POLICY AND PROCEDURE MANUAL

Policy Title: Infertility	**Policy Number: C.01**
Primary Department: Medical Management **Affiliated Department(s): N/A**	**NCQA Standard: N/A** **URAC Standard: N/A**
Last Revision Date: 09/2018 **Revision Dates: 02/21/2014; 10/31/2014; 07/29/2015; 09/28/2016; 08/23/2017; 08/24/2018; 05/2020** **Effective Date: 03/28/2014**	**Next Review Date: 05/2020** **Review Dates: 04/30/2014; 12/19/2014; 09/25/2015; 09/29/2016; 09/28/2017; 09/26/2018; 05/31/2021**
Applicable Lines of Business:☐MeridianCare ☒MeridianHealth ☐MeridianComplete ☒MeridianChoice	
Applicable States: ☐All ☒MI ☐IL ☐OH ☐_______ ☐________	
Applicable Programs: ☒All ☐Other ________________________	
Policy is to be published: Internally Only ☐ Internally & Externally ☒	

This policy applies to Michigan Medicaid and Individual plans only. For all other lines of business this service is considered not a covered benefit.

Definitions:

Infertility	The inability of a couple to conceive a child within a 12 month period of unprotected, frequent heterosexual intercourse if female partner is < age 35 or 6 months if female partner is > age 35.

Policy: As a provider of Medicaid managed care , Meridian Health Plan (MHP) must adhere to Medicaid regulatory and contractual requirements that exclude certain services from coverage and must ensure that services rendered meet standards for quality of care and cost effectiveness.
In accordance with Medicaid laws, Meridian Health Plan does not cover services or procedures for the treatment of infertility for males or females. Thus all services and supplies relating to treatments for infertility including (not an all-inclusive list) in vitro fertilization (IVF), artificial insemination, embryo testing, in vitro maturation (IVM), surrogacy assistance, and fertility drugs, and services to reverse sterilizations are not covered benefits.

Procedure:
Diagnostic evaluation of infertility is a covered benefit for members > age 18 and < age 45 if the procedure has been determined to be appropriate and medically necessary to diagnose the underlying cause of infertility and neither partner has had a previous sterilization procedure, with or without surgical reversal, and females have not undergone a hysterectomy.

Examples of covered diagnostic procedures include:

1. Female:
   - Hysterosalpingogram;

- Huhners' test;
- Hormone evaluation;
- Endometrial biopsy;
- Diagnostic Laparoscopy with or without Chromotubation or Hysteroscopy

2. Male:
    - Semen analysis;
    - Hormone evaluation;

Line of Business Applicability:
This policy applies to Michigan Medicaid and Individual plans.

For **Medicaid/Medicaid Expansion Plan** members, this policy will apply. Coverage is based on medical necessity criteria being met and the codes being submitted and considered for review being included on either the Michigan Medicaid Fee Schedule (located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html), or the Illinois Medicaid Fee Schedule (located at: http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx). If there is a discrepancy between this policy and either the Michigan Medicaid Provider Manual (located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html), or the Illinois Medicaid Provider Manual (located at: http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx) the applicable Medicaid Provider Manual will govern.

For **Individual** members, consult the individual insurance policy. If there is a discrepancy between this policy and the individual insurance policy document, the guidelines in the individual insurance policy will govern.

State specific special instructions:

None: ☐
MI:
IL:
OH:
Individual Plans: Cover diagnostic, counseling, and planning services for treatment of an underlying cause of infertility. This includes:

- Sperm count tests.
- Endometrial biopsy.
- Hysterosalpingography.
- Diagnostic laparoscopy.
- Prescription drugs to treat underlying causes of infertility.

Individual plans do not cover services and supplies relating to the actual treatment for infertility.

References:

1. Michigan Department of Community Health (MDCH). Medicaid Provider Manual, General Information for Providers Section 8.3. p. 29. Version Date: April 1, 2020
2. Illinois DHFS. Handbook for Providers of Hospital Services, Chapter H-204 Non-covered services, Policy and Procedures for Hospitals Services. Accessed Date: June 8, 2020.
3. CMS NCD 230.3
4. American Society for Reproductive Medicine. “Diagnostic Testing for Female Infertility”. Revised 03/15/18
5. American Society for Reproductive Medicine. “Diagnostic Testing for Male Factor Infertility”. Revised 11/22/19
6. World Health Organization. Sexual and Reproductive Health. Infertility Definitions and Terminology. WHO 2020

State Letters/Bulletins					
CMS National/Local Coverage Determination (NCD/LCD)	NCD 230.3				
Medicare Managed Care Manual:					
Medicaid CFR:					
State Administrative Codes:					
Contract Requirements:					
Related Policies:					