Coverage Summary

Infertility Services

Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee  Last Review Date: 08/18/2020

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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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I. COVERAGE

Coverage Statement: Infertility services are covered when Medicare criteria are met.

Guidelines/Notes:


   a. Medical history
   b. 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

2. 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 for Infertility Diagnosis and Treatment. (IMPORTANT NOTE: After searching the Medicare Coverage Database, if no LCD/LCA is found, then use the above referenced policy).
   • Committee approval date: August 18, 2020
   • Accessed August 4, 2020

3. Infertility services that are not reasonable and necessary for the treatment of illness or injury are not covered. See the Social Security Act Sec.1862 (a)(1)(A) and the Medicare Benefit Policy Manual, Chapter 16, §20 – Services Not Reasonable and Necessary. (Accessed August 4, 2020)

   Examples include, but are not limited to:
   a. Infertility from a previous elective vasectomy or tubal ligation
   b. Inoculation of women with husband’s white cells
   c. Microdissection of the zona or sperm microinjection
   d. For post-menopausal women
   e. Reversal of a previous elective vasectomy or tubal ligation
   f. Treatment of female sterility in which a donor ovum would be necessary (e.g., post-menopausal syndrome)
   g. Other infertility treatment when continued treatment has no reasonable chance to produce a pregnancy

4. 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.

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

II. 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 August 4, 2020)

III. REFERENCES

See above.

IV. REVISION HISTORY

08/18/2020 • Routine review; no change to coverage guidelines