Infertility Diagnosis and Treatment

Reimbursement Policy ID: RPC.0041.0900

Recent review date: 05/2025

Next review date: 06/2026

AmeriHealth Caritas New Hampshire reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas New Hampshire may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses reimbursement for diagnosis and treatment of infertility. AmeriHealth Caritas New Hampshire considers the use of any diagnostic service for evaluation of male or female infertility to be non-reimbursable. Other services may be reimbursable except when related to infertility, including, but not limited to, hysterosalpingography, vasography, vesiculography, epididymography, and thyroid panel.

AmeriHealth Caritas New Hampshire considers the use of any medical procedure or pharmaceutical product related to treating infertility, including assisted reproductive technology, to be non-reimbursable.

Exceptions

The use of cryopreservation fertility preservation for patients with cancer is reimbursable.

Reimbursement Guidelines

The plan covers infertility services limited to determining the cause and treatment of medical condition(s) causing infertility. For example, thyroid dysfunction screening is reimbursable if the patient has a history of infertility.

Definitions

Infertility
For this policy, infertility is defined as failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse with the same partner or due to an impairment of a person's capacity to reproduce either as an individual or with their partner.

Edit Sources

I. Current Procedural Terminology (CPT).
II. Healthcare Common Procedure Coding System (HCPCS).
III. International Classification of Diseases,10th revision, Clinical Modification (ICD-10-CM), and associated publications and services.
IV. American Society of Reproductive Medicine, 2017.
V. Applicable New Hampshire Medicaid Fee Schedule(s).
VI. https://www.amerihealthcaritasnh.com/assets/pdf/provider/resources/clinical/policies-20221130/ccp1424-thyroid-dysfunction-screening.pdf
VII. https://www.amerihealthcaritasnh.com/assets/pdf/member/eng/member-handbook.pdf

Attachments

N/A

Associated Policies

N/A

Policy History

06/2025	Minor updates to formatting and syntax
05/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
03/2025	Annual policy review • No major changes
07/2024	Reimbursement Policy Committee Approval
04/2024	Revised preamble
09/2023	Reimbursement Policy Committee Approval

08/2023	Removal of policy implemented by AmeriHealth Caritas New Hampshire from Policy History section
01/2023	Template revised • Preamble revised • Applicable Claim Types table removed • Coding section renamed to Reimbursement Guidelines • Associated Policies section added