

## Infertility Services

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 [Instructions for Use](#)

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### Related Policies

- [Infertility Diagnosis and Treatment](#)
- [Preimplantation Genetic Testing](#)

## Applicable States

This Coverage Determination Guideline only applies to the states of Illinois and Maryland.

## Coverage Rationale

### Indications for Coverage

Check the member specific benefit plan document for inclusion or exclusion. Some states mandate benefit coverage for Infertility services. Refer to the state mandates.

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)

Covered health services include procedures to diagnose infertility and therapeutic (medical or surgical) procedures to correct a physical condition, which is the underlying cause of the Infertility (e.g., for the treatment of a pelvic mass or pelvic pain, thyroid disease, pituitary lesions, etc.).

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

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

For the purposes of this Benefit, "Therapeutic Donor Insemination" means using insemination with a donor sperm sample for the purpose of conceiving a child.

## ***Gestational Carrier or Surrogate***

A member with an Infertility benefit that is using a Gestational Carrier/Surrogate 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.

## **Benefit Limitations and Exclusions**

When the member's plan includes benefits for Infertility, the following services are not covered:

- Any Infertility services or supplies beyond the benefit maximum [dollars or procedure limit(s)].
- 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.
- Cryo-preservation and other forms of preservation of reproductive materials, e.g., sperm, oocytes (eggs), embryos or ovarian.  
Note: Certain plans may include coverage for Cryo-preservation. Refer to the member specific benefit plan document to determine if this coverage applies.
- Long-term storage (greater than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue.  
Note: Short Term storage under one year may be eligible for benefits.
- 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.
- Infertility treatment when the cause of the Infertility was a procedure that produces sterilization, e.g., vasectomy or tubal ligation.
- 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.
- 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 these services. Refer to the Coverage Determination Guideline titled [Preimplantation Genetic Testing \(PGT\) and Related Services](#) and 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.
- In vitro fertilization regardless of the reason for treatment.
- Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

Note: Refer to the Coverage Determination Guidelines titled [Fertility Preservation for Iatrogenic Infertility](#) and [Preimplantation Genetic Testing \(PGT\) and Related Services](#) as the above exclusions may not apply to benefits outlined in those policies; also check the member specific benefit plan document.

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

- Costs of donor eggs and donor sperm.
- 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.
- 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.
- Unproven tests or procedures for Infertility. Refer to the Medical Policy titled [Infertility Diagnosis and Treatment](#).

### ***Gestational Carrier or Surrogate***

The following services related to a Gestational Carrier or Surrogate:

- All costs related to reproductive techniques including:
  - Assisted Reproductive Technology (ART)
  - Artificial insemination
  - Intrauterine insemination
  - Obtaining and transferring embryo(s)
  - Preimplantation Genetic Testing (PGT) and related services
  - The exclusion for costs related to reproductive techniques does not apply when the Gestational Carrier or Surrogate is a Covered Person for whom Benefits are provided as described in the Indications for coverage section
- Health care services including:
  - Inpatient or outpatient prenatal care and/or preventive care
  - Screenings and/or diagnostic testing
  - Delivery and post-natal care

The exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.
- All fees including:
  - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees
  - Surrogate insurance premiums
  - Travel or transportation fees

### ***Additional Information***

- Advanced Reproductive Technology Services (IVF, GIFT, ZIFT, PROS, and TET) requested for reasons other than Infertility, must be reviewed in accordance with the member specific benefit plan document (case by case determination).
- 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 the [Surrogate Parenting](#) exclusion above).
- For information regarding preservation of reproductive materials prior to cancer treatments, refer to the Coverage Determination Guideline titled [Fertility Preservation for Iatrogenic Infertility](#).

### **Documentation Requirements**

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

Provide medical notes documenting all of the following:

- Initial history and physical
- Rationale for proposed treatment plan
- All ovarian stimulation sheets for timed intercourse, IUI and/or IVF cycles
- All embryology reports
- All operative reports
- Laboratory reports including, but not limited to, FSH, AMH, estradiol and any other pertinent information
- Ultrasound reports including, but not limited to, antral follicle count and any other pertinent information

- HSG report
- Semen analysis

## 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:** A female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The Gestational Carrier does not provide the egg and is therefore not biologically related to the child.

**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) for the purpose of carrying the fetus for another person.

**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

American Society for Reproductive Medicine. Patient Information Series. Age and fertility: a guide for patients. 2012d.

Pittsburgh Cryobank, Inc. Glossary of Terms. Available at: <https://pittsburghcryobank.com/glossary-of-terms/>. Accessed October 6, 2021.

Society for Assisted Reproductive Technology and American Society for Reproductive Medicine. Preimplantation genetic testing: a practice committee opinion. Fertil Steril. 2008 Nov; 90(5 Suppl):S136-43.

Zegers-Hochschild F, Adamson GD, Dyer S, et al. The International glossary on infertility and fertility care, 2017. Fertil Steril. 2017 Sep;108(3):393-406.

## Guideline History/Revision Information

Date	Summary of Changes
02/01/2022	<p><b>Coverage Rationale</b></p> <p><b><i>Benefit Limitations and Exclusions</i></b></p> <ul style="list-style-type: none"> <li>Added language to indicate: <ul style="list-style-type: none"> <li>Certain plans may include coverage for cryo-preservation; refer to the member specific benefit plan document to determine if this coverage applies</li> <li>Short-term storage (under one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue may be eligible for benefits</li> <li>[The exclusions listed in the policy] may not apply to benefits outlined in the following Coverage Determination Guidelines (also refer to the member specific benefit plan document): <ul style="list-style-type: none"> <li><i>Fertility Preservation for Iatrogenic Infertility</i></li> <li><i>Preimplantation Genetic Testing (PGT) and Related Services</i></li> </ul> </li> <li>All costs related to Preimplantation Genetic Testing (PGT) and related services for a Gestational Carrier or Surrogate are excluded from coverage</li> </ul> </li> <li>Revised language pertaining to Preimplantation Genetic Testing – monogenic/single gene defects (PGT-M) and Preimplantation Genetic Testing – chromosomal structure rearrangements (PGT-SR) to indicate these services are excluded from coverage unless the member has a benefit for Infertility that includes these services; refer to the Coverage Determination Guideline titled <i>Preimplantation Genetic Testing (PGT) and Related Services</i> and the member specific benefit plan document</li> <li>Added reference link to the Coverage Determination Guideline titled <i>Fertility Preservation for Iatrogenic Infertility</i> for information regarding preservation of reproductive materials prior to cancer treatments</li> </ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"> <li>Archived previous policy version IEX.CDG.025.02</li> </ul>

## 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.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, 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.