MedStar Family Choice

ADMINISTRATIVE POLICY AND PROCEDURE		
Policy #:	**1433**	
Subject:	**Fertility Preservation Services**	
Section:	**Medical Non-Pharmacy Protocols**	
Initial Effective Date:	**10/07/23, 07/24**	
Revision Effective Date(s):		
Review Effective Date(s):		
Responsible Parties:	**Medical Director**	
Responsible Department(s):	**Clinical Operations**	
Regulatory References:	**Maryland Department of Health MCO Transmittal No. 195, December 12, 2023 (PT 46-24)**	
Approved:	**AVP Clinical Operations**	**Chief Medical Officer**

Purpose: **To define the conditions under which MedStar Family Choice (MFC) physicians may or may not approve fertility preservation procedures.**

Scope: **MedStar Family Choice**

Policy: **It is the policy of MFC to approve fertility preservation procedures only when certain conditions are met. All fertility preservation procedures will require prior authorization and medical director review.**

Background:

Fertility Preservation Services are procedures that are medically necessary to preserve fertility due to the need for medically necessary treatment that may directly or indirectly cause iatrogenic infertility. Fertility preservation services are distinct and different from infertility services.

Definitions:

"Medically necessary treatment that may directly or indirectly cause iatrogenic infertility" means medically necessary treatment with a likely side effect of infertility as established by the American College of Obstetricians and Gynecologists, American Society for Reproductive Medicine, or the American Society of Clinical Oncology.

"Iatrogenic infertility" is the impairment of fertility caused by surgery, chemotherapy, radiation treatment, gender-affirming treatments, or other medical treatment affecting the reproductive organs or processes.

"Standard fertility preservation procedures" means procedures used to preserve fertility that are consistent with professional guidelines published by the American Society for Reproductive Medicine, The American Society of Clinical Oncology, or the American College of Obstetricians and Gynecologists.

"Standard fertility preservation procedures" do **NOT** include storage of sperm or oocytes.

Covered Services

- Fertility Preservation consult
- Fertility Preservation Procedures including applicable laboratory assessments, medications, and medically necessary treatments.
- For the purpose of oocyte **retrieval** only - ovulation induction, monitoring, oocyte retrieval
- Oocyte cryopreservation and evaluation
- Ovarian tissue cryopreservation and evaluation
- Sperm extraction, cryopreservation, and evaluation
- Transposition of the ovary(ovaries)
- Gonadal suppression with GNRH analogs
    - GnRH agonists may be offered to breast cancer patients to reduce the risk of premature ovarian insufficiency
    - GnRH are NOT to be used in place of other fertility preservation alternatives

Non-Covered Services

- Donor sperm
- Donor oocytes
- Fertility procedures
    - For example:
        - Intrauterine insemination procedures
        - In vitro fertilization procedures
- Storage and/or thawing of testicular tissue including associated charges
- Prepubertal testicular tissue cryopreservation (It is considered investigational)
- Sperm and oocyte banking/storage
- Thawing of cryopreserved sperm
- Thawing of cryopreserved oocytes
- Medications not approved by the FDA

Criteria for Approval

- Prior Authorization is required.
- Member must be of reproductive age, i.e., from puberty to before menopause (except as noted below for ovarian tissue preservation)
    - MDH defines puberty as when an adolescent reaches sexual maturity and becomes capable of reproduction.
    - MDH defines menopause as the routine, non-pathologic condition involving the permanent cessation of menses for at least twelve (12) months.
- Fertility preservation services must be performed by a board-certified Reproductive Endocrinologist; therefore, the request must come from a board-certified reproductive endocrinologist.
- If the request is for a minor parental consent is required

    - The current Maryland Minor Consent Laws will be followed

- Fertility preservation might be considered for coverage with documentation of iatrogenic infertility. These are procedures that are necessary to preserve fertility in members due to the need for medically necessary medical treatment that may directly or indirectly cause iatrogenic infertility. This includes impairment of fertility by surgery, radiation, chemotherapy, gender-affirming treatments, or other medical treatment/intervention that affects the reproductive organs or processes.
- A copy of the complete treatment plan of the proposed Fertility Preservation Services

- For approval of Gonadal Suppression with GnRH Analogs:
    - GnRH agonists may only be used in specific breast cancer members to decrease the risk of premature ovarian insufficiency.
    - GnRH analogs cannot be used in place of other fertility preservation alternatives.

- For approval of Ovarian Tissue Cryopreservation:
    - There must be insufficient time for oocyte retrieval OR the member is prepubertal **AND**
    - Ovarian tissue does not have any malignancy

Storage/Banking is not a covered Benefit

- Since storage/banking is not a covered benefit, practitioners must discuss with the member what provisions have been made for storage/banking. This must be documented in the medical record sent to MFC.

See above section "**Non-Covered Services"** for other exclusions.

Length of Authorization

- Fertility preservation services that require prior approval will be authorized for three (3) months when the criteria above are met

- Cryopreservation of ovarian tissue and sperm would be a one-time benefit.
- A maximum of three cycles of ovarian stimulation and oocyte preservation will be covered.

Summary of Changes:	**07/24:** • Removed specific names for "Responsible Parties" and "Approved"; just using titles • Updated Regulatory Reference **01/24:** • New policy.