GUIDELINES
This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder contract. Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards. This guideline is solely for explaining correct procedure reporting and does not imply coverage and reimbursement.

DESCRIPTION
Infertility is defined as one year of frequent unprotected intercourse during which pregnancy has not occurred. Often the diagnosis and the procedures related to the diagnosis of infertility are considered medical services because the basis may be medically based, and not infertility based. Once the medical condition has been resolved and active infertility treatment begins, the services are then considered covered under the infertility benefit.

There are basic medical services related to infertility; however, they are not defined as infertility because the overlying cause is a metabolic disorder, or may be related to other disease process. Procedure codes are defined as infertility services by the diagnosis reported.

POLICY
Infertility and Reproductive Services do not require prior authorization if a member has the reproductive infertility benefit.
(See terms of coverage below)

Covered Services
Medical services/procedures for individuals related to the treatment of infertility include (not an all-inclusive list):

1. Specific drug treatments related to infertility (most drugs are provided through the member’s pharmacy benefit and not medical benefit)
   A. Estrogens (e.g., estrone and conjugated estrogens - Premarin)
   B. Corticosteroids (e.g., dexamethasone, prednisone)
   C. Progestins (oral or intramuscular progestins, and progesterone vaginal suppositories, Metformin (Glucophage) combined with clomiphene citrate for anovulatory individuals with polycystic ovary syndrome who have not responded to clomiphene citrate
   D. Prolactin inhibitors (bromocriptine - Parlodel), pergolide (Permax) for individuals with ovulatory disorders due to hyperprolactinemia clomiphene (Clomid, Serophene)
   E. Anti-estrogens (tamoxifen - Nolvadex)) for men with elevated estrogen levels
   F. Prolactin inhibitors (bromocriptine - Parlodel), cabergoline (Dostinex) for persons with hyperprolactinemia
   G. Thyroid hormone replacement for men with thyroid deficiency
   H. Androgens (testosterone) for persons with documented androgen deficiency
   I. Aromatase inhibitors
2. Surgical interventions, treatments, or procedures related to infertility
   A. Endometrial biopsy
   B. Hysterosalpingography (HSG), or hysterosalpingo contrast-ultrasonography to screen for tubal occlusion
   C. Laparoscopy and contrast dye to assess tubal and other pelvic pathology, and to follow up on HSG abnormalities
   D. Hysteroscopy, salpingoscopy (falloscopy), hydrotubation where clinically indicated
   E. Ultrasound (e.g., ovarian, trans-vaginal, pelvic)
   F. Sonohysterogram
   G. Laparoscopy for treatment of pelvic pathology
   H. Ovarian wedge resection or ovarian drilling for individuals with polycystic ovarian syndrome who have not responded to clomiphene citrate
I. Removal of myomas, uterine septa, cysts, ovarian tumors, and polyps open or laparoscopic resection, vaporization, or fulguration of endometriosis implants plus adhesiolysis in individuals with endometriosis

J. Laparoscopic cystectomy for individuals with ovarian endometriosis

K. Hysteroscopic adhesiolysis for individuals with amenorrhea who are found to have intra-uterine adhesions

L. Tubal ligation (salpingectomy) for individuals with hydrosalpinges who are contemplating in vitro fertilization, as this has been demonstrated to improve the chance of a live birth before in vitro fertilization treatment

M. Hysteroscopic or fluoroscopic tubal cannulation (salpingostomy, fimbrioplasty), selective salpingography plus tubal catheterization, or transcervical balloon tuboplasty for individuals with proximal tubal obstruction

N. Surgical tubal reconstruction (unilateral or bilateral tuboplasty) and tubal anastomosis for individuals with mid or distal tubal occlusion and for individuals with proximal tubal disease where tubal cannulation has failed or where severe proximal tubal disease precludes the likelihood of successful cannulation

O. Scrotal exploration

P. Testicular biopsy

Q. Scrotal (testicular) ultrasound

R. Venography

S. Vasography Transrectal ultrasound

T. CT or MR Imaging of sella turcica if prolactin is elevated

3. Laboratory procedures related to infertility

A. Anti-sperm antibodies (e.g., immunobead or mixed antiglobulin method)

B. Chlamydia trachomatis screening

C. Post-coital testing (Simms-Huhner test) of cervical mucus

D. Fasting and 2 hours post 75 gram glucose challenge levels lipid panel (total cholesterol, HDL cholesterol, triglycerides)

