Filing # 109399831 E-Filed 06/25/2020 01:16:14 PM

IN THE COUNTY COURT, OF THE NINTH JUDICIAL CIRCUIT, IN AND FOR ORANGE COUNTY, FLORIDA

CASE NO: 2019-SC-014080-O
DIVISION: 70

KISSIMMEE INJURY CLINIC, LLC a/a/o WILLIAM MALDONADO,

Plaintiff,
vs.

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,

Defendant.
_____/

DEFENDANT'S NOTICE OF FILING AFFIDAVIT

Defendant, STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, hereby files this Notice of Filing of an Affidavit of Denisha M. Lich, MS, RHIA, HRM.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 25th day of June, 2020, a true and correct copy of the foregoing was sent to Eduardo Rodriguez, Esq., Pardy & Rodriguez, P.A., PO Box 3747, Orlando, FL 32802 erodriguez@pardyrodriguezlaw.com; piplegal@pardyrodriguezlaw.com through the Florida Courts E-Filing Portal system.

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IN THE COUNTY COURT, OF THE NINTH JUDICIAL CIRCUIT,
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KISSIMMEE INJURY CLINIC, LLC a/a/o
WILLIAM MALDONADO,

Plaintiff,

vs.

CASE NO: 2019-SC-014080-O
DIVISION: 70

STATE FARM MUTUAL AUTOMOBILE
INSURANCE COMPANY,

Defendant.
_____/

AFFIDAVIT OF DENISHA M. LICH, MS, RHIA, HRM,

STATE OF FLORIDA)

COUNTY OF PINELLAS)

Before me, the undersigned authority duly authorized to take oaths and acknowledgments, personally appeared Denisha M. Lich, who after being duly sworn, states:/

1. My name is Denisha M. Lich and I am over the age of eighteen and I am competent to testify.

2. I have personal knowledge of the matters contained in this affidavit.

3. My testimony is based upon sufficient facts and data. My testimony is the product of reliable principles and methods. I have applied the principles and methods reliably to the facts of this case.

4. I am a Registered Health Information Administrator by the American Health Information Management Association.

5. I possess specialized knowledge of coding based on AMA guidelines. A true and

correct copy of my current CV detailing my knowledge and experience is attached as Exhibit 1.

6. I have reviewed the documentation received for date of loss 5/8/15, more specifically the Kissimmee Injury Clinic, LLC's medical records, corresponding CMS 1500 forms and Explanation of Reviews (EORs) pertaining to the electrodes supply submitted with electrical muscle stimulation services for 5/11/15 date of service and the modality service submitted for 5/27/15 date of service. Exhibit 2

7. I have reviewed the Office of Inspector General's Compliance Program for Individual and Small Group Physician Practices, 2015 HCPCS Level II Coding Manual, American Medical Association (AMA) 2015 CPT Manual, AMA CPT Assistant, Centers for Medicare and Medicaid website and the Medicare Physician Fee Schedule related to the coding and billing of the following HCPCS Level II and CPT codes:

   - A4556 (Electrodes (eg., Apnea monitor), per pair);
   - G0283 (Electrical stimulation (unattended) to one or more areas for indication(s) other than wound care, as part of a therapy plan of care);
   - 97010 (Application of a modality to 1 or more areas; hot/cold pack).

8. The Office of Inspector General (OIG) Compliance Program for Individual and Small Group Physician Practices states the following,

   "...The OIG has developed a list of four potential risk areas affecting physician practices. These risk areas include: (a) Coding and billing; (b) reasonable and necessary services; (c) documentation...This list of risk areas is not exhaustive, or all encompassing..."

   In the area of Coding and billing, the OIG notes,

"The following risk areas associated with billing have been among the most frequent subjects of investigations and audits by the OIG...Billing for items or services not rendered or not provided as claimed; Submitting claims for equipment, medical supplies and services that are not reasonable and necessary, Billing for non-covered services as if covered; Unbundling (billing for each component of the service instead of billing or using an all-inclusive code) ..."

The OIG also notes in the area of Medical Record Documentation,

"In addition to facilitating high quality patient care, a properly documented medical record verifies and documents precisely what services were actually provided... (a) the site of the service; (b) the appropriateness of the services provided; (c) the accuracy of the billing; and (d) the identity of the care giver..." Exhibit 3

9. Kissimmee Injury Clinic, LLC., inappropriately unbundled electrodes, submitted as HCPCS code A4556 when separately billing with electrical stimulation therapy, HCPCS code G0283 for 5/11/15 date of service.

10. Review of the Patient's Progress and Treatment notes dated 5/11/15 under the Plan/Recommendation section, shows that in addition to other services, the provider checked the line items representing the following,

"G0283 – Electrical Stimulation and A4556 – Electrodes." Please see Exhibit 2

Electrodes are a necessary component in the delivery of the electrical stimulation services submitted as HCPCS Level II Code G0283 in this case. The electrode supplies were furnished as an integral part of the physician's course of treatment of the injury performed in the physician's office.

11. As noted in the above paragraph, the documentation shows that the provider performed electrical stimulation services, submitted as HCPCS Level II code G0283, during the same encounter. There is no documentation to indicate that the

patient purchased a take-home TENS unit and that the electrodes were given to the patient as take-home and/or replacement supplies for the TENS unit that has been purchased. Rather, review of the documentation shows that the electrodes were issued specifically for use with the electrical stimulation services performed in the office during the same and future encounters.

12. Electrodes are a necessary component in the delivery of the electrical stimulation services, in this case submitted as HCPCS Level II Code G0283. The electrodes were furnished as an integral part of the physician's course of treatment, the electrical stimulation service, performed in the physician's office. Therefore, the electrodes supply would not be billed separately. The payment for the electrodes supply is already included within the payment of the Electrical Stimulation procedure, HCPCS Level II code G0283.

Based on the guidelines and documentation received, the provider was not compliant with the coding and billing guidelines when submitting HCPCS Level II code A4556 for disposable/re-usable electrodes for 5/11/15 date of service.

13. The Centers for Medicare and Medicaid Services (CMS) assists providers by defining the HCPCS coding system as seen in the following,

> "... HCPCS is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA)... Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established for

submitting claims for these items."

The 2015 HCPCS Level II Coding Manual describes HCPCS code A4556 as,

"Electrodes (eg. Apnea monitor), per pair".

The Manual further states under the code description,

"If "**incident to" a physician's service, do not bill.**" Exhibit 4

Therefore, when the electrodes are incidental to the physicians service, in this case the electrical stimulation service, they are not separately payable. The electrodes were furnished as an integral part of the physician's personal professional service in the course of treatment performed in the physician's office.

14. A Review of the Medicare Physician Fee Schedule (MPFS) pertaining to HCPCS Level II code A4556 was done to assist with the determination of the Procedure Status Code/ Code Status of this code. The Procedure Status Code/ Code Status indicates whether the respective code is in the physician fee schedule and whether it is separately payable if the service is covered.

The detail information for the 2015 Medicare Physician Fee Schedule is no longer available for HCPCS Level II code A4556 therefore, a review of the 2016 fee schedule was reviewed to ascertain the detail information for the respective code. The 2016 MPFS shows that the HCPCS code A4556 has a Procedure Status Code indicator of "P" which states,

> "**Bundled**/excluded codes. There are no RVUs and no payment amounts for these services. **No separate payment is made** for them under the fee schedule. If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for

it is **bundled into the payment for the physician service to which it is incident** (an example is an elastic bandage furnished by a physician incident to a physician service)." Exhibit 5

As noted above, the payment for the electrodes, submitted as A4556, is bundled into the payment for the electrical stimulation services, submitted as HCPCS Code G0283. The electrodes are a necessary component in the delivery of the electrical stimulation services submitted as HCPCS Level II Code G0283 for the respective date of service. The electrodes were furnished as an integral part of the physician's personal professional service in the course of treatment of the injury performed in the physician's office. Therefore, no separate payment is made.

15. The CMS' website also contains the Medical Learning Network (MLN) to assist with the educational needs of the health care professional community. This Network provides free educational resources with the assistance from clinicians, billing experts and CMS subject matter experts to cover CMS programs, policies, and initiatives.

CMS' MLN Medicare Physician Fee Schedule Fact Sheet – ICN 006814- December 2014 shows how the payment rate for an individual service is determined. This document further provides the description of each component within the formula. One of the components is the Relative Value Unit (RVU). There are three RVUs associated with the calculation of the allowed amount, one of which is the Practice Expense (PE) Relative Value Unit (RVU) as seen below.

"PE RVU reflects the costs of maintaining a practice (for example, renting office space, buying supplies and equipment, and staff costs)." Exhibit 6

The payment of the electrical stimulation therapy represented in this case as HCPCS Level II code G0283, already reflects and includes the cost of the electrodes used when performing the service. Therefore, separately billing for electrodes used when performing the electrical stimulation service would be considered unbundling resulting in duplicate payment.

16. The is also seen upon review of the CMS website under the Physician Fee Schedule section- PFS Federal Regulation Notices Items - Details for title: CMS-1612-FC which provides a spreadsheet containing the descriptions of various items included in the calculation of the practice expense (PE) relative value units. Per CMS, the sources of these direct PE inputs are from one of the following:

1. Clinical Practice Expert Panels (CPEPs) convened in 1995 to develop estimates of the different types of resource inputs necessary to perform medical services;
2. A crosswalk to a related service developed based upon a clinical opinion by CMS;
3. The AMA's Relative Value Update Committee (RUC)2;
4. Refinement of the CPEP inputs by the AMA's Practice Expense Advisory Committee (PEAC)or the Practice Expense Review Committee (PERC) (which replaced the PEAC in September2004) or the RUC Practice Expense Subcommittee (which took over the PERC's role in September 2007).
5. CMS; or
6. A medical specialty society." Exhibit 7

Following are the items/inputs used in the calculation of HCPCS code G0283.

Table 1 – Excerpt of CMS-1612-FC_PUF_SUPPLY

hcpcs	source	category	cms_ code	description	unit	price	nf_ quantity	f_ quantity	global_ period	reference _code	ruc_ meeting	ruc_tab
G0281	RUC	Office Supply, Grocery	SK068	razor	item	0.389	1		XXX			
G0283	RUC	Gown, Drape	SB022	gloves, non-sterile	pair	0.084	1		XXX			
G0283	RUC	Accessory, Procedure	SD055	electrode, electrical stimulation	item	1.312	2		XXX			
G0283	RUC	Wound Care, Dressings	SG079	tape, surgical paper 1in (Micropore)	inch	0.002	6		XXX			
G0283	RUC	Pharmacy, NonRx	SJ024	electrolyte coupling gel	ml	0.016	1		XXX			
G0283	RUC	Pharmacy, NonRx	SJ053	swab-pad, alcohol	item	0.013	1		XXX			
G0283	RUC	Office Supply, Grocery	SK068	razor	item	0.389	1		XXX			
G0329	RUC	Gown, Drape	SB044	underpad 2ft x 3ft (Chux)	item	0.23	1		XXX			

As noted in Table 1 above, electrodes, regardless of whether they are re-usable or not, are included within the calculation of the of the PE RVU for the electrical stimulation service performed in non-facility settings such as a physician office. Therefore, the payment for the electrodes is included within the payment of the electrical stimulation service, submitted as HCPCS Level II code G0283, performed during each encounter. Separate billing for the electrodes used during the performance of the electrical stimulation service would be considered unbundling resulting in duplicate payment.

17. Per Medicare guidelines referenced above, the use of electrodes is considered an integral part of the physician professional services and therefore would not be separately payable.

Furthermore, as referenced in paragraph #14, the Procedure Status Code for A4556 is "P" which signifies that no separate payment is made for this under the fee schedule and if the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. Therefore, the

payment for the electrodes is included within the payment of the electrical stimulation services, HCPCS Level II code G0283 for the respective dates of service.

18. The Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners 20.3 - Bundled Services/Supplies provides further clarification of bundled supplies as seen below,

> "There are a number of services/supplies that are covered under Medicare and that have HCPCS codes, but they are services for which Medicare bundles payment into the payment for other related services. If carriers receive a claim that is solely for a service or supply that must be mandatorily bundled, the claim for payment should be denied by the carrier. **Separate payment is never made for routinely bundled services and supplies.** The CMS has provided RVUs for many of the bundled services/supplies. However, the RVUs are not for Medicare payment use. Carriers may not establish their own relative values for these services." Exhibit 8

Therefore, when the electrodes were given to the patient for use with electrical stimulation services performed in the physician's office, they are incidental to the electrical stimulation procedure and are not separately payable. The payment of the electrical stimulation therapy represented in this case as HCPCS Level II code G0283, already reflects and includes the cost of the electrodes used when performing the service. Separately billing for electrodes used when performing the electrical stimulation service would be considered unbundling resulting in duplicate payment.

19. Further review of the Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Section 20.4.4 – Supplies of the Manual shows that there are specific circumstances where separate payment for supplies furnished in

connection with a procedure may occur. Per the Manual,

> "Carriers make a separate payment for supplies furnished in connection with a procedure only when one of the two following conditions exists:
>
> > A. HCPCS code A4300 is billed in conjunction with the appropriate procedure in the Medicare Physician Fee Schedule Data Base (place of service is physician's office). However, A4550, A4300, and A4263 are no longer separately payable as of 2002. **Supplies have been incorporated into the practice expense RVU for 2002. Thus, no payment may be made for these supplies for serviced provided on or after January 1, 2002.**
> >
> > B. The supply is a pharmaceutical or radiopharmaceutical diagnostic imaging agent (including codes A4641 through A4647); pharmacologic stressing agent (code J1245); or therapeutic radionuclide (CPT code 79900). Other agents may be used which do not have an assigned HCPCS code…" Please see Exhibit 8

Review of the documentation received does not support the conditions noted above. Rather, the documentation shows that the electrodes were provided for in office use. The electrodes were an integral component in the delivery of the electrical stimulation service performed in the physician's office for the respective dates of service. As referenced above,

> **"Supplies have been incorporated into the practice expense RVU for 2002. Thus, no payment may be made for these supplies for serviced provided on or after January 1, 2002."** Please see Exhibit 8

Therefore, the payment for the electrodes is already included in the Practice Expense RVU used in the calculation of the MPFS allowed amount for the electrical stimulation service submitted as HCPCS Level II code G0283 for 5/11/15 date of service.

20. It is important to note that the documentation received does not indicate that the

patient purchased a take-home TENS unit and that electrodes were given to the patient as take-home and/or replacement supplies for the TENS unit that has been purchased. Rather, the documentation shows that the electrodes were issued specifically for use with the electrical stimulation services performed in the office during the same and future encounter.

Electrodes are a necessary component in the delivery of the electrical stimulation services submitted as HCPCS Level II Code G0283. The electrode supplies were furnished as an integral part of the physician's course of treatment, the electrical stimulation services, performed in the physician's office. Therefore, they are incidental to the services and are not separately payable.

Again, the payment of the electrical stimulation therapy represented in this case as HCPCS Level II code G0283, already reflects and includes the cost of the electrodes used when performing the service. Therefore, separately billing for electrodes used when performing the electrical stimulation service would be considered unbundling resulting in duplicate payment.

21. Based on the medical record documentation and the guidelines referenced in the paragraphs above, the provider was not compliant when coding and separately billing HCPCS code A4556 for 5/11/15 date of service.

Payment for the electrodes supply was already included within the PE RVU calculation for the payment of the electrical stimulation procedure performed during the same encounter for which they were used. Additional payment would be considered unbundling and result in duplicate payment.

22. As previously mentioned, there is no evidence within the documentation received that the shows the patient was given the electrodes to take home as a Durable Medical Equipment (DME) supply for use with an at home TENS unit. Furthermore, there is no documentation to indicate that the patient has a DME TENS unit at home.

When coding and billing for DME supplies the following guidelines apply.

23. The Medicare Claims Processing Manual Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Durable - 10.1.1 - Durable Medical Equipment (DME) defines what is considered a Durable Medical Equipment in the following.

> "DME is covered under Part B as a medical or other health service (§1861(s)(6) of the Social Security Act [the Act]) and is equipment that:
>
> a. Can withstand repeated use;
> b. Is primarily and customarily used to serve a medical purpose;
> c. Generally, is not useful to a person in the absence of an illness or injury; and
> d. is appropriate for use in the home.
>
> All requirements of the definition must be met before an item can be considered to be durable medical equipment." Exhibit 9

Again, there is no documentation to support that the patient had a DME – TENS unit at home and that electrode supplies were needed for DME use. The provision of the electrodes in this case does not meet the requirements of a DME supply.

24. The DME Jurisdiction C Provider Manual Chapter 9 does cover the Durable Medical Equipment benefit category when applicable as seen in the following.

> "All Medicare Part B covered services processed by the DME MAC

fall into one of the following benefit categories specified in the Social Security Act (§1861(s)):

1. Durable medical equipment (DME)..." Exhibit 10

The Manual also states that necessary supplies are covered under specific circumstances in the following.

"Supplies and accessories that are necessary for the effective use of medically necessary DME are covered. Supplies may include drugs and biologicals that must be put directly into the equipment in order to achieve the therapeutic benefit of the DME or to assure the proper functioning of the equipment." Please see Exhibit 10

Again, there is no documentation to support that the patient had a DME – TENS unit at home and that electrode supplies were needed for DME use. The provision of the electrodes in this case does not meet the requirements of a DME supply.

25. Review of Chapter 5, DMEPOS Fee Schedule Categories, of the Manual also states,

"Reimbursement for most durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) is established by fee schedules. Payment is limited to the lower of the actual charge or the fee schedule amount. See Chapter 10 of this manual for more information about fee schedules and pricing. The fee schedule classifies most DMEPOS into one of the six categories explained below:

- Inexpensive or other routinely purchased DME (IRP)
- Items requiring frequent and substantial servicing
- Customized items
- Other prosthetic and orthotic devices
- Capped rental items
- Oxygen and oxygen equipment" Exhibit 11

In order to determine in which category a specific HCPCS code is classified the Manual directs the provider to see Appendix-A HCPCS located at the end of

the manual. Appendix - A, shows HCPCS Level II code A4556 with a Payment category of "13" indicating supplies and that the code is not valid for Medicare as of 11/1/1996. Exhibit 12

26. Although the review of the DME fee schedule shows an allowed amount for HCPCS LEVEL II code A4556 as a DME supply, the provision of the electrodes in this case does not meet the requirements of a DME supply. Therefore, the DME allowed amount is not applicable in this case. Exhibit 13

Furthermore, per the DME Manual referenced above in paragraphs #26, HCPCS Level II code A4556 is not a valid code for DME MAC.

27. The Manual also provides direction as to the appropriate method of submitting claims for DME supplies as seen below.

> "For supplies and accessories used with beneficiary-owned equipment (equipment that is owned by the beneficiary, but was not paid for by the DME MAC/fee-for-service Medicare), all of the following information must be submitted with the initial claim in Item 19 on the CMS-1500 claim form or in the NTE segment for electronic claims:
>
> • HCPCS code of base equipment
>
> • A notation that this equipment is beneficiary-owned
>
> • Date the patient obtained the equipment
>
> Claims for supplies and accessories must include all three pieces of information listed above. Claims lacking any one of the above elements will be denied for missing information. Medicare requires that supplies and accessories only be provided for equipment that meets the existing coverage criteria for the base item. In addition, if the supply or accessory has additional, separate criteria, these must also be met. In the event of a documentation request from the DME MAC or a redetermination request, you should provide information justifying the medical necessity for the base item and the supplies and/or accessories. Refer to the applicable Local Coverage Determination(s) and related Policy Article(s) for information on

the relevant coverage, documentation, and coding requirements at http://www.cgsmedicare.com/jc/coverage/LCDinfo.html." Please see Exhibit 11

28. As directed in the above guideline, a review of the CMS Local Coverage Decision for (LCD) for Transcutaneous Electrical Nerve Stimulators (TENS) (L5031) guidelines, effective for services performed on or after 10/31/14 was performed. The LCD provides specifics as to the coverage, documentation and coding guidelines for supplies associated with the use of a DME TENS unit used at home. Per the LCD,

> "Supplies
>
> Separate allowance will be made for replacement supplies when they are reasonable and necessary and are used with a covered TENS. Usual maximum utilization is:
>
> 2 TENS leads - a maximum of one unit of A4595 per month
> 4 TENS leads - a maximum of two units of A4595 per month.
>
> If the use of the TENS unit is less than daily, the frequency of billing for the TENS supply code should be reduced proportionally.
>
> Replacement of lead wires (A4557) more often than every 12 months would rarely be reasonable and necessary.
>
> ...**Reimbursement for supplies is contingent upon use with a covered TENS unit. Claims for TENS supplies provided when there is no covered TENS unit will be denied as not reasonable and necessary.**
>
> Effective for claims with dates of service on or after June 8, 2012 supplies provided for use with a previously covered TENS unit used for CLBP (not as part of an approved study) are not eligible for reimbursement. These supply claims will be denied as not reasonable and necessary." Exhibit 14

Again, there is no documentation to support that the patient had a DME – TENS unit at home and that electrode supplies were needed for DME use. The

provision of the electrodes in this case does not meet the requirements of a DME supply.

29. In addition, review of the LCD's Article for Transcutaneous Electrical Nerve Stimulators (TENS) - Policy Article - Effective October 2014 (A37064) states, -

> "A TENS supply allowance (A4595) includes electrodes (any type), conductive paste or gel (if needed, depending on the type of electrode), tape or other adhesive (if needed, depending on the type of electrode), adhesive remover, skin preparation materials, batteries (9 volt or AA, single use or rechargeable), and a battery charger (if rechargeable batteries are used).
>
> Codes **A4556** (Electrodes, [e.g., apnea monitor], per pair), A4558 (Conductive paste or gel), and A4630 (Replacement batteries, medically necessary TENS owned by patient) are **not valid for claim submission to the DME MAC.** A4595 should be used instead.
>
> For code A4557, one unit of service is for lead wires going to two electrodes. If all the lead wires of a 4 lead TENS unit needed to be replaced, billing would be for two units of service.
>
> **There should be no billing and there will be no separate allowance for replacement electrodes (A4556)**, conductive paste or gel (A4558), replacement batteries (A4630), or a battery charger used with a TENS unit." Exhibit 15

Again, although the review of the DME fee schedule shows an allowed amount for HCPCS LEVEL II code A4556 as a DME supply, the provision of the electrodes in this case does not meet the requirements of a DME supply. Therefore, the DME allowed amount is not applicable in this case.

Furthermore, per the DME Manual referenced in the paragraphs above, HCPCS Level II code A4556 is not a valid code for DME MAC.

30. Lastly, the 2015 DME MAC Jurisdiction List for DMEPOS HCPCS Code states for HCPCS code A4555 – A4558 Electrodes; Lead Wires; Conductive Paste, shows,

"Local Carrier **if incident to a physician's service (not separately payable)**. If other DME MAC" Exhibit 16

The electrode supplies were furnished as an integral part of the physician's course of treatment, the electrical stimulation services, performed in the physician's office. Therefore, they are incidental to the services and are not separately payable.

31. As previously mentioned, review of the Initial Evaluation notes dated 5/11/15 shows that there is no documentation to indicate that the patient purchased a take-home TENS unit and electrodes were given to the patient as take-home and/or replacement supplies for the TENS unit that has been purchased. Rather, the electrodes were issued specifically for use with the electrical stimulation services performed in the office during the same encounter.

Electrodes are a necessary component in the delivery of the electrical stimulation services submitted as HCPCS Level II Code G0283. In this case, the electrodes were furnished as an integral part of the physician's course of treatment, the electrical stimulation services, performed in the physician's office. Therefore, the electrodes supply would not be billed separately. The payment for the electrodes supply is already included within the payment of the Electrical Stimulation procedure, HCPCS Level II code G0283.

As noted above in paragraph #13,

"If **"incident to" a physician's service, do not bill**." Please see Exhibit 4

Again, the payment of the electrical stimulation therapy represented in this case as HCPCS Level II code G0283, already reflects and includes the cost of the

electrodes used when performing the service. Therefore, separately billing for electrodes used when performing the electrical stimulation service would be considered unbundling resulting in duplicate payment.

32. As referenced above in paragraph #8, one of the potential risk areas affecting physician practices under Coding and Billing is Unbundling. The OIG further defines Unbundling as,

> "...the practice of a physician billing for multiple components of a service that must be included in a single fee..."

The payment for the electrodes is included within the payment of the electrical stimulation service, submitted as HCPCS Code G0283, performed during each encounter. Again, separate billing for the electrodes used during the performance of the electrical stimulation service would be considered unbundling resulting in duplicate payment.

33. Based on the guidelines and documentation received, the provider was not compliant with the coding and billing guidelines when submitting HCPCS Level II code A4556 for disposable/re-usable electrodes for 5/11/15 date of service.

There is no documentation to indicate that the patient purchased a take-home TENS unit and electrodes were given to the patient as take-home and/or replacement supplies for the TENS unit that has been purchased. Rather, the electrodes were issued specifically for use with the electrical stimulation service performed in the office during the same encounter.

Electrodes are a necessary component in the delivery of the electrical stimulation services submitted as HCPCS Level II Code G0283. The electrodes in

this case, were furnished as an integral part of the physician's course of treatment, the electrical stimulation services, performed in the physician's office. Therefore, the electrodes supply would not be billed separately.

Electrodes provided for sanitary reasons does not negate the fact that they are still a necessary component to the electrical stimulation procedure performed during the encounter. For example, many physician practices use various supplies for sanitary reasons such as the use of thermometer covers on thermometer probes when taking patients temperature, new syringes used for injections, individual specimen cups, disposable paper covers on examination tables, etc.

When electrodes are provided for use during the same encounter as the performance of the electrical stimulation therapy, per the guidelines, there is no separate payment for the electrodes which are incidental to the procedure. Payment for the electrodes supply was already included within the PE RVU calculation for the payment of the electrical stimulation procedure performed during the same encounter. Additional payment would be considered unbundling and result in duplicate payment.

34. Further review of the documentation received, specifically the claim representing services performed on 5/27/15, shows that the provider coded and billed CPT code 97010 with 2 units of service for the respective date of service.

As referenced in paragraph #7, the 2015 CPT Manual defines CPT code 97010 as,

"Application of a modality to 1 or more areas; hot/cold pack"

The number of areas treated is not considered a factor when reporting this code since the description represents 1 or more areas. Further, CPT code 97010 is not a timed code therefore, time is not a factor when reporting this code.

35. In addition to the CPT Manual, the American Medical Association (AMA) publishes the CPT Assistant, which provides coding guidance that is used by providers and coders throughout the country. The AMA created an editorial board for the CPT Assistant to set the groundwork for the evolution of the Newsletter into a multipurpose publication. The CPT Assistant Editorial Board is made up of 15 members representing various stake holders in the CPT code set as well as 5 individuals with relevant expertise and experience. The function of this Board is to review articles written by the AMA staff and/or specialty societies for the CPT Newsletter. This involves discussing the challenging issues facing both the physicians reporting and payer reimbursements and deciding the best course of action to address the issues posed. Per the AMA,

> "the goal of the CPT Assistant has always been to impart coding advice from the AMA's perspective, as well as a trusted unbiased source, as accepted by the CPT Editorial Panel."

According to CPT Assistant December 1998 page 1 - A Comparative Look at the Physical Medicine and Rehabilitation Codes,

> "...One of the most commonly asked questions regarding the use of the modality codes involves the intended number of times these services may be reported for a given date. Both the supervised modality codes (97010-97028) and the constant attendance codes (97032-97039) include language in the descriptor that indicates ". . . Application of a modality to one or more areas. . ."

Time is not a factor in determining the use of the supervised

modalities (ie, they do not include a time component in the descriptor), and therefore, are intended to be **used only once during an encounter**, regardless of the number of areas treated..." Exhibit 17

CPT code 97010 is a supervised modality which falls within the above range of referenced CPT codes for supervised modalities (97010 – 97028). Time is not a a factor when reporting this code nor is the number of areas since the description represents 1 or more areas. Therefore, it is to be reported only once per encounter.

36. CPT code 97010 is specifically addressed in CPT Assistant August 2002 - page 11, Coding Consultation: Medicine as seen in the following,

> "From a CPT coding perspective, codes 97010-97028 *(Application of a modality to one or more areas)* are intended to be reported **only one time** per modality, per treatment session. The length of a given treatment session is not stated in the CPT book; therefore, the therapist or physician would report each modality only one time for a given treatment session. If two separate treatment sessions are provided on the same date of service (eg, am and pm), then both may be reported. **Code 97010 should be reported only one time for the use of both cold and hot packs during a single session**." Exhibit 18

Again, CPT code 97010 falls within the above range of referenced CPT codes. Time is not a factor when reporting this code nor is the number of areas since the description represents 1 or more areas. Therefore, it is to be reported only once per encounter.

37. Further, CPT Assistant August 2010 page 13 - Coding Correction: Medicine: Physical Medicine and Rehabilitation provides specific instruction for reporting the number of units for supervised modalities such as CPT code 97010 in the following.

> "The supervised modality codes (97010-97028) ... include language in their code descriptors that indicate "application of a modality to one or more areas." The number of areas of application is not considered a factor when reporting these codes... **Only one unit of untimed or service-based**

codes should be reported, regardless of the number of body areas treated." Exhibit 19

Again, CPT code 97010 falls within the above range of referenced CPT codes. Time is not a factor when reporting this code nor is the number of areas since the description represents 1 or more areas. Therefore, it is to be reported only once per encounter.

38. Review of the claims representing the services performed on 5/27/15 date of service shows that the provider inappropriately coded CPT code 97010 with 2 units of service. Please see Exhibit 2

Therefore, the provider was not compliant with the guidelines when coding and billing CPT code 97010 with more than one unit for 5/27/15 date of service.

39. These statements are true and correct, and I have personal knowledge of all statements contained herein.

FURTHER AFFIANT SAYETH NOT

Denisha M. Lich

Denisha M. Lich, MS, RHIA, HRM

DENISHA M LICH

Print Name

STATE OF FLORIDA
COUNTY OF PINELLAS

The foregoing instrument was acknowledged before me by means of [X] physical presence or [ ] online notarization, this May 28th (date), 2020 by Denisha M. Lich, who [ ] is personally known to me or who [X] has produced FL driver's license (type of identification) as identification and has asserted under oath that the facts set forth in this document are true.

SUAD SARA GHANIE
MY COMMISSION # GG 281331
EXPIRES: December 3, 2022
Bonded Thru Notary Public Underwriters

NOTARY PUBLIC
[seal]

CURRICULUM VITAE

DENISHA M. LICH, MS, RHIA, HRM

100 16th AVENUE NORTH EAST
ST. PETERSBURG, FLORIDA 33704
(727) 515-2355

SUMMARY/ACCOMPLISHMENTS:

- *Motivated, energetic, self-starter* with twenty year record of achievement in management, quality improvement, and consulting in the health care industry.
- *In-depth knowledge* of ICD-9-CM, CPT and HCPCS Level 2 coding.
- *In-depth knowledge* of revenue cycle to include registration, chargemaster, order entry, billing and collection processes.
- *In-depth experience* with the implementation of a revenue cycle program for 22 hospital international health care system resulting in the successful first time billing to commercial insurance for both technical and professional components.
- *Expertise* as an expert witness in the area of medical record documentation, coding and billing resulting in court successes.
- *Creative Marketing skills* utilized to develop company marketing materials and website for coding, reimbursement and compliance product lines.
- *Developed and Implemented* product lines for coding, reimbursement and compliance products resulting in increased revenues.
- *Virtual management skills* used to direct outsourced coding team to meet customer needs and expectations.
- *Expertise* as a system consultant in HIM functions in development of an electronic patient record.
- *Implementation* of quality improvement systems in hospitals resulting in full TJC (JCAHO) Accreditation's.
- *Articulate and persuasive* in written and verbal communication with customers, staff and professional peers.
- *Experienced* national presenter in the areas of coding, reimbursement and compliance.
- *Proven ability* as an independent problem-solver, negotiator and in follow-through to meet deadlines.

EMPLOYMENT

March 2004 - Present: Torres-Lich & Associates, Inc, St. Petersburg, FL
President/CEO
- responsible for company's budget and strategic growth
- marketing and sales of company services
- create and develop all marketing materials for coding, consulting, and compliance product lines
- create and maintain organizational infrastructure for all HIM service lines
- develop and implement the corporate strategic plan
- oversee the daily operations of corporate activities
- expert witness services to include report/affidavit creation and testimony in the area of medical record documentation, coding and billing guidelines
- consultation services to insurance companies/payers in the area of ICD-9-CM, ICD-10-CM, CPT and HCPCS Level II coding protocols, CPT and HCPCS Level II Modifier guidelines, medical record documentation, billing guidelines, NCCI edits, facility and professional claims processing protocols, reimbursement guidelines, CMS Multiple Procedure Payment Rule, etc.
- consultation services to acute care facilities, physician practices and community health centers in the areas of: TJC (JCAHO) compliance, operational efficiencies, documentation and coding practices, staff and medical staff educational program, coding compliance, reimbursement, auditing, Health Information Management operational efficiencies, HIS project management, etc.
- educate and train in coding, compliance, and auditing practices.
- presentations to professional organizations such as American Health Information Management Association (AHIMA), South West Florida Health Information Management Association (SWFHIMA), Sun Coast Health Information Management Association (SCHIMA), Gulf Coast Health Information Management Association (GCHIMA), Medical Claims Defense Network (MCDN), Florida Insurance Fraud Education Committee (FIFEC), etc.

January 2010 – September 2010: Shriners Hospitals for Children – International Corporate Headquarters, St. Petersburg FL, Corporate Director HIM & Revenue Cycle Compliance – Revenue Cycle Project
- implement Revenue Cycle Roll-Out for 22 hospital international health care system
- build and implement Cerner Millennium applications to include all aspects of revenue cycle such as patient access, HIM, patient accounting and collections, etc.
- integrate of Cerner Millennium applications with system eHR
- develop and implement centralized charge description master for 20 hospitals
- create and implement centralized physician coding and billing system for professional services provided within the 20 system-wide hospitals
- develop and implement charge capture tools for both technical and professional billing
- develop productivity and accuracy standards and implement a centralized coding model resulting decreasing FTEs from 25 to 14
- implement system-wide utilization review process
- develop and implement revenue integrity program for SHC
- present revenue cycle, HIM and revenue integrity solutions to committees of the Board
- actively participate in the following committees: Corporate Compliance; Organizational Transformation; Revenue Cycle Committee of the Board; Physician Practice Management; Information Systems Committee, etc.

January 2005 - June 2006: Bayfront Medical Center
Manager, Health Information Management
- manage and oversee 30+ employees within the Health Information Management department
- responsible for department budget to include management of DNFB
- re-implement concurrent coding processes resulting in decrease of DNFB
- implement Cerner electronic health record to include re-defining the electronic medical record and setting policy
- oversee operations to include medical record correspondence, medical staff compliance with TJC (JCAHO) requirements, coding, birth vital statistics, transcription, etc.
- responsible for TJC (JCAHO), AHCA and CMS compliance
- work with offices of Corporate Compliance, Risk Management, Medical Staff and Revenue Cycle Management

January 2003- December 2005: C3 Partners, LLC, St. Petersburg, FL.
Managing Partner/Chief Operating Officer
- responsible for company budget and strategic growth;
- develop corporate business plan and promote coding, compliance and HIM service lines
- create and maintain organizational infrastructure for all service lines
- develop and implement the corporate strategic plan
- create and develop all marketing materials for coding, consulting, and compliance product lines
- oversee the daily operations of corporate activities
- develop and administer the Corporate Compliance Plan in accordance with OIG
- maintain written standards of ethical conduct as well as policies and procedures which demonstrate the C3 Partners', LLC commitment to compliance and ethics
- consultation services to acute care facilities, physician practices and community health centers in the areas of: TJC (JCAHO) compliance, operational efficiencies, documentation and coding practices, staff and medical staff educational program, etc.

Exhibit 1

September 2000 - December 2002:

CareMedic Systems, Inc., St. Petersburg, FL.
Vice President of Compliance and HIPAA Solutions:

- develop and administer the Corporate Compliance Plan in accordance with OIG;
- maintain written standards of ethical conduct as well as policies and procedures which demonstrate the CareMedic Systems, Inc.'s commitment to compliance and ethics;
- develop, implement and administer a HIPAA Readiness Plan to address the regulations as they pertain to CareMedic Systems product lines;
- direct the HIPAA Program Office and provide guidance to the HIPAA Team to ensure compliance;
- actively participate in Compliance and HIPAA focused organizations to include HCCA, WEDI-SNIP, AFECHT, FHA, FHCCA, etc.;
- administer an effective, documented training and education program which includes training for all employees on compliance topics to include business code of ethics, and pertinent HIPAA topics;
- participate in enforcing standards through well-publicized disciplinary guidelines;
- participate in Strategic Planning and contributes to overall success of organization;
- Product Executive of Local Medical Review Policy (LMRP) Product to include assisting with all development efforts, overseeing product operations, assisting with product support issues, product consultation services, keeping apprised of competition, supporting sales executives, and keeping abreast of Medicare regulations pertinent to product;
- oversee activities of Customer Support department;

July 1998 - September 2000:

Sarasota Memorial Health Care System, Sarasota, FL.
Corporate Compliance Officer:

- develop, implement and administer the Corporate Compliance Plan in accordance with the OIG's "Corporate Compliance Program Guidance for Hospitals;"
- maintain written standards of conduct as well as policies and procedures which demonstrate the Sarasota County Public Hospital Board's commitment to compliance and ethics;
- administer an effective, documented training and education program which includes training for all employees on standards of conduct;
- participate in enforcing standards through well-publicized disciplinary guidelines;
- coordinate activities for enterprise wide legal audits established to investigate and monitor compliance;
- present a quarterly report of compliance activity to the Corporate Compliance Committee of the Board;
- maintain "hotline" and promotes open lines of communication with all employees;
- participate in system-wide Quality Improvement Teams;
- assist various departments with operational analyses to ensure compliance with Medicare regulations pertaining to coding, billing and charging practices.

August 1999 – 2004, 2014 - Present

St. Petersburg Junior College, St. Petersburg, Florida
Adjunct Instructor:

- teach traditional and online coding courses for American Health Information Management Association approved RHIT and Coding Certificate (CCA, CCS & CCS-P) programs in CPT, ICD-9-CM/PCS, ICD-10 CM/PCS and Professional Practice II;
- clinical coordinator for coding internships;
- assist with advising students and provide clinical education.

