

# UPMC Health Plan POLICY AND PROCEDURE MANUAL

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**SUBJECT:** Infertility - Diagnosis  
**INDEX TITLE:** Medical Management  
**ORIGINAL DATE:** February 2006

**This policy applies to the following lines of business: (Check those that apply.)**

<b>Commercial:</b>					
HMO ( )		POS ( )		PPO ( )	
Fully Insured ( )		Self-funded/ASO ( )		HSA ( )	
Medicare Select ( )		Medicare Supplement ( )			
<b>DPW-MA:</b>					
Health Choices ( )			Voluntary ( )		All (X )
<b>CMS-MA:</b>					
OH ( )		WV ( )		PA ( )	All (X )
HMO (X )	PPO (X )	Specialty Needs Plan (X )		Part D ( )	PFFS (X )
<b>PID-CHIP:</b>					
Free ( )		Sub ( )		Full ( )	All ( )
<b>APPLICABLE TO:</b>					
Community Care ( )		Work Partners ( )			

## **I. POLICY**

It is the policy of UPMC Health Plan to recognize services provided for the diagnosis of infertility as appropriate and consistent with good medical practice when conducted after consideration of medical necessity, generally accepted standards of medical practice, and review of literature-based evidence and regulatory approval status. Coverage will be considered for the specific indications detailed in this policy. Testing conducted for the purposes of diagnosing infertility is not a covered benefit for UPMC *for Kids* CHIP members.

Many of the tests performed for the diagnosis of infertility may be performed in diagnosing other medical conditions involving the reproductive system. The diagnostic tests, therefore, are considered medically necessary under the members' general medical benefit package.

## **II. DEFINITIONS**

**Infertility** is the documented inability of a woman to conceive a child within a 12-month period: (a) of unprotected coitus (sexual intercourse); or (b) after at least six (6) episodes of artificial insemination.

## **III. PURPOSE**

The purpose of this policy is to define the process for coverage of benefits related to the diagnosis of infertility.

#### IV. SCOPE

This policy applies to various UPMC Health Plan departments as indicated by the Benefit and Reimbursement Committee. These include but are not limited to: Medical Management, Benefit Configuration and Claims departments.

#### V. PROCEDURE

##### A. Medical Description

Infertility is the documented inability of a woman to conceive a child within a 12 month period: (a) of unprotected coitus (sexual intercourse) or (b) after at least six (6) episodes of artificial insemination. Infertility may be caused by female factors (e.g. pelvic adhesions, ovarian dysfunction, function or transport, or prior ligation); male factors (e.g. abnormalities in sperm production, function or transport or prior vasectomy), a combination of both male and female factors, and unknown causes. Once infertility is diagnosed, treatments for infertility may begin. Treatment of the *causes* of infertility is not addressed in this policy.

The focus of this policy is the *diagnosis* of infertility. Treatment using assisted reproduction technologies (ART) is conception by artificial means. According to the Center for Disease Control and Prevention (CDC), based on the Fertility Clinic Success Rate and Certification Act of 1992, ART may be defined as all clinical and laboratory treatments in which both human oocytes and sperm or embryos, are handled with the intent of establishing pregnancy.

##### B. Specific Indications for Diagnosis

1. Member must fit the definition for infertility
2. Females must be premenopausal and reasonably expect fertility as a natural state or if menopausal, should have experienced it at an early age.

##### C. Diagnosis of Infertility

Depending on the member's unique medical situation, the following diagnostic tests to diagnose fertility in males and females may be considered medically necessary:

- History & Physical
- Sperm function tests
- Hysterosalpingogram
- Hysteroscopy
- Sonohysterogram
- Prediction of Ovarian Reserve Hormone Evaluation
- Evaluation of folliculogenesis
- Endometrial biopsy
- Diagnostic laparoscopy

- Follow-up conference

#### **D. Limitations/Contraindications**

- Normal Physiological causes of infertility such as menopause
- Infertility resulting from voluntary sterilization
- The following diagnostic tests are considered investigational:
  - Tests to assess/improve sperm movement, or computer-assisted sperm analysis (CASA)
  - Analysis of adenosine triphosphate (ATP) in ejaculation
  - Tubalscopy
  - Anti-zona pellucida antibodies
  - Hyaluronan binding assay (HBA)
  - Sperm washing and swim-up when performed at part of insemination

In order to assess medical necessity for infertility services, adequate information must be furnished by the treating physician. Necessary documentation includes, but is not limited to the following:

- Member's age, clinical history, physical and functional status;
- Documentation of infertility, testing if done, and treatment history
- Documentation of any history of substance abuse, including smoking;
- Social Service evaluation
- Lab results: HIV antibody

Diagnostic tests for infertility may be ordered by a participating provider. However, most ART drugs and procedures should only be ordered or performed by credentialed Reproductive Endocrinologists.

If a member lives in an out-of-network area, then the credentials of the nearest Reproductive Endocrinologist or Ob/Gynecologist must be reviewed by the Credentials Specialist prior to approval for coverage. Refer to plan-specific infertility riders.

**Member acting as a Surrogate mother and all services and supplies associated with surrogate motherhood are not covered by the UPMC Health Plan, nor are supplies and services related to the following:**

- **Pre-pregnancy evaluations**
- **Prenatal care**
- **Perinatal care**
- **Postnatal care**

#### **E. Variations**

N/A

## **F. Quality Audit**

Quality Audit may monitor policy compliance or billing accuracy at the request of the UPMC Health Plan's Technology Assessment Committee or the Benefits Reimbursement Committee.

## **G. Records Retention**

Records Retention for UPMC Health Plan documents, regardless of medium are provided within the UPMC Health System Policy and as indicated in the UPMC Insurance Services Division Policy and Procedure.

## **H. References**

1. American Society of Reproductive Medicine (ASRM): State Infertility Laws - Infertility Resources
2. World Medical Association – Statement on In Vitro Fertilization and Embryo Transplantation –adopted by the 39<sup>th</sup> World Medical Assembly. Madrid, Spain – October, 1987.
3. Center for Disease Control and Prevention, Reproductive Health, [www.cdc.gov/reproductivehealth](http://www.cdc.gov/reproductivehealth)
4. American Society Reproductive Medicine, A practice committee report: Definition of Infertility, July, 1993.
5. Blue Cross/Blue Shield Assoc of Medical Policy Reference Manual
6. Sauer, M., Treating Infertility in Women of Advanced Reproductive Age, Contemporary OB/GYN, October 1996: 68-76.
7. Textbook of Gynecology, L Copeland, W.B.Saunders, Co., 1993
8. The American Fertility Society – Guideline for Practice- Intrauterine Insemination

**Disclaimer:**

UPMC Health Plan medical payment and prior authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. The policies constitute only the reimbursement and coverage guidelines of UPMC Health Plan and its affiliated managed care entities. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies.

UPMC Health Plan reserves the right to review and update the medical payment and prior authorization guidelines in its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.

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