Money-Back Fertility Treatment Payment Plans

Money-Back Payment Plans

Money-back fertility treatment payment plans or shared risk plans are payment plans that offer unsuccessful patients a portion of their money back. They usually include two or three fresh IVF cycles followed by the transfer of resulting frozen embryos. Money – back fertility plans commonly include fertility financing programs, fertility medication program and some re-arrange or restrict benefits through employer (sponsor) or insurance plan. All together called the bundle.

Who Qualifies for Money-Back Fertility Treatment Payment Plans?

IVF programs that offer money back plans usually require certain age limits and normal to excellent ovarian reserve markers. Older women and those with low egg reserve usually do not qualify for such plans. Programs also place contingencies on ovarian reserve and transferring more embryos. Hence they exclude women interested in a single embryo transfer.

Some of the money – back fertility enterprise do not operate clinical IVF programs. They offer the financial scheme for payment and in some instances fertility drugs. They refer patients to clinics but do not conduct the treatment. The specifics of the couple may not coincide with the contingencies for money – back arrangement. The result is either you are alert to dismiss the plan or follow the plan and take your chances with the success rate. This is the most disturbing aspect of money-back fertility plans.

The delivery rates after fresh IVF in women commonly included in money back plans is close to 40% with single embryo

transfer, 50% with two embryo transfer. Use of frozen embryos add approximately 30% chance for delivery after transfer of frozen embryos from the first fresh IVF cycle. In other words they are the least likely to require multiple cycles in the IVF population. Moreover, they are the most likely to get pregnant with multiple babies. The cost for money back fertility treatment plan is maybe higher than a single fresh IVF cycle and a transfer of frozen embryos. Interest is associated with monthly payment plans. Medicine and multiple treatment cycles are also sometimes bundled. In addition cost can escalate due to obstetric care for multiple pregnancy.

At New York City IVF we educate women and recommend single embryo transfer up to age 38.

One opinion about money back fertility treatment plans is New York State Department of Health Task Force Report: Executive Summary on ART

> *Payment plans that offer unsuccessful patients a portion of their money back create significant ethical concerns.*
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> *Physicians whose payment depends on the success of treatment have an incentive to accept only those patients with a strong chance of success (perhaps patients who do not qualify as infertile under generally accepted standards) and to turn away needy patients whose outcome may be less certain. In addition, when payment is linked to outcome, physicians may encourage patients to accept aggressive treatments that increase the chance of success without due regard for the risk those treatments may entail.*
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> *Nonetheless, while the Task Force members are deeply troubled by the risks created by money-back payment plans, they do not believe that these plans are inherently unethical in all cases. Programs that offer money-back payment plans should clearly inform patients of all essential terms of the plan. No plan should require patients to provide a blanket consent*

> *to all treatments and procedures recommended by their physician.*
>
> *Patients enrolled in money-back payment plans should receive a prorated refund if they withdraw from treatment before they have completed all of the cycles covered under the plan. The most appropriate definition of "success" in the context of money-back payment plans is a live birth. The condition of the child should never be a factor in the definition of success*

IVF programs can address this ethical question using different arrangement. Reducing fees for the second cycle as opposed to selling multiple cycles together would be one suggestion.

Male Factor Infertility: Azospermia

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Male Factor Infertility: Azospermia means no sperm are found in the ejaculate. Azospermia requires careful evaluation and treatment so that the couple has the best chance to conceive with IVF. The evaluation should be methodical and compassionate to guide the couple through such a multifaceted process to pregnancy and delivery of a healthy child.

Four Things Have to Happen at Initial

Evaluation for Azospermia

a. Is it truly azospermia? sometimes repeat sperm analysis together with spinning of the ejaculate multiple times may yield few sperm. This has to be performed by a diligent andrologist and in a facility that can freeze sperm immediately if found. In some azospermic men, repeat analysis and freezing can avoid a surgical procedure to retrieve sperm.

b. A genetic cause for azospermia should be excluded. Specifically three known genetic problems should be excluded because they can be passed to offspring and because they can predict the success of surgical sperm retrieval. A chromosome analysis should be done to exclude sex chromosome abnormalities e.g klinefelter Syndrome (47XXY). Y chromosome microdeletion study should be conducted to exclude a deletion of the part of Y chromosome related to sperm production. Cystic fibrosis carrier screening should also be run to detect defect in the CF gene that may be associated with absence of the ducts conducting the sperm outside of the testes.

