**Vasectomy Reversal Instruction**

**Prior to the procedure**
- Contact the Surgery Center regarding specific instructions, direction and payment.
- Sign the enclosed consent form for vasovasostomy.
- Avoid aspirin, vitamin E or Motrin-like product for one week. You may take Tylenol prior to surgery.
- Speak to your doctor about stopping other blood thinners such as Plavix or Coumadin prior to surgery. These could result in excess bleeding after any surgical procedure.

**The day before and the morning of the procedure**
- Familiarize the location of the surgery center and allow enough time to arrive.
- Shower the night before and the morning of the procedure and GENTLY wash the genital area with soap, no scrubbing to avoid abrasion or roughing of the skin.
- Do Not shave the genital area; we will do so right before the procedure.
- Nothing by mouth for at least 8 hours before the procedure; you may take routine medication with a sip of water.

**After the procedure**
- Apply ice pack for 8 hours.
- Long-acting local anesthetic will be applied at the end of the procedure to alleviate the immediate pain for 3 to 4 hours. Do not be alarmed if you begin to notice pain a few hours later as the local anesthetic wears off.
- You may shower in 24 hours, no bath for 7 days.
- Sutures are dissolvable and will fall off in several weeks.
- Intravenous antibiotic will be given at the time of the procedure and will be used postop.
- Off your feet and take it easy for 3 to 5 days following VV and 5 to 7 days following EV. Wear scrotal support for 2 weeks.
- No heavy exercising or running for 3 weeks; you may walk and do weight training in 2 weeks.
- No intercourse or biking for 6 weeks.
- Please call the office for an appointment in 2 to 3 weeks unless you live afar.
- The first semen analysis will be at a 3-month postop, which we perform to check for patency; formal analysis will be obtained in 6 months.

**Follow-up appointment**
We realize that some of our patients may come from a considerable distance, including foreign countries. There are several hotels close by. The nearest hotel is the Comfort Suites on Orange Avenue: Comfort Suites, 2416 North Orange Avenue, Orlando, Florida 32804, (407) 228-4007

www.wpurology.com
Financial Policy and Fee Schedule

- The approximate fee for vasovasostomy is $7,500, inclusive of the surgery and anesthesia charges. Routine postop care and initial office semen analyses are included as part of the package. Please note that we perform all procedures at an accredited full service surgery center with board certified anesthesiologists. This fee may vary depending on the time of anesthesia.

- Full payment must be made in order to schedule the procedure. We accept cashier's check, MasterCard, Visa, Discover or American Express. We accept personal checks, with the provision that bank clearance is required 2 weeks prior to the procedure. The anesthesiologist requires payment by check or cash.

- We do not offer any extended payment plan.

- A cancellation fee of $500 will be charged if the surgery is canceled within two weeks of scheduled procedure date.

- Insurance coverage and reimbursement: As discussed in "Vasectomy Reversal 101." Insurance companies very infrequently cover for reversal. In the event that the procedure is covered, payment policy is the same. We will assist you in filing for the procedure with your insurance carrier, but we will not file on your behalf.

- All fees are subject to change without notice.
About the Surgical Procedure

Q: Exactly what happens during vasectomy reversal?
A: Simply stated, we undo the vasectomy in vasovasostomy and bypass the blockage. In VV, a small incision is made on either side of the scrotum and the vas deferens is examined. The vasectomy site and the vas deferens are identified and excised back to healthy tissue. The side of the vas is now unblocked and typically oozes fluid of various consistencies, depending on the obstructive interval. For VV, the ends are then brought together and reconnected, using surgical sutures with the aid of an operative microscope. A modified one-layer technique may be used, depending on the surgeon's preference and the degree of vas lumen disparity. In EV, a larger incision will be needed to gain access to the epididymis. The vasectomy site is similarly approached and excised. The thick fluid consistency and the lack of sperm will mandate the performance of EV. The epididymis is examined and a single tubule is selected for the bypass. Various techniques have been used to connect the vas to the epididymis. The current approach relies on invaginating the epididymal tubule to the lumen of the vas. The approach or its variations has the distinct advantage of being easier to perform and has a higher success rate when compared with the traditional "end-to-side" technique.

