Diagnosis and Treatment of Infertility

Disclaimer

Clinical guidelines are developed and adopted to establish evidence-based clinical criteria for utilization management decisions. Clinical guidelines are applicable according to policy and plan type. The Plan may delegate utilization management decisions of certain services to third parties who may develop and adopt their own clinical criteria.

Coverage of services is subject to the terms, conditions, and limitations of a member's policy, as well as applicable state and federal law. Clinical guidelines are also subject to in-force criteria such as the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) for Medicare Advantage plans. Please refer to the member's policy documents (e.g., Certificate/Evidence of Coverage, Schedule of Benefits, Plan Formulary) or contact the Plan to confirm coverage.

Summary

The Plan considers the diagnosis and treatment of infertility medically necessary when the cause is an anatomical issue, acquired disease, inherited disease, or other conditions resulting in an inability to conceive or establish pregnancy. Basic diagnostic services to determine the cause of infertility may include semen analysis, serum hormone levels, hysterosalpingogram, and evaluation of ovulatory function. If basic infertility services do not result in a pregnancy, comprehensive treatment services may include surgical and non-surgical treatments (e.g., ovulation induction, intrauterine insemination).

Note: Infertility services may include diagnosis, treatment, or fertility preservation. Coverage is subject to the terms, conditions, and limitations of a member's policy as well as applicable state and federal law. Assisted reproductive technologies such as in vitro fertilization (IVF), gamete intrafallopian tube transfers (GIFT), zygote intrafallopian tube transfers (ZIFT), or donor services (oocyte, ovum, sperm) are also subject to the member's benefit plan for coverage eligibility. Furthermore, infertility medications and delivery (e.g., pumps) may be subject to the member's pharmacy benefit plan.

Note: For transgender members experiencing iatrogenic infertility due to sex reassignment surgery, coverage for fertility preservation (freezing egg, sperm) and/or other infertility services is subject to the member's policy and applicable state and federal law. Please refer to the Plan Clinical Guideline: Gender-Affirming Services (CG017) for sex reassignment procedures for gender dysphoria.

Definitions

"Assisted reproductive technology (ART)" refers to fertility treatments in which both eggs and sperm, or embryos, are handled outside the body to achieve pregnancy. According to the American Society for Reproductive Medicine (ASRM), examples of ART include, but are not limited to, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and donor eggs or sperm.

"Cryopreservation" for fertility preservation refers to freezing eggs (oocytes), sperm, or embryos at a storage bank for future reproduction.

"Fertility preservation" refers to medical interventions intended to protect or retain an individual's ability to have biological children in the future, such as freezing (cryopreserving) eggs, sperm, embryos, or reproductive tissue before medical treatment or age-related fertility decline.

"Iatrogenic infertility" refers to transient or permanent infertility caused by a necessary medical intervention such as chemotherapy, pelvic radiotherapy, gonadotoxic therapies, or the surgical removal of the reproductive organs for the treatment of disease or gender dysphoria.

"Infertility" refers to the failure to establish a successful pregnancy after 12 months/cycles for women (biological females) before 35 years of age, or after 6 months/cycles for women greater or equal to 35 years of age with unprotected heterosexual intercourse or therapeutic donor insemination. Infertility may be caused by disease, dysfunction, or malformation.

- Primary infertility refers to couples who have never established a pregnancy.
- Secondary infertility refers to couples who are experiencing infertility after having a history of a live birth.

"In vitro fertilization" (IVF) refers to a series of procedures that involve extracting egg and sperm from biological parents (or donors) and fertilizing mature eggs with sperm in a lab. The fertilized egg/s (embryo) are transferred into the uterus of the biological mother, a gestational carrier (who has no genetic connection to the embryo), or a traditional surrogate (whose own egg is fertilized by the intended father's sperm). Embryos not transferred can be cryopreserved (frozen) for future use.

"Pregnancy" refers to clinical pregnancy documented by ultrasonography, biochemical or histopathologic examination.

"Recurrent pregnancy loss" refers to two or more failed pregnancies, or miscarriages, and is not considered infertility.

"Therapeutic donor insemination" refers to the process of inserting laboratory-processed sperm into the reproductive tract of a woman from a man who is not her intimate sexual partner for the purpose of initiating a pregnancy.

