Assisted Reproductive Technology

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Abstract

For Members

Assisted reproductive technology (ART) includes any lawful treatments offered to couples experiencing reproductive problems for the purpose of establishing a pregnancy. These treatments including ovulation induction with timed intercourse, intrauterine insemination, in vitro fertilization, intracytoplasmic sperm injection, gamete cryopreservation and gamete intra fallopian transfer (GIFF). All techniques of surgical sperm extraction for the purpose of ART. In addition to cytogenetic analysis of gametes or embryos including pre implantation genetic diagnosis and screening.

For Medical Professionals

Assisted reproductive technologies will be covered for medical indications and necessities according to the DOH standard for assisted reproductive technology services and treatment (January 2020), Principles of Care for the Provision of ART services in Abu Dhabi Emirate and in conjunction with related UAE laws.

The use of donor eggs/sperms/embryos is NOT covered by Daman, since it is not allowed as per Federal Law (no. 11) of 2008 which applies to all of UAE.

Any additional technology or device will require the DOH approval prior coverage.
Assisted Reproductive Technology

Scope
This adjudication rule aims at highlighting the coverage of assisted reproductive technology (ART) as infertility treatment for all health insurance plans administered by Daman, subject to policy terms and conditions.

Adjudication Policy

Eligibility / Coverage Criteria

➢ Patient eligibility criteria 1:

- The couple have been trying for pregnancy for at least 1 year, one or both individuals have been diagnosed with infertility problems.
- Both husband and wife have consented for IVF treatment.
- Both husband and wife commit to undertake the necessary follow up by an ART Consultant/Specialist.

➢ Definitions 1:

- Infertility: is defined as the inability of a married, sexually active couple to achieve pregnancy within one year of unprotected regular intercourse for females under the age of 35 and 6 months for those older than 35 years unless infertility has been diagnosed.

  *Infertility may be diagnosed prior to one year if there are features or findings indicative of sub-fertility features as per the DOH standard.*

  *It is classified into primary and secondary infertility.*

- Single IVF Cycle: is one or more episodes of ovarian stimulation resulting in embryo transfer or more than one embryo transfer cycle originating from the same stimulation. The maximum allowed ART cycles per year is three cycles as defined in this standard.

- The maximum allowed trials per year of ovulation induction and/or ovarian superovulation with gonadotropins injections is six trials.
- The preferred age range for women seeking fertility treatment is between 18-45 years old. However, ART treatment can be given for women aged 46-48 with AMH level ≥1.1.
- Cryopreservation of unfertilized gametes of couples is permitted for up to 5 years and must not exceed it according to Federal Law No.11 of 2008.
- Cryopreservation of fertilized oocytes of couples is permitted according to Federal Law no. 7 of 2019, for up to 5 years and must not exceed it.

Assisted Reproductive Technology procedures covered by Daman:

1. Intrauterine insemination (IUI) or Artificial insemination (AI)
2. In Vitro Fertilization (IVF)
3. Intracytoplasmic Sperm Injection (ICSI)
4. Gamete Intrafallopian Transfer (GIFT)
1. **Intrauterine insemination (IUI) or Artificial insemination (AI):** Placing sperm inside a woman’s uterus to facilitate fertilization.

   - Indications:
     - Unexplained infertility
     - Ejaculation dysfunction
     - Cervical mucus abnormalities.
     - Cervical scar tissue from past procedures which may hinder the sperms’ ability to enter the uterus.
     - Failure of pharmacological treatment

2. **In Vitro Fertilization:** An ART procedure involving extracorporeal fertilization. Below are the steps for In vitro fertilization steps:

   - Baseline fertility investigations (Cycle preparation)
   - Ovarian stimulation (induction)
   - Egg retrieval (Ovum pickup)
   - Insemination and oocytes lab-fertilization
   - Embryo quality assessment and genetic investigations
   - Embryo transfer and implantation.

   - Indications:
     - Tubal factor (IVF is primary therapy if tubes are completely blocked).
     - Severe male factor infertility.
     - Failing treatment with less invasive therapies (e.g. IUI).
     - Ovarian failure.
     - Unexplained Infertility.

   *Allowed number of transferred embryos as per the woman age*:

   1. Not transfer more than two embryos for women aged 30-35 years at the time of transfer.
   2. If a decision is taken to transfer three embryos in women 30-35 years old, then this must be documented, stating the rationale and evidence base supporting the decision.
   3. Not transfer more than three embryos for women aged above 35 years at the time of transfer.
   4. Consider a single embryo transfer for women who have a good prognosis for pregnancy (i.e. women <30 years old or couples with unexplained infertility).
   5. Not transfer more than two embryos for cases that already did PGT-A (PGS) tests.

