**INFERTILITY SERVICES**

**Guideline Number:** CDG.025.08  
**Effective Date:** February 1, 2019

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### RELATED COMMERCIAL POLICIES

- Infertility Diagnosis and Treatment
- Preimplantation Genetic Testing

**MEDICARE ADVANTAGE COVERAGE SUMMARY**

- Infertility Services

### COVERAGE RATIONALE

#### Indications for Coverage

Therapeutic (medical or surgical) procedures to correct a physical condition, which is the underlying cause of the Infertility, are a covered health service (e.g., for the treatment of a pelvic mass or pelvic pain, thyroid disease, pituitary lesions, etc.).

Services for the treatment of Infertility when provided by or under the care or supervision of a Physician are limited to the following procedures:

- Ovulation induction (or controlled ovarian stimulation);
- Insemination procedures: Artificial Insemination (AI) and Intra Uterine Insemination (IUI);
- Assisted Reproductive Technologies (ART).

To be eligible for Benefits, you must meet all of the following:

- You are a female under age 44.
- You are not able to become pregnant after the following periods of time of regular, unprotected intercourse or Therapeutic Donor Insemination:
  - One year, if you are a female under age 35.
  - Six months, if you are a female age 35 or older.
- You have Infertility not related to voluntary sterilization or to failed reversal of voluntary sterilization.

#### Surrogate/Gestational Carrier

A member with an Infertility benefit that is using a Surrogate/Gestational Carrier because of a known medical cause of Infertility (this does not include a member who has had a voluntary sterilization or a failed reversal of a sterilization procedure) will have coverage for the following services. These services will be paid per the member’s coverage.

- Female member’s ovary stimulation and retrieval of eggs are covered when a member is using a Surrogate (host uterus). **Note:** The implantation of eggs or oocytes or donor sperm into a host uterus is not covered even if the member has the Infertility benefit.
- Male member retrieval of sperm.

**When applying the Infertility benefit, consider the following:**

- Female Infertility: Infertility caused by a problem that results in the inability to produce an egg, if an embryo is unable to travel to the womb, or there is a process that prevents use of the womb for reproduction.
- Male Infertility: Infertility caused by problems due to inability to ejaculate or insufficient number or motility of sperm.

Check the member specific benefit plan document for inclusion or exclusion.

Some states mandate benefit coverage for Infertility services. Check state mandates.
When the member’s plan includes benefits for Infertility, the following services are not covered:

- Assisted Reproductive Technologies, ovulation induction and insemination procedures are excluded from coverage unless the member has a benefit for Infertility and the criteria listed in the Indications for Coverage section has been met.
- Preimplantation Genetic Testing – Monogenic/Single Gene Defects (PGT-M) and Preimplantation Genetic Testing – Chromosomal Structure Rearrangements (PGT-SR) unless the member has a benefit for Infertility that includes the Assisted Reproductive Technologies, the criteria listed in the Indications for Coverage section has been met, and the procedure is being performed for the diagnosis of known genetic disorders only when the fetus is at risk for an inheritable genetic disorder.
  - This would include, but is not limited to the following:
    - Autosomal dominant disorders;
    - Sex-linked (X or Y chromosome) disorders;
    - Autosomal recessive diseases for which very specific mutations in heterozygosity can lead to a phenotype;
    - Recessive disorders (e.g., Spinal Muscular Atrophy) where it is not atypical for an affected child to have inherited one of the deletions in a de novo fashion.
  - Check the benefit documents and state mandates for coverage of PGT-M or PGT-SR. PGT-M or PGT-SR may be considered a covered expense if the fetus is at risk for a genetic disorder.
- Preimplantation Genetic Testing – Aneuploidy (PGT-A)
- Cryo-preservation and other forms of preservation of reproductive materials, e.g., sperm, oocytes (eggs), embryos or ovarian.
- Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.
- Preservation of reproductive materials prior to cancer treatments and elective preservation of reproductive materials are not covered. This includes all services related, including but not limited to drug therapy, retrieval, cryopreservation and storage.
- Donor services for donor sperm, ovum or oocytes (eggs), or embryos.
  - Donor Eggs: The cost of donor eggs, including medical cost related to donor stimulation and egg retrieval is excluded. Cost for fertilization (in vitro fertilization or intracytoplasmic sperm injection), embryo culture, and embryo transfer may be covered if the member has an Infertility benefit that allows for Assisted Reproductive Technology.
  - Donor sperm: The cost of procurement and storage of donor sperm is excluded. However, the thawing and insemination are covered if the member has an Infertility benefit that allows for artificial donor insemination.
- In-vitro fertilization that is not an Assisted Reproductive Technology for the treatment of Infertility. This would include but is not limited to elective fertility preservation, embryo accumulation/banking.
- Any Infertility services or supplies beyond the benefit maximum (dollars or procedures).
- Infertility treatment when the cause of the Infertility was a procedure that produces sterilization, e.g., vasectomy or tubal ligation. (Check the member specific benefit plan document).

