EVH Clinical Guideline 2737.CC for Fertility Preservation for Iatrogenic Infertility

Guideline Number:	Applicable Codes	
EVH_CG_2737.CC		
"Evolent" refers to Evolent Health LLC and Evolent Specialty Services, Inc.		
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STATEMENT

General Information

- *It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *Where a specific clinical indication is not directly addressed in this guideline, medical necessity determination will be made based on widely accepted standard of care criteria. These criteria are supported by evidence-based or peer-reviewed sources such as medical literature, societal guidelines, and state/national recommendations.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*

Special Note

Public Act 100-1102 requires the Illinois Department of Healthcare and Family Services (HFS) to cover medically necessary expenses for standard fertility preservation services when related to iatrogenic infertility, which may be directly or indirectly caused by necessary medical treatment. [1]

INDICATIONS

Fertility preservation services are medically necessary for members at risk* of iatrogenic infertility due to [2–4]:

- Surgery directly or indirectly resulting in infertility
- Radiation therapy or exposure
- Chemotherapy
- Gonadotoxic medications
- Other medical treatments affecting reproductive organs or processes.

*At risk members are any members undergoing a treatment or procedure that may directly or indirectly cause infertility, or have infertility as a possible side-effect, based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence- based standards of care [2–4].

Services

Services include [1,5]:

- Office visits
- Pelvic ultrasounds
- Sperm and oocyte cryopreservation and storage
- Oocyte retrieval and culture
- Assisted embryo hatching
- Insemination of oocytes
- Medications/injectables
- Laboratory testing and analyses

Documentation

Medical notes documenting the following may be required for authorization, when applicable:

- Initial history and physical
- All clinical notes including rationale for proposed treatment plan
- All ovarian stimulation sheets
- All operative reports
- Laboratory report FSH, AMH, estradiol, and any other pertinent information
- Ultrasound report antral follicle count and any other pertinent information
- Hysterosalpingography (HSG) report
- Semen analysis
- Genetic testing
- Testicular biopsies

LIMITATIONS AND EXCLUSIONS

Medically necessary fertility preservation services are limited to [1,5]:

- Participants aged 14 through 45
- Iatrogenic causes of infertility
    - Fertility preservation services for members who have undergone voluntary sterilization procedures are considered not medically necessary and not eligible for reimbursement.
- Cryopreservation and storage of testicular tissue (CPT Code 55899, 89335, 89344,

89398) or ovarian tissue (CPT Codes 58999, 89344, 89398) is considered investigational and not eligible for reimbursement

- Other limitations as outlined by Department of Healthcare and Family Services (HFS)

CODING AND STANDARDS

Codes

Providers should reference the Department of Healthcare and Family Services (HFS) for professional coding guidance prior to the submission of claims for reimbursement of covered services.

Code	Description
58970	Follicle Puncture for oocyte retrieval, any method
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, micro techniques (any method)
89254	Oocyte identification from follicular fluid
89258	Cryopreservation, embryo(s)
89259	Cryopreservation; sperm
89260	Sperm isolation; simple prep (e.g., sperm wash and swim-up) for insemination or diagnosis with semen analysis
89261	Sperm isolation; complex prep (e.g., 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

Code	Description
89320	Semen analysis; volume, count motility and differential
89337	Cryopreservation, mature oocyte(s)
89342	Storage (per year); embryo(s)
89343	Storage (per year); sperm/semen
89346	Storage (per year); oocyte(s)
99000	Handling and/or conveyance of specimen for transfer from office to a laboratory
99001	Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory (distance may be indicated)
99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)
99078	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)
S0122	Injection, menotropins, 75 IU
S0126	Injection, follitropin alfa, 75 IU
S0128	Injection, follitropin beta, 75 IU
S0132	Injection, ganirelix acetate 250 mcg
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
S4022	Assisted oocyte fertilization, case rate
S4030	Sperm procurement and cryopreservation services; initial visit
S4031	Sperm procurement and cryopreservation services; subsequent visit

ICD-10 Codes

Code	Description
Z31.62	Encounter for fertility preservation counseling
Z31.84	Encounter for fertility preservation procedure

Applicable Lines of Business

☐	CHIP (Children's Health Insurance Program)
☐	Commercial
☐	Exchange/Marketplace
☒	Medicaid
☐	Medicare Advantage

POLICY HISTORY

Date	Summary
December 9, 2025	• Annual Review – Added Special Note; added in-text citations; updated Indications, Services, Documentation, Limitations and Exclusions sections; updated description of procedure codes 89258, 89272, 89342, 89343, 89346 and 99078; reordered ICD-10 Codes; replaced outdated References with updated References
November 20, 2025	• This guideline replaces PA.251.CC Fertility Preservation for Iatrogenic Infertility • Editorial changes to match the formatting and layout of the new template

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Administrative Services Medical Policy Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

REFERENCES

1. Illinois General Assembly. *Public Act 100-1102*. **https://www.ilga.gov/documents/legislation/ilcs/documents/021500050K356z.32.htm; 2019**
2. Daar J, Benward J, Collins L, et al. Planned oocyte cryopreservation for women seeking to preserve future reproductive potential: an Ethics Committee opinion. *Fertil Steril*. 2018;110(6):1022-1028. doi:10.1016/j.fertnstert.2018.08.027
3. Practice Committee of the American Society for Reproductive Medicine. Fertility preservation in patients undergoing gonadotoxic therapy or gonadectomy: a committee opinion. *Fertil Steril*. 2019;112(6):1022-1033. doi:10.1016/j.fertnstert.2019.09.013
4. Su HI, Lacchetti C, Letourneau J, et al. Fertility Preservation in People With Cancer: ASCO Guideline Update. *Journal of Clinical Oncology*. 2025;43(12):1488-1515. doi:10.1200/JCO-24-02782
5. State of Illinois. *Proposed Changes in Methods and Standards For Establishing Medical Assistance Payment Rates*.; 2019. **https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/050719fertilitypreservationservicespublicnotice.pdf**