September 1997 – July 1998:

HMI Inc., Brentwood, Tennessee.
Executive Director:

- provide assistance in compliance in the areas of hospital chargemaster, coding, billing, and documentation, etc., within the various departments;
- assist with workflow and charge capture analyses for various client outpatient departments such as radiology, cardiology, physical therapy, laboratory, and emergency room, etc.;
- working knowledge of OIG work plan, regulatory and Medicare documentation, coding and billing requirements for various services and specialties within the hospital setting for Florida and South Carolina;

- working knowledge of correct coding initiatives, Medicare regulations including medical necessity;
- working knowledge of physician regulatory and compliance issues;
- perform physician practice analysis;
- perform educational training seminars to medical staff and other healthcare professionals in the numerous areas of compliance to include but not limited to laboratory medical necessity and "bad bundle", appropriate documentation and billing practices and other pertinent issues;
- participant in Medicare Task Force;
- manage and maintain client relationships.

April 1995 – September 1997:

Coopers & Lybrand, L.L.P., Tampa, FL.
Manager, Healthcare Regulatory Group:

- develop and market Health Information Management practice services (chargemaster reviews, coding and documentation education and training , coding review software, operational analyses, laboratory compliance reviews, etc.) throughout the country;
- perform inpatient and outpatient coding audits, compliance audits, IL372/ PATH II documentation reviews for large teaching facilities, 72-hour rule audits;
- perform practice analysis for multi-specialties and large faculty practice plans, review charge capture processes for physician practices resulting in redesigning of office operations and policies and procedures;
- provide consulting services to hospitals and physicians' offices in the areas of coding, billing, charge capture processes, operational analyses, compliance, medical record documentation, health information management operations;
- develop and conduct client in-service training seminars to clients in the areas of Compliance Programs and the various areas of compliance to include but not limited to laboratory "Bad Bundle", IL372/Path II, 72 hour rule, Inpatient Coding (DRG 79vs89), Chargemaster, teaching physician guidelines, and other fraud and abuse issues, etc. as well as topics in the outpatient and inpatient coding and prospective payment systems, chargemaster review, reimbursement, risk management, etc.;
- develop and coordinate educational programs to clinical and medical staff regarding documentation issues to assist with compliance and appropriate coding practices;
- initiate and coordinate student internships in the area of health information management.

August 1992 – April 1995:

Quality Medical Consultants, Winter Park, FL.
Director of the Health Information Management and Reimbursement Division:

- market Division services (charge master reviews, medical record coding reviews, physician billing, physician support services, etc.) throughout the country;
- implement new physician billing department within Division;
- manage the Division, developing and maintaining Division budget, position descriptions and procedures for HIM&R personnel;
- coordinate and implement the consolidation of 22 hospitals' chargemasters for national hospital chain which resulted in the development of a new corporate charge master;
- work with IT to automate Charge master maintenance;
- perform operational analysis for outpatient service departments and ambulatory surgery centers;
- perform coding and operational client in-services in the area of outpatient services such as cardiology, emergency room, radiology, etc.;
- consulting services to hospitals and physicians' offices in the areas of chargemaster reviews and updates, ambulatory diagnostic and procedural coding, practice management, and the Resource Base Relative Value Scale payment system, etc.

January 1991 – May 1992:

University of Central Florida, Orlando, FL.
Graduate Teaching Assistant/ Adjunct Instructor:

- teach medical terminology, health records and standards, CPT coding;
- assist in coding labs;
- counsel students and provide clinical education;
- update student manual for Health Information Management Administration Program;

- participate in Kuwait Project to teach students from College of Kuwait in the areas of health information management.

EDUCATION

Badge: AHIMA-Approved Revenue Cycle Trainer
Awarded: November 2019

Degree: Master of Science in Health Administration, University of Central Florida
Awarded: August 1992

License: Healthcare Risk Manager, Florida Department of Insurance
Awarded: December 1992

Certificate: Risk Management, University of Central Florida
Awarded: May 1992

Degree: Bachelor of Science in Medical Record Administration, University of Central Florida
Awarded: July 1987

PROFESSIONAL ACTIVITIES

AHIMA (American Health Information Management Association)
Member, 1985 – Present
Member, AHIMA Annual Convention Program Committee 1999 - 2000
Member, Corporate Compliance Taskforce 1998 -2000
Member, Credentials Committee 1996

FHIMA (Florida Health Information Management Association)
Member, 1985 – Present
Past President, 1999 - Present
President, 1998 - 1999
President – Elect, 1997-1998
Director, 1996-1997
Director, 1990-1993
Project Manager, Arrangements Committee 1995-1996
Project Manager, Mid-Year Symposium 1993-1994
Project Manager, "Coastlines" Editor 1990-1991
Project Manager, Scholarships 1992
Member, Nominating Committee 1990-1991
Member, Arrangements Committee 1989-1991
Member, Program Committee 1988-1989

SPC (St. Petersburg College)
Member, Health Information Technical Program Advisory Committee 1997 – 2006, Present

Gulf Coast HIMA (Gulf Coast Health Information Management Association)
Member, 1989-2006
Member, Membership Committee 1989-1990
Project Manager, Membership Raffle 1989-1990

FHA (Florida Hospital Association)
Member, 1995 – 2005
Member, Florida Healthcare Corporate Compliance Association 1999 – 2005

HCCA (Health Care Compliance Association)
Member, 1998 – 2006

HFMA (Healthcare Financial Management Association)
Member, 1995 – 2001
Member, Healthcare Industry Liaison Committee 1996 - 1998

WEDI (Workgroup for Electronic Data Interchange)
Member, 2002

AFEHCT (Association For Electronic Health Care Transactions)
Member, 2002

SHARP (Southern HIPAA Administrative Regional Process)
Member, 2002

CFHIMA (Central Florida Health Information Management Association)
Member 1985-1997
Past President, 1990-1991
President, 1989-1990
President – Elect, 1988-1989
Delegate, 1989
Chairperson, Bylaws Committee 1992-1993
Chairperson, Program Committee 1988-1989
Member, Bylaws Committee 1988-1989
Member, Nominating Committee 1988

UCF (University of Central Florida)
Member, Health Information Management Program Advisory Committee 1991-1992
Member, Health Information Management Program Advisory Committee 1997-1998

Leadership Orlando, Greater Orlando Chamber of Commerce
Graduate, 1996
Alumni, Present

ARTICLES/PUBLICATIONS

"Demystifying Non-physician Practitioner Billing"
Journal of AHIMA
February, 2000

PRESENTATIONS

"Elements of the Electronic Health Record…Charting the Road to Appropriate Reimbursement"
AIMSVAR 18 Annual Conference
San Antonio, TX, March 24, 2018

"CODING & DOCUMENTATION… Where the Rubber Meets the Road"
Medical Claims Defense Network - 2014 Fall Seminar
Orlando, FL, September 17, 2014

"Juggling the Outpatient Revenue Cycle: Use of Physician Extenders, Outpatient Edits, Payer Requirements"
2012 Florida Health Information Management Association Annual Convention
Orlando, FL, July 19, 2012

"CPT Coding – Is It An Art Or Science?"
2012 FIFEC Conference
Orlando, FL, June 14, 2012

"ICD-10 –CM and the Impact on Physician Practices"
1450 Winter VAR Conference
Palm Beach, FL, February 3, 2012

"PIP Fraud as a Business Practice - Finding and Proving It"
2011 FIFEC Conference – Panel Discussion
Orlando, FL, June 9, 2011

"HIPAA... EHR and the Evolution of HIM"
Educational Seminar – South West Florida Health Information Management Association
Naples, FL, March 19, 2011

"PIP Panel Discussion"
3rd Annual Liability & Property Claims Seminar – Haas Lewis DiFiore & Amos, P.A.
Tampa, FL, October 29, 2010

"National Correct Coding Initiative and Medically Unlikely Edits... Coding and Reimbursement Challenges Continued"
Educational Seminar – South West Florida Health Information Management Association
Sarasota, FL, November 7, 2009

"HIPAA... EHR and the Evolution of HIM"
Annual Symposium – Gulf Coast Health Information Management Association
Clearwater, FL May 20, 2009

"NCCI Edits: Don't Let Them Manage You"
Strategies for Effective Revenue Cycle Management – AHIMA
Orlando, FL March 16, 2009

"PIP Law... The Impact to HIM and Your Practice"
South West Florida Health Information Management Association
Port Charlotte, FL September 2008

"Facility E&M Coding"
Optimizing the Revenue Cycle Through HIM Conference - *AHIMA*
Nashville, TN March 2008

"Ancillary Data Quality Monitoring Training Session" – One Day Auditing Boot Camp
Shriners International Headquarters
Tampa, FL January 2007

"Real World Tips to Help Implement and Audit an Effective Compliance Plan"
Healthcare Compliance Analyst Institute – AHIMA
Denver, CO October 2006

"Data Quality Monitoring Training Session" – Three Day Coding/Auditing Boot Camp
Shriners International Headquarters
Tampa, FL April 2006

"Real World Tips to Help Implement and Audit an Effective Compliance Plan"
Healthcare Compliance Analyst Institute – AHIMA
San Diego, CA October 2005

"CMS and the National Coverage Determinations (NCDs)"
American Health Information Management Association – Audio Conference
National, July 2005

"Evaluation & Management and Modifiers"
Physician Office Staff - Bayfront Medical Center
St. Petersburg, FL June 2005

"E/M Audits: Data Analysis & Reporting"
American Health Information Management Association – Audio Conference
National, June 2005

"Health Information Services Outpatient Coding Presentation"
Health Information Services Directors Meeting - Shriners International Headquarters
Tampa, FL June 2005

"2005 OIG Workplan & OIG Draft Supplemental Compliance Guidance for Hospitals"
Southwest Florida Health Information Management Association
November 2004

"Identifying Compliance Variances in Code Set Patterns/Compliance Issues Related to Coding Activities"
Healthcare Compliance Analyst Institute – AHIMA
Washington, DC October 2004

"Coding and Compliance Go Hand in Hand"
Florida Health Information Management Association Annual Meeting – Data Quality
Gaylord Palms Hotel, Orlando, FL July 2004

"Remote Coding – The Next Natural Phase in E-coding"
Meta Health Technology Users Group Meeting - Weston Hotel
Hilton Head, SC May 2004

"Compliance in Coding and HIM Practices"
Sun Coast Health Information Management Association - Good Samaritan Medical Center
West Palm Beach, FL May 2004

"Outpatient Coding Educational Presentation"
St. Joseph's Baptist Health Care System
August 2004

"Health Insurance Portability and Accountability Act"
North East Florida Health Information Management Association - Radisson Hotel
Jacksonville, FL April 2004

"CPT/RBRVS – A Presentation of Introduction and Application"
Shriners Hospitals for Children
Corporate Headquarters
Tampa, FL March 2004

"Physician Evaluation and Management Service Reporting"
AHIMA Audio Seminar
National, November 2003

"Identifying Compliance Variances in Code Set Patterns"
Healthcare Compliance Analyst Institute – AHIMA
Minneapolis, MN 2003

"HIPAA & Optometry"
Optician Continuing Education – St. Petersburg College
St. Petersburg, FL 2003

"Compliance in a Physician Practice"
Office Managers' Group – Sarasota County Chapter
Sarasota, FL. 2000

"Corporate Compliance and Internal Audit"
Medical Auditors' Association – Sarasota County Chapter
Sarasota, FL. 1999

"Compliance Check-Up: Completing an Effective Coding Audit"
AHIMA Audio Seminar
National, 1999

"Corporate Compliance: OIG 1999 Workplan"
Southwest Florida Health Information Management Association
Sarasota, FL. 1999

"Corporate Compliance Guidance and Risk Management"
Risk Managers Association - Sarasota County Chapter
Sarasota, FL. 1999

"Compliance Panel: Compliance Elements"
Florida Health Information Management Association Annual Convention
Tampa, FL. 1999

"Evaluation & Management 1998 Update"
Tuomey Regional Medical Center
Sumter, SC. 1998

"Fraud & Abuse" (Co-Presenter)
Florida Health Information Management Association Mid-Year Symposium
St. Petersburg, FL. 1998

"OIG and Compliance"
St. Joseph's Hospital
Atlanta, GA. 1997

"Outpatient Prospective Payment System"
Colegio de Administradores de Servicios de Salud (Healthcare Administrators) - Hotel El Conquistador, Fajardo, PR. 1996

"Medicare Fraud" (Co-Presenter)
Florida Health Information Management Association Annual Conference
Saddlebrook Resort – Tampa, Wesley Chapel, FL. 1996

"APGs"
Central Florida Health Information Management Association Monthly Educational Meeting -
Florida Hospital Altamonte, Altamonte Springs, FL. 1996

"APGs Issues in Admitting"
Michigan Alliance of Healthcare Access Professionals - The Hotel Baronette,
Novi, MI. 1995

"HIM & the Future of Coding & Data Quality ... A Look at APGs"
Quorum Health Resources, Inc. Quarterly Conference - Clearwater Beach Hotel
Clearwater, FL. 1995

"Office of Inspector General's Impact on Medical Records"
American Association of Healthcare Internal Auditors - Tampa General Hospital,
Tampa, FL. 1995

"Cardiology – A Coding Seminar"
QMC, Inc. - Georgetown Memorial Hospital, GA

"Why Consider a Chargemaster Coding Review and Update?"
Quorum Health Resources, Inc. Quarterly Conference - Marriott Hotel
Miami, FL. 1993

"Medical Records and Risk Management"
Risk Management Class, University of Central Florida - University of Central Florida
Orlando, FL. 1993

"CPT-4, ICD-9-CM and Revenue Codes: A Chargemaster Review. Medical Record and Business Office are You Up to Snuff?"
South East Medical Record Association - Holiday Inn
Punta Gorda, FL. 1992

"CPT-4 Coding Procedures"
West Orange Hospital Monthly Physician Office Manager Seminar - West Orange Hospital

West Orange, FL. 1991

"Medical Records: A Challenge!"
Florida Health Information Management Association Mid-Year Symposium
Orlando, FL. 1990

"Setting Up a Medical Record Department"
University of Central Florida, Orlando, FL. 1989

CPT-4, The Future of Ambulatory Coding"
Florida Health Information Management Association Annual Conference
West Palm Beach, FL. 1988

PERSONAL

Bilingual: English/Spanish

HONORS AND AWARDS

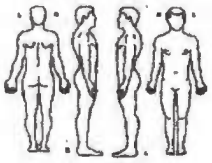
Recipient of the University of Central Florida Alumni Association Professional Achievement Award, 1998
Recipient of the College of Health and Public Affairs, University of Central Florida, Alumni Professional Achievement Award, 1998
Recipient of FHIMA Outstanding New Professional Award, 1992
Recipient of AHIMA "Edna Huffman" Graduate Scholarship, 1991
Recipient of FHIMA Graduate Scholarship, 1991
President's List – Two consecutive semesters
Dean's List – Four consecutive semesters

KISSIMMEE INJURY CLINIC
PATIENT PROGRESS AND DAILY TREATMENT KISS.

NAME: [redacted] DATE: 6/8/15 M,T,W,R,F A.P. D.C. M.D. L.M.T

TREATMENT TODAY CONSISTED OF THE FOLLOWING PROCEDURES:

EVALUATION & MANAGEMENT
( ) 99201 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT: ____
( ) 99202 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT: ____
( ) 99203 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT: ____
ESTABLISHED PATIENT
( ) 99211 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT: ____
( ) 99212 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT: ____
( ) 99213 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT: ____
( ) 99214 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT: ____



KEY: P=Pad Placement M=Massage Region
U=Ultrasound region A=Acupuncture Needles
SYNERGY REHABILITATION KITS
( ) 99071 Educational Supplies ( ) 99070HCPCS A9300 ( ) 99070HCPCS E0942 Cervical Harness/Halter
( ) 99070HCPCS A9300 Cervical Resistance Band ( ) Other: _____ ( ) Other: _____
JOINT DYSFUNCTION/FIXATIONS ( ) OTHER: _____
Occ, C1, C2, C3, C4, C5, C6, C7, T1, T2, T3, T4, T5, T6, T7, ( ) OTHER: _____
T8, T9, T10, T11, T12, L1, L2, L3, L4, L5, SAC, RSI, LSI ( ) OTHER: _____
EXTREMITIES: _____ ( ) OTHER: _____

MANIPULATION:
( ) 98940 1 to 2 Regions: C T L S P
( ) 98941 3 to 4 Regions: C T L S P
( ) 98942 5 > Regions: C T L S P
( ) 98943 Extremities
( ) 97012 Mechanical Traction
( ) 97530 Kinetic Activities:
( ) 97026 Infrared Heat
( ) 95851 ROM Testing:
( ) 99158 R.O.F.
( ) 97039 Wanotherapy

( ) 97032 Attended Stimulation:
(✓) 00283 Electric Stimulation: 45 T
( ) 95831 Muscle Testing:
( ) 97035 Ultra Sound:
( ) 97112 Neuro Re-Ed:
(✓) 97110 Ther. Exercise: TRX bp Ant.
( ) 97535 Activ o/Daily Living:
(✓) 97010 Hot Pack:
(✓) 97140 Manual Therapies: QL 45 bp.
( ) A4556 Electrode Pads:
( ) Other
( ) Other

HOME CARE SUPPLIES: ( ) 99070 Hot/Ice Pack:
( ) A4565- Arm Sling: ( ) E0720 Tens Unit:
( ) L0625-LS Lumbar Support: ( ) L0140-CC Cervical Collar:
( ) E0190-CP Cervical Pillow: ( ) L1906 Ankle Support:
EXAMINATION/ASSESMENT: __ Initial __ Interim __ with __ without / Radiographs)

__ Referral for assessment to include: _____
Patient to return for additional care: __M__T__W__R__F__S__D
I HEREBY CERTIFY THAT ON THIS DATE I HAVE RECEIVED THE ABOVE INDICATED SERVICES AND I UNDERSTAND AND ACCEPT THE CHARGES FOR EACH SERVICE.

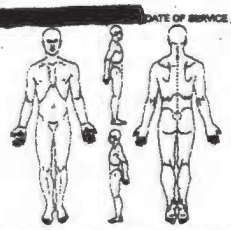
PATIENT SIGNATURE: [redacted] DATE: _____

Kissimmee Injury Clinic [redacted]

08/22/2015

Kissimmee Injury Clinic

PATIENT NAME [redacted] DATE OF SERVICE 6/8/15



0 = Trigger Point - = Tenderness Δ = Pain X = Inflamed = = Adhesions * = Referred Pain |= Increased ROM ↓ = Decreased ROM

OBJECTIVE: Myospasms persist in the following muscles.

Sub-Occipital Muscles	___ Mild	___ Moderate	___ Severe	___ Palpable Nodules
Cervical Paravertebral	___ Mild	___ Moderate	___ Severe	___ Palpable Nodules
Trapezius Muscles	___ Mild	___ Moderate	___ Severe	___ Palpable Nodules
Thoracic Paravertebral	___ Mild	___ Moderate	___ Severe	___ Palpable Nodules
Lumbar Paravertebral	___ Mild	___ Moderate	___ Severe	___ Palpable Nodules
Shoulder Musculature	___ Mild	___ Moderate	___ Severe	___ Palpable Nodules
Arm/ Forearm Muscles	___ Mild	___ Moderate	___ Severe	___ Palpable Nodules
Hip/ Buttock Muscles	___ Mild	___ Moderate	___ Severe	___ Palpable Nodules
Thigh/ Leg Muscles	___ Mild	___ Moderate	___ Severe	___ Palpable Nodules

Notes: Joint Tenderness, Myospasms, Palpable Nodules, Limited Stretching, Pain with ROM

Maria Cano, L.M.T.
MA58699

08/22/2015

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improving alignment and minimizing the recurrence of his clinical status.

CLOSING COMMENTS:
DR. J. KHAN

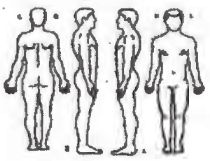
08/22/2015

KISSIMMEE INJURY CLINIC
PATIENT PROGRESS AND DAILY TREATMENT KISS.

NAME: [redacted] DATE: 6/8/15 M,T,W,R,F A.P. D.C. M.D. L.M.T

TREATMENT TODAY CONSISTED OF THE FOLLOWING PROCEDURES:

EVALUATION & MANAGEMENT
( ) 99201 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT: ____
( ) 99202 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT: ____
( ) 99203 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT: ____
ESTABLISHED PATIENT
( ) 99211 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT: ____
( ) 99212 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT: ____
( ) 99213 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT: ____
( ) 99214 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT: ____



KEY: P=Pad Placement M=Massage Region
U=Ultrasound region A=Acupuncture Needles
SYNERGY REHABILITATION KITS
( ) 99071 Educational Supplies ( ) 99070HCPCS A9300 ( ) 99070HCPCS E0942 Cervical Harness/Halter
( ) 99070HCPCS A9300 Cervical Resistance Band ( ) Other: _____ ( ) Other: _____
JOINT DYSFUNCTION/FIXATIONS ( ) OTHER: _____
Occ, C1, C2, C3, C4, C5, C6, C7, T1, T2, T3, T4, T5, T6, T7, ( ) OTHER: _____
T8, T9, T10, T11, T12, L1, L2, L3, L4, L5, SAC, RSI, LSI ( ) OTHER: _____
EXTREMITIES: _____ ( ) OTHER: _____

MANIPULATION:
( ) 98940 1 to 2 Regions: C T L S P
( ) 98941 3 to 4 Regions: C T L S P
( ) 98942 5 > Regions: C T L S P
( ) 98943 Extremities
( ) 97012 Mechanical Traction
( ) 97530 Kinetic Activities:
( ) 97026 Infrared Heat
( ) 95851 ROM Testing:
( ) 99158 R.O.F. TRX OTL
( ) 97039 Wanotherapy

( ) 97032 Attended Stimulation:
(✓) 00283 Electric Stimulation: T 45
( ) 95831 Muscle Testing:
( ) 97035 Ultra Sound:
( ) 97112 Neuro Re-Ed:
(✓) 97110 Ther. Exercise:
( ) 97535 Activ o/Daily Living:
(✓) 97010 Hot Pack:
(✓) 97140 Manual Therapies: L 45 bp ant.
( ) A4556 Electrode Pads:
( ) Other
( ) Other

HOME CARE SUPPLIES: ( ) 99070 Hot/Ice Pack:
( ) A4565- Arm Sling: ( ) E0720 Tens Unit:
( ) L0625-LS Lumbar Support: ( ) L0140-CC Cervical Collar:
( ) E0190-CP Cervical Pillow: ( ) L1906 Ankle Support:
EXAMINATION/ASSESMENT: __ Initial __ Interim __ with __ without / Radiographs)

__ Referral for assessment to include: _____
Patient to return for additional care: __M__T__W__R__F__S__D
I HEREBY CERTIFY THAT ON THIS DATE I HAVE RECEIVED THE ABOVE INDICATED SERVICES AND I UNDERSTAND AND ACCEPT THE CHARGES FOR EACH SERVICE.

PATIENT SIGNATURE: [redacted] DATE: 6/8/15

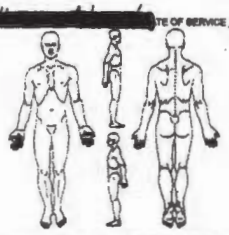
Kissimmee Injury Clinic [redacted]

08/22/2015

Exhibit 2

Kissimmee Injury Clinic

PATIENT NAME [redacted] DATE OF SERVICE 6/9/15



0 = Trigger Point • = Tenderness Δ = Pain X = Inflamed = = Adhesions * = Referred Pain ↑= Increased ROM ↓ = Decreased ROM

OBJECTIVE: Myospasms present in the following muscles.

Sub-Occipital Muscles:	Mild	Moderate	Severe	Palpable Nodules
Cervical Paravertebral:	Mild	Moderate	Severe	Palpable Nodules
Trapezius Muscles:	Mild	Moderate	Severe	Palpable Nodules
Thoracic Paravertebral:	Mild	Moderate	Severe	Palpable Nodules
Lumbar Paravertebral:	Mild	Moderate	Severe	Palpable Nodules
Shoulder Musculature:	Mild	Moderate	Severe	Palpable Nodules
Joint Forearm Muscles:	Mild	Moderate	Severe	Palpable Nodules
Hip/ Buttock Muscles:	Mild	Moderate	Severe	Palpable Nodules
Thigh/ Leg Muscles:	Mild	Moderate	Severe	Palpable Nodules

Notes: Myofascial Release, HP Modalities, Supervised

Maria Diaz, C.M.T.
MA58889

6/9/2015 08:54AM 4074866666 PAGE 02/02 FAX 6/9/2015 08:54AM 4074866666 PAGE 02/02

DAILY ROUTINE

PATIENT NAME [redacted]

DATE OF SERVICE 6-9-15

SUBJECTIVE: Patient complains of pain in these areas

Headache	Shoulder	L R	Hip	L R
Neck	Upper Arm	L R	Thigh	L R
Chest	Elbow	L R	Knee	L R
Upper Back	Forearm	L R	Calf	L R
Mid Back	Wrist	L R	Ankle	L R
Lower Back	Hand	L R	Foot	L R
Abdomen/Abdomen	Fingers	L R	Toes	L R
SI Joint L/R				
Other				

Severity: Sharp Pain Scale: 1=Moderate 2=Constant 3=Intermittent 4=Lumbar 5=Other 6=none 10= Maximum

A Brief Review of the following SYSTEMS was performed: Neck Back Upper/Lower Extremities

OBJECTIVE: Myospasms present in the following muscles on the L R Bilaterally

Sub-Occipital Muscles:	Mild	Moderate	Severe	Palpable Nodules
Cervical Paravertebral:	Mild	Moderate	Severe	Palpable Nodules
Trapezius Muscles:	Mild	Moderate	Severe	Palpable Nodules
Thoracic Paravertebral:	Mild	Moderate	Severe	Palpable Nodules
Lumbar Paravertebral:	Mild	Moderate	Severe	Palpable Nodules
Shoulder Musculature:	Mild	Moderate	Severe	Palpable Nodules
Joint Forearm Muscles:	Mild	Moderate	Severe	Palpable Nodules
Hip/ Buttock Muscles:	Mild	Moderate	Severe	Palpable Nodules
Thigh/ Leg Muscles:	Mild	Moderate	Severe	Palpable Nodules

Motion is restricted to: C Spine, T Spine, L Spine, Hip, Wrist, Hip, Knee, Ankle

Prognosis: Fair Impaired, Slower, Much slower, Poorer, Much Poorer
Patient Feels: Much better, A Little Better, About the Same, A Little Worse, Much Worse

CMS: C1 C2 C3 C4 C5 C6 C7 T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12 L1 L2 L3 L4 L5 SI JOINT - L/R

ASSESSMENT/RULE: Cervical Strain/Sprain/Contusion due to MVA or Work DDD/Osteoarthritis

STAGE OF CARE: Relief Rehabilitative/Therapeutic Wellness

RECOMMENDED:

CMS: Daily 3x/Week, 2x/Week, 3x/Week, 2x/Week, Bi-Monthly PRN

THERAPY: Daily 3x/Week, 2x/Week, 3x/Week, 2x/Week, Bi-Monthly PRN

Additional Comments: [redacted]

L RNAN, D.C.

6/9/2015 08:54AM 4074866666 PAGE 02/02 FAX 6/9/2015 08:54AM 4074866666 PAGE 02/02

Re: Mr [redacted] - Visit Date: Tuesday, June 9, 2015

STATE FARM
P.O BOX 106134
Atlanta, GA 30348-6134

Date of Injury/Onset: May 8, 2015

Policy No: 996309854
Claim No: C934438A3199-4

To Whom It May Concern:

On June 9, 2015, the above named patient presented himself for treatment of his complaints relating from a motor vehicle accident that he was involved in on May 8, 2015.

SUBJECTIVE COMPLAINTS:
Mr. [redacted] current signs and symptoms were assessed today.

Mr. [redacted] low back pain was 4, on the 1 to 10 Pain Scale. It feathers him between 25% and 50% of the time he is awake. His daily activities are currently somewhat affected by this symptom.

ASSESSMENT/TREATMENT:
Today's Modalities & Procedures: These were the procedures that were performed and/or recommended today: manual therapies (97140) for 30 minutes, therapeutic procedures (97110) for 15 minutes, and R.O.F, along with hydrotherapy, interferential current and chiropractic adjustments. The above was for the purpose of decreasing pain, decreasing swelling and inflammation, decreasing spasm, increasing function and relieving symptoms of exacerbation.

Today's Assessment: The patient is progressing as expected.

723.1	Cervicalgia (Pain in neck)
847.0	Neck sprain/strain (whiplash injury)
307.81	Tension headache
724.1	Pain in thoracic spine
847.1	Thoracic sprain/strain
724.2	Lumbago (Low back pain)
847.2	Lumbar sprain/strain
728.85	Spasm of muscle

FUTURE CARE PLAN:
The follow conditions is to be the case for Mr [redacted] future care.
Present Care Plan: Mr. [redacted] is presently in a Relief phase of care.
Future Treatment Plan: Our recommended future care plan for this patient consists of ultrasound, home exercises, moist heat therapy, hydrotherapy, physiotherapy, spinal traction, massage therapy, lumbar traction, interferential current, chiropractic adjustments, relative exercises and physical therapy exercises every day for three weeks.

Goals of Treatment Plan: Our goals for the above proposed treatment plan are decreasing pain decreasing swelling and inflammation, decreasing spasm, increasing range of motion, increasing the ability to perform normal activities of daily living, returning the patient to his pre-accident status, increasing function, correcting muscle imbalance, reducing frequency and severity of probable exacerbations, relieving symptoms of exacerbation, improving alignment and minimizing the recurrence of his clinical status.

CLOSING COMMENTS:
DR. J. RNAN

6/9/2015 08:54AM 4074866666 PAGE 02/02 FAX 6/9/2015 08:54AM 4074866666 PAGE 02/02

KISSIMMEE INJURY CLINIC
PATIENT PROGRESS AND DAILY TREATMENT KISS.

NAME: [redacted] DATE: 6/9/15 M.T,W.R.F A.P. D.C. M.D. L.M.T

TREATMENT TODAY CONSISTED OF THE FOLLOWING PROCEDURES:

EVALUATION & MANAGEMENT:
( ) 99201 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99202 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99203 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
ESTABLISHED PATIENT:
( ) 99211 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99212 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99213 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99214 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
KEY: P=Pad Placement M=Massage Region
U=Ultrasound region Acupuncture Needles

SYNERGY REHABILITATION KITS
( ) 99071 Educational Supplies ( ) 99070/HCPCS A6500 ( ) 99070/HCPCS E0942 Cervical Harness/Halter
( ) 99070/HCPCS A6448 Cervical Resistance Band ( ) Other: ( ) Other:
JOINT DYSFUNCTION/FIXATIONS ( ) OTHER:
Occ. C1, C2, C3, C4, C5, C6, C7, T1, T2, T3, T4, T5, T6, T7, T8, T9, T10, T11, T12, L1, L2, L3, LA, LS, SAC, RSI, LSI ( ) OTHER:
EXTREMITIES: ( ) OTHER:
( ) OTHER:

MANIPULATION:
( ) 98940 1 to 2 Regions: C T L S P
( ) 98941 3 to 4 Regions: C T L S P
( ) 98942 5 > Regions: C T L S P
( ) 98943 Extremities
( ) 97012 Mechanical Traction SP
( ) 97530 Kinetic Activities:
( ) 97026 Infrared Heat
( ) 95851 ROM Testing:
( ) 98958 R.O.F.
( ) 97039 Hydrotherapy

( ) 97032 Attended Stimulation:
( ) G0283 Electric Stimulation: 45
( ) 95831 Muscle Testing:
( ) 97035 Ultra Sound:
( ) 97112 Neuro Re-Ed:
( ) 97110 Ther. Exercise: with L
( ) 97535 Activ a/Daily Living:
( ) 97810 Hot Pack:
( ) 97140 Manual Therapies: SP 45 HP
( ) A4338 Electrode Pads:
( ) Other:
( ) Other:

HOME CARE SUPPLIES: ( ) 99070 Hot/Ice Pack:
( ) A4565- Arm Sling: ( ) E0720 Tens Unit:
( ) L0625-LS Lumbar Support: ( ) L0140-CC Cervical Collar:
( ) E0190-CP Cervical Pillow: ( ) L1906 Ankle Support:

EXAMINATION/ASSESSMENT: Initial Interim with without / Radiographs)

Referral for assessment to include:
Patient to return for additional care: M T W R F S D

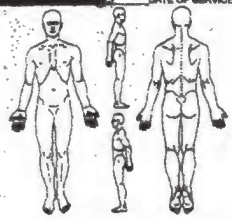
I HEREBY CERTIFY THAT ON THIS DATE I HAVE RECEIVED THE ABOVE INDICATED SERVICES AND I UNDERSTAND AND ACCEPT THE CHARGES FOR EACH SERVICE.

PATIENT SIGNATURE: [redacted] DATE: 6/9/15

6/9/2015 08:54AM 4074866666 PAGE 02/02 FAX 6/9/2015 08:54AM 4074866666 PAGE 02/02

Kissimmee Injury Clinic

PATIENT NAME: [redacted] DATE OF SERVICE: 5/27/15



0 = Trigger Point · = Tenderness Δ = Pain X = Inflamed = = Adhesions * = Referred Pain ↑= Increased ROM ↓ = Decreased ROM

OBJECTIVE: Myospasms persist in the following muscles.

✓ Sub-Occipital Muscles:	___ Mild	✓ Moderate	___ Severe	___ Palpable Nodules
✓ Cervical Paravertebral:	___ Mild	✓ Moderate	___ Severe	___ Palpable Nodules
___ Trapezius Muscles:	___ Mild	✓ Moderate	___ Severe	___ Palpable Nodules
✓ Thoracic Paravertebral:	___ Mild	✓ Moderate	___ Severe	___ Palpable Nodules
✓ Lumbar Paravertebral:	___ Mild	✓ Moderate	___ Severe	___ Palpable Nodules
___ Shoulder Musculature:	___ Mild	___ Moderate	___ Severe	___ Palpable Nodules
___ Arm/ Forearm Muscles	___ Mild	___ Moderate	___ Severe	___ Palpable Nodules
✓ Rt/ Buttock Muscles:	___ Mild	___ Moderate	___ Severe	___ Palpable Nodules
___ Thigh/ Leg Muscles:	___ Mild	___ Moderate	___ Severe	___ Palpable Nodules

Notes:

Marta Cano, L.M.T.
MA99899

Re: Mr. [redacted] Visit Date: Thursday, May 28, 2015

STATEFARM
P.O BOX 108134
Atlanta, GA 30348-8134

Date of Injury/Onset: May 8, 2015
Policy No: 996505956
Claim No: C954438A3150-4

To Whom it May Concern:

The patient named above came to our office on May 28, 2015 for treatment of his complaints arising from a motor vehicle accident that he was involved in on May 8, 2015.

SUBJECTIVE COMPLAINTS:

Mr. [redacted] current signs and symptoms were assessed today. He also stated his neck pain has experienced slight [redacted] since his last visit. On the 1 to 10 scale, it was 2. It bothers him less than 25% of the time he is awake. Presently his daily activities are not affected by this symptom. It usually is worse in the morning hours.
The patient's low back pain was 3, on the 1 to 10 Pain Scale. It bothers him between 25% and 30% of the time he is awake. This symptom is presently having some affect on his daily activities.

ASSESSMENT//TREATMENT:

Today's Modalities & Procedures: Following were the modalities used and/or recommended today: manual therapies (97140) for 30 minutes, and therapeutic procedures (97110) for 15 minutes, along with moist heat therapy, intersegmental traction and electrostimulation current. The above was for the purpose of decreasing pain, decreasing swelling and inflammation, decreasing spasms, increasing function and relieving symptoms of exacerbation.

Today's Assessment:

723.1	Cervicalgia (Pain in neck)
847.0	Neck sprain/strain (whiplash injury)
307.81	Tension headache
724.1	Pain in thoracic spine
847.1	Thoracic sprain/strain
724.2	Lumbago (Low back pain)
847.2	Lumbar sprain/strain
728.85	Spasm of muscle

FUTURE CARE PLAN:

The following plan remains virtually unchanged since Mr. [redacted] last visit:

Present Care Phase: Mr. [redacted] is presently in a relief phase of care.

Future Treatment Plan: Our recommended future care plan for this patient consists of ultrasound, home exercises, moist heat therapy, hydrotherapy, physiotherapy, spinal traction, massage therapy, lumbar traction, interferential current, chiropractic adjustments, palpative exercises and physical therapy exercises every day for three weeks.

Goals of Treatment Plan: The preceding treatment plan has the goal of decreasing pain, decreasing swelling and inflammation, decreasing spasms, increasing range of motion, increasing the ability to perform normal activities of daily living, returning the patient to his pre-accident status, increasing function, correcting muscle imbalance, reducing frequency and severity of probable exacerbations, relieving symptoms of exacerbation, improving alignment and minimizing the recurrence of his clinical status.

CLOSING COMMENTS:

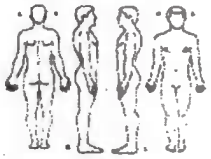
DR. J. KHAN

KISSIMMEE INJURY CLINIC
PATIENT PROGRESS AND DAILY TREATMENT KISS

NAME: [redacted] DATE: 5/27/15 M,T,W,R,F A.P. D.C. M.D. L.M.T

TREATMENT TODAY CONSISTED OF THE FOLLOWING PROCEDURES:

EVALUATION & MANAGEMENT
( ) 99201 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99202 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99203 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
ESTABLISHED PATIENT
( ) 99211 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99212 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99213 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99214 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:



KEY: P=Pad Placement M=Massage Region
U=Ultrasound +plus A=Acupuncture Needles
SYNERGY REHABILITATION KITS
( ) 99071 Educational Supplies ( ) 99070HCPCS A9300 ( ) 99070HCPCS S8042 Cervical Harness/Halter
( ) 99070HCPS A9300 Cervical Resistance Band ( ) Other: ( ) Other:
JOINT DYSFUNCTION/FIXATIONS
Occ. C1, C2, C3, C4, C5, C6, C7, T1, T2, T3, T4, T5, T6, T7, T8, T9, T10, T11, T12, L1, L2, L3, LA, LS, SAC, RSI, LSI
EXTREMITIES:
( ) OTHER:
( ) OTHER:
( ) OTHER:
( ) OTHER:

MANIPULATION:
( ) 98940 1 to 2 Regions: C T L S P
( ) 98941 3 to 4 Regions: C T L S P
( ) 98942 5 > Regions: C T L S P
( ) 98943 Extremities
( ) 97012 Mechanical Traction
( ) 97530 Kinetic Activities:
( ) 97026 Infrared Heat
( ) 97811 ROM Testing:
( ) 98168 H.O.T.
( ) 97039 Unlisted Modality

( ) 97032 Attended Stimulation:
( ) G0283 Electric Stimulation: 45
( ) 95851 Muscle Testing:
( ) 97035 Ultra Sound:
( ) 97112 Neuro Re-Ed:
( ) 97110 Ther. Exercises: 15
( ) 97535 Activ o/Daily Living:
( ) 97010 Hot Pack:
2 ( ) 97140 Manual Therapies: 45 45
( ) A4556 Electrode Pads:
( ) Other
( ) Other

HOME CARE SUPPLIES: ( ) 99070 Hot/Ice Pack:
( ) A4565- Arm Sling:
( ) L0625-LS Lumbar Support:
( ) E0190-CP Cervical Pillow:
( ) E0720 Tens Unit:
( ) L0140-CC Cervical Collar:
( ) L1906 Ankle Support:

EXAMINATION/ASSESMENT: ___ Initial ___ Interim ___ with ___ without / Radiographs)

___ Referral for assessment to include:
___ Patient to return for additional care: ___ M T W R F S D

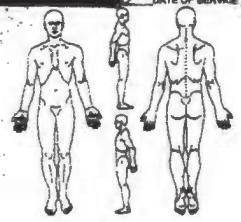
I HEREBY CERTIFY THAT ON THIS DATE I HAVE RECEIVED THE ABOVE INDICATED SERVICES AND I UNDERSTAND AND ACCEPT THE CHARGES FOR EACH SERVICE.