Medical Necessity Criteria for Clinical Review

General Medical Necessity Criteria

The Plan considers infertility services medically necessary when ALL of the following criteria are met:

1. The requested service is covered per the member's plan benefits; *and*
2. The requested service is NOT associated with the reversal of voluntary sterilization, which was originally performed for the primary purpose of preventing pregnancy, in males (e.g., vasectomy) or females (e.g., tubal ligation); *and*
3. The requested infertility service is NOT for a member who has a history of voluntary sterilization (biological male or female) or completed a reversal procedure for sterilization; *and*
4. Infertility services are not being requested beyond 10 weeks of pregnancy; *and*
5. Infertility is the result of disease, dysfunction, iatrogenic infertility (see *Definitions* section), or malformation.
    a. Infertility is not defined to include the inability to conceive due to lack of a sex partner; *and*
6. ONE of the below:
    a. For ages <35, after trying to conceive after 12 months (including unprotected heterosexual intercourse and/or therapeutic donor insemination); *or*
    b. For ages ≥35, after trying to conceive after 6 months (including unprotected heterosexual intercourse and/or therapeutic donor insemination); *or*
    c. For a biological female ≥ 40 years old (who has not yet reached a diagnosis of natural menopause as reflected by the permanent cessation of menses for at least 12 months),

more immediate evaluation and treatment may be medically necessary; *or*

d. If the member already has a documented condition to cause infertility, immediate evaluation is warranted. In the scenarios that there are reversible causes of infertility that can be medically managed, the member must have maximized the therapies and treatment (except for a history of voluntary sterilization); *and*

7. ONE of the below:
    a. For comprehensive infertility services, BOTH of the following criteria are met:
        i. Clinical documentation indicates that basic fertility services did not result in a pregnancy; *and*
        ii. One of the criteria under Comprehensive Infertility Services (Treatment) is met; *or*
    b. For assisted reproductive technology, BOTH of the following criteria are met:
        i. Clinical documentation indicates that comprehensive fertility services did not result in a pregnancy; *and*
        ii. Assisted Reproductive Technologies criteria are met; *or*
    c. For fertility preservation due to iatrogenic infertility, Fertility Preservation criteria are met; *or*
    d. Fertility preservation related to sex reassignment surgery is subject to plan benefits. For fertility preservation services due to iatrogenic infertility associated with sex reassignment surgery, BOTH of the following criteria are met:
        i. General Medical Necessity Criteria in Gender-Affirming Services (CG017); *and*
        ii. Gonadectomy and Hysterectomy criteria in Gender-Affirming Services (CG017).

California State and New York State Lines of Business

1. Same-sex couples, non-binary, and transgender individuals may receive infertility services if medically appropriate.
2. Oscar does not discriminate based on a member's partnership status or sexual orientation.
3. Notwithstanding, all members must meet the definition of infertility and the General Medical Necessity Criteria to meet medical necessity for infertility services.

Indication-Specific Criteria

Basic Infertility Services (Diagnosis)

Basic female infertility services may include:

1. Initial evaluation: History & physical exam
2. Laboratory:
    a. Chlamydia trachomatis screening
    b. Viral status screening (HIV, hepatitis B, hepatitis C, rubella)
    c. Hormone level testing
        i. Thyroid stimulating hormone (TSH)
        ii. Prolactin (PRL)
        iii. Follicle-stimulating hormone (FSH)

iv. Estrogens
v. Progesterone
vi. Luteinizing hormone (LH)
vii. Human chorionic gonadotropin (hCG)
viii. Androgens (if there is evidence of hyperandrogenism)
ix. Anti-mullerian hormone (AMH)

d. Ovarian reserve testing
e. Karyotype testing

3. Imaging: Sonohysterography (saline infusion sonography), pelvic or transvaginal ultrasonography, hysterosalpingography, hysteroscopy, CT or MR imaging of sella turcica if prolactin is elevated
4. Diagnostic procedures: Laparoscopy and chromopertubation

Basic male infertility services may include:

1. Initial evaluation: History & physical exam
2. Laboratory:
    a. Chlamydia trachomatis screening
    b. Viral status screening (HIV, hepatitis B, hepatitis C)
    c. Hormone level testing (TSH, FSH, LH, PRL, total and free testosterone, estrogens)
    d. Karyotype testing
    e. Y-chromosome microdeletion testing
    f. Cystic fibrosis gene (CFTR) mutation testing in males with congenital bilateral absence of the vas deferens (CBAVD)
3. Post-ejaculatory urinalysis
4. Imaging: CT or MR imaging of sella turcica if prolactin is elevated, transrectal or scrotal ultrasonography, vasography or venography
5. Tissue analysis or testis biopsy
6. Scrotal exploration
7. Semen & sperm analysis
    a. Quantification of leukocytes in semen
    b. Sperm concentration and motility
    c. Seminal fructose
    d. Cultures of prostatic secretion, semen, urine

<u>Comprehensive Infertility Services (Treatment)</u>

Comprehensive female infertility services may include (please check the member's plan benefits):

1. Non-surgical treatments
    a. Endocrine management
    b. Gonadotropins, gonadotropin releasing hormone (GnRH), gonadotropin releasing hormone (GnRH) antagonists, corticosteroids, estrogens, progestins, aromatase inhibitors, lutropin alfa in combination with human FSH

c. Hepatitis B vaccination of partners of people with hepatitis B
d. Rubella vaccination of women susceptible to rubella
e. Oral clomiphene citrate, tamoxifen, or letrozole for ovulation induction (please check member's pharmacy plan benefits)
f. Metformin and/or letrozole for women with anovulatory disorders such as polycystic ovarian syndrome (please check member's pharmacy plan benefits)
g. Prolactin inhibitors for women with hyperprolactinemia
h. Artificial/intrauterine insemination [IUI] (including sperm washing)
i. Donor insemination for ONE of the following indications:
    i. Obstructive or non-obstructive azoospermia; *or*
    ii. Severe deficits in semen quality in couples who do not wish to undergo intracytoplasmic sperm injection (ICSI); *or*
    iii. Severe rhesus isoimmunization; *or*
    iv. High risk of transmitting a genetic disorder or infectious disease (such as HIV) in the male partner to the offspring.

