Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

# Assisted Reproductive Technology Services – Rhode Island Products

*Effective: July 1, 2026*

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|---|---|
| **Prior Authorization Required**<br>If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below. | Yes ☒ No ☐ |
| **Notification Required** | Yes ☐ No ☒ |

**Applies to:**

- Harvard Pilgrim Health Care Commercial products

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product).
For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

**Note:** While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service

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## Overview

These Medical Necessity Guidelines include the clinical coverage criteria for all assisted reproductive technology/infertility services covered by the Plan for Rhode Island-based commercial products and employer groups in accordance with the applicable plan documents.

## General Information

Assisted reproductive technology/infertility services are considered to be medically necessary for all members (male, female, and other gender identities) when criteria in this policy are met. For the purposes of this guideline, the term biological female refers to an individual having ovaries and a uterus and includes other gender identities. The term biological male refers to an individual having sperm and/or testes and includes other gender identities.

This medical necessity guideline is meant to be inclusive of people of all gender identities, sexual orientation, and relationships, intending to support equitable access to assistive reproductive services in accordance with plan covered benefits.

This medical necessity guideline is administered in accordance with R.I Gen. Laws § 27-18-30 "Infertility means the condition of an otherwise presumably healthy individual who is unable to conceive or sustain a pregnancy during a period of one year. Iatrogenic infertility means an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes " The Plan "shall provide coverage for medically necessary expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25) and forty-two (42) years and for standard fertility-preservation services when a medically necessary medical treatment may directly or indirectly cause iatrogenic infertility to a covered person."[1]

Assisted Reproductive Technology (ART) services, for the purposes of this guideline, include, but are not limited to:

- In vitro fertilization (IVF) and/or embryo transfer (ET)
- Frozen embryo transfer (FET)
- Gamete intra-fallopian transfer (GIFT)
- Donor oocyte (DO/IVF)
- Donor embryo/frozen embryo transfer (DE/FET)
- Intracytoplasmic sperm injection (ICSI)
- Assisted hatching (AH)
- Cryopreservation of embryos/sperm/eggs

ART/Infertility services will be covered when criteria are met, during the time when fertility is naturally expected. Additionally, there must be a 5%, or greater, chance of live birth as demonstrated by the treating provider. [2,3]

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# Clinical Guideline Coverage Criteria

## ART/Infertility Services

### Eligibility Requirements

**The Member must meet ALL** of the following:

1. The Member must be the recipient of the intended services;
2. Coverage for assisted reproductive technology/infertility treatment is based on the Member's individual medical history and should demonstrate > 5% chance of live birth, using the members own eggs
3. The Member must expect fertility as a natural state or must be experiencing menopause at a premature age. Hormone levels and medical history, among other factors, may be considered in this evaluation. Members who are unable to achieve a viable birth outcome using their own eggs/embryos,(unless criteria is met for donor egg) and are experiencing a normal and expected physiological decline in fertility (not consistent with a disease process) are not covered for infertility *services.*

In addition, the Member must meet **ONE** of the following requirements to demonstrate infertility:

1. The Member has been diagnosed with infertility, the condition of a presumably healthy individual who has been unable to conceive or produce conception with exposure to sperm (e.g., at home insemination, sexual intercourse) during a period of six months, if the biological female is over the age of 35, and a period of one year if the biological female is age 35 or younger, as represented in the medical record; **or**
2. The Member may also demonstrate infertility by **ONE** or more of the following:
    a. An otherwise healthy member, who has completed four cycles of intrauterine inseminations (IUIs) with or without medication and has not been able to conceive [4]; **or**
    b. A member with an ovulation disorder who has been:

i. Treated with medication, with or without IUI for up to four cycles and has been unable to conceive [4]; **or**

c. A member with **ONE** of the following documented conditions (including but not limited to):

i. Tubal factor infertility; **or**

ii. Adnexal adhesive disease; **or**

iii. Endometriosis (class III or IV)[5]; **or**

iv. Member's partner has male factor infertility as defined in this policy

**Intrauterine Insemination**

Members seeking Intrauterine Insemination (IUI) service must meet **ONE** of the following:

1. History of more than one Loop electrosurgical excision procedure (LEEP) for conization procedure that is considered a factor in the member's infertility
2. Diagnosis of vaginismus
3. The Member or partner has met the eligibility requirements for ART services

