Infertility for FEHB Plans

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Line of Business: Commercial Only ☒ QHP/Exchange Only ☐ Medicare Only ☐ Commercial & QHP/Exchange ☐ Commercial, QHP/Exchange, & Medicare ☐		

Purpose:
To provide guidelines for Infertility for Federal Employee Health (FEHB) Plans for Population Health and Provider Alliances associates for reference when making benefit determinations.

Definition:
Infertility is defined as the inability of an individual to achieve conception after one year for individuals under age 35 and six months for individuals age 35 and older; or the inability of an individual to achieve conception after egg-sperm contact through the use of artificial insemination. Infertility may also be established through an evaluation based on medical history and diagnostic testing.

Coverage Guidelines:
- The following are covered:
  - Endometrial biopsies
  - Semen analysis
  - Hysterosalpingography
  - Sims-Huhner test (smear)
  - Diagnostic laparoscopy
  - Artificial insemination
    - Intravaginal insemination (IVI)
    - Intracervical insemination (ICI)
    - Intrauterine insemination (IUI)
  - Fertility medications (such as but not limited to Clomiphene citrate, hCG (human Chorionic Gonadotropin), FSH (follicle-stimulating hormone), Menotropins, and other products available on the formulary) to increase production and release of as many eggs as possible- Limited to 3 cycles annual limit.

Exceptions and Limitations:
The following treatments are excluded from coverage under the infertility benefit:
- Reversal of voluntary sterilization, and infertility service required because of such reversal.
- Donor egg and any other programs unless listed under the Iatrogenic Infertility Guidelines.
- Reproductive material storage unless listed under the Iatrogenic Infertility Guidelines.
- Any non-listed treatment related to sexual organ function, dysfunction, or inadequacies, including but not limited to impotency.

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Disclaimer Information:

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed's benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.