PATIENT SIGNATURE: [redacted] DATE: 5/27/15

Kissimmee Injury Clinic, [redacted] Ave. Suite 313, Kissimmee, FL 34741 Ph: 407-434-PAIN Fax: 407-870-4703

Kissimmee Injury Clinic

PATIENT NAME: [redacted] DATE OF SERVICE: 5/27/15



0 = Trigger Point · = Tenderness Δ = Pain X = Inflamed = = Adhesions * = Referred Pain ↑= Increased ROM ↓ = Decreased ROM

OBJECTIVE: Myospasms persist in the following muscles.

✓ Sub-Occipital Muscles	___ Mild	✓ Moderate	___ Severe	___ Palpable Nodules
✓ Cervical Paravertebral:	___ Mild	✓ Moderate	___ Severe	___ Palpable Nodules
✓ Trapezius Muscles:	___ Mild	✓ Moderate	___ Severe	___ Palpable Nodules
✓ Thoracic Paravertebral:	___ Mild	✓ Moderate	___ Severe	___ Palpable Nodules
✓ Lumbar Paravertebral:	___ Mild	✓ Moderate	___ Severe	___ Palpable Nodules
___ Shoulder Musculature	___ Mild	___ Moderate	___ Severe	___ Palpable Nodules
___ Arm/ Forearm Muscles	___ Mild	___ Moderate	___ Severe	___ Palpable Nodules
✓ Rt/ Buttock Muscles:	___ Mild	___ Moderate	___ Severe	___ Palpable Nodules
___ Thigh/ Leg Muscles:	___ Mild	___ Moderate	___ Severe	___ Palpable Nodules

Notes:

Marta Cano, L.M.T.
MA99899

DAILY SOAP NOTE

PATIENT NAME: [redacted]

DATE OF SERVICE: 5/29/15

SUBJECTIVE: Patient complains of pain in these areas

Shoulder	LR	Hip	LR
Upper Arm	LR	Thigh	LR
Elbow	LR	Knee	LR
Forearm	LR	Calf	LR
Wrist	LR	Ankle	LR
Hand	LR	Foot	LR
Fingers	LR	Toes	LR

Other _____

Secondary Pain Scale: _Headache _Cervical _Thoracic _Lumbar _Other _____ Pain on 10= Maximum

A Brief Review of the following SYSTEMS was performed: ✓WNL _Abnl _____ Normalcy _____

OBJECTIVE: Myospasm noted in the following muscles on the L R bilaterally

Cervical Muscles:	Mild	Moderate	Severe	Palpable Nodules
Cervical Paravertebral:	Mild	Moderate	Severe	Palpable Nodules
Trapezius Muscles:	Mild	Moderate	Severe	Palpable Nodules
Thoracic Paravertebral:	Mild	Moderate	Severe	Palpable Nodules
Lumbar Paravertebral:	Mild	Moderate	Severe	Palpable Nodules
Shoulder Musculature:	Mild	Moderate	Severe	Palpable Nodules
Arm/ Forearm Muscles:	Mild	Moderate	Severe	Palpable Nodules
Hip/ Buttock Muscles:	Mild	Moderate	Severe	Palpable Nodules
Thigh/ Leg Muscles:	Mild	Moderate	Severe	Palpable Nodules

Motion is restricted to ✓C Spine, _P Spine, _L Spine, _Shld, _Hip, _Wr, _Hip, ✓Knee, _Ankle

Prognosis: ✓Is Impaired, _Normal, _Much slower, _Poorer, _Much Poorer
Patient Feels: _Much better, _A Little Better, _About the Same, _A Little Worse, _Much Worse

CMT: C1 C2 C3 C4 C5 C6 C7 T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12 L1 L2 L3 L4 L5 SI JOINT SACRUM

ASSESSMENT DX: Acute Strain/Sprain/Contusion due to MVA _____ ICD 9 DX: Unavailable

STAGE OF CARE: _Initial _Rehab/Restore/Therapeutic _Wellness

PLAN/TREATMENT:

CMT: _3X/Week, _2x/Week, _1x/Week, _1x/Week, _Bi-Monthly _PRN

THERAPY: _Daily _4x/Week, _3x/Week, _2x/Week, _1x/Week, _Bi-Monthly _PRN

Additional Comments: _____

_____

_____

Dr. Khan

RECEIVED 05/27/2015 11:35AM 4074784753 SPINE INJURY SCHEDULED INJURY 05/28 2PM

06082015

Re: Mr. [redacted] Visit Date: Wednesday, May 27, 2015

STATEFARM
P.O BOX 106134
Atlanta, GA 30348-6134

Date of Injury/Claim#: May 8, 2015

Policy No: 396308934
Claim No: C934436A3150-4

To Whom it May Concern:

The patient named above came to our office on May 27, 2015 for treatment of his complaints arising from a motor vehicle accident that he was involved in on May 8, 2015.

SUBJECTIVE COMPLAINTS:
An assessment of Mr. [redacted] current signs and symptoms was performed today. He stated that his pain in the KNEE has experienced slight improvement. On the 1 to 10 scale today, this complaint was rated at 2. It's experienced less than 25% of the time he is awake. This symptom is not presently affecting his daily activities. His neck pain has seen some slight improvement. On the 1 to 10 scale, it was 2. It bothers him less than 25% of the time he is awake. His daily activities are presently unaffected by this symptom.

His low back pain has improved a bit since his last visit with us. On the 1 to 10 Pain Scale, it was 3. It bothers him between 25% and 50% of the time he is awake. This symptom is presently having some effect on his daily activities.

ASSESSMENT/TREATMENT:
Today's Modalities & Procedures: These were the procedures that were performed and/or recommended today: manual therapies (97140) for 30 minutes, and therapeutic procedures (97110) for 30 minutes, along with moist heat therapy, hydrotherapy and interferential current. The above was for the purpose of decreasing pain, decreasing swelling and inflammation, decreasing spasms, increasing function and relieving symptoms of concussion.

Today's Assessment:

723.1	Cervicalgia (Pain in neck)
847.0	Neck sprain/strain (whiplash injury)
307.81	Tension headache
724.1	Pain in thoracic spine
847.1	Thoracic sprain/strain
724.2	Lumbago (Low back pain)
847.2	Lumbar sprain/strain
728.85	Spasm of muscle

FUTURE CARE PLAN:
The following plan remains virtually unchanged since Mr. [redacted] last visit:
Present Care Plans: Currently, we have the patient in a relief phase of care.

Future Treatment Plan: Our future care recommendations include ultrasound, home exercises, moist heat therapy, hydrotherapy, physiotherapy, spinal traction, massage therapy, lumbar traction, interferential current, chiropractic adjustments, rotative exercises and physical therapy exercises every day for three weeks.

Goals of Treatment Plan: The goals intended to be achieved with the preceding treatment plan are decreasing pain, decreasing swelling and inflammation, decreasing spasms, increasing range of motion, increasing the ability to

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06082015

perform normal activities of daily living, returning the patient to his pre-accident status, increasing function, decreasing muscle imbalance, reducing frequency and severity of probable concussions, relieving symptoms of concussion, improving alignment and minimizing the recurrence of his clinical status.

CLOSING COMMENTS:
DR. Z. KHAN

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06082015

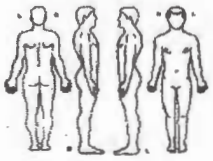
KISSIMMEE INJURY CLINIC
PATIENT PROGRESS AND DAILY TREATMENT **KISS.**

NAME: [redacted] DATE: 5/29/15 M,T,W,R,F A.P. D.C. M.D. L.M.T

TREATMENT TODAY CONSISTED OF THE FOLLOWING PROCEDURES:

EVALUATION & MANAGEMENT
( ) 99201 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT: _____
( ) 99202 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT: _____
( ) 99203 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT: _____

ESTABLISHED PATIENT
( ) 99211 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT: _____
( ) 99212 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT: _____
( ) 99213 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT: _____
( ) 99214 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT: _____



KEY: P=Pad Placement M=Massage Region
U=Ultrasound region A=Acupuncture Needles
SYNERGY REHABILITATION KITS
( ) 99071 Educational Supplies ( ) 99070HCPCS A9300 ( ) 99070HCPCS E0942 Cervical Harness/Holter
( ) 99070HCPCS A9500 Cervical Resistance Band ( ) Other: _____ ( ) Other: _____
JOINT DYSFUNCTION/FIXATIONS ( ) OTHER: _____
Occ, C1, C2, C3, C4, C5, C6, C7, T1, T2, T3, T4, T5, T6, T7, ( ) OTHER: _____
T8, T9, T10, T11, T12, L1, L2, L3, L4, L5, SAC, RSI, LSI ( ) OTHER: _____
EXTREMITIES: _____ ( ) OTHER: _____

MANIPULATION:
( ) 98940 1 to 2 Regions: C T L S P
( ) 98941 3 to 4 Regions: C T L S P
( ) 98942 5> Regions: C T L S P
( ) 98943 Extremities _____
( ) 97012 Mechanical Traction _____
( ) 97530 Kinetic Activities: _____
( ) 97026 Infrared Heat _____
( ) 95851 ROM Testing: _____
( ) 99558 R.O.F. _____
( ) 97039 Weatherapy _____

( ) 97032 Attended Stimulation:
( ) G0283 Electric Stimulation: M15
( ) 95831 Muscle Testing: _____
( ) 97035 Ultra Sound: _____
( ) 97112 Neuro Re-Ed: _____
( ) 97110 Ther. Exercises: M15
( ) 97535 Activ m/Daily Living: M1
( ) 97010 Hot Pack: 45W
( ) 97140 Manual Therapies: _____
( ) A4556 Electrode Pads: _____
( ) Other _____
( ) Other _____

HOME CARE SUPPLIES: ( ) 99070 Hot/Ice Packs: _____
( ) A4565 Arm Sling: _____ ( ) E0720 Tens Unit: _____
( ) L0625-LS Lumbar Support: _____ ( ) L0140-CC Cervical Collar: _____
( ) E0190-CP Cervical Pillow: _____ ( ) L1906 Ankle Support: _____

EXAMINATION/ASSESMENT: ___ Initial ___ Interim ___ with ___ without / Radiographs)

___ Referral for assessment to Include: _____
Patient to return for additional care: ___M ___T ___W ___R ___F ___S ___D

I HEREBY CERTIFY THAT ON THIS DATE I HAVE RECEIVED THE ABOVE INDICATED SERVICES AND I UNDERSTAND AND ACCEPT THE CHARGES FOR EACH SERVICE.

PATIENT SIGNATURE: _____ DATE: 5/29/15

Kissimmee Injury Clinic 111 East Monument Ave. Suite 210, Kissimmee, FL 34741 Ph: 407-846-7888 Fax: 407-846-7788

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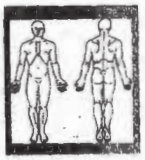
05292015

DAILY SOAP NOTE

PATIENT NAME [redacted]

DATE OF SERVICE 5-11-15



SUBJECTIVE: Patient complains of pain in these areas

Shoulder	Shoulder	L R	Hip	L R
Neck	Upper Arm	L R	Thigh	L R
Chest	Elbow	L R	Calves	L R
Upper Back	Forearm	L R	Calf	L R
Mid Back	Wrist	L R	Ankle	L R
Lower Back	Hand	L R	Foot	L R
Ribcage/Abdomen	Fingers	L R	Toes	L R
SI Joint L/R				

Other _____

Severity: Sharp Pain Scale _Headache _Cervical _Thoracic _Lumbar _Other _____Present 10= Maximum

A Brief Exam of the following SYSTEMS was performed: _Neck _Back _Upper / Lower Extremities _____

OBJECTIVE: Myospasms persist in the following muscles on the ___L ___R ___Bilaterally

Sub-Occipital Muscles:	Mild	Moderate	Severe	Palpable Nodules
Cervical Paravertebral:	Mild	Moderate	Severe	Palpable Nodules
Trapezius Muscles:	Mild	Moderate	Severe	Palpable Nodules
Thoracic Paravertebral:	Mild	Moderate	Severe	Palpable Nodules
Lumbar Paravertebral:	Mild	Moderate	Severe	Palpable Nodules
Shoulder Musculature:	Mild	Moderate	Severe	Palpable Nodules
Arm/ Forearm Muscles:	Mild	Moderate	Severe	Palpable Nodules
Hip/ Buttock Muscles:	Mild	Moderate	Severe	Palpable Nodules
Thigh/ Leg Muscles:	Mild	Moderate	Severe	Palpable Nodules

Motion is restricted in ___C Spine, ___T Spine, ___L Spine, ___Mid, ___Rt, ___Lft, ___Rt, ___Lft, ___Flexn, ___Ankle

Prognosis: ___Ad Hominem, ___Poor/G, Month unsure, ___Poor, ___Month Poorer
Patient Feels: ___Much better, ___A Little Better, ___About the Same, ___A Little Worse, ___Much Worse

DX(S): C1 C2 C3 C4 C5 C6 C7 T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12 L1 L2 L3 L4 L5 SI JOINT - L / R

ASSESSMENT DX: ___Joint Strain/Sprain/Contusion due to MVA or _____ SI JOINT / DDD/Connectivitis

STAGE OF CARE: ___Relief ___Rehabilitative/Therapeutic ___Wellness

PLAN/TREATMENT:

CHIRO: ___Daily ___x/Week ___3x/Week ___2x/Week ___1x/Week ___Bi-Monthly ___PRN

THERAPY: ___Daily ___x/Week ___3x/Week ___2x/Week ___1x/Week ___Bi-Monthly ___PRN

Additional Comments: MMJ Refused Dr.
C & L MMJ.

Dr. I. KHAN, D.C.

Re: Mr. W[redacted]o - Visit Date: Tuesday, May 19, 2015

STATEFARM
P.O BOX 106134
Atlanta, GA 30348-6134

Date of Injury/Onset: May 8, 2015

Policy No: 396588854
Claim No: CB04438A5199-4

To Whom It May Concern:

Mr. Maldonado presented himself at our office on May 19, 2015 for treatment of his complaints arising from a motor vehicle accident that he was involved in on May 8, 2015.

SUBJECTIVE COMPLAINTS:
Mr. [redacted] with current signs and symptoms were assessed today. His computed headache complaint has ceased to bother him. The patient's pain in the KNEE has gotten a bit better. On the 1 to 10 scale today, this complaint was rated as 2. It's experienced less than 25% of the time he is awake. This symptom is not presently affecting his daily activities. It usually is worse in the morning hours. He also stated his neck pain has experienced slight improvement. On the 1 to 10 scale, it was 2. It bothers him less than 25% of the time he is awake. Presently his daily activities are not affected by this symptom. The morning hours usually finds it worse.

Mr. [redacted] low back pain has slightly improved since his last visit. On the 1 to 10 Pain Scale, it was 3. It bothers him between 25% and 50% of the time he is awake. This symptom is presently having some affect on his daily activities.

ASSESSMENT/TREATMENT:
Today's Modalities & Procedures: These were the procedures that were performed and/or recommended today: manual therapies (97140) for 30 minutes, and therapeutic procedures (97110) for 15 minutes, along with moist heat therapy, hydrotherapy and interferential current. The above was for the purpose of decreasing pain, decreasing swelling and inflammation, decreasing spasms, increasing function and relieving symptoms of exacerbation.

Today's Assessment:

723.1	Cervicalgia (Pain in neck)
847.0	Neck sprain/strain (whiplash injury)
307.81	Tension headache
724.1	Pain in thoracic spine
847.1	Thoracic sprain/strain
724.2	Lumbago (Low back pain)
847.2	Lumbar sprain/strain
728.85	Spasm of muscle

FUTURE CARE PLAN:
What follows continues to be the plan for Mr. [redacted] future care:
Present Care Phase: Currently, we have the patient in a relief phase of care

Future Treatment Plan: Mr. [redacted] future care plan includes ultrasound, lower exercises, moist heat therapy, hydrotherapy, physiotherapy, spinal traction, massage therapy, lumbar traction, interferential current, chiropractic adjustment, resistive exercises and physical therapy exercises every day for three weeks.

Goals of Treatment Plan: The presenting treatment plan has the goal of decreasing pain, decreasing swelling and

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inflammation, decreasing spasms, increasing ranges of motion, increasing the ability to perform normal activities of daily living, returning the patient to his pre-accident status, increasing function, correcting somatic imbalances, reducing frequency and severity of probable exacerbations, relieving symptoms of exacerbation, improving alignment and minimizing the recurrence of his clinical status.

CLOSING COMMENTS:
DR. I. KHAN

KISSIMMEE INJURY CLINIC
PATIENT PROGRESS AND TREATMENT

NAME: [redacted] DATE: 5-11-15 M.T.W.TH.F.S CASE # _____

Examination today consisted of the following procedures:

EXAMINATION:
( ) 99201 NP 10 MIN ( ) 99202 NP 30 MIN ( ) 99203 NP 30 MIN
( ) 99204 NP 45 MIN ( ) 99205 NP 60 MIN ( ) OTHER:_____
( ) 99211 EP 5 MIN ( ) 99212 EP 10 MIN ( ) 99213 EP 15 MIN
( ) 99214 EP 25 MIN ( ) 99215 EP 60 MIN ( ) OTHER:_____
( ) 99241 FOCUSED 15 ( ) 99242 CONSULT 30 ( ) 99243 CONSULT 40 MIN

RADIOLOGY (CERVICALS)
( ) 72020 SINGLE ( ) 72010 AP/LAT ( ) 72050 4 VIEWS ( ) 72050 DAVIS 5
( ) 72052 DAVIS 7 ( ) OTHER:_____

RADIOLOGY (THORACICS)
( ) 72020 SINGLE ( ) 72070 AP/LAT ( ) 71100 RIBS UNILATERAL 2 VIEWS

RADIOLOGY (LUMBARS/PELVIS/HIP)
( ) 72020 SINGLE ( ) 72100 L-SACRO AP/LAT ( ) 72110 L-SACRO 4 VIEWS
( ) 72170 PELVIS A-P ( ) 72190 PELVIS 3 VIEWS ( ) 73510 HIP 2 VIEWS

RADIOLOGY (UPPER EXTREMITIES)
( ) 73020 SHOULDER ( ) 73030 SHOULDER 2 VIEWS ( ) OTHER:_____
( ) 73070 ELBOW AP/LAT ( ) 73070 ELBOW AP/LAT ( ) 73080 ELBOW 3 VIEWS
( ) 73100 WRIST AP/LAT ( ) 73110 WRIST 3 VIEWS ( ) OTHER:_____
( ) 73120 HAND 2 VIEWS ( ) 73130 HAND 3 VIEWS ( ) OTHER:_____

RADIOLOGY (LOWER EXTREMITIES)
( ) 73560 KNEE AP/LAT ( ) 73562 KNEE AP/LAT/OBL ( ) OTHER:_____
( ) 73600 ANKLE AP/LAT ( ) 73610 ANKLE 3 VIEWS ( ) OTHER:_____
( ) 73610 FOOT AP/LAT ( ) 73630 FOOT 3 VIEWS ( ) OTHER:_____

PLAN/RECOMMENDATIONS:
1. Treatment today consisted of the following procedures:

MANIPULATION:
( ) 98940 1 to 2 Regions: C T L S P
( ) 98941 3 to 4 Regions: C T L S P
( ) 98942 5 > Regions: C T L S P
( ) 98943 Extremities: _____
( ) 97012 Mechanical Traction: _____
( ) 97535 Activ. of Daily Living: _____
( ) 97039 Water Therapy: _____
( ) 95851 ROM TESTING: _____
( ) 99358 R.O.F. _____
( ) 97026 infrared: _____
( ) 20552: Injection: _____

( ) 97032 Attended Stimulation: _____
( ) 00283 Electric Stimulation: _____
( ) 95831 Muscle Testing: _____
( ) 97035 Ultra Sound: _____
( ) 97112 Neuro Re-Ed: _____
( ) 97110 Ther. Exercise: _____
( ) 97010 Hot Pack: _____
( ) 97530 Theratic Activities: _____
2 ( ) 97140 Manual Therapy: C T L S
( ) A4556 Electrode Pads: _____
( ) 97810 Acupuncture: _____
( ) 97813 Acupuncture w/Electrical Stimulation: _____
( ) 97811 Re-Insertion: _____

HOME CARE SUPPLIES:
( ) 97070 Hot Pack/Ice Pack/Biofreeze: _____
( ) L0625 Lumber Support: _____
( ) E0190 Cervical Pillow: _____
( ) L1906 Ankle Support: _____
( ) A4565 Arm Sling: _____
( ) L0140 Cervical Collar: _____
( ) E0720 Tens Unit: _____
( ) Other: _____

EXAMINATION/ASSESMENT: ___ Inital ___ Interim ___ with ___ without / Radiographs)
2. The following recommendations are made with regards to the ongoing Clinical Management of this patient.
___ Continue Treatment Plan, ___ Modify Treatment Plan, ___ Referral for Medical/Orthopedic Evaluation,
___ Referral for diagnostic assessment to include: _____
3. Patient to return for additional care: ___M ___T ___W ___R ___F ___S ___D

I HEREBY CERTIFY THAT ON THIS DATE I HAVE RECEIVED THE ABOVE INDICATED SERVICES AND I UNDERSTAND AND ACCEPT THE CHARGES FOR EACH SERVICE.

PATIENT SIGNATURE: [redacted] DATE: 5-11-15

DR. SIGNATURE: _____ DATE: 5-11-15

Kissimmee Injury Clinic: 111 E Monument Ave Suite 515, Kissimmee, FL 34741 Ph: (407) 344-8411

PIP
ATTENDING PHYSICIAN'S REPORT

DATE | POLICYHOLDER | DATE OF ACCIDENT | CLAIM #
5/11/15 | | 5-09

DETERMINATION OF BENEFITS DUE UNDER "NO FAULT" AUTO INSURANCE, REQUIRES THE ATTENDING PHYSICIAN TO COMPLETE THIS FORM AND RETURN IT DIRECTLY.

TO: _____ CLAIM DEPARTMENT

1. PATIENT'S NAME AND ADDRESS: [redacted] MALDONADO
2. AGE: 39 | 3. SEX: M | 4. OCCUPATION (IF KNOWN): SECURITY
5. HISTORY OF OCCURRENCE AS DESCRIBED BY PATIENT: MVA 5/9/15 R-CURBED → ER TRANS
6. DIAGNOSIS AND CONCURRENT OR CONTRIBUTING CONDITIONS: 723.1, 339.9, 847.1, 724.2, 726.5, 719.41
7. WHEN DID THE SYMPTOMS FIRST APPEAR? DATE: 5-09-15
8. WHEN DID THE PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: 5-11-15
9. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES (NO) — IF "YES" STATE AND DESCRIBE
10. IS THIS CONDITION SOLELY A RESULT OF THIS ACCIDENT? YES (NO) — IF "NO" EXPLAIN:
11. IS THIS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES (NO)
12. WILL CONDITION RESULT IN PERMANENT DISFIGUREMENT OR DISABILITY? YES (NO)
13. PATIENT WAS DISABLED (unable to work): FROM _____ THROUGH _____
14. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:
15. REPORT OF SERVICES

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	CHARGES
5-09-15	HOSPITAL	(ER)	$
5/11/15	KIC		$
			$
		TOTAL CHARGES TO DATE	$

16. IS THE PATIENT STILL UNDER CARE FOR THIS CONDITION? YES (NO) — ESTIMATE FUTURE CHARGES $

Pursuant to Florida Statute 817.234 any person who knowingly and with intent to injure, defraud or deceive any insurance company by filing a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.)

Pursuant to Florida Statute 627.736(5), I declare that the treatment or services rendered to the patient named in this report, with respect to the bodily injury sustained was reasonable and necessary, and that the charges for said treatment or services were incurred as a result of such bodily injury. Under penalty of perjury, I declare that I have read the foregoing and the facts alleged are true to the best of my knowledge and belief.

5/11/15 — JUNOTO KHANOK — 47-1144720

Date | Physician's Name (Print) | Physician's Signature | Tax/Tax Identification #

111 E. Monument Ave Suite 515 | Kissimmee | FL | 34741

Street Address | City | State | Zip Code

05262015

PATIENT'S STATUS REPORT
DIAGNOSIS AND CLINICAL MANAGEMENT

Patient _____
Claim/Policy # _____
DOA / DOC _____ / _____
Date of Exam _____

Phase of Treatment | Initial | Interim | Final

- ___ Phase One / Relief (Acute Inflammatory / Exudatory) | Initial _____
- ___ Phase Two / Correction (Regeneration) | Initial _____
- ___ Phase Three / Strengthening (Remodeling) | Initial _____
- ___ Patient Released (See Patient Resolution Status Section)

Clinical Impression / Diagnosis

Primary Diagnosis
Stage A S C | Severity M M S | Location C T L S
Other _____ | Injury Classification: Ligament Laxity / Muscle Strain
Associated with: _____
ICD9 Codes _____

Secondary Diagnosis
Stage A S C | Severity M M S | Location C T L S
Other _____ | Injury Classification: Ligament Laxity / Muscle Strain
Associated with: _____
ICD9 Codes _____

Objective Scale of Prognosis
(Reference: Foreman & Croft) (Based on patient history, examination results and radiographic findings).

- ___ Excellent (little / no objective findings of an occasional and mild nature.
- ___ Good (residual objective findings of an occasional / intermittent and mild / moderate nature).
- ___ Poor (moderate objective findings of an intermittent / recurrent and moderate nature).
- ___ Guarded (moderate / severe objective findings of a recurrent / constant and moderate nature).
- ___ Clinically Unstable (high probability of severe objective findings of a constant nature, referral indicated).
- ___ Modifiers to Prognosis: _____

Current Clinical Management
Procedure(s): ___ Chiropractic Manipulative Therapy ___ Structural Support: _____
___ Physical Therapeutics / Kinetic Activities:
___ Electric Muscle Stimulation (Interferential / Premodulated / Russian Stimulation)
___ Therapeutic Ultra Sound
___ Electromuscular Reeducation Therapy
___ Moist Heat Therapy ___ Cryotherapy
___ Home Therapeutic Exercise: Location C T L S ___ Active ___ Passive
___ Structured Progressive Resistance Rehabilitation: Location C T L S
Frequency / Duration: Daily ___ Wks 3x/week ___ Wks 2x/week ___ Wks 1x/week ___ Wks
Re-evaluation: ___ End of Schedule ___ Immediately Following Change in Patient Status
Clinical Goals / Objectives:
___ Reduction
___ Pain ___ Spasm
___ Fibrotic Scar Formation
___ Edematous Infiltration
___ Activities Of Daily Function
___ Range of Motion
___ Neuromotor Integrity

Kissimmee Injury Clinic 111 E Monument Ave Suite 515 Kissimmee, FL 34741 Ph: (407) 434-PAIN

KIC FORM PTSD&CMJK072503 PAGE 1 OF 2

05262015

Current Clinical Management (continued)
___ Consultant Second Opinion Recommended: ___ Orthopedist ___ Neurologist ___ General Practitioner
___ None recommended

Recommended Diagnostic Procedure(s)
___ Additional Testing Recommended — Area of Study
___ Magnetic Resonance Imaging _____
___ Electromyography _____
___ Digital Range of Motion _____
___ Nerve Conduction Velocity _____
___ Somato Sensory Evoked Potential _____
___ Functional Assessment Evaluation _____
___ Lab Evaluation: ___ CBC ___ Chemistry ___ Urinary Analysis _____
___ Medical Necessity Substantiated by Medical records
___ Confirm / Rule out _____
___ Comments _____
___ None recommended at this time.

Patient Resolution Status
___ Resolution of condition, no residual symptoms expected: Date _____
___ Resolution of condition, mild / moderate residual symptoms expected: Date 7/15
___ Maximal Medical Improvement (Static and Stable State) Anticipated: Date _____
___ Maximal Medical Improvement (Static and Stable State) not yet attained.
Length of continued clinical management unknown.
___ Maximal Medical Improvement (Static and Stable State) attained:
___ Patient released and placed on Supportive basis Date _____
___ Patient released and not placed on Supportive basis Date _____

Employment Status
___ Patient Working; no restrictions. ___ Patient not currently employed.
___ Patient Working; with restrictions ___ Patient not working: ___ Prior restrictions in force
See Return to Work form. See Return to Work form.

THIS CLINICAL MANAGEMENT FORM IS PROVIDED TO ASSIST ALL INTERESTED PARTIES IN THE MANAGEMENT OF THIS PATIENT. ALL RECOMMENDATIONS MADE ARE BASED UPON EVALUATIVE RESULTS. ALL RECOMMENDED DIAGNOSTIC TESTING ARE BASED UPON EVALUATIVE RESULTS AND ARE CONSIDERED MEDICALLY NECESSARY TO DIRECT THIS PHYSICIAN IN THE MANAGEMENT AND TREATMENT OF THIS PATIENT.

Doctor's Signature _____ Date 5/11/15

Kissimmee Injury Clinic 111 E Monument Ave Suite 515 Kissimmee, FL 34741 Ph: (407) 434-PAIN

05262015

KISSIMMEE INJURY CLINIC
111 E MONUMENT AVE SUITE 515
KISSIMMEE, FL 34741
TEL: 407-434-7246 FAX: 407-918-6793

First class mail and certified receipt

NOTICE OF INITIATION OF TREATMENT

Claimant/Insured: [redacted]
Patient: [redacted]
Policy No: C954438A3159-4
Claim No.: 596505954
Date of Service: 05/11/2015

Dear Sir or Madam,

This letter is to inform you that we initiated treatment on the above referenced patient on 5/11/15. Pursuant to the billing requirements under Section 627.736(5) © 2, Florida Statues. 2001. If by chance the claim number above is incorrect, please contact this office immediately with the correct claim number.

Should you have any questions, please contact the office at (407) 434-7246.

Sincerely,

KISSIMMEE INJURY CLINIC STAFF

05262015

Kissimmee Injury Clinic
111 E. Monument Ave
Kissimmee, Fl. 34744

CERTIFIED MAIL

7014 2870 0001 8228 1140

$4.00

MAY 26 2015

State Farm
Dallas, TX 75284-0001

303486134

Kissimmee Injury Clinic
111 E. Monument Ave
Kissimmee, Fl. 34744
TEL: (407)434-7246
Fax(407)910-4793

ASSIGNMENT OF BENEFITS

I hereby assign from any and all health care insurance policies, Medicare, Medicaid, and automobile insurance policies which provide medical benefits or no-fault benefits, all benefits, rights, title and interest to Kissimmee Injury Clinic ("ASSIGNEE"), for payment of services rendered unto me both by reason of accident or illness. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided.

ASSIGNMENT OF CAUSE OF ACTION

In the event my insurance company fails to pay Assignee the full amount due and owing to Assignee after notice is given, I hereby assign and transfer to Assignee any and all causes of action, and proceeds from such causes of action, that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

DIRECTION OF PAYMENT

I hereby authorize my or any insurance company or attorney to pay directly to Assignee the amount of this and/or any future bills for services rendered to me. I also agree to pay in a prompt manner any difference between the total charges and the amount paid by the insurance company directly to Assignee. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered. I hereby further give an irrevocable lien to said Assignee against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the Assignee.

PIP LOG REQUEST

I hereby authorize Assignee to release any information requested that is pertinent to my case to my insurance company or attorney involved in this case. Pursuant to §627.4137 Florida Statutes (2001), I hereby request a copy of the pip log and declaration sheet, which reflects the policy limits available at the time of this accident, to be provided to Assignee. I hereby authorize Assignee to request and receive a copy of my pip log periodically as they deem to be necessary.

RESERVATION OF BENEFITS

Please be advised that I am hereby placing you on notice that, pursuant to Florida case law, should you deny, reduce or fail to pay either a portion of or an entire bill submitted on my behalf from this healthcare provider, I am requesting that you reserve, or hold aside, that same amount until this dispute is resolved.

If any term of this Assignment or the application thereof to any person or circumstances shall be determined invalid or unenforceable the remainder of this Assignment shall not be affected thereby, and each term and provision of this Assignment shall be valid and enforced to the fullest extent of the law.

PATIENT NAME: (PRINT) [redacted] DATE 5/11/15

PATIENT NAME: (SIGNATURE) [redacted] S.S.# 596-[redacted]

05262015

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services set forth below were actually rendered. This means that these services have already been provided.
   MRI-Lumbar
2. I have the right and the duty to confirm that the services have already been provided.
3. I was not solicited by any person to seek any services from the medical provider of the services described above. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
4. The medical provider has explained the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

The undersigned licensed medical professional affirms the statement numbered 1 above and also:

A. I have not solicited or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. I have explained the services rendered to the insured person, or his or her guardian, sufficiently for that person to sign this form with informed consent.

C. The accompanying statement or bill is properly completed in all material particulars and all relevant information has been provided thereto. This means that such request for information has been responded to truthfully, accurately, and in a substantially complete manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that no service has been upcoded, unbundled, or otherwise as invalid or not medically necessary diagnostic test as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)8, Florida Statutes.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

[redacted] [redacted] 5/11/15
Name (PRINT or TYP) Signature Date

Licensed Medical Professional Rendering Treatment (Signature by his or her own hand):

JUAN RAMIREZ 5/11/15
Name (PRINT or TYP) Signature Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(11)(b), Florida Statutes.

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

OIR-B1-1527
10/03

05262015

KISSIMMEE INJURY CLINIC
111 E. MONUMENT AVE SUITE 519
KISSIMMEE FL 34741
TEL: 407-434-7246 FAX: 407-910-4793

Dear Claims Examiner,

Pursuant to Florida Personal Injury Protection Statute and Guidelines the following forms are attached for your claims file.

PATIENT NAME: [redacted]
INSURANCE PROVIDER: State Farm
CLAIM NUMBER: [redacted]
DATE OF ACCIDENT: 5/8/15

- ☐ Original PIP Disclosure and Acknowledgment Form
- ☐ Services Rendered Form with Patient Signature
- ☐ Attending Physician Report
- ☐ Kissimmee Injury Clinic Current Clinical Management/Diagnosis Form
- ☐ Initiation of Treatment Form
- ☐ Assignment of benefits

Our facility has always maintained a high standard of patient care, and insurance compliance. Our daily Kissimmee Injury Clinic Treatment Form, clearly describes the appropriate CPT codes, services rendered along with the patient signature for each and every daily visit; which suffices for our Chronological Log of Patient Treatment.

If we can be of any further assistance please contact us at the above aforementioned contacts.

Sincerely,

The Kissimmee Injury Clinic Staff

05262015

KISSIMMEE INJURY CLINIC
PATIENT PROGRESS AND TREATMENT

NAME: [redacted] DATE: 5-11-15 M,T,W,TH,F,S CASE # _____
Examination today consisted of the following procedures:

EXAMINATION:
( ) 99201 NP 10 MIN ( ) 99202 NP 20 MIN ( ) 99203 NP 30 MIN
( ) 99204 NP 45 MIN ( ) 99205 NP 60 MIN ( ) OTHER: _____
( ) 99211 EP 5 MIN ( ) 99212 EP 10 MIN ( ) 99213 EP 15 MIN
( ) 99214 EP 25 MIN ( ) 99215 EP 60 MIN ( ) OTHER: _____
( ) 99241 FOCUSED 15 ( ) 99242 CONSULT 30 ( ) 99243 CONSULT 40 MIN

RADIOLOGY (CERVICALS)
( ) 72030 SINGLE ( ) 72010 AP/LAT ( ) 72050 4 VIEWS ( ) 72050 DAVIS 5
( ) 72052 DAVIS 7 ( ) OTHER: _____ ( ) OTHER: _____

RADIOLOGY (THORACICS)
( ) 72020 SINGLE ( ) 72070 AP/LAT ( ) 71100 RIBS UNILATERAL 2 VIEWS

RADIOLOGY (LUMBARS/PELVIS/SHIP)
( ) 72020 SINGLE ( ) 72100 L-SACRO AP/LAT ( ) 72110 L-SACRO 4 VIEWS
( ) 72170 PELVIS A-P ( ) 72190 PELVIS 3 VIEWS ( ) 73510 HIP 2 VIEWS

RADIOLOGY (UPPER EXTREMITIES)
( ) 73020 SHOULDER ( ) 73030 SHOULDER 2 VIEWS ( ) OTHER: _____
( ) 73070 ELBOW AP/LAT ( ) 73070 ELBOW AP/LAT ( ) 73080 ELBOW 3 VIEWS
( ) 73100 WRIST AP/LAT ( ) 73110 WRIST 3 VIEWS ( ) OTHER: _____
( ) 73130 HAND 2 VIEWS ( ) 73130 HAND 3 VIEWS ( ) OTHER: _____

RADIOLOGY (LOWER EXTREMITIES)
( ) 73560 KNEE AP/LAT ( ) 73562 KNEE AP/LAT/OBL ( ) OTHER: _____
( ) 73600 ANKLE AP/LAT ( ) 73610 ANKLE 3 VIEWS ( ) OTHER: _____
( ) 73610 FOOT AP/LAT ( ) 73630 FOOT 3 VIEWS ( ) OTHER: _____

PLAN/RECOMMENDATIONS:
1. Treatment today consisted of the following procedures:

MANIPULATION:
( )98940 1 to 2 Regions: C T L S P
( )98941 3 to 4 Regions: C T L S P
( )98942 5> Regions: C T L S P
( )98943 Extremities: _____
( )97012 Mechanical Traction: _____
( )97535 Activ. of Daily Living: _____
( )97039 Water Therapy: _____
( )95851 ROM TESTING: _____
( )99358 R.O.F. _____
( )97026 Infrared: _____
( )20552: Injection. _____

( )97032 Attended Stimulation: _____
( )G0283 Electric Stimulation : MP
( )95831 Muscle Testing: _____
( )97035 Ultra Sound: _____
( )97112 Neuro Re-Ed. _____
( )97110 Ther. Exercises: _____
( )97010 Hot Pack: _____
( )97530 Kinetic Activities: _____
( )97140 Manual Therapy: S-T-MP
( )A4556 Electrode Pads: L-SPINE
( )97810 Acupuncture : _____
( )97813 Acupuncture w/electrical Stimulation: _____
( )97811 Re-Insertion: _____

HOME CARE SUPPLIES:
( )99070 Hot Pack/Ice Pack/Biofreeze: ___
( )L0625 Lumbar Support: _____
( )E0190 Cervical Pillow: _____
( )L1906 Ankle Support. _____

( )A4565 Arm Sling: _____
( )L0140 Cervical Collar: _____
( )E0720 Tens Unit: _____
( )Other: _____

EXAMINATION/ASSESMENT: ___ Initial ___ Interim ___ with ___ without / Radiographs)
2. The following recommendations are made with regards to the ongoing Clinical Management of this patient.
___ Continue Treatment Plan, ___ Modify Treatment Plan. ___ Referral for Medical/Orthopedic Evaluation,
___ Referral for diagnostic assessment to include: _____
3. Patient to return for additional care: ___M ___T ___W ___R ___F ___S ___D

I HEREBY CERTIFY THAT ON THIS DATE I HAVE RECEIVED THE ABOVE INDICATED SERVICES AND I UNDERSTAND AND ACCEPT THE CHARGES FOR EACH SERVICE.

