Advanced Infertility Services and In Vitro Fertilization (IVF)

Policy Number: **M20260826040**

Effective Date: **10/1/2026**

Sponsoring Department: **Health Care Services**

Impacted Department(s): **Health Care Services**

Type of Policy: ☒ Internal ☒ External

Data Classification: ☐Confidential ☐Restricted ☒Public

Applies to (Line of Business):

☐ Corporate (All)

✦ State Products, if yes which plan(s): ☒MediSource; ☒MediSource Connect; ☒Child Health Plus; ☒Essential Plan

✦ Medicare, if yes, which plan(s): ☒MAPD; ☒PDP; ☒ISNP; ☒CSNP

✦ Commercial, if yes, which type: ☒Large Group; ☒Small Group; ☒Individual

☒ Self-Funded Services *(Refer to specific Summary Plan Descriptions (SPDs) to determine any pre-authorization or pre-certification requirements and coverage limitations. In the event of any conflict between this policy and the SPD of a Self-Funded Plan, the SPD shall supersede the policy.)*

Excluded Products within the Selected Lines of Business (LOB)

This section is intended to list specific LOB products that are excluded from adhering to this policy (due to differences in law/regulations). If not applicable, please indicate N/A.

Applicable to Vendors? Yes ☐ No☒

Purpose and Applicability:

To set forth the medical necessity criteria for Advanced Infertility Services and In Vitro Fertilization (IVF).

Policy:

Background

This policy addresses coverage of advanced infertility services including treatment with in vitro fertilization for those customers that have plan coverage and met the criteria for infertility. In order to determine eligibility, Independent Health uses guidelines established by the American College of Obstetricians and Gynecologists, the American Society of Reproductive Medicine and New York State Department of Financial Services.

Authorization Requirements

Independent Health's authorization requirements comply with all relevant statutes and regulations, including but not limited to Part L of the Health and Mental Hygiene portion of the budget (A.2007-C/S.1507-C); New York State Insurance Laws §3216, §3221, §4303.
Independent Health's authorization requirements comply with all billing and coverage guidance issued by the NY State Department of Health.
For plans that have fertility preservation services coverage; see the Independent Health Fertility Preservation Services Medical Policy.
For plans that do not have in vitro fertilization coverage; see the Independent Health Basic Infertility Services Medical Policy.
For pharmacologic treatment of infertility please refer to the applicable Independent Health Pharmacy policies.
Some Self-Funded products may have advanced infertility and IVF coverage. Please consult the customers individual plan description (SPD) regarding group coverage for IVF. If a Self-Funded group has coverage for IVF, then the coverage criteria described in this policy applies.

Documentation Requirements
Diagnostic work-up demonstrating infertility per medical policy must be documented in the medical record.
Documentation of infertility history and treatment plan must be submitted for requests for In vitro fertilization (IVF).
Advanced Services must be performed by an OB-GYN specialist or a reproductive endocrinologist qualified to provide such services within the guidelines established by the American Society for Reproductive Medicine.
Coverage for infertility services must be prescribed as part of a treating physician's overall plan of care and must be consistent with the criteria set forth below. Coverage for infertility is for persons who reasonably expect fertility as a natural state.
Infertility is determined by:

- The inability of opposite-sex partners to establish a clinical pregnancy after twelve months of regular, unprotected intercourse; OR
- The inability of opposite-sex partners to establish a clinical pregnancy after six months of regular, unprotected intercourse for a female thirty-five years of age or older; OR
- The inability of an individual to establish a clinical pregnancy due to sexual orientation or gender identity.

Coverage for advanced services are for individuals who have been unable to conceive or sustain a successful pregnancy through reasonable effort with conservative medically viable infertility treatments or procedures covered by Independent Health policy, unless the individual's physician determines that those treatments are likely to be unsuccessful.

If donor sperm is used, related fees such as cost of sperm or preparation of the sperm will not be covered (except sperm washing) and are the responsibility of the member.
Specialized sperm retrieval techniques are part of the IVF benefit. Techniques such as microsurgical epididymal sperm aspiration (MESA) percutaneous epididymal sperm aspiration (PESA), testicular sperm aspiration (TESA); or percutaneous biopsy of the testis (PercBiopsy) are covered.
Cryopreservation, storage and thawing of embryos is considered medically necessary while the individual is currently under covered active infertility treatment (IVF).
External pump for the administration of infertility drugs other than GnRH will be considered only on a case-by-case-basis.

Coverage for preimplantation biopsy for the purpose of preimplantation genetic testing must meet the criteria established in the preimplantation genetic testing policy found in the Independent Health's Preimplantation Genetic Testing.

Commercial and Self-Funded: Advanced Infertility Services and In Vitro Fertilization (IVF) may be covered utilizing the criteria below. In vitro fertilization (IVF) is contract dependent. Some Self-Funded products may have IVF coverage. Please consult the member's individual plan description (SPD) regarding Self-Funded group coverage for IVF. If a Self-Funded group has coverage for IVF, then the coverage criteria described in this policy applies.

Medicare Advantage: Advanced Infertility Services and In Vitro Fertilization (IVF) are not a covered benefit for Medicare advantage members.

Child Health Plus: No basic or advanced infertility services for Child Health Plus.

Essential Plan: Advanced Infertility Services and In Vitro Fertilization (IVF) are not covered benefits.

MediSource, MediSource Connect: In vitro fertilization (IVF) is not a covered benefit for MediSource plans. Any drug or services rendered in connection with any non-covered infertility procedure, including frozen embryo transfer (FET), IVF, GIFT, ZIFT program, cycle or treatment are not covered. Infertility treatments and/or FDA-approved drugs not indicated by the NYS mandate are not covered. Not covered if member's age for treatment is less than 21 years or greater than 44 years.