**In addition, Members seeking (IUI) services, the member must submit clinical evidence demonstrating ALL of the following:**

1. Eligibility for ART services
2. Ovarian Reserve Testing-Cycle Day 3 (within one year)
   a. Follicle Stimulating Hormone (FSH) level ≤ 15 mIU/ml
   **AND**
   b. Estradiol (E2) level ≤100 pg/mL
   **OR**
   c. Anti-Mullerian Hormone (AMH) (documentation is required with reason why FSH/E2 cannot be performed)[6]
3. Thyroid Stimulating Hormone (TSH) completed:
   a. <35 years within two years
   b. ≥35 years within one year
4. Rubella Status (all non-immune members must be vaccinated and wait one month thereafter before seeking approval for ART)[7]
5. Uterine cavity evaluation[10]
   a. A uterine cavity evaluation (e.g., Hysterosalpingogram (HSG), Hysterosalpingo-Contrast Sonography (HyCoSy) within one year prior to the initial ART cycle
   b. Uterine cavity follow-up evaluation is required every two years
   c. A uterine cavity evaluation is needed following a pregnancy that resulted in an antenatal, intrapartum, or postpartum complications

**Limitation**: Cycle or treatment limitations may apply based on the plan. Please refer to the member's benefit document for any applicable benefit coverage limitations

## In Vitro Fertilization

**Members seeking In Vitro Fertilization (IVF) services, the Member must submit clinical demonstrating ALL of the following:**

1. Eligibility requirements for ART services
2. Thyroid Stimulating Hormone (TSH) completed:
   a. <35 years within two years
   b. ≥35 years within one year
3. Rubella Status (all non-immune members must be vaccinated and wait one month thereafter before seeking approval for ART)[7]
4. Urine or Serum Cotinine level (for a member who has quit smoking within one year)[8]
5. Ovarian Reserve Testing
   a. For members ≥40 years of age
      i. Clomiphene Citrate Challenge Test (CCCT) should occur every 12 months with an interval Cycle

Day 3 test at six months. Anti-Mullerian (AMH) testing may be considered when documentation indicates a contraindication to CCCT [9]

a. Cycle Day 3
   - FSH level ≤15 mIU/ml

   **AND**
   - Estradiol (E2) level ≤100 pg/mL

b. Cycle Day 10
   - FSH level ≤ 15 mIU/ml

ii. Interval Cycle Testing-Day 3 labs (6 months after CCCT)
   a. FSH level ≤ 15 mIU/ml

   **AND**

   b. Estradiol (E2) level ≤ 100 pg/mL

iii. Anti-Mullerian Hormone [18]
   a. Performed every six months If CCCT contraindicated
   b. AMH greater than 0.3 ng/ml

b. For members < 40 years of age
   i. Cycle Day 3 Ovarian Reserve Testing with FSH and E2 should occur every 12 months. Anti-Mullerian (AMH) testing may be considered when documentation indicates a contraindication to FSH and E2 testing.
      a. Cycle Day 3
         - FSH level ≤15 mIU/ml

         **AND**
         - Estradiol (E2) level ≤100 pg/mL

         **OR**

      b. Anti-Mullerian Hormone [18]
         - Performed every 12 months if ovarian reserve testing contraindicated
         - AMH greater than 0.3 ng/ml

6. Uterine cavity evaluation[10]
   a. A uterine cavity evaluation (e.g., Hysterosalpingogram (HSG), Hysteroscopy (HSC), Sonohysterography (SHG), or Hysterosalpingo-Contrast Sonography (HyCoSy) within one year prior to the initial ART cycle
   b. Uterine cavity follow-up evaluation is required every two years
   c. A uterine cavity evaluation is needed following a pregnancy that resulted in an antenatal, intrapartum, or postpartum complications

**Limitations:**

- Cycle or treatment limitations may apply based on the plan. Please refer to the member's benefit document for any applicable benefit coverage limitations

## In-Vitro Fertilization (IVF) Services

Authorization for IVF cycles are considered on a case-by-case basis based upon the member's probability of a 5% or greater chance of live birth related to requested cycle and individual medical history. Medical history may include age, previous pregnancies with or without ART, length of time attempting pregnancy, ovarian reserve, results of previous IVF cycles and male factor infertility. If approved for IVF, members will be approved for one fresh cycle or one freeze-all cycle per request.