E. Rubella serology

F. Serum hormone levels

G. Androgens (testosterone, free testosterone, androstenedione, dehydroepiandrosterone sulfate) if there is evidence of hyperandrogenism (e.g., hirsuitism, acne, signs of virilization), or ovulatory dysfunction

H. Gonadotropins (serum FSH, LH)

I. FSH is the standard of care for determination of menopausal status

J. Prolactin for individuals with an ovulatory disorder, galactorrhea, or a pituitary tumor

K. Prolactin for men with reduced sperm counts, galactorrhea, or pituitary tumors

L. Progestins (progesterone, 17-hydroxyprogesterone)

M. Estrogens (e.g., estradiol, estrone)

N. Thyroid stimulating hormone (TSH)

O. Adrenocorticotrophic hormone (ACTH) to rule out Cushing's syndrome or Addison's disease in individuals who are amenorrheic, clomiphene citrate challenge test

P. Anti-sperm antibodies (e.g., immunobead or mixed antiglobulin method)

Q. Cultures

R. Urine

S. Semen

T. Prostatic secretion

U. Sex hormone binding globulin (SHGB) for men with signs and symptoms of hypogonadism, and low normal testosterone levels

V. Semen analysis is primarily performed for infertility analysis, and considered the primary screening test for the male anatomy factor infertility. The analysis will review volume concentration, motility, pH, fructose, leukocytes, and morphology to make a clinical diagnosis. Procedure codes G0027 and 89310 are included in the medical benefit when reported specifically with diagnosis code V25.8 (Other specified contraceptive management, postvasectomy sperm count) or ICD-10 CODE; EFFECTIVE 10/01/2015 Z30.8 (Encounter for other specified contraceptive management, encounter for postvasectomy sperm count) in the first diagnosis field on the claim form.
Non-Covered Services
These services are related to infertility but are excluded from the infertility benefit
1. Artificial insemination placement of semen into the vagina with a syringe, rather than through intercourse
2. Advanced reproductive technology
   ▪ In-vitro fertilization [IVF] - the egg is fertilized with sperm in a dish at a laboratory, rather than inside a woman's body. The resulting embryo is placed into the uterus later. One "cycle" of IVF includes using medicines to stimulate the ovaries to ovulate, and "harvesting" the eggs with an instrument
   ▪ Gamete intrafallopian transfer [GIFT] - eggs are harvested from the ovary, loaded into a tube with sperm, and immediately placed into the fallopian tube with a special scope for fertilization inside the body
   ▪ Zygote intrafallopian transfer [ZIFT]) - eggs are harvested, and fertilized in a dish in the laboratory. About a day later, the fertilized egg is placed inside the fallopian tube
3. Specialized sperm retrieval techniques including, vasal sperm aspiration, microsurgical epididymal sperm aspiration (MESA), percutaneous epididymal sperm aspiration (PESA), electroejaculation, testicular sperm aspiration (TESA), seminal vesicle sperm aspiration, and sperm recovery from bladder or urine for retrograde ejaculation, are considered not medically necessary.
4. Services not covered under any infertility benefit include, services for a surrogate, a partner who is not covered under the member’s medical benefits, patient has no medical coverage by this Plan, or if there is a minimal chance for a live birth.

These services are considered experimental:
▪ Serum inhibin B measurement (value in assessing ovarian reserve is uncertain)
▪ Antiprothrombin antibodies
▪ Embryotoxicity assay
▪ Endometrial function test (cyclin E and p27)
▪ Sperm chromatin assay
▪ Sperm DNA fragmentation assay
▪ Hemizona assay In vitro testing of sperm penetration
▪ Hypoosmotic swelling test
▪ Sperm nucleus maturation
▪ Hyaluronan binding assay

Cryopreservation is the process of preserving and storing living systems in a viable condition at low temperatures for future use. Cryopreservation of ovarian tissue with subsequent auto or heterotopic transplant has been researched as a technique to sustain the reproductive function of individuals who are faced with sterilizing procedures (e.g., chemotherapy, radiation therapy, or surgery that is frequently due to malignant diseases). Cryopreservation of testicular tissue may be considered medically necessary in adult men with azospermia as part of an intracytoplasmic sperm injection (ICSI) procedure.
Cryopreservation services are considered contract/policy exclusion. These services will be denied. The Advantage member must have signed a waiver of financial liability; otherwise, the claim may be adjusted to be provider liability. Likewise, Elite members must have a signed ABN.