Q: Will local anesthesia with sedation suffice?
A: In my experience, local anesthesia is inadequate and is not used in my vasectomy reversal. The problem with local anesthesia is that the patient will have to remain still for an extended period of time despite sedation. The delicate nature of the procedure and the greatly magnified operative field do not allow for any patient movement. Despite being touted by some as a money-saving alternative, local anesthesia has not gained popularity among the majority of surgeons for vasectomy reversal.

Q: What about two-layer vs. modified one-layer vasectomy reversal?
A: Depending on the surgeon's preference and the size difference between the ends of the vas, one may choose either one of above. In two-layer reversal, the lining of the vas lumen and the inner thickness are incorporated in the first layer of suture closure. The outer aspect is then approximated with the second layer of suture.

In modified one-layer reversal, the initial layer incorporates the full thickness of the vas, including the lining. This is the approach I prefer.

With either technique, one may then choose to further reinforce using the surrounding soft tissue coating. Success rate with either approach is the same (VVSG, 1991).

Q: What is micro-dot vasectomy reversal?
A: Micro-dot is the dotting the vas with a miniature marking pen to pre-select suture entry and exit points. In theory, it adds another degree of precision in suture placement and vas alignment. I personally have not found this extra step helpful in suture placement, and I do not utilize this technique.
Sperm Extraction and Aspiration

Advances in Assisted Reproductive Technique, namely IVF with sperm injection (IVF/ICSI), now allow pregnancy to occur with very few sperm.

Several groups of men may require IVF/ICSI to father children. These are some of the groups:

1. Men with reduced sperm production with extremely low (severe oligospermia) or no sperm in the semen (nonobstructive azoospermia, NOA).

2. Men with normal sperm production but obstruction or absence of the vas (obstructive azoospermia, OA) prevent sperm from reaching the ejaculate. This includes men who had vasectomy or had failed vasectomy reversal.

In men with severely reduced sperm count, the sperm obtained from the ejaculate may not be suitable for IUI (intrauterine insemination), since they tend to be low in number.

For nonobstructive azoospermia:

Testicular sperm extraction, TESE, non-microscopic

In the NOA group, patchy area of sperm production may be present. Sperm may be obtained directly from the testis, and sperm, if present, can then be used in the laboratory for IVF/ICSI. In the TESE procedure, a small incision is made on the scrotum and several small pieces of testicular tissue are submitted to the lab for extraction.

Micro-TESE

In a more refined approach, an operating microscope is used to magnify tissue prior to tubule removal. Sperm-containing tubules have a different appearance when examined under high magnification; this difference allows for selection of only sperm-containing tubules and avoids unnecessary removal of testicular tissue. This procedure is done in men with nonobstructive azoospermia.

Please note that micro-TESE is not a testis biopsy. It is labor intensive and expensive. Operative time varies but typically is 1½ to 2 hours, as one must painstakingly examine the testicular content prior to excision. Inability to retrieve sperm with micro-TESE is the effective end of retrieval attempts. The approximate cost for this procedure is $2,300.

In men with obstructive azoospermia, more options are possible:

1. Percutaneous Epididymal Sperm Aspiration or PESA
2. Testicular Sperm Aspiration or TESA
3. Testicular Sperm Extraction or TESE
4. Microscopic Epididymal Sperm Aspiration or MESA

PESA and TESA are similar procedures. A small needle is placed in the testis, suction is applied and a small number of sperm are obtained. It is easily performed in the office under IV sedation and is an inexpensive collection method. Only a small number of sperm are obtained to be immediately used in IVF but not enough for cryopreservation.

