POLICY:

The diagnosis and treatment of infertility MAY BE ELIGIBLE FOR COVERAGE and may include, but is not limited to:

- Evaluation and basic workup:
  - fertility history and physical examination,
  - routine semen analysis, including and limited to count, motility, volume and morphology,
  - documentation of ovulation (basal body temperature, serum progesterone, or endometrial biopsy),
  - postcoital test (sperm-cervical mucus interaction),
  - evaluation of tubal patency (hysterosalpingography),
  - urologic consultation for disorders such as hypospadias, cryptorchidism, varicocele, or genitourinary system infection,
  - diagnostic/surgical laparoscopy for diagnosis or treatment of endometriosis,

- Therapeutic drugs including self injectables such as: hormones, Danazol, Parlodol, Clomiphene Citrate, Pergonal, Metrodin, etc. (Check all appropriate contract provisions.)

- Artificial Insemination (AI),

- Assistive Reproductive Technology (A.R.T.) procedures which include:
  - in vitro fertilization (IVF)
  - uterine embryo lavage
  - gamete intrafallopian tube transfer (GIFT), sperm
  - intracytoplasmic injection (ICSI)
  - low tubal ovum transfer
  - embryo transfer (ET)
  - zygote intrafallopian tube transfer (ZIFT).

Services that ARE NOT ELIGIBLE FOR COVERAGE include:

- Reversal of voluntary sterilization;

- Payment for medical services or supplies rendered to a surrogate for purposes of child birth;

- When the contract is silent on the cost associated with cryopreservation and storage of sperm, eggs, and embryos, then it is assumed that benefits are not available. (Subsequent services utilizing such cryopreserved and stored materials are eligible for benefit if they otherwise would have been without cryopreservation);

- When the contract is silent on the cost associated with the
procurement of sperm, or harvesting of eggs and embryos from a donor then it is assumed that benefits are not available;

• Experimental treatments; and

• Travel costs.

The following immunologic therapeutic approaches have been used to avoid recurrent spontaneous abortion but to date have not been documented to be effective and should continue to be considered investigational:

• Immunotherapy utilizing paternal leukocytes,
• Immunotherapy utilizing seminal plasma, and/or
• Immunotherapy utilizing trophoblastic membranes.
• Therapy utilizing Intravenous Immune Globulin (IVIG).

DESCRIPTION:

ASSISTED REPRODUCTIVE TECHNOLOGIES (ART) refer to an array of interventions designed to establish a viable pregnancy for those couples who have been diagnosed with infertility. Infertility is defined as the inability to achieve pregnancy after one year of unprotected sexual intercourse despite purposeful attempts at impregnation or the inability to sustain a successful pregnancy. The inability to sustain a successful pregnancy after the loss of three or more consecutive pregnancies, is sometimes referred to as Recurrent Spontaneous Abortion or RSA.

RATIONALE:

None

DISCLAIMER:

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, takes precedence over Medical Policy and must be considered first in determining coverage. The member’s contract benefits in effect on the date that services are rendered must be used. Any benefits are subject to the payment of premiums for the date on which services are rendered. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically. HMO Blue Texas physicians who are contracted/affiliated with a capitated IPA/medical group must contact the IPA/medical group for information regarding HMO claims/reimbursement information and other general polices and procedures.

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