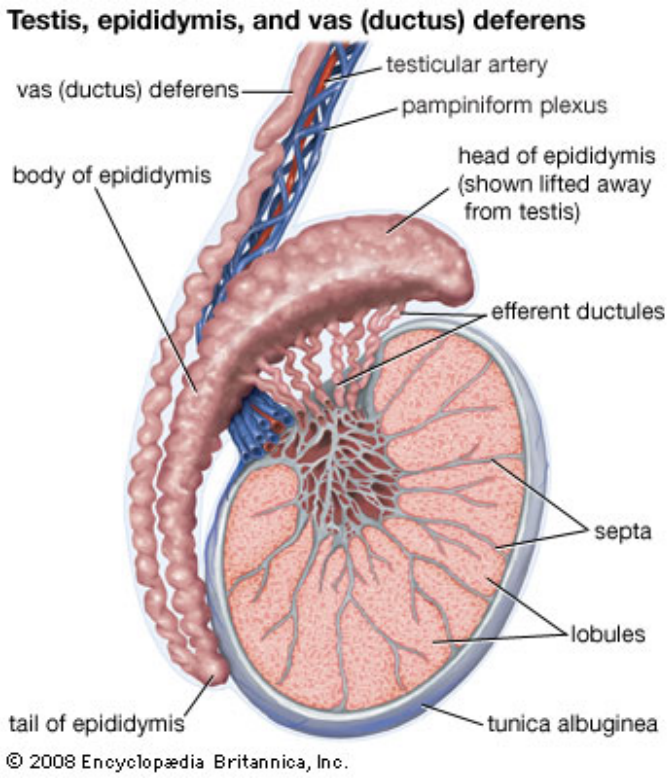
c. Evaluation of Ovarian Reserve for Female Partner. If ovarian reserve evident by day 3 FSH, AMH levels and antral follicle count seen on vaginal ultrasound is not diminished, this predicts reasonable chance for success with IVF-ICSI if sperm are found. Extremely low ovarian reserve or advanced female age may preclude surgical sperm retrieval, unless an donor eggs are acceptable.

d. Urological evaluation. This has to be the last step in evaluation. Male urologists are the physicians specializing in evaluating the chance for successful sperm retrieval (TESE) as well perform these procedures. Before referral by a reproductive endocrinologist and infertility specialist, there should be every reason to think that if sperm were obtained there is a reasonable chance for conception after IVF-ICSI. The urologist should be a specialist in male reproduction and well versed in the techniques of sperm retrieval. You actually

need to ask your urologist two questions: what are my personalized chance for finding sperm when surgery (TESE) is performed? What the technique used to obtain sperm? Authorities generally agree that the technique for TESE markedly affect the chance for finding sperm.

Moreover, every workup should end with an important question; would you accept donor sperm if no sperm were obtained after surgery?

How is TESE Performed?



Testes and ducts

Testicular sperm extraction is a surgical procedure that entails sampling of multiple areas of the testes aiming at finding sperm to be used for IVF-ICSI. The tested is delivered outside the scrotum, bisected and multiple biopsies obtained from several areas of the testes. The tissue is examined for the presence of sperm. If no sperm were found, more biopsies are obtained till sperm are found. There are generally two types of azospermia: obstructive azospermia (due to

obstruction of the ducts of the testes while sperm production is intact). Sperm is obtained in close to 100% of these cases. Non-obstructive azospermia (NOA) where is a defect in sperm production, approximately 60 to 70% of the procedures yield sperm.

Blind biopsy from one area of the testes has no place in modern treatment of azospermia. Asking your urologist about the technique of TESE is of paramount importance. The first surgical attempt carries the highest chance for success.

Recently, Doppler ultrasound mapping of the testes can help localize the areas of that should be biopsies because they yield a higher chance for finding sperm.

Why is IVF-ICSI Required after Sperm Retrieval?