2. Surgery and imaging, when MCG criteria are met:
    a. Hysteroscopic adhesiolysis for women with amenorrhea and intrauterine adhesions
    b. Hysteroscopic or fluoroscopic tubal cannulation (salpingostomy, fimbrioplasty), selective salpingography plus tubal catheterization, or transcervical balloon tuboplasty for women with proximal tubal obstruction (except for a history of voluntary sterilization)
    c. Laparoscopy for treatment of pelvic pathology
    d. Open or laparoscopic resection, vaporization, or fulguration of endometriosis implants plus adhesiolysis in women with endometriosis
    e. Ovarian wedge resection or ovarian drilling for women with polycystic ovarian syndrome who have not responded to clomiphene citrate and comparable estrogen modulators such as letrozole
    f. Removal of myomas, uterine septa, cysts, ovarian tumors, polyps, hydrosalpinx
    g. Surgical tubal reconstruction (unilateral or bilateral tubal microsurgery, laparoscopic tubal surgery, tuboplasty and tubal anastomosis), except in the case of prior tubal sterilization

Comprehensive male infertility services may include (please check the member's plan benefits):

1. Non-surgical treatments
    a. Non-parenteral (oral) endocrine management is subject to plan benefits:
        i. Androgens (e.g., testosterone) for men with documented androgen deficiency
        ii. Anti-estrogens (e.g., tamoxifen) for men with elevated estrogen levels
        iii. Selective estrogen receptor modulators (SERMs) and/or aromatase inhibitors (AIs) for men with documented testosterone deficiency
        iv. Corticosteroids (e.g., dexamethasone, prednisone)
        v. Prolactin inhibitors (dopamine agonists e.g., bromocriptine, cabergoline) for

men with hyperprolactinemia

vi. Thyroid hormone replacement for men with thyroid deficiency

vii. Antibiotics for men with an identified infection (note: intra-prostatic antibiotic injection is considered experimental and investigational)

b. Injectable parenteral (subcutaneous/infusion pump) endocrine management is subject to plan benefits

i. For men with primary or secondary hypogonadotropic hypogonadism that is not due to primary testicular failure:

1. Human chorionic gonadotropins (hCG)
2. Human menopausal gonadotropins (hMG) (menotropins)
3. Gonadotropin-releasing hormone (GnRH), also known as luteinizing hormone-releasing hormone (LHRH), by intermittent subcutaneous injections or by GnRH infusion pump
4. Recombinant follitropin products (recombinant FSH) (e.g., follitropin alfa; follitropin beta)

ii. Human chorionic gonadotropins (hCG) for men with prepubertal cryptorchidism not due to anatomic obstruction.

c. Electroejaculation for diabetic neuropathy, prior retroperitoneal surgery or spinal cord injury

2. Surgery and imaging, when MCG criteria are met:

a. Varicocelectomy (spermatic vein ligation):

i. For men with palpable varicocele(s), infertility, and abnormal semen parameters

1. Not medically necessary for men with azoospermia
2. Not medically necessary for non-palpable varicocele or those detected solely by imaging

b. Spermatocelectomy and hydrocelectomy

c. Surgical repair of vas deferens (e.g., vasovasostomy)

i. Except when done for the reversal of a prior voluntary sterilization procedure such as vasectomy

d. Surgical correction of epididymal blockage for men with obstructive azoospermia, including:

i. Epididymectomy

ii. Epididymovasostomy

iii. Excision of epididymal tumors and cysts

iv. Epididymostomy

e. Transurethral resection of ejaculatory ducts (TURED) for obstruction of ejaculatory ducts

f. Orchiopexy

g. For retrograde ejaculation, the following are subject to plan benefits:

i. Alpha sympathomimetic agents (for retrograde ejaculation)

ii. Alkalinization of the urine with or without ureteral catheterization

iii. Induced ejaculation (such as using sympathomimetics, vibratory stimulation, and/or electroejaculation)
iv. Surgical sperm retrieval (see below)

h. For impotence treatments, refer to the Plan Clinical Guideline: Erectile Dysfunction (CG037).
i. Sperm retrieval procedures for men with aspermia or azoospermia (except for members seeking treatment associated with reversal of voluntary sterilization, e.g., vasectomy):
    i. Testicular sperm extraction (TESE)
    ii. Microsurgical epididymal sperm aspiration (MESA)
    iii. Testicular sperm aspiration (TESA)
    iv. Testicular fine needle aspiration (TEFNA)
    v. Percutaneous epididymal sperm aspiration (PESA)
    vi. Vasal sperm aspiration
    vii. Seminal vesicle sperm aspiration