PATIENT SIGNATURE: _____ DATE: 5-11-15
DR. SIGNATURE: _____ DATE: 5-11-15

OFC FORM 040 Kissimmee Injury Clinic 111 E Monument Ave Suite 518, Kissimmee, FL 34741 Ph: (407) 436-PAIN

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KISSIMMEE INJURY CLINIC
111 E. MONUMENT AVE
KISSIMMEE, FL 34741
P: (407)434-7246 F: (407)910-4793

Name: [redacted] DOB: [redacted]
27
5'9" 260

Date: 5-11-15

MVA 5/6/15 Re-evaluation

Hospital visit: ARMC in [illegible] SOUTHERN [illegible]

CC
Thigh
Neck

CC Sac
Lumbar
Spine
L-S

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Re: Mr. [redacted] - Visit Date: Monday, May 11, 2015

STATEFARM
P.O BOX 106134
Atlanta, GA 30348-6134

Date of Injury/Onset: May 6, 2015

Policy No: 59430B954
Claim No: C954438A3159-4

To Whom It May Concern:

On May 11, 2015, the above named patient presented himself for an initial examination and evaluation of his complaints arising from a motor vehicle accident that he was involved in on May 6, 2015.

DESCRIPTION OF INJURY:
Mr. Maldonado stated that he was the driver in a car which was stopped in traffic at approximately 0 m.p.h. He stated that the other vehicle struck his vehicle on the left rear side.

Mr. [redacted] also reported that, at the time of the accident, visibility was good. In addition, he stated the damage to his car was moderate. Damage to the other vehicle was mild. He also stated that he did not see the accident coming, and therefore was not braced for the impact. Also, he was wearing his seat belt but he did not have his shoulder harness on. No front or side air bags deployed at the moment of impact. His car was equipped with headrests, his own headrest being even with the bottom of his head at the time of the accident. This patient's body struck the inside of his vehicle on impact, "left knee." He stated that he did not lose consciousness during the accident. According to the patient, the police showed up at the scene. An accident report was filled out at that time

INITIAL COMPLAINTS:
Immediately following the accident, the patient's main complaints included tension, anxiety, stiffness in the neck, headaches, neck pain, dizziness and pain in the low back. Following the accident Mr. [redacted] was taken by ambulance to the hospital emergency room. X-rays were taken of his left knee and foot, which revealed normal. He was given a prescription for ibuprofen and released.

SUBJECTIVE COMPLAINTS:
An assessment of Mr. [redacted] nervous signs and symptoms was performed today. His first symptom is throbbing temporal headaches. He reported that the pain radiates into the right side of the neck. It occurs between one fourth and one half of the time when he is awake, is tolerated, but does cause some disturbance to his capacity to carry out daily activities. He further indicated the symptom is brought on by bending forward.

Mr. [redacted] second stated symptom is aching pain in the KNEE. It occurs less than one fourth of the time when he is awake, is tolerated, but do not cause any disturbance in his capacity to carry out daily activities.

He stated his third symptom is pain in the neck on the right side. He stated that this symptom radiates into the right shoulder. It occurs between one half and three fourths of the time he is awake, and is tolerated but it does cause some disturbance in his capacity to carry out daily activities. It is aggravated by standing and by sitting.

His next symptom is sharp pain in the low back on the left side. It occurs between one half and three fourths of the time when he is awake, is tolerated, but does cause some disturbance in his capacity to carry out daily activities. It is aggravated by sitting.

ACTIVITIES OF DAILY LIVING ASSESSMENT:
Based on an assessment of Mr. Maldonado's history, along with his subjective complaints, objective findings, and other test results, it is evident from a standpoint of medical certainty, that his current condition did result from the type of injury/onset described in this report. He reported suffering varying degrees of losses of functional capacity with the following activities:

With regard to *Self Care and Personal Hygiene*, Mr. [redacted] stated: showering, combing his hair, brushing his teeth, making his bed, putting on his shirt, putting on his shoes, tying his shoes and going to the toilet can be managed by himself, despite marked pain; bathing, washing his hair, drying his hair, washing his face, putting on his pants, preparing meals, eating, cleaning dishes, taking out the trash and doing the laundry can be done without much difficulty, despite some pain.

With regard to *Physical Activity*, Mr. [redacted] stated: sitting, reclining, stooping, squatting, sitting consciously, kneeling, reaching, bending forward, bending backward, bending to the left, twisting to the left, leaning forward, leaning backwards, leaning to the left and kneeling for long periods can be managed alone, despite marked pain; standing for long periods, walking, bending to the right, walking for long periods, twisting to the right and leaning to the right can be done, but not without some difficulty because of the resulting pain.

Regarding *Functional Activities*, Mr. [redacted] stated: carrying large purses, lifting weights off of the floor, lifting weights off of a table, climbing stairs and ascending his lower body can be managed by himself, despite marked pain; carrying small objects, carrying large objects, carrying a brief case, pushing things while seated, pushing things while standing, pulling things while seated, pulling things while standing, exercising his upper body and exercising his legs can be done without much difficulty, despite some pain; exercising his arms can be done without difficulty.

With regard to *Social and Recreational Activities*, he stated: participating in competitive sports can be managed alone, despite marked pain; participating in hobbies, dating and dining out can be performed without any problem.

Regarding *Travel*, Mr. [redacted] stated: driving for long periods of time and riding as a passenger for long periods can be managed by himself, despite marked pain; driving a motor vehicle and riding as a passenger in a motor vehicle can be done without difficulty.

With regard to *Communication*, Mr. [redacted] reported the following: his ability to communicate is slightly affected by his condition; his ability to hear, listen, speak, read, write and use a computer or typewriter are not affected by his condition.

With regard to *Sensory Functions*, he stated the following: his sight, hearing, sense of touch, sense of taste and sense of smell are not affected by his condition.

With regard to *Hand Functions*, Mr. [redacted] reported the following: his ability to grasp things, hold onto things, pinch things with his fingers, perform pervasive hand movements and discriminate things by touch are not affected by his condition.

GENERAL PHYSICAL EXAMINATION:
Mr. Maldonado is a right-handed 26 year-old male.

Date of Birth: July 28, 1988.

His superficial appearance did not indicate any obvious distress.

Weight: 259.00 pounds. Height: 5 feet 9 inches.

Blood Pressure (Right Side): 116/701 mm Hg. On the right side, Mr. Maldonado's blood pressure measurement indicated a mild hypertension.

Pulse Rate (resting): 89 beats per minute (normal).

OBJECTIVE EVALUATION:

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Range of Motion Studies: The following is an evaluation of the patient's present condition with regard to spinal joint motion. Cervical Spine: Flexion: 50 degrees (norm = 50), with pain. Extension: 50 degrees (norm = 60), with pain. Left lateral flexion: 40 degrees (norm = 45). Right lateral flexion: 40 degrees (norm = 45), with pain. Left rotation: 65 degrees (norm = 80). Right rotation: 70 degrees (norm = 80), with pain. Thoracic Spine: Left rotation: 30 degrees (norm = 30), with pain. Right rotation: 30 degrees (norm = 30), with pain. Lumbar Spine: Left lateral flexion: 25 degrees (norm = 25). Right lateral flexion: 25 degrees (norm = 25), with pain.

Orthopedic Tests: Straight Leg Tests: Bechterew's Test (seated straight-leg raising) was positive bilaterally. If the patient is unable to perform any of the maneuvers of this test because of low back and /or radicular pain, or if the patient is able to extend one leg normally but is only able to extend the other leg by bringing the trunk backwards in a semi-sitting position because of pain, the test is considered positive. This test causes an increase in neuralgia when the sciatic nerve is stretched by this version of the straight leg raise test.

The Jackson Compression Test was positive bilaterally. In this test, the patient, sitting upright, attempts to laterally flex the neck and head toward the affected shoulder. Then the examiner exerts downward pressure with clasped hands on top of the patient's head. The test is positive if this action exacerbates the patient's cervical and/or radicular pain indicating nerve root compression

The Maximum Cervical Compression Test was positive bilaterally. In this test, the patient, sitting upright, attempts to laterally flex the neck and head toward the affected shoulder. Then the examiner directs the patient to bring the chin as close as possible to the shoulder. The test may be repeated passively if there is no response when the patient does the action actively. The test is positive when the action causes radicular pain on the side of the flexion and rotation. A positive test reveals cervical nerve root compression in that the action narrows the diameters of the intervertebral foramina as much as anatomically possible.

The Shoulder Depression Test was positive bilaterally. This test is done with the patient supine. The examiner standing at the head of the patient, flexes the neck to the side opposite to the shoulder being tested while pushing the shoulder caudadward. Then, while maintaining the depression of the shoulder, the head is rotated, again to the side opposite to the shoulder being tested. If radicular pain is either produced or aggravated by the first action and then confirmed by the second, the test is considered positive.

Supine Tests: The Lasegue (Straight Leg Raise) Test was positive bilaterally. On this patient, pain at LOWER LUMBAR was elicited at 70 degrees, which is when the fifth lumbar nerve root is receiving maximum pull, possibly indicating an L4-5 disk herniation. This test is done with the patient supine and with the knee in extension. The examiner, actively flexes each thigh slowly while holding the other leaned on the knee to prevent its flexion. The leg is lifted 90 degrees or until pain prevents further motion. The final angle of flexion at which pain occurs, as well as the location and intensity of the pain are noted by the examiner. This test is considered positive when the straight leg cannot be raised to 90 degrees without pain.

Soto-Hall Test was positive, with the patient's pain being localized at lower cervical. This test is performed with the patient supine and the examiner exerting pressure on the sternum to prevent either lumbar or thoracic flexion. The examiner places the other hand under the patient's occiput and flexes the head and neck slowly and forcibly upon the sternum. This causes more and more of a pull on the posterior spinous ligaments, starting at the Ligamentum Nuchae, moving downward until it reaches the spinous process of the involved vertebra. There the pull acts as a lever compressing the vertebral body, thus causing localized pain

Prone Tests: Hibb's Test was positive bilaterally. This test is performed with the patient in a prone position. The examiner, while stabilizing the pelvis on the side nearest to him, flexes the opposite knee to a right angle. From this position, the examiner slowly laterally pushes the leg causing strong internal rotation of the femoral head. The test is done bilaterally. Pelvic pain reveals a positive test.

Palpation Evaluation: Paraspinal Studies: Palpation of the left suboccipital muscle group of the neck demonstrated moderate pain. In the neck, palpation of the nuchi (bases of the occiput-mastline) demonstrated moderate pain. The right suboccipital muscle group of the neck revealed moderate pain. Palpating the left paravertical muscles revealed moderate pain. The midline structures (spinous process tips and nuchal ligament from C1 through C7) of the paracervical muscles disclosed moderate pain. The right paracervical muscles demonstrated moderate pain. Palpation of the left upper thoracic group of the dorsum disclosed moderate pain. The upper thoracic midline structures of the dorsum demonstrated moderate pain. The right upper thoracic group of the dorsum revealed moderate pain. Palpation of the left mid thoracic group disclosed moderate pain. The mid thoracic midline structures demonstrated moderate pain. The right mid thoracic group revealed moderate pain. Palpation of the left thoracolumbar group disclosed moderate pain. The thoracolumbar midline structures demonstrated moderate pain. The right thoracolumbar group revealed moderate pain. Palpating the left iliolumbar group of the low back disclosed moderate pain. The iliolumbar midline structures of the low back demonstrated moderate pain. The right iliolumbar group of the low back revealed moderate pain. Trigger Point Studies: The left trapezius muscle group disclosed moderate pain. The right trapezius muscle group elicited moderate pain. The left rhomboid muscle group revealed moderate pain. The right rhomboid muscle group disclosed moderate pain. Palpating the left mid scapular muscles revealed moderate pain. The right mid scapular muscles disclosed moderate pain. The left gluteal muscle group revealed moderate pain. The right gluteal muscle group disclosed moderate pain.

ASSESSMENT/TREATMENT:

Today's Modalities & Procedures: These were the procedures that were performed and/or recommended today: NP (20 MIN), and manual therapies (97140) for 30 minutes, along with cryotherapy and interferential current. The above was for the purpose of decreasing pain, decreasing swelling and inflammation, decreasing spasms, increasing function and relieving symptoms of exacerbation.

Today's Assessment: It appears this patient will respond as expected to treatment and will experience favorable results

723.1	Cervicalgia (Pain in neck)
847.0	Neck sprain/strain (whiplash injury)
307.81	Tension headache
724.1	Pain in thoracic spine
847.1	Thoracic sprain/strain
724.2	Lumbago (Low back pain)
847.2	Lumbar sprain/strain
728.85	Spasm of muscle

FUTURE CARE PLAN:

Present Care Plans: Presently, Mr. [redacted] is in a relief phase of care.

Future Treatment Plan: Our future care recommendations include ultrasound, home exercises, moist heat therapy, hydrotherapy, physiotherapy, spinal traction, massage therapy, lumbar traction, interferential current, chiropractic adjustments, resistive exercises and physical therapy exercises every day for three weeks.

Goals of Treatment Plan: The above treatment plan has the goal of decreasing pain, decreasing swelling and inflammation, decreasing spasms, increasing range of motion, increasing the ability to perform normal activities of daily living, returning the patient to his pre-accident status, increasing function, correcting muscle imbalance, reducing frequency and severity of probable exacerbations, relieving symptoms of exacerbation, improving alignment and minimizing the recurrence of his clinical status.

CLOSING COMMENTS:

DR. J. KHAN

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Kissimmee Injury Clinic
REGISTRATION FORM

Today's Date: [redacted] DOB: [redacted]

Patient's Last Name: [redacted] First: [redacted] Middle: [redacted] Mr. Mrs. Miss Ms. Marital Status: Sgl Mar Div Sep Wid

Is this your legal name? Yes No If not, what is your legal name? (Former Name): [redacted] Birth Place: [redacted] Sex: [redacted]

Street Address: [redacted] City: [redacted] State: [redacted] ZIP Code: [redacted] Social Security: [redacted] Home/Cell Phone No: [redacted]

P.O. Box: [redacted] City: [redacted] State: [redacted] ZIP Code: 34769

Occupation: Security officer Employer: Universal protection services Employer Phone No.: (786) 397-1600

Clinic Clinic Referred/Referred to Clinic by (Please check one box): Family Friend Clinic or Home/Work Yellow Pages Other: Lawyer Dr. Insurance Plan Personal

Other Family Members Seen: none

Person Responsible for Bill: [redacted] Birth Date: [redacted] Address (if different): [redacted] Home Phone No.: [redacted]

Is this person a patient: none? Yes No

Occupation: Security officer Employer: [redacted] Employer Address: 332 W. Irlo Bronson Memorial Hwy, Kissimmee, FL Employer Phone No: (786) 397-1600

Is this patient covered by insurance? Yes No

Please indicate primary insurance: Auto Workmens Comp LOP Medicare Medicaid PPO HMO Unassigned Other

Subscriber's Name: [redacted] Subscriber's Social Security #: [redacted] Birth Date: [redacted] Group #: [redacted] Policy #: [redacted] Co-Payment: [redacted]

Patient's Relationship to Subscriber: Self Spouse Child Other

Name of Secondary Insurance (if applicable): [redacted] Subscriber's Name: [redacted] Group #: [redacted] Policy #: [redacted]

Patient's Relationship to Subscriber: Self Spouse Child Other

Name of Local Friend or Relative (not living at same address): Angela E Maldonado Relationship to Patient: mother Home Phone No.: (407) 409-7206 Work Phone No: [redacted]

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Kissimmee Injury Clinic. I understand that I am financially responsible for any balance. I also authorize Kissimmee Injury Clinic or my insurance company to release any information required to process my claims.

X [redacted] PATIENT/GUARDIAN SIGNATURE 5/14/15 DATE

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PIP VERIFICATION FORM

Pt Name: [redacted]
Insurance Company: State Farm
*Insured NAME: [redacted]
*Relationship: Self
*DOB of Insured: [redacted]
*Phone of Insured: [redacted]
*Address of Insured: [redacted] Saint Cloud, FL 34769
Claim #: 52L2055284
Policy #: C.95AA338131B4-4
Insurance PH: 8002028445 x: 8333182845
Fax #: 8002181180 Adjuster: Becky King
D.O.A.: 4/6/15

Law Firm: Pardy & Rodriguez Law
Attorney's name: Pardy
Contact person: Alex
Telephone: 407-482-4604

Is there a deductible? Y (N)

If so how much? $_____

What % is covered after deductible? _____%

Is med pay available? NO

What is the maximum pip available? $ 10,000

Address for mailing claims:
PO Box 105138 Atlanta GA 30348-5138

Who am I speaking with? Becky King Date: 5/19/15

NOTES: _____

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PATIENT NAME: _____

DIAGNOSIS SHEET

CERVICAL DIAGNOSIS		SACRUM / SACROCOCCYX DIAGNOSIS	
723.1	Cervicalgia	724.6	Disorder of Sacrum(Ankylosis/Instability)
723.3	Cervicobrachial syndrome	953.3	Injury to Sacral Nerve Root
953.0	Injury to the nerve root	839.42	Subluxation of Sacrum(Sacroiliac Joint)
722.4	Degeneration of Cervical	847.3	Sacral Sprain/Strain
723.0	Brachial Radiculitis	848.80	Sacroiliac Sprain/Strain
847.0	Cervical Sprain/Strain	729.3	Edema
839.01	1st Cervical Subluxation	736.8	Unequal Leg Length
839.02	2nd Cervical Subluxation	847.4	Coccyx Sprain/Strain
839.03	3rd Cervical Subluxation		
839.04	4th Cervical Subluxation	**HIP AND PELVIS DIAGNOSIS**	
839.05	5th Cervical Subluxation	843.8	Sprain/Strain Hip/Thigh
839.06	6th Cervical Subluxation	719.45	Pain Hip/Thigh
839.07	7th Cervical Subluxation	729.2	Neuritis/Neuralgia-Hip/Thigh
839.08	Multiple Cervical Vertebrae	733.0	Paralysis-Hip/Thigh
721.0	Cervical Spondylosis w/ or myelopathy	718.35	Osteoarthritis Hip
728.85	Ligament Laxity	719.05	Inflammation-Hip/Thigh
307.81	Headache/Tension	839.01	Dislocation of Pelvis
346.0	Headache/Migraine		
780.4	Vertigo/Dizziness		
723.0	Cervical Hyper/Retro/Hyperextension	**SHOULDER DISORDER DIAGNOSIS**	
344.6	Post Concussion Syndrome	840.8	Sprain/Strain Shoulder
959.09	Injury of face and neck	719.41	Pain Shoulder
		762.0	Paresthesia-Shoulder
THORACIC DIAGNOSIS		715.11	Osteoarthritis
721.3	Thoracic Spondylosis w/o Myelopathy	719.81	Inflammation-Shoulder
724.1	Thoracic Spondylosis w/Myelopathy	959.2	Injury-Shoulder
724.1	Pain in Thoracic Spine	726.0	Adhesive-Capsulitis/Shoulder
847.1	Thoracic Sprain/Strain	726.10	Rotator Cuff Syndrome
839.21	Thoracic Subluxation	726.11	Calcific-Tendinitis
846.42	Chondrosternal Joint Sprain/Strain	726.12	Bicipital Tenosynovitis
724.4	Thoracic/Lumbosacral Neuritis	841.8	Sprain/Strain-Elbow
737.30	Scoliosis/Idiopathic	726.30	Tendon Myositis/Bx---Elbow
736.8	Thoracic Rib Segment Dysfunction	719.4	Pain--Elbow/Forearm
724.01	Spinal Stenosis,Thoracic Region	782.0	Paresthesia--Elbow/Forearm
		723.4	Radiculitis
LUMBAR DIAGNOSIS		726.31	Medial Epicondylitis
722.10	Lumbar IVD Displacement w/o Myelopathy	726.32	Lateral Epicondylitis
721.42	Lumbar Spondylosis w/Myelopathy	716.03	Inflammation/Forearm
721.3	Lumbar Spondylosis w/o Myelopathy	959.3	Injury--Elbow/Forearm/Hand
738.4	Degeneration of Lumbar IVD		
724.3	Lumbago	**WRIST/HAND/FINGER DIAGNOSIS**	
724.5	Backache	842.0	Sprain/Strain-Wrist
724.6	Lumbo-Sacral Radiculitis	842.10	Sprain/Strain Hand
847.2	Lumbar Strain	719.44	Pain--Wrist/Hand
839.20	Lumbar Subluxation	726.2	Neuritis/Neuralgia-Wrist/Hand
738.11	Lumbar Spondylosis	723.4	Radiculitis--Wrist/Hand
846.0	Lumbosacral Sprain/Strain	782.0	Paresthesia--Wrist/Hand/Finger
724.02	Interstitial Myositis	718.84	Inflammation--Wrist/Hand
724.09	Muscle Spasm	959.3	Injury--Wrist
738.X	Lumbar Ligament Instability	959.4	Injury--Hand
720.1	Spinal Enthesopathy	959.5	Injury--Finger
953.4	Lumbosacral Plexus	354.0	Carpal Tunnel Syndrome

Kissimmee Injury Clinic
111 E. Monument Ave Suite 515
Kissimmee, FL 34741
Tel.: (407)434-7246 Fax (407)910-6763

FORM OPD-KIC0503

ASHLEY SMITH 407-758-6753 RECEIVED 05/18/2015 11:18AM 05232015

KISSIMMEE INJURY CLINIC
111 E. MONUMENT AVE SUITE 515
KISSIMMEE FL 34741
TEL: 407-434-7246 FAX: 407-910-6793

Dear Claims Examiner,

Pursuant to Florida Personal Injury Protection Statute and Guidelines the following forms are attached for your claims file.

PATIENT NAME: [redacted]

INSURANCE PROVIDER: Statefarm

CLAIM NUMBER: 586089[redacted]

DATE OF ACCIDENT: 51815

- ☐ Original PIP Disclosure and Acknowledgment Form
- ☐ Services Rendered Form with Patient Signature
- ☐ Attending Physician Report
- ☐ Kissimmee Injury Clinic Current Clinical Management/Diagnosis Form
- ☐ Initiation of Treatment Form
- ☐ Assignment of benefits

Our facility has always maintained a high standard of patient care, and insurance compliance. Our daily Kissimmee Injury Clinic Treatment Form, clearly describes the appropriate CPT codes, services rendered along with the patient signature for each and every daily visit; which outlines for our Chronological Log of Patient Treatment.

If we can be of any further assistance please contact us at the above aforementioned contacts.

Sincerely,

The Kissimmee Injury Clinic Staff

ASHLEY SMITH 407-758-6753 RECEIVED 05/18/2015 11:18AM 05232015

PIP
ATTENDING PHYSICIAN'S REPORT

DATE: 5/14 | ROLE/WHOSE: | DATE OF ACCIDENT: 5-8-15 | CLAIM #:

DETERMINATION OF BENEFITS DUE UNDER "NO FAULT" AUTO INSURANCE, REQUIRES THE ATTENDING PHYSICIAN TO COMPLETE THIS FORM AND RETURN IT DIRECTLY.

TO: _____ CLAIM DEPARTMENT

1. PATIENT'S NAME AND ADDRESS: [redacted]

DOB: [redacted] | SEX: M | 4. OCCUPATION (IF KNOWN): SECURITY

5. HISTORY OF OCCURRENCE AS DESCRIBED BY PATIENT: MVA 5/8/15. R-ended → CR / Horn

6. DIAGNOSIS AND CONCURRENT OR CONTRIBUTING CONDITIONS: 723.1, 339.0, 847.1, 724.2, 728.85, 719.41

7. WHEN DID THE SYMPTOMS FIRST APPEAR? 5-8-15 | 8. WHEN DID THE PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: 5-11-15

9. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? YES (No) | IF "YES" STATE AND DESCRIBE

10. IS CONDITION SOLELY A RESULT OF THIS ACCIDENT? YES (No) | IF "NO" EXPLAIN

11. IS THE CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES (No)

12. WILL PATIENT SUFFER PERMANENTLY IF PERMANENT DISFIGUREMENT OR DISABILITY? YES (No)

13. PATIENT WAS DISABLED (months or weeks) FROM: _____ THROUGH: _____ | 14. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK: _____

15. REPORT OF SERVICES

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	CHARGES
5-8-15	Hospital (ER)		$
5-11-15	KIC		$
			$
		TOTAL CHARGES TO DATE	$

16. IS THE PATIENT STILL UNDER CARE FOR THIS CONDITION? YES (No) | ESTIMATE FUTURE CHARGES: $

Pursuant to Florida Statute 817.234 any person who knowingly and with intent to injure, defraud or deceive any insurance company by filing a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.)

Pursuant to Florida Statute 627.736(5), I declare that the treatment or services rendered to the patient named in this report, with respect to the bodily injury sustained was reasonable and necessary, and that the charges for said treatment or services were incurred as a result of such bodily injury. Under penalty of perjury, I declare that I have read the foregoing and the facts alleged are true to the best of my knowledge and belief.

5-14 Date: _____ Physician's Name (print): Junyo Kwon Physician's Signature: _____ 87-1164729 SS# or Identification #

111 E. Monument Ave Suite 515 | Kissimmee | FL | 34741
Street Address | City | State | Zip Code

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PATIENT'S STATUS REPORT
DIAGNOSIS AND PLAN OF MANAGEMENT

Patient _____
Claim/Policy # _____
DOA / DOC _____ / _____

Date of Exam _____

Phase of Treatment	Initial	Interim	Final
Phase One / Relief (Acute Inflammatory / Reactionary)		Subjective	
Phase Two / Correction (Regenerative)		Subjective	
Phase Three / Strengthening (Remodeling)		Subjective	
Patient Released		(See Patient Resolution Status Section)	

Clinical Impressions / Diagnosis

Primary Diagnosis
Stage A S C Severity M M S Location C T L S
Other _____ Injury Classification: Ligament Laxity Sprain/Strain
Associated with: _____
ICD9 Codes _____

Secondary Diagnosis
Stage A S C Severity M M S Location C T L S
Other _____ Injury Classification: Ligament Laxity Sprain/Strain
Associated with: _____
ICD9 Codes _____

Objective Scale of Prognosis
(Reference: Foreman & Croft) (Based on patient history, examination results and radiographic findings).

- Excellent (little / no objective findings of an occasional and mild nature.
- Good (residual objective findings of an occasional / intermittent and mild / moderate nature).
- Poor (moderate objective findings of an intermittent / recurrent and moderate nature).
- Guarded (moderate / severe objective findings of a recurrent / constant and moderate nature).
- Clinically Untenable (high probability of severe objective findings of a constant nature, referral indicated)
- Modified to Prognosis: _____

Current Clinical Management

Procedure(s):
- Chiropractic Manipulative Therapy — Structural Support
- Physical Therapeutics / Kinetic Activities:
  - Electric Muscle Stimulation (Interferential / Premodulated / Russian Stimulation)
  - Therapeutic Ultra Sound
  - Cervical Traction Reduction Therapy
  - Moist Heat Therapy
  - Active Therapeutic Exercise: Location: Cervical Thoracic $ ___ Active: ___ Passive
  - Myofascial Progressive Resistance Rehabilitation: Location C T L S

Frequency / Duration: Daily 3 Wks In/week ___ Wks In/week ___ Wks In/week ___ Wks

Re-evaluation: ___ End of Schedule ___ Immediately Following Change in Patient Status

Clinical Goals / Objectives:
- Reduction: Pain 7 Spasm; Chronic Scar Formation; Edematous Infiltration
- Increase: Activities Of Daily Function; Range of Motion; Neurotonous Integrity

Kissimmee Injury Clinic 111 E Monument Ave Suite 515 Kissimmee, FL 34741 Ph: (407) 434-PAIN

KIC FORM PTSDSCMMC072503 PAGE 1 OF 2

ASHLEY SMITH 407-758-6753 RECEIVED 05/18/2015 11:18AM 05232015

Current Clinical Management (continued)

___ Consultant Second Opinion Recommended ___ Orthopedist ___ Neurologist ___ General Practitioner

___ Neuro recommended

Recommended Diagnostic Procedure(s)

___ Additional Testing Recommended Area of Study

___ Magnetic Resonance Imaging

___ Electromyography

___ Digital Range of Motion

___ Nerve Conduction Velocity

___ Somato Sensory Evoked Potential

___ Functional Assessment Evaluation

___ Lab Evaluation: ___ CBC ___ Chemistry ___ Urinary Analysis

___ Medical Necessity Substantiated by Medical records

___ Confirm / Rule out

___ Comments

___ None recommended at this time.

Patient Resolution Status

___ Resolution of condition, no residual symptoms expected: Date

___ Resolution of condition, mild / moderate residual symptoms expected: Date 9/15

___ Maximal Medical Improvement (Static and Stable State) Anticipated: Date

___ Maximal Medical Improvement (Static and Stable State) not yet attained.

Length of continued clinical management as above.

___ Maximal Medical Improvement (Static and Stable State) attained:

___ Patient released and placed on Supportive basis Date

___ Patient released and not placed on Supportive basis Date

Employment Status

___ Patient Working; no restrictions. ___ Patient not currently employed.

___ Patient Working, with restrictions ___ Patient not working. ___ Prior restrictions in force

See Reports to Work form. See Return to Work form.

THIS CLINICAL MANAGEMENT FORM IS PROVIDED TO ASSIST ALL INTERESTED PARTIES IN THE MANAGEMENT OF THIS PATIENT. ALL RECOMMENDATIONS MADE ARE BASED UPON EVALUATIVE RESULTS. ALL RECOMMENDED DIAGNOSTIC TESTING ARE BASED UPON EVALUATIVE RESULTS AND ARE CONSIDERED MEDICALLY NECESSARY TO DIRECT THIS PHYSICIAN IN THE MANAGEMENT AND TREATMENT OF THIS PATIENT.

Doctor's Signature _____ Date 5/11/15

Kissimmee Injury Clinic 111 E Monument Ave Suite 515 Kissimmee, FL 34741 Ph: (407) 434-PAIN

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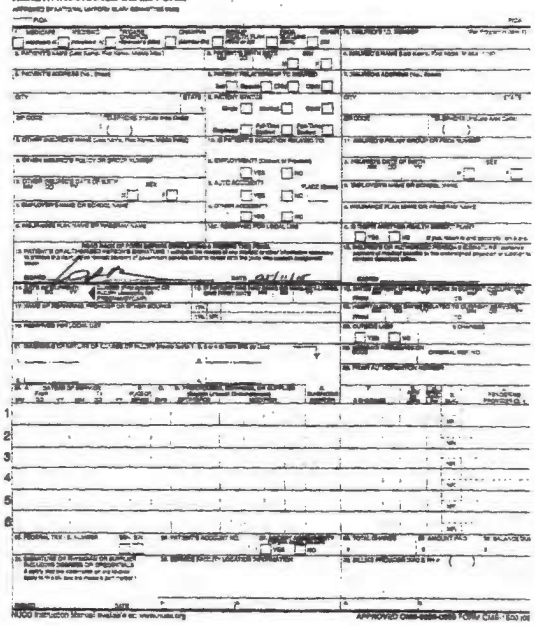
HEALTH INSURANCE CLAIM FORM



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KISSIMMEE INJURY CENTER
111 E. MONUMENT AVE SUITE 515
KISSIMMEE, FL 34741
PHONE (407) 434-7246(PAIN) FAX (407)916-4793

Authorization For Release of Protected Health Information (PHI)

Name of Patient [redacted] D.O.B 03/26/1965

I. The undersigned patient, named below, hereby executes this authorization in compliance with Federal Health Portability and Accountability Act, HIPPA. 45 CFR 164.104.

II. The undersigned patient, named below, hereby executes this information in compliance with the Federal regulations governing Confidentiality and Drug Abuse Records, 42 CFR, Part 2.

III. This authorization is directed to the following healthcare provider(s) (including its agents, employees and associates):

1.
2.
3.

IV. The above named healthcare provider is requested to release the protected health information (PHI) that is described below, to the patient's pain management doctor:

Name of Facility: Kissimmee Injury Clinic
Address: 111 E Monument Ave Suite 515 Kissimmee, FL 34741
Telephone (407) 434-7246
Facsimile (407) 916-4793
Attn: MEDICAL RECORDS DEPARTMENT

V. The protected health information of any nature whatsoever, from any source whatsoever, which is maintained by you in your records regarding the referenced patient and which is requested by KISSIMMEE INJURY CLINIC. If you are a physician or an outpatient clinic, you are authorized to send your entire chart upon request, including not only dictated handwritten notes, but also, outside medical records or correspondence maintained in my chart. If you are hospital or medical clinic, you are authorized to release my complete records including x-rays, MRI, or related studies, office notes, face sheets, history and physical, consultation notes, ante-operative records, operative reports, pathology reports, medication administration records, therapy notes, physician orders, progress notes, laboratory notes, anesthesiology records, reports of all x-rays, CT scans, MRI or PET scans, emergency room records, transfer records, anesthesia records, admitting summary, discharge summary, pharmacy and drug records, concerning my medical treatment I have received from you at your institution. I hereby authorize release of all records to include mental

PAGE 1 of 2

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Name of Patient _____ D.O.B _____

health, chemical dependency and any Federal and State protected information under Florida Statute 394.459(9) (psychiatric information), Florida Statutes 397.053 and 396.112 (drug and/or Alcohol Abuse information) and Florida Statute 381.609(2), Human Immunodeficiency Virus, Acquired Immunodeficiency Syndrome or test for sexually transmitted diseases.

The records include, but are not limited to the following items:

- **Physician progress/care notes**
- **Discharge summary**
- **Most recent history and physical**
- **Pre/Post operative reports**
- **Diagnostic reports (MRI, CT scan, X-ray to include Dr.)**
- **Laboratory services and reports**
- **Medication administration records**
- **Other:**

V. **REQUIRED DISCLOSER 45CFR 164.508(C)**

i. This protected health information is to be used for the following purpose:
LIST THE PURPOSE OF DISCLOSURE OR THE NATURE OF SERVICES PROVIDED

ii. This authorization may be revoked by a signed and properly dated written revocation, delivered to the healthcare provider named above, provided that this release cannot be revoked as to protected health information that had been previously released in reliance on this document.

iii. The undersigned acknowledges that a refusal to sign this form will not result in a denial of services by KISSIMMEE INJURY CLINIC and that this release not be accessed by this health care entity or any of its business associates.

iv. The undersigned acknowledges that once the PHI is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulations such as expert witnesses, litigants, insurance companies, and even may become public record if filed with a court of law.

v. This authorization will expire twelve (12) months after the date executed, unless it's revoked earlier in writing.

Patient Signature [redacted]

Print Name [redacted]

D.O.B. [redacted] SS#: [redacted]

Witness _____ Date ____/____/____

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Original Date: ___/___/___
Dates Revised: ___/___/___
___/___/___
___/___/___
___/___/___

Kissimmee Injury Clinic

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: (Last, First, M.I.) [redacted] ☒ M ☐ F DOB: [redacted]

Marital Status: ☐ Single ☐ Partnered ☒ Married ☐ Separated ☐ Divorced ☐ Widowed

Previous or Referring Doctor: Date of Last Physical Exam: ___

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and Doses: ☐ Tetanus ___ ☐ Pneumonia ___ ☐ Hepatitis ___ ☐ Chickenpox ___ ☐ Influenza ___ ☐ MMR ___

Measles, Mumps, Rubella

List Any Medical Problems That Other Doctors Have Diagnosed:

n/a

Surgeries:

Year	Reason	Hospital
	n/a	

Other Hospitalizations:

Year	Reason	Hospital
	n/a	

Have you ever had a blood transfusion? ☐ Yes ☒ No

Please turn to next page

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List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name the Drug	Strength	Frequency Taken
Ibuprofen	800mg	2 a day

Allergies to Medications:

Name the Drug	Reaction You Had
n/a	

HEALTH HABITS AND PERSONAL SAFETY

Exercise: ☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf) ☐ Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.) ☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet:
Are you dieting? ☐ Yes ☒ No
If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No
# of meals you eat in an average day? ___
Rank Salt Intake ☐ Hi ☐ Med ☐ Low Rank Fat Intake ☐ Hi ☐ Med ☐ Low

Caffeine: ☐ None ☒ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day? ___

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Alcohol:
Do you drink alcohol? ☐ Yes ☒ No
If yes, what kind? ___ How many drinks per week? ___
Are you concerned about the amount you drink? ☐ Yes ☒ No
Have you considered stopping? ☐ Yes ☐ No
Have you ever experienced blackouts? ☐ Yes ☐ No
Are you prone to "binge" drinking? ☐ Yes ☐ No
Do you drive after drinking? ☐ Yes ☐ No

Tobacco:
Do you use tobacco? ☐ Yes ☒ No
☐ Cigarettes - Pks/day ___ ☐ Chew - #/day ___ ☐ Pipe - #/day ___
☐ Cigars - #/day ___ ☐ # of Years ___ ☐ or Year Quit ___

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Drugs:
Do you currently use recreational or street drugs? ☐ Yes ☒ No
Have you ever given yourself street drugs with a needle? ☐ Yes ☒ No

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All questions contained in this questionnaire are optional and will be kept strictly confidential.