TESE is identical to the procedure outlined for men with NOA, except that more sperm are easily obtained for either immediate use of cryopreservation. The approximate cost of TESE is $1,600.

MESA is similar to micro-TESE in that it is an operating room procedure. The engorged epididymis is examined under an operating microscope and the fluid laden with sperm is then collected for either immediate use or cryopreservation. MESA is expensive and, given the ease of performing aspiration in men with a comparable pregnancy rate, it is rarely used in practice.

The advantages of PESA and TESA are their ease to perform, but the disadvantage is the small number of sperm obtained.

On the other hand, the advantage of TESE and MESA is the large number of sperm retrieved for cryopreservation, which obviates the need for a future retrieval procedure. The disadvantage is that of these procedures are more involved and their cost higher.

We almost exclusively perform TESE or TESA. Although these sperm are quite capable of fertilization and achieving normal pregnancy, they do not have the ability to penetrate eggs on their own, and IVF/ICSI is necessary to initiate fertilization.

Please feel free to contact us if you have any questions regarding these procedures.

www.wpurology.com
Vasectomy IVF/ICSI

In vitro fertilization with intracytoplasmic sperm injection (IVF/ICSI) is the treatment of choice for severe male factor infertility and obstructive azoospermia not amenable to reconstructive surgery.

IVF/ICSI involves ovarian hyperstimulation to produce a large number of eggs simultaneously. These eggs are then retrieved, usually via ultrasound guidance via a transvaginal approach. Sperm, whether ejaculated, aspirated or extracted, are injected, one per egg, with special micromanipulation instruments. The injected eggs are incubated and examined for fertilization and embryo development. They are then transferred to the uterus to achieve pregnancy. ICSI represents extension of the conventional IVF. Conventional IVF involves mixing sperm in the test tubes; sperm attach and penetrate on their own. This approach works well with high quality eggs and sperm such as in females with blocked fallopian tubes require 50,000 motile sperm per egg is required. In men with severe male infertility, 50,000 morphologically normal and motile sperm per egg is not possible, not to mention the minimal 1 to 3 million motile sperm post-wash needed for artificial insemination.

Several groups of men require IVF/ICSI:
1. Severe male factor infertility: Severe oligospermia/asthenospermia may require Sperm Extraction and Testis Biopsy. In men with NOA, consideration should be given to donor sperm backup at the time of TESE and egg retrieval, since 30% to 60% of all TESE may fail to yield sperm despite the diagnostic biopsy report and previous TESE results.
2. Obstructive azoospermia: Men with CBAVD or failed vasectomy reversal may need TESE with ICSI.
3. Intrinsic sperm defects: Sperm without the acrosomal cap or with defective tail ultrastructure (Kartagener's) will require ICSI.
4. Necrospermia: An unusual phenomenon, which leads to dead sperm in the ejaculate, TESE may be needed to obtain live sperm.
5. Preimplantation genetic diagnosis, PGD: IVF provides us the opportunity to remove 1 or 2 cells from the developing embryo for genetic testing prior to the transfer, only the non-affected embryos are transferred. PGD has been applied in conditions such as hemophilia, TAY-Sachs disease, CF and Kleinfelter's.

The major determining factor, in terms of pregnancy rate (PR) following ICSI, is female age. Source of the sperm may also impact on the PR. In general, all sperm do fairly well, provided they are carefully selected to ensure viability. In men with NOA requiring TESE, the overall PR is less vs. for obstructive azoospermia.

