



Procedure Title:	Collecting for Pellet Therapy
Date:	10/11/2021
Version:	
Department:	CIC
Approved By:	

Purpose: Accurately collecting for Pellet Therapy Services

Upon check-in patients scheduled for Pellet Hormone Replacement Therapy will be required to either pay TOS for services or follow insurance billing steps.

- **Time of Service (TOS)** (no contracted insurance) patients will pay a flat rate per below for both the insertion and the pellets
 - o \$325.00 for female (this includes implantation and medication)
 - o \$600.00 for male (this includes implantation and medication)
- **Insurance Patients**
 - o Patients will pay TOS for the pellets (See pellet medication section on pg. 5.
 - o We will attempt to bill insurance for the insertion procedure IF the patient signs one of the applicable waivers below. This procedure is often covered by insurance.

Procedure: Collection for hormone pellet implantation procedure

11980 Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)

- Insurance patients: No fees will be collected for the procedure at check-in. A fee of \$269.00 will be billed to patient’s insurance after the patient signs one of the applicable non-covered service waivers below.
 - o Patient must sign acknowledging services may not be eligible for benefits if determined to be non-covered, investigational or not medically necessary per patient benefit package.
 - o After check-in front desk will immediately scan “non-covered service waiver” “Pellet Medicare ABN” or “OHP Waiver” form into the **Admin → Billing** folder within the patient chart.



SCENARIO 1: FOR ALL INSURANCES W/EXCEPTION OF MEDICARE & MEDICAID

- For all insurance plans other than Medicare or Medicaid use **“athenaFORM: Non-Covered Services Waiver”** under print forms, directly from patient’s chart and fill out accordingly. (See image below)

3144 State Street
Medford, OR 97504
541.773.9772 (Ph)
541.773.1113 (Fax)



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Non-Covered Service Waiver

I _____, DOB _____ understand that the services I will be receiving may not be considered eligible for benefits (services may be determined not medically necessary, non-covered or investigational) by my health insurance provider. I understand that my health insurance coverage has certain restrictions and limitations, such as prior-authorization requirements and non-covered service guidelines.

By signing this form, I understand that I am agreeing in advance to receive these specific services and to pay for the services indicated below if my insurer denies payment because the services are not covered by my health insurance plan.

<input type="checkbox"/> Injection(s) tendon sheath/ligament	20550	\$147.00 per site
<input type="checkbox"/> Injection(s) single tendon	20551	\$150.00 per site
<input type="checkbox"/> Trigger Point Injection(s) 3 or more	20553	\$174.00
<input type="checkbox"/> Trigger Point Injection(s) 1-2 muscles	20552	\$151.00
<input type="checkbox"/> Injection/aspiration of joint	20800-20810	\$139.00-\$402 (dependent on location)
<input type="checkbox"/> Tangential biopsy of skin; single lesion	11102	\$275.00
<input type="checkbox"/> Each additional lesion	11103	\$150
<input type="checkbox"/> Punch biopsy of skin; single lesion	11104	\$349.00
<input type="checkbox"/> Each additional lesion	11105	\$171.00
<input type="checkbox"/> Incisional biopsy of skin; single lesion	11106	\$422.00
<input type="checkbox"/> Each additional lesion	11107	\$202.00
<input checked="" type="checkbox"/> Pellet placement female and Male	11980	\$269.00

Signature of patient or representative

Date of Service

Initial of employee providing form



SCENARIO 2: FOR MEDICARE PART B PATIENT'S ONLY:

- For Medicare part B patients use **“Pellet Medicare ABN”** under print forms, directly from patient’s chart and fill out accordingly. (See image below)

A. Notifier:

B. Patient Name: First name, Last name

C. Identification Number: write patient Medicare ID here

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D. procedure below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
11980	Medicare does not pay for this procedure for your condition	\$269.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. procedure listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Must select one option here.

G. OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the D. listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the D. listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- OPTION 3.** I don't want the D. listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:

J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



SCENARIO 3: FOR MEDICARE PART C PLANS (MEDICARE ADVANTAGE)

For all Medicare Part C plans we are required to obtain a pre-determination request through the insurance carrier prior to providing pellets to the patient. Please see steps below for the following plans: Regence BCBS, MODA, Aetna, Atrio, Allcare, & CareOregon.

