Penile Prosthesis Procedure Cancellations: Avoiding case interruption

Best Practices and Templates

Coloplast

Content

Templates

Introduction

Welcome to the Coloplast Men's Health Penile Prosthesis Procedure Cancellations: Avoiding Case Interruption Guide.

As a health care practitioner, you have undoubtedly experienced challenges with patients canceling procedures due to a variety of reasons. **Every time a patient doesn't show up for a scheduled surgery, it can be frustrating and creates extra cost due to expended resources.** With that challenge in mind, we have developed this guide. You'll never eliminate cancellations and no-shows entirely, but if you follow these tips you'll significantly reduce them.

This is a guide to help provide suggestions on pre- and post-op follow-up with patients who were not cleared for penile prosthetic surgery, canceled, or need further information about the procedure.

As you review this guide, keep in mind the many processes and steps your practice already executes very well. After reviewing this IPP Cancellation Guide, you and your team can determine what process changes or templates may be beneficial to implement in your practice.

What's Inside

PATIENT TEMPLATES

Template 1: Patient Pre-Surgery Checklist
Review all proper IPP expectations and requirements with patients and send them home with this checklist as a reminder.

Patient Cancellation Follow-Up Letters
Template letters to send out to patients whose surgery was canceled due to:

Template 3: Insurance denial
Template 4: Patient cancellations
Template 5: Medical reasons

Information on "Talk to a Patient" program available on www.ColoplastMensHealth.com to refer patients who have questions about IPPs or want to talk to someone who has gone through the same procedure.

PRACTICE TEMPLATES

Template 2: Pre-Surgery Checklist
Checklist designed to prevent last minute cancellations due to lab testing and medical clearance. Your practice may need to be modified based on your hospital requirements.

Template 6: Request for Medical Clearance
Form to refer a patient to schedule an appointment for medical clearance and/or to request a formal response that the patient is medically cleared for the Titan® IPP procedure.

Template 7: Prior Authorization Request Letter
A template to send to insurance companies requesting a prior authorization for the insertion of Titan® IPP.

Template 8: Cancellation Follow-up Form
Tracking form to be completed after a patient cancels a Titan® procedure.

These document templates are merely a representative sample of the type of forms others might use in their practice. By using these templates, you agree to be solely responsible for the content and usage and to hold Coloplast Corp. harmless with respect to any content or omitted content. It is your obligation alone to ensure the content complies with your independent medical judgment; and your further duty to modify or delete any content to fit with your independent medical judgment, patient requirements, practice preferences.

Procedure Cancellation Best Practices

Educate and set proper expectations for your patients –

The fact is, uneducated patients are less likely to show up for their scheduled IPP surgery. Take the time to educate your patients about the Titan IPP implant and pre-op instructions for surgery. Look for opportunities to provide this education in every patient interaction. How?

- Show them a Coloplast Titan® IPP demo to help them understand how it works
- Offer them educational brochures
- Refer them to www.ColoplastMensHealth.com for more information
- Suggest they schedule an appointment to speak with a man who has an implant through our "Talk to a Patient" program on our website at www.ColoplastMensHealth.com

Answer any questions they have, and make sure they understand the risks of not going forward with the surgery.

Look for opportunities to educate your patient –

Every time you or a team member interacts with a patient, think of it as an opportunity to educate

- Reinforce this with educational materials in the waiting room and at the appointment desk
- When you send a patient a statement, or any piece of mail, include patient education materials such as a pamphlet
- Sending an email? Be sure to attach a PDF of the patient education brochure and/or pre-op instructions

When a patient schedules a surgery, be sure to go over every detail with that patient before he leaves your practice

Always confirm appointments –

Confirm appointments two days in advance. Ask patients for their preferred method of contact, whether it's via phone call, email, or text message

- If a patient prefers a phone call, make sure your scheduler knows leaving a voicemail isn't enough— they should actually talk to the patient to confirm the surgery

IPP Cancellation Template Summary:

Reason for Cancellation	Action
Pre-surgery	1. Send patient Template 1: Patient Pre-Surgery Checklist 2. Use Template 2 in the office
Insurance benefit exclusion	1. Send patient Template 3: Insurance Denial Follow-Up Letter 2. For patients who want to appeal their insurer's denial, inform them of the support available. If you have questions about the appeal process, please contact the Coloplast Reimbursement Support line at 844-297-2620. The Coloplast Reimbursement Support line is available to assist you and your patient through the appeal process. **Contact your Coloplast Sales Representative for information about the Reimbursement Support Program**
Patient cancellation	1. Send patient Template 4: Patient Cancellation Follow-Up Letter
Medical reasons prior to surgery	1. Reschedule appointment to obtain medical clearance 2. Send patient Template 5: Medical Clearance Follow-Up Letter 3. Send referring physician office Template 6: Request for Medical Clearance Letter

TEMPLATE 1 – Patient Pre-Surgery Checklist

Dear Mr. [LAST NAME]:

This letter is to help you prepare for your upcoming Titan® Penile Prosthesis procedure. In order to prepare for your upcoming surgery, it is very important that you follow through with the following checklist outlined in this letter.