<u>Assisted Reproductive Technologies</u>

The Plan considers assisted reproductive technologies medically necessary when ALL of the following criteria are met:

1. General Medical Necessity Criteria are met; *and*
2. MCG A-0504 (Assisted Reproductive Technology) criteria are met; *and*
3. Assisted reproductive technologies may include:
    a. In vitro fertilization (IVF); *or*
    b. Gamete intrafallopian tube transfers (GIFT); *or*
    c. Zygote intrafallopian tube transfers (ZIFT); *or*
    d. Donor services (oocyte, ovum, sperm).

<u>Fertility Preservation</u>

(Please refer to the member's plan documents for benefits)

The Plan considers fertility preservation medically necessary when BOTH of the following criteria are met:

1. General Medical Necessity Criteria are met; *and*
2. ONE of the below:
    a. MCG A-0504 (Assisted Reproductive Technology) criteria are met; *or*
    b. Member has a medical procedure/treatment that will lead to iatrogenic infertility.

Fertility preservation may include:

1. Cryopreservation and storage of the following:
    a. Ejaculated or testicular sperm
    b. Embryo, with or without ovarian stimulation
    c. Mature oocytes

    d. Ovarian tissue for prepubertal patients or when there is not time for ovarian stimulation
2. Gonadotropin releasing hormone (GnRH) agonists for patients with breast cancer and potentially other cancers for the purpose of protection from ovarian insufficiency
3. Ovarian transposition (oophoropexy) for patients undergoing pelvic radiation
4. Radiation (gonadal) shielding
5. Cervicectomy/trachelectomy for patients with early stage (IA2 or small IB1) cervical adenocarcinoma
6. Laparoscopic cystectomy for patients with ovarian endometriomas or early stage ovarian cancer

Experimental or Investigational / Not Medically Necessary

Infertility service requests for members 40 years or older who have a diagnosis of natural menopause (permanent cessation of menses for at least 12 months) are considered NOT medically necessary.

Services or procedures considered experimental, investigational, or unproven are not covered, including but not limited to:

1. Acrosome reaction test
2. Acupuncture
3. Bariatric surgery
4. Comet assay
5. Computer-assisted sperm analysis (CASA)/computer-assisted sperm motion analysis
6. Cryopreservation, storage, and thawing of immature oocytes
7. Cryopreservation, storage, and thawing of testicular tissue
8. Dehydroepiandrosterone (DHEA)
9. Direct intra-peritoneal insemination, fallopian tube sperm transfusion, intra-follicular insemination, and the use of sperm precursors
10. Double IUI (intrauterine insemination)
11. Drainage of ovarian cyst, when billed for egg retrieval
12. EmbryoGlue
13. Endometrial microbiome testing (i.e., Endometrial Microbiome Metagenomic Analysis [EMMA] and Analysis of Infectious Chronic Endometritis [ALICE])
14. Endometrial receptivity testing, uterine receptivity testing
15. Fine needle aspiration ("mapping") of testes
16. FSH manipulation of women with elevated FSH levels
17. Growth hormone (GH) and growth hormone antagonists
18. Hemizona assay
19. Hyaluronan binding assay
20. Hypoosmotic swelling test
21. Intravenous immunoglobulins
22. In-vitro maturation (IVM) of oocytes
23. In-vitro testing of sperm penetration

24. Leukocyte immunization (immunizing the female partner with the male partner's leukocytes)
25. Microdissection of the zona
26. Natural killer (NK) cell measurement
27. Partial zonal dissection (PZD)
28. Reactive oxygen species (ROS) test
29. Sonohysterosalpingography or saline hysterosalpingography for tubal occlusion
30. Sperm chromatin assay
31. Sperm DNA condensation test
32. Sperm DNA fragmentation assay
33. Sperm function tests
34. Sperm nucleus maturation
35. Subzonal sperm insertion (SUZI)
36. TUNEL assay
37. Uterine transplant

Applicable Billing Codes

Table 1	
Infertility Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
49186	Excision or destruction, open, intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 5 cm or less
49187	Excision or destruction, open, intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 5.1 to 10 cm
49188	Excision or destruction, open, intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 10.1 to 20 cm
49189	Excision or destruction, open, intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 20.1 to 30 cm
49190	Excision or destruction, open, intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); greater than 30 cm

