Globe Drug & Surgical
405 86th Street
Brooklyn, NY 11209

Incontrol Medical products are covered by many insurances.

Attain/Apex are covered by traditional **Medicare,** provided your patient meets 3 criteria:

1) Patient must have stress, urge, or mixed urinary incontinence.
2) Doctor must indicate Attain/Apex are medically necessary
3) Patient must have failed a 4 week trial of kegel within one year

   ex. "Mrs. _____ did kegels for 4 weeks and they were unsuccessful"

   We need a copy of the progress notes documenting that criteria has been met plus the detailed written order form or a prescription with a diagnosis.

We also accept Medicare Advantage plans, Aetna, and United Healthcare for Apex devices.
For other insurances send us the order and we will check the patient's benefits to see if they include out of network.

We accept Care Credit and offer a payment plan up to 12 months interest free as well as accepting flexible spending and health savings cards.

Shipping is free to your patients and we are here to answer all your questions.
Please don't hesitate to call. Brett 9178489172

INCONTROL™ MEDICAL

Globe Drug
& Surgical
Fax: 866-910-0351

FACSIMILE TRANSMITTAL

To:	**Globe Drug and Surgical**	Fax:	**866-910-0351**
From:		Date:	
Re:		Pages:	
	Please include: **1. Medical Notes:** **1. Patient Instruction in Kegels** **2. Patient Shows No Improvement After Completing Kegels x4 Weeks** **2. Copy of Insurance Card (front & back)** **3. Face-to-Face Visit to Prescribe the Product Using Detailed Written Order Form**		**DME Billing code: E0740** **Select product below:** **Apex ____ (Female SUI)** **Attain ____ (Female SUI/MUI/UUI) (And Fecal Incontinence)**

☐ Urgent	x For review	☐ Please comment	☐ Please reply	☐ Please shred

Notes/ Special Requests:

GLOBE DRUG & SURGICAL

403 86TH STREET

BROOKLYN,NY 11209

Phone : (718) 745- 1252

Fax: (866) 910 - 0351

globedrug@aol.com

www.globedrugstore.net

Medicare Face-to-Face Policy

What is face-to-face?
The face-to-face encounter requirement is one of the anti-fraud provisions in the Patient Protection and Affordable Care Act.

Under the final rule, released by the Centers for Medicare & Medicaid Services (CMS) on January 1, 2014, The Medicare Physician Fee Schedule includes among other policy and payment changes, provisions establishing new DME written order and face-to-face encounter requirements. Under this rule, it requires a detailed written order and face-to-face encounter prior to delivery.

Section 6407(b) mandates that there is documentation in the medical record by the physician or other prescribing practitioner of a face-to-face evaluation of the patient prior to prescribing DME.

Face-to-face encounters are an in-person examination that must document evaluation and/or treatment of the conditions that justify the need to the item prescribed. This visit must occur on or before the date of the detailed written order.

Why was this regulation put into place?
The face-to-face requirement is designed to ensure that the order for DME is based on a physician's current knowledge of the patient's clinical condition. A supplier will be reimbursed by Medicare for applicable DME only when a face-to-face encounter has occurred between the physician and the patient and the encounter has been documented.

CMS objective: reduce fraud, waste, and abuse by forcing more involvement by physicians in the ordering of DME.

The Face-to-Face encounter does NOT apply to Medicare Advantage Plans at this time.

Who can conduct the face-to-face encounter?
The treating physician, PA (Physician's Assistant), NP (Nurse Practitioner), or CNS (Clinical Nurse Specialist)

When the encounter is performed by a PA, NP, or CNS, a physician must document that the face-to-face encounter was performed by signing or cosigning the portion of the medical record that documents the face-to-face encounter. (The signed detailed written order alone is not sufficient - meaning the physician must sign or co-sign the medical record)

Medicare has established a G billing code (G0454) to compensate physicians who document that a PA, NP, or CNS practitioner performed the face-to-face encounter. This code does not apply when a physician bills an evaluation and management code when performing the face-to-face encounter himself/herself. Additionally, if multiple DME orders originate from one visit, the physician is only eligible for the G-code payment once. (This billing is completed by the physician's office, not the DME provider.)