*****PLEASE NOTE THERE MAY BE OTHER MEDICARE ADVANTAGE PLANS NOT LISTED BELOW. IF THAT IS THE CASE PLEASE REACH OUT TO THE INSURANCE COMPANY AND INQUIRE WHAT STEPS NEED TO BE TAKEN IN ORDER TO FILE A PREDETERMINATION REQUEST*****

1. Regence BCBS:

- a. Go to <https://www.regence.com/provider/pre-authorization/medicare>
- b. Go down to **'Phone or Fax'** and click on **'Medical Services (PDF)'** and fill out accordingly. In section 3 the CPT or HCPC code you would list is, **'11980'** The diagnoses codes listed on the form should be the one(s) that the provider will use for charting the procedure.
- c. Fax form to 1-855-232-0085

2. MODA:

- a. Go to <https://www.modahealth.com/medicare/support/member-rights/prior-authorization>
- b. Click on **'prior authorization request form'** and fill out accordingly. In section 5 the CPT or HCPC code you would list is, **'11980'** The diagnoses codes listed on the form should be the one(s) that the provider will use for charting the procedure
- c. Fax form to 1-855-637-2666

3. Aetna:

- a. Go to <https://www.aetna.com/health-care-professionals/health-care-professional-forms.html>
- b. Go to drop down **'Medicare precertification'** and click on **'Standard Organization Determination Information Request Form (PDF)'** the CPT or HCPC code you would list is, **'11980'** The diagnoses codes listed on the form should be the one(s) that the provider will use for charting the procedure.
- c. Once you've filled out the form, submit it and all requested medical documentation to our Predetermination Department by:
 - We prefer you submit predetermination requests electronically. Use our provider portal on Availity® to also upload clinical documentation, check statuses, and make changes to existing requests. Register today at availity.com/aetnaproviders.
 - Send your information via confidential fax to: Predetermination: Medicare using FaxHub: 1-833-596-0339
 - The fax number above (FaxHub) is for clinical information only. Please send specific information that supports your medical necessity review.



Please continue to send all other information (claims etc.) to appropriate fax numbers.

- To expedite requests, submit the request electronically (EDI) or call us at 1-800-624-0756.

4. Atrio:

- Go to <https://www.atrionhp.com/oregon/providers/provider-resources/>
- Under **'Medical Prior Authorization'** click on **'Medical and DME (Including Diabetic Supplies) Prior Authorization Request Form'** the CPT or HCPC code you would list is, **'11980'** The diagnoses codes listed on the form should be the one(s) that the provider will use for charting the procedure.
- Fax form to 1-866-500-8773

5. Allcare:

- Go to <https://www.allcarehealth.com/doctors-providers/resources/downloads?locale=en>
- Under **'Provider Prior Authorization Forms'** click on **'Provider request for prior authorization (non-medication (PDF))'**
- Under **'SERVICE requested item/procedure'** list **'11980.'** The diagnoses codes listed on the form should be the one(s) that the provider will use for charting the procedure.
- Fax form to 541-471-4128

6. CareOregon: TBD



SCENARIO 4: FOR MEDICAID (OPEN CARD, CAREOREGON, ALLCARE)

- For all Medicaid plans please use **“OHP waiver”** under print forms, directly from patient’s chart and fill out accordingly. (See image below) In Section 2



OHP Client Agreement to Pay for Health Services



This is an agreement between a *Client* and a *Provider*, as defined in OAR 410-120-0000. The client agrees to pay for service(s) not covered by the Oregon Health Plan (OHP), the Oregon Health Authority (OHA) or OHA-contracted managed care entities (MCEs).

Provider section

① Provider completing this form is (check one):

Rendering provider (the person providing the service) Prescribing provider

Hospital Pharmacy Ancillary (other) provider:

② Services requested. These include, but are not limited to, treatment, equipment, supplies and medications.
Pellet Insertion

Service codes (CDT/CPT/HCPCS/NDC): 11980

③ Expected date(s) of service (if services will occur over several months, please say how often, with start and end dates): List DOS here

④ Condition being treated: MA or Provider to fill out (list dx code)

⑤ Estimated fees \$ 269 To \$ 269 . Check one of the following statements about these fees:

There are no other costs that are part of the service(s).