1. ART/infertility services, as outlined in this medical necessity guideline, is a covered benefit for member who demonstrate infertility as defined above and for whom fertility is otherwise expected as a natural state (e.g., biological female < age 40 with an abnormal CCCT or AMH)

Note: For biological females over the age 40, There must be no evidence of significant diminished ovarian reserve as evidenced by abnormal lab values within the past six months

2. ART/infertility services using a biological female's own eggs continues to be the treatment of choice for biological

female > age 40 and < age 44 when the following outcome is achieved for each previous ART cycle initiated:

a. At least three embryos on Day 3, each of which are at least six to eight cells, or at least one on Day 5 of average grade (Gardner 3BB or better)[14]

**AND**

b. Reasonable quality (grade B or its equivalent) is available for transfer per cycle (including up to fair fragmentation <25%-50%)

3. For IVF for preimplantation genetic diagnosis, refer to applicable Preimplantation Genetic Diagnosis Medical Necessity Guideline or applicable AIM criteria

Note: Members who have a documented medical contraindication to pregnancy, are using their own eggs, and are self-paying for a gestational carrier, may be authorized for ovarian stimulation, egg retrieval, and fertilization. Embryo transfer to the gestational carrier would not be covered.

## In-Vitro Fertilization (IVF) due to Inadvertent Ovarian Hyperstimulation:

ART/Infertility services include a wide range of treatments and procedures to assist infertile individuals in achieving successful reproduction. One of these procedures includes intrauterine insemination (IUI), in which washed sperm is deposited directly the uterine cavity in an effort to achieve successful fertilization. Preparation for this procedure can include pre- treatment with various pharmacologic agents (including, but not limited to gonadotropins, clomiphene citrate, GnRH agonists and antagonists) to produce controlled ovarian hyperstimulation. When the use of these agents results in Ovarian Hyperstimulation Syndrome (OHSS), the only safe alternative to cancellation of the cycle is to convert it to IVF.[15]

### Clinical Coverage Criteria

1. Coverage for IVF services due to inadvertent ovarian hyperstimulation during preparation for a stimulated intrauterine insemination cycle may be approved when **ALL** of the following are met:
   a. The Member must be < age 40 with an infertility diagnosis, with an Estradiol level > 1000, with at least three or more follicles >16mm or four to eight follicles that are ≥ 14mm and/or a large number of smaller follicles on day the decision is made to convert; **and**
   b. For members ≥40 years, it is not medically necessary to convert an IUI cycle to IVF due to ovarian hyperstimulation unless E2 is > 2000 and therefore coverage will be based on prior cycle response and individual history

## Donor Egg

Donor Egg and/or Donor embryo transfer may be covered for members when they meet **ONE** of the following criteria:

1. Infertility is demonstrated pursuant to the criteria above
   a. Premature menopause or premature ovarian failure (onset prior to age 40 with an FSH ≥15 mIU/ml on Cycle Day 3). Members with abnormal FSH levels after age 40 are not eligible for donor egg coverage regardless of evidence of abnormal FSH levels prior to age 40; **or**
      i. Previously failed IVF in members with acceptable ovarian reserve between age 40-42 as noted under the in Vitro Fertilization section

**Note**: Anonymous or designated donors must be ≤ 35 years of age, or between ages 36 and 39 with normal ovarian reserve as noted above in ART requirements. Individuals aged 40 or older are not generally appropriate candidates to donate oocytes/embryos

The Plan does not cover the transfer of the embryo if the member is using a gestational carrier. The Plan does not cover surrogacy services.

## Single Embryo/Frozen Embryo Transfer

### Single Embryo Transfer (SET)

1. For the first two IVF cycles ever for members <35 years of age:
   a. Coverage for the initial SET will be provided, when there are at least two good-quality embryos available at the time of transfer
   b. If coverage for a second SET cycle is requested, authorization will not be given for a single fresh embryo transfer, unless a frozen embryo is not available for transfer

2. For the first IVF cycles ever for members 35 through 37 years of age:
    a. Coverage will be provided for SET, when at least two good quality embryos are available at the time of transfer[16,17,18]

If a live birth results from this cycle, then one additional SET cycle will be approved, when there are at least two good-quality embryos available at the time of transfer. If only a frozen embryo is available for transfer, then a Frozen Embryo Transfer cycle will be approved.

