

Assisted Reproductive Technology Professional Payment Policy

Applies to the following Tufts Health Plan products:

- Tufts Health Plan Commercial (including Tufts Health Freedom Plan)¹
- Tufts Medicare Preferred HMO (a Medicare Advantage product)
- Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting assisted reproductive technology (ART) providers.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the [Professional Services and Facilities Payment Policy](#).

Note: Audit and disclaimer information is located at the end of this document.

POLICY

Tufts Health Plan covers ART services when approved in advance, as described below.

ART services include but are not limited to:

- In vitro fertilization (IVF), embryo transfer (ET) and/or single embryo transfer (SET)
- Frozen embryo transfer (FET)
- Gamete intra-fallopian transfer (GIFT)
- Donor oocyte (DO/IVF)
- Donor embryo/frozen embryo transfer (DE/FET)
- Intracytoplasmic sperm injection (ICSI)
- Assisted hatching (AH)
- Cryopreservation of embryos/blasts
- Cryopreservation of sperm
- [Preimplanation genetic diagnosis \(PGD\)](#)

DEFINITION

Infertility is defined as the condition of a presumably healthy individual who has been unable to conceive or produce conception during a period of one year (if the female is age 35 or younger) or during a period of six months (if the female is over the age of 35).

ART is defined as procedures designed to unite sperm and eggs, or enhance implantation, bypassing some of the factors causing infertility.

GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider [website](#) or by contacting the Tufts Health Plan Infertility Line at 617.923.5879 or 888.880.8699 ext. 43405.

AUTHORIZATION REQUIREMENTS

Prior authorization is required for infertility services. Refer to the following medical necessity guidelines for additional information:

- [Infertility Services — Massachusetts Products](#)
- [Infertility Services — Rhode Island Products](#)
- [Infertility Services — New Hampshire products](#)
- [Preimplanation Genetic Diagnosis \(PGD\)](#)

¹ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.

Note: Providers must request coverage of a cancelled cycle within 30 days of the cancelled procedure(s) by submitting an [infertility authorization form](#) with the appropriate HCPCS code(s).

BILLING INSTRUCTIONS

- Submit only the procedure codes listed in the ancillary provider agreement
- Submit claims using the Provider ID number assigned for ART services as both the provider and payee. If any ID number other than the ART-specific provider number is used, the claim will deny.
- Submit claims for a cycle only when the cycle is complete. Depending on a cycle completion point, only one global fee can be billed, regardless of the number of services involved in the member's course of treatment, with the exception of HCPCS code S4025.
- Submit claims for an incomplete cycle **only** if a cycle is cancelled/terminated. Canceled cycle billing may occur during endocrine monitoring and after attempted or completed egg retrieval.
- Submit ART claims for CareLink members directly to Tufts Health Plan. Refer to the [Commercial Provider Manual](#) or the [Commercial Resource Guide](#) for additional information.

Global Services

Procedure Code	Description
S4013	GIFT – complete
S4015	IVF – complete IVF, case rate
S4016	Frozen IVF cycle, case rate – complete
S4018	Frozen embryo transfer procedure cancelled before transfer, case rate – incomplete
S4020	IVF/GIFT – Incomplete endocrine monitoring/in vitro fertilization procedure cancelled before aspiration, case rate (stage 2)
S4021	IVF/GIFT – Incomplete retrieval/IVF procedure cancelled after aspiration, case rate (stage 3)
S4025	Egg donor services for IVF, case rate (use this code in conjunction with S4015, complete IVF, case rate, to bill for a completed donor egg cycle) Note: Do not use this code to bill for donor sperm

ART global services include, but are not limited to, the following:

- Anesthesia services and preparatory testing
- Embryo preparation/catheter loading
- Facility charges, including all ambulatory surgery, operating room and recovery room charges and supplies
- Laboratory tests (including pre- and post-retrieval)
- Semen preparation for insemination
- Nonsel-administered drugs
- Nursing
- Office visits, including consultation and evaluation (following initial evaluation)
- Ovulation induction monitoring
- Pre- and post-surgical services
- Radiological and ultrasound procedures
- Teaching
- Surgical procedures and management, including technical and professional components of all services
- Other ancillary services

Nonglobal Services

Procedure Code	Description
89258	Cryopreservation of embryo associated with active fertility services
89259	Cryopreservation of sperm associated with active fertility services
89280	Assisted oocyte fertilization, less than or equal to 10 oocytes
89281	Assisted oocyte fertilization, greater than 10 oocytes
89290	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for PGD); less than or equal to 5 embryos
89291	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for PGD); greater than 5 embryos
89342	Long-term storage of previously frozen embryo associated with active infertility services; billed semi-annually

Procedure Code	Description
90801	Psychodiagnostic consultation
90804	Individual psychotherapy, 25–30 minutes
90806	Individual psychotherapy, 45–50 minutes
90847	Family/conjoint therapy
99245	Initial ART consultation

Note: Professional and/or technical services provided by a practitioner or hospital outside of the services defined in the ART contract, including gynecological/infertility services, should not be billed separately to Tufts Health Plan. The ART facility should submit once for the complete cycle. All services rendered will be paid as a global payment in accordance with the applicable financial exhibits of their provider agreements.

It is the ART provider’s responsibility to educate other providers who perform ART-related services for members (e.g., laboratories or anesthesiology groups) that they should not submit separate claims to Tufts Health Plan. Payment for their services is included in the global compensation for the ART procedure codes listed.

OBSTETRICAL AND GYNECOLOGICAL ULTRASOUNDS

Providers who are nonradiologists and who provide imaging services within an office setting may be eligible for global compensation for services billed with both professional (modifier 26) and technical (modifier TC) components, if appropriate.

For a complete list of procedure codes included in the Imaging and Privileging Program, refer to the [Imaging Services Professional Payment Policy](#) and the [Imaging Privileging Program](#) chapter of the Commercial Provider Manual.

DOCUMENT HISTORY

- December 2019: Added link to Infertility Services medical necessity guidelines for New Hampshire products, effective for dates of service on or after January 1, 2020
- May 2019: Removed reference to Claims Submission Policy (retired)
- October 2018: Clarified prior authorization requirements for cancelled cycles
- June 2018: Template updates
- April 2017: Reviewed by committee; removed AIUM certification language for obstetrical and gynecological ultrasound providers, as this is no longer a requirement for participating providers
- January 2017: Template updates
- January 2016: Template updates
- September 2015: Template conversion, template updates
- February 2015: Added information regarding coverage for single embryo transfer (SET) effective for dates of service on or after April 1, 2015, template updates
- September 2013: Template conversion
- April 2012: Template updates
- March 2012: Updated CareLink disclaimer language
- October 2011: Template updates, no content changes
- May 2011: Removed reference to separate Tufts Medicare Preferred HMO payment policy
- February 2011: Reviewed document for clarity; removed reference to CPT codes 89252 and S4027 as these codes were no longer effective as of 2004 and 2007, respectively
- September 2008: Added CPT Procedure codes 89290 & 89291 as these became effective on January 1, 2008
- February 2008: Revised general benefit information with self-service channels information

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan’s [audit policies](#), refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLinkSM for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.