There may be other costs. You may have to pay for them, too. Other costs may be for (check all that apply):

Lab X-ray Hospital Anesthesia Other:

⑥ As the rendering or prescribing provider:

- I tried all reasonable covered treatments for your condition.
- I confirmed that the proposed service(s) are not covered for your condition.
- I informed you of covered treatments for your condition, and you chose a treatment that is not covered.

Check marks here → As any other provider (check one of the following statements):

I understand that your provider has talked with you about other choices and completed a separate Agreement to Pay form.

Please see your provider to ask about other choices and to complete a separate Agreement to Pay form.

Provider name: List provider that is rendering the service to patient NPI:

Provider signature: Provider must sign Date:

OHP client section

⑦ Client name: DOB: Client ID#:

⑧ I understand the following, and still choose to get the service(s) listed above:

- The services listed above are not covered for payment by OHP or my plan.
- If I get the services I agree to pay the costs. After having the services, I will get bills for them that I must pay.
- My other options, which are written on the back of this form and were explained by my provider.
- The medically appropriate treatment I can have, including services that OHA or my MCE may pay for.

Client (or representative's) signature – Representative must have proof of legal authority to sign for this client Date

If signed by the client's representative, print their name here:

⑨ Witness signature: Front desk signs here Date:

Witness name: Front desk print name

This agreement is valid only if the estimated fees listed above do not change and the services are scheduled within 30 days of the member's signature.



Pellet Medication: Collection for hormone pellet medication

- **Time of Service (TOS)**
 - Hormone pellet medication fees will be collected on a flat fee basis for males and females. (See fees on page 1).
- **Insurance Patients:** We do not bill the pellet medication to any insurance carrier unless otherwise stated on a pop up note within the patients account. If billing insurance for the medication please see page 5. Otherwise, proceed with below consent for all insurance patients.
 - At check-in front desk will print **“athenaFORM: Pellet Patient Consent for Non-Covered Services”** form into the **Admin → Billing** folder within the patient chart. (See below)

Complete Integrative Care • 3144 State St, MEDFORD OR 97504-8450

MOUSE TEST, MICKEY E (id #136463, dob: 11/11/1956)

MOUSE TEST, MICKEY 11/11/56 #136463



* 671982w12515 A-Consent

Patient Consent for Non-Covered Services - Pellet Hormone Replacement Therapy

Names: Patient Name: MOUSE TEST, MICKEY
Patient ID: 136463
Patient DOB: 11/11/1956

Certain services are not considered medically necessary by your health plan. They may be helpful to you, but the terms of your plan do not pay for these services. These non-reimbursable services and/or supplies are typically the responsibility of the patient. Listed below are services not covered under your current health plan contract but are being recommended by your provider.

By signing this form, I, _____, (please print) DOB _____ understand that I am agreeing in advance to receive these specific services and to pay for the services indicated below as they are not a covered benefit with my insurance plan.

Male pellet \$439.00 _____

Female pellet \$164.00 _____

Printed Name _____ Date _____

Patient Signature

- Front desk will mark which pellet medication applies (male or female) have patient sign and collect appropriate fees before check-in can be completed.
- After check-in front desk will immediately scan consent into patient’s chart.
 - Must be completed at TOS, cannot be sent to scan pile
- All TOS fees are to be collected in square and will be verified by the billing team when posting.



- Billing insurance for medication:** All applicable patients that we are billing insurance for will have pop up notes on their account. If you do not see a pop up stating we are billing the patient's insurance for the medication, please follow TOS procedure above.
 - If billing insurance, please fill out the non-covered service waiver form and in the 'other' field please put HCPC codes S0189 (for testosterone) or J3490 (for anastrozole or estradiol). This section should be filled out by the MA since they know which medications patient will be administered. See example below:

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<input type="checkbox"/> Each additional lesion	11105	\$171.00
<input type="checkbox"/> Incisional biopsy of skin; single lesion	11106	\$422.00
<input type="checkbox"/> Each additional lesion	11107	\$202.00
<input checked="" type="checkbox"/> Pellet placement female and Male	11980	\$269.00
Other: Pellet Medication	S0189 -testosterone J3490 -estradiol and/or anastrozole	\$ dependent on dosage

Signature of patient or representative

Date of Service

Initial of employee providing form