Basic Infertility Services

Policy Number: **M20260826041**

Effective Date: **10/1/2026**

Sponsoring Department: **Health Care Services**

Impacted Department(s): **Health Care Services**

Type of Policy: ☒ Internal ☒ External

Data Classification: ☐Confidential ☐Restricted ☒Public

Applies to (Line of Business):

☐ Corporate (All)

✦ State Products, if yes which plan(s): ☒MediSource; ☒MediSource Connect; ☒Child Health Plus; ☒Essential Plan

✦ Medicare, if yes, which plan(s): ☒MAPD; ☒PDP; ☒ISNP; ☒CSNP

✦ Commercial, if yes, which type: ☒Large Group; ☒Small Group; ☒Individual

☒ Self-Funded Services *(Refer to specific Summary Plan Descriptions (SPDs) to determine any pre-authorization or pre-certification requirements and coverage limitations. In the event of any conflict between this policy and the SPD of a Self-Funded Plan, the SPD shall supersede the policy.)*

Excluded Products within the Selected Lines of Business (LOB)

This section is intended to list specific LOB products that are excluded from adhering to this policy (due to differences in law/regulations). If not applicable, please indicate N/A.

Applicable to Vendors? Yes ☐ No☒

Purpose and Applicability:

To set forth the medical necessity criteria for Basic Infertility services.

Policy:

Background:

This medical policy addresses diagnostic testing to establish the diagnosis of infertility and basic infertility treatments. Basic infertility treatments can be medical treatments or surgical procedures.

Advanced infertility services are available for plans that have the New York State mandated in vitro fertilization (IVF) coverage or groups that cover IVF. For coverage of in vitro fertilization and related advanced infertility services, see the Independent Health Advanced Infertility Services Medical Policy.

For plans that have the New York State mandated fertility preservation services coverage, see the Independent Health Fertility Preservation Services Medical Policy.

For pharmacologic treatment of infertility please refer to the applicable Independent Health Pharmacy policies.

Documentation Requirements
Diagnostic work-up demonstrating infertility per medical policy must be documented in the medical record. Documentation of infertility history and treatment plan must be submitted for artificial insemination (usually intrauterine insemination) or for the use of injectable follicle stimulating hormone (FSH)-containing preparations.

Commercial and Self-Funded: basic infertility services, may be covered utilizing the criteria below.

Medicare Advantage: Basic fertility services are not a covered benefit for Medicare advantage members.

Child Health Plus: No basic or advanced infertility services for Child Health Plus.

Essential Plan: Infertility Treatment: Independent Health covers services for the diagnosis and treatment (surgical and medical) of infertility. "Infertility" is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. Earlier evaluation and treatment may be warranted based on a Member's medical history or physical findings.

Basic Infertility Services: Basic infertility services will be provided to a member who is an appropriate candidate for infertility treatment. In order to determine eligibility, we will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. Basic infertility services include:

- Initial evaluation
- Semen analysis
- Laboratory evaluation
- Evaluation of ovulatory function
- Postcoital test
- Endometrial biopsy
- Pelvic ultra sound
- Hysterosalpingogram
- Sono-hystogram
- Testis biopsy
- Blood tests
- Medically appropriate treatment of ovulatory dysfunction

Additional tests may be covered if the tests are determined to be medically necessary.

MediSource, MediSource Connect: Medicaid Managed Care plans cover ovulation enhancing drugs and the services related to prescribing and monitoring the use of such drugs. The ovulation enhancing drug benefit is limited to coverage for 3 cycles of treatment per lifetime.
The infertility medical benefit includes the office visits, x-rays of the uterus and fallopian tubes, pelvic ultrasounds and blood testing for infertility.
Independent Health MediSource and MediSource Connect (HARP) members are eligible for infertility services if they meet the following criteria:

- 21-34 years old and are unable to get pregnant after 12 months of regular, unprotected sex.
- 35-44 years old and are unable to get pregnant after 6 months of regular, unprotected sex.

- The inability of an individual to establish a clinical pregnancy due to sexual orientation or gender identity.

