دائـــــرة الـصـــحـــة
DEPARTMENT OF HEALTH

DOH POLICY ON THIQA COVERAGE FOR ASSISTED REPRODUCTIVE TREATMENT AND SERVICES

February 2022

PUBLIC عـــام

دائـــــرة الـــصـــحـــة
DEPARTMENT OF HEALTH

Document Title:	DOH Policy on THIQA Coverage for Assisted Reproductive Treatment and Services
Document Type:	Coverage Policy
Document Ref. Number:	DOH/STR/CPL/0.9/2022
Effective Date:	February 2022
Document Owner:	Healthcare Payers Sector Please email hsf@doh.gov.ae for further information.
Applies to:	• DOH licensed Healthcare Providers of Assisted Reproductive Services. • Daman/THIQA.

This Policy should be read in conjunction with related Abu Dhabi and UAE laws, DOH Standards, Policies and Manuals including but not limited to:

- HAAD Standard Provider Contract.
- DOH Standard on Assisted Reproductive Treatment and Services
- DOH Quality Policy.
- DOH Regulator Manual.
- DOH Healthcare Provider Manual.
- DOH Health Professional Manual.
- DOH Standard on Patient Healthcare Data Privacy.
- DOH Policy on Health Information Exchange.
- Federal Law on Medical Liability.
- Federal Law on the Practice of Human Medicine.
- Federal Law on Assisted Reproduction.

.

ABOUT DEPARTMENT OF HEALTH (DOH)

The Department of Health (DOH) is the regulatory body of the Health System in the Emirate of Abu Dhabi and seeks excellence in Health for the community by regulating and monitoring the health status of the population. DOH defines the strategy for the health system, monitors and analyses the health status of the population and performance of the system. In addition, DOH shapes the regulatory framework for the health system, inspects against regulations, enforce regulations, and encourages the adoption of best practices and performance targets by all health service providers. DOH also drives programs to increase awareness and adoption of healthy living standards among the residents of the Emirate of Abu Dhabi in addition to regulating scope of services, premiums and reimbursement rates of the health system in the Emirate of Abu Dhabi.

The Health System of the Emirate of Abu Dhabi is comprehensive, encompasses the full spectrum of health services and is accessible to all residents of Abu Dhabi. The health system encompasses, providers, professionals, patients, Insurers and the regulator. Providers of health services include public and private services and the system is financed through mandatory health insurance (with the exception to Thiqa) and has three main sources of financing: Employers or Sponsors, the Government and Individuals. The Health Insurance scheme places responsibilities on any Insurer, Broker, Third Party Administrator, Health Provider, Employer, Sponsor (including educational establishments), Limited Income Investors and Insured Persons to participate in the Health Insurance Scheme.

Table of Content

1. Introduction

This policy sets out the eligibility criteria for coverage of Assisted Reproductive Services by THIQA, the services that THIQA will cover and the reimbursement packages that THIQA will use to administer benefits.

This document is not a guideline on clinical management. In no way does it replace the clinical judgement of the physician.

2. Definitions

Term	Definition
Assisted Reproductive Techniques (ART)	ART includes any lawful treatments offered to couples experiencing reproductive problems for the purpose of establishing a pregnancy. These treatments include, but are not limited to, ovulation induction with timed intercourse, intrauterine insemination, in vitro fertilization, intracytoplasmic sperm injection, gamete cryopreservation, gamete intra fallopian transfer (GIFT).
Fertilization centers	Fertilization centers are any licensed facilities where assisted reproductive techniques are performed, including all clinical and biological procedures that are necessary to effectuate extracorporeal conception.
Infertility	For the purpose of this Policy, 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 and for those who are 35 years and older unless infertility has been diagnosed.
Reduced Ovarian Reserve	A patient with a condition of low fertility where at least one of the following criteria is met: • Advanced maternal age >40 years • A previous POR (≤3 oocytes with a conventional stimulation protocol). • An abnormal ovarian reserve test [i.e. antral follicle count (AFC) less than 5–7 follicles or anti-Müllerian hormone (AMH) less than1.1 ng/ml]. OR Two cycles with poor ovarian response after maximum stimulation in the absence of the other criteria above
Complete Full Cycle	Is one or more episodes of ovarian stimulation resulting in embryo transfer or more than one embryo transfer cycles originating from the same stimulation.
Incomplete Cycle	The ART cycle, which is not completed at any stage for any reason before oocyte or embryo freezing or embryo transfer.
Intracytoplasmic Sperm Injection (ICSI)	Procedure of injecting a spermatozoon into the cytoplasm of a mature oocyte.

