ligation of spermatic veins for varicocele

C. Assisted Reproduction Technology

Any services billed with the following diagnoses *are not covered: (Check plan rules for any coverage exceptions)*

ICD-10 Codes that are required for billing these services:

Z31.81 Encounter for male factor infertility in female patient
Z31.83 Encounter for assisted reproductive fertility procedure cycle
Z31.89 Encounter for other procreative management
Z31.9 Encounter for procreative management, unspecified

Z52.810 Egg (Oocyte) donor under age 35, anonymous recipient
Z52.811 Egg (Oocyte) donor under age 35, designated recipient
Z52.812 Egg (Oocyte) donor age 35 and over, anonymous recipient
Z52.813 Egg (Oocyte) donor age 35 and over, designated recipient
Z52.819 Egg (Oocyte) donor, unspecified

CPT/HCPCS Codes:
All procedures billed with the diagnoses above will be denied as not covered (unless the member's plan specifies coverage (infertility rider, ART benefit, or other reproductive services benefit)), including but not limited to:

- **Anesthesia**
- **Medication**
- **Radiology**
- **Physician Services**
- **Office Visits**

Artificial Insemination (Intrauterine Insemination (ICI/IUI))

The following services are Not Covered (unless plan specifies coverage):

Ovulation Induction

S4022 Assisted oocyte fertilization, case rate
S4042 Management of ovulation induction (interpretation of diagnostic tests and studies, nonface-to-face medical management of the patient), per cycle

- **Surgery/Procedures/ Laboratory**

  58321 Artificial insemination; intra-cervical
  58322 Artificial insemination; intra-uterine
  58323 Sperm washing for artificial insemination
  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
  89268 Insemination of oocytes
  S4035 Stimulated intrauterine insemination (IUI), case rate

Advanced Reproductive and Fertilization (IVF) Services

- **Surgery/Procedures**

  58970 Follicle puncture for oocyte retrieval, any method
  58974 Embryo transfer, intrauterine
  76948 Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation

- **Laboratory/Embryology Services**

  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
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
S4040 Monitoring and storage of cryopreserved embryos, per 30 days

Gamete Intra-Fallopian Transfer (GIFT)
58976 Gamete, zygote, or embryo intrafallopian transfer, any method
S4013 Complete cycle, gamete intrafallopian transfer (GIFT), case rate

Zygote Intra-Fallopian Transfer (ZIFT)
S4014 Complete cycle, zygote intrafallopian transfer (ZIFT), case rate

Cryopreserved (Frozen) Embryo Transfers (FET)
S4037 Cryopreserved embryo transfer, case rate
S4018 Frozen embryo transfer procedure cancelled before transfer, case rate

Intracytoplasmic Sperm Injection (ICSI); or Ovum Microsurgery
55870 Electroejaculation
89280 Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes
89281 Assisted oocyte fertilization, microtechnique; greater than 10 oocytes

Donor Services
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

Preimplantation Genetic Testing/Diagnosis
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

- **See Related Policy:** Genetics: Counseling, Testing, Screening No. 91540

D. Sperm and Oocyte Preservation, Storage and Thawing

ICD-10 Codes that apply to this policy:

Z31.81 Encounter for male factor infertility in female patient
Z31.83 Encounter for assisted reproductive fertility procedure cycle
Z31.84 Encounter for fertility preservation procedure
Z31.89 Encounter for other procreative management
Z31.9 Encounter for procreative management, unspecified
Z52.810 Egg (Oocyte) donor under age 35, anonymous recipient
Z52.811 Egg (Oocyte) donor under age 35, designated recipient
Z52.812 Egg (Oocyte) donor age 35 and over, anonymous recipient
Z52.813 Egg (Oocyte) donor age 35 and over, designated recipient
Z52.819 Egg (Oocyte) donor, unspecified

CPT/HCPCS Codes
Basic services billed with the above diagnoses are not covered including but not limited to: Office Visits, Surgery, Medicine services, Anesthesia, Lab/Pathology, Pharmacy, and Radiology covered (unless plan specifies coverage).

- **Laboratory/Pathology**

The following services are Not Covered (unless plan specifies coverage):

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

E. Services Not Covered Regardless of Diagnosis Billed:

Sterilization Reversal / Gestational Carrier Related Diagnoses

*Any service billed with the following diagnoses are **not covered***

ICD-10 Codes

Z31.0 Encounter for reversal of previous sterilization
Z31.7 Encounter for procreative management and counseling for gestational carrier
Z31.42 Aftercare following sterilization reversal

CPT/HCPCS

*The following services are **not medically necessary** regardless of diagnosis billed:*

Uterus Transplantation and Related Donor Services

0664T	Donor hysterectomy (including cold preservation); open, from cadaver donor
0665T	Donor hysterectomy (including cold preservation); open, from living donor
0668T	Backbench standard preparation of cadaver or living donor uterine allograft prior to transplantation, including dissection and removal of surrounding soft tissues and preparation of uterine vein(s) and uterine artery(ies), as necessary
0669T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; venous anastomosis, each
0670T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; arterial anastomosis, each

Sterilization Reversal Services

55400	Vasovasostomy, vasovasorrhaphy
58750	Tubotubal anastomosis
58760	Fimbrioplasty
58672	Laparoscopy, surgical; with fimbrioplasty
58673	Laparoscopy, surgical; with salpingostomy (salpingoneostomy)

Donor Services (Donor Gametes and Embryos)

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

VII. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, devices, services and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service or procedure is medically necessary. For more information, refer to the Priority Health Provider Manual.