3. **Intracytoplasmic Sperm Injection (ICSI):** Procedure of injecting a spermatozoon into the cytoplasm of a mature oocyte. Surgical sperm extraction techniques which can be used in (ICSI) include:

   - Percutaneous epididymal sperm aspiration (PESA).
   - Testicular sperm aspiration (TESA).
   - Testicular Sperm Extraction (TESE).
   - Micro Testicular Sperm Extraction (Micro-TESE).
   - Microsurgical Epididymal Sperm Aspiration (MESA).
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➢ Indications 6:
   - primarily for the treatment of male infertility factor (oligospermia and other causes of poor semen quality).
   - failed fertilization in a prior IVF cycle.
   - obstructive or non-obstructive azoospermia that requires surgical sperm extraction.

4. Gamete Intrafallopian Transfer (GIFT): is an assisted reproductive procedure which involves removing a woman’s eggs, mixing them with sperm, and immediately placing them into a fallopian tube 7.
   ➢ Indications 7:
     - Couples with Unexplained Infertility.
     - Failure of or unsuccessful IVF.
     - Women who have at least one healthy fallopian tube.
     - Male infertility factor.

Coverage Policy

Assisted reproductive technology as a treatment for infertility is covered only for the following plans administered by Daman as per policy terms and conditions as mentioned below

<table>
<thead>
<tr>
<th>Plan</th>
<th>Coverage of ART</th>
<th>Mode of Billing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thiqa</td>
<td>Maximum of 3 attempts annually*</td>
<td>Direct billing</td>
</tr>
<tr>
<td>Aounak &amp; Reaaya</td>
<td>Covered</td>
<td>Direct billing</td>
</tr>
<tr>
<td>Premier</td>
<td>Covered (maximum lifetime limit AED 365,000 per person)</td>
<td>Reimbursement</td>
</tr>
<tr>
<td>Thiqa Top Up</td>
<td>Pre-authorization required (as per SOBs)</td>
<td>As per Schedule of Benefits (SOBs)</td>
</tr>
<tr>
<td>Customized Plans</td>
<td>As per Schedule of Benefits (SOBs)</td>
<td>As per Schedule of Benefits (SOBs)</td>
</tr>
</tbody>
</table>

*For those members with a 3-year renewal, a maximum of 3 attempts will be covered annually (9 attempts in 3 years).

Requirements for Coverage

➢ ICD and CPT codes must be coded to the highest level of specificity.
➢ Oocytes retrieval, Embryo transfer, Surgical sperm extractions, PGD and PGS will require prior authorization.

Non-Coverage

➢ Assisted reproductive Technologies are not covered for plans without infertility benefits.
➢ Assisted reproductive technologies will not be covered for indications that do not meet the medical necessity and the DOH patient eligibility criteria for ART.
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Payment and Coding Rules

Please apply DOH payment rules and regulations and relevant coding manuals for ICD and CPT

Denial codes

<table>
<thead>
<tr>
<th>Code description</th>
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<tbody>
<tr>
<td>Diagnosis(es) is (are) not covered</td>
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<tr>
<td>Service is not clinically indicated based on good clinical practice</td>
</tr>
<tr>
<td>Service is no clinically indicated based on good clinical practice, without additional supporting diagnoses/activities</td>
</tr>
<tr>
<td>Service/supply may be appropriate but too frequent</td>
</tr>
<tr>
<td>Prior approval is required and was not obtained</td>
</tr>
<tr>
<td>Service(s) is (are) not covered</td>
</tr>
<tr>
<td>Patient is not a covered member</td>
</tr>
</tbody>
</table>

Appendices

A. References

1. DOH standard for assisted reproductive technology services and treatment
2. UAE Federal Law No. (11) of 2008 regarding reproductive
5. https://www.hfea.gov.uk/treatments/explore-all-treatments/surgical-sperm-extraction/

B. Revision History

<table>
<thead>
<tr>
<th>Date</th>
<th>Change(s)</th>
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<tbody>
<tr>
<td>01-07-2013</td>
<td>V1.1: New template</td>
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<tr>
<td>1-03-2014</td>
<td>V1.2: Disclaimer updated as per system requirements</td>
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<tr>
<td>06-04-2015</td>
<td>V2.1: PGD coverage criteria updated along with more elaboration</td>
</tr>
<tr>
<td>19-03-2020</td>
<td>V3.0</td>
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