Sex:
Are you sexually active? ☒ Yes ☐ No
If yes, are you trying for a pregnancy? ☐ Yes ☒ No
If not trying for a pregnancy list contraceptive or barrier method used? ___ ☐ Yes ☒ No
Any discomfort with intercourse? ☐ Yes ☒ No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? ☐ Yes ☒ No

Personal Safety:
Do you live alone? ☐ Yes ☒ No
Do you have frequent falls? ☐ Yes ☒ No
Do you have vision or hearing loss? ☐ Yes ☒ No
Do you have an Advance Directive and/or Living Will? ☐ Yes ☒ No
Would you like information on the preparation of these? ☐ Yes ☒ No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ☐ Yes ☒ No

Please remember that the following recommendations are very important to maintaining your health.

When in a car, wear your safety belt at all times.

While riding a motorcycle or bicycle, wear a helmet.

Always have functional smoke detectors and fire extinguishers in your home.

If you own a firearm, make sure that it is accessible only to you. Take every precaution to ensure that children do not have access to a loaded firearm.

Keep the firearm and ammunition in separate locations.

FAMILY HEALTH HISTORY

	Age / Death	Significant Health Problems or Cause of Death		Age at Death	Significant Health Problems or Cause of Death
Father	47		Children ☐ M ☐ F	☐ M ☒ F 7	
Mother	44			☐ M ☐ F 6	
Brothers and Sisters	☒ M ☐ F 35			☐ M ☐ F	
	☒ M ☐ F 32			☐ M ☐ F	
	☐ M ☐ F		Grandparents/Brothers'-Sisters' Side		
	☐ M ☐ F		Male	60	60 Lung cancer
	☐ M ☐ F		Female	59	
	☐ M ☐ F		Grandparents (Father's Side)		
	☐ M ☐ F		Male	59	
	☐ M ☐ F		Female	62	

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MENTAL HEALTH

Is stress a major problem for you?	☐ Yes ☒ No
Do you feel depressed?	☐ Yes ☒ No
Do you panic when stressed?	☐ Yes ☒ No
Do you have problems with eating or your appetite?	☐ Yes ☒ No
Do you cry frequently?	☐ Yes ☒ No
Have you ever attempted suicide?	☐ Yes ☒ No
Have you ever seriously thought about hurting yourself?	☐ Yes ☒ No
Do you have trouble sleeping?	☐ Yes ☒ No
Have you ever been to a counselor?	☐ Yes ☒ No

WOMEN ONLY

Age at onset of menstruation: ___ Date of last menstruation: ___/___/___
Period every ___ days. Heavy periods, irregularity, spotting, pain or discharge? ☐ Yes ☐ No
Number of pregnancies ___ Number of live births ___

Are you pregnant or breastfeeding?	☐ Yes ☐ No
Have you had a D&C, hysterectomy or cesarean?	☐ Yes ☐ No
Any urinary tract, bladder or kidney infections within the last year?	☐ Yes ☐ No
Any blood in your urine?	☐ Yes ☐ No
Any problems with control of urination?	☐ Yes ☐ No
Any hot flashes or sweating at night?	☐ Yes ☐ No
Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around time of period?	☐ Yes ☐ No
Experienced any recent breast tenderness, lumps or nipple discharge?	☐ Yes ☐ No
Date of last pap and rectal exam? ___/___/___	

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes ☒ No If yes, # of times ___
Do you feel pain or burning with urination?	☐ Yes ☒ No
Any blood in your urine?	☐ Yes ☒ No
Do you feel burning discharge from penis?	☐ Yes ☒ No
Has the force of your urination decreased?	☐ Yes ☒ No
Have you had any kidney, bladder or prostate infections within the last 12 months?	☐ Yes ☒ No
Do you have any problems emptying your bladder completely?	☐ Yes ☒ No
Any difficulty with erection or ejaculation?	☐ Yes ☒ No
Any testicle pain or swelling?	☐ Yes ☒ No
Date of last prostate and rectal exam? ___/___/___	

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin ___	☒ Back ___	☐ Energy Level ___
☒ Head/Neck ___	☐ Intestinal ___	☐ Ability to Sleep ___
☐ Ears ___	☐ Bladder ___	Other Pain/Discomfort:
☐ Nose ___	☐ Bowel ___	___
☐ Throat ___	☐ Circulation ___	___
☐ Lungs ___	Recent Changes In:	___
☐ Chest/Heart ___	☐ Weight ___	___

Patient Basic Information

Personal Information:

Last Name: [redacted]	First Name: [redacted]	Mid. Init.
Address: [redacted] Apt. #	City, State, Zip: [redacted]	
Home Phone: [redacted]	Work Phone:	Social Security No.: 146-18-4220
Date of Birth: [redacted]	Date of Injury/Onset:	
Dominant Hand: ☒ Right	☐ Left ☐ Both	
Insurance Information: Policy Holder (if different than patient): Stacie Fagan		Policy No.: A31 J9 4 CAR 4436

Special Note: If your injury involved a motor vehicle, skip to page 2. Otherwise, use the spaces below to fully describe your accident, injury or onset, slip and fall, etc.

1. **Description of Accident/Injury/Onset**
Enter a full description of the accident, injury or onset in the spaces below.

2. **Your condition during and immediately after injury/onset**
Enter the details of your condition during and immediately after your injury/onset.

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Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type: ☒ Car ☐ Station Wagon ☐ Van ☐ Pickup Truck ☐ Large Truck ☐ SUV
2. Your position in vehicle: ☒ Driver ☐ Front Passenger ☐ Left Rear Passenger ☐ Right Rear Passenger
3. Whose your vehicle doing at the time of the accident? ☐ Stopped at Intersection ☐ Stopped in traffic ☐ Stopped at Light ☐ Making a left turn ☐ Making a right turn ☐ Parking ☐ Proceeding along ☐ Backing down ☐ Accelerating
4. Time/Speed/Damage: Time of accident: ____ Your vehicle speed: 0 mph Their vehicle speed: ____ mph Damage to your vehicle: ☐ Mild ☒ Moderate ☐ Totaled
5. Details of Accident: Visibility at time of accident: ☐ Poor ☐ Fair ☒ Good. Was it dark/lighted? ☒ Yes It was dark outside ☒ Other vehicle hit you Yes Mr. Judgment
6. Road conditions: Road conditions at time of accident: ☐ Icy ☐ Snowy ☐ Muddy ☐ Dark ☒ Clear and dry. Point of Impact: ☐ Head-On ☐ Rear-End ☐ Left Rear ☐ Left Front ☐ Right Front ☐ Right Rear
7. Body Position, etc.: Did you see the accident coming: Yes ☐ No ☒. Were you braced for the impact? Yes ☐ No ☒. Did you have a seat belt on? Yes ☐ No ☐. Did you have a shoulder harness on? Yes ☐ No ☐. Was your vehicle hit broadside? Yes ☐ No ☐. What was the position of your head at the time of the impact? ☐ Back with top of head ☐ Back with bottom of head ☐ Middle of back. What was the direction of your head at the time of the impact? ☐ Facing straight forward ☐ Turned to the right ☐ Turned to the left. Did other side air bags deploy? Yes ☐ No ☒. Did passenger side airbags deploy? Yes ☐ No ☐. Did side airbags deploy? Yes ☐ No ☐.
8. Additional accident information: In the case of a motor vehicle accident, enter any additional information below that is not covered by the above questions.
9. During the accident: Did your body strike the inside of your vehicle? Yes ☐ No ☐. If yes, describe: Left knee. Did you lose consciousness during the injury? Yes ☐ No ☐. If yes, for how long? ____. Your vehicle's estimated damage? ____. Damage to their vehicle: ☒ Mild ☐ Moderate ☐ Totaled. Did police arrive on at the scene? Yes ☐ No ☐. Was an accident report filed out? Yes ☐ No ☐.
10. After the accident: Check off your symptoms right after and a few days following: ☒ Headache ☒ Dizziness ☐ Mild back pain ☐ Cold hands ☒ Neck pain ☐ Nausea ☐ Low back pain ☐ Cold feet ☒ Back stiffness ☐ Confusion ☐ Nervousness ☐ Diarrhea ☐ Fainting ☐ Fatigue ☐ Loss of bowel ☐ Drowsiness ☐ Ringing in ears ☐ Tender ☐ Toe numbness ☒ Anxiety ☐ Loss of smell ☐ Irritability ☐ Constipation ☐ Chest Pain ☐ Pain behind eyes ☐ Blurriness of breath ☐ Sleeping problems. Other: ____
11. Emergency Room?: Where did you go after the accident? ☐ Home ☐ Work ☐ Hospital ER ☐ Private Doctor. Hows'd you get there? ☐ Drove self ☐ Somebody else ☐ Ambulance ☐ Police. Were X-rays taken? Yes ☐ No. Was lab work done? Yes ☐ No. Body parts X-rayed? left knee and left foot. What lab work? ____. The X-rays showed: ____. Treatments: ☐ Cervical Collar ☐ Back Brace. Medications: Ibuprofen 800 mg. Follow-up instructions: ____
12. Treatment History: Pain in any other shoulder/neck areas prior to your injury? Yes ☐ No ☐. 1. Dr. ____ First visit date: ____. Specialty: ____ X-rayed/scans? Yes ☐ No ☐. Types of treatments received: ____. How many treatments received? ____ Currently treating? Yes ☐ No ☐. Did treatments benefit you? Yes ☐ No ☐. Last visit date: ____. 2. Dr. ____ First visit date: ____. Types of treatments received: ____. How many treatments received? ____ Currently treating? Yes ☐ No ☐. Did treatments benefit you? Yes ☐ No ☐. Last visit date: ____

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05232015

Description of Symptoms

(Describe your symptoms in the sections below, in the order of severity, if possible.)

I. Most Current Symptoms: (Please check off the boxes below to describe your most recent symptoms. Describe only ONE symptom at a time.)
1. Check only one body location below: ☐ Headache ☐ Neck ☐ Upper Back ☐ Mid Back ☐ Low Back ☐ Chest ☐ Abdomen ☐ Hips ☐ Buttocks ☐ Shoulder ☐ Upper Arm ☐ Forearm ☐ Hand ☐ Thigh ☐ Knee ☐ Calf ☐ Foot. Other locations
2. Types of pain: ☐ Dull ☐ Throbbing ☐ Shooting ☐ Stabbing ☐ Sharp ☐ Burning ☐ Aching ☐ Numbing ☐ Heavy ☐ Tingling ☐ Cutting ☐ Tight ☐ Crushing ☐ Pounding ☐ Other types of pain
3. Pain Frequency: ☐ Doesn't affect ☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time ☐ 1/2 to 3/4 of awake time ☐ Most of the time
4. Pain Intensity (How it affects your daily activities): ☐ Doesn't affect ☐ Somewhat affects ☐ Seriously affects ☐ Severely affects ☐ Prevents activities
5. Does this pain radiate into other body parts? Left: ☐ Head ☐ Neck ☐ Shoulder ☐ Arm ☐ Hand ☐ Leg ☐ Foot. Right: ☐ Head ☐ Neck ☐ Shoulder ☐ Arm ☐ Hand ☐ Leg ☐ Foot. Other locations of radiation:
6. Accident affecting this pain: ☐ In the A.M. ☐ In the P.M. ☐ Bending forward ☐ Bending back ☐ Bending left ☐ Bending right ☐ Twisting left ☐ Twisting right ☐ Coughing ☐ Sneezing ☐ Standing ☐ Sitting ☐ Lifting. Other Activities:

II. Second Current Symptom: (Please check off the boxes below to describe your second most recent symptoms.)
1. Check only one body location below: ☐ Headache ☐ Neck ☐ Upper Back ☐ Mid Back ☐ Low Back ☐ Chest ☐ Abdomen ☐ Hips ☐ Buttocks ☐ Shoulder ☐ Upper Arm ☐ Forearm ☐ Hand ☐ Thigh ☐ Knee ☐ Calf ☐ Foot. Other locations
2. Types of pain: ☐ Dull ☐ Throbbing ☐ Shooting ☐ Stabbing ☐ Sharp ☐ Burning ☐ Aching ☐ Numbing ☐ Heavy ☐ Tingling ☐ Cutting ☐ Tight ☐ Crushing ☐ Pounding ☐ Other types of pain
3. Pain Frequency: ☐ Doesn't affect ☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time ☐ 1/2 to 3/4 of awake time ☐ Most of the time
4. Pain Intensity (How it affects your daily activities): ☐ Doesn't affect ☐ Somewhat affects ☐ Seriously affects ☐ Severely affects ☐ Prevents activities
5. Does this pain radiate into other body parts? Left: ☐ Head ☐ Neck ☐ Shoulder ☐ Arm ☐ Hand ☐ Leg ☐ Foot. Right: ☐ Head ☐ Neck ☐ Shoulder ☐ Arm ☐ Hand ☐ Leg ☐ Foot. Other locations of radiation:
6. Accident affecting this pain: ☐ In the A.M. ☐ In the P.M. ☐ Bending forward ☐ Bending back ☐ Bending left ☐ Bending right ☐ Twisting left ☐ Twisting right ☐ Coughing ☐ Sneezing ☐ Standing ☐ Sitting ☐ Lifting. Other Activities:

III. Third Current Symptom: (Please check off the boxes below to describe your third most recent symptoms.)
1. Check only one body location below: ☐ Headache ☐ Neck ☐ Upper Back ☐ Mid Back ☐ Low Back ☐ Chest ☐ Abdomen ☐ Hips ☐ Buttocks ☐ Shoulder ☐ Upper Arm ☐ Forearm ☐ Hand ☐ Thigh ☐ Knee ☐ Calf ☐ Foot. Other locations
2. Types of pain: ☐ Dull ☐ Throbbing ☐ Shooting ☐ Stabbing ☐ Sharp ☐ Burning ☐ Aching ☐ Numbing ☐ Heavy ☐ Tingling ☐ Cutting ☐ Tight ☐ Crushing ☐ Pounding ☐ Other types of pain
3. Pain Frequency: ☐ Doesn't affect ☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time ☐ 1/2 to 3/4 of awake time ☐ Most of the time
4. Pain Intensity (How it affects your daily activities): ☐ Doesn't affect ☐ Somewhat affects ☐ Seriously affects ☐ Severely affects ☐ Prevents activities
5. Does this pain radiate into other body parts? Left: ☐ Head ☐ Neck ☐ Shoulder ☐ Arm ☐ Hand ☐ Leg ☐ Foot. Right: ☐ Head ☐ Neck ☐ Shoulder ☐ Arm ☐ Hand ☐ Leg ☐ Foot. Other locations of radiation:
6. Accident affecting this pain: ☐ In the A.M. ☐ In the P.M. ☐ Bending forward ☐ Bending back ☐ Bending left ☐ Bending right ☐ Twisting left ☐ Twisting right ☐ Coughing ☐ Sneezing ☐ Standing ☐ Sitting ☐ Lifting. Other Activities:

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05232015

Description of Symptoms

(Describe your symptoms in the sections below, in the order of severity, if possible.)

I. Most Current Symptoms: (Please check off the boxes below to describe your most recent symptoms. Describe only ONE symptom at a time.)
1. Check only one body location below: ☐ Headache ☐ Neck ☐ Upper Back ☐ Mid Back ☐ Low Back ☐ Chest ☐ Abdomen ☐ Hips ☐ Buttocks ☐ Shoulder ☐ Upper Arm ☐ Forearm ☐ Hand ☐ Thigh ☐ Knee ☐ Calf ☐ Foot. Other locations
2. Types of pain: ☐ Dull ☐ Throbbing ☐ Shooting ☐ Stabbing ☐ Sharp ☐ Burning ☐ Aching ☐ Numbing ☐ Heavy ☐ Tingling ☐ Cutting ☐ Tight ☐ Crushing ☐ Pounding ☐ Other types of pain
3. Pain Frequency: ☐ Doesn't affect ☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time ☐ 1/2 to 3/4 of awake time ☐ Most of the time
4. Pain Intensity (How it affects your daily activities): ☐ Doesn't affect ☐ Somewhat affects ☐ Seriously affects ☐ Severely affects ☐ Prevents activities
5. Does this pain radiate into other body parts? Left: ☐ Head ☐ Neck ☐ Shoulder ☐ Arm ☐ Hand ☐ Leg ☐ Foot. Right: ☐ Head ☐ Neck ☐ Shoulder ☐ Arm ☐ Hand ☐ Leg ☐ Foot. Other locations of radiation:
6. Accident affecting this pain: ☐ In the A.M. ☐ In the P.M. ☐ Bending forward ☐ Bending back ☐ Bending left ☐ Bending right ☐ Twisting left ☐ Twisting right ☐ Coughing ☐ Sneezing ☐ Standing ☐ Sitting ☐ Lifting. Other Activities:

II. Second Current Symptom: (Please check off the boxes below to describe your second most recent symptoms.)
1. Check only one body location below: ☐ Headache ☐ Neck ☐ Upper Back ☐ Mid Back ☐ Low Back ☐ Chest ☐ Abdomen ☐ Hips ☐ Buttocks ☐ Shoulder ☐ Upper Arm ☐ Forearm ☐ Hand ☐ Thigh ☐ Knee ☐ Calf ☐ Foot. Other locations
2. Types of pain: ☐ Dull ☐ Throbbing ☐ Shooting ☐ Stabbing ☐ Sharp ☐ Burning ☐ Aching ☐ Numbing ☐ Heavy ☐ Tingling ☐ Cutting ☐ Tight ☐ Crushing ☐ Pounding ☐ Other types of pain
3. Pain Frequency: ☐ Doesn't affect ☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time ☐ 1/2 to 3/4 of awake time ☐ Most of the time
4. Pain Intensity (How it affects your daily activities): ☐ Doesn't affect ☐ Somewhat affects ☐ Seriously affects ☐ Severely affects ☐ Prevents activities
5. Does this pain radiate into other body parts? Left: ☐ Head ☐ Neck ☐ Shoulder ☐ Arm ☐ Hand ☐ Leg ☐ Foot. Right: ☐ Head ☐ Neck ☐ Shoulder ☐ Arm ☐ Hand ☐ Leg ☐ Foot. Other locations of radiation:
6. Accident affecting this pain: ☐ In the A.M. ☐ In the P.M. ☐ Bending forward ☐ Bending back ☐ Bending left ☐ Bending right ☐ Twisting left ☐ Twisting right ☐ Coughing ☐ Sneezing ☐ Standing ☐ Sitting ☐ Lifting. Other Activities:

III. Third Current Symptom: (Please check off the boxes below to describe your third most recent symptoms.)
1. Check only one body location below: ☐ Headache ☐ Neck ☐ Upper Back ☐ Mid Back ☐ Low Back ☐ Chest ☐ Abdomen ☐ Hips ☐ Buttocks ☐ Shoulder ☐ Upper Arm ☐ Forearm ☐ Hand ☐ Thigh ☐ Knee ☐ Calf ☐ Foot. Other locations
2. Types of pain: ☐ Dull ☐ Throbbing ☐ Shooting ☐ Stabbing ☐ Sharp ☐ Burning ☐ Aching ☐ Numbing ☐ Heavy ☐ Tingling ☐ Cutting ☐ Tight ☐ Crushing ☐ Pounding ☐ Other types of pain
3. Pain Frequency: ☐ Doesn't affect ☐ Up to 1/4 of awake time ☐ 1/4 to 1/2 of time ☐ 1/2 to 3/4 of awake time ☐ Most of the time
4. Pain Intensity (How it affects your daily activities): ☐ Doesn't affect ☐ Somewhat affects ☐ Seriously affects ☐ Severely affects ☐ Prevents activities
5. Does this pain radiate into other body parts? Left: ☐ Head ☐ Neck ☐ Shoulder ☐ Arm ☐ Hand ☐ Leg ☐ Foot. Right: ☐ Head ☐ Neck ☐ Shoulder ☐ Arm ☐ Hand ☐ Leg ☐ Foot. Other locations of radiation:
6. Accident affecting this pain: ☐ In the A.M. ☐ In the P.M. ☐ Bending forward ☐ Bending back ☐ Bending left ☐ Bending right ☐ Twisting left ☐ Twisting right ☐ Coughing ☐ Sneezing ☐ Standing ☐ Sitting ☐ Lifting. Other Activities:

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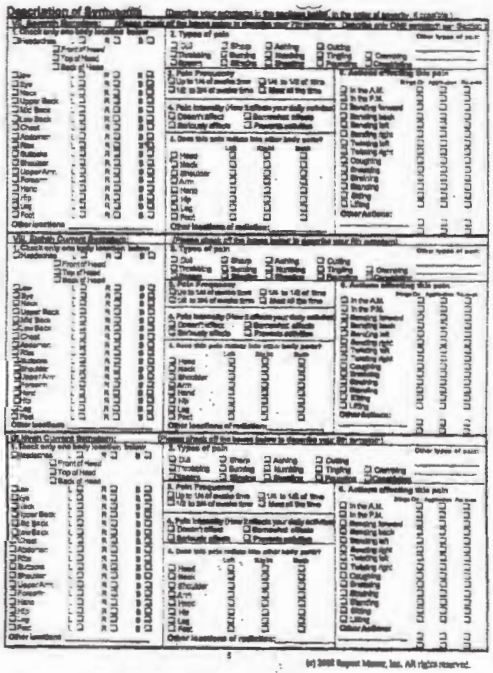

Description of Symptoms

Describe your symptoms in the sections below. In the order of severity, if possible.

VI. Symptom Description - Please check all the boxes below to describe your pain.

1. Check only one body location below

2. Types of pain

3. Pain Frequency

4. Pain Intensity (How it affects your daily activities)

5. Does this pain radiate into other body parts?

6. Activities affecting this pain

Other locations of radiation:

VII. Pain(s) Current Symptoms - Please check all the boxes below to describe your pain symptoms.

1. Check only one body location below

2. Types of pain

3. Pain Frequency

4. Pain Intensity (How it affects your daily activities)

5. Does this pain radiate into other body parts?

6. Activities affecting this pain

Other locations of radiation:

VIII. Pain(s) Current Symptoms - Please check all the boxes below to describe your pain symptoms.

1. Check only one body location below

2. Types of pain

3. Pain Frequency

4. Pain Intensity (How it affects your daily activities)

5. Does this pain radiate into other body parts?

6. Activities affecting this pain

Other locations of radiation:

5

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3

Activities of Daily Living Assessment

Rate your current difficulties, results from your limitations, with respect to the various activities listed below. Use the following 1 to 5 scale and record in the APPROPRIATE column each answer that most closely describes your current degree of difficulty: 1 = "I can do it without any difficulty, despite some pain"; 2 = "I manage to do it by myself, despite marked pain"; 4 = "I manage to do it despite the pain, but only if I have help"; 5 = "I cannot do it at all, because of the pain". NOTE: Only fill in boxes that are affected.

Difficulties with Self Care and Personal Hygiene Activities

Difficulties with Physical Activities

Difficulties with Functional Activities

Difficulties with Social and Recreational Activities

Difficulties with Traveling

Use the following 1 to 5 score to describe the difficulties below:
1 = "This area is not affected by my condition"; 2 = "This area is slightly affected by my condition"; 3 = "My condition moderately interfere my ability in this area"; 4 = " My condition seriously limits my ability in this area"; 5 = "My condition prevents me from doing this ability"

Difficulties with Different Forms of Communication

Difficulties with the Senses

Difficulties with Hand Functions

Difficulties with Sleep and Sexual Function

Write in below any additional information regarding your Activities of Daily Living that you feel is relevant:

Prior Symptom History

Prior Similar Symptoms

Injury and Illness contributed to your Current Symptoms?

My Medical History

My recent prior similar symptoms (if applicable) occurred

Write in below any other Prior Symptom History, not covered above:

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KISSIMMEE INJURY CLINIC

PATIENT PROGRESS AND DAILY TREATMENT **KISS.**

NAME: [redacted] DATE: 5-8-15 M,T,W,R,F · A.P. D.C. M.D. L.M.T

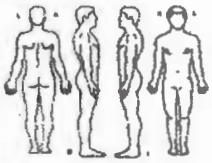
TREATMENT TODAY CONSISTED OF THE FOLLOWING PROCEDURES:

EVALUATION & MANAGEMENT

( ) 99201 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99202 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99203 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT:

ESTABLISHED PATIENT

( ) 99211 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99212 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99213 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99214 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:



KEY: P=Pad Placement M=Massage Region
U=Ultrasound region A=Acupuncture Needles

SYNERGY REHABILITATION KITS

( ) 99071 Educational Supplies ( ) 99070HCPCS A9300 ( ) 99070HCPCS E0942 Cervical Harness/Halter
( ) 99070HCPS A9300 Cervical Resistance Band ( ) Other: _____ ( ) Other: _____

JOINT DYSFUNCTION/FIXATIONS

Occ, C1, C2, C3, C4, C5, C6, C7, T1, T2, T3, T4, T5, T6, T7, T8, T9, T10, T11, T12, L1, L2, L3, L4, L5, SAC, RSI, LSI
EXTREMITIES: _____

( ) OTHER: _____
( ) OTHER: _____
( ) OTHER: _____
( ) OTHER: _____

MANIPULATION.

( ) 98940 1 to 2 Regions: C T L S P
( ) 98941 3 to 4 Regions: C T L S P
( ) 98942 5> Regions: C T L S P
( ) 98943 Extremities _____
( ) 97012 Mechanical Traction _____
( ) 97530 Kinetic Activities: _____
( ) 97026 Infrared Heat _____
( ) 95851 ROM Testing: _____
( ) 99058 R.O.F. _____
(✓) 97039 Wanderbergy 5M

( ) 97032 Attended Stimulation:
(✓) 00283 Electric Stimulation: MD
( ) 95831 Muscle Testing:
( ) 97035 Ultra Sound.
( ) 97112 Neuro Re-Ed:
(✓) 97110 Ther. Exercise: MT
( ) 97535 Activ o/Daily Living:
(✓) 97010 Hot Pack: MD
(✓) 97140 Manual Therapies: MD QD DT
( ) A4556 Electrode Pads:
( ) Other _____
( ) Other _____

HOME CARE SUPPLIES: ( ) 99070 Hot/Ice Pack: _____

( ) A4565- Arm Sling: _____ ( ) E0720 Tens Unit: _____
( ) L0625-LS Lumbar Support: _____ ( ) L0160-CC Cervical Collar: _____
( ) E0190-CP Cervical Pillow: _____ ( ) L1906 Ankle Support: _____

EXAMINATION/ASSESSMENT: ___Initial ___Interim ___with ___without / Radiographs)

___Referral for assessment to include: _____

Patient to return for additional care: ___M ___T ___W ___R ___F ___S ___D

I HEREBY CERTIFY THAT ON THIS DATE I HAVE RECEIVED THE ABOVE INDICATED SERVICES AND I UNDERSTAND AND ACCEPT THE CHARGES FOR EACH SERVICE.

PATIENT SIGNATURE: [redacted] DATE: 5-12-15

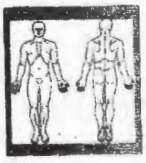
[redacted]

05252015

DAILY SOAP NOTE

PATIENT NAME: [redacted]

DATE OF SERVICE: 5-12-15



SUBJECTIVE: Patient complaint of pain in these areas

___Headache	___Shoulder	L R	___Hip	L R
___Neck	___Upper Arm	L R	___Thigh	L R
___Chest	___Elbow	L R	___Knee	L R
___Upper Back	___Forearm	L R	___Calf	L R
___Mid Back	___Wrist	L R	___Ankle	L R
___Lower Back	___Hand	L R	___Foot	L R
___Rib cage/Abdomen	___Fingers	L R	___Toes	L R
___SI Joint L/R				

___Other _____

Severity: Sharp Pain Scale ___Headache ___Cervical ___Thoracic ___Lumbar ___Other_____0=none 10= Maximum

A Brief Exam of the following SYSTEMS was performed: ___Neck ___Back ___Upper / Lower Extremities _____

OBJECTIVE: Myofascial pain(s) in the following muscles on the ___L ___R ___Bilaterally

___Sub Occipital Muscles:	___Mild	___Moderate	___Severe	___Palpable Nodules
___Cervical Paravertebral:	___Mild	___Moderate	___Severe	___Palpable Nodules
___Trapezius Muscles:	___Mild	___Moderate	___Severe	___Palpable Nodules
___Thoracic Paravertebral:	___Mild	___Moderate	___Severe	___Palpable Nodules
___Lumbar Paravertebral:	___Mild	___Moderate	___Severe	___Palpable Nodules
___Shoulder Musculature:	___Mild	___Moderate	___Severe	___Palpable Nodules
___Arm/ Forearm Muscles:	___Mild	___Moderate	___Severe	___Palpable Nodules
___Hip/ Buttock Muscles:	___Mild	___Moderate	___Severe	___Palpable Nodules
___Thigh/ Leg Muscles:	___Mild	___Moderate	___Severe	___Palpable Nodules

Motion is restricted in ___C Spine, ___T Spine, ___L Spine, ___Shld, ___Elb, ___Wr, ___Hip, ___Knee, ___Ankle

_____

Prognosis: ___As Expected, ___Slower, ___Much slower, ___Faster, ___Much Faster
Patient Feels ___Much better, ___A Little Better, ___About the Same, ___A Little Worse, ___Much Worse

ORDER: C1 C2 C3 C4 C5 C6 C7 T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12 L1 L2 L3 L4 L5 SI JOINT - L / R

ASSESSMENT/DX: ___Acute Strain/Sprain/Contusion due to MVA or _____ ICD9 # DOE/Consecutive/ish

_____

STAGE OF CARE: ___Relief ___Rehabilitative/Therapeutic ___Wellness

RECOMMENDATIONS:

ORDER: ___Daily ___x/Week, ___x/Week, ___x/Week, ___x/Week, ___Bi-Monthly ___PRN

THERAPY: ___Daily ___x/Week, ___x/Week, ___x/Week, ___x/Week, ___Bi-monthly ___PRN

Additional Comments: _____

_____

_____

_____

[redacted] D.C.

05252015

Re: Mr. [redacted] - Visit Date: Tuesday, May 12, 2015

STATEFARM
P.O BOX 106134
Atlanta, GA 30348-6134

Date of Injury/Onset: May 8, 2015

Policy No: 996382934
Claim No: C954438A3158-4

To Whom It May Concern:

Mr. [redacted] presented himself at our office on May 12, 2015 for treatment of his complaints arising from a motor vehicle accident that he was involved in on May 8, 2015.

SUBJECTIVE COMPLAINTS:
Mr. [redacted] current signs and symptoms were assessed today. The patient's temporal headache complaint has ceased to bother him. The patient's pain at the KNEE has experienced slight improvement. On the 1 to 10 scale today, this complaint was rated at 4. It's experienced between 25% and 50% of the time he is awake. This symptom is having some affect on his daily activities. The afternoon hours usually finds it worse. His neck pain has worsened somewhat. On the 1 to 10 scale, it was 4. It bothers him between 25% and 50% of the time he is awake. His daily activities are presently somewhat affected by this symptom. It usually is worse in the morning hours.

Mr. [redacted] low back pain has gotten a bit worse since his last visit with us. On the 1 to 10 Pain Scale, it was 5. It bothers him between 25% and 50% of the time he is awake. His daily activities are currently somewhat affected by this symptom.

ASSESSMENT/TREATMENT:
The following modalities performed remain virtually unchanged since Mr. Maldonado's last visit:
Today's Modalities & Procedures: These were the procedures that were performed and/or recommended today: manual therapies (97140) for 30 minutes, and therapeutic procedures (97110) for 15 minutes, along with moist heat therapy, hydrotherapy and interferential current. The above was for the purpose of decreasing pain, decreasing swelling and inflammation, decreasing spasms, increasing function and relieving symptoms of exacerbation.

FUTURE CARE PLAN:
The following plan remains virtually unchanged since Mr. [redacted] last visit:
Present Care Plan: Mr. [redacted] presently in a relief phase of care.

Patient Treatment Plan: My recommendation for future treatment consists of ultrasound, home exercises, moist heat therapy, hydrotherapy, physiotherapy, spinal traction, massage therapy, lumbar traction, interferential current, chiropractic adjustments, resistive exercises and physical therapy exercises every day for three weeks.

Goals of Treatment Plan: The preceding treatment plan has the goal of decreasing pain, decreasing swelling and inflammation, decreasing spasms, increasing range of motion, increasing the ability to perform normal activities of daily living, returning the patient to his pre-accident status, increasing function, correcting muscle imbalance, reducing frequency and severity of probable exacerbations, relieving symptoms of exacerbation, improving alignment and minimizing the recurrence of his clinical state.

CLOSING COMMENTS:
DR. I KHAN

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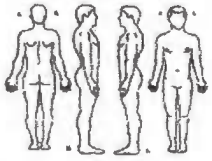
KISSIMMEE INJURY CLINIC
PATIENT PROGRESS AND DAILY TREATMENT **KISS.**

NAME: [redacted] DATE: 5-12-15 M.T.W.R.F A.P. D.C. M.D. L.M.T
TREATMENT TODAY CONSISTED OF THE FOLLOWING PROCEDURES:

EVALUATION & MANAGEMENT
( ) 99201 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99202 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99203 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
ESTABLISHED PATIENT
( ) 99211 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99212 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99213 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99214 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:



KEY: P=Pad Placement M=Manage Region
U=Ultrasound region A=Acupuncture Needles
SYNERGY REHABILITATION KITS
( ) 99071 Educational Supplies ( ) 99070HCPCS A9300 ( ) 99070HCPS E0942 Cervical Harness/Halter
( ) 99070HCPS A9500 Cervical Resistance Band ( ) Other: _____ ( ) Other: _____
JOINT DYSFUNCTION/FIXATIONS ( ) OTHER: _____
One, C1, C2, C3, C4, C5, C6, C7, T1, T2, T3, T4, T5, T6, T7, ( ) OTHER: _____
T8, T9, T10, T11, T12, L1, L2, L3, L4, L5, SAC, RSI, LSI ( ) OTHER: _____
EXTREMITIES: _____ ( ) OTHER: _____

MANIPULATION:
( ) 98940 1 to 2 Regions: C T L S P
( ) 98941 3 to 4 Regions: C T L S P
( ) 98942 5> Regions: C T L S P
( ) 98943 Extremities
( ) 97012 Mechanical Traction
( ) 97530 Kinetic Activities
( ) 97026 Infrared Heat
( ) 95851 ROM Testing:
( ) 99358 R.O.F.
( ) 97039 Waterherapy: 5'

( ) 97032 Attended Stimulation:
( ) G0283 Electric Stimulation: 4/5
( ) 95831 Muscle Testing:
( ) 97035 Ultra Sound:
( ) 97112 Neuro Re-Ed:
( ) 97110 Ther. Exercise:
( ) 97535 Activ of/Daily Living:
( ) 97010 Hot Pack:
( ) 97140 Manual Therapies: C/T 4/5
( ) A4556 Electrode Pads:
( ) Other
( ) Other

HOME CARE SUPPLIES ( ) 99070 Hot/Ice Pack:
( ) A4565- Arm Sling: ( ) E0720 Tens Unit:
( ) L0625-LS Lumbar Support: ( ) L0140-CC Cervical Collar:
( ) E0100-CP Cervical Pillow: ( ) L1906 Ankle Support:
EXAMINATION/ASSESMENT: __Initial __ Interim __ with ___ without / Radiographs)

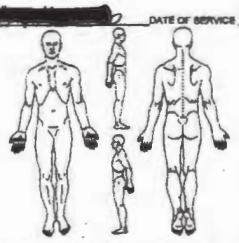
__Referral for assessment to include: _____
Patient to return for additional care: __M__T__W__R__F__S__D
I HEREBY CERTIFY THAT ON THIS DATE I HAVE RECEIVED THE ABOVE INDICATED SERVICES AND I UNDERSTAND AND ACCEPT THE CHARGES FOR EACH SERVICE.

PATIENT SIGNATURE: [redacted] DATE: 5-12-15
Kissimmee Injury Clinic, 1111 East Monument Ave. Suite 515, Kissimmee, FL 34744 Ph: 407-404-9600 Fax: 407-846-9788

05/18 3PM pg4 ANTHEM BLUE CROSS 4074706666 RECEIVED 05/14/2015 05:35PM 4074706666 SPINE INJURY 4075104793 05/14/2015 05:31PM 05252015

Rhinestone Injury Clinic

PATIENT NAME [redacted] DATE OF SERVICE 5/13/15



0 = Trigger Point + = Tenderness Δ = Pain X = Inflamed = = Adhesions * = Referred Pain ↑= Increased ROM ↓ = Decreased ROM

OBJECTIVE: Myospasms persist in the following muscles.

✓ Sub-Occipital Muscles:	Mild	Moderate	Severe	Palpable Nodules
✓ Cervical Paravertebral:	Mild	Moderate	Severe	Palpable Nodules
✓ Trapezius Muscles	Mild	Moderate	Severe	Palpable Nodules
Thoracic Paravertebral:	Mild	Moderate	Severe	Palpable Nodules
✓ Lumbar Paravertebral:	Mild	Moderate	Severe	Palpable Nodules
Shoulder Musculature	Mild	Moderate	Severe	Palpable Nodules
Arm/ Forearm Muscles:	Mild	Moderate	Severe	Palpable Nodules
Hip/ Buttock Muscles	Mild	Moderate	Severe	Palpable Nodules
Thigh/ Leg Muscles:	Mild	Moderate	Severe	Palpable Nodules

Notes:

Maria Ca[illegible], L.M.T.
MA[illegible]

05/14/2015 05:35PM 4079104793 RECEIVED 05/14/2015 05:35PM 4074786666 05232015

Re: Mr. [redacted] Visit Date: Wednesday, May 13, 2015

STATEFARM
P.O BOX 106134
Atlanta, GA 30348-6134

Date of Injury/Onset: May 8, 2015

Policy No: 39698f854
Claim No: CR54436A3139-4

To Whom It May Concern:

The patient named above came to our office on May 13, 2015 for treatment of his complaints arising from a motor vehicle accident that he was involved in on May 8, 2015.