Signatures must comply with the CMS signature requirements outlined in Medicare's Program Integrity Manual (cannot be stamped signatures).

What needs to be in the documentation?
The face-to-face requirement requires physicians to conduct a face-to-face exam that addresses the medical condition for which the DME is being prescribed. For example, face-to-face documentation should refer to a visit for incontinence when prescribing InControl products. This visit and documentation may take place up to 6 months before the product is ordered.

When the physician performs the face-to-face encounter, there must be "sufficient documentation" in the pertinent portions of the beneficiary's medical record to document that the beneficiary meets the Medicare medical policy requirements for the DME ordered. For example, InControl products will require documentation that supports that the patient was instructed in Kegels, completed them for at least 4 weeks, and demonstrated no improvement.

Physicians are required to provide the medical record documentation to the DME supplier.

What are the required elements for a valid detailed written order?
The detailed written order must include at a minimum the following:
1. Beneficiary name
2. Detailed description of DME item ordered
   (Either a narrative description or a brand name/model number)
3. The prescribing physicians NPI
4. Signature of the prescribing practitioner
5. The date of the order

When can the product be dispensed?
The face-to-face encounter and the detailed written order must be received and date stamped (or similar indicator) prior to the dispense date of the product/equipment.

If the dispensed date is on or before the date that the face-to-face and WOPD are received, the claim will be denied and not reasonable and necessary.

The Attain, Apex, and ApexM devices now require this face-to-face on all Medicare patients.

INCONTROL MEDICAL

Detailed Written Order

Globe Drug & Surgical
Fax to (866) 910-0351

Patient Information

Name: _____ Date of Birth: _____
Address: _____ Phone #: _____
_____ Gender: _____
Insurance Name: _____ Group #: _____
Insurance #: _____ Insurance Phone #: _____
Secondary Insurance: _____ Group #: _____
Insurance #: _____ Insurance Phone #: _____

Medical Information

Diagnosis & ICD10 - CM Codes:

- ☐ N31.9 Neuromuscular dysfunction of bladder, unspecified
- ☐ N39.3 Stress Incontinence (female) (male)
- ☐ N39.41 Urge Incontinence
- ☐ N39.46 Mixed Incontinence
- ☐ Other: _____
- ☐ N39.498 Other Specified Urinary Incontinence
- ☐ M62.81 Muscle Weakness (Generalized)
- ☐ M62.838 Other Muscle Spasm
- ☐ R15.9 Full Incontinence of Feces

Has patient undergone and failed a 4 week documented trial of Pelvic Muscle Exercise (Within One Year) ☐ Yes ☐ No
PME Training Start Date: _____ PME Training End Date: _____

Is patient cognitively intact?	☐ Yes	☐ No
InControl Device is prescribed to:	☐ Improve urethral closure function	☐ Improve anal sphincter function
	☐ Improve urethral sphincter function	☐ Other
	☐ Inhibit unwanted bladder contractions	☐ Other
Are the pelvic nerves intact?	☐ Yes	☐ No
Prognosis:	☐ Excellent ☐ Good	☐ Fair ☐ Poor
Anticipated benefit from use:	☐ Increased pelvic muscle strength	☐ Decreased urinary leakage
	☐ Decreased involuntary detrusor contractions	☐ Other

I am prescribing the InControl Medical Incontinence Device HCPCS Code E0740.
Quantity: 1/999
Length of Need: 99 months (99 = lifetime) if other specify _____

Prescribing Physician Name: _____ UPIN#: _____
Address: _____ NPI#: _____
_____ Phone #: _____
Fax #: _____
Physician Signature: _____ Date: _____
Printed Name: _____

I certify that I am the physician identified in this form. I have reviewed all sections of the physician's written order. Any statement on my letterhead attached here to has been reviewed and signed by me. I certify that the patient/caregiver is capable and will be provided direct training in utilizing the products prescribed in this written order. The patient's record contains supporting documentation which substantiates the utilization and medical necessity of the products listed and physician notes will be provided to an authorized distributor upon request. I understand any falsification, omission or concealment of material fact may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record. By faxing this form you are acknowledging that the patient is aware that a representative from an authorized distributor may be contacting them for any additional information to process this order.