Any procedure or service performed for reversal of sterilization is also excluded from coverage. This surgery and/or related services (including sterilization by tubal ligation or vasectomy) are excluded services for couples in which either of the partner has had a previous sterilization procedure. These services will be denied for all product lines. The Advantage member must have signed a waiver of financial liability, otherwise the claim may be adjusted to deny to the provider. The Elite member must have signed an ABN, otherwise the claim may be adjusted to deny to the provider.

HMO, PPO, Individual Marketplace, Elite
If the member has the infertility benefit, select infertility services will be covered under this benefit. These services may be considered medical if performed for medical indications and/or diagnoses. Infertility defined services will be denied if the member does not have any type of infertility benefit.

Advantage
Infertility and Reproductive Services are not covered. All services clearly identified as reproductive assisting in any type of infertility procedure, will be denied.
CODING/BILLING INFORMATION

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

Services Included in the Medical Benefit

When reported specifically with diagnosis code V25.8 (Other specified contraceptive management, postvasectomy sperm count) or ICD-10 CODE; EFFECTIVE 10/01/2015 Z30.8 (Encounter for other specified contraceptive management, encounter for postvasectomy sperm count) in the first diagnosis field on the claim form.

89310    Semen analysis; motility and count (not including Huhner test)
G0027    Semen analysis; presence and/or motility of sperm excluding Huhner

Services Included in the Infertility Benefit Definition

When accompanied by an infertility diagnosis (as listed below) reported in the first diagnosis field on the claim form.

49320    Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
54500    Biopsy of testis, needle (separate procedure)
54505    Biopsy of testis, incisional (separate procedure)
58340    Catheterization and introduction of saline or contrast material for saline infusion hysterosonography (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
58555    Hysteroscopy, diagnostic (separate procedure)
58660    Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)
58662    Laparoscopy, surgical; with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method
58740    Lysis of adhesions (salpingolysis, ovariolysis)
74740    Hysterosalpingography, radiological supervision and interpretation
74742    Transcervical catheterization of fallopian tube, radiological supervision and interpretation
76830    Ultrasound, transvaginal
76831    Saline infusion sonohysterography (SIS), including color flow Doppler, when performed
76856    Ultrasound pelvic (nonobstetric), real time with image documentation; complete
76857    Ultrasound pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)
76870    Ultrasound, scrotum and contents
76872    Ultrasound, transrectal
80415    Chorionic gonadotropin stimulation panel; estradiol response
82670    Estradiol
82671    Estrogens, fractionated
82672    Estrogens, total
82679    Estrone
82757    Fructose, semen
83001    Gonadotropin; follicle stimulating hormone (FSH)
83002    Gonadotropin; luteinizing hormone (LH)
84144    Progesterone
84146    Prolactin
84402    Testosterone; free
84403    Testosterone; total
89300    Semen analysis; presence and/or motility of sperm including Huhner test (post coital)
89320    Semen analysis; complete (volume, count, motility, and differential)
89321    Semen analysis, sperm presence and/or motility of sperm, if performed
89322    Semen analysis; volume, count, motility, and differential using strict morphologic criteria (eg, Kruger)
G0027    Semen analysis; presence and/or motility of sperm excluding huhner

Services NOT Included in the Infertility Benefit Definition

These services are never covered under the Infertility Benefit or Medical Benefit; members will always have financial liability for these services. The financial arrangement for reimbursement exists between the provider and the member. These services are not expected to be submitted for reimbursement.