The number of sperm obtained after TESE is small in the magnitude of tens to hundreds of sperm, too small to use the sperm for IUI. ICSI is absolutely required for all cases of surgical retrieval of sperm. The sperm can be used in one of two ways

a. Frozen TESE sperm: The sperm are frozen to be thawed at a later date, on the day of egg retrieval for the female partner. This method saves the cost of IVF if no sperm were retrieved and donor sperm use is unacceptable.

b. Fresh TESE sperm: Ovarian stimulation is started and TESE is performed on the day of egg retrieval or the day before. Fresh sperm are used for ICSI. Donor sperm (if acceptable) is obtained as a backup. Though suggested, there no concrete evidence that fresh TESE sperm is superior to frozen TESE sperm.

In addition in some caes with associated genetic problems, preimplantation genetic diagnosis (PGD) can be performed

followed by the transfer of normal embryos.

Can the Chance for Pregnancy be predicted in Male Factor Infertility: Azospermia ?

There are several predictive factors for pregnancy in female partners of men with azospermia. These can be categorized into:

i. Successful sperm retrieval is related to whether the procedure is the first one or a repeat procedure, the volume of the testes, medical treatment before surgery, the technique used and the cause for azospermia. Some causes are associated to minimal chance for obtaining sperm.

ii. Pregnancy after sperm retrieval is related to the female partner age and her ovarian reserve. Younger women have a very good chance of conceiving if sperm are obtained. This is the most important factor once sperm are retrieved.

iii. Obstructive azospermia has a higher chance for sperm retrieval than non-obstructive azospermia.

iv. Moving sperm at the time of ICSI has a higher chance to yield a pregnancy than non moving sperm

v. Men with higher testosterone levels and lower LH levels has higher chance of sperm retrieval

vi. The effect of using of frozen TESE sperm is controversial. Some authorities think that using a fresh TESE sperm is better than frozen sperm.

vii. Use of Doppler: recent work indicates that the use of Doppler study of the testes before the procedure may help localize the areas that should be biopsies and yield a higher chance for sperm harvest.

Male Factor Infertility: Azospermia requires a

multidisciplinary approach; first consultation with a reproductive endocrinologist (female age is still the most important factor) followed by a consultation with a reproductive urologist for the TESE procedure for successful sperm harvest and pregnancy

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Hepatitis C: what do you need to know if trying to conceive

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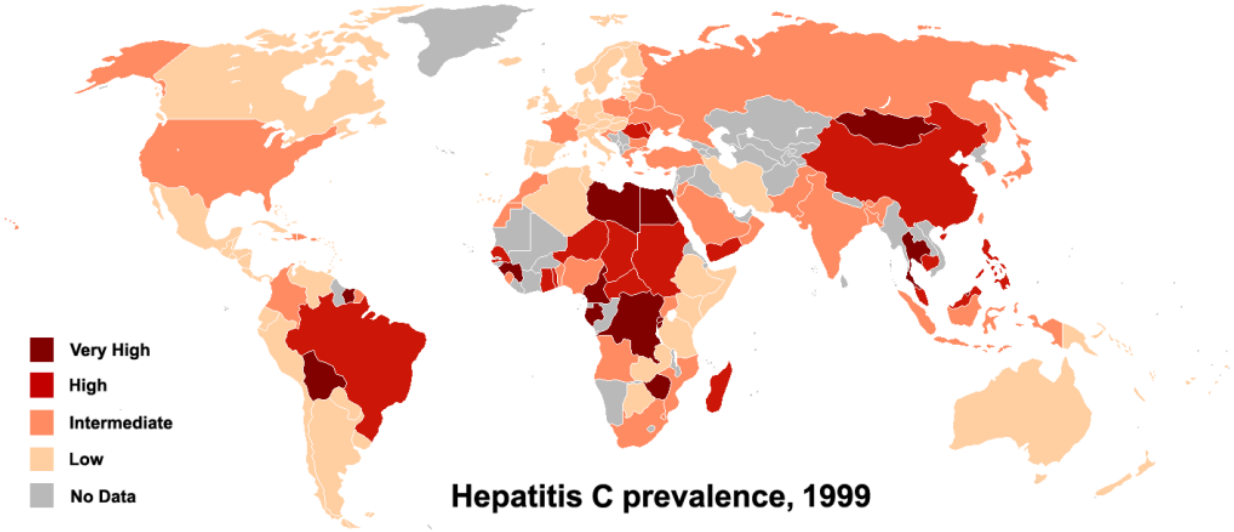
Hepatitis C Infection

Hepatitis C Virus (HCV) infects 3% of the world's population. Over 170 million chronic carriers. Approximately 2.7 million Americans (1.8%) are infected with HCV in addition to 30,000 new cases reported yearly. In the United States, 65% of persons with HCV infection are aged 30-49 years. There are several types of the virus that vary in geographical distribution and response to medications.