Ovulation induction	A pharmacological treatment of women with anovulation or oligo-ovulation with the intention of inducing normal ovulatory cycles[1]. The maximum allowed trials per year of ovulation induction with gonadotropins injections is six trials.
Superovulation	A pharmacological treatment of ovulatory women with the intention of superovulation (for unexplained infertility, endometriosis etc). The maximum allowed trials per year and superovulation with gonadotropins injections is six trials.
Ovarian hyper-stimulation syndrome (OHSS)	An exaggerated systemic response to ovarian stimulation characterized by a wide spectrum of clinical and laboratory manifestations. It is classified as mild, moderate or severe according to the degree of abdominal distention, ovarian enlargement and respiratory, hemodynamic and metabolic complications[2].
THIQA	Thiqa is a comprehensive health insurance programme offered by the UAE government to members of the THIQA insurance program.
THIQA patients	Members of the THIQA insurance program.

3. Purpose

The purpose of this policy is to ensure that:

3.1. THIQA eligible patients in medical need of Assisted Reproductive Techniques, and who fulfill the legal requirements for initiating ART treatments, are covered for these treatments in accordance with evidence-based medical criteria Per Patient Per Year (PPPY);

3.2. Fertilization Centers will be reimbursed as per the package of services provided.

4. Scope

This Policy applies to the THIQA program and all DOH licensed ART providers.

5. Policy Statement

THIQA patients will be covered for Assisted Reproductive treatments where it is determined that such treatments are medically necessary and fulfill the here stated medical criteria.

6. Determination of Medical Necessity in Assisted Reproductive Treatments

6.1. The married couple have been trying for pregnancy for at least 1 year or one or both individuals have been diagnosed with infertility problems in line with definition of infertility in this Policy;

[1] https://www.who.int/reproductivehealth/publications/infertility/art_terminology.pdf
[2] https://www.who.int/reproductivehealth/publications/infertility/art_terminology.pdf

6.2. Infertility may be diagnosed prior to one year if there are features or findings indicative of subfertility. These include:
  6.2.1. Oligo or amenorrhea;
  6.2.2. Inability to have intercourse;
  6.2.3. Previous adjuvant therapy for cancer in either partner;
  6.2.4. History indicating an increased risk of Fallopian tube occlusion (i.e. previous pelvic infection or previous pelvic surgery);
  6.2.5. Pelvic inflammatory disease;
  6.2.6. Advanced female age (>35 years);
  6.2.7. Abnormality in one or more semen parameters as an indication of male factor infertility (volume <1.5 ml; pH <7.2; sperm concentration <15 million spermatozoa/ml; total sperm number: <39 million spermatozoa per ejaculate; total motility <40% motile, or <32% with progressive motility; vitality: <58% live spermatozoa; percentage of sperm with normal morphology <4%)[3];
  6.2.8. Reduced ovarian reserve;
  6.2.9. Men with diagnosed reproductive problems;
  6.2.10. Cases where ART candidates are known to have chronic viral infection (e.g. HIV, Hepatitis B or Hepatitis C);
  6.2.11. Known genetic/chromosomal disorders;
6.3. Pre-Cancer treatment Fertility Preservation: offered to married or single individuals prior to any oncology treatment due to its potential adverse effects on fertility.
6.4. Any other medically necessary fertility preservation treatment offered to married or single individuals prior to applying any medicinal regimen due to its potential adverse effects on fertility.

7. Case mix and Patient Eligibility

7.1. The age range for women seeking ART services must be between 18-45 years;
7.2. BMI eligibility range for women seeking THIQA coverage for fertility treatment is from 19-40. However, women with BMI between 35-40 who are seeking fertility treatments should be:
  7.2.1. Informed of the increased risk of failure in fertility treatment and risk to pregnancy and child as a direct result of their physical condition; and
  7.2.2. Advised to consult a registered dietitian for weight management intervention for minimum of three months.

[3] WHO – World Health Organization

8. Covered Services

8.1. Treatment:

8.1.1. The most effective and least risk associated procedure should always be offered as a first line treatment option;

8.1.2. ART candidates known to have chronic viral infection (e.g. HIV, Hepatitis B or Hepatitis C) must be referred to DOH licensed facilities that have appropriate expertise in infectious diseases and facilities to provide investigation and specialized treatment.

8.1.3. Women beyond the age of 45 may complete a treatment of a cycle that they started before the age of 45

8.2. Oocyte and embryo cryopreservation and pooling

8.2.1. Freezing of healthy oocytes and embryos as clinically required is covered for the first year as part of the Bundled Package.