Table 1	
Infertility Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
49320	Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
49321	Laparoscopy, surgical; with biopsy (single or multiple)
49322	Laparoscopy, surgical; with aspiration of cavity or cyst (eg, ovarian cyst) (single or multiple)
52402	Cystourethroscopy with transurethral resection or incision of ejaculatory ducts
54500	Biopsy of testis, needle (separate procedure)
54505	Biopsy of testis, incisional (separate procedure)
54640	Orchiopexy, inguinal or scrotal approach
54650	Orchiopexy, abdominal approach, for intra-abdominal testis (eg, Fowler-Stephens)
54692	Laparoscopy, surgical; orchiopexy for intra-abdominal testis
54800	Biopsy of epididymis, needle
54830	Excision of local lesion of epididymis
54840	Excision of spermatocele, with or without epididymectomy
54860	Epididymectomy; unilateral
54861	Epididymectomy; bilateral
54865	Exploration of epididymis, with or without biopsy
54900	Epididymovasostomy, anastomosis of epididymis to vas deferens; unilateral
54901	Epididymovasostomy, anastomosis of epididymis to vas deferens; bilateral
55000	Puncture aspiration of hydrocele, tunica vaginalis, with or without injection of medication
55040	Excision of hydrocele; unilateral
55041	Excision of hydrocele; bilateral
55110	Scrotal exploration

Table 1	
Infertility Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
55300	Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral
55400	Vasovasostomy, vasovasorrhaphy
55500	Excision of hydrocele of spermatic cord, unilateral (separate procedure)
55530	Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral
55540	Vasovasostomy, vasovasorrhaphy
55870	Electroejaculation
57530	Trachelectomy (cervicectomy), amputation of cervix (separate procedure)
58925	Ovarian cystectomy, unilateral or bilateral
58140	Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; abdominal approach
58145	Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; vaginal approach
58146	Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g, abdominal approach
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
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
58545	Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myomas with total weight of 250 g or less and/or removal of surface myomas

Table 1	
Infertility Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
58546	Laparoscopy, surgical, myomectomy, excision; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g
58555	Hysteroscopy, diagnostic (separate procedure)
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
58562	Hysteroscopy, surgical; with removal of impacted foreign body
58563	Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)
58575	Laparoscopy, surgical, total hysterectomy for resection of malignancy (tumor debulking), with omentectomy including salpingo-oophorectomy, unilateral or bilateral, when performed
58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
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)
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58740	Lysis of adhesions (salpingolysis, ovariolysis)
58750	Tubotubal anastomosis

Table 1	
Infertility Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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
58900	Biopsy of ovary, unilateral or bilateral (separate procedure)
58920	Wedge resection or bisection of ovary, unilateral or bilateral
58970	Follicle puncture for oocyte retrieval, any method
58974	Embryo Transfer, Intrauterine
58976	Gamete, zygote, or embryo intrafallopian transfer, any method
70480	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material
70481	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)
70482	Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections
70551	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material
70552	Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)
70553	Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences
74440	Vasography, vesiculography, or epididymography, radiological supervision and interpretation
74740	Hysterosalpingography, radiological supervision and interpretation

Table 1	
Infertility Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
76830	Ultrasound, transvaginal
76831	Saline infusion sonohysterography (SIS), including color flow Doppler, when performed
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete
76870	Ultrasound, scrotum and contents
76872	Ultrasound, transrectal
76948	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation
80400	ACTH stimulation panel;for adrenal insufficiency This panel must include the following: Cortisol (82533 x 2)
80402	ACTH stimulation panel;for 21 hydroxylase deficiency This panel must include the following: Cortisol (82533 x 2) 17 hydroxyprogesterone (83498 x 2)
80406	ACTH stimulation panel;for 3 beta-hydroxydehydrogenase deficiency This panel must include the following: Cortisol (82533 x 2) 17 hydroxypregnenolone (84143 x 2)
80408	Aldosterone suppression evaluation panel (eg, saline infusion) This panel must include the following: Aldosterone (82088 x 2) Renin (84244 x 2)
80410	Calcitonin stimulation panel (eg, calcium, pentagastrin) This panel must include the following: Calcitonin (82308 x 3)
80412	Corticotropic releasing hormone (CRH) stimulation panel This panel must include the following: Cortisol (82533 x 6) Adrenocorticotropic hormone (ACTH) (82024 x 6)
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, total (82670 x 2 on 3 pooled blood samples)
80416	Renal vein renin stimulation panel (eg, captopril) This panel must include the following: Renin (84244 x 6)
80417	Peripheral vein renin stimulation panel (eg, captopril) This panel must include the following: Renin (84244 x 2)

