Welcome!

Thank you for choosing Medical Necessities and Services as your provider for home medical equipment and supplies. We appreciate your business and any chance to service you. Our main goal is to provide a friendly, caring staff to assist in your home medical and oxygen needs.

SERVICES

We currently provide the following:

- Home Oxygen (gas and liquid)
- CPAP and BiPAP Machines and Supplies
- Nebulizer Machines
- Hospital Beds (semi and full electric)
- Wheelchairs (standard and custom)
- Power Mobility Products (motorized wheelchairs and scooters)
- Walking Aids
- Bathroom Aids
- Trapeze Bars and Patient Lifts
- Specialty Mattresses (low air loss, gel overlay and alternating pressure pads)
- Off-the-Shelf Orthoses (back braces)

Please feel free to contact us if you have any home medical need.

January 2017

BUSINESS LOCATIONS AND HOURS

We have eight locations to conveniently serve you:

Medical Necessities & Services LLC
907 West James M Campbell Blvd
Columbia, TN 38401
Phone 931-840-8694
Fax 931-840-0166
Hours: 8:00am to 5:00pm
Monday – Friday
(Closed daily from 12:00-1:00 for lunch)

Medical Necessities & Services LLC
1811 Charlotte Ave.
Nashville, TN 37203
Phone: 615-515-3669
Fax: 615-515-3649
Hours: 8:00am to 5:00pm
Monday-Friday
(Closed daily from 12:00-1:00 for lunch)

Medical Necessities & Services LLC
150 Uptown Square Memorial Blvd.
Suite B
Murfreesboro, TN 37130
Phone: 615-225-2180
Fax: 615-225-2184
Hours: 8:00am to 4:30pm
Monday-Friday
(Closed daily from 12:00-1:00 for lunch)

Medical Necessities & Services LLC
111 Imperial Blvd.
Suite B-200
Hendersonville, TN 37075
Phone: 615-431-2429
Fax: 615-447-5094
Hours: 8:00am to 4:30pm
Monday-Friday
(Closed daily from 12:00-1:00 for lunch)

Medical Necessities & Services LLC
3616 Netherland Inn Rd., Suite 6
Kingsport, TN 37660
Phone: 423-390-8002
Fax: 423-530-7505
Hours: 8:00am to 4:30pm
Monday-Friday
(Closed daily from 1:00-2:00 for lunch)

Medical Necessities & Services LLC
9327 S. Northshore Dr.
Knoxville, TN 37922
Phone: 865-347-2310
Fax: 865-381-0435
Hours: 8:30am to 5:00pm
Monday-Friday
(Closed daily from 12:00-1:00 for Lunch)

Medical Necessities & Services LLC
1410 N. Mount Juliet Rd. STE 101
Mt. Juliet, TN 37122
Phone: 615-997-0861
Fax: 615-515-3649
Hours: 8:00am to 4:30pm
Monday-Friday
(Closed daily from 12:00-1:00 for lunch)

Medical Necessities & Services LLC
7405 Shallowford Road
Suite 190
Chattanooga, TN 37421
Phone: 423-648-9856
Fax: 888-711-5775
Hours: 8:30am to 5:00pm
Monday-Friday
(Closed daily from 12:30-1:30 for lunch)

In order to service you effectively, please call in advance for an appointment or supplies. We will be happy to assist you in any way we can. By calling ahead you may avoid a high wait time due to other scheduled appointments at one of our offices.

We have an after-hours call service for emergencies. You can contact them by calling any of the telephone numbers for any of the locations. The answering service will contact the technician on call and they will contact you. You can also leave a message for the office with the answering service.

If you are having medical problems, please call 911 or your physician.

We have a therapist on call to manage any emergencies. We consider emergencies with PAP therapy for patients who are on PAP therapy for respiratory failure. It is the patient's responsibility to let us know if you are a respiratory failure patient. Patients who have sleep apnea and require PAP therapy are urged to have extra supplies on hand in case of a need for supplies outside of our regular business hours.

What is Obstructive Sleep Apnea?

Sleep Apnea is a potentially serious sleep disorder in which breathing repeatedly stops and starts during sleep. Several types of sleep apnea exist, but the most common type is obstructive sleep apnea, which occurs when your throat muscles intermittently relax and block your airway during sleep. The most noticeable sign of obstructive sleep apnea is snoring, although not everyone who has obstructive sleep apnea snores. Common symptoms are excessive daytime sleepiness (hypersomnia), loud snoring, observed episodes of breathing cessation during sleep, abrupt awakenings accompanied by shortness of breath, awakenings with dry mouth or sore throat, morning headache, frequent urination at night, and difficulty staying asleep (insomnia). Your doctor felt that you may suffer from this condition so you were sent to a Sleep Lab for further evaluation. A sleep study consists of 1 or 2 different studies: a PSG, which is the diagnostic portion and a titration which is the portion where your pressure was determined. During the PSG it was determined that you had sleep apnea. You could have had a split night study if your study was recognized as severe. A split night study is where they watched you for a couple of hours and then began your titration.

- Untreated apnea is associated with several medical conditions including but not limited to:
    - High blood pressure
    - Heart disease
    - Heart attack
    - Irregular heart beat
    - Stroke
    - Type 2 diabetes
- It is important to note the OSA may also contribute to driving and work related accidents.
- PAP therapy will relieve the airway obstruction while you sleep. It acts as an air splint to keep airway open so that you can sleep throughout the night without interruption. By wearing your machine all night every night you may see these positive benefits from therapy:
    - Increased energy level and attentiveness
    - Reduced irritability
    - Improved memory
    - Less waking during the night to go to the bathroom
    - Increased ability to exercise
    - Increased effectiveness at home or work
    - Fewer morning headaches

Most patients who start PAP therapy are on it long term. Things that may affect your pressures or need for PAP therapy include surgery and weight loss. You are to notify your physician if you have any of the above.

BILLING

Medicare and some other insurance companies rent PAP equipment. Most private insurances purchase PAP devices. All insurances purchase the supplies that are used with the PAP device.

Explanation of Capped Rental Benefits

PAP devices are paid under a capped rental format through Medicare. Medicare and some other insurances will pay for rental for 13 months and then the equipment becomes yours. This means that during the 13 months you or your secondary insurance will be responsible for the 20% co-pay monthly until the cap has been reached. Medical Necessities is responsible for maintenance and service needed during the 13 months. Once the 13 months payment is completed it will then become your responsibility for all maintenance, service, repair or replacement parts. You will be informed before delivery if equipment being ordered by your physician is rental or purchase.

Billing Procedures

The cost of medical equipment provided by Medical Necessities and Services, LLC is ultimately the customer's responsibility. However, as a courtesy to you, we will file claims with your insurance. If you have a change in insurance carrier, please notify our billing department immediately. **If we receive a denial due to change in insurance, we will bill the patient directly.**

It is the patient's responsibility to know his or her health insurance benefits. Patients will be charged for any deductible or co-pay that their health plan does not cover.

Medical billing is confusing because there is a list price that we would charge if you did not have insurance and a contract price that varies depending on if you have Medicare, Tenncare, or private insurance.

Very rarely does insurance pay 100% of the cost of medical treatment. Most insurance plans have an annual deductible that is an out of pocket expense to you and they usually pay 80%-90% of the contracted price after the deductible has been met. Even Medicare has an annual deductible that has to be met, and then pays 80% of the contracted price.