Your surgery has been scheduled for [DAY, DATE @ X:XX A.M., HOSPITAL NAME].

- ☐ Your pre-surgery testing is scheduled for [DAY, DATE @ X:XX A.M. ADDRESS].
- ☐ [DOCTOR NAME] would like to see you prior to this procedure. I have scheduled you to see him or her on [DAY, DATE @ X:XX A.M.] (immediately before your testing at the hospital)
- ☐ You will need medical clearance from your Primary Care Provider. If you are under the care of a cardiologist on a regular basis, you will need clearance from them as well.
- ☐ Please stop all ALL BLOOD THINNERS 7 DAYS prior to your procedure. Check with your doctor before stopping any medications.
- ☐ If you require antibiotics for any dental procedures, please alert the hospital and your doctor.
- ☐ If you have sleep apnea, please let me know.
- ☐ You will not be permitted to drive home after your surgery. Please make arrangements for a responsible person over the age of 18 to drive you home.

We have your current insurance as [INSURER NAME]. If this is incorrect, please call our office immediately at: [OFFICE #] to make the appropriate changes or you could be responsible for your surgery and other hospital charges.

PLEASE PLAN ON ARRIVING AT THE FACILITY 1-HOUR PRIOR TO YOUR ANTICIPATED TIME OF SURGERY.

As a reminder, you must not take aspirin or any products that contain aspirin for seven days prior to surgery. All patients will be given antibiotics and a surgical soap to start the day before surgery to sterilize the operative area. **It is important that you do not eat or drink anything, including water, starting from mid-night the night before your procedure until after your procedure.**

If you have any questions or if there is anything you do not understand, please do not hesitate to call this office. We would be happy to assist you.

Sincerely,

[UROLOGIST NAME]

TEMPLATE 2 – Pre-Surgery Checklist

Pre-Surgery Checklist

For Office Use Only

Patient Name: _____ Date of Surgery: ____/____/____

Date of Birth:____/____/____ Location: _____

Diagnosis:

☐ Organic Erectile Dysfunction (607.84)
☐ Peyronie's Disease (607.85)

History and Physical:

☐ Inpatient
☐ Outpatient
☐ ASC
☐ Previously done; Date: ____/____/____

Surgical Clearance:

☐ Not required
☐ Cardiac
☐ General Medicine
☐ Other
☐ Previously completed; Date: ____/____/____

Pre-op anesthesia:

☐ Not indicated
☐ Yes, completed
☐ Previously completed; Date: ____/____/____

Labs:

☐ No labs required
☐ Complete Blood Count (CBC)
☐ Partial Thromboplastin Time (PT/PTT)
☐ UA/Urine C&S; Negative urine culture documented within one month of surgery date
☐ Complete
☐ Basic
☐ If diabetic, HgBA1C level less than 10% documented within one month of surgery date
☐ Other:

Secondary Diagnosis:

☐ Common diagnostic codes for IPPs listed on next page

ECG/EKG:

ECG required for males 45 or older unless indicated otherwise by your state.
☐ Not required
☐ Yes, completed
☐ Previously completed; Date: ____/____/____

CXR:

☐ Not required
☐ Yes, completed
☐ Previously completed; Date: ____/____/___
☐ Other Test Required:

Consent:

☐ Complete

Other:

☐ Sent patient Pre-Surgery Checklist
☐ Referred patient to a Patient Educator & received Coloplast Patient Education material
☐ Incomplete; Reason:

TEMPLATE 3 – Insurance Denial Follow-Up Letter

[DATE]

Dear Mr. [LAST NAME]:

On [DATE], we were notified by your insurance carrier that the authorization request for your surgical procedure was denied due to [_____]. We would like to know if you are interested in appealing this decision by your health insurance carrier. Every enrollee of a health insurance plan has the right to have an insurance denial appealed. The type of appeal is dependent on the type of denial made by the insurer.

You expressed interest in having this procedure done as soon as possible. If you are interested in appealing your insurer's denial, call [OFFICE MANAGER] at [TEL] to discuss the appeal process for the medically necessary treatment you are seeking.

If you have any questions or if there is anything you do not understand, please do not hesitate to call us as we are happy to assist you.

Sincerely,

[UROLOGIST NAME]
[CONTACT INFO]

TEMPLATE 4 – Patient Cancellation Follow-Up Letter

[DATE]

Dear Mr. [LAST NAME]:

We are reaching out to you regarding the cancellation of your Titan® Penile Prosthesis procedure. You may be wondering if this treatment option is right for you. You are not alone.