When the member’s plan does not include benefits for Infertility, the following services are not covered:

- All health care services and related expenses for infertility treatments, including Assisted Reproductive Technology, regardless of the reason for the treatment.
- Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
- In vitro fertilization regardless of the reason for treatment.

The following services are excluded on all plans (even when the plan provides benefits for Infertility):

- Surrogate Parenting: Services and treatments for a Gestational Carrier of a pregnancy that is not our member and all related services including, but not limited to:
  - Fees for the use of a Gestational Carrier or Surrogate.
  - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.
- Costs of donor eggs and donor sperm.
- Unproven tests or procedures for Infertility. Refer to the Medical Policy titled Infertility Diagnosis and Treatment.
- Self-injectable drugs for Infertility. Refer to the exclusion for self-injectable drugs in the member specific benefit plan document. Refer to the pharmacy benefit administrator for self-injectable medication benefit information.

Additional Information

- As a standard, coverage is provided for maternity services (prenatal, delivery and postnatal pregnancy) for our members. If a female member is pregnant and functioning as a Surrogate, coverage is provided for maternity services. Coverage is not provided for maternity services for a Surrogate that is not a member (see Surrogate Parenting exclusion above).
**DEFINITIONS**

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

**Assisted Reproductive Technology (ART):** The comprehensive term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs, and/or embryos) to achieve Pregnancy. Examples of such procedures are:
- In vitro fertilization (IVF)
- Gamete intrafallopian transfer (GIFT)
- Pronuclear stage tubal transfer (PROST)
- Tubal embryo transfer (TET)
- Zygote intrafallopian transfer (ZIFT)

**Gestational Carrier:** Female that carries the pregnancy but is not the source of the egg.

**Infertility:** A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or Therapeutic Donor Insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.

**Preimplantation Genetic Testing (PGT):** A test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA)-typing or for determining genetic abnormalities. These include:
- PGT-A: For aneuploidy screening (formerly PGS)
- PGT-M: For monogenic/single gene defects (formerly single-gene PGD)
- PGT-SR: For chromosomal structural rearrangements (formerly chromosomal PGD)

(Zegers-Hochschild et al., 2017)

**Surrogate:** A female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) to her uterus for the purpose of carrying a fetus for another person (Merriam Webster medical dictionary).

**Therapeutic Donor Insemination (TDI):** Insemination with a donor sperm sample for the purpose of conceiving a child. The donor can be an anonymous or directed donor.

**REFERENCES**

- Merriam Webster Medical Dictionary (Surrogate definition).

**GUIDELINE HISTORY/REVISION INFORMATION**

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<tr>
<th>Date</th>
<th>Action/Description</th>
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<tbody>
<tr>
<td>06/01/2019</td>
<td>Updated list of related policies; added reference link to the Commercial policy titled Preimplantation Genetic Testing</td>
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| 02/01/2019 | Reorganized policy template:  
|           | o Simplified and relocated Instructions for Use  
|           | o Removed Benefit Considerations section |
**INSTRUCTIONS FOR USE**

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

This Coverage Determination Guideline may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Coverage Determination Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

For self-funded plans with SPD language other than fully-insured Generic COC language, please refer to the member specific benefit plan document for coverage.