The information is requested to document medical necessity for the use and purchase of InControl products. This form must be completed and signed by the patient's attending physician to be valid. If ordering from our website, www.globedrugstore.net, please fax to (866) 910-0351.

Globe Drug & Surgical
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Brooklyn, New York 11209
Phone:718.745.1252
Fax: 866.910.0351

Joint Commission
on Accreditation of Healthcare Organizations

Medicare Capped Rental
Notification for Services on or after April 1, 2014

I have received instructions and understand that Medicare defines the Pelvic floor exerciser as being a capped rental.

FOR CAPPED RENTAL ITEMS:

- Medicare will pay a monthly rental fee for a period of 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 and repair.

Please also note that Medicare has a yearly deductible, as we bill your device monthly and you have not met your yearly deductible you will be responsible for it.

Any questions please call,

Brett, 917-848-9172

Globe Drug & Surgical - PRODUCT AGREEMENT

Globe Drug & Surgical ~ 405 86th Street 718.745.1252

PATIENT INFORMATION (MANDATORY)	
Patients First Name, MI, Last Name	
Billing Address	City, State, Zip
Phone (Home) ( ) -	Phone (Alternate) ( ) -
Gender (Check One) ☐ Male ☐ Female	Date of Birth / /
Prescribing Physician Name:	Patient Diagnosis ICD-9 Code
Physician Address	Phone ( ) - Fax ( ) -

INSURANCE INFORMATION			
Insurance Co. Name		Secondary Insurance	
Policy Number		Guarantor's Name	
Address		Address	
City, State, Zip		City, State, Zip	
Phone ( ) -	Guarantor's DOB / /	Phone ( ) -	Guarantor's DOB / /
Policy #	Group #	Policy #	Group # / Employer Name:

CHECK ALL PRODUCTS THAT APPLY	LIST PRICE	MEASURE
☐ Attain (E0740) ☐ Apex (E0740)	Rental $58.00/month	Each

I permit a copy of this authorization to be as valid as the original. I agree to use all products only in the manner for which they were intended and not attempt to make any modifications or changes of any kind of description in the product. These products are prescription only. These products are to be utilized only as directed by my Health Care Provider. I agree that Globe Drug & Surgical or InControl Medical Company are not responsible for defects in, or damages caused by, non-Globe Drug & Surgical Company's or InControl Medical Company products. There is a 1 year warranty for the InTone system that covers parts and defects in manufacturing.

CONSENT FOR TREATMENT, AUTHORIZATION TO RELEASE INFORMATION AND PERMIT PAYMENT OF INSURANCE BENEFITS TO HEALTH CARE PROVIDER, Globe Drug & Surgical AND INCONTROL MEDICAL COMPANY, LLC OR ITS BUSINESS PARTNERS.

I acknowledge that I will be instructed in the proper use and care of the product listed above by my prescribing physician. I certify that the information given to Globe Drug & Surgical in applying for product purchase is correct. I acknowledge that I have read, understand, and agree to the terms and conditions as stated. I also acknowledge that I have received and understand the information included on the back of this form.

My signature and date in the box below authorizes each of the following: Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Globe Drug & Surgical for medical supplies furnished to me by Globe Drug & Surgical; Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s); Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns; Globe Drug & Surgical to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies provided; Globe Drug & Surgical to contact me by telephone or mail regarding my medical supplies order; In the event that my insurance carrier does not pay Globe Drug & Surgical in full or denies services as not medically necessary, non-covered or investigational, I will be responsible for all unpaid balances; Should the insurance/settlement reimburse me directly, it is my responsibility to forward the payment for services to Globe Drug & Surgical; If litigation is instituted to collect any unpaid balance or for loss or damage to the equipment, I agree to pay all costs of collection including reasonable attorney's fees incurred by Globe Drug & Surgical; NSF (non-sufficient funds) a charge of $40.00 will be applied to your account for any returned check.

I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

Patient Or Guardian Signature	Date	Relationship to patient, if other than self	Date

Please fax signed agreement to (866) 910-0351