00938    Anesth, insert penis device
54900    Epididymovasostomy, anastomosis of epididymis to vas deferens; unilateral
54901    Epididymovasostomy, anastomosis of epididymis to vas deferens; bilateral
55400    Vasovasostomy, vasovasorrhaphy
55870    Electroejaculation
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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>58321</td>
<td>Artificial insemination; intra-cervical</td>
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<tr>
<td>58322</td>
<td>Artificial insemination; intra-uterine</td>
</tr>
<tr>
<td>58323</td>
<td>Sperm washing for artificial insemination</td>
</tr>
<tr>
<td>58750</td>
<td>Tubotubal anastomosis</td>
</tr>
<tr>
<td>58752</td>
<td>Tubouterine implantation</td>
</tr>
<tr>
<td>58760</td>
<td>Fimbrioplasty</td>
</tr>
<tr>
<td>58770</td>
<td>Salpingostomy (salpingoneostomy)</td>
</tr>
<tr>
<td>58970</td>
<td>Follicle puncture for oocyte retrieval, any method</td>
</tr>
<tr>
<td>58974</td>
<td>Embryo transfer, intrauterine</td>
</tr>
<tr>
<td>58976</td>
<td>Gamete, zygote, or embryo intrafallopian transfer, any method</td>
</tr>
<tr>
<td>76948</td>
<td>Ultrasonic guidance for aspiration of ova, imaging and supervision</td>
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<tr>
<td>82397</td>
<td>Chemiluminescent assay</td>
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<tr>
<td>89250</td>
<td>Culture of oocyte(s)/embryo(s), less than 4 days</td>
</tr>
<tr>
<td>89251</td>
<td>Culture of oocyte(s)/embryo(s), less than 4 days; with co-culture of oocyte(s)/embryos</td>
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<tr>
<td>89253</td>
<td>Assisted embryo hatching, microtechniques (any method)</td>
</tr>
<tr>
<td>89254</td>
<td>Oocyte identification from follicular fluid</td>
</tr>
<tr>
<td>89255</td>
<td>Preparation of embryo transfer (any method)</td>
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<tr>
<td>89257</td>
<td>Sperm identification from aspiration (other than seminal fluid)</td>
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<tr>
<td>89258</td>
<td>Cryopreservation; embryo(s)</td>
</tr>
<tr>
<td>89259</td>
<td>Cryopreservation; sperm</td>
</tr>
<tr>
<td>89260</td>
<td>Sperm isolation; simple prep (e.g., sperm wash and swim-up) for insemination or diagnosis with semen analysis</td>
</tr>
<tr>
<td>89261</td>
<td>Sperm isolation; complex prep (e.g., Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis</td>
</tr>
<tr>
<td>89264</td>
<td>Sperm identification from testis tissue, fresh or cryopreserved</td>
</tr>
<tr>
<td>89266</td>
<td>Inseminatation of oocytes</td>
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<tr>
<td>89272</td>
<td>Extended culture of oocyte(s)/embryo(s), 4-7 days</td>
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<tr>
<td>89280</td>
<td>Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes</td>
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<tr>
<td>89281</td>
<td>Assisted oocyte fertilization, microtechnique; greater than 10 oocytes</td>
</tr>
<tr>
<td>89290</td>
<td>Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos</td>
</tr>
<tr>
<td>89291</td>
<td>Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos</td>
</tr>
<tr>
<td>89325</td>
<td>Sperm antibodies</td>
</tr>
<tr>
<td>89329</td>
<td>Sperm evaluation; hamster penetration test</td>
</tr>
<tr>
<td>89330</td>
<td>Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test</td>
</tr>
<tr>
<td>89331</td>
<td>Sperm evaluation; for retrograde ejaculation, urine (sperm concentration, motility, and morphology, as indicated)</td>
</tr>
<tr>
<td>89342</td>
<td>Storage, (per year); embryo(s)</td>
</tr>
<tr>
<td>89343</td>
<td>Storage, (per year); sperm/semen</td>
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<tr>
<td>89346</td>
<td>Storage, (per year); oocyte(s)</td>
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<tr>
<td>89352</td>
<td>Thawing of cryopreserved; embryo(s)</td>
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<tr>
<td>89353</td>
<td>Thawing of cryopreserved; sperm/semen, each aliquot</td>
</tr>
<tr>
<td>89354</td>
<td>Thawing of cryopreserved; reproductive tissue, testicular/ovarian</td>
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<tr>
<td>89356</td>
<td>Thawing of cryopreserved; oocytes, each aliquot</td>
</tr>
<tr>
<td>89398</td>
<td>Unlisted reproductive medicine laboratory procedure</td>
</tr>
<tr>
<td>S4011</td>
<td>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</td>
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<tr>
<td>S4013</td>
<td>Complete cycle, gamete intrafallopian transfer (GIFT), case rate</td>
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<tr>
<td>S4014</td>
<td>Complete cycle, zygote intrafallopian transfer (ZIFT), case rate</td>
</tr>
<tr>
<td>S4015</td>
<td>Complete in vitro fertilization cycle, case rate not otherwise specified</td>
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<tr>
<td>S4016</td>
<td>Frozen in vitro fertilization cycle, case rate</td>
</tr>
<tr>
<td>S4017</td>
<td>Incomplete cycle, treatment canceled prior to stimulation, case rate</td>
</tr>
<tr>
<td>S4018</td>
<td>Frozen embryo transfer procedure canceled before transfer, case rate</td>
</tr>
<tr>
<td>S4020</td>
<td>In vitro fertilization procedure canceled before aspiration, case rate</td>
</tr>
<tr>
<td>S4021</td>
<td>In vitro fertilization procedure canceled after aspiration, case rate</td>
</tr>
<tr>
<td>S4022</td>
<td>Assisted oocyte fertilization, case rate</td>
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<tr>
<td>S4023</td>
<td>Donor egg cycle, incomplete, case rate</td>
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<tr>
<td>S4025</td>
<td>Donor services for in vitro fertilization (sperm or embryo), case rate</td>
</tr>
<tr>
<td>S4026</td>
<td>Procurement of donor sperm from sperm bank</td>
</tr>
<tr>
<td>S4027</td>
<td>Storage of previously frozen embryos</td>
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<tr>
<td>S4028</td>
<td>Microsurgical epididymal sperm aspiration (mesa)</td>
</tr>
<tr>
<td>S4030</td>
<td>Sperm procurement and cryopreservation services; initial visit</td>
</tr>
</tbody>
</table>
S4031 Sperm procurement and cryopreservation services; subsequent visit
S4035 Stimulated intrauterine insemination (IU), case rate
S4037 Cryopreserved embryo transfer, case rate
S4040 Monitoring and storage of cryopreserved embryos, per 30 days
S4042 Management of ovulation induction (interpretation of diagnostic test and studies, non-face-to-face medical management of the patient), per cycle

