KAISER PERMANENTE® Mid-Atlantic States	**Fertility Preservation for Iatrogenic Infertility** **Medical Coverage Policy**

Utilization *ALERT*

- Prior to use of this MCP for evaluation of medical necessity, benefit coverage MUST be verified in the member's EOC or benefit document.
- This policy applies only to members whose benefit plans cover fertility preservation services. The member benefit documents (EOC or brochure or Medicaid handbook) are the primary source of benefit coverage and all coverage is subject to the terms and conditions of the member's benefit plan.
- For Medicare members, please refer to CMS guidelines through Medicare Coverage Database requirements.
- This MCP applies if no CMS guidelines are available

I. Procedure: **Fertility Preservation for Iatrogenic Infertility**
Related Medical Coverage Policies: Pre-Implantation Genetic Diagnosis (PGD), Infertility Treatments and Services

II. Diagnoses: **Iatrogenic infertility**

III. Specialties/Services: OB/GYN, Urology, Oncology, Surgery, Reproductive Endocrinology, Laboratory and Radiology

IV. Fertility Preservation for Iatrogenic Infertility

Fertility preservation is only covered if a patient is expected to have iatrogenic infertility. Iatrogenic Infertility means an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment affecting the reproductive organs or processes. Fertility preservation is a separate benefit from the Infertility benefit.

A. For patients with fertility preservation benefit, oocyte retrieval or sperm collection with cryopreservation are covered. The costs of storage are not generally covered. For males with azoospermia TESE will be covered.
B. For female patients with an IVF benefit cryopreservation of an embryo instead of an oocyte will be covered.

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Approval History

Effective June 01, 2016, state filing is no longer required per Maryland House Bill HB 798 – Health Insurance – Reporting

Date approved by RUMC	Date of Implementation
08/26/2020	08/26/2020
08/17/2021	08/17/2021
07/26/2022	07/26/2022
04/25/2023	04/25/2023
04/25/2024	04/25/2024

*The Regional Utilization Management Committee received delegated authority in 2011 to review and approve designated Utilization Management and Medical Coverage Policies by the Regional Quality Improvement Committee.

Note: Kaiser Permanente Mid-Atlantic States (KPMAS) include referral and authorization criteria to support primary care and specialty care practitioners, as appropriate, in caring for members with selected conditions. Medical Coverage Policies are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by a practitioner in any particular set of circumstances for an individual member.