Benefit Coverage
Covered Benefit for lines of business including: Health Benefits Exchange (HBE),

Excluded from Coverage: Rite Care (MED), Children with Special Needs (CSN), Substitute Care (SUB), Rhody Health Partners (RHP), Rhody Health Expansion (RHE), Rhody Health Options (RHO), Extended Family Planning (EFP)

*Please see the Infertility Services-Integrity policy for MMP members.

Description
The State of Rhode Island mandates coverage for the diagnosis and treatment of infertility. This is an administrative policy to document Rhode Island General Laws (RIGL) 27-18-30. Coverage for infertility.

(a) Any nonprofit medical service contract, plan, or insurance policies delivered, issued for delivery, or renewed in this state, except contracts providing supplemental coverage to Medicare or other governmental programs, which includes pregnancy related benefits shall provide coverage for the medically necessary expenses of diagnosis and treatment of infertility. To the extent that a nonprofit medical service corporation provides reimbursement for a test or procedure used in the diagnosis or treatment of conditions other than infertility, those tests and procedures shall not be excluded from reimbursement when provided attendant to the diagnosis and treatment of infertility, provided, that a subscriber copayment, not to exceed twenty percent (20%), may be required for those programs and/or procedures the sole purpose of which is the treatment of infertility.

(b) For the purposes of this section, "infertility" means the condition of an otherwise presumably healthy married individual who is unable to conceive or sustain a pregnancy during a period of one year.

Infertility is the condition of a presumably healthy individual who is unable to conceive or sustain pregnancy to delivery during a period of one year. For the purpose of this policy, infertility is defined as:

1. For women who have miscarried; infertility is the attempted time to conceive or sustain pregnancy to delivery during a period of one year
2. For women up to 35 years old with a male partner; infertility is the inability to conceive after one year of unprotected intercourse with exposure to sperm. For women over 35 years old with a male partner, infertility is the inability to conceive after 6 months of unprotected intercourse with exposure to sperm.
3. For women without a male partner; infertility is the inability to conceive after 6 intrauterine insemination (IUI) cycles performed by a qualified specialist using normal quality donor sperm. Note these 6 cycles of IUI with donor sperm are not a covered benefit as a diagnosis of infertility is not established until the cycles are completed.

Criteria
Infertility services are covered when all of the following conditions are met:

- Married (which includes valid common law marriage and civil union) according to the laws of the state in which she resides
- Unable to conceive or sustain a pregnancy during a period of one year; and presumably healthy individual who can reasonably expect fertility as a natural state
- Infertile member must be the recipient of intended infertility services
- Covered infertility procedures are covered up to eight (8) cycles per lifetime

Cycles may include:
1. Clomid or aromatase inhibitor with or without intrauterine insemination (IUI)
2. Ovulation stimulation with gonadotropins with or without intrauterine insemination (IUI)
3. In-vitro fertilization (IVF) – lifetime maximum of three (3) cycles
4. Frozen embryo transfer – lifetime maximum of three (3) cycles
5. Donor egg cycle – lifetime maximum of one (1) cycle

Please refer to specific criteria for Assisted Reproductive Technology (ART) below.

**Establishing the diagnosis of infertility**

**Evaluation of the Female**
The following must occur for eligibility for infertility treatment approval and cycle initiation.
1. Thyroid stimulating hormone (TSH)
2. Follicle Stimulating Hormone (FSH) and Estradiol (E2) test on cycle day 2 or 3 for women less than age 40

Ovarian reserve can be tested using either the Clomid Citrate Challenge Test (CCCT) or Anti-Mullerian Hormone (AMH). Members with abnormal ovarian reserve can be approved for one donor egg cycle.

The following tests/procedures are covered for use in the diagnosis of infertility in female patients and should be within 1 year of the request for authorization of infertility treatment.

- Hormone assays (luteinizing hormone, progesterone, prolactin)
- Hysterosalpingogram (HSG) or Hysterosalpingo-contrast sonography (screen for tubal occlusion and uterine cavity)
- Hysteroscopy
- Laparoscopy with or without Chromotubation

**Evaluation of the Male**
The following must occur for eligibility for infertility treatment approval and cycle initiation.
1. Semen analysis done within the year

**Coverage Determination**
Some procedures for the diagnosis of infertility require prior authorization.

All procedures for the treatment of infertility require prior authorization. Up to three (3) IUI cycles with or without medication can be covered at one time. IVF cycles will be covered per cycle.

Retroactive requests for procedures already performed may not be covered.

All requests are to be submitted on Neighborhood’s Infertility Prior Authorization form available on Neighborhood’s website, [www.nhpri.org](http://www.nhpri.org)

Requests with incomplete information will be returned for completion prior to review.

Members must receive infertility services at a Neighborhood Health Plan of Rhode Island contracted provider.