In order to bill for most types of equipment, your physician has to fill out a form called a Certificate of Medical Necessity. It frequently takes 30 days or longer to get this form back from the physician before we can bill your insurance. Our normal billing procedure is to bill your primary insurance first. Once they process the claim, we will bill your secondary insurance, if you have one. This procedure can take several months.
If you have any questions about our billing, please call and ask to speak to someone in our Billing Department. Columbia's local number is 931-840-8694 or toll-free 1-800-680-8008.

Collections Notice

It is the policy of Medical Necessities, upon default, to send patient accounts to third parties for purpose of collection. At that point, the patient/responsible party is liable for all costs associated with the recovery of the defaulted account.

Care Centrix is the national clearinghouse for some insurance. We submit our claims to Care Centrix. Care Centrix will then collect from you any coinsurance or deductibles that are due, according to your specific insurance plan. If you have questions regarding your benefits, you should call the member services number on the back of your insurance card.

Regarding Insurance

Insurance is billed as a courtesy to our patients. All balances are your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. All copay's and deductibles are due and will be collected at the time services are rendered via credit card or auto pay with ACH or Credit Card.

Usual and Customary Rates

Our company is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We are an in-network provider for the majority of insurance companies and work out fee schedules with them in accordance with what is usual and customary for them.

CPAP Supply Billing

Below is an outlined description of the billing procedures to assist you in better understanding a statement from our company:
You are able to exchange the mask within the first 30 days after set-up with another mask at no expense to the customer. However, if you wait until day 31-90 from the time you received the mask, you will be responsible for the charge of the mask as a private pay item. Headgear is replaceable every 6 months; however, typically most masks have the headgear attached. Therefore, you may see a bill statement where headgear has been charged but on the next bill statement you will not see that charge.

Some insurances require authorization or predetermination before you are able to receive replacement supplies the same day. This process can take 2-4 weeks depending on the response time of your insurance. These insurances could include Amerigroup, Healthspring, Northwood, Windsor, Humana, some Blue Cross Blue Shield, Cigna and Homelink plans. Please check with your insurance carrier if you have any questions.

SD Card

Medical Necessities provides and covers all expense related to the wireless modem in your device. We also include ONLY one SD card at the time of setup. It is your responsibility to make sure you received the SD card at the time of setup. If you need any additional SD cards after setup, you will be required to pay $10 for each card.

It is very important that you make sure you keep up with this card if you take it to your MD and make sure you have the card placed back into your machine after your visit.

CPAP SUPPLIES REPLACEMENT GUIDELINES

The following is a general guideline for replacement supplies that are typically covered by insurance. However, every insurance is different so if you have questions please be sure to contact your insurance company or our supply department @ 1-877-218-9725.

Mask (nasal, full face, or oral)	1 per 3 months (some plans 1 per 6 months)
Cushions (full face, or oral)	1 per month (not billable same month as mask)
Cushions (nasal)	2 per month (not billable same month as mask)
Pillows per pair (nasal)	2 per month (not billable same month as mask)
Headgear	1 per 6 months for Medicare (some plans allow 1 per 3 months)
Chinstrap	1 per 6 months for Medicare (some plans allow 1 per 3 months)
Tubing, any type or size	1 per 3 months
Filter, non-disposable	1 per 6 months for Medicare (some plans allow 1 per 3 months)
Filter, disposable	2 per 1 month for Medicare (some plans allow 1 per 3 months)
Chamber for PAP humidifier device	1 per 6 months

We offer several methods of contact to remind you of your replacement supplies. These are:

- Live Phone call
- Email notification
- Smart Phone Application

You will be contacted regarding these supplies when you are due.

RETURN POLICY

*Private Purchase items may be returned within 5 days with the original receipt and in original unused condition. Special order items have a 25% restocking fee. Bathroom equipment is non-returnable. ***Disposable supplies cannot be accepted for return or credit, with the exception of defective supplies which may be exchanged only.***

*Insurance billable "purchase" items may only be returned in original unused condition within 5 days of sale date**. Original delivery slips are required. Insurance will be billed for 1 rental cycle on any returned "purchase" medical equipment. ***Bedside commodes, bath benches, etc. cannot be accepted for return.* ***Disposable supplies cannot be accepted for return or credit, with the exception of defective supplies which may be exchanged only.***

*Oxygen and CPAP equipment (insurance billable "rental" medical equipment) may ONLY be returned with a written MD prescription to discontinue use of said equipment or by signing an AMA (Against Medical Advice).
*However, other insurance billable "rental" items like wheelchairs and hospital beds may be returned at any time they are not being used. It is the patient's responsibility to let us know monthly if these items are being used. If the items are not being used, you can call and request pickup and state the reason why the equipment is no longer needed. At the time of pick up, you will be required to sign a pick up ticket and a discharge summary stating the reason for pick up. If you disagree with the reasoning, you will need to notify the technician immediately and not sign the paperwork.

*If exchanging CPAP mask, this must be done within 30 days of set-up with no refund/credit. Starting on day 31-90 days you will be responsible for cost of mask.

WARRANTY POLICY

Medical Necessities honors the manufacturer's warranty for new equipment and parts. All new purchase equipment comes with the manufacturer warranty. These warranties are typically one year, but some items have a two-year manufacturer warranty, all PAP machines have a 2 year warranty. Medical Necessities will exchange or repair defective or damaged equipment within the manufacturer's guidelines. Equipment without a specified manufacturer's warranty will be warranted by Medical Necessities for 30 days against manufacturer defect.

Rental equipment also comes with a warranty. For rental equipment, all warranties are effective from the first day of rental. If the manufacturer warranty is no longer in effect, Medical Necessities offers repair or replacement service for the equipment as long as it is in a rental state, without a service charge. If the equipment converts from a rental to purchase, Medical Necessities will repair the equipment at an hourly rate plus the cost of parts, in accordance with insurance company guidelines.

Equipment that is no longer under manufacturers' warranty will not be warranted by Medical Necessities. You may opt to rent a previously used unit for 30 days and have Medical Necessities send your malfunctioning unit in for a repair estimate. You and/or your insurance company will be responsible for all repair and loaner rental costs.

Warranties do not cover equipment that was modified by the client, or when damaged due to negligence or abuse while not operating or caring for the equipment in a manner consistent with the use or care for which it was designed. (Power mobility equipment exposed to rain or dampness will cause the equipment to malfunction electronically and mechanically, and will be considered abuse of the equipment.) Misuse of the equipment includes patient use of equipment outside of the manufacturer specifications of height and or weight limits. Misuse also includes using the equipment outside of the home.
Labor and travel time are not covered under the warranty.

REPAIR PROCESS

Medical Necessities & Services would like to keep you informed of the process in which your PAP machine will be repaired.

A. You will be offered the same machine to use during the time your machine is being repaired. If we do not carry or have one in stock, then a similar one will be provided. It is up to you if you would like to continue to use PAP therapy while your equipment is being repaired and you assume full responsibility in your decision for this.

B. We will bill your insurance for the "loaner" machine for one month. If your insurance company does not pay for the loaner, your debit card will be billed one month rental, outlined in number 2 below. We must have a prescription on file that is less than a year old for PAP with your current pressure listed. If we do not have a current prescription on file, then you need to contact your doctor and have them send us one.

C. You are completely responsible for any co-insurance and deductible that is not met at the time of receiving the loaner unit. It is your responsibility to know insurance coverage per your policy.

D. We will send your unit to the manufacturer to be diagnosed. This process can take up to a month. If your heated humidifier water chamber is not compatible with the loaner unit, then you will be provided one. You will either have to private pay or, if eligible, it will be billed to your insurance.

E. You will be required to put a debit or credit card on file. If you do not have either, you must pay a cash advance in the amount that is outlined below for equipment you are seeking repair before we will send your machine off for an estimate. If you don't have the financial capability to cover this charge, it is your responsibility to find the financial means.