8.2.2. Coverage for cryopreservation for subsequent years will be on a year-by-year basis.

8.2.3. Pooling of oocytes and /or embryos before embryo transfer may be covered in cases of:

8.2.3.1. Advanced Maternal Age (above 35 years);

8.2.3.2. Patients with a previous POR (≤3 oocytes with a conventional stimulation protocol), or patients with an abnormal ovarian reserve test [i.e. antral follicle count (AFC) less than 5–7 follicles or anti-Müllerian hormone (AMH) less than1.1 ng/ml] or patients with two cycles with poor ovarian response after maximum stimulation in the absence of the POR and abnormal ovarian reserve criteria.

8.2.3.3. Couple fertility preservation;

8.2.3.4. Oncology patients;

8.2.3.5. Genetic testing is required;

8.2.3.6. Genetic conditions such as fragile X premutation and mosaicism for monosomy X;

8.2.3.7. Autoimmune diseases;

8.2.3.8. Endometriosis;

8.2.3.9. Women who have been identified as carrying a BRCA1 or BRCA2 genetic mutation and have an increased risk of developing ovarian cancer or as a risk-reduction measure for women at very high risk of breast cancer before definitive treatment;

8.2.3.10. Young women with borderline ovarian tumors where fertility preservation is advisable.

8.2.4. Cost of excess storage time beyond 5 years or beyond the age of 45 will be collected directly from patients.

8.2.5. All frozen embryos should be utilized before the start of a new fresh cycle except for patients who requires embryo pooling.

8.2.6. Clinical evidence such as radiological, laboratory results, and genetic reports should be provided for embryo pooling.

8.2.7. All frozen embryos should be utilized before the start of a new fresh cycle except for patients who requires embryo pooling.

8.3. Transfer of Embryos:

8.3.1. Patients with PGTA tests must have single embryo transferred at a time, regardless of patient age

8.3.2. Otherwise no more than two embryos to be transferred at a time.

8.4. Medications:

8.4.1. Usage of ovarian induction drugs by DOH licensed Reproductive Endocrinologists/ IVF Specialists and Consultants;

8.4.2. All medications required for fertility treatment require pre-authorization.

8.5. ICSI/IVF:

DOH laboratories licensed for IVF services should have in place written procedures approved by the nominated Director to manage the ICSI/IVF cases.

8.6. Mandatory and Baseline Investigations:

8.6.1. Screening of both husband and wife for HIV, Hepatitis B and Hepatitis C and syphilis prior to handling of their gametes for ART in line with Federal Law.

8.6.2. In addition, the following should be done as baseline investigations:

8.6.2.1. Female:

8.6.2.1.1. HIV I and II;
8.6.2.1.2. Hepatitis B surface Antigen, Hepatitis B Antibody, Hepatitis C Antibody;
8.6.2.1.3. Rubella IgG;
8.6.2.1.4. Blood Type and Rh Factor;
8.6.2.1.5. CBC, and/or HB electrophoresis;
8.6.2.1.6. TSH, Prolactin, AMH, FSH, LH, Estradiol;
8.6.2.1.7. Pap smear, chlamydia, gonorrhea and Syphilis;
8.6.2.1.8. High Vaginal Swabs;
8.6.2.1.9. HSG and/or HyCoSy and/or hysteroscopy;
8.6.2.1.10. Pelvic ultrasound;
8.6.2.1.11. Vitamin D (only if not done in the same facility within the last three months).

8.6.2.2. Male:

8.6.2.2.1. Semen analysis;
8.6.2.2.2. HIV I and II;
8.6.2.2.3. Hepatitis B surface Antigen, Hepatitis C Antibody;
8.6.2.2.4. Syphilis.

8.7. Genetic Investigations:

8.7.1. Genetic investigations (i.e. Karyotyping) for certain clinical indications including the following:

8.7.1.1. Recurrent miscarriages;
8.7.1.2. Recurrent IVF implantation failure; and
8.7.1.3. Severe male factor of infertility.

