Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines: **Fertility Services for Harvard Pilgrim Health Care Massachusetts Products (Large Group and Merged Market)**

Effective: July 1, 2026

Prior Authorization Required 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.

Overview

This fertility benefit provides coverage for certain fertility services, to members who do not meet the definition of infertility under Massachusetts law, in an effort to support inclusive family building for all members, including those across sexual orientation and gender identity spectra and those without coparenting partners or those who do not meet infertility criteria from the Assisted Reproductive Technology Services MNG.

These Medical Necessity Guidelines includes the clinical coverage criteria for fertility services that are available when benefit coverage exists in accordance with applicable plan documents. Benefit coverage is limited to Massachusetts Large Group and Merged Market commercial products and employer groups that have elected this benefit.

Note:

- **For members with documented infertility or who do not conceive using services outlined within this policy, please refer to the Assisted Reproductive Technology Services MNG**

Clinical Guideline Coverage Criteria

The following services are covered with prior authorization when eligibility and evaluation requirements are met

- Intrauterine Insemination (IUI)
  - Administered in the office setting with the support of a licensed clinician
- Donor sperm used for purposes of IUI, In-Vitro Fertilization (IVF), and reciprocal IVF services
- Donor egg, *for members who do not have a partner that can produce fertilizable eggs (biological male members),* including the cost of donor egg, insemination, processing, and cryopreservation
- IVF, including ICSI for approved cycle using frozen egg.
- Reciprocal IVF
- Laboratory and other associated testing (blood testing, sperm testing, ultrasound) related to the covered fertility services listed above.

Eligibility Requirements for Fertility Services

The member must meet all of the following:

1. The member must be the recipient of the intended services

Coverage for services in this guideline are based on the member's individual medical history and should demonstrate >5% chance of live birth. Additionally, the member must be of normal reproductive age and expected fertility as a normal state.

Evaluation Requirement

The Member must meet or submit ALL of the following:

For Members who can carry a pregnancy and are seeking IUI or IVF:

1. 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]
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. Uterine cavity evaluation[10]
    a. A uterine cavity evaluation (e.g., Hysterosalpingogram (HSG) 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

For Members seeking Reciprocal IVF:

1. **Egg Donor Member:**
    a. Ovarian Reserve Testing-Cycle Day 3 (within one year)
    - Follicle Stimulating Hormone (FSH) level ≤ 15 mIU/ml
        - **AND**
    - Estradiol (E2) level ≤100 pg/mL
        - **OR**
    - Anti-Mullerian Hormone (AMH) (documentation is required with reason why FSH/E2 cannot be performed)[6]

    b. Thyroid Stimulating Hormone (TSH) completed:
        i. <35 years within two years
        ii. ≥35 years within one year
2. **Egg Recipient Member:**
    a. Ovarian Reserve Testing-Cycle Day 3 (within one year)
        i. Follicle Stimulating Hormone (FSH) level ≤ 15 mIU/ml
        AND
        ii. Estradiol (E2) level ≤100 pg/mL
        OR
        iii. Anti-Mullerian Hormone (AMH) (documentation is required with reason why FSH/E2 cannot be performed)[6]
    b. Thyroid Stimulating Hormone (TSH) completed:
        i. <35 years within two years

ii. ≥35 years within one year

c. Rubella Status (all non-immune members must be vaccinated and wait one month thereafter before seeking approval for ART)[7]

d. Uterine cavity evaluation[10]

i. A uterine cavity evaluation (e.g., Hysterosalpingogram (HSG) or Hysterosalpingo-Contrast Sonography (HyCoSy) within one year prior to the initial ART cycle

ii. Uterine cavity follow-up evaluation is required every two years

iii. A uterine cavity evaluation is needed following a pregnancy that resulted in an antenatal, intrapartum, or postpartum complications

Donor Eggs or Oocytes:

Coverage for donor eggs or oocytes is provided to members who do not have a partner that can produce fertilizable eggs (biological male members) A semen analysis must be performed within one year. If the semen analysis is abnormal, 1 vial of sperm may be covered.

Abnormal semen analysis is defined as:

1. <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; OR
2. ≤1% normal forms (Strict Kruger Morphology)

Donor Sperm:

Coverage for donor sperm is provided to biological female members without a male partner, who can carry a pregnancy when evaluation criteria for IUI, IVF, or Reciprocal IVF are met.