F. Once an estimate of repair is made, we will call you for approval to repair your machine. Insurance does not always pay for the full amount of the cost of repairs. You will be responsible for the difference of the actual cost of repairs and what your insurance allows.

G. If you are unable to be reached after two weeks of receipt of the RA for your machine, it will be returned un-repaired to MNS at which time your credit card will be charged on a monthly basis per the fee schedule below until you decide to return the loaner machine. You will supply Medical Necessities the best contact number below to be reached and we will attempt to contact you one time on number below. It is your responsibility to return our calls.

    1. If you would like your machine repaired, we will bill your card the difference between the insurance allowable and the actual cost of the repairs including any deductible or copay that is not covered by your insurance. This charge will be reflective at the time Medical Necessities receives your insurance EOB. We will give you a call at the number below to let you know the final payment we will be deducting. We will only leave one message per patient.

    2. If you would like to keep your loaner machine instead of repairing your machine the charges are as follows

        a. CPAP $ 150 per month for 10 months = $1500

        b. BIPAP $ 300 per month for 10 months =$3000

        c. BIPAP W/Backup Rate $ 660 per month for 10 months = $6600

        d. Heated Humidifier $ 50 per month for 10 months = $500

H. If we repair your machine per your request and you do not show to pick your machine up within 30 days from date of our call your machine will belong to Medical Necessities at that point. You will continue to be responsible for the cost of the repair and ongoing monthly charges if you have a loaner machine. Once the machine becomes Medical Necessities property you will NOT be able to get your machine back.

I. ** Medicare patients will be required to follow the same rules outlined above with the only exception we will bill unassigned for the repair work. This means we will bill Medicare on your behalf but you will be responsible for the full repair work prior to billing Medicare. Once you have paid via CC or debt card we will submit the claim for repair to Medicare on your behalf and they will pay you directly for their agreed amount of your repair. Please note that we have no idea the amount you will receive from Medicare because each claim is different. Please note that Medicare only reimburses up to their allowable. If you have any disagreements with Medicare you will be responsible to take it up with Medicare directly. ** Also, if you have a secondary insurance it is your responsibility to submit the claim to them. Medicare usually does not do automatic crossover on non-assigned claims.

In addition, I realize that if I attempt to stop payment on my credit or debit card at any point I will be responsible for an additional fee of $100. If you stop payment at any point, you will also be responsible for all attorney and court fees necessary to recoup the charges listed within this agreement.

Medical Necessities & Services LLC

PAP EXPECTATION PLAN

Your physician has recently ordered you a PAP device used during sleep for the treatment of obstructive sleep apnea. According to insurance guidelines you qualify for this equipment and your doctor has asked us to set this up for you.

We have outlined the guidelines issued by your insurance company below. These are guidelines that you must follow in order for your insurance to pay for the equipment ordered by your physician. Please read them carefully. Failure to follow these requirements can result in payment denial from your insurer. In such a case, you will be responsible for payment of your bill.

- After you have used the device for at least 31 days, but no longer than 90 days, you will need to go in and see your doctor. Your doctor must re-evaluate you to see that you are benefitting from the use of the PAP therapy. In this re-evaluation, there must be documentation that your symptoms of obstructive sleep apnea have improved through use of this device.

Your physician may or may not have downloading capabilities. If your physician does and you visit your physician between days 31-90, you are not required to see our therapist. However, you need to call our office and let us know.

- Due to the guidelines set forth by your insurance company, it is imperative that the above steps are followed. If after day 90 you are not meeting the requirements set by insurance (which is greater than 4 hours nightly, 70% time of the time for 30 consecutive days), then you will be required to go back and have new sleep studies to keep the equipment. So, it is very important that you help us obtain the goals for payment that your insurance has set out.
- If you do not follow up with the physician or you fail to keep your appointment with the respiratory therapist and we are unable to get the information required by your insurance company, you will be responsible for the monthly rental of the equipment. This rental is as follows: $150.00 monthly for the CPAP device and $300 monthly for the BiPAP device. Please note that the insurance will not pay for supplies during this time if you are not compliant with the above steps to continue PAP therapy.
- When signing for receipt of this book you are stating that you understand that our monitoring activities as described above are solely for insurance qualification purposes. The monitoring services do not serve any clinical purposes, and we are not assuming responsibility for any clinical review or supervision.

When signing for receipt of this book you are further stating that you understand the insurance policy for continued coverage of PAP therapy and you will comply with the set guidelines. If you do not follow the set guidelines, you understand that you will be responsible for the payment of the devices and any supplies requested. You are also stating that we will be able to reach you via the contact information you have supplied us with. You are responsible for providing us with the correct contact information.

Tips when using the PAP device:

- Don't over-tighten your headgear. To help relieve undue pressure on the bridge of your nose, try to correct the problem by tightening the bottom straps first. You may see the need to increase tightening your straps because your cushion is wearing out or your headgear is stretched out. If this is the case, contact us to see about replacing your cushion or your mask. This will help to prevent over tightening, which leaves red marks on your face.

- If your mask is leaking, this may affect your pressure thus making the CPAP/BiPAP ineffective. Please let us know if you have any problems with your mask leaking. Please make sure you replace your cushions/pillows according to the replacement guidelines on page 5.

- If you experience nasal stuffiness, ear, nose sinus or eye pain, please contact us.

- If you have problems with your mask or the machine, please call us.

- It is very important to the life of your CPAP that your filters are changed as recommended by the manufacturer's guidelines. If they are not changed out properly, the machine will be affected. If you need a loaner machine and your supplies have not been maintained, there will be a fee of $150.00 per month for the CPAP and $300.00 for a BiPAP.

- To make sure to keep respiratory infections down to a minimum, please wash your tubing, mask and water chamber as indicated in the cleaning instructions. Please change them according to the replacement guidelines on page 5.

- It is important to replace your PAP equipment on a regular basis, especially your mask and tubing. Old masks, tubing and filters wear out and your equipment may not be as effective as possible.

- You may awaken in the night with the tube full of water or hear a banging noise. This noise occurs when the air pressure is trying to blow over a puddle of water in the tube and usually indicates the need to turn down your humidifier setting. You'll also want to dry out your tube during the day by hanging it over a door so that the air can circulate throughout the tube. If moisture still resides inside, attach the tube to your CPAP and let it blow through for a few minutes. You may have been insulating the tube during the winter months in order to stop condensation. Remove the covering until the fall and enjoy the spring season!

- Getting a rash or redness from your mask? It could be you are wearing it too tight, not cleaning it well enough or it may be wearing out.

- Even the highest grade of mask will cause skin irritation when it's nearing the end of its life span. When you are wearing your mask nightly, it will eventually wear out over time. When the cushion of a mask's flexibility degrades, the risk of leaks also increases.

PAP Cleaning Instructions:

Medical Necessities and Services Respiratory Therapy Department primarily uses one of 2 machines. We use machines made by Respironics and Resmed. Both machines are at the top of the market. Your doctor may have a preference for one over another. We will set up the one that your physician has ordered. Please let us know if you have a preference of machine. The therapist has indicated on your plan of care which machine you have received. Please follow the filter cleaning/replacement instructions for the machine indicated below:

- **Respironics:**
  - ❖ Check filter weekly. Wash the reusable filter every week and if your machine contains a disposable filter change it every 2 weeks.

- **Resmed:**
  - ❖ Check filter weekly. Filters are disposable, change every 2 weeks. Do not wash.