8.7.2. PGT-A (PGS) test for certain clinical indications including the following:

8.7.2.1. Maternal age of >35 years old;

8.7.2.2. Advanced paternal age (>50 years old);
8.7.2.3. Severe male factor of infertility, where ICSI cycle is required (azoospermia -obstructive and non-obstructive, severe oligoastenoteratozoospermia, Klinefelter syndrome (KS), and Y-chromosome microdeletion, and men whose semen analysis does not fulfill the current World Health Organization (WHO) criteria on repeat sample analysis;
8.7.2.4. Recurrent miscarriages- two or more pregnancy losses before 24 weeks of gestation;
8.7.2.5. Recurrent IVF implantation failure- three or more failed embryo transfers involving at least four high quality embryos;
8.7.2.6. Family history of chromosome problems such as Down's syndrome; and
8.7.2.7. Reduced ovarian reserve as defined on this policy

8.7.3. Pre-implantation Genetic Diagnosis (PGT-M) can be considered for:
8.7.3.1. Patients diagnosed with an autosomal dominant or X-linked genetic disorder;
8.7.3.2. Couples who were both diagnosed as carriers of the same autosomal recessive disorder;
8.7.3.3. Patients diagnosed with mitochondrial disorders caused by mitochondrial DNA (mtDNA);
8.7.3.4. Consanguine marriage with history of single gene disorders; and
8.7.3.5. History of children with single gene disorder.

8.8. Number of Covered Cycles in relevant Bundle:
8.8.1. Maximum of six stimulations/natural cycles of egg retrieval Per Patient Per Year (PPPY) with
8.8.2. Maximum of three embryo transfer cycles; i.e. embryo transfer episodes originating from one or more ART cycles Per Patient Per Year (PPPY).

8.9. Duration of covered bundle
8.9.1. Each bundle to be completed within 1 to 4 months.

9. Payment Authorization & Payment Bundles

9.1. Payer TPAs must comply with the health insurance pre-authorization requirements, where appropriate, for payment for Assisted Reproductive treatments in accordance with this Policy, billing & adjudication rules and consistent with the Standard Provider Contract.

9.2. Payments will be bundled as follows:
9.2.1. Bundle 1- Fresh Cycle:
Is a bundle that covers a fresh cycle starting with one or more episodes of ovarian stimulation resulting in a fresh embryo transfer, including consultation, investigation, monitoring, collection of oocytes, fertilization, and oocytes and embryos cryopreservation as required.

9.2.1.1. Limit:
9.2.1.1.1. Maximum six retrievals (stimulated or natural) Per Patient Per Year (PPPY);
9.2.1.1.2. AND three embryo transfer cycles. i.e. (embryo transfer episodes originating from one or more ART cycles) Per Patient Per Year (PPPY);
9.2.1.1.3. All embryos that are normal will be transferred until all euploid embryos are exhausted, or pregnancy is established;

9.2.1.1.4. All excess embryos to be frozen at blastocyst stage;
9.2.1.1.5. All excess cryopreserved embryos to be exhausted before new fresh cycle is started.

9.2.2. Bundle 2- Embryo Storage

Is a bundle that covers embryo cryopreservation, starting with one or more episodes of ovarian stimulation resulting in embryo(s) freezing, including consultation, investigation, monitoring, collection of oocytes, and fertilization.

9.2.2.1. To be offered when:
9.2.2.1.1. Genetic testing is required;
9.2.2.1.2. The patient is at risk for OHSS;
9.2.2.1.3. High progesterone level during the follicular phase P4> 1.5ng/ml;
9.2.2.1.4. Endometrial fluid or polyp found;
9.2.2.1.5. Elective freezing.

9.2.2.2. Patient who require embryo pooling as indicated in section 8.2.2;
9.2.2.3. Limit:
9.2.2.3.1. Maximum six retrievals (stimulated or natural) PPPY;
9.2.2.3.2. Resulting embryos could be used for PGTA (Preimplantation Genetic Testing for Aneuploidy), PGTM and/or PGT-SR;
9.2.2.3.3. All normal embryos following genetic testing will be transferred until exhausted, or pregnancy is established before another bundle cycle can be started;
9.2.2.3.4. For categories 9.2.2.1.2., 9.2.2.1.3, 9.2.2.1.4, 9.2.2.1.5. all frozen embryos will be transferred until exhausted, or pregnancy is established before another Bundle 1 or Bundle 2 cycle can be started;
9.2.2.3.5. Oncology patients: Due to the urgency for treatment usually only one cycle can be done. Exception would be in cases of borderline tumors where more stimulations can take place before definitive treatment.

9.2.3. Bundle 3- Frozen Embryo Cycle

Is a bundle of a frozen cycle including consultation and monitoring then thawing one embryo or more resulting in embryo transfer.

9.2.3.1. Prerequisite of Bundle 1 or Bundle 2 and availability of existing frozen embryos.
9.2.3.2. Limit:
9.2.3.2.1. Three embryo transfer cycles. i.e. (embryo transfer episodes originating from one or more ART cycles) PPPY;
9.2.3.2.2. All embryos that are normal will be transferred until all euploid embryos are exhausted, or pregnancy is established prior to the start of another cycle;

9.2.4. Bundle 4- Egg Storage

Is a bundle that covers eggs cryopreservation, starting with one or more episodes of ovarian stimulation resulting in eggs freezing, including consultation, monitoring investigation, and collection of oocytes.