Vasectomy Reversals or Sperm Aspiration/ICSI?
IVF/ICSI provides another reproductive option for men who had previous vasectomies. The decision to pursue either approach must be individualized, depending on the presence of any significant female factor(s) for which IVF may be needed. In men with long-standing vasectomies and spouses approaching 40 years of age, IVF/ICSI is reasonable. Male reproductive potential is not further lost while waiting for the sperm following vasectomy reversal, which may take up to one year or more. For most men, assuming significant female factors do not exist, vasectomy reversal is preferred for the following reasons:
1. Direct cost: Routine reversal (VV) is between $6,000 to $8,000. VV is a safe procedure with PR of 30% to 70% fro VVs (average 50%). IVF/ICSI costs between $6,000 and $15,000 per attempt, with a PR (pregnancy rate) of 30% to 40%. For men with obstructive intervals less than 10 years, reversals will be twice as likely to result in pregnancy than IVF/ICSI and at a lower cost.
2. Indirect cost: Some IVF attempts fail to reach the egg retrieval stage due to various reasons, including complications from ovarian hyperstimulation and prematurely terminated attempts, represent unrecoverable cost. In addition, there is a risk of multiple births after vasectomy reversal vs. up to 30% with IVF in the past. The latter figure is likely lower today with new IVF guidelines but is still higher than after vasectomy reversal. Modern obstetrical care has dramatically improved, but multiple births still have a much higher prenatal and postnatal cost (both financially, physically and emotionally). You should also review the adoption option and donor sperm insemination option with your gynecologist. Familiarity with these options will help you arrive at the right decision for you.
3. Multiple gestations: Pregnancies following reversal are conceived through natural means with 1% chance of being multiple births. 30% of all IVF pregnancies result in multigestational births. Modern obstetrical care has enabled us to obtain excellent pregnancy outcomes but at a significant pre- and postnatal cost. One should consider the long-term financial implications following such births.

I would like to remind you that adoptions and donor sperm are two just as viable options, and I encourage you to become familiar with all of them and only by being well informed can you arrive at a decision that is right for you.

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VASECTOMY REVERSAL OVERVIEW

Vasovasostomy (VV)

The vas deferens is the tube that carries sperm from the testicles to the ejaculatory duct. Vasectomy is the leading cause of obstruction of the vas deferens, but some men are born with or acquire obstruction later in life from trauma or infection.

The ultimate success of a reconstructive procedure is an unassisted pregnancy. This is dependent on several factors: the age and fertility of the female partner, surgeon's experience, the technique of vasectomy reversal and the length of time since the vasectomy was performed, so-called obstructive interval. In large study with 1,469 patients from multiple institutions, the success rate was inversely proportional to the obstructive interval. The shorter the interval, the higher the success. In men with obstructed intervals of less than 3 years, the likelihood of sperm in the semen after reversal (patency rate) was 96% and the pregnancy rate was 75%. On the other hand, when the obstructed interval was greater than 15 years, the patency rate was 50% while the pregnancy rate was 30%. Most men seeking reversal had obstructed intervals between 3 and 14 years, the patency rate was 44% to 53%. It is important to point out that, with a longer obstructed interval, the higher the chance that a more complex reconstruction may be required. The operation is called an epididymovasostomy (EV). At the time of the surgery, it will be determined if an EV will be necessary. The success for epididymovasostomy is lower than standard vasectomy reversal.

Vasectomy reversal is done as an outpatient. Anesthesia will be general. Oral pain medication will be prescribed and is generally required for 24 to 48 hours. Tylenol may also be used. No heavy lifting, sports or sexual activity may be undertaken for 4 to 6 weeks. You may return to work in 7 days unless your have a physically demanding job, then a 10 to 14 day wait is recommended. Semen analysis will be obtained at 3 months postop. Sperm may not return for 6 months or more with VV and for up to 12 months following EV. You should not drive for 7 to 14 days. It is preferable in the first 4 weeks that you be the rider rather than the driver in a car.

The average length of time to achieve pregnancy is about one year. 3% to 5% of initially successful VV may develop recurrent obstruction after sperm were initially present recommended that you consider sperm banking once sperm count has peaked to safeguard against this problem. Bleeding and infection are uncommon. Scarring and persistent pain at the operative site occur rarely.

The epididymis is the structure behind the testicle. It is made of coils of tubules through which the sperm migrate and mature. The procedure to correct epididymal obstruction is epididymovasostomy during which the vas deferens is attached to an epididymal tubule in order to bypass the obstruction in between.

