ROCKHILL PHARMACY
LONG TERM CARE SERVICES

*** REQUIRED ***
Order Date: ______________

Medical Necessity Form – Diabetic Testing Supplies

SECTION A: PATIENT INFORMATION		
Patient:		Medicare ID:
Address:		
City/State/Zip:		
Phone:	Male_____ Female_____	Date of Birth:

SECTION B: INFORMATION TO BE COMPLETED BY PHYSICIAN	
Do you treat this patient for diabetes? **YES NO**	Is the device designed for home use? **YES NO**
Are you maintaining medical records reflecting the care provided, but not limited to, evidence that the prescribed frequency of testing is reasonable & necessary?	**YES NO**
Has the patient (or patient's caregiver) successfully completed training or is scheduled to begin training in the use of the monitor, test strips, and lancing devices?	**YES NO**
Is the patient (or patient's caregiver) capable of using the test results to assure the patient's appropriate glycemic control?	**YES NO**
ICD-10 Diagnosis Code:	**Most Recent HBA1C**:

Prescribed Diabetic Testing Supplies (CIRCLE ALL THAT APPLY)

Glucose Meter   Test Strips   Lancet Device   Lancets   Control Solution   Replacement Battery

Testing Frequency: _____times/day	**Authorized Refills: 1 2 3 4 5 PRN**

(Number of strips and lancets prescribed for a 90-day period: 1x day=100, 2x day=200, 3x day=300, 4x day=400, 5x day=500)

Medicare Utilization Guidelines

Question		
Is the patient non-insulin dependent and tests more than 1 time per day?	YES	NO
Is the patient insulin dependent and tests more than 3 times per day?	YES	NO

If YES to either of the above, Medicare requires an explanation. Please note your reason for high testing frequency.

SECTION C: PHYSICIAN ATTESTATION AND SIGNATURE/DATE

I, the undersigned, certify that the above prescribed supplies/equipment are medically necessary for this patient's wellbeing. In my opinion, the supplies are both reasonable and necessary to the accepted standards of medical practice in treatment of this patient's condition and are not prescribed as convenience supplies. By signing this form, I am confirming that the above information is accurate.

Physician:	UPIN:	NPI:
Address:		
City/State/Zip:		
Phone:	Fax:	

PHYSICIAN SIGNATURE:	**DATE:**

*** * * * * FAX COMPLETED FORM TO ROCKHILL PHARMACY AT 816-931-0282 * * * * ***

PO Box 5930, Kansas City, Missouri 64171   T 816.799.0123   F 816.931.0282   rockhillpharmacy.com

ROCKHILL PHARMACY
LONG TERM CARE SERVICES

Medicare Capped Rental and Inexpensive or Routinely Purchased Items Notification Form

I have received instructions and understand that Medicare defines the Blood Glucose Testing Machine that I have received as being either a "capped rental" or an "inexpensive" or "routinely purchased" item.

FOR CAPPED RENTAL ITEMS:

- Medicare will pay for a monthly rental fee for a period not to exceed 13 months, after which ownership of the equipment is transferred to the Medicare beneficiary.
- After ownership of the equipment is transferred to the Medicare beneficiary, the beneficiary is responsible for arranging for any required equipment service or repair.
- Examples of this type of equipment include:

  Hospital beds, wheelchairs, alternating pressure pads, air-fluidized beds, nebulizers, suction pumps, continuous airway pressure (CPAP) devices, patient lifts, and trapeze bars.

FOR INEXPENSIVE OR ROUTINELY PURCHASED ITEMS:

- Equipment in this category can be purchased or rented; however, the total amount paid for the monthly rental cannot exceed the fee schedule purchase amount.
- Examples of this type of equipment include:

  Canes, walkers, crutches, commode chairs, low pressure and positioning equalization pads, home blood glucose monitors, seat lift mechanisms, pneumatic compressors (lymphedema pumps), bed side rails, and traction equipment.

