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## GETTING STARTED DOCUMENTS

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Welcome to QAS and the ProTime Microcoagulation System. QAS is dedicated to helping you successfully participate in your own healthcare by training you to obtain your INR from home or work using the ProTime Monitor and the Patient Prottime Monitoring system (PPM).

Studies show that weekly testing of your INR will increase your time in therapeutic range, improving your quality of life. QAS will provide the training, supplies and support to make this possible. Through the use of the PPM, you will phone your test results to QAS weekly where they will be monitored and relayed to your physician for prompt, accurate INR management.

Currently Medicare is covering one test per week for mechanical heart valve patients (V-43.3). Additional supplies, should you request them, are the financial responsibility of the patient.

Enclosed are the necessary forms for you and your physician to complete in order to begin this service.

- **Letter of Medical Necessity** ( *to be completed by your **physician***)
- **Physician Prescription Form** ( *to be completed by **you** and your **physician***)

Please make sure that you and your physician have completed and signed the attached documents as soon as possible and faxed them to QAS at the number located on each document.

Once QAS has completed patient training, the patient will be asked to demonstrate device proficiency at the physician's office.

Thank you for choosing QAS for your PT/INR monitoring, training, supplies and support. Feel free to contact us anytime at **800.298.4515** for answers to your anticoagulation questions.

We look forward to serving you.

*Quality Assured Services, Inc.*

1506 N. Orange Blossom Trail    Orlando, Florida 32804-6103  
Toll free 800.298.4515    Fax: 407-563-2861

# QAS Patient Privacy Policy

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

In accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996("HIPAA"), Quality Assured Services, referred to as QAS, is required to inform you of its practices in relation to the protected health information that it maintains about you.

HIPAA mandates minimum standards that a covered entity such as QAS must maintain in relation to your protected health information.

This Notice of Uses is being provided to help you understand how QAS meets these minimum standards. It is also meant to inform you of the ways that QAS may use the personal information it collects about you and how it may disclose it.

### **UNDERSTANDING YOUR PROTECTED HEALTH INFORMATION**

When you receive care from a healthcare provider, a record of that treatment is made. This record will typically contain information on your diagnosis, treatment, and future plan of treatment and is often collectively referred to as your medical record. The medical record includes protected health information that allows for a successful means of communication between all healthcare professionals that contribute to your care.

HIPAA protects information found in your medical record from disclosure without your authorization. The information protected by HIPAA includes:

1. Any information related to your past, present or future physical or mental health;
2. The past, present or future payment for health services you have received;
3. The specific care that you have received, are receiving or will receive;
4. Any information that identifies you as the individual receiving the care, and any information that someone could reasonably use to identify you as receiving the care. This information is referred to as protected health information throughout this Notice.

### **TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS**

As a Covered Entity, QAS is required to inform you of how it may use your protected health information. In providing treatment to you, QAS will use your protected health information for the purposes of treatment, payment and healthcare operations.

**Treatment** - As it pertains to QAS, treatment means providing to you supplies and durable medical equipment services as ordered by your physician. This may also include coordination and consultation with your physician and other health care providers. As QAS provides these services to you, information obtained during this process will be recorded in your medical record. QAS will use this information, in coordination with your physician, to determine the best course of treatment for you.

**Payment** - Payment purposes consist of activities required to obtain reimbursement from your insurance carrier for the services ordered by your physician and provided to you by QAS. This includes, but is not limited to, eligibility determination, pre-certification, billing and collection activities, obtaining documentation required by your insurer, and when applicable, disclosure of limited information to consumer reporting agencies.

**Healthcare operations** - Operations can include but are not limited to, review of your protected health information by members of QAS professional healthcare staff to ensure compliance with all federal and state regulations. This information will then be utilized to continually improve the quality and effectiveness of the services provided to you by QAS. Healthcare operations also include QAS business management and general administrative activities as well as informing you of new products afforded by QAS.

### **OTHER USES AND DISCLOSURES**

In order to release information contained in your medical record for purposes other than treatment, payment or healthcare operations, QAS must obtain a specific signed authorization from you. You may revoke such authorization at any time, except to the extent QAS has taken action in reliance on the authorization.

There are a limited number of other uses and disclosures of protected health information that do not require a specific authorization from you. QAS may in the following circumstances disclose your protected health information.

1. QAS may disclose to a member of your family, or any other person identified by you, the protected health information directly relevant to such person's involvement with your care or payment related to your health care.
2. QAS may disclose protected health information to others as required by law for purposes and in response to court orders or subpoenas.

3. QAS may disclose protected health information to agencies authorized by law to conduct health oversight activities, including audits, investigations, and licensing and similar activities.
4. QAS and our Business Associates - Certain of our business operations may be performed by other businesses. We refer to these companies as "business associates." In order for these business associates to perform the required service (billing, accounting services, etc.), we may need to disclose your health information to them so that they can perform the job we've asked them to do. To protect you, we require our business associates to appropriately safeguard your health information.

