Coverage Summary

Infertility Services

Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee  Last Review Date: 08/20/2019

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 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 20, 2019
   • Accessed December 11, 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 July 29, 2019)
   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 5, 2019)
III. REFERENCES

See above

IV. REVISION HISTORY

08/20/2019 Definitions
• Updated definition of “Infertility”

Attachments
• Updated Local Coverage Determination (LCD) Availability Grid to reflect the most current reference links

V. ATTACHMENT

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End of Attachment A