9.2.4.1. To be offered Fertility preservation for:
9.2.4.1.1. Oncology patients

9.2.4.1.2. Genetic conditions such as fragile X premutation and mosaicism for monosomy;
9.2.4.1.3. Autoimmune diseases;
9.2.4.1.4. Endometriosis;
9.2.4.1.5. Women who have been identified as carrying a BRCA1 or BRCA2 genetic mutation and have an increased risk of developing ovarian cancer or as a risk-reduction measure for women at very high risk of breast cancer before definitive treatment;
9.2.4.1.6. Young women with borderline ovarian tumors where oocyte preservation is advisable. Oncology patients: Due to the urgency for treatment usually only one cycle can be done. Exception would be in cases of borderline tumors where more stimulations can take place before definitive treatment.

9.2.4.2. Limit:
9.2.4.2.1. Maximum six retrievals (stimulated or natural) PPP.

9.2.5. Bundle 5- Frozen Egg Cycle
Is a bundle of a cycle starting with thawing eggs and resulting in embryo transfer, including consultation, monitoring, fertilization, and embryos cryopreservation as required.
9.2.5.1. Prerequisite of bundle 4 and availability of frozen eggs from previous cycles.
9.2.5.2. Limit:
9.2.5.2.1. Three embryo transfer cycles. i.e. (embryo transfer episodes originating from one or more ART cycles) PPPY;
9.2.5.2.2. Oncology patients: Due to the urgency for treatment usually only one cycle can be done. Exception would be in cases of borderline tumors where more stimulations can take place before definitive treatment.

9.3. Payments for services outside the bundle:
9.3.1. The following services will be covered outside the bundles:
9.3.1.1. Genetic screening of embryos - requires pre-authorization;
9.3.1.2. All medications- requires Pharmacy Benefits Approval;
9.3.1.3. Oocyte and embryo storage on yearly basis and up to 5 years OR the maximum age of 45;
9.3.2. All other ART services other than IVF and ICSI to be reimbursed as per the mandatory tariff.

9.4. Payments for incomplete cycles within the bundles
9.4.1. Successfully completed step(s) of an incomplete bundle shall be reimbursed as per the service codes specified on the DoH claims and adjudication rules and based on rates officially communicated by DOH.

10. Billing and Coding Information

Details on billing and coding rules can be found in the billing and adjudication rules published for ART bundled payments.

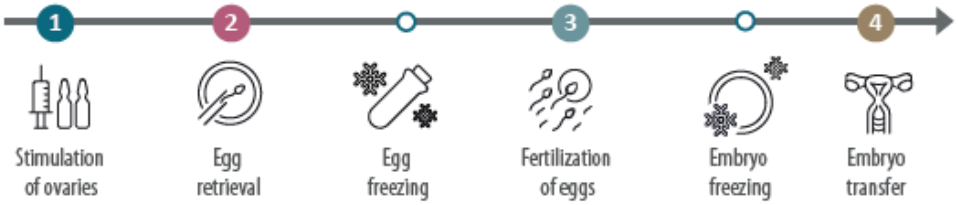
11. Enforcement and Sanctions

DOH-licensed healthcare service providers and the TPA (s) must comply with the terms and requirements of this Policy PPPY.

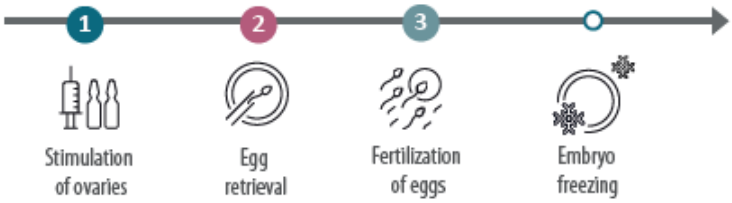
DOH may impose sanctions in relation to any breach of requirements under this Policy in accordance with the Disciplinary Regulation of the Healthcare Sector.

Appendix: ART bundle packages

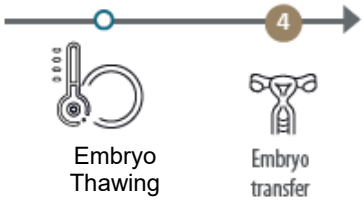
Bundle 1- Fresh Cycle



Bundle 2- Embryo Storage



Bundle 3- Frozen Embryo Cycle



Bundle 4- Egg Storage

Bundle 5- Frozen Egg Cycle