SUBJECTIVE COMPLAINTS:
An assessment was performed on Mr. [redacted] to determine his current signs and symptoms. The patient's temporal headache complaint has ceased to bother him. The patient's pain in the ICMIE has seen slight improvement. On the 1 to 10 scale today, this complaint was rated at 3. It's experienced less than 25% of the time he is awake. The patient's daily activities are somewhat affected by this symptom. It usually is worse during the evening. His neck pain has seen some slight improvement. On the 1 to 10 scale, it was 2. It bothers him less than 25% of the time he is awake. Presently, his daily activities are only somewhat affected by this symptom. The morning hours usually finds it worse.

His low back pain has gotten a bit worse since his last visit with us. On the 1 to 10 Pain Scale, it was 4. It bothers him between 25% and 50% of the time he is awake. This symptom is presently having some affect on his daily activities.

ASSESSMENT/TREATMENT:
Today's Modalities & Procedures: The following procedures were performed and/or recommended today manual therapies (97140) for 30 minutes, along with moist heat therapy, hydrotherapy and interferential current. The above was for the purpose of decreasing pain, decreasing swelling and inflammation, decreasing spasms, increasing function and relieving symptoms of exacerbation.

FUTURE CARE PLAN:
The following plan was the virtually unchanged since Mr. [redacted] last visit:
Present Care Phase: As of today's visit, Mr. [redacted] is in a relief phase of care.

Future Treatment Plan for Mr. [redacted] home care plan includes ultrasound, home exercises, moist heat therapy, hydrotherapy, physician tips, spinal traction, massage therapy, lumbar traction, interferential current, chiropractic adjustments, medical assistant and physical therapy exercises every day for three weeks.

Goals of Treatment Plan: The preceding treatment plan has the goal of decreasing pain, decreasing swelling and inflammation, decreasing spasms, increasing range of motion, increasing the ability to perform normal activities of daily living, returning the patient to his pre-accident status, increasing function, correcting muscle imbalance, reducing frequency and severity of symptom exacerbations, relieving symptoms of exacerbation, improving alignment and rebalancing the musculature of his affected areas.

CLOSING COMMENTS:
DR. J. KHAN

05/14/2015 05:35PM 4079104793 RECEIVED 05/14/2015 05:35PM 4074786666 05232015

KISSIMMEE INJURY CLINIC

PATIENT PROGRESS AND DAILY TREATMENT **KISS.**

NAME: [redacted] DATE: 5-19-15 M,T,W,R,F A.P. D.C. M.D. L.M.T

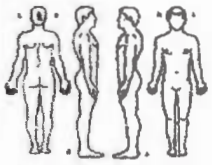
TREATMENT TODAY CONSISTED OF THE FOLLOWING PROCEDURES:

EVALUATION & MANAGEMENT

( ) 99201 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99202 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99203 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT:

ESTABLISHED PATIENT

( ) 99211 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99212 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99213 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99214 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:



KEY: P=Pad Placement M=Massage Region
U=Ultrasound region A=Acupuncture Needles

SYNERGY REHABILITATION KITS

( ) 98071 Educational Supplies ( ) 99070HCPCS A9300 ( ) 99070HCPCS E0942 Cervical Harness/Halter
( ) 99070HCPS A9300 Cervical Resistance Band ( ) Other: _____ ( ) Other: _____

JOINT DYSFUNCTION/FIXATIONS

Occ, C1, C2, C3, C4, C5, C6, C7, T1, T2, T3, T4, T5, T6, T7, T8, T9, T10, T11, T12, L1, L2, L3, L4, L5, SAC, RSI, LSI
EXTREMITIES: _____

( ) OTHER: _____
( ) OTHER: _____
( ) OTHER: _____
( ) OTHER: _____

MANIPULATION:

( ) 98940 1 to 2 Regions: C T L S P
( ) 98941 3 to 4 Regions: C T L S P
( ) 98942 5 > Region: C T L S P
( ) 98943 Extremities _____
( ) 97012 Mechanical Traction _____
( ) 97530 Kinetic Activities _____
( ) 97026 Infrared Heat _____
( ) 95851 ROM Testing: _____
( ) 95158 R.O.F. _____
( ) 97039 Warm therapy SP

( ) 99932 Attended Stimulation: _____
( ) G0283 Electric Stimulation: Unat
( ) 95831 Muscle Testing: _____
( ) 97035 Ultra Sound: _____
( ) 95812 Neuro Re-Ed: _____
( ) 97110 Ther. Exercise Unat
( ) 97535 Activ o/Daily Living: _____
( ) 97010 Hot Pack: _____
( ) 97140 Manual Therapies: Unat
( ) A4556 Electrode Pads. _____
( ) Other _____
( ) Other _____

HOME CARE SUPPLIES: ( ) 99070 Hot/Ice Pack: _____

( ) A4565- Arm Sling: _____
( ) L0625-LS Lumbar Support: _____
( ) 68190-CP Cervical Pillow: _____
( ) E0720 Tens Unit: _____
( ) L0140-CC Cervical Collar: _____
( ) L1906 Ankle Support: _____

EXAMINATION/ASSESSMENT: __ Initial __ Interim __ with __ without (Radiographs)

__ Referral for assessment to include: _____

Patient to return for additional care: __M __T __W __R __F __S __D

I HEREBY CERTIFY THAT ON THIS DATE I HAVE RECEIVED THE ABOVE INDICATED SERVICES AND I UNDERSTAND AND ACCEPT THE CHARGES FOR EACH SERVICE.

PATIENT SIGNATURE: [redacted] DATE: 5-19-15

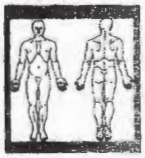
Kissimmee Injury, Clinic 111 Bill Beck Blvd, Suite 515, Kissimmee, FL 34744 Ph: 407-434-9484 Fax: 407-956-4980

05232015

DAILY SOAP NOTE

PATIENT NAME [redacted]

DATE OF SERVICE 5-19-15



SUBJECTIVE: Patient complains of pain in these areas

Headache	Shoulder	L R	Hip	L R
Neck	Upper Arm	L R	Thigh	L R
Chest	Elbow	L R	Knee	L R
Upper Back	Forearm	L R	Calf	L R
Mid Back	Wrist	L R	Ankle	L R
Lower Back	Hand	L R	Foot	L R
Shoulder/Abdomen	Fingers	L R	Toes	L R
SI Joint L/R				
Other				

Severity Berg Pain Scale: __Headache __Cervical __Thoracic __Lumbar __Other_____ Present 10= Maximum

A Brief Exam of the following SYSTEMS was performed: __Neck __Back __Upper / Lower Extremities _____

OBJECTIVE: Myospasms/ tender in the following muscles on the ___L ___R ___Bilaterally

Occ-Occipital Muscles:	Mild	Moderate	Severe	Palpable Nodules
Cervical Paravertebral:	Mild	Moderate	Severe	Palpable Nodules
Trapezius Muscles:	Mild	Moderate	Severe	Palpable Nodules
Thoracic Paravertebral:	Mild	Moderate	Severe	Palpable Nodules
Lumbar Paravertebral:	Mild	Moderate	Severe	Palpable Nodules
Shoulder Musculature:	Mild	Moderate	Severe	Palpable Nodules
Arm/ Forearm Muscles:	Mild	Moderate	Severe	Palpable Nodules
Hip/ Buttock Muscles:	Mild	Moderate	Severe	Palpable Nodules
Thigh/ Leg Muscles:	Mild	Moderate	Severe	Palpable Nodules

Motion is restricted in __C Spine, __T Spine, __L Spine, __Mild, __Mo, __Se, __Hip, __Knee, __Ankle

Progressing: Not Expected, __Slowly, __Much slower, __Faster, __Much Faster
Patient Feels: __Much better, __A Little Better, Same as Before, __A Little Worse, __Much Worse

CMT: C1 C2 C3 C4 C5 C6 C7 T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12 L1 L2 L3 L4 L5 SI JOINT - L / R

ASSESSMENT/ DX: Cervical Strain/Sprain/Contusion due to MVA or _____ @ HNP # DDD/Osteoarthritis

STAGE OF CARE: __Relief __Rehabilitative/ Therapeutic to __Wellness

PLAN/TREATMENT:

CMT: __Daily __4x/Week, __3x/Week, __2x/Week, __1x/Week, __Bi-Monthly __PRN

THERAPY: Daily __4x/Week, __3x/Week, __2x/Week, __1x/Week, __Bi-Monthly __PRN

Additional Comments: _____

M.D. Signature

05232015

Re: Mr [redacted] · Visit Date: Thursday, May 14, 2015

STATEFARM
P.O BOX 106134
Atlanta, GA 30348-6134

Date of Injury/Onset: May 8, 2015

Policy No: 996020954
Claim No: C954438A3159-4

To Whom it May Concern:

On May 14, 2015, Mr [redacted] came to our office for treatment of his complaints arising from a motor vehicle accident that he was involved in on May 8, 2015.

SUBJECTIVE COMPLAINTS:
Mr. [redacted] current signs and symptoms were assessed today. The patient's pain in the KNEE was 3 today, on the 1 to 10 Pain Scale. It's experienced less than 25% of the time he is awake. This symptom is having some affect on his daily activities. It usually is worse in the morning hours. His neck pain has gotten significantly better. On the 1 to 10 scale, it was 2. It bothers him less than 25% of the time he is awake. His daily activities are presently somewhat affected by this symptom. Bedtime usually finds it worse.

His low back pain has slightly improved since his last visit. On the 1 to 10 Pain Scale, it was 3. It affects him less than 25% of the time he is awake. His daily activities are currently somewhat affected by this symptom.

ASSESSMENT/TREATMENT:
Today's Modalities & Procedures: Following were the modalities used and/or recommended today: manual therapies (97140) for 30 minutes, and therapeutic procedures (97110) for 15 minutes, along with hydrotherapy and interferential current. The above was for the purpose of decreasing pain, decreasing swelling and inflammation, decreasing spasms, decreasing fixations and relieving symptoms of exacerbation.

FUTURE CARE PLAN:
The following plan remains virtually unchanged since Mr. [redacted] last visit:
Present Care Phase: Currently, we have the patient in a relief phase of care.

Future Treatment Plan: Our recommended future care plan for this patient consists of ultrasound, home exercises, moist heat therapy, hydrotherapy, physiotherapy, spinal traction, massage therapy, lumbar traction, interferential current, chiropractic adjustments, rehabive exercises and physical therapy exercises every day for three weeks.

Goals of Treatment Plan: The preceding treatment plan has the goal of decreasing pain, decreasing swelling and inflammation, decreasing spasms, increasing range of motion, increasing the ability to perform normal activities of daily living, returning the patient to his pre-accident status, increasing function, correcting muscle imbalance, reducing frequency and severity of probable exacerbations, relieving symptoms of exacerbation, improving alignment and rebalancing the transverse of his cranial zones.

CLOSING COMMENTS:
DR. J. KHAN

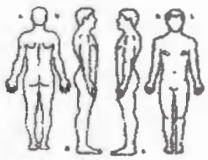
68/60 [redacted]
[redacted] 05/18/2015 04:15PM 4074786666 PAGE 02/03
05/18/2015 04:15PM 4074786666 PAGE 02/03
05232015

KISSIMMEE INJURY CLINIC
PATIENT PROGRESS AND DAILY TREATMENT KISS

NAME: [redacted] DATE: 5-14-15 M,T,W,R,F A.P. D.C. M.D. L.M.T

TREATMENT TODAY CONSISTED OF THE FOLLOWING PROCEDURES:

EVALUATION & MANAGEMENT
( ) 99201 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT.
( ) 99202 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT
( ) 99203 NP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
ESTABLISHED PATIENT
( ) 99211 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99212 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99213 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:
( ) 99214 EP Face to Face Series 1, 2, 3
Regions: C T L S EXT:



KEY: P=Pad Placement M=Massage Region
U=Ultrasound region A=Acupuncture Needles

SYNERGY REHABILITATION KITS
( ) 99071 Educational Supplies ( ) 99070HCPCS A9300 ( ) 99070HCPS E0942 Cervical Harness/Halter
( ) 99070HCPS A9300 Cervical Resistance Band ( ) Other: _____ ( ) Other: _____

JOINT DYSFUNCTION/FIXATIONS
Occ, C1, C2, C3, C4, C5, C6, C7, T1, T2, T3, T4, T5, T6, T7, T8, T9, T10, T11, T12, L1, L2, L3, L4, L5, SAC, RSI, LSI
EXTREMITIES: _____
( ) OTHER: _____
( ) OTHER: _____
( ) OTHER: _____
( ) OTHER: _____

MANIPULATION:
( ) 98940 1 to 2 Regions: C T L S P
( ) 98941 3 to 4 Regions: C T L S P
( ) 98942 5> Regions: C T L S P
( ) 98943 Extremities _____
( ) 98943 Mechanical Traction SP
( ) 97330 Kinetic Activities: _____
( ) 97026 Infrared Heat _____
( ) 95851 ROM Testing _____
( ) 99358 R.O.F _____
( ) 97039 Waterthearpy _____

( ) 97032 Attended Stimulation: _____
(X) G0283 Electric Stimulation: _____
( ) 95831 Muscle Testing: _____
(X) 97035 Ultra Sound: _____
( ) 97112 Neuro Re-Ed: _____
( ) 97110 Ther. Exercise: _____
(X) 97535 Activ o/Daily Living: _____
( ) 97530 Ther/Train. _____
(X) 97140 Manual Therapies: 30 MIN
( ) A4556 Electrode Pads: _____
( ) Other _____
( ) Other _____

HOME CARE SUPPLIES: ( ) 99070 Home Pack: _____
( ) A4565- Arm Sling _____ ( ) E0720 Tens Unit: _____
( ) L0625-LS Lumbar Support: _____ ( ) LA140-CC Cervical Collar: _____
( ) E0190-CP Cervical Pillow: _____ ( ) L-1900 Ankle Support: _____

EXAMINATION/ASSESMENT: ___ Initial ___ Reexam ___ with ___ without / Radiographs)

___ Referral for assessment to include: _____
Patient to return for additional care: _M_T_W_R_F_S_D_____

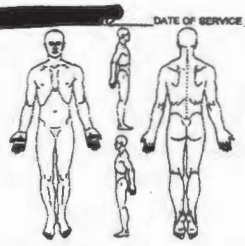
I HEREBY CERTIFY THAT ON THIS DATE I HAVE RECEIVED THE ABOVE INDICATED SERVICES AND I UNDERSTAND AND ACCEPT THE CHARGES FOR EACH SERVICE.

PATIENT SIGNATURE: [redacted] DATE: 5-14-15
[redacted]

[redacted] 05/18/2015 04:15PM 4074786666 PAGE 03/03
05/18/2015 04:15PM 4074786666 PAGE 03/03
05232015

Kleinmeyer Injury Clinic

PATIENT NAME: [redacted] DATE OF SERVICE 5/18/15



0 = Trigger Point • = Tenderness Δ = Pain X = Inflamed = = Adhesions * = Referred Pain ↑= Increased ROM ↓ = Decreased ROM

OBJECTIVE: Myospasms persist in the following muscles.

✓ Sub-Occipital Muscles:	___Mild	✓ Moderate	___ Severe	___ Palpable Nodules
✓ Cervical Paravertebral:	___Mild	✓ Moderate	___ Severe	___ Palpable Nodules
✓ Trapezius Muscles:	___Mild	✓ Moderate	___ Severe	___ Palpable Nodules
✓ Thoracic Paravertebral:	___Mild	✓ Moderate	___ Severe	___ Palpable Nodules
✓ Lumbar Paravertebral:	___Mild	✓ Moderate	___ Severe	___ Palpable Nodules
___ Shoulder Musculature:	___Mild	___ Moderate	___ Severe	___ Palpable Nodules
___ Arm/ Forearm Muscles:	___Mild	___ Moderate	___ Severe	___ Palpable Nodules
___ Hip/ Buttock Muscles:	___Mild	___ Moderate	___ Severe	___ Palpable Nodules
✓ Thigh/ Leg Muscles:	___Mild	✓ Moderate	___ Severe	___ Palpable Nodules

Notes:

[redacted], L.M.T.
MA5889

05252015

Re: Mr [redacted] · Visit Dates Monday, May 18, 2015

STATEFARM
P.O BOX 106134
Atlanta, GA 30348-6134

Date of Injury/Cause: May 8, 2015

Policy No: 394580954
Claim No: C954438A3139-4

To Whom It May Concern:

The patient named above came to our office on May 18, 2015 for treatment of his complaints arising from a motor vehicle accident that he was involved in on May 8, 2015.

SUBJECTIVE COMPLAINTS:

Mr. [redacted] current signs and symptoms were assessed today. The patient's presented headache complaints has ceased to bother him. The patient's pain in the ICHSB has seen slight improvement. On the 1 to 10 scale today, the complaint was rated at 2. It's experienced less than 25% of the time he is awake. Presently, this symptom is not affecting his daily activities. It usually is worse in the morning hours. Mr. [redacted] back pain has experienced slight improvement. It bothers him less than 25% of the time he is awake. Presently His daily activities are not affected by this symptom. The morning hours usually finds it worse.

The patient's low back pain has seen some slight improvement since his last visit. On the 1 to 10 Pain Scale, it was 3. It bothers him between 25% and 50% of the time he is awake. This symptom is presently having some affect on his daily activities.

ASSESSMENT/TREATMENT:

Today's Modalities & Procedures: These were the procedures that were performed and/or recommended today: manual therapies (97140) for 30 minutes, and therapeutic procedures (97110) for 15 minutes, along with ultrasound, interspinous traction and isorhythmic current. The above was for the purpose of decreasing pain, decreasing swelling and inflammation, decreasing spasms, increasing function and relieving symptoms of exacerbation.

Today's Assessment:

723.1	Cervicalgia (Pain in neck)
847.0	Neck sprain/strain (whiplash injury)
307.81	Tension headache
724.1	Pain in thoracic spine
847.1	Thoracic sprain/strain
724.2	Lumbago (Low back pain)
847.2	Lumbar sprain/strain
728.85	Spasm of muscle

FUTURE CARE PLAN:

The following continues to be the plan for Mr. [redacted] future treatment:
Present Care Phase: As of today's visit, Mr. [redacted] is in a relief phase of care.

Future Treatment Plan: My recommendation for future treatment consists of ultrasound, home exercises, moist heat therapy, hydrotherapy, physiotherapy, spinal traction, massage therapy, lumbar traction, interferential current, chiropractic adjustments, resistive exercises and physical therapy exercises every day for three weeks.

Goals of Treatment Plan: The above treatment plan has the goal of decreasing pain, decreasing swelling and

05252015

inflammation, decreasing spasm, increasing range of motion, increasing the ability to perform normal activities of daily living, returning the patient to his pre-accident status, increasing function, correcting muscle imbalance, reducing frequency and severity of probable exacerbations, relieving symptoms of exacerbation, improving alignment and maintaining the maximum of his clinical status.

CLOSING COMMENTS:
DR. J. KHAN

05252015

Kissimmee Injury Clinic
111 E Monument Ave Suite 515
Kissimmee, FL 34741A
Tel.: (407)434-7246 Fax (407)910-6793

INFORMED CONSENT TO CARE AND TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and other chiropractic procedures, including various methods of physical therapy and if necessary, diagnostic x-rays, and medical diagnostics and procedures by the staff of this office.

I understand and informed that as in all health care, in the practice of chiropractic there are some very slight risks to treatments. I expect the doctor to exercise judgment during the course of the procedure. The determination of such judgment is to be based upon the current available criteria.

I have read the above, and by signing below, I agree to the above named procedures. I intent this consent form to cover the entire course of treatment for my present condition for which I seek treatment.

[redacted] 5/15/15
PATIENT SIGNATURE DATE

[redacted]
PATIENT PRINTED NAME DATE

PARENT OR GUARDIAN (FOR MINOR) DATE

05252015

Kissimmee Injury Clinic
111 E. Monument Ave
Kissimmee, FL 34744
TEL: (407)434-7246
Fax:(407)910-4783

ASSIGNMENT OF BENEFITS

I hereby assign from any and all health care insurance policies, Medicare, Medicaid, and automobile insurance policies which provide medical benefits or no-fault benefits, all benefits, rights, title and interest to Kissimmee Injury Clinic ("ASSIGNEE"), for payment of services rendered unto me both by reason of accident or illness. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided.

ASSIGNMENT OF CAUSE OF ACTION

In the event my insurance company fails to pay Assignee the full amount due and owing to Assignee after notice is given, I hereby assign and transfer to Assignee my and all causes of action, and proceeds from such causes of action, that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

DIRECTION OF PAYMENT

I hereby authorize my or any insurance company or attorney to pay directly to Assignee the amount of this and/or any future bills for services rendered to me. I also agree to pay in a prompt manner any difference between the total charges and the amount paid by the insurance company directly to Assignee. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered. I hereby further give an irrevocable lien to said Assignee against any and all insurance benefits earned herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the Assignee.

PIP LOG REQUEST

I hereby authorize Assignee to release any information requested that is pertinent to my case to my insurance company or attorney involved in this case. Pursuant to §627.4137 Florida Statutes (2001), I hereby request a copy of the pip log and declaration sheet, which reflects the policy limits available at the time of this accident, to be provided to Assignee. I hereby authorize Assignee to request and receive a copy of my pip log periodically as they deem to be necessary.

RESERVATION OF BENEFITS

Please be advised that I am hereby placing you on notice that, pursuant to Florida case law, should you deny, reduce or fail to pay either a portion of or an entire bill submitted on my behalf from this healthcare provider, I am requesting that you reserve, or hold aside, that same amount until this dispute is resolved.

If any term of this Assignment or the application thereof to any person or circumstances shall be determined invalid or unenforceable the remainder of this Assignment shall not be affected thereby, and each term and provision of this Assignment shall be valid and enforced to the fullest extent of the law.

PATIENT NAME: (PRINT) [redacted] DATE 5/11/15

PATIENT NAME: (SIGNATURE) [redacted] D.O.B 3/26/1970

05252015

KISSIMMEE INJURY CLINIC
111 E MONUMENT AVE SUITE 515
KISSIMMEE, FL 34741
TEL: 407-434-7246 FAX: 407-910-4783

First class mail and certified receipt

NOTICE OF INITIATION OF TREATMENT

Claimant/Insured: [redacted]
Patient: [redacted]
Policy No: C95443RA3159-4
Claim No : 596505954
Date of Service: 05/11/2015

Dear Sir or Madam,

This letter is to inform you that we initiated treatment on the above referenced patient on 5/11/15. Pursuant to the billing requirements under Section 627.736(5) © 2, Florida Statues. 2001. If by chance the claim number above is incorrect, please contact this office immediately with the correct claim number.

Should you have any questions, please contact the office at (407) 434-7246.

Sincerely,

KISSIMMEE INJURY CLINIC STAFF

05252015

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services set forth below were already rendered. This means that these services have already been provided.
   97802 APCWC 80283 Ebtm 97110,12 Manual therapy
   A4556 2 PADS
2. I have the right and 14 days in addition, that the services have already been provided.
3. I was not solicited by any person to seek any services from the medical provider of the services described above. This means that no person has initiated contact with me and/or persuaded me to see the doctor or licensed professional, clinic, or medical institution that provided the services.
4. The medical provider has explained the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

The undersigned insured medical professional affirms the statement numbered 1 above and also:

A. I have not solicited or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. I have explained the services rendered to the insured person, or his or her guardian, sufficiently for that person to sign this form with informed consent.

C. The accompanying statement or bill is properly completed in all material provisions and all relevant information has been provided thereto. This means that each request for information has been responded to or overlooked, accurately, and in a substantially complete manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that no service has been upcoded, unbundled, or considered an invalid or not medically necessary diagnosis test as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)3, Florida Statutes.

Insured Person (patient receiving treatment or Child/ren of Insured Person

[redacted] [redacted] 5/11/17
Name (PRINT or TYPE) Signature Date

Licensed Medical Professional Rendering Treatment (Signature by he or her own hand):

JUAN RUBIO 5/11/17
Name (PRINT or TYPE) Signature Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(11)(b), Florida Statutes.

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

OIR-B1-197:
1960

05232015
RECEIVED 05/10/2015 11:10AM 4074766666
SPINE INJURY
4074766666 05/10/2015 11:10AM PAGE 03/13

STATE FARM INSURANCE
PO BOX 106134
ATLANTA GA 30348-6134

11/20/2017

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER — 1a. INSURED'S I.D. NUMBER: 596505954
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) — [redacted]
3. PATIENT'S BIRTH DATE / SEX — [redacted] M
4. INSURED'S NAME (Last Name, First Name, Middle Initial) — [redacted]
5. PATIENT'S ADDRESS (No., Street) — [redacted]
6. PATIENT RELATIONSHIP TO INSURED — Self
7. INSURED'S ADDRESS (No., Street) — [redacted]
CITY [redacted] STATE FL
8. RESERVED FOR NUCC USE
ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]
CITY [redacted] STATE FL
ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER — C954438A31594
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) NO
a. INSURED'S DATE OF BIRTH / SEX — [redacted] M
b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? YES PLACE (State) FL
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? NO
c. INSURANCE PLAN NAME OR PROGRAM NAME — STATE FARM
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? NO

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 06 17 15
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) — 05 08 15 QUAL. 431
15. OTHER DATE QUAL.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION — MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES — MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0
A. S47.0 B. S47.1 C. S47.2 D. T19.45
E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06 09 15	06 09 15	11		98941		A	85 00	1		NPI / ORD	CH10638
2 06 09 15	06 09 15	11		99358		A	195 00	1		NPI / ORD	CH10638
3 06 09 15	06 09 15	11		97039		A	17 00	1		NPI / ORD	CH10638
4 06 09 15	06 09 15	11		G0283		A	50 00	1		NPI / ORD	CH10638
5 06 09 15	06 09 15	11		97110		A	75 00	1		NPI / ORD	CH10638
6 06 09 15	06 09 15	11		97010		A	20 00	1		NPI / ORD	CH10638

25. FEDERAL TAX I.D. NUMBER SSN EIN — 11144790
26. PATIENT'S ACCOUNT NO. — 11131
27. ACCEPT ASSIGNMENT? YES NO
28. TOTAL CHARGE $ 442 00
29. AMOUNT PAID $ 0 00
30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNATURE ON FILE 06 17 15

32. SERVICE FACILITY LOCATION INFORMATION
KISSIMMEE INJURY CLINIC LLC
111 E MONUMENT AVE STE 515
KISSIMMEE FL 34741
(3053725747

33. BILLING PROVIDER INFO & PH # ( )
KISSIMMEE INJURY CLINIC
280 S STATE ROAD 434 1040A
ALTAMONTE SPRINGS FL 32714
(3053725747

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION
CARRIER

11/20/2017

Patient Visits

Report Criteria: Patient is 'MALDONADO-FIGUEROA, WILLIAM (Inactive)' and Patient Group is 'KISSIMMEE INJURY CLINIC'

Date	Procedure/Mod	Units	Charges	Ins Pmts	Pat Pmts	Adjs	Ins Bal	Pat Bal	Visits
KISSIMMEE INJURY CLINIC									
KISSIMMEE INJURY CLINIC LLC									
[redacted], WIL		62	3,514.00	2,348.24	498.88	667.08	2,128.82	-2,128.82	10
05/11/15	A4556	1	12.00	0.00	0.00	12.00	0.00	0.00	
05/11/15	97140 59	2	130.00	0.00	0.00	11.72	118.28	0.00	
05/11/15	G0283	1	50.00	0.00	0.00	22.46	27.54	0.00	
05/11/15	99202	1	155.00	235.54	59.86	6.40	0.00	-145.82	
05/12/15	97110	1	75.00	0.00	0.00	10.74	64.26	0.00	
05/12/15	97010	1	20.00	0.00	0.00	10.00	10.00	0.00	
05/12/15	G0283	1	50.00	0.00	0.00	22.46	27.54	0.00	
05/12/15	97039	1	17.00	188.06	47.02	2.00	0.00	-220.08	
05/12/15	97140 59	2	130.00	0.00	0.00	11.72	118.28	0.00	
05/13/15	97140 59	2	130.00	0.00	0.00	11.72	118.28	0.00	
05/13/15	97010	1	20.00	0.00	0.00	10.00	10.00	0.00	
05/13/15	97110	1	75.00	0.00	0.00	10.74	64.26	0.00	
05/13/15	G0283	1	50.00	0.00	0.00	22.46	27.54	0.00	
05/13/15	97039	1	17.00	188.06	47.02	2.00	0.00	-220.08	
05/14/15	97140 59	2	130.00	0.00	0.00	11.72	118.28	0.00	
05/14/15	97110	1	75.00	0.00	0.00	10.74	64.26	0.00	
05/14/15	G0283	1	50.00	0.00	0.00	22.46	27.54	0.00	
05/14/15	97039	1	17.00	0.00	0.00	2.00	15.00	0.00	
05/14/15	99941	1	85.00	245.25	61.31	3.52	0.00	-225.08	
05/16/15	97035	1	28.00	0.00	0.00	2.44	25.56	0.00	
05/16/15	97012	1	45.00	214.59	53.65	13.14	0.00	-236.38	
05/16/15	G0283	1	50.00	0.00	0.00	22.46	27.54	0.00	
05/16/15	97140 59	2	130.00	0.00	0.00	11.72	118.28	0.00	
05/16/15	97535	1	85.00	0.00	0.00	0.00	85.00	0.00	
05/19/15	99941	1	85.00	253.25	63.31	3.52	0.00	-235.08	
05/19/15	97140 59	2	130.00	0.00	0.00	11.72	118.28	0.00	
05/19/15	97010	1	20.00	0.00	0.00	10.00	10.00	0.00	
05/19/15	97110	1	75.00	0.00	0.00	10.74	64.26	0.00	
05/19/15	G0283	1	50.00	0.00	0.00	22.46	27.54	0.00	
05/19/15	97039	1	17.00	0.00	0.00	2.00	15.00	0.00	
05/27/15	97140 59	1	65.00	0.00	0.00	5.86	59.14	0.00	
05/27/15	97010	1	20.00	0.00	0.00	10.00	10.00	0.00	
05/27/15	97110	2	150.00	0.00	0.00	21.48	128.52	0.00	
05/27/15	G0283	1	50.00	0.00	0.00	22.46	27.54	0.00	
05/27/15	97039	1	17.00	0.00	0.00	2.00	15.00	0.00	
05/27/15	97012	1	45.00	70.71	0.00	13.14	0.00	-38.85	
05/27/15	99941	1	85.00	282.83	0.00	3.52	0.00	-201.35	
05/28/15	G0283	1	50.00	0.00	0.00	22.46	27.54	0.00	
05/28/15	97140 59	2	130.00	0.00	0.00	11.72	118.28	0.00	
05/28/15	97110	1	75.00	0.00	0.00	10.74	64.26	0.00	
05/28/15	97012	1	45.00	201.55	50.39	13.14	0.00	-220.08	
05/28/15	97010	1	20.00	0.00	0.00	10.00	10.00	0.00	
06/08/15	97140 59	1	65.00	0.00	0.00	5.86	59.14	0.00	
06/08/15	97110	1	75.00	0.00	0.00	10.74	64.26	0.00	
06/08/15	G0283	1	50.00	0.00	0.00	22.46	27.54	0.00	
06/08/15	97039	1	17.00	132.75	33.19	2.00	0.00	-150.94	

11/20/2017

Date	Procedure/Mod	Units	Charges	Ins Pmts	Pat Pmts	Adjs	Ins Bal	Pat Bal	Visits
06/08/15	97010	1	20.00	0.00	0.00	10.00	10.00	0.00	
06/08/15	97110	1	75.00	0.00	0.00	10.74	64.26	0.00	
06/08/15	G0283	1	50.00	0.00	0.00	22.46	27.54	0.00	
06/08/15	97039	1	17.00	0.00	0.00	2.00	15.00	0.00	
06/09/15	99358	1	195.00	0.00	0.00	92.00	0.00	103.00	
06/08/15	99941	1	85.00	335.65	83.91	3.52	0.00	-338.08	
06/09/15	97140 59	2	130.00	0.00	0.00	11.72	118.28	0.00	
KISSIMMEE INJURY CLINIC LLC:		62	3,514.00	2,348.24	498.88	667.08	2,128.82	-2,128.82	10
KISSIMMEE INJURY CLINIC:		62	3,514.00	2,348.24	498.88	667.08	2,128.82	-2,128.82	10
Grand Total:		62	3,514.00	2,348.24	498.88	667.08	2,128.82	-2,128.82	10

[redacted]

Kissimmee Injury Clinic
111 E. Monument Ave
Kissimmee, Fl. 34744
TEL: (407)934-7246
Fax(407)918-4793

11/20/2017

ASSIGNMENT OF BENEFITS

I hereby assign from any and all health care insurance policies, Medicare, Medicaid, and automobile insurance policies which provide medical benefits or no-fault benefits, all benefits, rights, title and interest to Kissimmee Injury Clinic ("ASSIGNEE"), for payment of services rendered unto me both by reason of accident or illness. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided.

ASSIGNMENT OF CAUSE OF ACTION

In the event my insurance company fails to pay Assignee the full amount due and owing to Assignee after notice is given, I hereby assign and transfer to Assignee any and all causes of action, and proceeds from such causes of action, that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

DIRECTION OF PAYMENT

I hereby authorize my or any insurance company or attorney to pay directly to Assignee the amount of this and/or any future bills for services rendered to me. I also agree to pay in a current manner any difference between the total charges and the amount paid by the insurance company directly to Assignee. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered. I hereby further give an irrevocable lien to said Assignee against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the Assignee.

PIP LOG REQUEST

I hereby authorize Assignee to release any information requested that is pertinent to my case to my insurance company or attorney involved in this case. Pursuant to §627.4137 Florida Statute (2001), I hereby request a copy of the pip log and declaration sheet, which reflects the policy limits available at the time of this accident, to be provided to Assignee. I hereby authorize Assignee to request and receive a copy of my pip log periodically as they deem to be necessary.

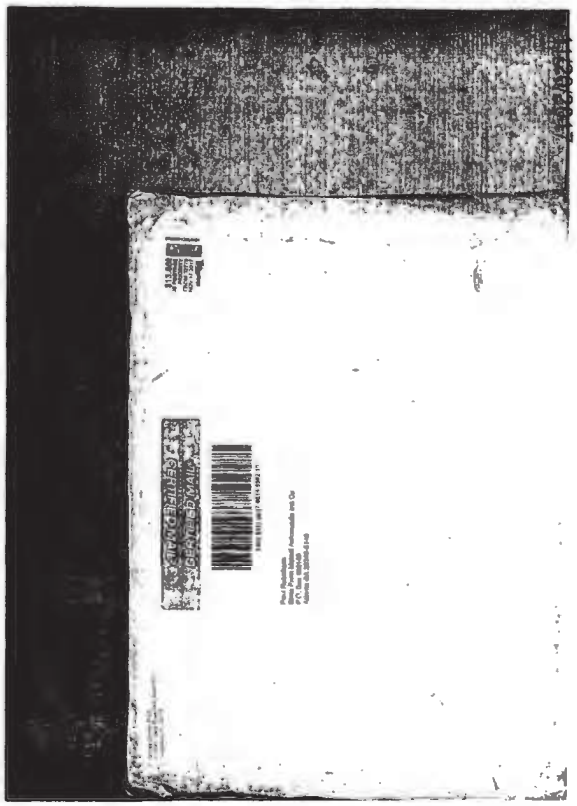
RESERVATION OF BENEFITS

Please be advised that I am hereby placing you on notice that, pursuant to Florida state law, should you deny, reduce or fail to pay either a portion of or an entire bill submitted on my behalf from this healthcare provider, I am requesting that you reserve, or hold aside, that same amount until this dispute is resolved.

If any term of this Assignment or the application thereof to any person or circumstances shall be determined invalid or unenforceable the remainder of this Assignment shall not be affected thereby, and each term and provision of this Assignment shall be valid and enforced to the fullest extent of the law.

