ADMINISTRATIVE POLICY STATEMENT
Georgia Marketplace

Policy Name & Number	Date Effective
Iatrogenic Infertility-GA MP-AD-1585	01/01/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject
Iatrogenic Infertility

B. Background
An individual may be entitled to coverage for standard fertility preservation services when a medically necessary treatment for cancer, sickle cell disease, or lupus may directly or indirectly affect fertility. Fertility preservation is an essential consideration when undergoing treatment for these disease processes. The American Society of Clinical Oncology (ASCO) and the American Society for Reproductive Medicine (ASRM) have published medical guidelines, which outline criteria for fertility preservation services.

Fertility preservation services for males includes sperm cryopreservation, which can be collected either by extraction or by providing a sample. Females may undergo embryo, oocyte, and/or ovarian tissue extraction for cryopreservation. It is recommended that fertility preservation services be conducted prior to treatment for the underlying disease to achieve the best outcomes.

C. Definitions
- **Iatrogenic Infertility** – An impairment of fertility caused directly or indirectly by a medically necessary treatment for cancer, sickle cell disease, or lupus.
- **Medically Necessary Treatment** – A medically necessary treatment for cancer, sickle cell disease, or lupus that may result in iatrogenic infertility. This treatment includes but is not limited to the surgical removal of the primary or secondary reproductive organs, chemotherapy, radiation therapy, and bone marrow transplantation.
- **Standard Fertility Preservation Services** – Procedures to preserve fertility that align with established medical practices or professional guidelines. Such services include but are not limited to egg, sperm, embryo, and ovarian tissue cryopreservation.

D. Policy
I. Beginning January 1, 2026, CareSource will cover standard fertility preservation services due to iatrogenic infertility from a medically necessary treatment, as defined above.

II. Members may undergo referrals to fertility specialists prior to initiating medically necessary treatment to ensure timely and comprehensive consideration. Coverage includes evaluation expenses, laboratory assessments, medications, and treatments associated with standard fertility preservation services, including storage of gametes for up to 1 year.

III. In addition to MCG Care Guidelines, the ASCO and the ASRM have published medical guidelines regarding standard fertility preservation services.

E. Conditions of Coverage
N/A

F. Related Policies/Rules
N/A

G. Review/Revision History

	DATE	ACTION
Date Issued	09/24/2025	Approved at Committee.
Date Revised		
Date Effective	01/01/2026	
Date Archived		

H. References

1. GA REV. CODE § 33-24-59.34 (2026).
2. Practice guidance. American Society for Reproductive Medicine. Accessed September 24, 2025. www.asrm.org
3. Su HI, Lacchetti C, Letourneau J, et al. Fertility preservation in people with cancer: ASCO guideline update. *J Clin Oncol*. 2025;43(12):1488-1511. doi:10.12000/JCO-24-02782