Subject: Infertility - Diagnostic*

Effective Date: May 28, 2002

Department(s): Utilization Management

Policy: Diagnostic services in the management of infertility are covered benefits under QualCare, Inc., if specified by the Plan design.

Coverage of females under this policy is limited to those 45 years of age or younger.

Objective: To ensure proper and consistent reimbursement and to delineate criteria for coverage of elements of the diagnostic evaluation of a specific type of medical problem.

Definitions:

A. For the purposes of this Policy and Procedure, the term “infertility” shall mean one of the following:

1. the inability to impregnate another person;
2. the inability of an opposite-sex couple to achieve conception after one year of unprotected intercourse; or, if the female is over the age of 35 years, after six months of unprotected intercourse;
3. the inability to carry a pregnancy to live birth;
4. The inability of a woman to achieve conception after six trials of medically supervised artificial insemination over a one-year period.
Earlier evaluation may be indicated based on medical history and physical findings

B. A “cycle” shall mean an ovulatory interval that includes at least one completed egg retrieval. (Refer to Policy “Infertility – Therapeutic.”)

ICD-9/ICD-10 Codes Commonly Indicating Infertility include but are not limited to the following:

Female:

614.1, N70.11-N70.13  Chronic salpingitis and oophoritis

617.0-617.9; N80-N80.9  Endometriosis

614.6, N73.6  Pelvic peritoneal adhesions, female

614.9, N73.5, N73.9  Unspecified inflammatory disease of female pelvic organs and tissues

218.0-218.2, 218.9, D25.0- D25.2, D25.9  Uterine Leiomyoma

253.1, E22.1, E22.8, E22.9  Other and Unspecified Anterior Pituitary Hyperfunction

253.2, E 23.0  Panhypopituitarism

253.4, E23.6  Other Anterior Pituitary Disorders

253.8, E24.1  Other Disorders of the Pituitary and Other Syndromes

256.0-256.2, E28.0, E28.1, E28.8, E89.40, E89.41  Ovarian Dysfunction

256.31, 256.39, E28.310, E28.319, E28.39  Other Ovarian Failure

256.4, E28.2  Polycystic Ovarian Disease

259.9, E34.9  Other Endocrine Disorders
628.0, N97.0  
    Infertility, Female, Associated with Anovulation

628.1, E23.0  
    Infertility, Female, of Pituitary/Hypothalamic Origin

628.2, N97.1  
    Infertility, Female, of Tubal Origin

628.3, N97.2  
    Infertility, Female, of Uterine Origin

628.4, N97.8  
    Infertility, Female, of Cervical or Vaginal Origin

628.8  
    Infertility, Female, of Other Specified Origin

628.9, N97.9  
    Infertility, Female, of Other Unspecified Origin

Male:

606  
    Infertility, Male

606.0, N46.021-N46.025  
    Azoospermia

N46.029  

606.1, N46.1, N46.121-N46.125  
    Oligospermia

N46.129  

606 N46.029  
    Infertility Due to Extratesticular Causes

606 N46.8, N46.9  
    Male Infertility, Unspecified

Procedure:  

    1.  Coverage includes, but is not limited to, the following diagnostic tests related to infertility:

        a.  in the female

            1.  cultures (cervical, vaginal, uterine)
               87109 – Mycoplasma
               87110 – Chlamydia
               87070 – generalized culture

            2.  endometrial biopsy
               58100 – endometrial biopsy (collection)

            3.  hormone assay
               83001 – FSH (follicle stimulating hormone)
               83002 – LH (luteinizing hormone)
               84144 – progesterone
               84146 – prolactin
               82670 – estradiol
               thyroid function studies
4. other laboratory studies
   88141 – cytology (Pap)
   89330 – post coital test/cervical mucus test
5. hysterosalpingogram
   74740 – hysterosalpingography, radiological supervision and interpretation
   74742 – transcervical catheterization of fallopian tube, radiological supervision and interpretation
   58345 – transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method, with or w/o hysterosalpingography)
   58340 – catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography
6. hysteroscopy
   58555 – diagnostic
   58558 – with biopsy and/or polypectomy
   58559 – with lysis of adhesions
   58560 – with division or resection of intrauterine septum
   58561 – with removal of leiomyomata
7. laparoscopy
   49320 – diagnostic
   49321 – with biopsy
   49322 – with aspiration of cavity or cyst
   58660 – with lysis of adhesions
   58662 – with excision of lesions
8. vaginal surgery
   57130 – excision of vaginal septum
9. pelvic ultrasound
   76830 – ultrasound, transvaginal
   76856 – ultrasound, pelvic, complete
   76857 – ultrasound, pelvic, limited
   76831 – hysterosonography (Saline US)
   58340 – catheterization and introduction of
saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography

10. anesthesia
   00840 – anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified

b. in the male

1. cultures (genital)
   87109 – Mycoplasma
   87110 – Chlamydia
   87070 – generalized culture

2. hormone assay
   83002 – LH (luteinizing hormone)
   83001 – FSH (follicle stimulating hormone)
   84146 – prolactin
   84402 – testosterone

3. ultrasound
   76872 – rectal ultrasound
   76870 – scrotal ultrasound

4. semen analysis
   89310 – semen analysis, motility and count
   89320 – semen analysis, complete, with volume, count, motility, and differential
   89321 – semen analysis, presence and/or motility of sperm
   89330 – sperm evaluation; cervical mucus penetration test, with our without spinnbarkeit test
   89331- sperm evaluation for retrograde ejaculation, urine

5. sperm antibodies (semen only)
   89325 – sperm antibodies

6. testicular biopsy
   54500 – needle biopsy of testis
   54505 – incisional biopsy of testis
   51110- scrotal exploration
7. vasography
   74440 – vasography, vesiculography, or epididymography, radiological supervision and interpretation

8. genetic testing
   88261/88262 karyotyping, when non-obstructive azoospermia or severe oligospermia(<5million/ml count) is present
   88273-Y-chromosome microdeletion testing when non-obstructive azoospermia or severe oligospermia(<5million/ml count) is present

2. The following infertility services are not covered:
   a. home ovulation, pregnancy or sperm testing supplies;
   b. provision of infertility services to members without documented impairment of fertility;
   c. provision of infertility services to non-members.

3. Dollar limits may be specified by the individual Plan.

Pre-implantation genetic diagnosis is addressed in the pre-implantation genetic diagnosis medical policy.

References


State of New Jersey Department of Banking and Insurance, Bulletin No. 02-09, Compliance with Mandated Infertility Benefit (P.L. 2001, c. 236), May 9, 2002

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*Consistent with Summary Plan Description (SPD). When there is discordance between this policy and the SPD, the provisions of the SPD prevail.