ICD-9 Codes Included in the Infertility Benefit Definition
The infertility diagnosis must be reported in the first diagnosis field on the claim form to identify infertility services.

256.1 Other ovarian hyperfunction
256.2 Postablative ovarian failure
256.31 Premature menopause
256.39 Other ovarian failure
256.4 Polycystic ovaries
256.8 Other ovarian dysfunction
256.9 Unspecified ovarian dysfunction
257.0 Testicular hyperfunction
257.1 Postablative testicular hypofunction
257.8 Other testicular dysfunction
257.9 Unspecified testicular dysfunction

606.0 Azoospermia
606.1 Oligospermia
606.8 Male infertility due to extratesticular causes
606.9 Male infertility, unspecified
617.3 Endometriosis of pelvic peritoneum
628.0 Infertility, female, associated with anovulation
628.1 Infertility, female, of pituitary-hypothalamic origin
628.2 Infertility, female, of tubal origin
628.3 Infertility, female, of uterine origin
628.4 Infertility, female, of cervical or vaginal origin
628.8 Infertility, female, of other specified origin
628.9 Infertility, female, of unspecified origin
V26.0 Tuboplasty or vasoplasty after previous sterilization
V26.1 Procreative management - Artificial insemination
V26.21 Fertility testing
V26.22 Aftercare following sterilization reversal
V26.8 Other specified procreative management
V26.9 Unspecified procreative management

ICD-10 CODES: EFFECTIVE 10/01/2015 Included in the Infertility Benefit Definition
The infertility diagnosis must be reported in the first diagnosis field on the claim form to identify infertility services.

