PROVIDER POLICIES & PROCEDURES

SURGICAL PROCEDURES: INFERTILITY EVALUATION AND DIAGNOSIS

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for surgical procedures used in the evaluation and diagnosis of infertility. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

The American Society for Reproductive Medicine (ASRM) defines infertility as a disease, condition, or status characterized by any of the following:

- The inability to achieve a successful pregnancy based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.
- The need for medical intervention, including, but not limited to, the use of donor gametes or donor embryos in order to achieve a successful pregnancy either as an individual or with a partner.
- In patients having regular, unprotected intercourse and without any known etiology for either partner suggestive of impaired reproductive ability, evaluation should be initiated at 12 months when the female partner is under 35 years of age and at 6 months when the female partner is 35 years of age or older.

Benefit and Prior Authorization Requirements

- Services to evaluate and diagnose potential infertility are typically covered if the service is listed on the applicable DSS Fee Schedule. (Note: Prior authorization may be required. See the *Clinical Guideline* section of this policy for related surgical services requiring prior authorization.)
- Once an infertility diagnosis has been established, **the treatment of infertility is not covered**.

CLINICAL GUIDELINE

Coverage guidelines for surgical procedures used in the evaluation and diagnosis of infertility are made in accordance with the DSS definition of Medical Necessity. The following criteria are guidelines *only*. Coverage determinations are based on an assessment of the individual and their unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

The following surgical procedures when used in the evaluation and diagnosis of infertility are typically considered medically necessary:

- Transcervical introduction of fallopian tube catheter, with or without hysterosalpingography (CPT code 58345)
- Chromotubation of oviduct (CPT code 58350)

Not Covered
The following surgical procedures, when used in the treatment of infertility, including reversal of voluntary sterilization, are not covered:

- Salpingolysis/ovariolysis (CPT code 58740)
- Tubotubal anastomosis (CPT code 58750)
- Tubouterine implantation (CPT code 58752)
- Fimbrioplasty (CPT code 58760)
- Salpingostomy (CPT code 58770)

NOTE: EPSDT Special Provision
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE
Prior authorization for surgical procedures used in the evaluation and diagnosis of infertility is required. Requests for coverage are reviewed in accordance with procedures in place for reviewing requests for surgical procedures. Coverage determinations are based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for services intended to evaluate and diagnose infertility:

1. Fully completed authorization request via on-line web portal; and
2. Clinical documentation supporting medical necessity.

EFFECTIVE DATE
This policy for the prior authorization for services intended to evaluate and diagnose infertility for individuals covered under the HUSKY Health Program is effective February 1, 2024.

LIMITATIONS
Infertility treatment is not covered under the HUSKY Health Program.

CODES FOR EVALUATION AND DIAGNOSIS OF INFERTILITY

Code	Description
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

CODES FOR TREATMENT OF INFERTILITY

Code	Description
58740	Lysis of adhesions (salpingolysis, ovariolysis)
58750	Tubotubal anastomosis
58752	Tubouterine implantation
58760	Fimbrioplasty
58770	Salpingostomy (salpingoneostomy)

DEFINITIONS

1. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.
8. **Prior Authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

REFERENCES

- Definition of Infertility: A Committee Opinion (2023). Practice Committee of the American Society

for Reproductive Medicine. American Society for Reproductive Medicine. October 2023. Available at: https://www.asrm.org/practice-guidance/practice-committee-documents/denitions-of-infertility/?_t_tags=siteid%3a01216f06-3dc9-4ac9-96da-555740dd020c%2clanguage%3aen&_t_hit.id=ASRM_Models_Pages_ContentPage/_1bd481cd-5547-4afe-a440-d6651a17391f_en&_t_hit.pos=1 Accessed on May 2, 2024.
- Regulations of Connecticut State Agencies Sec. 17b-262-342: Goods and Services Not Covered.
- UptoDate. Female Infertility: Evaluation. Topic last updated September 12, 2023.
- UptoDate. Female Infertility: Treatments. Topic last updated June 7, 2023.

PUBLICATION HISTORY

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