Mask: Wash the cushion of your mask daily with warm soapy water. Please be sure to use a mild soap with no moisturizers added or a face wash cloth with no oil. Make sure to wash your face before putting on the mask. Do not use moisturizers. The oils from the moisturizers and the natural oils from your skin will break the cushion down on the mask. Once per week wash the entire mask in warm soapy water using a mild detergent.

Headgear: Hand-wash your headgear as needed. Let it air dry. Do not put it in the dryer.

Tubing: Check your tubing daily for water condensation from your humidifier. Empty the tubing as needed. Once per week soak your tubing in warm soapy water using a mild detergent. Let it air dry. It is suggested to change your tubing at least every three months to prevent upper respiratory infections.

Humidifier Chamber: Use distilled water **ONLY** in your humidifier. Empty it daily. Once per week wash the unit in warm soapy water using a mild detergent.

Medical Necessities and Services, LLC
Code of Ethics Statement

- We always strive to provide the highest quality services to our clients/patients while meeting the highest professional and ethical standards possible.
- We provide home medical equipment and services in a prompt and reliable manner, ensuring that the equipment and services are safe and meet the client/patient's health care needs.
- We do not discriminate, either regarding clients/patients or employees, on the basis of any characteristic prohibited by law.
- We conduct our business professionally and ethically, and set up mechanisms to prevent fraud.
- We apply the highest standards of integrity in our advertising, marketing, and billing practices.
- We treat our clients/patients with respect, support their freedom of choice, and ensure that they are aware of their rights and responsibilities.
- We instruct each patient/client and/or caregiver in the correct operation of the equipment and service provided.
- We protect the confidential nature of client/patient health care records.
- We provide the appropriate insurance liability coverage for employees and clients/patients. We also provide Worker's Compensation.
- We screen staff via several means, including professional reference checks, before offering employment, and ensure that all staff members continue to improve their knowledge and skills so that the Company is able to provide home medical products and services competently.
- We provide employee orientation and continuing education opportunities to ensure that staff skills are current.
- We comply with all relevant federal, state, and local laws and regulations, as well as the requirements of federal, state, and private-payer health care programs and Accreditation Commission for Health Care.

MISSION STATEMENT

Medical Necessities and Services, LLC's mission is to meet home medical equipment needs of our clients/patients in our service area by providing the highest quality medical equipment supplies and services. We respect the rights of our clients/patients, and are dedicated to providing responsive, timely customer service. We ensure that members of our team received ongoing continuing education so that they are knowledgeable about home health care technology and are able to serve our clients/patients effectively.

SCOPE OF SERVICES

Policy/Goal: To provide durable medical equipment and respiratory homecare equipment to patient/client in a timely manner and with the highest quality of service.

Equipment and Services:

1. Provide oxygen concentrators and portable oxygen units.
2. Home fill units and liquid oxygen
3. Provide emergency backup cylinder tanks of oxygen (based on patient's liter flow). Provide written and oral instructions on home safety and the safe use of home medical and respiratory homecare equipment.
4. Provide hospital beds (semi-electric), patient lifts, wheelchairs, power mobility products, walkers, canes, bedside commodes, alternating pressure pads and other medical equipment.
5. Provide CPAP and BIPAP products
6. Portable concentrators
7. Custom made wheel chairs
8. Positioning / seating products
9. Provide Off-The-Shelf Orthoses (L0637, Aspen Medical Back Braces)
10. We do not provide any type of clinical services.

Medicare requires written orders before delivery for alternating pressure pads, gel overlays, power mobility devices, wheelchair cushions and backs.

Services are provided to all patients, regardless of race, sex, religion, social status, political belief, age or handicap.

Services are provided by:

1. Respiratory therapists
2. Delivery technicians
3. Staff RNs
4. ATPs
5. RTSs

Medical Necessities and Services, LLC will receive referrals from any outside referral source.

Medical Necessities and Services, LLC provides services from 8:00 a.m. to 5:00 p.m., Monday through Friday with staff on call 7 days a week, 24 hours per day. Our office can be contacted anytime by calling 931-840-8694 or 1-800-680-8008.

RIGHTS AND RESPONSIBILITIES

Information Disclosure:
You have the right to accurate and easily understand information about your health plan, health care professionals, and health care facilities. If you speak another language, have a physical or mental disability, or just don't understand something, assistance will be provided so you can make informed health care decisions.

Choice of Providers and Plans:
You have the right to a choice of health care providers that is sufficient to provide you with access to appropriate high-quality health care.

Access to Emergency Services:
If you have severe pain, an injury, or sudden illness that convinces you that your health is in serious jeopardy, you have the right to receive screening and stabilization emergency services whenever and wherever needed, without prior authorization or financial penalty.

Participation in Treatment Decisions:
You have the right to know your treatment options and to participate in decisions about your care. Parents, guardians, family members or other individuals that you designate can represent you if you cannot make your own decisions.

Respect and Non-discrimination:
You have the right to considerate, respectful and non-discriminatory care from your doctors, health plan representatives and other health care providers.

Confidentiality of Health Information:
You have the right to talk in confidence with health care providers, and to have your health care information protected. You also have the right to review and copy your own medical record, and request that your physician change your record if it is not accurate, relevant, or complete.

Complaints and Appeals:
You have the right to a fair, fast, and objective review of any complaint you have against your health plan, doctors, hospitals or other health care providers/personnel. This includes complaints about waiting times, operating hours, the conduct of health care personnel, and the adequacy of health care facilities.

Consumer Responsibilities:
It is reasonable to expect and encourage consumers to assume reasonable responsibilities. Greater individual involvement by consumers in their care increases the likelihood of achieving the best outcomes, and helps to support a quality improvement, cost-conscious environment.

Persons who receive home care services have these rights:

1. The right to receive written information about their rights in advance of receiving care/services, or during the initial evaluation visit, before the initiation of treatment and what to do if rights are violated.
2. The right to receive care and services according to a suitable and up- to-date plan, and subject to accepted medical or nursing standards. The provider must advise the recipient in advance of the right to participate in planning the care or treatment.
3. The right to be told in advance of services, what services will be provided, who will provide the services, the frequency of visits, other choices that are available, and the consequences of these choices, including the consequences of refusing services.
4. The right to refuse services and/or treatment.
5. The right to know the limits to the services and the provider's grounds for termination of services.
6. The Provider must advise the recipient of home care services, both orally and in writing, of any changes in coverage and the recipient's liability for charges as soon as possible, but no later than thirty (30) calendar days after the provider becomes aware of a change.
7. The rights to choose freely among available providers and to change providers after services have begun

8. The right to know what the charges are for services, no matter who will be paying for them
9. The right to have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information.
10. The right to be served by people who are properly trained and competent to perform their duties.
11. The right to be treated with respect and courtesy, as well as the patient's property.
12. The right to have access to records and written information from the records in accordance with State Statutes.
13. The right to voice grievances/complaints regarding treatment or care that is, or fails to be, finished
14. The right to know how to contact an individual with the provider who is responsible for handling problems and/or complaints/grievances. The provider shall document in writing all complaints, as well as document, in writing, any resolution/corrective action resulting from the complaint.
15. The right to assert these rights personally, or by a family member, or designated guardian when the patient has been judged incompetent, without retaliation.
16. The right to be informed of the name and address of the State or county agency to contact for additional information or assistance
17. It is the patient's responsibility to report any changes in insurance, address change or other important information.
    Failure to do this will result in patient's responsibility for cost of equipment.
18. Patients and caregivers have the responsibility to take care of equipment.
    If damaged or infested you will be charged the cost for repair or replacement.
19. Providers have the right to be free from threats of violence and actual violence.
20. Providers have the right to provide services in patients' homes that are structurally sound.
21. Providers have the right to be free from threatening behavior and/or physical injuries from animals.
22. Providers have the right to be treated with dignity and respect by patients and their families at all times.
23. Providers have the right to be free from unwanted remarks, either positive or negative, regarding their personal appearance.
24. Providers have the right to be free from discrimination on the basis of race, religion, and ethnic origin by patients and their families.
25. Providers have the right to work in patients' homes without being subjected to sexual remarks, advances, and/or harassment.
26. Providers have the right to pick up equipment in the home if the patient or patient's insurance is no longer covering the cost of the equipment.