**Coverage Exclusions**
Infertility treatment is not covered for:
- Members who do not meet the definition of infertility as outlined above
- Experimental infertility procedures
The costs of surrogacy**

Long term (longer than 90 days) sperm or embryo cryopreservation unless the member is in active infertility treatment. Note: Neighborhood may authorize short-term (less than 90 days) cryopreservation of sperm or embryos for certain medical conditions that may impact a member’s future fertility. Prior authorization is required for these services.

Costs associated with donor recruitment and compensation

Drugs for anonymous or designated egg donors that are directly related to a stimulated Assisted Reproductive Technology (ART) cycle, unless the member is the sole recipient of the donor’s eggs.

Infertility services which are necessary for conception as a result of voluntary sterilization or following an unsuccessful reversal of a voluntary sterilization

Donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner

Procurement of frozen donor oocytes

**The cost of surrogacy means:

- All costs incurred by a fertile woman to achieve a pregnancy as a surrogate or gestational carrier for an infertile member. These costs include, but are not limited to: costs of drugs needed for implantation, embryo transfer and cryopreservation of embryos; use of donor egg and a gestational carrier; and costs for maternity care if the surrogate is not a member.

- A surrogate is a person who carries and delivers a child for another either through artificial insemination or surgical implantation of an embryo. A gestational carrier is a surrogate with no biological connection to the embryo/child.

**Cycle Specific Criteria**

The following criteria are necessary for Assisted Reproductive Technology procedures.

In-vitro fertilization (IVF) is covered for:

1. Women who have failed 3 or more cycles of clomiphene citrate or gonadotropin ovarian hyperstimulation or

2. Couples for whom natural or artificial insemination would not be expected to be effective, including:
   a. Men with azoospermia or severe deficits in semen quality or quantity. Severe male factor is defined as meeting one of the following:
      i. less than 10 million total motile sperm/ejaculate (pre wash specimen) or less than 3 million total motile sperm (post-wash specimen) on two separate semen analysis performed at least 2 weeks apart or
      ii. poor (<50%) or failed fertilization in a current/previous cycle or
      iii. ≤ 1% normal forms (Strict Kruger Morphology)
   b. Women with tubal factor fertility:
      i. Bilateral tubal disease (e.g. tubal obstruction, absence or hydrosalpinges)
      ii. Endometriosis stage 3 or 4
      iii. Failure to conceive after pelvic surgery with restoration of normal pelvic anatomy – after trying to conceive for 6 months if less than 40 years or after trying to conceive for 3 months if 40 years of age and older
      iv. Infertility resulting from ectopic pregnancy
      v. Ectopic pregnancy occurring during infertility treatment
      vi. Unilateral hydrosalpinx with failure to conceive – after trying to conceive for 12 months if less than 40 years of age and after trying to conceive for 6 months if 40 years of age or older.
   c. Inadvertent ovarian hyperstimulation during preparation for a planned stimulated IUI cycle in women less than 40 years of age with a diagnosis other than polycystic ovarian syndrome.
In women 40 years of age or older, it is generally not medically necessary to convert an IUI cycle to in-vitro fertilization due to ovarian hyperstimulation.

**Intrauterine Insemination (IUI)**
If approved by Clinician Reviewer, Neighborhood may initially authorize up to three (3) IUI cycles. After the authorization end date, or completion of the authorized cycles, the member must go through a new prospective review approval process for coverage of additional cycles.

**Frozen embryo Transfers (FET)**
Before proceeding to the next fresh ART cycle, FET using cryopreserved embryos must be used if 3 or more cryopreserved embryos of similar developmental stage are available (4 for women 35 years of age or older)

**Intra-cytoplasmic sperm injection (ICSI)**
This is generally appropriate and will be approved for coverage if severe male factor exists as described in (a) above.

**Donor egg cycles**
This may be covered if infertility is a disease and the woman’s fertility is expected as a natural state and the member has premature menopause or premature ovarian failure (onset prior to age 40 with an FSH ≥ 15mIU on Cycle days 3 or 10). Women with abnormal FSH levels after age 40 are not eligible for donor egg coverage regardless of evidence of abnormal FSH levels prior to age 40.

**Please note:** Donor recruitment, compensation/stipend and medications are not a covered benefit.

**Previous Sterilization**
A couple will be presumed to be fertile if one partner has a sterilization procedure. The procedure will be assumed to be the cause of the inability to conceive or sustain a pregnancy, whether or not there has been a procedure to reverse the sterilization. Members who have a previous voluntary sterilization procedure will not be eligible for infertility treatment services.

**Other procedures**
Any procedure that has not been specified above will not be covered.
<table>
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<th>Description</th>
<th>ICD-9 Diagnosis Codes</th>
<th>ICD-9 Procedure Codes</th>
<th>CPT Code</th>
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**CMP Number:** 061  
**CMP Cross Reference:**

**References:**


**Prior References:**

Aetna Clinical Policy Bulletin: Infertility 05/1999


Diagnostic evaluation of the infertile male: a committee opinion. A practice Committee of the American Society for Reproductive Medicine 2012


Uptodate: Evaluation of female/male infertility, Overview of infertility

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