I select the following option:

_____Free No Charge Meter ____Purchase Option ___Rental Option

Patient's or Beneficiary's Signature: ____

Date: ______________

ROCKHILL PHARMACY
LONG TERM CARE SERVICES

EQUIPMENT WARRANTY INFORMATION FORM

Every product sold or rented by our company carries a 1-year manufacturer's warranty. ROCKHILL PHARMACY *(Name of the company)* will notify all Medicare beneficiaries of the warranty coverage, and we will honor all warranties under applicable law. ROCKHILL PHARMACY *(Name of the company)* will repair or replace, free of charge, Medicare-covered equipment that is under warranty. In addition, an owner's manual with warranty information will be provided to beneficiaries for all durable medical equipment where this manual is available.

My signature below is an acknowledgement that I have been instructed and understand the warranty coverage on the product I have received.

MEDICARE DMEPOS SUPPLIER STANDARDS

The products and/or services provided to you by ROCKHILL PHARMACY are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

My signature below is an acknowledgement that I have read and understand the DMEPOS Supplier Standards section above and may request a copy of such if desired.

Beneficiary's Signature ____________________ Date ____________

ROCKHILL PHARMACY
LONG TERM CARE SERVICES

SIGNATURE AGREEMENT

I authorize ROCKHILL PHARMACY *(Company Name)* or any other holder of medical information about me to release to Health Care Finance Administration Intermediaries or Insurance Carriers any information needed for this or a related claim. I request that payment under my medical insurance program be made directly to ROCKHILL PHARMACY *(Company Name)* for the glucose monitor and supplies.

Patient's Signature: ______________________________

Date: ______________________

Reason Patient Cannot Sign: ______________________________

Relationship to Patient: ______________________________

Medicare regulations state that if patients cannot sign for themselves, the person signing for them must sign the patient's name by their name. They must also indicate the reason the patient cannot sign and their relationship to the patient.

ROCKHILL PHARMACY
LONG TERM CARE SERVICES

AUTHORIZATION FORM

Statement to Permit Assignment of Medicare Benefits

I understand that I am giving ROCKHILL PHARMACY permission to ask for Medicare payments for my medical care, including supplies and equipment.

I understand that Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to Medicare and the companies that handle Medicare payment request.

I understand that the Health Care Financing Administration (HCFA) is the government's Medicare agency. I understand that a photocopy of this release is as valid as the original document.

Furthermore, I understand that I am responsible for paying any deductible or co-insurance amounts. Therefore, I ask that payment of authorized Medicare benefits are made either to me or on my behalf to ROCKHILL PHARMACY for any services or items furnished to me by ROCKHILL PHARMACY.
I authorize any holder of medical or other information about me to release such information to the Health Care Financing Administration (HCFA) and its agents as needed to determine these benefits or benefits for related services.

Name: ______________________ **Medicare No:** ______________

Signature: ______________________ **Date:** ______________

....

Statement to Permit Assignment of Medigap Benefits

Policy Name: ______________________ Policy Number: ______________

I understand that I am giving ROCKHILL PHARMACY permission to ask for Medigap payments for my medical care.

I understand that the above named Medigap Insurer needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to the above named insurer.

I ask that payment of authorized Medigap benefits are made either to me or on my behalf to ROCKHILL PHARMACY for any services or items furnished me by ROCKHILL PHARMACY.
I authorize any holder of medical information about me to release such information to the above named Medigap Insurer as needed to determine these benefits or the benefits payable for related services.

Signature: ______________________ **Date:** ______________

ROCKHILL PHARMACY
LONG TERM CARE SERVICES

FINANCIAL HARDSHIP

PATIENT WAIVER LETTER

I, ______________________________ herein state that my income is limited and I am unable to
(Patient Name)

pay the balance due after my insurance has paid on all charges with **ROCKHILL PHARMACY**.
(Company Name)

I agree that if at any time my financial status should change or I obtain secondary insurance, I will

contact the **ROCKHILL PHARMACY** to inform them of the change. At present, I have no other
(Company Name)

insurance to cover the balance of these or future charges.