PATIENT NAME: (PRINT) [redacted] DATE 11/11/17

PATIENT NAME: (SIGNATURE) [redacted] DOB 07-12-1980



Patient Ledger

[redacted]

Home [redacted]6

KISSIMMEE INJURY CLINIC
280 S STATE ROAD 434 104BA
ALTAMONTE SPRINGS, FL 32714
Tax ID: 471144780

Date	Code	Description	Provider	Amount
05/11/15	99202	OFFICE VISIT NEW PATIENT LEVAL 2	J.OJOHAN CH10838	185.00
05/11/15	G0283	ELECTRIC STIMULATION	J.OJOHAN CH10838	50.00
05/11/15	97140	MANUAL THERAPY/MYOFASCIAL RELEASE	J.OJOHAN CH10838	130.00
05/11/15	A4556	ELECTRODE PADS	J.OJOHAN CH10838	12.00
05/12/15	97039	WATERBED THERAPY	J.OJOHAN CH10838	17.00
05/12/15	G0283	ELECTRIC STIMULATION	J.OJOHAN CH10838	50.00
05/12/15	97110	THERAPEUTIC EXCERCISE 15 MIN	J.OJOHAN CH10838	75.00
05/12/15	97010	HOT PACK/COLD PACK	J.OJOHAN CH10838	20.00
05/12/15	97140	MANUAL THERAPY/MYOFASCIAL RELEASE	J.OJOHAN CH10838	130.00
05/13/15	97039	WATERBED THERAPY	J.OJOHAN CH10838	17.00
05/13/15	G0283	ELECTRIC STIMULATION	J.OJOHAN CH10838	50.00
05/13/15	97110	THERAPEUTIC EXCERCISE 15 MIN	J.OJOHAN CH10838	75.00
05/13/15	97010	HOT PACK/COLD PACK	J.OJOHAN CH10838	30.00
05/13/15	97140	MANUAL THERAPY/MYOFASCIAL RELEASE	J.OJOHAN CH10838	130.00
05/14/15	98941	ADJUSTMENT SPINAL3-4 REGIONS	J.OJOHAN CH10838	85.00
05/14/15	97039	WATERBED THERAPY	J.OJOHAN CH10838	17.00
05/14/15	G0283	ELECTRIC STIMULATION	J.OJOHAN CH10838	50.00
05/14/15	97110	THERAPEUTIC EXCERCISE 15 MIN	J.OJOHAN CH10838	75.00
05/14/15	97140	MANUAL THERAPY/MYOFASCIAL RELEASE	J.OJOHAN CH10838	130.00
05/18/15	97012	MECHANICAL TRACTION THERAPY	J.OJOHAN CH10838	45.00
05/18/15	G0283	ELECTRIC STIMULATION	J.OJOHAN CH10838	50.00
05/18/15	97035	ULTRASOUND	J.OJOHAN CH10838	28.00
05/18/15	97535	ACTIVITIES OF DAILY LIVING	J.OJOHAN CH10838	85.00
05/18/15	97140	MANUAL THERAPY/MYOFASCIAL RELEASE	J.OJOHAN CH10838	130.00
05/19/15	98941	ADJUSTMENT SPINAL3-4 REGIONS	J.OJOHAN CH10838	85.00
05/19/15	97039	WATERBED THERAPY	J.OJOHAN CH10838	17.00
05/19/15	G0283	ELECTRIC STIMULATION	J.OJOHAN CH10838	50.00
05/19/15	97110	THERAPEUTIC EXCERCISE 15 MIN	J.OJOHAN CH10838	75.00
05/19/15	97010	HOT PACK/COLD PACK	J.OJOHAN CH10838	30.00
05/19/15	97140	MANUAL THERAPY/MYOFASCIAL RELEASE	J.OJOHAN CH10838	130.00
05/27/15	98941	ADJUSTMENT SPINAL3-4 REGIONS	J.OJOHAN CH10838	85.00
05/27/15	97012	MECHANICAL TRACTION THERAPY	J.OJOHAN CH10838	45.00
05/27/15	97039	WATERBED THERAPY	J.OJOHAN CH10838	17.00
05/27/15	G0283	ELECTRIC STIMULATION	J.OJOHAN CH10838	50.00
05/27/15	97110	THERAPEUTIC EXCERCISE 15 MIN	J.OJOHAN CH10838	150.00
05/27/15	97010	HOT PACK/COLD PACK	J.OJOHAN CH10838	70.00
05/27/15	97140	MANUAL THERAPY/MYOFASCIAL RELEASE	J.OJOHAN CH10838	65.00
05/28/15	97012	MECHANICAL TRACTION THERAPY	J.OJOHAN CH10838	45.00
05/28/15	G0283	ELECTRIC STIMULATION	J.OJOHAN CH10838	50.00
05/28/15	97110	THERAPEUTIC EXCERCISE 15 MIN	J.OJOHAN CH10838	75.00
05/28/15	97010	HOT PACK/COLD PACK	J.OJOHAN CH10838	20.00

04/01/2019

05/28/15	97140	MANUAL THERAPY/MYOFASCIAL RELEASE	J.OJOHAN CH10838	130.00
06/08/15	97039	WATERBED THERAPY	J.OJOHAN CH10838	17.00
06/08/15	G0283	ELECTRIC STIMULATION	J.OJOHAN CH10838	50.00
06/08/15	97110	THERAPEUTIC EXCERCISE 15 MIN	J.OJOHAN CH10838	75.00
06/08/15	97140	MANUAL THERAPY/MYOFASCIAL RELEASE	J.OJOHAN CH10838	65.00
06/08/15	98941	ADJUSTMENT SPINAL3-4 REGIONS	J.OJOHAN CH10838	85.00
06/08/15	99205	REVIEW OF FINDINGS	J.OJOHAN CH10838	185.00
06/08/15	97039	WATERBED THERAPY	J.OJOHAN CH10838	17.00
06/08/15	G0283	ELECTRIC STIMULATION	J.OJOHAN CH10838	50.00
06/08/15	97110	THERAPEUTIC EXCERCISE 15 MIN	J.OJOHAN CH10838	75.00
06/08/15	97010	HOT PACK/COLD PACK	J.OJOHAN CH10838	20.00
06/08/15	97140	MANUAL THERAPY/MYOFASCIAL RELEASE	J.OJOHAN CH10838	130.00
				3,914.00

04/01/2019

04/01/2019

Kissimmee Injury Clinic
111 E. Monument Ave
Kissimmee, Fl. 34744
TEL: (407)434-7246
Fax(407)918-4793

ASSIGNMENT OF BENEFITS

I hereby assign from any and all health care insurance policies, Medicare, Medicaid, and automobile insurance policies which provide medical benefits or no-fault benefits, all benefits, rights, title and interest to Kissimmee Injury Clinic ("ASSIGNEE"), for payment of services rendered unto me both by reason of accident or illness. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided.

ASSIGNMENT OF CAUSE OF ACTION

In the event my insurance company fails to pay Assignee the full amount due and owing to Assignee after notice is given, I hereby assign and transfer to Assignee any and all causes of action, and proceeds from such causes of action, that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or Assignee's name and further I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

DIRECTION OF PAYMENT

I hereby authorize my or any insurance company or attorney to pay directly to Assignee the amount of this and/or any future bills for services rendered to me. I also agree to pay in a correct manner any difference between the total charges and the amount paid by the insurance company directly to Assignee. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered. I hereby further give an irrevocable lien to said Assignee against any and all insurance benefits owned herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by the Assignee.

PIP LOG REQUEST

I hereby authorize Assignee to release any information requested that is pertinent to any case to any insurance company or attorney involved in this case. Pursuant to §627.4137 Florida Statutes (2001), I hereby request a copy of the pip log and declaration sheet, which reflects the policy limits available at the time of this accident, to be provided to Assignee. I hereby authorize Assignee to request and receive a copy of my pip log periodically as they deem to be necessary.

RESERVATION OF BENEFITS

Please be advised that I am hereby placing you on notice that, pursuant to Florida case law, should you deny, reduce or fail to pay either a portion of or an entire bill submitted on my behalf from this healthcare provider, I am requesting that you reserve, or hold aside, that same amount until this dispute is resolved.

If any term of this Assignment or the application thereof to any person or circumstances shall be determined invalid or unenforceable the remainder of this Assignment shall not be affected thereby, and each term and provision of this Assignment shall be valid and enforced to the fullest extent of the law.

PATIENT NAME: (PRINT) [redacted] DATE: 2/11/15

PATIENT NAME: (SIGNATURE) [redacted] SS# 596-12-6220

State Farm

EXPLANATION OF REVIEW

This is not a bill

Claim Number: 59-8506-864 Date of Loss: 05-07-2015 Office Name: State Farm Mutual Automobile Insurance Company PIPMPC A1 Office - WIN

Patient: [redacted]

Provider: Kissimmee Injury Clinic
260 S STATE ROAD 434 STE 104BA
ALTAMONTE SPG, FL 32714-3859

Claim Handler: Bailey King
Address: PO Box 106134
Atlanta, GA 30348-6134
Phone: (844) 292-8816 Ext: 6633162845

Named Insured: [redacted]
Policy Number: C954-436-59

Date Received: 08-22-2015
Jurisdiction: Florida
Bill Reference Number: 11131

TIN: 471144780
Payment Number: 119436522J

Zip of Service: 34741

Diagnosis Codes: 719.45 - Pain in joint, pelvic region and thigh
847.0 - Neck sprain and strain
847.1 - Thoracic sprain and strain
847.2 - Lumbar sprain and strain

Ln	Date of Service	POS	CPT/ HCPCS	MODIFS	Units	Submitted Amount	Approved Amount	Reason Codes
1	05-05-2015 - 05-05-2015	11	97039		1.00	$17.00	$15.00	C720
2	05-05-2015 - 05-05-2015	11	G0283		1.00	$60.00	$27.54	305
3	05-05-2015 - 05-05-2015	11	97110		1.00	$75.00	$64.26	305
4	05-05-2015 - 05-05-2015	11	97140	59	1.00	$65.00	$58.14	305,179
5	05-05-2015 - 05-05-2015	11	98941		1.00	$95.00	$81.48	305
6	05-05-2015 - 05-05-2015	11	99358		1.00	$195.00	$103.00	433,4
7	05-05-2015 - 05-05-2015	11	97039		1.00	$17.00	$15.00	C720
8	05-05-2015 - 05-05-2015	11	G0283		1.00	$60.00	$27.54	305
9	05-05-2015 - 05-05-2015	11	97110		1.00	$75.00	$64.26	305
10	05-05-2015 - 05-05-2015	11	97010		1.00	$20.00	$10.00	433
11	05-05-2015 - 05-05-2015	11	97140	59	2.00	$130.00	$116.28	305,179

Total Submitted Charges:	$779.00
Total Approved Amount:	$586.90
Amount Not Payable:	$117.10
Deductible:	$0.00
CoPay:	$0.00
Apportionment / Pre Rata:	$0.00
Offset:	$0.00
Paid Amount:	$469.40

DATE: 05-26-2015 59-8506-864 Professional

Explanations
6 - The procedure (code) and/or supplies billed does not correlate to the listed traumatic diagnosis on the submitted bill. Please review this bill for possible errors or omissions of ICD diagnosis code(s) or inappropriate usage of the CPT/HCPCS code. Please submit additional documentation substantiating necessity and relating the service to the motor vehicle accident.
179 - The provider is using modifier -59 to indicate under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 will identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician.
305 - Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon 200% of the Participating Level of Medicare Part B fee schedule for the locale in which the services were rendered.
433 - Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon the payment methodology established pursuant to the Workers' Compensation Fee Schedule (s.440.13).
C720 - FL Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as F.S. 627.736(5)(a)1, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon the payment methodology established pursuant to the Worker's Compensation Fee Schedule (s.440.13).

Procedure Guide
97010 - Application of a modality to 1 or more areas; hot or cold packs
97039 - Unlisted modality (specify type and time if constant attendance)
97110 - Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97140 - Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
98941 - Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
99358 - Prolonged evaluation and management service before and/or after direct (face-to-face) patient care, first hour
G0283 - Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

Pursuant to Florida Statute, should you have any information to substantiate payment of an additional amount for the services rendered, please forward for our consideration within 15 days.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree. F.S. 817.234(1)(b).

Information on administering benefits under the 9810A policy form: Due to ongoing litigation in Myers v. McCarty, (Case No. 2013-CA-0073) (Fla. 2d Judl Cir.), the Emergency Medical Condition provisions of the No-Fault statute are not being applied. Please contact us if you have any questions.

DATE: 05-26-2015 59-8506-864 Professional

State Farm

EXPLANATION OF REVIEW

This is not a bill

Claim Number: 59-6506-854 Date of Loss: 05-07-2015 Office Name: State Farm Mutual Automobile Insurance Company PIPMPC A1 Office - WIN

Patient: [redacted] A

Provider: Kissimmee Injury Clinic
260 S STATE ROAD 434 STE 1049A
ALTAMONTE SPG, FL 32714-3859

Claim Handler: Becky King
Address: PO Box 106134
Atlanta, GA 30348-6134
Phone: (844) 292-8815 Ext: 8633182645

Named Insured: [redacted]
Policy Number: C954-436-59

Date Received: 06-08-2015
Jurisdiction: Florida
SIU Reference Number: 11131

TIN: 471144780
Payment Number: 119390518J
Zip of Service: 34741

Diagnosis Codes: 719.45 - Pain in joint, pelvic region and thigh
847.1 - Thoracic sprain and strain
847.2 - Lumbar sprain and strain
847.3 - Sprain and strain of sacrum

Ln	Date of Service	POS	CPT/ HCPCS	MODIFIER	Units	Submitted Amount	Approved Amount	Reason Codes
1	05-26-2015 - 05-26-2015	11	97012		1.00	$45.00	$31.86	305
2	05-26-2015 - 05-26-2015	11	G0283		1.00	$50.00	$27.54	305
3	05-26-2015 - 05-26-2015	11	97110		1.00	$75.00	$64.26	305
4	05-26-2015 - 05-26-2015	11	97010		1.00	$20.00	$10.00	433
5	05-26-2015 - 05-26-2015	11	97140	59	2.00	$130.00	$116.26	305,179

Total Submitted Charges:	$320.00
Total Approved Amount:	$251.94
Amount Not Payable:	$68.39
Deductible:	$0.00
CoPay:	$0.00
Apportionment / Pro Rata:	$0.00
Offset:	$0.00
Paid Amount:	$201.55

DATE: 08-15-2015 59-6506-854 Professional

Explanations
179 - The provider is using modifier -59 to indicate under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 will identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician.
305 - Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon 200% of the Participating Level of Medicare Part B fee schedule for the locale in which the services were rendered.
433 - Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon the payment methodology established pursuant to the Workers' Compensation Fee Schedule (s.440.13).

Procedure Guide
97010 - Application of a modality to 1 or more areas; hot or cold packs
97012 - Application of a modality to 1 or more areas; traction, mechanical
97110 - Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97140 - Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
G0283 - Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

Pursuant to Florida Statute, should you have any information to substantiate payment of an additional amount for the services rendered, please forward for our consideration within 15 days.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree. F.S. 817.234(1)(b).

Information on administering benefits under the 9810A policy form: Due to ongoing litigation in Myers v. McCarty, (Case No. 2013-CA-0073) (Fla. 2d Judl Cir.), the Emergency Medical Condition provisions of the No-Fault statute are not being applied. Please contact us if you have any questions.

DATE: 08-15-2015 59-6506-854 Professional

State Farm

EXPLANATION OF REVIEW

This is not a bill

Claim Number: 59-6506-854 Date of Loss: 05-07-2015 Office Name: State Farm Mutual Automobile Insurance Company PIPMPC A1 Office - WIN

Patient: [redacted]

Provider: Kissimmee Injury Clinic
260 S STATE ROAD 434 STE 1049A
ALTAMONTE SPG, FL 32714-3859

Claim Handler: Becky King
Address: PO Box 106134
Atlanta, GA 30348-6134
Phone: (844) 292-8815 Ext: 8633182645

Named Insured: [redacted]
Policy Number: C954-436-59

Date Received: 06-08-2015
Jurisdiction: Florida
SIU Reference Number: 11131

TIN: 471144780
Payment Number: 119384455J
Zip of Service: 34741

Diagnosis Codes: 719.45 - Pain in joint, pelvic region and thigh
847.0 - Neck sprain and strain
847.1 - Thoracic sprain and strain
847.2 - Lumbar sprain and strain

Ln	Date of Service	POS	CPT/ HCPCS	MODIFIER	Units	Submitted Amount	Approved Amount	Reason Codes
1	05-27-2015 - 05-27-2015	11	98941		1.00	$85.00	$81.48	305
2	05-27-2015 - 05-27-2015	11	97012		1.00	$45.00	$31.86	305
3	05-27-2015 - 05-27-2015	11	97039		1.00	$17.00	$15.00	C720
4	05-27-2015 - 05-27-2015	11	G0283		1.00	$60.00	$27.54	305
5	05-27-2015 - 05-27-2015	11	97110		2.00	$150.00	$128.52	305
6	05-27-2015 - 05-27-2015	11	97010		1.00	$20.00	$10.00	433,37
*	05-27-2015 - 05-27-2015	11	97010		1.00	$20.00	$0.00	99,37
7	05-27-2015 - 05-27-2015	11	97140	59	1.00	$85.00	$69.14	305,179

Total Submitted Charges:	$482.00
Total Approved Amount:	$353.54
Amount Not Payable:	$70.71
Deductible:	$0.00
CoPay:	$0.00
Apportionment / Pro Rata:	$0.00
Offset:	$0.00
Paid Amount:	$282.83

DATE: 08-12-2015 59-6506-854 Professional

Explanations
37 - Extra units have been separated from the original line item.
99 - The procedure code(s) referenced by the provider's office was used more than what is normally expected per visit.
179 - The provider is using modifier -59 to indicate under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 will identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician.
305 - Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon 200% of the Participating Level of Medicare Part B fee schedule for the locale in which the services were rendered.
433 - Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon the payment methodology established pursuant to the Workers' Compensation Fee Schedule (s.440.13).
C720 - FL Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the F.S. 627.736(5)(a)1. which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon the payment methodology established pursuant to the Worker's Compensation Fee Schedule (s.440.13).

Procedure Guide
97010 - Application of a modality to 1 or more areas; hot or cold packs
97012 - Application of a modality to 1 or more areas; traction, mechanical
97039 - Unlisted modality (specify type and time if constant attendance)
97110 - Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97140 - Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
98941 - Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
G0283 - Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

Pursuant to Florida Statute, should you have any information to substantiate payment of an additional amount for the services rendered, please forward for our consideration within 15 days.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree. F.S. 817.234(1)(b).

Information on administering benefits under the 9810A policy form: Due to ongoing litigation in Myers v. McCarty, (Case No. 2013-CA-0073) (Fla. 2d Judl Cir.), the Emergency Medical Condition provisions of the No-Fault statute are not being applied. Please contact us if you have any questions.

DATE: 08-12-2015 59-6506-854 Professional

State Farm

EXPLANATION OF REVIEW

This is not a bill

Claim Number: 59-8506-954 Date of Loss: 05-07-2015 Office Name: State Farm Mutual Automobile Insurance Company PIP/MPC A1 Office - WIN

Patient: [redacted]

Provider: Kissimmee Injury Clinic
280 S STATE ROAD 434 STE 1048A
ALTAMONTE SPG, FL 32714-3859

Claim Handler: Becky King
Address: PO Box 108134
Atlanta, GA 30348-8134
Phone: (844) 292-8815 Ext: 8633182845

Named Insured: [redacted]
Policy Number: C954-438-59

Date Received: 05-23-2015
Jurisdiction: Florida
Bill Reference Number: 11131

TIN: 471144780
Payment Number: 119384585J

Zip of Service: 34741

Diagnosis Codes: 719.45 - Pain in joint, pelvic region and thigh
847.0 - Neck sprain and strain
847.1 - Thoracic sprain and strain
847.2 - Lumbar sprain and strain

Ln	Date of Service	POS	CPT/ HCPCS	MODYS	Units	Submitted Amount	Approved Amount	Reason Codes
1	05-11-2015 - 05-11-2015	11	99202		1.00	$195.00	$148.80	305
2	05-11-2015 - 05-11-2015	11	G0283		1.00	$50.00	$27.54	305
3	05-11-2015 - 05-11-2015	11	97140	59	2.00	$130.00	$118.26	305,179
4	05-11-2015 - 05-11-2015	11	A4556		1.00	$12.00	$0.00	C1088
5	05-12-2015 - 05-12-2015	11	97039		1.00	$17.00	$15.00	C720
6	05-12-2015 - 05-12-2015	11	G0283		1.00	$50.00	$27.54	305
7	05-12-2015 - 05-12-2015	11	97110		1.00	$75.00	$84.26	305
8	05-12-2015 - 05-12-2015	11	97010		1.00	$20.00	$10.00	433
9	05-12-2015 - 05-12-2015	11	97140	59	2.00	$130.00	$118.26	305,179
10	05-13-2015 - 05-13-2015	11	97039		1.00	$17.00	$15.00	C720
11	05-13-2015 - 05-13-2015	11	G0283		1.00	$50.00	$27.54	305
12	05-13-2015 - 05-13-2015	11	97110		1.00	$75.00	$84.26	305
13	05-13-2015 - 05-13-2015	11	97010		1.00	$20.00	$10.00	433
14	05-13-2015 - 05-13-2015	11	97140	59	2.00	$130.00	$118.26	305,179
15	05-14-2015 - 05-14-2015	11	98941		1.00	$85.00	$81.48	305
16	05-14-2015 - 05-14-2015	11	97039		1.00	$17.00	$15.00	C720
17	05-14-2015 - 05-14-2015	11	G0283		1.00	$50.00	$27.54	305
18	05-14-2015 - 05-14-2015	11	97110		1.00	$75.00	$84.26	305
19	05-14-2015 - 05-14-2015	11	97140	59	2.00	$130.00	$118.26	305,179
20	05-18-2015 - 05-18-2015	11	97012		1.00	$45.00	$31.86	305
21	05-18-2015 - 05-18-2015	11	G0283		1.00	$50.00	$27.54	305
22	05-18-2015 - 05-18-2015	11	97035		1.00	$28.00	$25.58	305
23	05-18-2015 - 05-18-2015	11	97535		1.00	$85.00	$85.00	
24	05-18-2015 - 05-18-2015	11	97140	59	2.00	$130.00	$118.26	305,179

DATE: 06-08-2015 59-8506-954 Professional

Total Submitted Charges: $1,808.00
Total Approved Amount: $1,338.36
Amount Not Payable: $287.88
Deductible: $0.00
CoPay: $0.00
Apportionment / Pre Rata: $0.00
Offset: $0.00
Paid Amount: $1,071.80

Explanations
179 - The provider is using modifier -59 to indicate under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 will identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician.
305 - Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon 200% of the Participating Level of Medicare Part B fee schedule for the locale in which the services were rendered.
433 - Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon the payment methodology established pursuant to the Workers' Compensation Fee Schedule (s.440.13).
C1088 - FL Supplies and materials are included in the reported procedure and are not separately payable per Medicare Part B.
C720 - FL Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as F.S. 627.736(5)(a)1. which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon the payment methodology established pursuant to the Worker's Compensation Fee Schedule (s.440.13).

Procedure Guide
97010 - Application of a modality to 1 or more areas; hot or cold packs
97012 - Application of a modality to 1 or more areas; traction, mechanical
97035 - Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97039 - Unlisted modality (specify type and time if constant attendance)
97110 - Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97140 - Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97535 - Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
98941 - Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
99202 - Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies is/are provided consistent with the nature of the problem(s) and the patients and/or family's needs. Usually, the presing problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
A4556 - Electrodes (e.g., apnea monitor), per pair
G0283 - Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

DATE: 06-08-2015 59-8506-954 Professional

Pursuant to Florida Statute, should you have any information to substantiate payment of an additional amount for the services rendered, please forward for our consideration within 15 days.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree. F.S. 817.234(1)(b).

Information on administering benefits under the 6810A policy form: Due to ongoing litigation in Myers v. McCarty, (Case No. 2013-CA-0073) (Fla. 2d Judl Cir.), the Emergency Medical Condition provisions of the No-Fault statute are not being applied. Please contact us if you have any questions.

DATE: 06-08-2015 59-8506-954 Professional

State Farm

EXPLANATION OF REVIEW

This is not a bill

Claim Number: 59-8506-954 Date of Loss: 05-07-2015 Office Name: State Farm Mutual Automobile Insurance Company PIP/MPC A1 Office - WIN

Patient: [redacted]

Provider: Kissimmee Injury Clinic
280 S STATE ROAD 434 STE 1048A
ALTAMONTE SPG, FL 32714-3859

Claim Handler: Becky King
Address: PO Box 108134
Atlanta, GA 30348-8134
Phone: (844) 292-8815 Ext: 8633182845

Named Insured: [redacted]
Policy Number: C954-438-59

Date Received: 05-29-2015
Jurisdiction: Florida
Bill Reference Number: 11131

TIN: 471144780
Payment Number: 119347174J

Zip of Service: 34741

Diagnosis Codes: 719.45 - Pain in joint, pelvic region and thigh
847.0 - Neck sprain and strain
847.1 - Thoracic sprain and strain
847.2 - Lumbar sprain and strain

Ln	Date of Service	POS	CPT/ HCPCS	MODYS	Units	Submitted Amount	Approved Amount	Reason Codes
1	05-18-2015 - 05-18-2015	11	98941		1.00	$85.00	$81.48	305
2	05-18-2015 - 05-18-2015	11	97039		1.00	$17.00	$15.00	C720
3	05-18-2015 - 05-18-2015	11	G0283		1.00	$50.00	$27.54	305
4	05-18-2015 - 05-18-2015	11	97110		1.00	$75.00	$84.26	305
5	05-18-2015 - 05-18-2015	11	97010		1.00	$20.00	$10.00	433
6	05-18-2015 - 05-18-2015	11	97140	59	2.00	$130.00	$118.26	305,179

Total Submitted Charges: $377.00
Total Approved Amount: $316.88
Amount Not Payable: $63.31
Deductible: $0.00
CoPay: $0.00
Apportionment / Pre Rata: $0.00
Offset: $0.00
Paid Amount: $253.25

DATE: 06-03-2015 59-8506-954 Professional

Explanations

179 - The provider is using modifier -59 to indicate under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 will identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician.

305 - Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon 200% of the Participating Level of Medicare Part B fee schedule for the locale in which the services were rendered.

433 - Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon the payment methodology established pursuant to the Workers' Compensation Fee Schedule (s.440.13).

C720 - FL Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as F.S. 627.736(5)(a)1. which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon the payment methodology established pursuant to the Worker's Compensation Fee Schedule (s.440.13).

Procedure Guide

97010 - Application of a modality to 1 or more areas, hot or cold packs
97039 - Unlisted modality (specify type and time if constant attendance)
97110 - Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97140 - Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
98941 - Chiropractic manipulative treatment (CMT): spinal, 3-4 regions
G0283 - Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

Pursuant to Florida Statute, should you have any information to substantiate payment of an additional amount for the services rendered, please forward for our consideration within 15 days.

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing false, incomplete, or misleading information is guilty of a felony of the third degree. F.S. 817.234(1)(b).

Information on administering benefits under the 9810A policy form: Due to ongoing litigation in Myers v. McCarty, (Case No. 2013-CA-0073) (Fla. 2d Judl Cir.), the Emergency Medical Condition provisions of the No-Fault statute are not being applied. Please contact us if you have any questions.

DATE: 06-03-2015 59-6503-954 Professional

STATE FARM INSURANCE
PO BOX 106134
ATLANTA GA 30348-6134

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE / MEDICAID / TRICARE CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER: 596503954
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]	3. PATIENT'S BIRTH DATE / SEX: [redacted]
4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]	
5. PATIENT'S ADDRESS (No., Street): [redacted]	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other
7. INSURED'S ADDRESS (No., Street): [redacted]	
CITY: [redacted] STATE: FL	8. PATIENT STATUS: Single Married Other; Employed [X] Full-Time Student Part-Time Student
CITY: [redacted] STATE: FL	
ZIP CODE: [redacted] TELEPHONE (Include Area Code): ( )	
ZIP CODE: [redacted] TELEPHONE (Include Area Code): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER: C954438A31594
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [X] NO; a. INSURED'S DATE OF BIRTH [redacted] SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES [X] NO; PLACE (State) FL; b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [X] NO; c. INSURANCE PLAN NAME OR PROGRAM NAME: STATEFARM
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE; d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO (If yes, return to and complete item 9 a-d.)

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 06 17 15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 05 08 15	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE:
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: 17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES NO; $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 847.0 2. 847.2 3. 847.1 4. 719.45	22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06 09 15	06 09 15	11		98941		1	8500	1		NPI	0B CH10638
2 06 09 15	06 09 15	11		99358		1	19500	1		NPI	0B CH10638
3 06 09 15	06 09 15	11		97039		1	1700	1		NPI	0B CH10638
4 06 09 15	06 09 15	11		G0283		1	5000	1		NPI	0B CH10638
5 06 09 15	06 09 15	11		97110		1	7500	1		NPI	0B CH10638
6 06 09 15	06 09 15	11		97010		1	2000	1		NPI	

25. FEDERAL TAX I.D. NUMBER: 47144790 SSN EIN [X]	26. PATIENT'S ACCOUNT NO.: 11131	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO	28. TOTAL CHARGE: $ 442 00	29. AMOUNT PAID: $ 000	30. BALANCE DUE: $ 442 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNATURE ON FILE 06 17 15
SIGNED: [redacted] DATE:

32. SERVICE FACILITY LOCATION INFORMATION:
KISSIMMEE INJURY CLINIC
111 E MONUMENT AVE STE 515
KISSIMMEE FL 34741
1053725747

33. BILLING PROVIDER INFO & PH #:
KISSIMMEE INJURY CLINIC
280 S STATE ROAD 434 1049A
ALTAMONTE SPRINGS FL 32714
1053725747

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

06222015

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SPECIAL INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of criminal, civil and/or administrative sanctions.

REFERS TO GOVERNMENT PROGRAMS ONLY

BLACK LUNG AND FECA CLAIMS

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

SIGNATURE OF PHYSICIAN (OR SUPPLIER). I certify that the services listed above were medically indicated and necessary to the health of the patient and were personally furnished by me or my employee under my direction.

NOTICE: This claim is submitted pursuant to the Social Security Act and Federal law. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false statements, omissions, or concealment of a material fact may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

COPY ORIGINAL

7013 2630 0001 2741 5178

$ 92.26

Rose Radiology
2144 Duck Slough Blvd., Suite 101
Trinity, FL 34655

STATE FARM
PL BOX 106134
ATLANTA GA 30348-6134

FIRST CLASS MAIL

PLEASE DO NOT BEND

ooooo

IMPORTANT DOCUMENTS ENCLOSED

NOTE: OPEN THIS ENVELOPE FROM THE BOTTOM.

06222015

STATE FARM INSURANCE
PO BOX 106134
ATLANTA GA 30348-6134

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1\. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [ ] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 59650S954

2\. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3\. PATIENT'S BIRTH DATE / SEX: [redacted]

4\. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]

5\. PATIENT'S ADDRESS (No., Street): [redacted]

6\. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7\. INSURED'S ADDRESS (No., Street): [redacted]

CITY: [redacted] STATE: FL

8\. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [X] Full-Time Student [ ] Part-Time Student [ ]

CITY: [redacted] STATE: FL

ZIP CODE: [redacted] TELEPHONE (Include Area Code): ([redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): ([redacted]

9\. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10\. IS PATIENT'S CONDITION RELATED TO:

11\. INSURED'S POLICY GROUP OR FECA NUMBER: C954438A31594

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH: [redacted] SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [X] YES [ ] NO PLACE (State) FL

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATEFARM

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12\. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 06 17 15

13\. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14\. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 05 08 15

15\. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16\. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17\. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18\. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19\. RESERVED FOR LOCAL USE

20\. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21\. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1\. 847.0 3. 847.2
2\. 847.1 4. 719.45

22\. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23\. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From (MM DD YY)	To (MM DD YY)	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID. #
1	06 09 15	06 09 15	11		97140	59	1	130 00	2		0B / NPI	CH10638
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25\. FEDERAL TAX I.D. NUMBER: 471144790 SSN [ ] EIN [X]

26\. PATIENT'S ACCOUNT NO.: 11131

27\. ACCEPT ASSIGNMENT? [X] YES [ ] NO

28\. TOTAL CHARGE: $ 130 00

29\. AMOUNT PAID: $ 0 00

30\. BALANCE DUE: $ 130 00

31\. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
J.Q.KHAN CH10638
SIGNATURE ON FILE
SIGNED DATE 06 17 15

32\. SERVICE FACILITY LOCATION INFORMATION
KISSIMMEE INJURY CLINIC
111 E MONUMENT AVE 515
KISSIMMEE FL 34741
1053725747

33\. BILLING PROVIDER INFO & PH # ( )
KISSIMMEE INJURY CLINIC
280 S STATE ROAD 434 1049A
ALTAMONTE SPRINGS FL 32714
1053725747

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

06222015

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and [illegible] provided in Items 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes [illegible] medical and nonmedical information, including employment status, and whether the person has employer group health insurance [illegible] responsible to pay for the services for which the Medicare claim is made. See 42 CFR [illegible] patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS [illegible] agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient [illegible] for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the [illegible] CHAMPUS fiscal intermediary [illegible] less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health [illegible] through certain [illegible] in the Uniformed Services. Information on the patient's sponsor should be provided in those items [illegible] 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the [illegible] were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, [illegible]

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide [illegible]

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland [illegible]

STATE FARM INSURANCE
PO BOX 106134
ATLANTA GA 30348-6134

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1\. MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [ ] TRICARE CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (Member ID#) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [X]

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 59650S954

2\. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3\. PATIENT'S BIRTH DATE / SEX: [redacted]

4\. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]

5\. PATIENT'S ADDRESS (No., Street): [redacted]

6\. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7\. INSURED'S ADDRESS (No., Street): [redacted]

CITY: [redacted] STATE: FL

8\. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [X] Full-Time Student [ ] Part-Time Student [ ]

CITY: [redacted] STATE: FL

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

9\. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10\. IS PATIENT'S CONDITION RELATED TO:

11\. INSURED'S POLICY GROUP OR FECA NUMBER: C954438A31594

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH: [redacted] SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [X] YES [ ] NO PLACE (State) FL

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATEFARM

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12\. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 06 17 15

13\. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14\. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 05 08 15

15\. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16\. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17\. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18\. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19\. RESERVED FOR LOCAL USE

20\. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21\. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1\. 847.0 3. 847.2
2\. 847.1 4. 719.45

22\. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23\. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From (MM DD YY)	To (MM DD YY)	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID. #
1	06 08 15	06 08 15	11		97039		1	17 00	1		0B / NPI	CH10638
2	06 08 15	06 08 15	11		G0283		1	50 00	1		0B / NPI	CH10638
3	06 08 15	06 08 15	11		97110		1	75 00	1		0B / NPI	CH10638
4	06 08 15	06 08 15	11		97140	59	1	65 00	1		NPI	
5											NPI	
6											NPI	

25\. FEDERAL TAX I.D. NUMBER: 471144790 SSN [ ] EIN [X]

26\. PATIENT'S ACCOUNT NO.: 11131

27\. ACCEPT ASSIGNMENT? [X] YES [ ] NO

28\. TOTAL CHARGE: $ 207 00

29\. AMOUNT PAID: $ 0 00

30\. BALANCE DUE: $ 207 00

31\. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
J.Q.KHAN CH10638
SIGNATURE ON FILE
SIGNED DATE 06 17 15

32\. SERVICE FACILITY LOCATION INFORMATION
KISSIMMEE INJURY CLINIC
111 E MONUMENT AVE 515
KISSIMMEE FL 34741
1053725747

33\. BILLING PROVIDER INFO & PH # ( )
KISSIMMEE INJURY CLINIC
280 S STATE ROAD 434 1049A
ALTAMONTE SPRINGS FL 32714
1053725747

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

06222015

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PATIENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process this claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare or its agents information, including employment status, and whether the person has employer group health insurance, auto no-fault coverage or workers' compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 12 is signed, this certifies a signature authorizing release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations in the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured" in items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

I request payment of authorized benefits be made to the physician or supplier. I agree to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were rendered personally or were necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employer under my personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services are not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended. 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq, and 30 USC 901 et seq; 38 USC 613; E.O. 9397

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal programs that may require payment from or be responsible to pay primary to Federal payments and other benefits. It is also used to administer these programs. For example it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Records," published in the Federal Register, Vol. 55 No. 177 page 37549, Wed Sept 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register, Vol. 55 No. 40, Wed Feb. 28, 1990. See ESA-5, ESA-6 ESA-12 ESA 13, ESA-30 or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To maintain eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that it is services or supplies received are authorized by law.

ROUTINE USE(S): Information from claims, joint medical documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory responsibilities under CHAMPUS/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, or to debt collection agencies and consumer reporting agencies in connection with recoupment claims, and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign governmental agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse utilization review, quality assurance, peer review, program integrity, third party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURE: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of the claim under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be construed as obstruction.

It is mandatory that you tell us if you know that you, your family, a physician or paying for your treatment, Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 103-603, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept as payment in full the amount due for the Medicaid program for these claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payments or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

STATE FARM INSURANCE
PO BOX 106134
ATLANTA GA 30348-6134

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER: 596508954
2. PATIENT'S NAME: [redacted]	3. PATIENT'S BIRTH DATE / SEX: [redacted]
4. INSURED'S NAME: [redacted]	5. PATIENT'S ADDRESS: [redacted]
6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other	7. INSURED'S ADDRESS: [redacted]
CITY: [redacted] STATE: FL	8. PATIENT STATUS: Single Married [X] Other
ZIP CODE: [redacted] TELEPHONE: [redacted]	Employed [X] Full-Time Student Part-Time Student
9. OTHER INSURED'S NAME:	10. IS PATIENT'S CONDITION RELATED TO: C954438A31594
a. OTHER INSURED'S POLICY OR GROUP NUMBER:	a. EMPLOYMENT? (Current or Previous) YES [X] NO
b. OTHER INSURED'S DATE OF BIRTH:	b. AUTO ACCIDENT? YES [X] NO PLACE (State): FL
c. EMPLOYER'S NAME OR SCHOOL NAME:	c. OTHER ACCIDENT? YES [X] NO
d. INSURANCE PLAN NAME OR PROGRAM NAME:	10d. RESERVED FOR LOCAL USE
11. INSURED'S POLICY GROUP OR FECA NUMBER: [redacted]	a. INSURED'S DATE OF BIRTH / SEX: [redacted]
b. EMPLOYER'S NAME OR SCHOOL NAME:	c. INSURANCE PLAN NAME OR PROGRAM NAME: STATEFARM
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO If yes, return to and complete item 9 a-d.	

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE — DATE: 06 03 15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 05 08 15	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE:
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: 17a. 17b. NPI:
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO	19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? YES NO $ CHARGES	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 847.2 2. 847.2 3. 847.1 4. 719.45
22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.	23. PRIOR AUTHORIZATION NUMBER

24. A DATES OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 05 28 15	05 28 15	11		97012		1	45 00	1			0BCH10638
2 05 28 15	05 28 15	11		G0283		1	50 00	1			0BCH10638
3 05 28 15	05 28 15	11		97110		1	75 00	1			0BCH10638
4 05 28 15	05 28 15	11		97010		1	20 00	1			0BCH10638
5 05 28 15	05 28 15	11		97140	59	1	130 00	2			
6											

25. FEDERAL TAX I.D. NUMBER: 471144790 SSN EIN	26. PATIENT'S ACCOUNT NO.: 11131	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO	28. TOTAL CHARGE: $ 320 00	29. AMOUNT PAID: $ 0 00	30. BALANCE DUE: $ 320 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE 06 03 15 SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION: KISSIMMEE INJURY CLINIC 111 E MONUMENT AVE 315 KISSIMMEE FL 34741 1059725747 a. b.	33. BILLING PROVIDER INFO & PH #: ( ) KISSIMMEE INJURY CLINIC 280 S STATE ROAD 434 1049A ALTAMONTE SPRINGS FL 32714 1059725747 a. b.			

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-0999 FORM 1500 (08-05)

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

05 08 2015

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

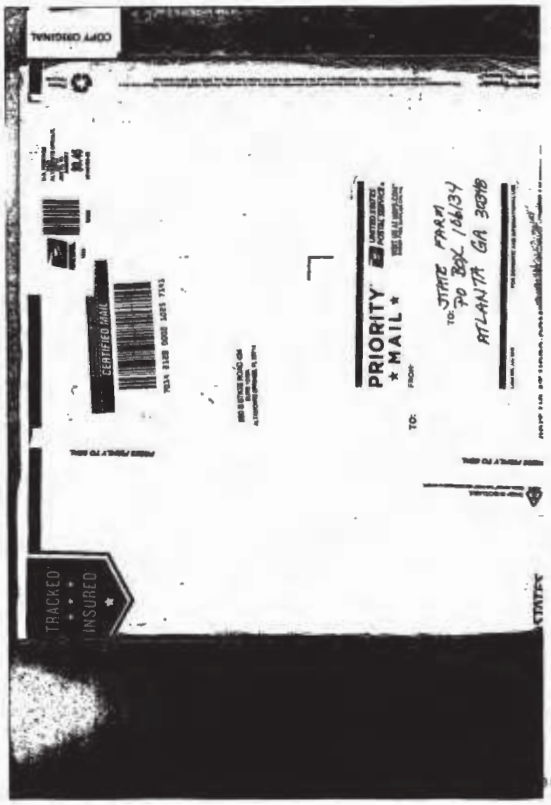
NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

BLACK LUNG AND FECA CLAIMS

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.



