In Vitro Fertilization

I. Description

In vitro fertilization is a method used to treat infertility. It involves the administration of medications to stimulate the development, growth and maturation of eggs that are within the ovaries. The eggs are retrieved from the follicles when they reach optimum maturation and are combined with sperm in the laboratory before being placed in an incubator to promote fertilization and embryo development. The embryos are then transplanted back into the woman's uterus.

II. Criteria/Guidelines

A. In vitro fertilization for opposite sex couples is covered (subject to Limitations/Exclusions and Administrative Guidelines) when all of the following criteria are met:
   1. The patient and spouse or civil union partner are legally married or joined according to the laws of the State of Hawaii.
   2. The couple has a five-year history of infertility, or infertility associated with one or more of the following conditions:
      a. Endometriosis
      b. Exposure in utero to diethylstilbestrol (DES)
      c. Blockage or surgical removal of one or both fallopian tubes
      d. Abnormal male factors contributing to the infertility
   3. The patient and spouse or civil union partner have been unable to attain a successful pregnancy through other infertility treatments for which coverage is available.

B. In vitro fertilization for female couples is covered (subject to Limitations/Exclusions and Administrative Guidelines) when all of the following criteria are met:
   1. The patient and civil union partner are legally joined according to the laws of the State of Hawaii.
2. The patient, who is not known to be otherwise infertile, has failed to achieve pregnancy following 3 cycles of physician directed, appropriately timed intrauterine insemination (IUI). This applies whether or not the IUI is a covered service.

C. The in vitro procedure must be performed at a medical facility that conforms to the American College of Obstetricians and Gynecologists (ACOG) guidelines for in vitro fertilization clinics or the American Society for Reproductive Medicine's (ASRM) minimal standards for programs of in vitro fertilization.

III. Limitations/Exclusions

A. Coverage is limited to a one-time only benefit for one outpatient in vitro fertilization procedure while the patient is an HMSA member. This benefit is limited to one complete attempt at in vitro fertilization per qualified married or civil union couple. If this benefit was received under one HMSA plan, the member is not eligible for in vitro fertilization benefits under any other HMSA plan, except for Federal Plan 87 which has a separate limit of one complete procedure.

1. A complete in vitro attempt or cycle is defined as a complete effort to fertilize eggs and transfer the resulting embryos into the woman. A complete cycle does not guarantee pregnancy. Members are liable for the costs of any subsequent attempts, regardless of the reason for the previous failure.

B. In vitro fertilization services are not covered for married or civil union couples when a surrogate is used. A surrogate is defined as a woman who carries a child for a couple or single person with the intention of giving up that child once it is born.

C. While most of HMSA's plans cover in vitro fertilization using donor oocytes and sperm, there are a few that do not. Providers should check the patient's plan benefits before considering the procedure.

1. While the patient may be precertified for the IVF procedure, HMSA will not cover the cost of donor oocytes and donor sperm, and any donor-related services, including, but not limited to collection, storage and processing of donor oocytes and donor sperm.

D. Coverage for in vitro fertilization services for civil union couples is limited to groups and individual plans that provide coverage for civil union couples.

IV. Administrative Guidelines

A. Precertification is required. To precertify, please complete the In Vitro Fertilization Precertification and mail or fax the form as indicated. Appropriate documentation to support a clinical diagnosis should be submitted with the precertification request.

B. For claims filing instructions, see Billing Instructions and Code Information. HMSA reserves the right to perform retrospective reviews to validate if services rendered met coverage criteria.

V. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is
intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

VI. References