### Frozen Embryo Transfer (FET)

1. Members seeking coverage for FET must demonstrate infertility and expect fertility as a natural state
2. Cryopreserved embryos must be used prior to authorization for additional fresh ART cycles under the following circumstances:
    a. Members aged ≤ 37 years old and undergoing 2nd SET cycle, only a single FET will be covered unless a frozen embryo is not available (see section for SET)
    b. Members aged < 35 years old and three cryopreserved embryos of a similar developmental stage are available for transfer
    c. Members aged > 35, and four cryopreserved embryos of a similar developmental stage are available for transfer

**Note**: It is recognized that some members may elect to do a FET cycle regardless of the number of available embryos before proceeding to another fresh cycle. Such requests will be approved as long as the member continues to be eligible for coverage of infertility treatment

## Intra-Cytoplastic Sperm Injections (ICSI)[19]

ICSI may be approved for coverage for **ONE** of the following:

1. Male factor infertility as defined by:
    a. <10 million total motile sperm/ejaculate (pre-wash specimen) or < 3 million total motile sperm (post-wash specimen) on two separate semen analysis performed at least two weeks apart[11], OR
    b. ≤1% normal forms pre or post wash on two separate semen analyses (Strict Kruger Morphology[12]), OR
    c. < 40% fertilization (for mature eggs) on an IVF cycle with drop insemination
2. Use of frozen eggs
3. ICSI may be authorized for members authorized, for the coverage of preimplantation genetic diagnosis (PGD)

## Assisted Hatching (AH)[20]

The Plan considers assisted hatching as reasonable and medically necessary when part of an IVF or FET procedure when documentation confirms **ONE** of the following:

1. Prior failed transfer using quality embryos
2. Need for assisted hatching in prior ART cycles
3. Member is >35
4. Use of frozen embryos

## ART Services for Biological Males

**For biological males ~~members~~ seeking donor sperm or ART services, the member must submit documentation meet the following:**

1. Semen analysis performed within one year
    a. Abnormal semen analysis confirming male factor infertility as defined by:
        i. <10 million total motile sperm/ejaculate (pre-wash specimen) or <3 million total motile sperm (post-wash specimen) on two separate semen analysis performed at least two weeks apart; [11] OR
        ii. ≤1% normal forms (Strict Kruger Morphology) [12] AND;
    b. Evaluation by a urologist
    c. Two semen analyses, including volume
    d. FSH and testosterone levels (within six months)
    e. Karyotyping and Y chromosome microdeletion (YCMD) for nonobstructive azoospermia and for all S/A <3 mil sperm/cc

f. Cystic fibrosis screening for obstructive azoospermia – Congenital Absence of the Vas Deferens (CAVD) Karyotyping

## Gamete and Zygote Intrafallopian Transfer (GIFT&ZIFT)

The plan considers GIFT/ZIFT to be medically necessary when the member meets the IVF criteria above

## Donor Sperm

Coverage for donor sperm is provided to members undergoing infertility/ART services when criteria is met:

1. Male factor infertility as defined by:
    a. <10 million total motile sperm/ejaculate (pre-wash specimen) or < 3 million total motile sperm (post-wash specimen) on two separate semen analysis performed at least two weeks apart[11], OR
    b. ≤1% normal forms pre or post wash on two separate semen analyses (Strict Kruger Morphology[12]), OR
    c. < 40% fertilization (for mature eggs) on an IVF cycle with drop insemination
    d. Significant genetic defect in the biological male, electing donor sperm over genetic testing

In addition, coverage decisions regarding donor sperm services will be based upon the following information: member's past medical/infertility history, including, but not limited to past infertility interventions.

