Neighborhood Health Plan OF RHODE ISLAND™

Clinical Medical Policy

Infertility Services - # 061

Last reviewed: 10/14/26

Application

Application of this Medical Policy applies to:
Commercial (HBE)
Application Excluded for:
Rite Care (MED), Children with Special Needs (CSN), Substitute Care (SUB), Rhody Health Partners (RHP), Rhody Health Expansion (RHE), Extended Family Planning (EFP), INTEGRITY for Duals (FIDE), Duals CONNECT (CO-DSNP)

Description

Infertility can result from factors affecting either the male or female reproductive system. Common causes include ovulatory dysfunction, diminished ovarian reserve, cervical factors, uterine abnormalities, tubal disease, and male factor infertility. Following a comprehensive evaluation and diagnosis, treatment options generally fall into three categories: medical therapies to restore fertility, surgical interventions to address correctable causes of infertility, and assisted reproductive technologies (ART).

Cryopreservation is the process of preserving cells, tissues, or reproductive material by cooling them to very low temperatures for future use. This technology may be used to store sperm, semen, oocytes (eggs), embryos, ovarian tissue, or testicular tissue. Cryopreservation can preserve reproductive potential for individuals who choose to delay childbearing or who are undergoing treatments, such as chemotherapy or radiation therapy, that may impair fertility. It is also commonly used to store gametes and embryos created through assisted reproductive technologies for future reproductive use.

Fertility preservation refers to interventions intended to safeguard reproductive potential before fertility may be compromised by age, disease, medical treatment, or other factors. Established fertility preservation methods include sperm cryopreservation, oocyte cryopreservation, and embryo cryopreservation. A multidisciplinary approach involving reproductive specialists, oncologists, genetic counselors, behavioral health professionals, and other healthcare providers, as appropriate, is recommended to support informed decision-making and optimize patient outcomes.

The State of Rhode Island mandates coverage for the diagnosis and treatment of infertility. This is a policy in reference to Rhode Island General Laws (RIGL) 27-20-20.

Definitions:

For the purpose of this policy, in alignment with the ASRM guidelines, infertility is defined as:

1. For patients up to thirty-five (35) years old with a male partner; infertility is the inability to conceive after one (1) year of unprotected intercourse with exposure to sperm. For patients over thirty-five (35) years old with a male partner, infertility is the inability to conceive after six (6) months of unprotected intercourse with exposure to sperm.
2. 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.
3. For patients utilizing intrauterine insemination (IUI), infertility is the inability to conceive after six (6) (IUI) cycles performed by a qualified specialist using normal quality donor sperm.
   Note these six (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.
4. Iatrogenic Infertility is defined as an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

Requires Authorization	Covered infertility services are authorized for a total of 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 *** Members must receive infertility services at a Neighborhood Health Plan of Rhode Island contracted provider.**

General Criteria

ALL of the following criteria must be met:

- ☐ The member must meet the definition of infertility as described above.
- ☐ The member with diagnosed infertility must be the recipient of the intended infertility services.

Documentation

Medical necessity documentation sent to Neighborhood for review MUST be submitted by a participating practitioner and MUST include the following documentation:

- ☐ Previous infertility cycles performed
- ☐ Previous testing performed to establish infertility diagnosis

- ☐ Information specific to the type of infertility service being requested as indicated in the section below on Assisted Reproductive Technology Treatment for Infertility

*All requests are to be submitted on Neighborhood's Infertility Prior Authorization form. Requests with incomplete information will be returned for completion prior to review.

Establishing the diagnosis of infertility:

- Some procedures for the diagnosis of infertility require prior authorization.
- Retroactive requests for procedures already performed may not be covered.

Evaluation of the Female

The following **must** occur for eligibility for infertility treatment approval and cycle initiation.

- ☐ Follicle Stimulating Hormone (FSH) and Estradiol (E2) test on cycle day 2 or 3 for members wishing to conceive 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 members assigned female at birth and should be within one (1) year of the request for authorization of infertility treatment.

- Hormone assays (luteinizing hormone, progesterone, prolactin)
- Hysterosalpingogram (HSG) or Hysterosalpingo-contrast sonography
- Hysteroscopy
- Laparoscopy with or without Chromotubation

Evaluation of the Members assigned Male at birth.

The following is covered for use in the diagnosis of infertility and must occur for eligibility for infertility treatment approval and cycle initiation.

- Semen analysis done within the year

Assisted Reproductive Technology treatment for infertility:

A. Criteria for authorization of In-vitro fertilization (IVF)

- ☐ Members assigned female at birth who have failed 3 or more cycles of clomiphene citrate or gonadotropin ovarian hyperstimulation, **OR**

- ☐ Couples for whom natural or artificial insemination would not be expected to be effective, including:
  - ☐ Members assigned male at birth with azoospermia or severe deficits in semen quality or quantity. Severe male factor is defined as meeting one of the following:
    - less than 10 million total motile sperm/ejaculate (prewash specimen) or less than 3 million total motile sperm (post-wash specimen) on two separate semen analysis performed at least 2 weeks apart; **OR**
    - poor (<50%) or failed fertilization in a current/previous cycle; **OR**
    - < 1% normal forms (Strict Kruger Morphology)

- ☐ Members assigned female at birth with tubal factor fertility:
  - ☐ Bilateral tubal disease (e.g. tubal obstruction, absence or hydrosalpinges)
  - ☐ Endometriosis stage 3 or 4
  - ☐ Failure to conceive after pelvic surgery with restoration of normal pelvic anatomy – after trying to conceive for six (6) months if less than 40years or after trying to conceive for three (3) months if forty (40) years of age and older
  - ☐ Infertility resulting from ectopic pregnancy
  - ☐ Ectopic pregnancy occurring during infertility treatment
  - ☐ Unilateral hydrosalpinx with failure to conceive – after trying to conceive for twelve (12) months if less than 35 years of age and after trying to conceive for six (6) months if thirty-five (35) years of age or older.