A home care provider may not require a person to surrender these rights as a condition to receive services. The provider must acknowledge, protect and promote these rights.

If you need assistance, have questions or a complaint, Please contact:

Medical Necessities and Services, LLC
907 W. James Campbell Blvd.
Columbia, TN 38401
931-840-8694

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.

Palmetto GBA
National Supplier Clearinghouse
PO Box 100142, Columbia, SC, 29202-3142, (866)238-9652
A CMS Contracted Intermediary and Carrier

NOTICE OF PRIVACY PRACTICES

This Notice is effective September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY

WE ARE REQUIRED BY LAW TO PROTECT MEDICAL INFORMATION ABOUT YOU

We are required by law to protect the privacy of medical information about you and that identifies you. This medical information may be information about healthcare we provide to you or payment for healthcare provided to you. It may also be information about your past, present, or future medical condition.

We are also required by law to provide you with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to medical information. We are legally required to follow the terms of this Notice. In other words, we are only allowed to use and disclose medical information in the manner that we have described in this Notice.

We may change the terms of this Notice in the future. We reserve the right to make changes and to make the new Notice effective for *all* medical information that we maintain. If we make changes to the Notice, we will:

- Post the new Notice in our waiting area.
- Have copies of the new Notice available upon request. Please contact our Privacy Officer at **931-375-1725** to obtain a copy of our current Notice.

The rest of this Notice will:

- Discuss how we may use and disclose medical information about you.
- Explain your rights with respect to medical information about you.
- Describe how and where you may file a privacy-related complaint.

If, at any time, you have questions about information in this Notice or about our privacy policies, procedures or practices, you can contact our Privacy Officer at **931-375-1725**.

WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU IN SEVERAL CIRCUMSTANCES

We use and disclose medical information about patients every day. This section of our Notice explains in some detail how we may use and disclose medical information about you in order to provide healthcare, obtain payment for that healthcare, and operate our business efficiently. This section then briefly mentions several other circumstances in which we may use or disclose medical information about you. For more information about any of these uses or disclosures, or about any of our privacy policies, procedures or practices, contact our Privacy Officer at **931-375-1725**.

1. **Treatment:** We may use and disclose medical information about you to provide treatment to you. In other words, we may use and disclose medical information about you to provide, coordinate or manage your healthcare and related services. This may include communicating with other healthcare providers regarding your treatment and coordinating and managing your healthcare with others.

***Example*:** *Information obtained by a therapist or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. We may provide your physician or subsequent healthcare provider with copies of various reports that should assist him or her in treating you.*

2. **Payment:** We may use and disclose medical information about you to obtain payment for healthcare services that you received. This means that we may *use* medical information about you to arrange for payment (such as preparing bills and managing accounts). We also may *disclose* medical information about you to others (such as insurers, collection agencies, and consumer reporting agencies). In some instances, we may disclose medical information about you to an insurance plan *before* you receive certain healthcare services because, for example, we may need to know whether the insurance plan will pay for a particular service.

***Example*:** *A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.*

3. **Healthcare Operations:** We may use and disclose medical information about you in performing a variety of business activities that we call "healthcare operations." These "healthcare operations" activities allow us to, for example, improve the quality of care we provide and reduce healthcare costs. For example, we may use or disclose medical information about you in performing the following activities:

- Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients.
- Cooperating with outside organizations that assess the quality of the care others and we provide, including government agencies and private organizations.
- Planning for our organization's future operations.
- Resolving grievances within our organization.
- Reviewing our activities and using or disclosing medical information in the event that control of our organization significantly changes.
- Working with others (such as lawyers, accountants and other providers) who assist us to comply with this Notice and other applicable laws.

Example: *Members of our quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide*.

4. **Persons Involved in Your Care:** We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. If the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances.
For more information on the privacy of minors' information, contact our Privacy Officer at **931- 375-1725.**

We may also use or disclose medical information about you to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) if we need to notify someone about your location or condition.

You may ask us at any time not to disclose medical information about you to persons involved in your care. We will agree to your request and not disclose the information except in certain limited circumstances (such as emergencies) or if the patient is a minor. If the patient is a minor, we may or may not be able to agree to your request.

5. **Required by Law:** We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. For example, state law requires us to report known or suspected abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

6. **National Priority Uses and Disclosures:** When permitted by law, we may use or disclose medical information about you without your permission for various activities that are recognized as "national priorities." In other words, the government has determined that under certain circumstances (described below), it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. We will only disclose medical information about you in the following circumstances when we are permitted to do so by law. Below are brief descriptions of the "national priority" activities recognized by law. For more information on these types of disclosures, contact our Privacy Officer at **931-375-1725.**

- **Threat to health or safety:** We may use or disclose medical information about you if we believe it is necessary to prevent or lessen a serious threat to health or safety.
- **Public health activities:** We may use or disclose medical information about you for public health activities. Public health activities require the use of medical information for various activities, including, but not limited to, activities related to investigating diseases, reporting child abuse and neglect, monitoring drugs or devices regulated by the Food and Drug Administration, and monitoring work-related illnesses or injuries. For example, if you have been exposed to a communicable disease (such as a sexually transmitted disease), we may report it to the State and take other actions to prevent the spread of the disease.
- **Abuse, neglect or domestic violence:** We may disclose medical information about you to a government authority (such as the Department of Social Services) if you are an adult and we reasonably believe that you may be a victim of abuse, neglect or domestic violence.
- **Health oversight activities:** We may disclose medical information about you to a health oversight agency – which is basically an agency responsible for overseeing the healthcare system or certain government programs. For example, a government agency may request information from us while they are investigating possible insurance fraud.
- **Court proceedings:** We may disclose medical information about you to a court or an officer of the court (such as an attorney). For example, we would disclose medical information about you to a court if a judge orders us to do so.
- **Law enforcement:** We may disclose medical information about you to a law enforcement official for specific law enforcement purposes. For example, we may disclose limited medical information about you to a police officer if the officer needs the information to help find or identify a missing person.
- **Coroners and others:** We may disclose medical information about you to a coroner, medical examiner, or funeral director or to organizations that help with organ, eye and tissue transplants.
- **Workers' compensation:** We may disclose medical information about you in order to comply with workers' compensation laws.

- **Research organizations:** We may use or disclose medical information about you to research organizations if the organization has satisfied certain conditions about protecting the privacy of medical information.
- **Certain government functions:** We may use or disclose medical information about you for certain government functions, including but not limited to military and veterans' activities and national security and intelligence activities. We may also use or disclose medical information about you to a correctional institution in some circumstances.

7. **Authorizations:** Other than the uses and disclosures described above (#1-6), we will not use or disclose medical information about you without the "authorization" – or signed permission – of you or your personal representative. In some instances, we may wish to use or disclose medical information about you and we may contact you to ask you to sign an authorization form. In other instances, you may contact us to ask us to disclose medical information and we will ask you to sign an authorization form.