Table 1	
Infertility Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
80418	Combined rapid anterior pituitary evaluation panel This panel must include the following: Adrenocorticotropic hormone (ACTH) (82024 x 4) Luteinizing hormone (LH) (83002 x 4) Follicle stimulating hormone (FSH) (83001 x 4) Prolactin (84146 x 4) Human growth hormone (HGH) (83003 x 4)Cortisol (82533 x 4) Thyroid stimulating hormone (TSH) (84443 x 4)
80420	Dexamethasone suppression panel, 48 hour This panel must include the following: Free cortisol, urine (82530 x 2) Cortisol (82533 x 2) Volume measurement for timed collection (81050 x 2)
80422	Glucagon tolerance panel;for insulinoma This panel must include the following: Glucose (82947 x 3) Insulin (83525 x 3)
80424	Glucagon tolerance panel;for pheochromocytoma This panel must include the following: Catecholamines, fractionated (82384 x 2)
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)
81220	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)
81221	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants
81222	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants
81223	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence
81224	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)
82670	Estradiol; total
82671	Estrogens; fractionated
82672	Estrogens; total
82677	Estriol
82679	Estrone

Table 1	
Infertility Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
83001	Gonadotropin; follicle stimulating hormone (FSH)
83002	Gonadotropin; luteinizing hormone (LH)
83498	Hydroxyprogesterone, 17-d
84144	Progesterone
84146	Prolactin
84402	Testosterone; free
84403	Testosterone; total
84443	Thyroid stimulating hormone (TSH)
84702	Gonadotropin, chorionic (hCG); quantitative
84703	Gonadotropin, chorionic (hCG); qualitative
86631	Antibody; Chlamydia
86632	Antibody; Chlamydia, IgM
86689	Antibody; HTLV or HIV antibody, confirmatory test (eg, Western Blot)
86701	Antibody; HIV-1
86702	Antibody; HIV-2
86703	Antibody; HIV-1 and HIV-2, single result
86704	Hepatitis B core antibody (HBcAb); total
86705	Hepatitis B core antibody (HBcAb); IgM antibody
86706	Hepatitis B surface antibody (HBsAb)
86762	Antibody; rubella
86803	Hepatitis C antibody
86804	Hepatitis C antibody; confirmatory test (eg, immunoblot)
87110	Culture, chlamydia, any source

Table 1	
Infertility Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
87270	Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis
87340	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg)
87341	Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg) neutralization
88261	Chromosome analysis; count 5 cells, 1 karyotype, with banding
88262	Chromosome analysis; count 15-20 cells, 2 karyotypes, with banding
88263	Chromosome analysis; count 45 cells for mosaicism, 2 karyotypes, with banding
88264	Chromosome analysis; analyze 20-25 cells
88271	Molecular cytogenetics; DNA probe, each (eg, FISH)
88272	Molecular cytogenetics; chromosomal in situ hybridization, analyze 3-5 cells (eg, for derivatives and markers)
88273	Molecular cytogenetics; chromosomal in situ hybridization, analyze 10-30 cells (eg, for microdeletions)
88274	Molecular cytogenetics; interphase in situ hybridization, analyze 25-99 cells
88275	Molecular cytogenetics; interphase in situ hybridization, analyze 100-300 cells
88280	Chromosome analysis; additional karyotypes, each study
88283	Chromosome analysis; additional specialized banding technique (eg, NOR, C-banding)
88285	Chromosome analysis; additional cells counted, each study
88289	Chromosome analysis; additional high resolution study
88291	Cytogenetics and molecular cytogenetics, interpretation and report

Table 1	
Infertility Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
88364	In situ hybridization (eg, FISH), per specimen; each additional single probe stain procedure (List separately in addition to code for primary procedure)
88365	In situ hybridization (eg, FISH), per specimen; initial single probe stain procedure
88366	In situ hybridization (eg, FISH), per specimen; each multiplex probe stain procedure
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)
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
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; volume, count, motility, and differential
89321	Semen analysis; sperm presence and motility of sperm, if performed

Table 1	
Infertility Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
89322	Semen analysis; volume, count, motility, and differential using strict morphologic criteria (eg, 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)
G0010	Administration of hepatitis B vaccine
G0027	Semen analysis; presence and/or motility of sperm excluding Huhner
G0472	Hepatitis C antibody screening for individual at high risk and other covered indication(s)
J0725	Injection, chorionic gonadotropin, per 1,000 USP units
J1000	Injection, depo-estradiol cypionate, up to 5 mg
J1100	Injection, dexamethasone sodium phosphate, 1 mg
J1380	Injection, estradiol valerate, up to 10 mg
J1410	Injection, estrogen conjugated, per 25 mg
J2675	Injection, progesterone, per 50 mg
J7512	Prednisone, immediate release or delayed release, oral, 1 mg
J9218	Leuprolide acetate, per 1 mg
S0122	Injection, menotropins, 75 IU
S0126	Injection, follitropin alfa, 75 IU
S0128	Injection, follitropin beta, 75 IU
S0132	Injection, ganirelix acetate, 250 mcg

Table 1	
Infertility Services	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
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
S4028	Microsurgical epididymal sperm aspiration (MESA)
S4030	Sperm procurement and cryopreservation services; initial visit
S4031	Sperm procurement and cryopreservation services; subsequent visit
S4035	Stimulated intrauterine insemination (IUI), case rate
S4037	Cryopreserved embryo transfer, case rate
S4042	Management of ovulation induction (interpretation of diagnostic tests and studies, nonface-to-face medical management of the patient), per cycle