- ☐ 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.

B. Intrauterine Insemination (IUI)

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.

C. Frozen embryo Transfers (FET)

Before proceeding to the next fresh ART cycle, FET using cryopreserved embryos must be used if three (3) or more cryopreserved embryos of similar developmental stage are available (4 for members assigned female at birth 35 years of age or older)

D. 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.

E. Donor egg cycles

This may be covered if infertility is a disease and the member who is assigned female at birth has fertility that is expected as a natural state and the member has premature menopause or premature ovarian failure (onset prior to age forty (40) with an FSH > 15mIU on Cycle days three (3) or ten

(10)). Members assigned female at birth with abnormal FSH levels after age forty (40) are not eligible for donor egg coverage regardless of evidence of abnormal FSH levels prior to age forty (40).

F. Iatrogenic Infertility

Standard fertility preservation services are covered for Commercial (HBE) plans only, when a medically necessary treatment may directly or indirectly cause iatrogenic infertility (defined above) to a covered person. "Standard fertility preservation services" are procedures consistent with establishes medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other reputable professional medical organizations.

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

Exclusions and Limitations:

1. Members who do not meet the definition of infertility as described above.
2. Experimental infertility procedures.
3. Infertility services which are necessary for conception because of a specific procedure to produce infertility.
4. Procurement of frozen donor oocytes.
5. Costs associated with donor recruitment and compensation.
6. The costs of surrogacy, defined as: 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.

References:

- ASRM Policy site. **https://www.asrm.org/practice-guidance/practice-committee-documents/definition-of-infertility/**
- The American College of Obstetricians and Gynecologist. Frequently Asked Questions: Treating Infertility. http://www.acog.org/-/media/For-Patients/faq137.pdf?dmc=1&ts=20151021T1029076257.
- The American College of Obstetricians and Gynecologist. (January 2014). Committee Opinion: Oocyte Cryopreservation. Number 584. http://www.acog.org/-/media/Committee-Opinions/Committee-on-Gynecologic-Practice/co584.pdf?dmc=1&ts=20151021T1036563581
- Kuohung, Wendy, MD, Hornstein, Mark, MD. (Reviewed July 8, 2015). Overview of treatment of female infertility.
- www.uptodate.com http://www.uptodate.com/contents/overview-of-treatment-of-female infertility?source=machineLearning&search=infertility+treatment&selectedTitle=1%7E150 &sectionRank=2 &anchor=H28#H28

- American Society for Reproductive Medicine. (April 2003). Reproductive Aging in Women. Patient's Fact Sheet.
- American Society for Reproductive Medicine. (August 1996). Prediction of Fertility Potential in Older Female Patients.
- Andersen A et al. (2010 August; 25). Prestimulation parameters predicting live birth in anovulatory WHO Group II patients undergoing ovulation induction with gonadotrophins. Hum Reprod, 2010 August; 25 (8): 1988-1995.
- Diagnostic evaluation of the infertile male: a committee opinion. A practice Committee of the American Society for Reproductive Medicine 2012.
- Hou HY et al, The outcome of laparoscopy guided hysteroscopic tubal catheterization for infertility due to proximal tubal obstruction. J Minim Invasive Gynecol 20123 Sep 27. pii: S1553-4650(13)01220-X
- Kamath et al, Predictive factors for pregnancy after intrauterine insemination: A prospective study of factors affecting outcome. J Hum Reprod Sci 2010 Sep-Dec; 3(3): 129 – 134.
- Stephens, A et al, Antichlamydial Antibodies, Human Fertility, and Pregnancy Wastage. Infect Dis Obstet Gynecol. 2011; 2011:525182.
- Testing and interpreting measures of ovarian reserve: a committee opinion. The Practice Committee of the American Society for Reproductive Medicine 2012 Fert Steril 2012;98:1407-15.

Authorization Request Forms

Access prior authorization request forms by visiting Neighborhood's website at www.nhpri.org.

1. Click on Providers
2. Click on Provider Resources
3. Click on Forms
4. Click on "Click here for a list of prior authorization request forms" – forms are listed alphabetically.

A phone messaging system is in place for requests/inquiries both during and outside of business hours. Providers can call 1-800-963-1001 for assistance.

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Neighborhood reviews clinical medical policies on an annual basis.

Disclaimer:
Neighborhood has developed medical policies to assist us in administering health benefits. This medical policy is made available to you for informational purposes only and does not constitute medical advice. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Members should always consult their physician before making any decisions about medical care. Treating providers are solely responsible for medical advice and treatment of members. Benefits and eligibility are determined by the member's coverage plan; a member's coverage plan will supersede the provisions of this medical policy. For information on member-specific benefits, call member services. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to review and revise this policy for any reason and at any time, with or without notice.