Clinical Indications

In vitro fertilization, IF covered by specific contract/benefit, is covered after meeting **ALL** of the following:

- Coverage criteria for infertility as determined by **1 or more** of the following:
    - The inability of opposite-sex partners to establish a clinical pregnancy after twelve months of regular, unprotected intercourse
    - The inability of opposite-sex partners to establish a clinical pregnancy after six months of regular, unprotected intercourse for a female thirty-five years of age or older
    - The inability of an individual to establish a clinical pregnancy due to sexual orientation or gender identity
- **1 or more** of the following:
    - Unable to conceive after six (6) failed intrauterine insemination (IUI) or artificial insemination (AI) cycles in a twelve (12) month period for a person less than thirty-five years of age
    - Unable to conceive after three (3) failed intrauterine insemination (IUI) or artificial insemination (AI) cycles in a six (6) months period for a person thirty-five years of age or older
- The member has not exceeded the lifetime limit of 3 cycles. An IVF cycle is defined as either all treatment that starts when preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing IVF using a fresh embryo transfer or medications are administered for endometrial preparation with the intent of undergoing IVF using a frozen embryo transfer.

Exclusions and Benefit Limitations:

NOT COVERED for **ANY** of the following:

- Any drug or services rendered in connection with any non-covered infertility procedure, including IVF (when not covered under customer contract or NYS mandate), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT) program, cycle or treatment are not covered
- Gamete Intrafallopian Transfer (GIFT) is not covered and excluded from all commercial plan contracts. Some Self-Funded products may have GIFT coverage. Please consult the customer's individual plan description (SPD) regarding Self-Funded group coverage for GIFT
- Zygote Intrafallopian Transfer (ZIFT) is not covered and excluded from all commercial plan contracts. Some Self-Funded products may have ZIFT coverage. Please consult the customer's individual plan description (SPD) regarding Self-Funded group coverage for ZIFT
- Gender selection is not covered
- There is no coverage for surgery to reverse a previous voluntary sterilization procedure

- Evaluation or treatment of infertility for customers who have undergone a previous voluntary sterilization procedure, or a reversal of a previous voluntary sterilization is not covered
- Donor fees including preparation or purchase of sperm and ovum (egg or embryo) are not covered
- Travel expenses
- Cloning services and procedures are not covered
- Infertility treatments and/or FDA-approved drugs not indicated by the NYS mandate
- Any services related to infertility for an individual who is not a customer of Independent Health
- Surrogacy and associated infertility services performed in conjunction with surrogacy are not covered
- Ovulation predictor kits
- Medical or surgical services or procedures for infertility that are deemed experimental or investigational are not covered in accordance with the guidelines and standards of the American College of Obstetricians and Gynecologists (ACOG) and the American Society of Reproductive Medicine (ASRM) which state: "A procedure for the treatment of infertility is considered experimental until there is adequate scientific evidence of safety and efficacy from appropriately designed, peer-reviewed, published studies by different investigator groups."
- Assisted embryo hatching. The use of assisted hatching has been proposed as a method to facilitate implantation and pregnancy rates. It may be performed in conjunction with IVF and ZIFT to enhance the probability of achieving pregnancy. Evidence in the published, peer-reviewed scientific literature has yielded few randomized clinical studies, inconsistent success rates, and no specific patient selection criteria
- Co-culture of oocyte(s)/embryos. Co-culturing of embryos is the culturing of embryos on a layer of cells that in theory, removes toxic substances produced by the embryo. However, co-culturing of embryos using feeder cells (e.g., granulosa, endometrial, tubal) in order to improve implantation success has not been demonstrated in the published, peer-reviewed scientific literature to improve implantation or pregnancy rates
- Mock embryo transfer has not been demonstrated in the published, peer-reviewed scientific literature to improve implantation or pregnancy rates
- In vitro fertilization (IVF) is not a covered benefit for MediSource Plans
- For MediSource Plans: Any drug or services rendered in connection with any non-covered infertility procedure, including frozen embryo transfer (FET), IVF, GIFT, ZIFT program, cycle or treatment are not covered
- For MediSource Plans: Infertility treatments and/or FDA-approved drugs not indicated by the NYS mandate are not covered
- For MediSource Plans: Customer's age for treatment is less than 21 years or greater than 44 years
- For Child Health Plus members: Basic or advanced infertility services are not covered
- For Essential Plan members: In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers, costs associated with an ovum or sperm donor including the donor's medical expenses, cryopreservation and storage of embryos, ovulation predictor kits, reversal of tubal ligations, reversal of vasectomies, costs for and relating to surrogate motherhood that are not otherwise covered services under the Essential Plan contract and/or cloning are not covered

Pre-Authorization Required? Yes ☒ No ☐

Definitions

Enter definitions here. Remember to **bold** words throughout Policy section that require definitions. Definitions should be included when: 1) The word may be unclear or may mean something different, in different situations/contexts; 2) The word is not commonly used or known. Please refer to the Policy Writing Toolkit for additional information and direction.

References

Related Policies, Processes and Other Documents

Independent Health Basic Infertility Services Policy
Independent Health Fertility Preservation Services Medical Policy

Non-Regulatory References

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Regulatory References

State of New York Insurance Law § 7657, Amendment 11723, effective 2003 Jan.

Part L of the Health and Mental Hygiene portion of the budget (A.2007-C/S.1507-C); New York State Insurance Laws §3216, §3221, §4303.

New York State Department of Financial Services Insurance Circular Letter No. 3 (2021) Health Insurance Coverage of Infertility Treatments Regardless of Sexual Orientation or Gender Identity. Available: https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2021_03.

Version Control

Signature / Approval on File? Yes ☒ No☐

Revision Date	Policy Author / Owner	Notes
10/1/2026	Health Care Services	New Policy
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