Benefit Coverage

Covered Benefit for lines of business including:
Health Benefits Exchange (HBE), Medicare-Medicaid Plan (MMP) Integrity
Excluded from Coverage:
Rite Care (MED), Children with Special Needs (CSN), Substitute Care (SUB), Rhody Health Partners (RHP), Rhody Health Expansion (RHE), Extended Family Planning (EFP)

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

Medicare Distinction

For INTEGRITY members: Neighborhood Health Plan of Rhode Island (Neighborhood) uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations, including medical necessity. Coverage determinations are based on applicable payment policies, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and other available CMS published guidance.

In the absence of an applicable or incomplete NCD, LCD, or other CMS published guidance OR if available Medicare coverage guidance is not met, then Neighborhood will apply coverage guidance from the Rhode Island Executive Office of Health & Human Services (EOHHS), or other peer-reviewed scientific evidence, such as InterQual® and/or internal Clinical Medical Policies as a means of secondary coverage through the members' Medicaid benefit.

Definitions:

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

1. For women who have miscarried; infertility is failure to conceive or sustain pregnancy to delivery during a period of one (1) year.
2. For women 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 women 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.
3. For women without a male partner, infertility is the inability to conceive after six (6) intrauterine insemination (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.

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.

Covered Codes: For information on coding, please reference the Authorization Quick Reference Guide.

Neighborhood Health Plan of RI-910 Douglas Pike, Smithfield, RI 02917. www.nhpri.org. Authorization Line 1-800-963-1001. Authorization Fax- 401-459-6023

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.

- ☐ 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 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 Male

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)

- ☐ Women 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:
  - ☐ Men 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 (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**
    - poor (<50%) or failed fertilization in a current/previous cycle; **OR**
    - < 1% normal forms (Strict Kruger Morphology)
- ☐ Women with tubal factor fertility:

Neighborhood Health Plan of RI-910 Douglas Pike, Smithfield, RI 02917. www.nhpri.org. Authorization Line 1-800-963-1001. Authorization Fax- 401-459-6023

- 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 40 years of age and after trying to conceive for six (6) months if forty (40) 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 women 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 woman's fertility 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)). Women 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**

<u>Coverage Exclusions:</u>

Neighborhood Health Plan of RI-910 Douglas Pike, Smithfield, RI 02917. www.nhpri.org. Authorization Line 1-800-963-1001. Authorization Fax- 401-459-6023

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. Donor sperm and associated laboratory services in the absence of diagnosed male factor infertility in the partner.
5. Procurement of frozen donor oocytes.
6. Costs associated with donor recruitment and compensation.
7. 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.

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Neighborhood reviews clinical medical policies on an annual base.

Disclaimer:

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. 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.

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