Table 2	
ICD-10 codes considered medically necessary with Table 1 codes if criteria are met:	
Code	*Description*
E28.310	Symptomatic premature menopause
E28.319	Asymptomatic premature menopause
E28.39	Other primary ovarian failure
E28.8	Other ovarian dysfunction
E28.9	Ovarian dysfunction, unspecified
E29.1	Testicular hypofunction
E29.8	Other testicular dysfunction
E29.9	Testicular dysfunction, unspecified
E89.40	Asymptomatic postprocedural ovarian failure
E89.41	Symptomatic postprocedural ovarian failure
E89.5	Postprocedural testicular hypofunction
I86.1	Scrotal varices (Varicocele)
N53.11	Retarded ejaculation
N53.12	Painful ejaculation
N53.13	Anejaculatory orgasm
N53.14	Retrograde ejaculation
N53.19	Other ejaculatory dysfunction
N53.8	Other male sexual dysfunction
N53.9	Unspecified male sexual dysfunction
N46.01 - N46.9	Male infertility
N97.0 - N97.9	Female infertility
Q55.4	Other congenital malformations of vas deferens, epididymis, seminal vesicles and prostate
Q96.0 - Q96.9	Turner's syndrome
R86.4	Abnormal immunological findings in specimens from male genital organs

Table 2	
ICD-10 codes considered medically necessary with Table 1 codes if criteria are met:	
Code	*Description*
R86.5	Abnormal microbiological findings in specimens from male genital organs
R86.6	Abnormal cytological findings in specimens from male genital organs
R86.7	Abnormal histological findings in specimens from male genital organs
R86.8	Other abnormal findings in specimens from male genital organs
R86.9	Unspecified abnormal finding in specimens from male genital organs
Z31.41	Encounter for fertility testing
Z31.7	Encounter for procreative management and counseling for gestational carrier
Z31.83	Encounter for assisted reproductive fertility procedure cycle
Z31.84	Encounter for fertility preservation procedure
Z31.89	Encounter for other procreative management

Table 3	
ICD-10 codes not considered medically necessary with Table 1 codes:	
Code	*Description*
N92.4	Excessive bleeding in the premenopausal period
N95.0 - N95.9	Menopausal and other perimenopausal disorders
Q50.02	Congenital absence of ovary, bilateral
Q55.0	Absence and aplasia of testis
Z31.0	Encounter for reversal of previous sterilization
Z78.0	Asymptomatic menopausal state
Z79.890	Hormone replacement therapy (postmenopausal)
Z98.51	Tubal ligation status
Z98.52	Vasectomy status

Table 4	
Fertility Preservation	
CPT/HCPCS codes considered medically necessary if criteria are met:	
Code	*Description*
57520	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser
57522	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; loop electrode excision
57530	Trachelectomy (cervicectomy), amputation of cervix (separate procedure)
57531	Radical trachelectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling biopsy, with or without removal of tube(s), with or without removal of ovary(s)
58323	Sperm washing for artificial insemination
58970	Follicle puncture for oocyte retrieval, any method
76948	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation
89254	Oocyte identification from follicular fluid
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
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; volume, count, motility, and differential
89321	Semen analysis; sperm presence and motility of sperm, if performed
89322	Semen analysis; volume, count, motility, and differential using strict morphologic criteria (eg, 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)
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
89398	Unlisted reproductive medicine laboratory procedure ● Due to the broad nature of this code and lack of specificity in certain scenarios, clarification is provided below: ● When this code is billed for ovarian reproductive tissue, it is considered medically necessary
J0725	Injection, chorionic gonadotropin, per 1,000 USP units
J1000	Injection, depo-estradiol cypionate, up to 5 mg
J1380	Injection, estradiol valerate, up to 10 mg
J1410	Injection, estrogen conjugated, per 25 mg
S0122	Injection, menotropins, 75 IU
S0126	Injection, follitropin alfa, 75 IU
S0132	Injection, ganirelix acetate 250 mcg
S4027	Storage of previously frozen embryos
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
S4042	Management of ovulation induction (interpretation of diagnostic tests and studies, nonface-to-face medical management of the patient), per cycle

Table 5	
ICD-10 codes considered medically necessary with Table 4 codes include but are not limited to the following (please see the member's plan benefits for fertility preservation related to gender-affirming procedures and hormone therapy):	
Code	*Description*
C00.0 - D49.89	Neoplasms
D27.0	Benign neoplasm of right ovary
D27.1	Benign neoplasm of left ovary
D39.10 - D39.12	Neoplasm of uncertain behavior of ovary
D40.10 - D40.12	Neoplasm of uncertain behavior of testis
F64.0	Transsexualism
F64.8	Other gender identity disorders
F64.9	Gender identity disorder, unspecified
N70.01 - N70.03	Acute salpingitis and oophoritis
N70.11 - N70.13	Chronic salpingitis and oophoritis
N83.511 - N83.519	Torsion of ovary and ovarian pedicle
Z31.62	Encounter for fertility preservation counseling
Z31.84	Encounter for fertility preservation procedure