### **YOUR RIGHTS AS A PATIENT OF QAS**

In accordance with HIPAA you have the following rights in relation to your protected health information.

You may request, in writing, additional restrictions to the use or disclosure of your protected health information; however, QAS is not required to agree to the request for restrictions.

1. You have the right to request amendments to your medical record.
2. You have the right to obtain a copy of this Notice of Uses.
3. You have the right of access to inspect and obtain a copy of your medical record, subject to certain limitations.
4. You have the right to obtain an accounting of disclosures of your medical record for purposes other than treatment, payment and healthcare operations.
5. You have the right to request communications of your medical record by alternative means (i.e. electronically) or at alternative locations.
6. You have the right to revoke authorization to use or disclose your protected health information except to the extent that action has already occurred.

### **RESPONSIBILITIES OF QAS**

In accordance with HIPAA, QAS is required to:

1. Maintain the confidentiality of your protected health information. Your state laws may provide more protection than the federal laws and, in that case, we will abide by the more restrictive statute.
2. Maintain appropriate security measures that will be documented and kept current for all electronic maintenance or transmission of health information in its possession.
3. Provide you with notice of our legal obligations and privacy practices regarding information it may accumulate about you and is obligated to abide by the terms of this notice.
4. Notify you if it is unable to agree to a requested restriction, and make every effort to accommodate reasonable requests for communication of health information by alternative means.
5. Post its Notice of Uses on its website at [www.hometestmed.com](http://www.hometestmed.com)

Please be advised that in addition to these responsibilities, QAS reserves the right to change the terms of its Notice of Uses and make those changes applicable to all protected health information maintained at that time. If there is a change to its Notice of Uses, it will provide you with a revised notice to the most recent address you have supplied to QAS.

QAS will not use or disclose your protected health information without your authorization, except as described in this notice.

### **FOR MORE INFORMATION OR TO REPORT A PROBLEM**

If you have questions, would like additional information or, if you suspect misuse of your protected health information and believe that your rights have been violated, you may, without fear of retaliation, contact:

QAS, Inc.  
1506 N Orange Blossom Trail  
Orlando FL 32804  
800-298-4515

Or

The Office of Civil Rights  
U.S. Department of Health & Human Services  
200 Independence Avenue SW  
Room 509F HHH Building  
Washington D.C. 20201  
1(800) 368-1019

# LETTER OF MEDICAL NECESSITY

**QAS**

Patient Name: _____		SSN: _____ - _____ - _____	
Address: _____			
City: _____		State: _____	Zip: _____

I am writing on behalf of the above named patient regarding patient self-testing of anticoagulation status with fingerstick prothrombin time (PT) testing. The patient's condition requires anticoagulation therapy to reduce the risks of thromboembolic complications. Thrombosis can result in clots forming or traveling to the brain or lung with serious adverse medical results, which in some cases can be life threatening. By using at-home monitoring, the patient will benefit with increased time in therapeutic range and is less likely to be a risk for complications resulting from anticoagulation therapy.

**I believe that patient self-testing is medically necessary for the care of this patient as summarized below;**

Diagnosis	Code	Diagnosis	Code
<input type="checkbox"/> Mechanical heart valve <input type="checkbox"/> Aortic <input type="checkbox"/> Mitral	V43.3	<input type="checkbox"/> Antiphospholipid syndrome	795.79
<input type="checkbox"/> Atrial fibrillation	427.31	<input type="checkbox"/> TIA	453.9
<input type="checkbox"/> Atrial Flutter	427.32	<input type="checkbox"/> Clotting disorder	286.9
<input type="checkbox"/> DVT (deep vein thrombosis)	453.8	<input type="checkbox"/> CVA	436.0
<input type="checkbox"/> Pulmonary emboli	415.1	<input type="checkbox"/> Congestive heart disease	428.0
<input type="checkbox"/> Multi-thrombophlebitis	451.9	<input type="checkbox"/> Cardiomyopathy	425.4
<input type="checkbox"/> Valve insufficiency	376.1	<input type="checkbox"/> Peripheral vascular disease	443.9
<input type="checkbox"/> Protein S deficiency	289.81	<input type="checkbox"/> Hypercoagulable disorder	289.8
<input type="checkbox"/> Protein C deficiency	289.81	<input type="checkbox"/> Lupus	710.0
<input type="checkbox"/> Other		<input type="checkbox"/> Budd Chiari syndrome	453.0

**Complications and Aggravating Circumstances**

Hospitalizations: # \_\_\_\_\_ Last date admitted: \_\_\_\_/\_\_\_\_/\_\_\_\_ Previous date admitted: \_\_\_\_/\_\_\_\_/\_\_\_\_

