Infertility Services

Policy Number: MCS050.02
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Instructions for Use

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Related Policies
None

Coverage Guidelines

Infertility services are covered when Medicare criteria are met.

Infertility Tests and Treatments

Reasonable and necessary tests and treatments for infertility when fertility would be expected are covered. Refer to the Medicare Benefit Policy Manual, Chapter 15, §20.1 – Physician Expense for Surgery, Childbirth, and Treatment for Infertility. (Accessed July 27, 2021)

- Medical history
- General physical examination
  - Females: Examples include, but are not limited to:
    - Pelvic exam
    - Routine laboratory investigation for hormonal disturbances (e.g., FSH, LH, prolactin)
    - Cultures for infectious agents
    - Serum progesterone determination
    - Hysterosalpingogram
  - Males: Examples include, but are not limited to:
    - Semen analysis 2 to 3 times following 5 days of abstinence
    - Laboratory studies (e.g., FSH, LH, prolactin, serum testosterone)
    - Testicular biopsy when member has demonstrated azoospermia
    - Scrotal ultrasound, when appropriate for azoospermia

Non-Covered Infertility Services

Infertility services that are not covered

- Medicare does not have a National Coverage Determination (NCD) which specifically addresses infertility services. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.
- For coverage guidelines, see the UnitedHealthcare Commercial Medical Policy titled Infertility Diagnosis and Treatment. Note: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the policy referenced above for coverage guidelines.

Infertility services that are not reasonable and necessary for the treatment of illness or injury are not covered.
Refer to the Social Security Act Sec.1862 (a)(1)(A) and the Medicare Benefit Policy Manual, Chapter 16, §20 – Services Not Reasonable and Necessary. (Accessed July 27, 2021)
Examples include, but are not limited to:

- Infertility from a previous elective vasectomy or tubal ligation
- Inoculation of women with husband's white cells
- Microdissection of the zona or sperm microinjection
- For post-menopausal women
- Reversal of a previous elective vasectomy or tubal ligation
- Treatment of female sterility in which a donor ovum would be necessary (e.g., post-menopausal syndrome)
- Other infertility treatment when continued treatment has no reasonable chance to produce a pregnancy

Oral Prescriptions

Oral prescription medications such as Clomid (clomiphene citrate) are not covered.

Note: May be covered under the member's pharmacy benefit. See the Member's Pharmacy Booklet or contact the Prescription Solutions customer service department to determine coverage eligibility for UnitedHealthcare prescription drug plan benefit.

Non-Member Infertility Services

Infertility services for non-members (e.g., surrogate mothers who are not UnitedHealthcare Medicare members) are not covered.

Definitions

Infertility: Infertility is a condition sufficiently at variance with the usual state of health to make it appropriate for a person who normally is expected to be fertile to seek medical consultation and treatment. Medicare Benefit Policy Manual, Chapter 15, §20.1 – Physician Expense for Surgery, Childbirth, and Treatment for Infertility. (Accessed July 27, 2021)

Policy History/Revision Information

Date	Summary of Changes
08/17/2021	• Routine review; no change to coverage guidelines • Archived previous policy version MCS050.01

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The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). 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).

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