To implement Chapter 645 of the Laws of 2005, which seeks to ensure that the Medicaid program will not provide coverage for erectile dysfunction (ED) drugs, procedures, or supplies to convicted sex offenders, prior approval is required for electroejaculation (CPT Code 55870) with Independent Health. Prior approval requests for recipient's ineligible for ED services per Chapter 645 of the Laws of 2005 will be denied.

Medicaid Managed Care Exclusion:

- Any drug or services rendered in connection with any non-covered infertility procedure, including frozen embryo transfer (FET), IVF, GIFT, ZIFT program, cycle or treatment are not covered;
- Infertility treatments and/or FDA-approved drugs not indicated by the NYS mandate;
- Customer's age for treatment is less than 21 years or greater than 44 years

Indications/Criteria

In order to determine eligibility, Independent Health uses guidelines established by the American College of Obstetricians and Gynecologists, the American Society of Reproductive Medicine, and New York State Department of Financial Services.

Infertility is determined by **1 or more** of the following:

- The inability of opposite-sex partners to establish a clinical pregnancy after twelve months of regular, unprotected intercourse.
- The inability of opposite-sex partners to establish a clinical pregnancy after six months of regular, unprotected intercourse for a person with internal reproductive organs thirty-five years of age or older.
- The inability of an individual to establish a clinical pregnancy due to sexual orientation or gender identity.

Basic Infertility Services

The following basic infertility services are eligible for coverage when the above criteria are met:

- Initial history and physical exam of the covered partner.
- Education regarding infertility. Assessment for ovulatory dysfunction based on history (e.g., amenorrhea or oligomenorrhea) or testing (e.g., basal body temp recording, timed serum progesterone determinations, urinary luteinizing hormone (LH) surge monitoring, and/or endometrial biopsy.
- Laboratory evaluations and blood tests, as clinically indicated for the causes of infertility, such as hyperprolactinemia, thyroid disease, polycystic ovary syndrome, diminished ovarian reserve, (e.g., in cases of amenorrhea, grossly irregular cycles, luteal phase ≤10 days, or follicular phase ≤10 days).
- Cervical cultures as clinically indicated (e.g., history of prior cervical/pelvic infection or exam suggestive of active infection).
- Post coital test.
- Hysterosalpingogram (HSG) - optional in patients at low-risk for tubal disease, recommended for all others and in patients who have not conceived after three (3) clomiphene cycles. This is required for patients at high-risk for tubal disease (e.g., history of PID, tubal pregnancy).
- Sono-Hysterogram as clinically indicated (usually if abnormal bleeding pattern suggestive of uterine cavity abnormality, ultrasound evidence for intracavitary filling defect, or non-diagnostic HSG).
- Pelvic ultrasound study as clinically indicated (e.g., history and physical exam suggestive of endometriosis, myomas, congenital malformations, or PCOS).
- Ovulation induction and monitoring.
- Semen analysis
- Vasography, testicular biopsy or testicular fine-needle aspiration for evaluation of conditions such as obstructive or non-obstructive azoospermia.

- Endocrine evaluation including follicle-stimulating hormone (FSH) and total testosterone. Abnormal total testosterone results may require measurement of repeat total testosterone, free testosterone, luteinizing hormone (LH), Prolactin, and thyroid-stimulating hormone (TSH).
- Post-ejaculatory urinalysis should be performed with an ejaculate volume <1.0 mL, except in those with hypogonadism or CBAVD, to exclude retrograde ejaculation.
- Scrotal or transrectal ultrasound as clinically indicated.
- Intrauterine Insemination (IUI) or Artificial Insemination (AI).
    - A total of nine (9) cycles of artificial insemination (AI) or nine (9) intrauterine inseminations (IUI) per pregnancy.
    - Sperm washing is a covered benefit when done in conjunction with artificial insemination.
    - If donor sperm is used, related fees such as cost of sperm or preparation of the sperm will not be covered (except sperm washing).
    - Although the minimal number of sperm required to produce a pregnancy is not well established, a semen analysis within a year before a prior authorization request must indicate the presence of at least 1,000,000 motile sperm (before processing), since it is very unlikely that pregnancy will otherwise occur.
    - Ectopic pregnancy is included in the number of covered cycles.
- Surgical procedures
    - Operative laparoscopy or other surgical procedures (such as a laparotomy) for pelvic diseases such as adhesions or endometriosis is covered.
    - Laparoscopy and/or hysteroscopy as clinically indicated (e.g., abnormal HSG findings, ultrasound findings suggestive of endometriosis, history strongly suggestive of abnormal pelvic anatomy [e.g., history of pelvic infection or pelvic surgery likely to result in tubal disease]).
    - Varicocele surgery or other surgical procedure to correct infertility in persons with external reproductive organs, except when the infertility diagnosis is due to a previous voluntary sterilization procedure.
- Infertility Medications
    - For coverage of Clomiphene citrate, injectable FSH containing preparations, GnRH antagonists, GnRH agonists, and human chorionic gonadotropin please refer to the applicable Independent Health Pharmacy policies.