Note: One vial of sperm may be provided per IUI treatment

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 fertility care or when 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

Limitations

The Plan considers fertility services 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' (<5% chance of live birth)
2. Fertility services for individuals with current infertility or failure of prior infertility treatment.
3. 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.
4. Sperm cryopreservation as a routine procedure for sperm backup in the absence of a confirmed physical or psychological diagnosis requiring cryopreservation
5. ART/fertility services (including but not limited to consultations, labs, radiology studies, infertility drugs, ART cycles, and other services to assess fertility 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
6. ART/fertility services in cases in which normal embryos have been or will be discarded because of gender selection

7. 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
8. ART/fertility services for members who are actively smoking cigarettes and/or are using nicotine containing products such as gum, patches, or electronic cigarettes
9. 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
10. Compensation for the recruitment of egg donors including but not limited to testing, screenings, services fees, and charges
11. Chromosome studies of donor (sperm or egg)
12. Services or drugs directly related to non-covered services (when the procedure is outside the scope of the Medical Necessity Guidelines)
13. Cryopreservation, storage, and thawing of reproductive tissue (ovarian/testicular) (CPT codes 89335, 89344, and 89354 are considered experimental)
14. No coverage is provided for reciprocal IVF services for non-Members

Codes

The following code(s) is associated with this service:

Table 1: CPT/HCPCS Codes

Code	Description
58322	Artificial insemination; intra-uterine
89258	Cryopreservation; embryo(s)
89268	Insemination of oocytes
89280	Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes
89281	Assisted oocyte fertilization, microtechnique; greater than 10 oocytes
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
S4026	Procurement of donor sperm from sperm bank

Table 2: ICD 10 Diagnosis Codes

Code	Description
Z31.9	Encounter for procreative management, unspecified

References:

1. Harris BS, Acharya KS, Weber JM, Truong T, Eaton JL. Can high antimüllerian hormone mitigate some of the age- related decline in live birth rates? The association between antimüllerian hormone and live birth among women over 40 undergoing in vitro fertilization. F S Rep. 2021 Sep 8;2(4):440-447. doi: 10.1016/j.xfre.2021.08.009. PMID: 34934985; PMCID: PMC8655414
2. Pregnancy and Rubella. Center for Disease Control and Prevention. https://www.cdc.gov/rubella/pregnancy.html. Published 2022. Accessed September 19, 2022.
3. Practice Committee of the American Society for Reproductive Medicine. Electronic address: asrm@asrm.org; Practice Committee of the American Society for Reproductive Medicine. Smoking and infertility: a committee opinion. Fertil Steril. 2018;110(4):611-618. doi:10.1016/j.fertnstert.2018.06.016
4. Practice Committee of the American Society for Reproductive Medicine. Aging and infertility in women: a committee opinion. Fertil Steril. 2002 Jul;78(1):215-9. doi: 10.1016/s0015-0282(02)03212-0. PMID: 12095531.
5. Gu P, Yang X, Zhao X, Xu D. The value of transvaginal 4-dimensional hysterosalpingo-contrast sonography in predicting the necessity of assisted reproductive technology for women with tubal factor infertility. Quant Imaging Med Surg. 2021;11(8):3698-3714. doi:10.21037/qims-20-1193
6. Practice Committee of the American Society for Reproductive Medicine. Diagnostic evaluation of the infertile female: a committee opinion. Fertil Steril. 2015;103(6):e44-e50. doi:10.1016/j.fertnstert.2015.03.019

7. Penzias, Bendikson, K., Butts, S., Coutifaris, C., Fossum, G., Falcone, T., Gitlin, S., Gracia, C., Hansen, K., La Barbera, A., Mersereau, J., Odem, R., Paulson, R., Pfeifer, S., Pisarska, M., Rebar, R., Reindollar, R., Rosen, M., Sandlow, J., & Vernon, M. (2017). Guidance on the limits to the number of embryos to transfer: a committee opinion. Fertility and Sterility, 107(4), 901–903.https://doi.org/10.1016/j.fertnstert.2017.02.107
8. Practice Committee of the American Society for Reproductive Medicine. Electronic address: asrm@asrm.org. Evidence-based outcomes after oocyte cryopreservation for donor oocyte in vitro fertilization and planned oocyte cryopreservation: a guideline. Fertil Steril. 2021;116(1):36-47. doi:10.1016/j.fertnstert.2021.02.024

Approval And Revision History

October 18, 2023: Reviewed by the Medical Policy Approval Committee (MPAC) as a new coverage guideline for Harvard Pilgrim Health Care Commercial Large Group and Merged Market Products effective January 1, 2024

Subsequent endorsement date(s) and changes made:

- November 2023: Unify name changed to One Care effective, January 1, 2024
- June 20, 2024: Reviewed by MPAC, criteria clarified to note that IVF may include ICSI if members are using frozen eggs, donor eggs are available for members who do not have a partner who can produce fertilizable eggs; time frame for ovarian reserve testing added; effective August 1, 2024
- May 21, 2025, Reviewed at MPAC. Removed Harvard Pilgrim Health Care Stride Medicare from list of applicable products template. 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 M ember'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.