To access Evicore guidelines: Log into Priority Health Prism → Authorizations → Authorization Criteria Lookup.

Individual case review may allow coverage for care or treatment that is investigational yet promising for the conditions described. Requests for individual consideration require prior plan approval. All determinations of coverage for experimental, investigational, or unproven treatment will be made by a Priority Health medical director or clinical pharmacist. The exclusion of coverage for experimental, investigational, or unproven treatment may be reviewed for exception if the condition is either a terminal illness, or a chronic, life threatening, severely disabling disease that is causing serious clinical deterioration.

VIII. APPLICATION TO PRODUCTS

Coverage is subject to the member's specific benefits. Group-specific policy will supersede this policy when applicable.

- **HMO/EPO**: This policy applies to insured HMO/EPO plans.
- **POS**: This policy applies to insured POS plans.
- **PPO**: This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
- **ASO**: For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
- **INDIVIDUAL**: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.
- **MEDICARE**: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
- **MEDICAID/HEALTHY MICHIGAN PLAN**: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

    - **Michigan Medicaid/Healthy Michigan Plan:**

        - **Diagnostic services** are covered as described in the Medicaid and the Healthy Michigan Plan COC Section 5.B (20).

        - **Services and Supplies Relating to Treatments for Infertility (Artificial Reproduction Technologies):** The Medicaid and Healthy Michigan Plan Certificates of Coverage (COC) Section 6 (28) state that all services and supplies relating to treatments for infertility including, among other things, artificial insemination, in-vitro fertilization, embryo or ovum transfer procedures, any other assisted reproduction procedure, fees to a surrogate parent, prescription drugs designed to achieve pregnancy, harvest preservation and storage of eggs or sperm and services to reverse voluntary sterilizations are an **exclusion from coverage.**

IX. REFERENCES

Society Guidelines and Publications

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11. Su HI, Lacchetti C, Letourneau J, Partridge AH, Qamar R, Quinn GP, Reinecke J, Smith JF, Tesch M, Wallace WH, Wang ET, Loren AW. Fertility Preservation in People With Cancer: ASCO Guideline Update. J Clin Oncol. 2025 Apr 20;43(12):1488-1515. doi: 10.1200/JCO-24-02782. Epub 2025 Mar 19. Erratum in: J Clin Oncol. 2025 May 20;43(15):1847. doi: 10.1200/JCO-25-00662. Erratum in: J Clin Oncol. 2025 Aug;43(22):2553. doi: 10.1200/JCO-25-01373. PMID: 40106739.

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SUMMARY OF CHANGES

Deletions:

- Removed Medicaid-specific language to support multi-state applicability
- Removed note regarding the prior consolidation of the Sperm and Oocyte Retrieval and Storage policy, as the policy integration was completed in 2022.
- Removed outdated references and replaced with current society guidelines and literature.

Additions:

- Added examples of medically necessary diagnostic testing and procedures for evaluation of female and male infertility.
- Added examples of medically necessary treatments for underlying causes of female and male infertility.
- Added specific inclusion, exclusion, and limitation criteria for diagnostic evaluation of female and male infertility.
- Added examples of medically necessary assisted reproductive technology (ART) services when an applicable infertility rider or fertility benefit is present.
- Updated background section and references to align with current ASRM, AUA/ASRM, ACOG, WHO, ASCO, and NICE guidance.

Changes:

- Converted the policy to the new template structure with Inclusions, Exclusions, and Limitations sections.
- Reorganized infertility diagnostic services into separate female-factor and male-factor evaluation sections.
- Reorganized infertility treatment services into separate female-factor and male-factor treatment sections.
- Expanded and reorganized Assisted Reproductive Technology (ART) benefit requirements, inclusions, exclusions, and limitations.

Clarifications:

- Updated policy language throughout for clarity, consistency, and alignment with current reproductive medicine terminology and template standards.
- Clarified that coverage for infertility diagnostic, treatment, ART, and fertility preservation services remains subject to member-specific benefits, riders, and plan provisions.

Past committee review dates: 01/1993, 12/1999, 12/2001, 11/2002, 11/2003, 11/2004, 10/2005, 10/2006, 07/2007, 06/2008, 06/2009, 06/2010, 06/2011, 06/2012, 06/2013, 08/202014, 05/2015, 05/2016, 05/2017, 05/2018, 05/2019, 05/2020, 02/2021, 02/2022, 08/2022, 08/2023, 08/2024, 08/2025, 08/2026

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