In Vitro Fertilization

I. Policy

University Health Alliance (UHA) will reimburse for in vitro fertilization when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

A. In vitro fertilization is covered for opposite sex couples (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 has 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 otherwise known to be infertile, has failed to achieve pregnancy following three cycles of physician directed, appropriately timed intrauterine insemination (IUI). This applies whether or not the IUI is a covered service.

C. UHA does not cover IVF services for couples in which either of the partners has had a previous sterilization procedure, with or without surgical reversal.

D. 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.

E. NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members’ individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.
UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

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 UHA member irrespective of plan. This benefit is limited to one complete attempt at in vitro fertilization per qualified married or civil union couple.

1. A complete in vitro attempt or cycle is defined as a complete effort to fertilize eggs and transfer the resulting embryos into the patient. 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 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. UHA will not cover the cost of in vitro fertilization when the procedure is done with donor oocytes and/or donor sperm, and does not cover any donor-related services, including, but not limited to collection, storage and processing of donor oocytes and donor sperm.

D. Cryopreservation of oocytes, embryos or sperm is not covered.

IV. Administrative Guidelines

1. Prior authorization is required. Appropriate documentation to support a clinical diagnosis should be submitted with the prior authorization request.

2. To request prior authorization, please go to UHA’s website: http://www.uhahealth.com/forms/form_request_auth_invitro.pdf and submit to:

   Via Fax: 1-866-572-4384

   Via Mail:
   UHA Health Care Services
   700 Bishop Street, Suite 300
   Honolulu, HI 96813

V. Policy History

Policy Number: M.OBG.03.120301
Current Effective Date: 03/01/2013
Original Document Effective Date: 03/01/2012
Previous Revision Dates: 07/01/2013