The patency rate for epididymovasostomy is about 50% to 60% with a pregnancy rate of 30% to 40%. Some men may not have sperm present for up to 12 months afterwards. Pregnancy may take one to two years to achieve. Up to 10% of initially successful EV patients may develop recurrent obstruction after sperm were initially present. I recommend sperm banking as a safeguard against this problem.
Frequently Asked Questions

Q: Who are the candidates for vasectomy reversal?
A: With a few exceptions, nearly all vasectomised men are candidates for reversal procedures, either a vas-vas (vasovasostomy, VV) or a vas-epididymis (edididymo-vasostomy, EV) connection may be performed. Couples with special female fertility issues, such as fallopian tube blockage, should consider in vitro fertilization (IVF) since the restoration of normal male fertility may not overcome the co-existing female factor.

Q: What are the factors which determine pregnancy rate following vasectomy reversal?
A: Four major factors are considered in advising individuals regarding the pregnancy rate following vasectomy reversal:

1. Obstructive interval or number of years since vasectomy: as reported by the authoritative study based on the results of 1,469 men (vasovasostomy Study Group 1991), the pregnancy rates are 76% for reversal performed within 3 years of vasectomy, 53% for 3 to 8 years, 44% for 9 to 14 years and 30% for 15 or more.

2. Age of the female partner: for those couples with the female partner 30 or younger, this is not likely to be an issue. In a study of 115 couples (Fuch), pregnancy rates were 49% with the female age at 31 to 35, 45% at age 36 to 40 and 20% at age 41 to 45. Delivery rates were proportionally lower in the older group, as you would expect. Since the success rate is inversely proportional to the passage of time, the consensus is to proceed with vasectomy reversal sooner rather than later when the decision is made.

3. The use of an operating microscope is recommended and is standard in our practice.

4. The surgeon: carefully choosing your physician simply makes sense. Dr. Gundian has been performing this procedure since 1990, following his urologic training at the Mayo Clinic in Minnesota. His CV is available on this website.

Q: How involved is the surgery and what's the recovery like?
A: For routine reversal or VV, two one-inch incisions are made high in the scrotum. The amount of dissection is limited, and you can almost equate the reversal with a "super-sized" vasectomy. The operative time is 2 to 3 hours. For more complex reversals or EV, the incisions are longer in order to deliver the testes onto the operative field. A fair amount of tissue swelling is expected postop. The time is 3 to 5 hours, since epididymal exploration may be time consuming. Recovery varies according to the procedure; routine VV is well tolerated with minimal to moderate narcotic requirement, and one may return to a desk job in 3 to 5 days. EV is taxing, one should be prepared to rest for 7 days or more.

Q: What is sperm aspiration?
A: Sperm aspiration, in conjunction with in vitro fertilization and sperm in IVF/ICSI, is an invaluable tool in the management of infertile couples. Aspiration is done under IV sedation with a butterfly needle to obtain sperm; however, IVF/ICSI is not. Aspirated sperm are few in number and immature in function; fertilization requires that these sperm be injected into each egg in the laboratory. Pregnancy is then established following successful fertilization and embryo transfer to the uterus. Direct insemination is not possible with these sperm.

Q: Reversal or IVF, and what's the bottom line?
A: Academic argument for either approach notwithstanding, one needs to compare the direct cost for each approach. To a significant degree, the medical specialist consulted, whether a urologist performing the reversal or the reproductive endocrinologist overseeing the IVF will influence the couple's decision. On average, an IVF attempt with sperm aspiration costs $12,000 to $15,000, with a pregnancy rate of 25% to 50%. In contrast, a reversal costs $6,000 to $8,000, with pregnancy rate at least that of an IVF.

