

Debunking the Myth Behind Insurance Coverage for Oncofertility Treatment



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Fertility treatment is expensive. The average cost of a live-birth baby using assisted reproductive technology (ART) is more than \$40,000. ART includes hormonal therapy, procedures including egg retrievals and embryo transfers, and cryopreservation of eggs, sperm, and/or embryos. For

oncology patients, who already face the high costs of surgical procedures, chemotherapy, and multiple hospitalizations, this added cost is especially challenging. As such, cancer patients will often avoid pursuing reproductive technology options.

Most services are cash-pay, as many patients and providers believe commercial insurance plans do not offer coverage. Many providers have been denied when submitting for authorization, but do not appeal this denial. Even more concerning is the practice of providers assuming there will not be coverage for treatment and, as a result, do not submit authorizations to health plans.

Many oncofertility providers rely on charitable organizations, such as The Lance Armstrong Foundation and Fertile Hope, to aid cancer patients who are limited financially. However, with only a few small changes to the submission process, many of our oncology patients can be granted coverage for their treatment plan, allowing the charitable funds to be distributed to more patients following receipt of initial insurance benefits.

Ninety percent of commercial insurance plans are regulated by the California Department of Managed Health Care (DMHC). This includes many private and Medi-Cal plans. While a minority of insurance/HMO policies cover "infertility" treatment, fertility preservation falls more into the bucket of cancer treatment, like wigs and reconstruction. Do not let lack of infertility coverage dissuade an attempt for coverage. If the treatment is medically indicated, as is noted in the American Society of Clinical Oncology guidelines, it should be covered.

While denials of coverage are common, don't stop there. Both the DMHC and Department of Insurance have procedures in place to have Independent Medical Reviews (IMR). Approximately 60 percent of denials are overturned. In urgent cases, the IMR process should take no more than 72 hours. Fertile Action and the Alliance for Fertility Preservation are now pushing to educate physicians and patients about the IMR option. Once a number of denials are overturned, the DMHC can issue a letter to the insurers/HMOs to make clear that these are covered services.

We ask that instead of relying on cash-pay and charitable organizations, all providers should submit for prior-authorization for all cancer patients receiving fertility treatment. When submitting for insurance coverage, use the patient's cancer diagnosis and always write "URGENT" on authorization forms. If a request for approval is originally denied, always appeal to the respective insurance carrier. If the request is declined, you and your patients can request an IMR from the state of California through the DMHC. Useful V codes include:

- "Encounter for fertility preservation counseling" - V26.42
- "Other specified procreative management" - V26.82.

Helpful CPT codes include the following:

- Embryo or oocyte cryopreservation include monitoring and lab visits – 99213

- Semen cryopreservation – 89259
- Semen analysis – 89320
- LH level – 83002
- Progesterone level – 84144
- FSH level – 83001

Regardless of your spectrum of practice, you may come across a patient, friend, or family member who may need oncofertility treatment. Keep in mind that fertility preservation may be needed for a condition where the treatment could render the person infertile, such as transgender transition care or stem cell transplants for sickle cell disease. Be a champion for authorization and help mitigate the myth that coverage does not exist.