Table 6	
CPT/HCPCS codes considered experimental, investigational, or unproven for infertility diagnosis or treatment:	
Code	*Description*
0607U	Reproductive medicine (endometrial microbiome assessment), real-time PCR analysis for 31 bacterial DNA targets from endometrial biopsy, reported with quantified levels of bacterial presence and targeted treatment recommendations
0608U	Reproductive medicine (endometrial microbiome assessment), real-time PCR analysis for 10 bacterial DNA targets from endometrial biopsy, reported with quantified levels of bacterial presence and targeted treatment recommendations
0664T	Donor hysterectomy (including cold preservation); open, from cadaver donor
0665T	Donor hysterectomy (including cold preservation); open, from living donor
0666T	Donor hysterectomy (including cold preservation); laparoscopic or robotic, from living donor
0667T	Donor hysterectomy (including cold preservation); recipient uterus allograft transplantation from cadaver or 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
43631	Gastrectomy, partial, distal; with gastroduodenostomy
43632	Gastrectomy, partial, distal; with gastrojejunostomy
43633	Gastrectomy, partial, distal; with Roux-en-Y reconstruction
43634	Gastrectomy, partial, distal; with formation of intestinal pouch
43635	Vagotomy when performed with partial distal gastrectomy (List separately in addition to code[s] for primary procedure)
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption

Table 6	
CPT/HCPCS codes considered experimental, investigational, or unproven for infertility diagnosis or treatment:	
Code	*Description*
43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)
43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only
43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only
43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only
43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)
43886	Gastric restrictive procedure, open; revision of subcutaneous port component only
43887	Gastric restrictive procedure, open; removal of subcutaneous port component only
43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only
82626	Dehydroepiandrosterone (DHEA)

Table 6	
CPT/HCPCS codes considered experimental, investigational, or unproven for infertility diagnosis or treatment:	
Code	*Description*
86357	Natural killer (NK) cells, total count
89240	Unlisted miscellaneous pathology test ● Due to the broad nature of this code and lack of specificity in certain scenarios, clarification is provided below: ● When this code is billed for perm DNA fragmentation testing, it is considered experimental/investigational
89335	Cryopreservation, reproductive tissue, testicular
89398	Unlisted reproductive medicine laboratory procedure ● Due to the broad nature of this code and lack of specificity in certain scenarios, clarification is provided below: ● When this code is billed for cryopreservation of immature oocytes or hyaluronan binding assay, it is considered experimental/investigational
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with insertion of needle(s) (List separately in addition to code for primary procedure)
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)
S9558	Home injectable therapy; growth hormone, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

Table 7	
CPT/HCPCS codes considered medically necessary for testicular fine needle aspiration (TEFNA):	
Code	*Description*
10004	Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure)
10005	Fine needle aspiration biopsy, including ultrasound guidance; first lesion

Table 7	
CPT/HCPCS codes considered medically necessary for testicular fine needle aspiration (TEFNA):	
Code	*Description*
10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)
10007	Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion
10008	Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion (List separately in addition to code for primary procedure)
10009	Fine needle aspiration biopsy, including CT guidance; first lesion
10010	Fine needle aspiration biopsy, including CT guidance; each additional lesion (List separately in addition to code for primary procedure)
10011	Fine needle aspiration biopsy, including MR guidance; first lesion
10012	Fine needle aspiration biopsy, including MR guidance; each additional lesion (List separately in addition to code for primary procedure)
10021	Fine needle aspiration biopsy, without imaging guidance; first lesion

Table 8	
CPT/HCPCS codes considered experimental, or investigational, or unproven for testicular mapping:	
Code	*Description*
10004	Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure)
10005	Fine needle aspiration biopsy, including ultrasound guidance; first lesion
10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)
10007	Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion
10008	Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion (List separately in addition to code for primary procedure)
10009	Fine needle aspiration biopsy, including CT guidance; first lesion
10010	Fine needle aspiration biopsy, including CT guidance; each additional lesion (List separately in addition to code for primary procedure)
10011	Fine needle aspiration biopsy, including MR guidance; first lesion

10012	Fine needle aspiration biopsy, including MR guidance; each additional lesion (List separately in addition to code for primary procedure)
10021	Fine needle aspiration biopsy, without imaging guidance; first lesion

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Clinical Guideline Revision / History Information

Original Date: 5/24/2017 Reviewed/Revised: 1/18/2018, 4/13/2018, 4/15/2019, 5/5/2020, 04/21/2021, 08/04/21, 12/01/2021, 7/26/2022, 10/20/2022, 05/2/2023, 04/16/2024, 09/01/2025, 08/01/2026