If you sign a written authorization allowing us to disclose medical information about you, you may later revoke (or cancel) your authorization in writing (except in very limited circumstances related to obtaining insurance coverage). If you would like to revoke your authorization, you may write us a letter revoking your authorization or fill out an Authorization Revocation Form. Authorization Revocation Forms are available from our Privacy Officer. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization and taken some action.

The following uses and disclosures of medical information about you will only be made with your authorization (signed permission):

- Uses and disclosures for marketing purposes.
- Uses and disclosures that constitute the sales of medical information about you.
- Most uses and disclosures of psychotherapy notes, if we maintain psychotherapy notes.
- Any other uses and disclosures not described in this Notice.

YOU HAVE RIGHTS WITH RESPECT TO MEDICAL INFORMATION ABOUT YOU

You have several rights with respect to medical information about you. This section of the Notice will briefly mention each of these rights. If you would like to know more about your rights, please contact our Privacy Officer at **931-375-1725**.

1. **Right to a Copy of This Notice:** You have a right to have a paper copy of our Notice of Privacy Practices at any time. In addition, a copy of this Notice will always be posted in our waiting area. If you would like to have a copy of our Notice, ask the receptionist for a copy or contact our Privacy Officer at **931-375-1725**.

2. **Right of Access to Inspect and Copy:** You have the right to inspect (which means see or review) and receive a copy of medical information about you that we maintain in certain groups of records. If we maintain your medical records in an Electronic Health Record (EHR) system, you may obtain an electronic copy of your medical records. You may also instruct us in writing to send an electronic copy of your medical records to a third party. If you would like to inspect or receive a copy of medical information about you, you must provide us with a request in writing. You may write us a letter requesting access or fill out an **Access Request Form**. Access Request Forms are available from our Privacy Officer.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. We will also inform you in writing if you have the right to have our decision reviewed by another person.

If you would like a copy of the medical information about you, we will charge you a fee to cover the costs of the copy. Our fees for electronic copies of your medical records will be limited to the direct labor costs associated with fulfilling your request.
We may be able to provide you with a summary or explanation of the information. Contact our Privacy Officer for more information on these services and any possible additional fees.

3. **Right to Have Medical Information Amended:** You have the right to have us amend (which means correct or supplement) medical information about you that we maintain in certain groups of records. If you believe that we have information that is either inaccurate or incomplete, we may amend the information to indicate the problem and notify others who have copies of the inaccurate or incomplete information. If you would like us to amend information, you must provide us with a request in writing and explain why you would like us to amend the information. You may either write us a letter requesting an amendment or fill out an **Amendment Request Form**. Amendment Request Forms are available from our Privacy Officer.

We may deny your request in certain circumstances. If we deny your request, we will explain our reason for doing so in writing. You will have the opportunity to send us a statement explaining why you disagree with our decision to deny your amendment request and we will share your statement whenever we disclose the information in the future.

4. **Right to an Accounting of Disclosures We Have Made:** You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting, fill out an **Accounting Request Form**, or contact our Privacy Officer. Accounting Request Forms are available from our Privacy Officer.

The accounting will not include several types of disclosures, including disclosures for treatment, payment or healthcare operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request that include disclosures for treatment, payment or healthcare operations. The accounting will also not include disclosures made prior to April 14, 2003.

If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

5. **Right to Request Restrictions on Uses and Disclosures:** You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations. Under federal law, we must agree to your request and comply with your requested restriction(s) if:

1. Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of healthcare operations (and is not for purposes of carrying out treatment); and,
2. The medical information pertains solely to a healthcare item or service for which the healthcare provided involved has been paid out-of-pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

You also have the right to request that we restrict disclosures of your medical information and healthcare treatment(s) to a health plan (health insurer) or other party, when that information relates solely to a healthcare item or service for which you, or another person on your behalf (other than a health plan), has paid us for in full. Once you have requested such restriction(s), and your payment in full has been received, we must follow your restriction(s).

6. **Right to Request an Alternative Method of Contact:** You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing. You may write us a letter or fill out an **Alternative Contact Request Form**. Alternative Contact Request Forms are available from our Privacy Officer.

7. **Right to Notification if a Breach of Your Medical Information Occurs:** You also have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs, and if that information is unsecured (not encrypted), we will notify you promptly with the following information:

- A brief description of what happened;
- A description of the health information that was involved;
- Recommended steps you can take to protect yourself from harm;
- What steps we are taking in response to the breach; and,
- Contact procedures so you can obtain further information.

8. **Right to Opt-Out of Fundraising Communications:** If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us. Please contact our Privacy Officer to opt-out of fundraising communications if you chose to do so.

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a written complaint either with us or with the federal government.

We will not take any action against you or change our treatment of you in any way if you file a complaint.

To file a written complaint with us, you may bring your complaint directly to our Privacy Officer, or you may mail it to the following address:

Attn: Privacy Officer
Medical Necessities & Services LLC
907 W James Campbell Blvd.
Columbia, TN 38401

To file a written complaint with the federal government, please use the following contact information:

Office for Civil Rights
U.S. Department of Health and Human Services 200 Independence Avenue, S.W.
Room 509F, HHH Building Washington, D.C. 20201

Toll-Free Phone: 1-(877) 696-6775

Website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Email: OCRComplaint@hhs.gov

COMPLAINT PROCEDURE

Procedure for filing a complaint or grievance concerning Medical Necessities and Services LLC:

1. Notify the person logging the complaint of action taken within 24 hours.
2. Record information about the complaint on the phone log (if one is used) and/or complete an incident report (if indicated). This information should include the following:
   - Date
   - Time
   - Description of complaint
   - Name of persons involved, or description of product involved (along with any serial or control numbers)
3. Determine what actions the caller thinks should be taken to resolve the complaint.
4. If the complaint involves equipment or a product, arrange for evaluation, repair, or replacement of defective items if applicable.
5. Speak with employees involved as appropriate.
6. Attempt to resolve the complaint to the patient's/client's satisfaction.
7. If the complaint is not resolved within 24 hours, report status of activities to the patient/client within two (2) days after the complaint is received and weekly thereafter until the complaint is resolved.
8. Submit written follow-up letter as appropriate.
9. When a complaint cannot be resolved as described above, forward the information to the supervisor.
10. When a complaint has been resolved, the completed report (including a description of the steps taken to achieve resolution) is forwarded to the supervisor.
11. The supervisor reviews the complaint and collects additional data as required to resolve the complaint, and responds to the complaint within 24 hours after receipt. If the supervisor cannot resolve the complaint to the patient's/clients satisfaction, the supervisor documents the grievance and action taken to date, and submits it to upper management. Upper management makes every effort to resolve the complaint to the patient's/client's satisfaction, and notifies the patient/client and appropriate management personnel of all actions taken on the customer's behalf within 10 days.
12. The person filing the compliant has the right to call the Medicare Hotline (1-800- Medicare), Tennessee Department of Health Division of Health Care Facilities Centralized Complaint Intake Unit (1-877-287-0010) or ACHC (our accrediting organization) (1-919-785-1214) if they are not satisfied with our response.

Medicare providers:
Within five (5) calendar days of receiving a patient/client complaint, Medical Necessities notifies the patient/client, using either oral, telephone, e-mail, fax, or letter format, that it has received the complaint and that it is investigating. Within 14 calendar days, Medical Necessities provides written notification to the beneficiary of the results of its investigation and response. Medical Necessities maintains documentation of all complaints that it receives, copies of the investigations, and responses to beneficiaries.

