**Coverage Summary**

**Infertility Services**

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<tr>
<td>Approved by:</td>
<td>UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td>Last Review Date: 09/18/2018</td>
</tr>
</tbody>
</table>

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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:
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- 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 lists infertility services that are not covered.
- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For state-specific LCDs/LCAs, see the LCD Availability Grid (Attachment A).
- For states with no LCDs/LCAs, see the UnitedHealthcare Commercial Medical Policy for Infertility Diagnosis and Treatment for coverage guideline.

(IMPORTANT NOTE: After checking the LCD Availability Grid and searching the Medicare Coverage Database, if no state LCD/LCA is found, then use the above referenced policy.)

- Committee approval date: August 21, 2018
- Accessed February 21, 2019

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 7, 2018)

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. In this policy, a condition sufficiently at variance with the usual state of health is defined as the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular attempts to conceive. Medicare Benefit Policy Manual, Chapter 15, §20.1 - Physician
III. REFERENCES

See above

IV. REVISION HISTORY

04/01/2019  • Updated policy introduction; added language to clarify:
  o There are instances where [the Coverage Summary] may direct readers to a
    UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy,
    and/or Coverage Determination Guideline (CDG)
  o 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*)
  • Retitled reference link that directs users to UnitedHealthcare Commercial policy

09/18/2018  Updated Local Coverage Determination (LCD) Availability Grid; removed instruction to “use the applicable LCD based on member’s residence/place and type of service” (this note only applies when selecting the appropriate DME LCD Policy)

08/21/2018  Annual review; no updates.

01/16/2018  Re-review with the following update:
  Guideline 2 (Infertility services that are not covered) - Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

08/15/2017  Annual review; no updates.

08/16/2016  Annual review; no updates.

05/17/2016  Re-review with the following update: LCD Availability Grid Links condensed.

09/15/2015  Annual review; no updates.

03/12/2015  Formatting change only.

10/21/2014  Annual review with following updates:
  • Guidelines #2 (Infertility services that are not covered) – Changed default for states without LCDs from LCD for Non-Covered Services (L29288) to UnitedHealthcare Medical Policy for Infertility Diagnosis and Treatment.
  • Guidelines #3 (Infertility services that are not reasonable and necessary for the treatment of illness or injury are not covered) – Added reference link to the Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage, Section 20 – Services Not Reasonable and Necessary.
  • Guideline # 3.b.(Infertility services for non-members ) – Moved to guideline #5.
  • Guideline # 3.e.(Oral prescription medications such as Clomid (clomiphene citrate), without supplemental pharmacy benefit) – Moved to guideline #4.
  • Definitions:
Infertility - Added reference link to the Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services section 20.1 - Physician Expense for Surgery, Childbirth, and Treatment for Infertility.

- Removed the definitions of: Artificial Insemination or Intrauterine Insemination (IUI), In-Vitro Fertilization (IVF) and Zygote Intrafallopian Transfer (ZIFT).

10/24/2013 Annual review; no updates.
10/31/2012 Annual review; no updates.
10/13/2011 Annual review; no updates.
11/30/2010 LCD links updated.
09/07/2010 Policy updated to include an expanded list of services that are not covered.

V. ATTACHMENT(S)

### Attachment A - LCD Availability Grid

**Non Covered Services – Infertility Services**

CMS website accessed February 21, 2019

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>L34555</td>
<td>Non-Covered Category III CPT Codes</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>NC, SC, VA, WV AL, GA, TN</td>
</tr>
<tr>
<td>L36954</td>
<td>Noncovered Services other than CPT® Category III Noncovered Services</td>
<td>MAC A and B</td>
<td>Palmetto GBA</td>
<td>SC, VA, WV, NC</td>
</tr>
<tr>
<td>L33777</td>
<td>Noncovered Services</td>
<td>A and B MAC</td>
<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
</tr>
<tr>
<td>L35008</td>
<td>Non-Covered Services</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK., ID, OR, WA, AZ, MT, ND, SD, UT, WY</td>
</tr>
<tr>
<td>L33392</td>
<td>Category III CPT® Codes</td>
<td>MAC - Part A and B</td>
<td>National Government Services, Inc.</td>
<td>IL, MN, WI, CT, NY, ME, MA, NH, RI, VT</td>
</tr>
<tr>
<td>L36219</td>
<td>Non-Covered Services</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AS, CA, GU, HI, MP, NV</td>
</tr>
<tr>
<td>L35094</td>
<td>Services That Are Not Reasonable and Necessary</td>
<td>A and B MAC</td>
<td>Novitas Solutions, Inc.</td>
<td>CO, NM, OK, TX, AR, LA, MS, DE, DC, MD, NJ, PA</td>
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End of Attachment A