bmchp.org | 888-566-0008

wellsense.org | 877-957-1300

Reimbursement Policy

Infertility Services

Policy Number: 4.34
Version Number: 6
Version Effective Date: 06/01/2021

Product Applicability	☐ **All Plan⁺ Products**
Well Sense Health Plan ☐ Well Sense Health Plan	**Boston Medical Center HealthNet Plan** ☐ MassHealth MCO ☐ MassHealth ACO ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan reimburses covered services based on the provider's contractual rates with the Plan and the terms of reimbursement identified within this policy**.**

This policy applies to BMC HealthNet Plan Qualified Health Plans, including ConnectorCare and Employer Choice Direct only. Infertility services are specifically excluded for MassHealth except for services related to the diagnosis of infertility and treatment of underlying medical conditions.

Prior-Authorization

Please refer to the Plan's Prior Authorization Requirements Matrix at www.bmchp.org.

⁺ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Definitions

Assisted Reproductive Technology (ART) - A general term referring to methods used to achieve pregnancy by artificial or partially artificial means.

Infertility – The condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger, or 6 months if the female is over the age of 35. For purposes of meeting the criteria for infertility in this section, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1 year or 6 month period, as applicable.

Intrauterine Insemination (IUI) - A fertility treatment that uses a catheter to place a number of washed sperm directly into a woman's uterine cavity in an effort to achieve successful fertilization.

In-Vitro Fertilization (IVF) - The process of fertilization by manually combining an egg and sperm in a laboratory container

Cycle – For billing purposes all medical services provided up to the point of a positive or negative blood pregnancy test result are considered part of the cycle and are reimbursed by the global payment. Any initiated ART cycle, whether completed or cancelled, is counted as a cycle against the total number of approved ART cycles.

- ART: There is a cycle limit of six (6) per lifetime of member and is independent of the insurance coverage. ART services are reimbursed based on the member's schedule of benefits.
- IUI: There is cycle limit for IUI of three (3) per member's lifetime.
- IVF: There is a cycle limit for In-Vitro Fertilization (IVF) of six (6) whether the member's egg or a donor egg is used, and whether or not previous cycles were covered by the Plan.

Guidelines regarding cycle coverage limits are subject to individual consideration based on the member's particular clinical situation and unique medical circumstances. Fewer than 6 cycles may be reimbursed when medically appropriate, including situations where additional cycles are unlikely (<5% probability) to result in a live birth.

Provider Reimbursement

Infertility services are reimbursed only for members who meet the criteria referenced the Plan's medical policy, *Infertility Services, OCA 3.725* and who meet **all** of the following criteria:

- Must be Massachusetts residents; and
- Must meet the plan's clinical review criteria for coverage of infertility services, which are based on the member's medical history, diagnostic testing and medical evaluations;
- Must meet the eligibility requirements of network infertility services providers; and

- With respect to the procurement and processing of donor eggs, sperm or inseminated eggs, or banking of donor sperm or embryos: to the extent the costs of such services are not reimbursed by the donor's health insurance or other health coverage and the member is in active infertility treatment.

To be eligible for reimbursement, the member's plan must include infertility benefits, and the member must meet the Plan's medical necessity criteria.

ART Global Services Fee Includes

- Post-Initial Office Visits: Includes any additional consultations, evaluations, comprehensive examinations, pre- and post- operative visits, psychological or psychosocial assessments, nursing services, educational classes, medication instruction and monitoring.
- Laboratory Services: Includes lab testing, pre- and post- retrieval analyses, embryology, assisted hatching blood serology, drawing/venipuncture, semen analysis, and all lab tests for hormonal evaluation.
- Diagnostic Imaging and Radiology Services: Ultrasounds and hysterosalpingography, including the guided ultrasound for aspiration or laparoscopy procedures.
- Facility Services: Includes all ambulatory surgery, operating, recovery and supply charges.
- Anesthesia Services: Includes all professional anesthesiology fees, supplies and drugs.
- Drugs: Includes all non-self-administered drugs.

ART Global Services Fee Excludes

- Medications: Self-Administered drugs (should be submitted under member's pharmacy benefit)
- Early Pregnancy Monitoring

Service Limitations

Cycle Limitations

- ART: There is a cycle limit of six (6) per lifetime of member and is independent of the insurance coverage. ART services are reimbursed based on the member's schedule of benefits.
- IUI: There is cycle limit for IUI of three (3) per member's lifetime.
- IVF: There is a cycle limit for In-Vitro Fertilization (IVF) of six (6) whether the member's egg or a donor egg is used, and whether or not previous cycles were covered by the Plan.