Exclusions

- Any drug or services rendered in connection with any non-covered infertility procedure, including in vitro fertilizations (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) procedures, cycle or treatment are not covered
- Gender selection is not covered
- There is no coverage for surgery to reverse a previous voluntary sterilization procedure
- Evaluation or treatment of infertility for customers who have undergone a previous voluntary sterilization procedure, or a reversal of a previous voluntary sterilization is not covered
- Donor fees including preparation or purchase of sperm and ovum (egg or embryo) are not covered
- Travel expenses
- Sperm banking is not covered
- Cloning is not covered
- Infertility treatments and/or FDA-approved drugs not indicated by the NYS mandate
- Specialized sperm retrieval techniques such as microsurgical epididymal sperm aspiration (MESA) percutaneous epididymal sperm aspiration (PESA), testicular sperm aspiration (TESA); or percutaneous biopsy of the testis (PercBiopsy) are not covered
- Any services related to infertility for an individual who is not a customer of MVP
- Surrogacy and associated infertility services performed in conjunction with surrogacy are not covered.
- Ovulation predictor kits

Investigational Exclusions:

Medical or surgical services or procedures for infertility that are deemed experimental or investigational are not covered in accordance with the guidelines and standards of the American College of Obstetricians and Gynecologists (ACOG) and the American Society of Reproductive Medicine (ASRM) which state: "A procedure for the treatment of infertility is considered experimental until there is adequate scientific evidence of safety and efficacy from appropriately designed, peer-reviewed, published studies by different investigator groups."

Pre-Authorization Required? Yes ☒ No ☐

Definitions

Enter definitions here. Remember to **bold** words throughout Policy section that require definitions. Definitions should be included when: 1) The word may be unclear or may mean something different, in different situations/contexts; 2) The word is not commonly used or known. Please refer to the Policy Writing Toolkit for additional information and direction.

References

Related Policies, Processes and Other Documents

Independent Health Advanced Infertility Services Medical Policy
Independent Health Fertility Preservation Services Medical Policy

Non-Regulatory References

American Society for Reproductive Medicine (ASRM). Definitions of infertility and recurrent pregnancy loss: a committee opinion. Fertil Steril. 2008; 90(Suppl 3):S60. Revised Fertil Steril® January 2013; 99:63. Available: Definitions of infertility and recurrent pregnancy loss - Fertility and Sterility

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Guzick D.S., Carson S.A., Coutifaris C., Overstreet J.W., Factor-Litvak P., Steinkampf M.P., et al. Efficacy of super ovulation and intrauterine insemination in the treatment of infertility. National Cooperative Reproductive Medicine Network [see comments]. N Engl J Med 1999; 340:177-83.

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Trans Care BC. Provincial Health Services Authority. Gender Inclusive Language. Available: Gender_Inclusive_Language_Clinical.pdf (phsa.ca).

Regulatory References

State of New York Insurance Law § 3216 (13), § 3221 (6) and § 4303 (1990, 2002, 2011).New York Insurance Law §§ 3221(k)(6)(New York Insurance Law §§ 3221(k)(6)(C) Laws of New York (state.ny.us)

New York Insurance Law §§ 4303(s)(3) Laws of New York (state.ny.us)

Version Control

Signature / Approval on File? Yes ☒ No☐

Revision Date	Policy Author / Owner	Notes
10/1/2026	Health Care Services	New Policy
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