<input type="checkbox"/> Unstable INR- % time out of range _____	<input type="checkbox"/> Child	<input type="checkbox"/> Lab/clinic not accessible due to travel
<input type="checkbox"/> Venipuncture difficulty	<input type="checkbox"/> Infant	<input type="checkbox"/> Extensive travel
<input type="checkbox"/> Elderly/frail	<input type="checkbox"/> Requires frequent testing	<input type="checkbox"/> Homebound
<input type="checkbox"/> Condition precludes travel for testing	<input type="checkbox"/> Remote location	<input type="checkbox"/> Long-term anticoagulation therapy
<input type="checkbox"/> Major bleed history	<input type="checkbox"/> Slow lab results	<input type="checkbox"/> Other: _____

**Comorbidities**

Diabetes     Congestive heart failure     COPD     Thyroid disorder     Other: \_\_\_\_\_

Patient on warfarin therapy. Explain:

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(Attach a separate sheet of explanation if necessary)

The patient (patient's caregiver) is fully capable of performing these tests, understanding the implications of the test results, contacting our office as directed to review the test results, and making adjustments to anticoagulation therapy as directed. For these reasons, I believe that patient self-testing is reasonable and necessary for this patient, and it should be covered. If you require additional information, feel free to contact me.

**Physician Signature** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Printed Physician Name** \_\_\_\_\_

**PLEASE FAX TO QAS: 407-563-2863**

**PATIENT INFORMATION SHEET**

**QAS**

Patient Name: _____		SSN: _____ - _____ - _____	
Address: _____			
City: _____		State: _____	Zip: _____
Patient E-mail: _____			
Phone _____	DOB _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Other contact _____		Other phone _____	
Managed Care: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS Physician's Name _____ Phone ( ) _____ - _____			
<b>Primary Ins. Name</b> _____ Address _____ City _____ Zip _____ Phone ( ) _____ - _____ Subscriber: _____ Date of birth ____/____/____ SSN # _____ - _____ - _____ Policy # _____ Group ID # _____ Employer: _____		<b>Secondary Ins. Name</b> _____ Address _____ City _____ Zip _____ Phone ( ) _____ - _____ Subscriber: _____ Date of birth ____/____/____ SSN # _____ - _____ - _____ Policy # _____ Group ID # _____ Employer: _____	

**Release of Information:** I authorize the release of any medical or other information necessary to process claims for services by **QAS** (provider) and for supply of products by **QAS** (provider). I also authorize the release of any medical or other information to CMS, its agents, contractors, my insurance company or **QAS** (provider) necessary to determine the benefits payable. **Assignment of Benefits:** I request that Medicare and/or any other insurance plans under which I am covered make payment to the provider of authorized benefits on my behalf for services and supplies furnished to me for which they bill. I (the below signed) agree to accept the charge determination of the insurance carrier as the full charge. I am responsible for the deductible, co-insurance and non-covered services. **Privacy Policy:** I have read and understand the attached privacy policy.

⇒ ⇒ Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Fax signed form to 407-563-2863 Fax signed form to 407-563-2863 Fax signed form to 407-563-2863

**PHYSICIAN PRESCRIPTION FORM**

Prescribing Physician Information	Follow-up Physician Information
Name _____	Name _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Ph. ( ) _____ - _____	Ph. ( ) _____ - _____
Fax ( ) _____ - _____	Fax ( ) _____ - _____
Lic # _____	Lic # _____
UPIN# _____	UPIN# _____

**Diagnosis Code:** \_\_\_\_\_ **Start date of Warfarin therapy** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Date of surgery** \_\_\_\_/\_\_\_\_/\_\_\_\_.  
 Maintain INR range between a low of \_\_\_\_\_ and a high of \_\_\_\_\_ with a target of \_\_\_\_\_  
 (Achieved through the PPM Monitoring Program. Call 800-298-4515 for details.)

Items Prescribed	Product Number	Qty.	Refills	Prescribed Frequency
ProTime Microcoagulation System	L11-01-01C	1	N/A	<input type="checkbox"/> 1 test per week <input type="checkbox"/> Other _____ test(s) per _____
Cuvettes (4 pack)	L21-01-0004		<input type="checkbox"/> Lifetime <input type="checkbox"/> Other	
Cuvettes ( box of 25)	L21-01-0025		<input type="checkbox"/> Lifetime <input type="checkbox"/> Other	

I will insure the patient receives appropriate training on the monitoring device. I, the undersigned, certify that the above prescribed product supplies and medically necessary for this patient's well being. In my opinion, these products are reasonable and necessary in reference to accepted standards of medical practice in the treatment of this patient's condition and are not prescribed as convenience items.

**Physician Signature** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (Signature must be hand written. No stamps allowed.)

**Printed Physician name** \_\_\_\_\_

**Please fax completed and signed order immediately to QAS: 407-563-2863**