Assisted Reproductive Technology Professional Payment Policy

The following payment policy applies to Tufts Health Plan contracting assisted reproductive technology (ART) providers. This policy applies to Commercial\(^1\) products (including Tufts Health Freedom Plan).

In addition to the specific information contained here, providers must adhere to the policy information outlined in the professional payment policies for Commercial and Tufts Medicare Preferred HMO/Tufts Health Plan SCO products, located in the Provider Resource Center or on the Payment Policies page.

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

## POLICY

Tufts Health Plan covers ART services when approved in advance by a Tufts Health Plan authorized reviewer, as described below.

## 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 our secure Provider website, or by contacting the Tufts Health Plan Infertility Line at 617.923.5879 or 888.880.8699, ext. 43405.

Assisted Reproductive Technology (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

Refer to the [Infertility Services: Massachusetts](#), [Infertility Services: Rhode Island](#) and [Preimplantation Genetic Determination](#) medical necessity guidelines for additional information.

## 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 indicating a non-contracted procedure code for the provider ID.
- 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 when a cycle is cancelled or terminated. Canceled cycle billing can occur at two different points in the treatment cycle:
  - During endocrine monitoring
  - After attempted or completed egg retrieval

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\(^1\) Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink\(^\text{SM}\) when Tufts Health Plan is the primary administrator.
• Submit ART claims for CareLink members directly to Tufts Health Plan. Refer to the Claims Submission Policy for additional information.

Global Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S4013</td>
<td>GIFT – complete</td>
</tr>
<tr>
<td>S4015</td>
<td>IVF – complete IVF, case rate</td>
</tr>
<tr>
<td>S4016</td>
<td>Frozen IVF cycle, case rate – complete</td>
</tr>
<tr>
<td>S4018</td>
<td>Frozen embryo transfer procedure cancelled before transfer, case rate – incomplete</td>
</tr>
<tr>
<td>S4020</td>
<td>IVF/GIFT – Incomplete endocrine monitoring/in vitro fertilization procedure cancelled before aspiration, case rate (stage 2)</td>
</tr>
<tr>
<td>S4021</td>
<td>IVF/GIFT – Incomplete retrieval/IVF procedure cancelled after aspiration, case rate (stage 3)</td>
</tr>
<tr>
<td>S4025</td>
<td>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)</td>
</tr>
</tbody>
</table>

**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
- Nonself-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

Non-global Services

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>89258</td>
<td>Cryopreservation of embryo associated with active fertility services</td>
</tr>
<tr>
<td>89259</td>
<td>Cryopreservation of sperm associated with active fertility services</td>
</tr>
<tr>
<td>89280</td>
<td>Assisted oocyte fertilization, less than or equal to 10 oocytes</td>
</tr>
<tr>
<td>89281</td>
<td>Assisted oocyte fertilization, 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>89342</td>
<td>Long-term storage of previously frozen embryo associated with active infertility services; billed semi-annually</td>
</tr>
<tr>
<td>90801</td>
<td>Psychodiagnostic consultation</td>
</tr>
<tr>
<td>90804</td>
<td>Individual psychotherapy, 25–30 minutes</td>
</tr>
<tr>
<td>90806</td>
<td>Individual psychotherapy, 45–50 minutes</td>
</tr>
<tr>
<td>90847</td>
<td>Family/conjoint therapy</td>
</tr>
<tr>
<td>99245</td>
<td>Initial ART consultation</td>
</tr>
</tbody>
</table>

**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

- 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 your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance. For more information about Tufts Health Plan’s [audit policies](#), refer to our website.

This policy provides information on Tufts Health Plan claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction 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 guidelines when applicable, and 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 does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options, Tufts Health Public Plans or the Private Health Care Systems (PHCS) network (also known as Multiplan). This policy applies to CareLink for providers in the 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. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.