Iatrogenic Infertility: Preservation of Fertility

Origination: 08/26/2021	**Revised:**	**Annual Review:** 11/12/24
Line of Business: Commercial Only ☐ QHP/Exchange Only ☐ Medicare Only ☐ Commercial & QHP/Exchange ☐ Commercial, QHP/Exchange, & Medicare ☒		

Purpose:

To provide guidelines for Iatrogenic Infertility: Preservation of Fertility for Population Health and Provider Alliances associates for reference when making benefit determinations.

Coverage Guidelines:

Certain plans may include coverage for fertility preservation. Refer to the member specific benefit plan to determine if this coverage applies.

If benefits are available, then fertility preservation is covered for medical reasons that cause irreversible infertility such as chemotherapy, radiation treatment, and bilateral oophorectomy due to cancer.

Covered services include the following procedures, when provided by or under the care or supervision of a participating Physician and facility and require prior authorization.

- Collection of sperm
- Cryo-preservation of sperm
- Ovarian stimulation, retrieval of eggs and fertilization
- Oocyte cryo-preservation
- Embryo cryo-preservation

Benefits for medications related to the treatment of fertility preservation are considered under the members Outpatient Prescription Drug benefit. Check the member specific benefit plan for inclusion or exclusion.

Documentation required:
Medical notes documenting the following:

- Initial history and physical
- All clinical notes including rationale for proposed treatment plan
- All ovarian stimulation sheets for timed intercourse, IUI, and/or IVF cycles
- All embryology reports
- All operative reports
- Laboratory report FSH, AMH, estradiol, and any other pertinent information
- Ultrasound report antral follicle count and any other pertinent information
- HSG report
- Semen analysis

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Exclusion Criterion:

- Embryo transfer is not covered
- Long-term storage costs (greater than one year) are not covered.

References:

1. American Society for Reproductive Medicine. Fertility preservation in patients undergoing gonadotoxic therapy or gonadectomy: a committee opinion. December 2019.

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.