Numerous cost-effectiveness studies have been performed to examine the difference between reversal and IVF. The average out-of-pocket cost per delivery following vasectomy reversal is $15,000 to $31,000, factoring into various prognostic factors and the procedure performed (VV or EV). In contrast, out-of-pocket cost for IVF, at a very reasonable 35% delivery rate per cycle, is at least $35,000. This figure does not include the third party obstetric and perinatal expenses associated with multiple gestations. A Cornell study (Schigel, 1997) placed the overall cost per delivery at $25,475 following reversal vs. $75,521 for IVF. It is fair to state that vasectomy reversal is at least as effective, if not more so in many couples, at half the cost.
One may argue that IVF obviates the need of a surgical procedure with the attendant risks. The fact that IVF is an intense and time-consuming process, lasting weeks, repeated office visits and in-home shot administrations, it then culminates in retrieval and subsequent embryo transfer. In contrast, reversal is straightforward, with minimal morbidity and short recovery. Furthermore, since patients are young and healthy, it has extremely low incidence of complications. In most couples, the decision is easy; typically, the man had a vasectomy years ago and is now married to a lady in her late 20s or early 30s with no fertility problems. Vasectomy reversal makes sense. On the other hand, if the vasectomy was performed 20-plus years ago and the wife is only 25 in whom IVF may achieve a 50% birth rate, then it is perfectly reasonable to consider IVF if one is willing to accept the higher cost.

Q: Nevertheless, we are really interested in IVF/ICSI and are considering several IVF centers. Where can we find out more about IVF and these centers?
A: By law, assisted reproductive outcome nationwide is tallied and reported each year. The annual report takes 2 to 3 years to comprise. Furthermore, each IVF center's results are also available on the internet on the CDC website.

Q: Will vasectomy reversal work, considering my wife is 38 years old?
A: Provided that no major obstacle exists in the female, vasectomy reversal continues to be the preferred approach. Fuch et al. in 2001 reviewed the results in 115 men who underwent reversal 15 years or more after vasectomy and reported the pregnancy and delivery rate based on the partner's age. The results are as follow: pregnancy and delivery rate: < 25: 57 to 57%, 26 to 30: 58 to 46%, 31 to 35: 49 to 49%, 36 to 40: 45 -32%, 41-45: 20 to 13% and > 45: 0 to 0%.

I believe it is reasonable to suggest 30 to 40% pregnancy rate in couples with the female partner in her late 30s following reversal. My approach is this group is individually based. For example, if the vasectomy was within 10 years with a partner of proven fertility, reversal is favored. If the vasectomy was 15 years or more in whom EV will be needed which may be associated with delayed sperm appearance up to one year postop, IVF may be more expedient to take advantage of the female “window of opportunity” prior to her 40th birthday. All patients' wives or partners are advised to be screened by a gynecologist to ensure that they do not have an undiscovered female infertility problem that would make vasectomy reversal futile.

Q: Is it worthwhile to even consider a re-do? Does it ever work?
A: Repeat vasectomy reversal should be considered not only in those who demonstrated zero sperm count postop but also in those with low sperm count and low motility due to partial blockage of the system. The success rate is low compared with “virgin” reversal but it still very reasonable with 75% patency and 43% pregnancy rate (VSG, 1991).

It is difficult to convince one to undergo yet another attempt at reversal, but let's repeat it as an alternative.

The caveat is that up to three-quarters of the re-dos require EV on at least one side (Hernandez, 1999), a procedure requiring microsurgical expertise. Chose your physician carefully for your re-do or, for that matter, your "virgin" reversal.

Q: Will my insurance pay for this procedure? If not, can you tell them the reason for reversal is because of chronic pain to justify coverage?
A: Insurance companies rarely pay for vasectomy reversal, and I have never heard of being reimbursed by an insurance carrier for this indication. As a contracted provider with the insurance company, we are obligated to submit claims truthfully without exception. We will not engage in any effort to secure insurance reimbursement using an alternative diagnosis for the performance of vasectomy reversal.

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