## Microsurgical Epididymal Sperm Aspiration (MESA)

The Plan considers Microsurgical Epididymal Sperm Aspiration (MESA) as medically necessary for members with sperm with a documented congenital absence or obstruction, or traumatic obstruction, of the vas deferens, excluding obstruction resulting from prior sterilization or sterilization reversal procedures. [21,22]

## Testicular Sperm Extraction (TESE)

The Plan considers testicular sperm extraction (TESE) or micro-TESE as medically necessary when documentation confirms members with testicles/sperm has documented non-obstructive azoospermia or have failed a prior MESA procedure. [21,22]

## For Members with a History of a Sterilization Procedure Reversal

The Plan considers coverage of ART/Infertility services after successful reversal of prior sterilization as medically necessary for members who have undergone a previous sterilization procedure (e.g., tubal ligation or vasectomy) and subsequent surgical reversal, only when there is clinical documentation confirming **ALL** the following:

1. The Member meets all applicable medical necessity criteria for infertility treatment in this policy, and the member has undergone a successful reversal procedure
    a. The Member's infertility is independent of the previous sterilization procedure, and the successful reversal procedure has been followed by appropriate attempts of natural conception
2. There is documentation of **one** of the following:
    a. For members with testicles/sperm, two consecutive semen analyses within three months of the request for infertility services demonstrating a normal fertility threshold (as noted in Guidelines below) and continued success of the reversal
    b. Documentation of a successful reversal of tubal ligation as evidenced by a normal hysterosalpingogram demonstrating unilateral or bilateral tubal spill

# Cryopreservation

## Clinical Coverage Criteria for Cryopreservation of Sperm, Oocyte, or Embryos[23]

The Plan may authorize, with prior authorization, coverage for the harvest, procurement, and storage of sperm, oocytes, or embryos and said storage for up to 24 months in association with ongoing infertility care when or documentation confirms **ONE** of the following is met:

1. When a member is undergoing medical treatment that may result in infertility (e.g., chemotherapy, radiation, gender affirming services)
2. When there is a high probability of an adverse impact on the member's health and well-being (e.g., severe hyperstimulation syndrome)
3. Single embryo transfer requirements or the high risk of multiple gestations from the transfer of an excessive number of available embryos
4. When eggs cannot be fertilized during an authorized IVF cycle due to lack of sperm or sperm of poor quality on the

day of egg procurement

5. When a member has been diagnosed with a medical condition (excluding prior sterilization procedure) which requires that sperm be obtained directly from testicular tissue (including MESA or TESE)

### Clinical Coverage Criteria for Cryopreservation of Reproductive Tissue[24]

The Plan may authorize, with prior authorization, coverage for the storage of ovarian and testicular tissue for up to 24 months in members undergoing gonadotoxic treatment (e.g., chemotherapy, radiation)

## Limitations

The Plan considers Services for fertility and infertility/assisted reproductive technology, for all other indications, not medically necessary and therefore not covered. In addition, the plan does not cover services for **any** of the following:

1. Services for individuals who do not have with a likelihood of 'success' (defined as a live birth rate less than 5%)
2. ART/Infertility services for members with age-related infertility and/or who do not demonstrate infertility
3. Infertility treatment when infertility is the result of a non-reversed voluntary sterilization
4. Treatment and related expenses not otherwise outlined above when the member is not the recipient of said services (e.g., gestational carrier or transfer of embryo to a gestational carrier, donor egg recruitment, or surrogacy related expenses) and drugs that are directly related to a stimulated ART cycle for anonymous or designated donor unless the ART service is prior authorized, and the Member is the sole recipient of the donor's eggs
5. Sperm cryopreservation as a routine procedure for sperm backup in the absence of a confirmed physical or psychological diagnosis requiring cryopreservation
6. ART/Fertility services (including but not limited to consultations, labs, radiology studies, infertility drugs, ART cycles, and other services to assess and/or treat infertility in a member or a member's partner) requested as a result of a prior voluntary sterilization or unsuccessful sterilization reversal procedure unless there is documentation that criteria (above) are met
7. Treatments requested solely for the convenience, lifestyle, personal or religious preference of the member in the absence of medical necessity
8. ART/Fertility services in cases in which normal embryos have been or will be discarded because of gender selection
9. Infertility services for biological females who are not Rubella immune7
10. ART/fertility services when clinical documentation indicates a member or member's partner has active or uncontrolled alcohol use disorder or substance use disorder. Results of serum or urine drug screening may be requested before ART services are authorized
11. ART/Infertility services for biological females who are actively smoking cigarettes and/or are using nicotine containing products such as gum, patches, or electronic cigarettes
12. Treatment to reverse voluntary sterilization, or MESA/TESE, for a member who has undergone prior sterilization
13. Charges for the storage of eggs, sperm or embryos that remain in storage after the completion of approved fertility service beyond the authorization period described above
14. Compensation for the recruitment of egg donors including but not limited to testing, screenings, services fees, and charges
15. Chromosome studies of donor (sperm or egg)
16. ICSI for any IVF cycle involving use of donor sperm
17. Services or drugs directly related to non-covered services (when the procedure is outside the scope of the Clinical Coverage Guidelines
18. Members aged 40 or older are not appropriate candidates to donate oocytes/embryos