BASIC HOME SAFETY

Equipment Operation

- Follow the provided instructions for operating the equipment.
- Never reset, bypass, or cover alarms, and be sure alarms are not covered up when the device is carried in a bag.

Fire safety

- Install smoke detectors in the home. Test them monthly and change the batteries twice a year.
- Identify doors, windows, or alternative exits that may be used in a fire.
- Post the fire department's phone number by each phone.
- Purchase a fire extinguisher and ensure that family members know how to use it.
- Be careful with smoking materials.
- Never use oxygen in the presence of smoking materials or open flames.

Electric

- Use approved surge protectors rather than extension cords when possible.
- Do not stretch electrical cords across walkways where they may present a tripping hazard.
- Arrange furniture so that outlets may be used without an extension cord.
- Do not set furniture on top of electrical cords. The cord could become damaged and create potential fire and shock hazards.
- Do not run electrical cords under carpeting as it may cause a fire.
- Do not overload outlets.
- Use a light bulb of the correct type and wattage to avoid overheating and potential fire hazards.
- Keep heaters away from passageways and flammable items (e.g., curtains).

Lighting

- Make sure stairways are clearly lit from top to bottom so that each step is visible.
- Install light switches at the top and bottom of the stairs.
- Keep a flashlight close at hand.
- Motion sensors that activate lighting in outdoor environments may offer safety and security.

Floors

- Remove loose carpeting or throw rugs that slide.
- Secure rugs and runners by attaching double-faced carpet tape or rubber matting to the underside.
- Be sure that handrails run from the top to the bottom of a flight of stairs.
- Make sure there are no bulges in floor coverings.

Telephones

- A telephone with lighted keypads and large numbers may be recommended.
- Place a phone where it would be accessible in case of an accident where the client/patient is unable to stand.
- Post emergency numbers and the residence address near each phone.

Kitchens

- Do not store non-cooking equipment (e.g., towels, plastic utensils) near the stovetop as it may present a fire or burn hazard.
- Do not let loose-fitting clothing drape over burners when cooking.
- Use rear burners when possible.
- Turn handles on pots and pans in towards the back wall to avoid accidents.

Bathrooms

- Install a nightlight in the bathroom.
- Apply non-slip strips on shower and bathtub floors.
- Avoid water temperatures higher than 120 degrees to avoid scalding
- Install grab bars to help patients/clients get in and out of the tub and shower

EMERGENCY PREPAREDNESS

It is important to prepare for possible disasters and other emergencies. The following information is provided to you as a guide to help you be prepared should a natural or human-caused disaster strike your area.

The following items should be kept in an easy-to-carry kit that you can use at home or take with you should you be forced to evacuate your home:

- Water – one gallon per person, per day (3-day supply for evacuation, 2-week supply for home)
- Food – non-perishable, easy-to-prepare items (3-day supply for evacuation, 2-week supply for home)
- Flashlight
- Battery-powered or hand-crank radio (NOAA Weather Radio is suggested)
- Extra batteries
- First aid kit
- Medications (7-day supply) and medical items
- Multi-purpose tool
- Sanitation and personal hygiene items
- Copies of personal documents
    - Medication list and pertinent medical information
    - Proof of address
    - Deed/lease to home
    - Passports, birth certificates, insurance policies
- Cell phone with chargers
- Family and emergency contact info
- Extra cash
- Emergency blanket
- Map(s) of the area
- Additional items may be needed to accommodate your family's needs

Make a plan with your family or household members

- Plan what to do in case you are separated during an emergency
- Plan what to do if you have to evacuate

Be informed

- Be aware of how local authorities will notify you during a disaster
- Make sure that at least one member of your household is trained in First Aid and CPR
- The American Red Cross is an excellent resource to help you be prepared for emergencies. Their website address is: www.RedCross.org

Patient/Client care

Medical Necessities has policies and procedures in place to ensure that customer service and care of our patients are not interrupted in the event of an emergency or disaster. All employees are educated about the process to meet client/patient needs in a disaster or crisis situation.

Medical Necessities & Services, LLC

ADVANCE DIRECTIVES POLICY

Advance Directives are instructions to let family, caregivers, physicians and healthcare providers know your decisions for health care if you become unable to decide for yourself. They include written instructions regarding resuscitation and withholding or withdrawing treatment. These directives may include, but are not limited to, designating another person to make medical decisions for you should you become unable to make these decisions. Care will not be withheld if an Advanced Directive is not present.

You or your caregiver(s) should discuss the Rights and Responsibilities of Advance Directives with your physicians and obtain a specific form signed by all responsible parties involved.

The Tennessee Department of Health provides resources for Advance Directives on their website: https://health.state.tn.us/AdvanceDirectives

Medical Necessities and Services, LLC employees are instructed not to perform CPR and therefore no training is required.

Our employees are instructed to follow these steps in the event of an emergency:

- Call 911 if indicated
- Notify the appropriate Company supervisors.
- Provide support and help to the patient/client family.
- Document actions in the patient/client record.
- Complete an incident report.

MEDICAL NECESSITIES & SERVICES LLC
EQUIPMENT ORIENTATION CHECKLIST/PLAN OF CARE
CPAP, BiPAP or RAD SETUP

Patient Name: _____

Type of Machine:_____ **Pressure:**_____cmH2O **Supplies:** Yes No

To be completed by patient/caregiver

I, the patient/caregiver, certify that I have been instructed on the following:

- ☐ How to turn on the unit
- ☐ How to open the humidifier/water chamber
- ☐ How to change disposable filter and/or how to clean non-disposable filter
- ☐ Data card/Modem
- ☐ Adjusting humidifier settings
- ☐ Ramp settings (if applicable)
- ☐ How to clean machine and supplies
- ☐ When to replace supplies
- ☐ Insurance compliance requirements
- ☐ How to order supplies
- ☐ Making sure the humidifier chamber is empty before packing the machine to travel
- ☐ Advance Directives _____Yes _____No
- ☐ I understand pressure settings are not adjustable without a prescription from the physician

To be completed by the MNS clinical representative

- ☐ Patient gave return demonstration of all components of equipment and supplies successfully.
- ☐ Patient had the following concerns about their equipment and/or supplies at time of setup:
  _____
- ☐ Patient was instructed to bring their card/machine with them to all of their appointments with sleep physicians. Their next appointment is scheduled at:_____
- ☐ Patient was given handout/education about replacement supplies and how to get them and how often. They were signed up in S3 program.
- ☐ Patient was educated on proper mask fit and demonstrated the most success with _____ mask. Patient understands the 30 day return policy and was educated that any mask not returned within the 30 days of setup will be replaced at the expense of the patient.
- ☐ Patient understands they are involved in their plan of care with physician and Medical Necessities. They are responsible to assist with getting adherence data to Medical Necessities/physician in one week, one month, 3 months, 6 months, and 12 months. Failure to comply with these protocols could lead to non-coverage of their machine and supplies. In addition, they were educated that any time a physician changes a prescription on their equipment they need to get another download in 2 weeks to assess effectiveness of the new pressure.
- ☐ Patient was educated to contact OUR office if they have any issues/problems that arise and we will communicate with physician to rectify any and all situations.
- ☐ Enrolled patient in EncoreAnywhere/Airview/U-Sleep with modem.

GOALS	PLAN – ACTIONS
1. Initial equipment/supplies service provided with above listed equipment/supplies	1. Set-up equipment/supplies. Patient instructed on proper use of equipment and supplies
2. Patient/caregiver trained to operate equipment/supplies in safe manner	2. Set-up equipment/supplies. Patient educated on safe placement of equipment/supplies
3. Patient/caregiver understands cleaning, trouble-shooting and treatment guidelines for equipment/supplies.	3. Instruct patient/caregiver in cleaning, troubles-shooting and treatment guidelines.