E23.0 Hypopituitarism
E28.1 Androgen excess
E28.2 Polycystic ovarian syndrome
E28.39 Other primary ovarian failure
E28.8 Other ovarian dysfunction
E28.9 Ovarian dysfunction, unspecified
E29.0 Testicular hyperfunction
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
N46.01 Organic azoospermia
N46.021 Azoospermia due to drug therapy
N46.022 Azoospermia due to infection
N46.023 Azoospermia due to obstruction of efferent ducts
N46.024 Azoospermia due to radiation
N46.025 Azoospermia due to systemic disease
N46.029 Azoospermia due to other extratesticular causes
N46.11 Organic oligospermia
N46.121 Oligospermia due to drug therapy
<table>
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<td>N46.122</td>
<td>Oligospermia due to infection</td>
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<td>N46.123</td>
<td>Oligospermia due to obstruction of efferent ducts</td>
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<td>N46.124</td>
<td>Oligospermia due to radiation</td>
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<tr>
<td>N46.125</td>
<td>Oligospermia due to systemic disease</td>
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<td>N46.129</td>
<td>Oligospermia due to other extratesticular causes</td>
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<tr>
<td>N46.8</td>
<td>Other male infertility</td>
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<td>N46.9</td>
<td>Male infertility, unspecified</td>
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<td>N80.3</td>
<td>Endometriosis of pelvic peritoneum</td>
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<td>N97.0</td>
<td>Female infertility associated with anovulation</td>
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<td>N97.1</td>
<td>Female infertility of tubal origin</td>
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<tr>
<td>N97.2</td>
<td>Female infertility of uterine origin</td>
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<tr>
<td>N97.8</td>
<td>Female infertility of other origin</td>
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<td>N97.9</td>
<td>Female infertility, unspecified</td>
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<tr>
<td>N98.1</td>
<td>Hyperstimulation of ovaries</td>
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<tr>
<td>N98.2</td>
<td>Complications of attempted introduction of fertilized ovum following in vitro fertilization</td>
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<tr>
<td>N98.3</td>
<td>Complications of attempted introduction of embryo in embryo transfer</td>
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<tr>
<td>N98.8</td>
<td>Other complications associated with artificial fertilization</td>
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<td>N98.9</td>
<td>Complication associated with artificial fertilization, unspecified</td>
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<td>Z30.8</td>
<td>Encounter for other contraceptive management</td>
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<td>Z31.0</td>
<td>Encounter for reversal of previous sterilization</td>
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<td>Z31.41</td>
<td>Encounter for fertility testing</td>
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<td>Z31.42</td>
<td>Aftercare following sterilization reversal</td>
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<td>Z31.89</td>
<td>Encounter for other procreative management</td>
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<td>Z31.9</td>
<td>Encounter for procreative management, unspecified</td>
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</table>

**REVISION HISTORY EXPLANATION**

05/16/11: Per the Medical Policy Steering Committee review/determination, procedure 89322 (semen analysis) will be reimbursed under the medical benefit when billed with diagnosis V25.8 (other specified contraceptive management).

11/04/11: Per the Medical Policy Steering Committee review/determination, procedures 89300, 89320, and 89322 will be reimbursed under the infertility benefit (these procedures were previously policy exclusions under the infertility benefit).

12/04/12: Per Medical Review, procedure 89321 will be reimbursed under the infertility benefit (this procedure was previously a policy exclusion under the infertility benefit) with the same review logic addressed on 11/04/11.

12/09/14: Per the Medical Policy Steering Committee review/determination, procedure 89310 (semen analysis) reimbursed under the medical benefit when billed with diagnosis V25.8 (other specified contraceptive management). ICD-10 codes added from ICD-9 conversion. Policy reviewed and updated to reflect most current clinical evidence.

03/18/16: Added ICD-10 codes N98.1, N98.2, N98.3, N98.8 and N98.9 to policy.

11/23/16: Gender verbiage changes completed per Meaningful Access Section 1557 of the Affordable Care Act.

**REFERENCES/RESOURCES**

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
Ohio Department of Medicaid [http://jfs.ohio.gov/](http://jfs.ohio.gov/)
Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
Industry Standard Review
Hayes, Inc.