Genotype 1a occurs in 50-60% of patients in the United States. Genotype 1b occurs in 15-20% of patients in the United States; this type is most prevalent in Europe, Turkey, and Japan. Genotype 1c occurs in less than 1% of patients in the United States

Genotypes 2a, 2b, and 2c occur in 10-15% of patients in the United States; are widely distributed and are most responsive to medication

Genotypes 3a and 3b occur in 4-6% of patients in the United States; most prevalent in India, Pakistan, Thailand, Australia, and Scotland

Genotype 4 occurs in less than 5% of patients in the United States; it is most prevalent in the Middle East and Africa

Genotype 5 occurs in less than 5% of patients in the United States; it is most prevalent in South Africa

Genotype 6 occurs in less than 5% of patients in the United States; it is most prevalent in Southeast Asia, particularly Hong Kong and Macao

Transfusion of blood contaminated with HCV was once an important source of transmission. Since 1990. Persons who inject illegal drugs with non-sterile needles or who snort

cocaine with shared straws are at now at the highest risk for HCV infection.

Transmission of HCV to health care workers may occur via needle-stick injuries or other occupational exposures. Nosocomial patient-to-patient transmission may occur by means of a contaminated colonoscope, via dialysis, or during surgery, including organ transplantation before 1992.

HCV may also be transmitted via tattooing, sharing razors, and acupuncture. The use of disposable needles for acupuncture, which has become standard practice in the United States, eliminates this transmission route. Other uncommon routes of transmission of HCV, which affect less than 5% of the individuals at risk, include high-risk sexual activity and maternal-fetal transmission. 10% unknown.

Tests for detecting hepatitis C virus (HCV) infection include:

- Hepatitis C antibody testing
- Recombinant immunoblot assay
- Qualitative and quantitative assays for HCV RNA
- HCV genotyping

Hepatitis C Treatment

Significant progress in the treatment of hepatitis C infection took place in the past year. Several medications or combinations can lead to cure in about 10 weeks in the majority of hepatitis C infected patients. Medications include Sovaldi (sofosbuvir 400 mg), Harvoni (ledipasvir (90 mg)/sofosbuvir 400 mg) or Vikera pak, with or without ribaverin.

One treatment regimen is a single daily tablet of ledipasvir 90mg / sofosbuvir 400mg for 8 to 24 weeks (according to genotype, viral load and functional status of the liver).

Hepatitis C and Reproduction

Significant effort is excreted by reproductive endocrinologist to detect hepatitis C and other viral infections and to prevent the transmission of hepatitis C to women and babies during reproduction.

Intimate partners: both partners are screened for HCV antibodies. If one partner is infected, he or she is referred for treatment with one of the modern drug regimens for 8 to 12 weeks before fertility treatment. If viral load does not drop to an undetectable level then a protocol exists for infected men to test semen for the virus and use the frozen sperm for IVF and ICSI to minimize transmission to mother and baby.

Egg and sperm donors: extensive history, exam and screening for donors is performed. Those with high risk factors are excluded. Donors with no risk factors are further tested using hepatitis C antibody and hepatitis C RNA performed in an FDA approved lab. Sperm donors are tested before sperm donation, sperm are quarantined for 6 months and the donor is retested again before releasing sperm. Egg donors are tested in an FDA approved lab within one month of egg retrieval. So far, there is no reported case of hepatitis C transmission after sperm or egg donation.

Gestational carriers: Intended parents are screened in an FDA lab for viral infections to minimize transmission to surrogates. Gestational carriers are also screened to prevent transmission to the baby.

Frozen sperm, eggs and embryos: liquid nitrogen in storage tanks can very rarely transmit infection. All patients are screened before storage. Tissues and cells can be stored in nitrogen vapor and sealed devices. Liquid nitrogen can also be filtered and sterilized using ultraviolet rays.