Note: You have been instructed or already understand the proper use of this equipment. Your physician has ordered this equipment and the specific parameters for its use. We make no warranty or guarantee of the effectiveness of its use or any therapeutic results.

By signing this form, I, the patient, am expressing that I fully understand the treatment protocol that Medical Necessities and my sleep physician have outlined for me. I understand all of the procedures above and will comply with them to my fullest extent.

_____ _____ _____

Patient/Caregiver Signature **Date** **MNS Clinical Representative Signature**

Medical Necessities & Services LLC
EQUIPMENT ORIENTATION CHECKLIST/PLAN OF CARE
NEW SUPPLY PATIENTS

Patient Name: _____

Type of Machine:_____ **Pressure:**_____cmH2O

To be completed by patient/caregiver

I, the patient/caregiver, certify that I have previous knowledge/understand the following:

- ☐ How to use PAP machine
- ☐ How to open the humidifier/water chamber
- ☐ How to change disposable filter and/or how to clean non-disposable filter
- ☐ Data card/Modem
- ☐ Adjusting humidifier settings
- ☐ Ramp settings (if applicable)
- ☐ How to clean machine and supplies
- ☐ When to replace supplies
- ☐ How to order supplies
- ☐ Making sure the humidifier chamber is empty before packing the machine to travel
- ☐ Advance Directives _____Yes _____No
- ☐ I understand pressure settings are not adjustable without a prescription from the physician
- ☐ I need to be contacted to go over the following questions:

  _____
  _____
  _____

Note: You understand the proper use of this equipment. Your physician has ordered this equipment and the specific parameters for its use. We make no warranty or guarantee of the effectiveness of its use or any therapeutic results.

_____ _____
Patient/Caregiver Signature **Date**

To be completed by the MNS clinical representative

Patient requested to be contacted or had questions during supply setup? ☐ Yes ☐ No

If yes, were questions addressed: ☐ In person/during setup ☐ By phone

For phone follow-ups, were patient's questions answered to their satisfaction?

☐ Yes ☐ No/required follow-up appt. scheduled on: _____

Patient requested:

- ☐ Mask used with previous company: _____
- ☐ Mask Fitting. Patient was educated on proper mask fit and demonstrated the most success with _____ mask. Patient understands the 30 day return policy and was educated that any mask not returned within the 30 days will be replaced at the expense of the patient.
- ☐ Patient was given handout/education about replacement supplies and how to get them and how often. They were signed up in S3 program.

_____ _____
MNS Clinical Representative Signature **Date**

MEDICAL NECESSITIES AND SERVICES, LLC

1. Medicare or my insurance has not purchased or rented same or similar items stated above. _____ (initials)

2. I received instructions and understand that Medicare defines the _____ that I received as being either a capped rental or an inexpensive or routinely purchased item.

____ FOR CAPPED RENTAL ITEMS:

- Medicare will pay 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, it is the beneficiary's responsibility to arrange 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 monthly rentals cannot exceed the fee schedule purchase amount.
- Examples of this type of equipment include:
  Canes, walkers, crutches, commode chairs, and bed side rails.
- I select the:
  Purchase Option _____ Rental Option _____

PAP machines sold or rented by our company carry a 2-year manufacturer's warranty. Medical Necessities & Services will notify all Medicare beneficiaries of the warranty coverage, and we will honor all warranties under applicable law. Medical Necessities & Services LLC 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. I have been instructed and understand the warranty coverage on the product I have received_____ (initials)

I authorize the following individuals to receive equipment and /or supplies on my behalf. The following people can be contacted on my behalf:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship:_____ Phone:_____

May we leave a message? ____ Yes _____No
If yes, where? _____ Voice Mail _____ Family Member _____ Work

Email: _____ DL #_____ Photo ID verified____ PCP:_____

AUTHORIZATION TO ASSIGN BENEFITS TO PROVIDER & RELEASE OF MEDICAL INFORMATION:
I request that payment of authorized Medicare and other benefits be made on my behalf to the above company for products and services that they have provided for me. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of medical information about me to release to Medical Necessities & Services, to aid in payment and/or precertification of equipment.

By signing this form, I am stating that I have received a copy of the following and that I have been fully instructed and understand how to operate equipment prescribed for me and that I have been instructed on the plan of care.

***Notice of Privacy Policies**
(as required by the Health Information Portability and Accountability Act of 1996-HIPAA).
***Medicare Supplier Standards**
***Patient Rights and Responsibilities**
***Customer Information Booklet**
***Business Hours**
***Return Policy**
***Grievance and Complaint Policy**
***Equipment Cleaning Instructions**
***Equipment Orientation Checklists**
***O2 Safety**
***Billing Procedures**
***Basic Home Safety**
***Emergency Preparedness**
***Warranty Policy**
***Advance Directives Policy**
*** Scope of Services**

_____ Cell phone:_____
Patient name

_____ Date:_____
Patient signature

_____ Date:_____
Medical Necessities Representative

Medical Necessities & Services, LLC
BASIC HOME SAFETY CHECKLIST

Patient:_____ **HICN#:**_____ **DOB:** _____

1. Are lamp, extension, and telephone cords placed out of the flow of traffic?	Yes	No
2. Are cords out from beneath furniture and rugs?	Yes	No
3. Are electrical cords in good condition, not frayed or cracked?	Yes	No
4. Are all small rugs and runners slip-resistant?	Yes	No
5. Are emergency numbers posted near the telephone?	Yes	No
6. Are smoke detectors properly located and working properly?	Yes	No
7. Do all outlets and switches have cover plates, so that no wiring is exposed?	Yes	No
8. Are hallway and other heavy traffic areas well-lit and free from obstruction?	Yes	No
9. Is there enough room for the patient/caregiver to maneuver around the equipment?	Yes	No
10. What is the condition of the home?		

Are you making any recommendations to the patient/caregiver?_____ **If so, please make a note of what concern you informed the patient/caregiver about.**

_____

Type of Equipment delivered: ☐ **Bed Side Commode** ☐ **Cane** ☐ **Home Oxygen**
☐ **Hospital Bed** ☐ **Hoyer Lift** ☐ **Nebulizer** ☐ **Walker** ☐ **Wheel Chair**

☐ **Other:** _____

Type of Home: ☐ **Single Story** ☐ **Multi-Story** ☐ **Apt./Condo** ☐ **Mobile Home**

Handicap Accessible: **Yes** **No**

Smallest Doorway Measurements:_____ **Hallway Measurement:**_____

Does the patient's home provide adequate access between rooms, maneuvering space and surfaces for the placement of the equipment provided? Yes No

_____

Supplier Attestation:
I have completed an assessment of the patient's home and conclude based upon this information the patient's home will accommodate the equipment delivered.

Delivery Tech Signature:_____ **Date:** _____

Medical Necessities

Patient's Name: _____ Pt ID: _____

Set up date: _____

Patient must be **at least 70% compliant** by _____ (date).

After patient is compliant he/she must go back to see Dr. _____ by _____ (date).

Your insurance requires that the doctor addresses the following **in his office notes:**

1. Patient's signs & symptoms have improved
2. Address the patient's compliance in office notes and/or sign the compliance
3. Patient is tolerating and doing well with CPAP/BiPAP
4. Patient should continue to use nightly

Once this information is received from your doctor then you will be eligible to receive your future PAP supplies.

We look forward to being part of your CPAP/BiPAP therapy.

Patient's signature: _____

RT signature: _____