Non-reimbursable Services

The Plan does not reimburse any of the following services:

- Lutenizing hormone (LH) ovulation kits
- Donor egg obtained from non-contracted providers
- Infertility services for members who do not have a diagnosis of medical infertility
- Reversal of voluntary sterilization
- Ovulation prediction kits
- PGD for human leukocyte antigen tissue typing or gender identification
- Sperm identification when not medically necessary (e.g., gender identification)

- Self-administered prescription drugs if the member is not in an active and authorized infertility cycle or if infertility treatment is not a covered benefit under member's plan
- Surrogacy/Gestational carrier costs
- Surgical procedures intrinsic to an ART cycle (e.g., hysteroscopy to evaluate the endometrial lining after an ART cycle)
- Non-ART providers who perform ART-related services, e.g., laboratories and anesthesiology offices. (These services are reimbursed by the ART provider)
- Specimen collection or venipuncture charges made in conjunction with laboratory services or evaluation and management services
- Shipping and/or specimen handling charges, including those related to PGD services
- Non-medical services related to donor egg procurement including, but not limited to, finder's fees, broker fees, and legal fees

Applicable Coding and Billing Guidelines

Applicable coding is listed below, subject to codes being active on the date of service. Because the American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Health and Human Services may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes may not be all inclusive. These codes are not intended to be used for coverage determinations.

CPT/ HCPCS Code	Description
55870	Electroejaculation
58321	Artificial insemination; intra-cervical
58322	Artificial insemination; intra-uterine
58323	Sperm washing for artificial insemination
58340	Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography
58970	Follicle puncture for oocyte retrieval, any method
58974	Embryo transfer, intrauterine
58976	Gamete, zygote, or embryo intrafallopian transfer, any method
59866	Multifetal pregnancy reduction
74742	Transcervical catheterization of fallopian tube, radiological supervision and interpretation
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
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
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
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
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)
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 cyropreserved; reproductive tissue, testicular/ovarian
89356	Thawing of cyropreserved; 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
S4013	Complete cycle, gamete intrafallopian transfer (GIFT), case rate
S4014	Complete cycle, zygote intrafallopian transfer (ZIFT), case rate
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
S4022	Assisted oocyte fertilization, case rate
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 - per vial
S4028	Microsurgical epididymal sperm aspiration (MESA) and testicular sperm extraction (TESE)
S4030	Sperm procurement and cryopreservation services, initial visit
S4031	Sperm procurement and cryopreservation services, subsequent visits
S4035	Stimulated intrauterine insemination (SIUI) (formerly known as IUI), case rate
S4037	Cryopreserved embryo transfer, case rate

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
10/11/2011	01/01/2012	Payment Policy	Payment Policy Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
12/02/2013	Updated template and product applicability section for BMC HealthNet Plan Qualified Health Plans, including ConnectorCare; Removed cryopreservation of eggs from Service Exclusions	12/02/2013	Payment Policy Committee
12/22/2014	Updated Coding	01/01/2015	Payment Policy Committee
05/12/2015	Annual review, Updated template and product applicability section	07/01/2015	Payment Policy Committee
8/20/2019	Annual review, Updated template and product applicability section	10/01/2019	Payment Policy Committee
05/18/2021	Annual Review, no changes	06/01/2021	Payment Policy Committee

Other Applicable Policies

Reimbursement Policies

- Free Standing Surgical Facility Services, 4.114
- General Billing and Coding Guidelines, 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, 4.108
- Obstetrical, 4.105
- Outpatient Hospital, 4.17
- Physician and Non Physician Practitioner Services, 4.608

Medical Policies

- Infertility Services (QHP/ConnectorCare/Employer Choice Direct only), OCA 3.725
- Preimplantation Genetic Testing, OCA 3.726

References

- M.G.L.c. 175, section 47H
- M.G.L.c. 176A, section 8K
- M.G.L.c. 176B, section 4J;
- M.G.L.c. 176G, section 4
- 211 C.M.R 37.09
- BMC HealthNet Plan Qualified Health Plans, including ConnectorCare Evidence of Coverage
- BMC HealthNet Plan Employer Choice Direct Evidence of Coverage, Form No. BMCHP-EmpChoiceDirect2015ver.1

Disclaimer Information

This Policy provides information about the Plan's reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member's benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan's discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan's audit policies, refer to the Provider Manual.