Approximately 30 million men are affected by ED, and many men have asked the same questions. The condition can be distressing, but it's important to remember that it can be overcome. Some men have found that speaking with another man who has experienced ED and underwent the penile prosthetic surgery helped put their mind at ease.

I encourage you to go to **www.coloplastmenshealth.com/talk-to-a-patient/** where you can schedule an appointment to speak with a patient who is another man that has undergone penile prosthesis surgery, and is willing to share his experience. You can speak to him directly regarding your questions or concerns. These are men who have taken control of their ED by getting a penile implant. They've likely gone through the same sadness, depression, anxiety, and anger that you may be struggling with and are now enjoying satisfying sexual experiences once more. If you would like to know more about what it's like to have a penile implant, these men can help. If you decide this is the right option for you, please contact us and set up an appointment. We look forward to hearing from you.

Sincerely,

[UROLOGIST NAME]
[CONTACT INFO]

TEMPLATE 5 – Medical Clearance Follow-Up Letter

[DATE]

Dear Mr. [LAST NAME]:

On [DATE], we were notified that you were not cleared for surgery due to _____ _____. At that time, we suggested that you schedule a follow-up appointment with your Primary Care Physician or Specialist to get the medical condition corrected. If you have not yet scheduled this appointment, please do so immediately.

You expressed interest in having this procedure done as soon as possible. Once you have medical clearance, call [OFFICE MANAGER] at [TEL] to schedule your pre-surgery appointment.

If you have any questions or if there is anything you do not understand, please do not hesitate to call us as we are happy to assist you.

Sincerely,

[UROLOGIST NAME]
[CONTACT INFO]

TEMPLATE 6 – Request for Medical Clearance

Request for Medical Clearance

Patient Name: _____

Date of Birth:____/____/____

Date of Surgery: ____/____/____

To Whom It May Concern:

Mr. _____ is scheduled for _____
_____on_____
at _____.

We have advised the patient to schedule an appointment with your office for medical clearance. If the patient is medically cleared, the hospital has requested the medical clearance form states "Patient is medically optimized for procedure".

This should be faxed to:

[DOCTOR/OFFICE]
ATTENTION: [OFFICE MANAGER]
[OFFICE FAX]

AND

[HOSPITAL]
[HOSPITAL FAX]

Please contact our office should you have any questions.

Thank you,

[UROLOGIST NAME]
[CONTACT INFO]

TEMPLATE 7 – Prior-Authorization Request Letter

Re: Prior Authorization Request for Insertion of multi-component, inflatable penile prostheses, including placement of pump, cylinders, and reservoir.

[DATE]

[INSURANCE NAME]
ATTN: [PRIOR-AUTHORIZATION] Department
FAX: [XXX-XXX-XXXX]
Patient Name: _____

CPT/HCPCS Code(s): [XXX]
Diagnosis Code(s): [XXX]
Insurance ID: XXXXX
Date of Birth:____/____/____

Dear Medical Reviewer:

I am writing to request a [prior authorization] for insertion of a penile prosthesis for my patient, _____. This procedure is medically necessary for Mr. [LAST NAME] in order to correct the malfunction of an otherwise healthy body part.

Implantation of penile prosthesis is the indicated treatment for men suffering from organic erectile dysfunction who have failed treatment with therapeutic and non-invasive therapies. Surgical insertion of an inflatable penile prosthesis is well documented as a safe and effective procedure. It has an extremely low risk of complication, and a very high rate of success and long term patient satisfaction.

Mr. [LAST NAME] was diagnosed with erectile dysfunction attributed to [XXXXX]. Over the [PAST YEAR], he has attempted available non-invasive treatment options including [XXXXX]; all without success. Additionally, Mr. [LAST NAME] suffers from: _____.

Erectile dysfunction (ED), also sometimes called impotence, is the inability to attain or sustain an erection satisfactory for coitus (the normal function of the erectile structures in the healthy penis). The penile implant procedure will restore function to Mr. [LAST NAME], allowing him to resume normal activity levels, without reliance on drugs or external devices.

Based on the above information and enclosed clinical documentation I request that you validate prior authorization for this medically necessary procedure for Mr. [LAST NAME]. The procedure will be scheduled as outpatient, upon approval at _____
If you need additional information, please contact me at [XXX-XXX-XXXX].

Sincerely,

[UROLOGIST NAME]
[CONTACT INFO]

TEMPLATE 8 – Cancellation Follow-up Form – Office Use Only

Cancellation Follow-Up
For Office Use Only

Patient Name: _____

Date of Birth:____/____/____

Date of Surgery: ____/____/____

Insurance: _____

Procedure: Coloplast Titan® IPP

Reason for Cancellation:

Follow-up date: ____/____/____

Ostomy Care / Continence Care / Wound & Skin Care / Interventional Urology

Coloplast Corp. Minneapolis, MN 55411 / Interventional Urology Surgical Support 1-800-258-3476

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