Signed: ______________________________ Date: ______________

INSTRUCTIONS
Suppliers are required to collect the 20% coinsurance on Medicare claims unless it would create a financial hardship for the patient to make this payment.

If the patient cannot afford to pay the coinsurance, you must have the appropriate documentation reflecting this information in the patient's file.

PROTOCOL FOR RESOLVING COMPLAINTS FROM MEDICARE BENEFICIARIES

The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services. Service, equipment, and billing complaints will be communicated to management and upper management. These complaints will be documented in the *Medicare Beneficiaries Complaint Log*, and completed forms will include the following:

- patient's name
- patient's address
- patient's telephone number
- patient's health insurance claim number
- summary of the complaint
- date complaint was received
- name of the person receiving the complaint
- summary of actions taken to resolve the complaint.

All complaints will be handled in a professional manner. All logged complaints will be investigated, acted upon, and responded to in writing or by telephone by a manner within a reasonable amount of time after the receipt of the complaint. If there is no satisfactory resolution of the complaint, the next level of management will be notified progressively and up to the president or owner of the company.

The patient will be informed of this complaint resolution protocol at the time of setup of service.

ROCKHILL PHARMACY
LONG TERM CARE SERVICES

MEDICARE BENEFICIARY COMPLAINT LOG

Date of Receipt of Complaint: ____________________

Patient's Name: ____

Address: ____

City: ______________________________________ State: __________ Zip: ______________

Phone Number: ______________________ Medicare Number: ____________________________

Description of Complaint: ____

____

____

____

____

____

Action Taken to Resolve the Complaint: ____

____

____

____

____

____

____ ____________________

Signature of Representative **Date**

The Medicare Supplier Standards require that you record beneficiary complaints. A beneficiary complaint can cause an <u>unnecessary</u> and <u>unwanted</u> audit. Be sure they are handled timely and completely.

ROCKHILL PHARMACY
LONG TERM CARE SERVICES

NOTICE OF POSSIBLE MEDICARE DENIAL

Medicare will only pay for services that it determines to be "Reasonable and Necessary" under Section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular item, although it would otherwise be covered, is "Not Reasonable and Necessary" under Medicare Program Standards, Medicare will deny payment for the item(s) listed for the following reasons:

DELIVERY DATE	PROCEDURE CODE/DESCRIPTION
______________	____
______________	____
______________	____

_____ Medicare usually does not pay for this quantity of supplies

_____ Medicare does not pay for this equipment/supply for your condition

_____ Other, please specify: ____

BENEFICIARY AGREEMENT

"I have been notified by my supplier that he or she believes that in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment."

____ ________________

Patient's Signature Date

A waiver of liability form should be obtained on assigned and non-assigned claims for Medicare patients if you have reason to believe the equipment and/or supplies may be denied because of medical necessity.

A GA modifier must be used by the HCPCS code by the supplier to advise Medicare that you have this information in the patient's file.

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MEDICARE DMEPOS SUPPLIER STANDARDS

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. A supplier must have an authorized individual (whose signature is binding) sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory, or contract with other companies for the purchase of items necessary to fill orders. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR § 424.57 (c) (11).
12. A supplier is responsible for delivery of and must instruct beneficiaries on the use of Medicare covered items, and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair cost either directly, or through a service contract with another company, any Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 CFR § 424.57 (d).
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 CFR § 424.516(f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848(j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics.

MEDICARE DMEPOS SUPPLIER STANDARDS

DMEPOS suppliers have the option to disclose the following statement to satisfy the requirement outlined in Supplier Standard 16 in lieu of providing a copy of the standards to the beneficiary.

The products and/or services provided to you by (supplier legal business name or DBA) are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g. honoring warranties and hours of operation). The full text of these standards can be obtained at http://www.ecfr.gov. Upon request we will furnish you a written copy of the standards.