## Administrative Process

1. The member must have a diagnosis of infertility and be eligible for coverage of medically necessary services as defined by these guidelines.
2. The member must receive infertility services at a Plan OB/GYN, or infertility specialist as required by the member's benefit document.
3. The member must receive ART services at a Plan contracting ART Center as required by the member's benefit document.
4. The Provider must complete the applicable prior authorization forms when requesting services.
5. The Provider must complete the Infertility Treatment Summary Form when requesting services.
6. Authorized services may be approved for up to one year for biological females < 40 years old and up to six months for biological females ≥ 40 years old.

7. If a request or clinical need for treatment such as FSH/IUI OR a conversion from IUI to IVF due to inadvertent ovarian hyperstimulation occurs outside of the Plan's normal business hours, the Member's physician should make the treatment decision based on their clinical judgment at the time. The physician must contact the Plan on the next business day. Retrospective coverage may be approved if the medical necessity guidelines and eligibility requirements are met.
8. After the authorization period ends, the member must go through a new prospective review process for coverage of any additional cycles.

## Codes

The following code(s) require prior authorization:

**Table 1: CPT/HCPCS Codes**

| Code | Description |
|---|---|
| 58321 | Artificial insemination; intra-cervical |
| 58322 | Artificial insemination; intra-uterine |
| 58970 | Follicle puncture for oocyte retrieval, any method |
| 58974 | Embryo transfer, intrauterine |
| 58976 | Gamete, zygote, or embryo intrafallopian transfer, any method |
| 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, micro techniques (any method) |
| 89254 | Oocyte identification from follicular fluid |
| 89255 | Preparation of embryo for transfer (any method) |
| 89258 | Cryopreservation; embryo(s) |
| 89259 | Cryopreservation; sperm |
| 89268 | Insemination of oocytes |
| 89272 | Extended culture of oocyte(s)/embryo(s), 4-7 days |
| 89280 | Assisted oocyte fertilization, micro technique; less than or equal to 10 oocytes |
| 89281 | Assisted oocyte fertilization, micro technique; greater than 10 oocytes |
| 89290 | Biopsy, oocyte polar body or embryo blastomere, micro technique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos |
| 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) |
| 89354 | Thawing of cryopreserved; reproductive tissue, testicular/ovarian |
| 89356 | Thawing of cryopreserved; oocytes, each aliquot |
| 89398 | Unlisted reproductive medicine laboratory procedure |
| 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 |

| Code | Description |
|---|---|
| 58321 | Artificial insemination; intra-cervical |
| 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 |
| S4028 | Microsurgical epididymal sperm aspiration (MESA) |
| S4037 | Cryopreserved embryo transfer, case rate |

## References:


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## Approval And Revision History

September 21, 2022: Reviewed and approved by the Medical Policy Approval Committee (MPAC) for an effective date of January 1, 2023.

Subsequent endorsement date(s) and changes made:

- January 27, 2023: Clarified formatting of evaluation requirements for biological males seeking services.
- July 19, 2023: Reviewed by MPAC; criteria for ICSI and assisted hatching clarified; limitations modified for clarity effective September 1, 2023
- November 2023: Unify name changed to OneCare effective January 1, 2024
- December 20, 2023: Reviewed by MPAC, limitations updated with clarifying language effective February 1, 2024
- June 20, 2024: Reviewed by MPAC, format updated, donor egg criteria clarified effective October 10, 2024
- September 19, 2024: Reviewed by MPAC, criteria updated to include coverage for cryopreservation and storage of reproductive tissue (ovarian and testicular) when members are undergoing gonadotoxic treatment; Codes 89335, 89344, 89354, and 89398 added to require prior authorization, effective November 1, 2024
- May 21, 2025: Reviewed by MPAC, Harvard Pilgrim Health Care Stride Medicare Advantage removed from applicable products in template. Limitation updated. Effective May 30, 2025.
- May 20, 2026: Reviewed by MPAC; administrative update to guideline template, renewed without changes effective July 1, 2026

## Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes

available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.