STATE FARM INSURANCE
PO BOX 106134
ATLANTA GA 30348-6134

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
	596508954
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE / SEX
[redacted]	[redacted]
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]
[redacted]	
CITY	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]
[redacted]	Employed [X] Full-Time Student [ ] Part-Time Student [ ]
STATE: FL	
ZIP CODE: [redacted]	TELEPHONE (Include Area Code): [redacted]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]
b. OTHER INSURED'S DATE OF BIRTH: MM DD YY / SEX: M [ ] F [ ]	b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): FL
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE

1a. INSURED'S I.D. NUMBER (For Program in Item 1)	PATIENT AND INSURED INFORMATION
596508954	
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
[redacted]	
7. INSURED'S ADDRESS (No., Street)	
[redacted]	
CITY	STATE: FL
[redacted]	
ZIP CODE	TELEPHONE (Include Area Code)
[redacted]	[redacted]
11. INSURED'S POLICY GROUP OR FECA NUMBER	
C954438A31594	
a. INSURED'S DATE OF BIRTH: MM DD YY / SEX: M [X] F [ ]	
[redacted]	
b. EMPLOYER'S NAME OR SCHOOL NAME	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
STATEFARM	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.	

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE — SIGNED — DATE: 06 03 15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE — SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 05 08 15	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. [redacted] / 17b. NPI
16. RESERVED FOR LOCAL USE	18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM TO
	19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO
	20. OUTSIDE LAB? YES [ ] NO [ ] / $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 847.0 — A. 847.2
2. 847.1 — B. [illegible] 719.45

22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 05 27 15	05 27 15	11		98941		1	85 00	1		ORD	CH10638
2 05 27 15	05 27 15	11		97012		1	45 00	1		ORD	CH10638
3 05 27 15	05 27 15	11		97039		1	17 00	1		ORD	CH10638
4 05 27 15	05 27 15	11		G0283		1	50 00	1		ORD	CH10638
5 05 27 15	05 27 15	11		97110		1	150 00	2		ORD	CH10638
6 05 27 15	05 27 15	11		97010		1	40 00	2		ORD	CH10638

25. FEDERAL TAX I.D. NUMBER: 471144790 SSN / EIN: EIN [X]	26. PATIENT'S ACCOUNT NO.: 21552	27. ACCEPT ASSIGNMENT? (For govt. claims, see back): YES [X] NO [ ]	28. TOTAL CHARGE: $ 387 00	29. AMOUNT PAID: $ 0 00	30. BALANCE DUE: $ 387 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNATURE ON FILE — SIGNED: 06 03 15

32. SERVICE FACILITY LOCATION INFORMATION
FIRSTIMMEE INJURY CLINIC
111 E MONUMENT AVE 515
KISSIMMEE FL 34741
1053725747

33. BILLING PROVIDER INFO & PH #
KISSIMMEE INJURY CLINIC
700 E STATE ROAD 434 1049A
ALTAMONTE SPRINGS FL 32714
1053725747

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50812015

STATE FARM INSURANCE
PO BOX 106134
ATLANTA GA 30348-6134

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [X]	1a. INSURED'S I.D. NUMBER: 596505954
2. PATIENT'S NAME: [redacted]	3. PATIENT'S BIRTH DATE: [redacted] SEX: [redacted]
4. INSURED'S NAME: [redacted]	
5. PATIENT'S ADDRESS: [redacted]	6. PATIENT RELATIONSHIP TO INSURED: Self [X]
7. INSURED'S ADDRESS: [redacted]	
CITY: [redacted] STATE: FL	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]
CITY: [redacted] STATE: FL	
ZIP CODE: [redacted] TELEPHONE: [redacted]	Employed [X] Full-Time Student [ ] Part-Time Student [ ]
ZIP CODE: [redacted] TELEPHONE: [redacted]	
9. OTHER INSURED'S NAME:	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: C954438A31594	
a. OTHER INSURED'S POLICY OR GROUP NUMBER:	a. EMPLOYMENT? (Current or Previous) NO [X]
a. INSURED'S DATE OF BIRTH: [redacted] SEX: [redacted]	
b. OTHER INSURED'S DATE OF BIRTH:	b. AUTO ACCIDENT? YES [X] PLACE (State): FL
b. EMPLOYER'S NAME OR SCHOOL NAME:	c. OTHER ACCIDENT? NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME: STATEFARM	
d. INSURANCE PLAN NAME OR PROGRAM NAME:	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? NO [X]	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 06 03 15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 05 08 15	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE:
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: 17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 847.0 2. 847.2 3. 847.1 4. 719.45	22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:
	23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 27 15	05 27 15	11		97140	59	1	65 00	1		NPI	0BCH10638
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 471144790 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.: 11131	27. ACCEPT ASSIGNMENT? YES [X] NO [ ]	28. TOTAL CHARGE: $ 65 00	29. AMOUNT PAID: $ 0 00	30. BALANCE DUE: $ 65 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE DATE: 06 03 15	32. SERVICE FACILITY LOCATION INFORMATION: KISSIMMEE INJURY CLINIC 111 E MONUMENT AVE 515 KISSIMMEE FL 34741 1053725747		33. BILLING PROVIDER INFO & PH #: KISSIMMEE INJURY CLINIC 280 S STATE ROAD 434 1049A ALTAMONTE SPRINGS FL 32714 1053725747		

SIGNED: a. DATE: b. a. b.

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

05062015

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

[redacted]

STATE FARM INSURANCE
PO BOX 106134
ATLANTA GA 30348-6134

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [X]	1a. INSURED'S I.D. NUMBER: 596505954
2. PATIENT'S NAME: [redacted]	3. PATIENT'S BIRTH DATE: [redacted] SEX: [redacted]
4. INSURED'S NAME: [redacted]	
5. PATIENT'S ADDRESS: [redacted]	6. PATIENT RELATIONSHIP TO INSURED: Self [X]
7. INSURED'S ADDRESS: [redacted]	
CITY: [redacted] STATE: FL	8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]
CITY: [redacted] STATE: FL	
ZIP CODE: [redacted] TELEPHONE: [redacted]	Employed [X] Full-Time Student [ ] Part-Time Student [ ]
ZIP CODE: [redacted] TELEPHONE: [redacted]	
9. OTHER INSURED'S NAME:	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: C954438A31594	
a. OTHER INSURED'S POLICY OR GROUP NUMBER:	a. EMPLOYMENT? (Current or Previous) NO [X]
a. INSURED'S DATE OF BIRTH: [redacted] SEX: [redacted]	
b. OTHER INSURED'S DATE OF BIRTH:	b. AUTO ACCIDENT? YES [X] PLACE (State): FL
b. EMPLOYER'S NAME OR SCHOOL NAME:	c. OTHER ACCIDENT? NO [X]
c. INSURANCE PLAN NAME OR PROGRAM NAME: STATEFARM	
d. INSURANCE PLAN NAME OR PROGRAM NAME:	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? NO [X]	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 05 26 15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 05 08 15	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE:
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: 17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 847.0 2. 847.2 3. 847.1 4. 719.45	22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:
	23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 19 15	05 19 15	11		90941		1	85 00	1		NPI	0BCH10638
2 05 19 15	05 19 15	11		97039		1	17 00	1		NPI	0BCH10638
3 05 19 15	05 19 15	11		G0283		1	50 00	1		NPI	0BCH10638
4 05 19 15	05 19 15	11		97110		1	75 00	1		NPI	0BCH10638
5 05 19 15	05 19 15	11		97010		1	20 00	1		NPI	0BCH10638
6 05 19 15	05 19 15	11		97140	59	1	130 00	2		NPI	0BCH10638

25. FEDERAL TAX I.D. NUMBER: 471144790 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.: 11131	27. ACCEPT ASSIGNMENT? YES [X] NO [ ]	28. TOTAL CHARGE: $ 377 00	29. AMOUNT PAID: $ 0 00	30. BALANCE DUE: $ 377 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE DATE: 05 26 15	32. SERVICE FACILITY LOCATION INFORMATION: KISSIMMEE INJURY CLINIC 111 E MONUMENT AVE 515 KISSIMMEE FL 34741 1053725747		33. BILLING PROVIDER INFO & PH #: KISSIMMEE INJURY CLINIC 280 S STATE ROAD 434 1049A ALTAMONTE SPRINGS FL 32714 1053725747		

SIGNED: a. DATE: b. a. b.

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

05292015

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

STATE FARM INSURANCE
PO BOX 106134
ATLANTA GA 30348-6134

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE / MEDICAID / TRICARE / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER: 596505954
2. PATIENT'S NAME: [redacted]	3. PATIENT'S BIRTH DATE / SEX: [redacted]
4. INSURED'S NAME: [redacted]	5. PATIENT RELATIONSHIP TO INSURED: Self
6. PATIENT'S ADDRESS: [redacted] CITY: [redacted] STATE: FL	7. INSURED'S ADDRESS: [redacted] CITY: [redacted] STATE: FL
8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student	
9. OTHER INSURED'S NAME	10. IS PATIENT'S CONDITION RELATED TO: EMPLOYMENT? NO; AUTO ACCIDENT? NO; OTHER ACCIDENT? NO
11. INSURED'S POLICY GROUP OR FECA NUMBER: C954438A31594	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. INSURED'S DATE OF BIRTH / SEX: [redacted]
b. OTHER INSURED'S DATE OF BIRTH / SEX	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. INSURANCE PLAN NAME OR PROGRAM NAME: STATEFARM
d. INSURANCE PLAN NAME OR PROGRAM NAME	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? NO
10d. RESERVED FOR LOCAL USE	

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNATURE ON FILE DATE: 05 19 15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 05 08 15	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO	
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? NO; $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. 847.0 2. 847.2 3. 847.1 4. 719.45	22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05 18 15	05 18 15	11	97012		1	45 00	1			UB CH10638
2	05 18 15	05 18 15	11	G0283		1	50 00	1			UB CH10638
3	05 18 15	05 18 15	11	97035		1	20 00	1			UB CH10638
4	05 18 15	05 18 15	11	97535		1	65 00	1			UB CH10638
5	05 18 15	05 18 15	11	97140	59	1	130 00	2			
6											

25. FEDERAL TAX I.D. NUMBER: 471144790 SSN EIN	26. PATIENT'S ACCOUNT NO.: 11131	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES	28. TOTAL CHARGE: $ 318 00	29. AMOUNT PAID: $ 0 00	30. BALANCE DUE: $ 318 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE OF PHYSICIAN OR SUPPLIER DATE: 05 19 15

32. SERVICE FACILITY LOCATION INFORMATION: KISSIMMEE INJURY CLINIC, 111 E HORSHOEPEN AVE 319, KISSIMMEE FL 34741, 1053725747

33. BILLING PROVIDER INFO & PH #: KISSIMMEE INJURY CLINIC, 280 S STATE ROAD 434 1049A, ALTAMONTE SPRINGS FL 32714, 1053725747

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

05232015

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly makes a false statement or misrepresentation on this form may be subject to criminal and civil penalties.

PRIVACY ACT AND PAPERWORK REDUCTION NOTICE

The Privacy Act of 1974 and the Paperwork Reduction Act of 1995 require that we notify you of the information we request on this form. We are requesting the information on this form in order to determine your eligibility for benefits under the CHAMPUS program. Authority to request this information is granted to us by Title 10, United States Code, Chapter 55. The primary purpose for requesting the information is to determine your eligibility for benefits and to properly pay your claim. Routine uses of this information include disclosure to the Department of Veterans Affairs, the Department of Health and Human Services, and the Department of Transportation, and to other Federal agencies, State, local and foreign governments, private business or individuals as necessary to administer the CHAMPUS program. Information may be disclosed to law enforcement agencies and private business or individuals for the purpose of obtaining information relating to civil or criminal proceedings. Failure to provide the requested information may result in delay in payment or denial of your claim. Social Security Number (SSN) is requested to assist in verifying your identity and to properly administer the CHAMPUS program.

BLACK LUNG AND FECA CLAIMS

The Department of Labor requires that all Black Lung and FECA authorizations requiring medical providers and beneficiaries' signatures

SIGNATURE OF PHYSICIAN OR SUPPLIER (CHAMPUS, CHAMPVA, FECA AND BLACK LUNG)

I certify that the services listed above were medically indicated and necessary for the health of the patient, were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise permitted by CHAMPUS regulations. For CHAMPUS claims, I agree to abide by CHAMPUS program regulations, including those relating to the amount I will bill and accept as payment in full. I agree to submit additional documentation when requested by the CHAMPUS contractor. For CHAMPUS claims, I authorize any holder of medical or other information about me, including copies of records, to release such information to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), its contractors, and their authorized agents, for claims processing, review, program integrity, and payment purposes. I authorize release of information about the health care provided me and the amount charged to me to my sponsor, employer, or other person responsible for payment of the charges. For all claims, I hereby assign to the United States Government all benefits payable to me under Medicare, Medicaid, CHAMPUS, CHAMPVA, FECA, Black Lung, or any other Federal program that pays for or provides medical benefits or services. I understand that I may be subject to criminal and civil penalties for making false statements or claims in connection with Federal health care programs. I certify that I will not bill the patient, the patient's family, or any other person for any amount that CHAMPUS determines is not due for the services listed above, including the patient's annual deductible, co-insurance, and amounts in excess of the CHAMPUS maximum allowable charge. I understand that payment and satisfaction of this claim will be from Federal funds, and that it is a crime to receive and conceal payments from the Federal Government which are not due to me according to Federal laws and regulations. I understand that any false statements or claims may also be subject to prosecution under applicable State laws.

SIGNATURE OF PHYSICIAN OR SUPPLIER (CHAMPUS, CHAMPVA, FECA AND BLACK LUNG)

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF CHAMPUS, CHAMPVA, FECA, AND BLACK LUNG INFORMATION

We may ask you to provide information on this form so that we can determine if you or your sponsor is entitled to benefits under the Military Health Services System (MHSS) CHAMPUS, CHAMPVA, FECA, or Black Lung program. We are authorized by Title 10 U.S.C. Chapter 55 and Executive Order 9397 to ask for this information. We will use the information you provide to make decisions about your eligibility for benefits. We may also use it to collect debts owed to the United States Government. We may disclose information to other Federal agencies, State, local or foreign governments, private business or individuals as necessary to administer the CHAMPUS, CHAMPVA, FECA, or Black Lung program. Information may be disclosed to law enforcement agencies and private business or individuals for the purpose of obtaining information relating to civil or criminal proceedings. Failure to provide the requested information may result in delay in payment or denial of your claim. Social Security Number (SSN) is requested to assist in verifying your identity and to properly administer the CHAMPUS, CHAMPVA, FECA, or Black Lung program.

This statement may also be given to other providers of care or services who request CHAMPUS, CHAMPVA, FECA, or Black Lung certification of your health status.

FOR MEDICARE CLAIMS: See the Publication for the Region in which services were furnished, or the Medicare Intermediary or Carrier with which your claim is filed.

FOR OFFICE CLAIMS: See the Publication for the Region in which services were furnished, or the Medicare Intermediary or Carrier with which your claim is filed.

FOR CHAMPUS CLAIMS: See the Publication for the Region in which services were furnished, or the Medicare Intermediary or Carrier with which your claim is filed.

ROUTINE USES: Information you furnish may be disclosed to Veterans Affairs, the Dept. of Health and Human Services, and the Dept. of Transportation, and to other Federal agencies, State, local or foreign governments, private business or individuals as necessary to administer the CHAMPUS, CHAMPVA, FECA, or Black Lung program. Information may be disclosed to law enforcement agencies and private business or individuals for the purpose of obtaining information relating to civil or criminal proceedings. Information may be disclosed to a Congressional office in response to an inquiry made at the request of the individual. Social Security Numbers (SSN) may be used to request information from other persons or sources in connection with determining eligibility, utilization or payment under CHAMPUS, CHAMPVA, FECA, or Black Lung, or to other Federal agencies for debt collection purposes.

PENALTY: Criminal penalties may be imposed under 18 U.S.C. 287, 1001, and 1002 and civil penalties under 31 U.S.C. 3729 and 3801-3812.

YOUR RESPONSIBILITY FOR CHARGES NOT PAID BY CHAMPUS, CHAMPVA, FECA, OR BLACK LUNG

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO ACT ON PATIENT'S BEHALF

STATE FARM INSURANCE
PO BOX 106134
ATLANTA GA 30348-6134

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
					X	

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 596505954

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3. PATIENT'S BIRTH DATE / SEX: [redacted]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]

5. PATIENT'S ADDRESS (No., Street): [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street): [redacted]

CITY: [redacted] | STATE: FL

8. PATIENT STATUS: Single | Married | Other

ZIP CODE: [redacted] | TELEPHONE (Include Area Code): [redacted]

Employed X | Full-Time Student | Part-Time Student

CITY: [redacted] | STATE: FL

ZIP CODE: [redacted] | TELEPHONE (Include Area Code): [redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: C95443BA31594

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous): YES | X NO

a. INSURED'S DATE OF BIRTH / SEX: [redacted] X F

b. OTHER INSURED'S DATE OF BIRTH / SEX

b. AUTO ACCIDENT? X YES | NO | PLACE (State): FL

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATEFARM

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | X NO — If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 05 19 15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): MM DD YY 05 08 15

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE: MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM ... TO ...

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM ... TO ...

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB: YES | NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 847.0
2. 847.1
3. [redacted]
4. 719.45
5. 847.2
6. [redacted]

22. MEDICAID RESUBMISSION: CODE ... ORIGINAL REF. NO. ...

23. PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 14 15	05 14 15	11		99941		1	85 00	1		NPI / OB	CHI0638
2 05 14 15	05 14 15	11		97039		1	17 00	1		NPI / OB	CHI0638
3 05 14 15	05 14 15	11		G0283		1	50 00	1		NPI / OB	CHI0638
4 05 14 15	05 14 15	11		97110		1	75 00	1		NPI / OB	CHI0638
5 05 14 15	05 14 15	11		97140	59	1	130 00	2		NPI / OB	CHI0638
6										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
471144790		X	11131	X YES / NO	$ 357 00	$ 0.00	$ 357 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNATURE ON FILE
SIGNED: [redacted] DATE: 05 19 15

32. SERVICE FACILITY LOCATION INFORMATION:
KISSIMMEE INJURY CLINIC
111 E MONUMENT AVE 515
KISSIMMEE FL 34741
1053725747

33. BILLING PROVIDER INFO & PH #: ( )
KISSIMMEE INJURY CLINIC
200 S STATE ROAD 434 1048A
ALTAMONTE SPRINGS FL 32714
1053725747

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org — PLEASE PRINT OR TYPE — APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

05232015

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO CONTRACTOR PROGRAMS ONLY

FECA BLACK LUNG AND MEDICARE SECONDARY PAYER CLAIMS

BLACK LUNG AND FECA CLAIMS

SIGNATURE OF PHYSICIAN (FECA, BLACK LUNG)

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA AND BLACK LUNG INFORMATION

PRIVACY ACT STATEMENT

FOR MEDICARE CLAIMS:

FOR OWCP CLAIMS:

FOR CHAMPUS CLAIMS:

ROUTINE USES:

DISCLOSURES:

SIGNATURE OF PATIENT OR AUTHORIZED PERSON (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

SIGNATURE OF PHYSICIAN OR SUPPLIER

NOTICE:

STATE FARM INSURANCE
PO BOX 106134
ATLANTA GA 30348-6134

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)
X					X	

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 596505954

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3. PATIENT'S BIRTH DATE: [redacted] SEX: [redacted]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]

5. PATIENT'S ADDRESS (No., Street): [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): [redacted]

CITY: [redacted] STATE: FL

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: [redacted] STATE: FL

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

Employment? Full-Time Student [X] Part-Time Student [ ]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: C954438A31594

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: [redacted] SEX: M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH: SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): FL

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATEFARM

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNATURE ON FILE

DATE: 05 19 15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNATURE ON FILE

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 05 08 15

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 847.0
2. 847.2
3. 847.1
4. 719.45

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 05 13 15	05 13 15	11		97039		1	17 00	1		NPI	OB CH10638
2 05 13 15	05 13 15	11		G0283		1	50 00	1		NPI	OB CH10638
3 05 13 15	05 13 15	11		97110		1	75 00	1		NPI	OB CH10638
4 05 13 15	05 13 15	11		97010		1	20 00	1		NPI	OB CH10638
5 05 13 15	05 13 15	11		97140	59	1	130 00	2		NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 471144790 SSN EIN: EIN [X]

26. PATIENT'S ACCOUNT NO.: 11131

27. ACCEPT ASSIGNMENT? (For govt. claims, see back): YES [X] NO [ ]

28. TOTAL CHARGE: $ 292 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 292 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNATURE ON FILE

SIGNED: [redacted] DATE: 05 19 15

32. SERVICE FACILITY LOCATION INFORMATION:

KISSIMMEE INJURY CLINIC
111 E MONUMENT AVE 515
KISSIMMEE FL 34741
1053725747

33. BILLING PROVIDER INFO & PH #

KISSIMMEE INJURY CLINIC
280 S STATE ROAD 434 1049A
ALTAMONTE SPRINGS FL 32714
1053725747

NUCC Instruction Manual available at: www.nucc.org

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APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

05232015

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO CONTRACTOR PROGRAMS ONLY

FECA BLACK LUNG AND MEDICARE SECONDARY PAYER CLAIMS

BLACK LUNG AND FECA CLAIMS

SIGNATURE OF PHYSICIAN (FECA, BLACK LUNG)

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA AND BLACK LUNG INFORMATION

PRIVACY ACT STATEMENT

FOR MEDICARE CLAIMS:

FOR OWCP CLAIMS:

FOR CHAMPUS CLAIMS:

ROUTINE USES:

DISCLOSURES:

SIGNATURE OF PATIENT OR AUTHORIZED PERSON (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

SIGNATURE OF PHYSICIAN OR SUPPLIER

NOTICE:

STATE FARM INSURANCE
PO BOX 106134
ATLANTA GA 30348-6134

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE X | MEDICAID | TRICARE CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG X | OTHER

1a. INSURED'S I.D. NUMBER: 596505954

2. PATIENT'S NAME: [redacted]

3. PATIENT'S BIRTH DATE: [redacted] SEX: [redacted]

4. INSURED'S NAME: [redacted]

5. PATIENT'S ADDRESS: [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS: [redacted]

CITY: [redacted] STATE: FL

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: [redacted] STATE: FL

ZIP CODE: [redacted] TELEPHONE: [redacted]

Employment? Full-Time Student [X] Part-Time Student [ ]

ZIP CODE: [redacted] TELEPHONE: [redacted]

9. OTHER INSURED'S NAME:

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: C954438A31594

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous): YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: [redacted] SEX: M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH: SEX: M [ ] F [ ]

b. AUTO ACCIDENT? YES [X] NO [ ] PLACE (State): FL

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: STATEFARM

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNATURE ON FILE

DATE: 05 19 15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNATURE ON FILE

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 05 08 15

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 847.0
2. 847.2
3. 847.1
4. 719.45

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 05 12 15	05 12 15	11		97039		1	17 00	1		NPI	OB CH10638
2 05 12 15	05 12 15	11		G0283		1	50 00	1		NPI	OB CH10638
3 05 12 15	05 12 15	11		97110		1	75 00	1		NPI	OB CH10638
4 05 12 15	05 12 15	11		97010		1	20 00	1		NPI	OB CH10638
5 05 12 15	05 12 15	11		97140	59	1	130 00	2		NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 471144790 SSN EIN: EIN [X]

26. PATIENT'S ACCOUNT NO.: 11131

27. ACCEPT ASSIGNMENT? (For govt. claims, see back): YES [X] NO [ ]

28. TOTAL CHARGE: $ 292 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 292 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

SIGNATURE ON FILE

SIGNED: [redacted] DATE: 05 19 15

32. SERVICE FACILITY LOCATION INFORMATION:

KISSIMMEE INJURY CLINIC
111 E MONUMENT AVE 515
KISSIMMEE FL 34741
1053725747

33. BILLING PROVIDER INFO & PH #

KISSIMMEE INJURY CLINIC
280 S STATE ROAD 434 1049A
ALTAMONTE SPRINGS FL 32714
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PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

STATE FARM INSURANCE
PO BOX 106134
ATLANTA GA 30348-6134

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE	1a. INSURED'S I.D. NUMBER		
59650S954			
2. PATIENT'S NAME	3. PATIENT'S BIRTH DATE / SEX	4. INSURED'S NAME	
[redacted]	[redacted]	[redacted]	
5. PATIENT'S ADDRESS	6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other	7. INSURED'S ADDRESS	
[redacted]		[redacted] APT A	
CITY: [redacted]	STATE: FL	CITY: [redacted]	STATE: FL
ZIP CODE: [redacted]	TELEPHONE: [redacted]	ZIP CODE: [redacted]	TELEPHONE: [redacted]
8. PATIENT STATUS: Single Married Other			
Employed [X] Full-Time Student Part-Time Student			
9. OTHER INSURED'S NAME	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	
		C954438A31594	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [X] NO	a. INSURED'S DATE OF BIRTH / SEX	
[redacted]		[redacted] M [X] F	
b. OTHER INSURED'S DATE OF BIRTH / SEX	b. AUTO ACCIDENT? [X] YES NO PLACE (State) FL	b. EMPLOYER'S NAME OR SCHOOL NAME	
M F			
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME	
		STATEFARM	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO If yes, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNATURE ON FILE — DATE 05 19 15

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
05 09 15		MM DD YY FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
		MM DD YY FROM TO	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO	$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 847.0	2. 847.2	22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
3. 847.1	4. 719.45	23. PRIOR AUTHORIZATION NUMBER	

24. A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 11 15	05 11 15	11		99202		1	155 00	1		NPI	OB CHI0638
2 05 11 15	05 11 15	11		G0283		1	50 00	1		NPI	OB CHI0638
3 05 11 15	05 11 15	11		97140	59	1	130 00	2		NPI	OB CHI0638
4 05 11 15	05 11 15	11		A4556		1	12 00	1		NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
471144790	[X]	11131	[X]	347 00	0 00	347 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the services shown on this form were rendered by me personally or under my supervision.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
[redacted] SIGNATURE ON FILE 05 19 15	KISSIMMEE IN-JURY CLINIC 111 E MONUMENT AVE STE 310 KISSIMMEE FL 34741 1053725747	KISSIMMEE INJURY CLINIC 250 S STATE ROAD 434 STE 1049A ALTAMONTE SPRINGS FL 32714 1053725747

DATE: 05 19 15

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05232015

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

technology to minimize the information collection burden.

(1) *Type of Information Collection Request:* New Collection;

Title of Information Collection: Employee Building Pass Application and File;

Form No.: HCFA–730 & 182 (OMB# 0938–NEW);

Use: The purpose of this system and the forms are to control United States Government Building Passes issued to all HCFA employees and non-HCFA employees who require continuous access to HCFA buildings in Baltimore and other HCFA and HHS buildings.;

Frequency: Other; as needed;

Affected Public: Federal Government, and business or other for-profit;

Number of Respondents: 150;

Total Annual Responses: 150;

Total Annual Hours: 37.50.

(2) *Type of Information Collection Request:* Extension of a currently approved collection;

Title of Information Collection: Limitation on Liability and Information Collection Requirements Referenced in 42 CFR 411.404, 411.406, and 411.408;

Form No.: HCFA–R–77 (OMB# 0938–0485);

Use: The Medicare program requires to provide written notification of noncovered services to beneficiaries by the providers, practitioners, and suppliers. The notification gives the beneficiary, provider, practitioner, or supplier knowledge that Medicare will not pay for items or services mentioned in the notification. After this notification, any future claim for the same or similar services will not be paid by the program and the affected parties will be liable for the noncovered services.;

Frequency: Other; as needed;

Affected Public: Individuals or households;

Number of Respondents: 890,826;

Total Annual Responses: 3,563,304;

Total Annual Hours: 296,942.

To obtain copies of the supporting statement for the proposed paperwork collections referenced above, access HCFA's Web Site Address at http://www.hcfa.gov/regs/prdact95.htm, or E-mail your request, including your address and phone number, to Paperwork@hcfa.gov, or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 30 days of this notice directly to the OMB Desk Officer designated at the following address: OMB Human Resources and Housing Branch, Attention: Allison Eydt, New Executive Office Building, Room 10235, Washington, D.C. 20503.

Dated: September 11, 2000.

John P. Burke III,

HCFA Reports Clearance Officer, HCFA, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards.

[FR Doc. 00–25581 Filed 10–4–00; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

OIG Compliance Program for Individual and Small Group Physician Practices

AGENCY: Office of Inspector General (OIG), HHS.

ACTION: Notice.

SUMMARY: This **Federal Register** notice sets forth the recently issued Compliance Program Guidance for Individual and Small Group Physician Practices developed by the Office of Inspector General (OIG). The OIG has previously developed and published voluntary compliance program guidance focused on several other areas and aspects of the health care industry. We believe that the development and issuance of this voluntary compliance program guidance for individual and small group physician practices will serve as a positive step towards assisting providers in preventing the submission of erroneous claims or engaging in unlawful conduct involving the Federal health care programs.

FOR FURTHER INFORMATION CONTACT: Kimberly Brandt, Office of Counsel to the Inspector General, (202) 619–2078.

SUPPLEMENTARY INFORMATION:

Background

The creation of compliance program guidances is a major initiative of the OIG in its effort to engage the private health care community in preventing the submission of erroneous claims and in combating fraudulent conduct. In the past several years, the OIG has developed and issued compliance program guidances directed at a variety of segments in the health care industry. The development of these types of compliance program guidances is based on our belief that a health care provider can use internal controls to more efficiently monitor adherence to applicable statutes, regulations and program requirements.

Copies of these compliance program guidances can be found on the OIG web site at http://www.hhs.gov/oig.

Developing the Compliance Program Guidance for Individual and Small Group Physician Practices

On September 8, 1999, the OIG published a solicitation notice seeking information and recommendations for developing formal guidance for individual and small group physician practices (64 FR 48846). In response to that solicitation notice, the OIG received 83 comments from various outside sources. We carefully considered those comments, as well as previous OIG publications, such as other compliance program guidance and Special Fraud Alerts, in developing a guidance for individual and small group physician practices. In addition, we have consulted with the Health Care Financing Administration and the Department of Justice, in an effort to ensure that all parties had a reasonable opportunity to provide input into a final product, draft guidance for individual and small group physician practices was published in the **Federal Register** on June 12, 2000 (65 FR 36818) for further comments and recommendations.

Components of an Effective Compliance Program

This compliance program guidance for individual and small group physician practices contains seven components that provide a solid basis upon which a physician practice can create a voluntary compliance program:

- Conducting internal monitoring and auditing;
- Implementing compliance and practice standards;
- Designating a compliance officer or contact;
- Conducting appropriate training and education;
- Responding appropriatly to detected offenses and developing corrective action;
- Developing open lines of communication; and
- Enforcing disciplinary standards through well-publicized guidelines.

Similar components have been contained in previous guidances issued by the OIG. However, unlike other guidances issued by OIG, this guidance for physicians does not suggest that physician practices implement all seven components of a full scale compliance program. Instead, the guidance emphasizes a step by step approach to follow in developing and implementing a voluntary compliance program. This change is in recognition of the financial and staffing resource constraints faced

the physician practice will have about the results. However, the OIG is aware that this may be burdensome for some physician practices, so, at a minimum, we would encourage the physician practice to conduct a review of claims that have been reimbursed by Federal health care programs.

If problems are identified, the physician practice will need to determine whether a focused review should be conducted on a more frequent basis. When audit results reveal areas needing additional information or education of employees and physicians, the physician practice will need to analyze whether these areas should be incorporated into the training and educational system.

There are many ways to identify the claims/services from which to draw the random sample of claims to be audited. One methodology is to choose a random sample of claims/services from either all of the claims/services a physician has received reimbursement for or all claims/services from a particular payor. Another method is to identify risk areas or potential billing vulnerabilities. The codes associated with these risk areas may become the universe of claims/services from which to select the sample. The OIG recommends that the physician practice evaluate claims/services selected to determine if the codes billed and reimbursed were accurately ordered, performed, and reasonable and necessary for the treatment of the patient.

One of the most important components of a successful compliance audit protocol is an appropriate response when the physician practice identifies a problem. This action should be taken as soon as possible after the date the problem is identified. The specific action a physician practice takes should depend on the circumstances of the situation. In some cases, the response can be as straight forward as generating a repayment with appropriate explanation to Medicare or the appropriate payor from which the overpayment was received. In others, the physician practice may want to consult with a coding/billing expert to determine the next best course of action. There is no boilerplate solution to how to handle problems that are identified.

It is a good business practice to create a system to address how physician practices will respond to and report potential problems. In addition, preserving information relating to identification of the problem is as important as preserving information that tracks the physician practice's reaction to, and solution for, the issue.

Step 2: Establish Practice Standards and Procedures

After the internal audit identifies the practice's risk areas, the next step is to develop a method for dealing with those risk areas through the practice's standards and procedures. Written standards and procedures are a central component of any compliance program. Those standards and procedures help to reduce the prospect of erroneous claims and fraudulent activity by identifying risk areas for the practice and establishing tighter internal controls to counter those risks, while also helping to identify any aberrant billing practices. Many physician practices already have something similar to this called "practice standards" that include practice policy statements regarding patient care, personnel matters and practice standards and procedures on complying with Federal and State law.

The OIG believes that written standards and procedures can be helpful to all physician practices, regardless of size and capability. If a lack of resources to develop such standards and procedures is genuinely an issue, the OIG recommends that a physician practice focus first on those risk areas most likely to arise in its particular practice.[8] Additionally, if the physician practice works with a physician practice management company (PPMC), independent practice association (IPA), physician-hospital organization, management services organization (MSO) or third-party billing company, the practice can incorporate the compliance standards and procedures of those entities, if appropriate, into its own standards and procedures. Many physician practices have found that the adoption of a third party's compliance standards and procedures, as appropriate, has many benefits and the result is a consistent set of standards and procedures for a community of physicians as well as having just one entity that can then monitor and refine the process as needed. This sharing of compliance responsibilities assists physician practices in rural areas that do not have the staff to perform these functions, but do belong to a group that does have the resources. Physician practices using another entity's compliance materials will need to tailor those materials to the physician practice where they will be applied.

Physician practices that do not have standards or procedures in place can develop them by: (1) Developing a written standards and procedures manual; and (2) updating clinical forms periodically to make sure they facilitate and encourage clear and complete documentation of patient care. A practice's standards could also identify the clinical protocol(s), pathway(s), and other treatment guidelines followed by the practice.

Creating a resource manual from publicly available information may be a cost-effective approach for developing additional standards and procedures. For example, the practice can develop a "binder" that contains the practice's written standards and procedures, relevant HCFA directives and carrier bulletins, and summaries of informative OIG documents (*e.g.*, Special Fraud Alerts, Advisory Opinions, inspection and audit reports).[9] If the practice chooses to adopt this idea, the binder should be updated as appropriate and located in a readily accessible location.

If updates to the standards and procedures are necessary, those updates should be communicated to employees to keep them informed regarding the practice's operations. New employees can be made aware of the standards and procedures when hired and can be trained on their contents as part of their orientation to the practice. The OIG recommends that the communication of updates and training of new employees occur as soon as possible after either the issuance of a new update or the hiring of a new employee.

1. Specific Risk Areas

The OIG recognizes that many physician practices may not have in place standards and procedures to prevent erroneous or fraudulent conduct in their practices. In order to develop standards and procedures, the physician practice may consider what types of fraud and abuse related topics need to be addressed based on its specific needs. One of the most important things in making that determination is a listing of risk areas where the practice may be vulnerable.

To assist physician practices in performing this initial assessment, the OIG has developed a list of four potential risk areas affecting physician practices. These risk areas include: (a) Coding and billing; (b) reasonable and necessary services; (c) documentation;

[8] Physician practices with laboratories or arrangements with third-party billing companies can also check the risk areas included in the OIG compliance program guidance for those industries.

[9] The OIG and HCFA are working to compile a list of basic documents issued by both entities that could be included in such a binder. We expect to complete this list later this fall, and will post it on the OIG and HCFA web sites, as well as publicize this list to physician organizations and representatives (information on how to contact the OIG is contained in Footnote 3; HCFA information can be obtained at www.hcfa.gov/medlearn or by calling 1–800–MEDICARE).

Exhibit 3

and (d) improper inducements, kickbacks and self-referrals. This list of risk areas is not exhaustive, or all-encompassing. Rather, it should be viewed as a starting point for an internal review of potential vulnerabilities within the physician practice.[10] The objective of such an assessment is to ensure that key personnel in the physician practice are aware of these major risk areas and that steps are taken to minimize, to the extent possible, the types of problems identified. While there are many ways to accomplish this objective, clear written standards and procedures that are communicated to all employees are important to ensure the effectiveness of a compliance program. Specifically, the following are discussions of risk areas for physician practices:[11]

a. Coding and Billing. A major part of any physician practice's compliance program is the identification of risk areas associated with coding and billing. The following risk areas associated with billing have been among the most frequent subjects of investigations and audits by the OIG:

- Billing for items or services not rendered or not provided as claimed;[12]
- Submitting claims for equipment, medical supplies and services that are not reasonable and necessary;[13]
- Double billing resulting in duplicate payment;[14]
- Billing for non-covered services as if covered;[15]
- Knowing misuse of provider identification numbers, which results in improper billing;[16]
- Unbundling (billing for each component of the service instead of billing or using an all-inclusive code);[17]
- Failure to properly use coding modifiers;[18]
- Clustering;[19] and
- Upcoding the level of service provided.[20]

The physician practice written standards and procedures concerning proper coding reflect the current reimbursement principles set forth in applicable statutes, regulations[21] and Federal, State or private payor health care program requirements and should be developed in tandem with coding and billing standards used in the physician practice. Furthermore, written standards and procedures should ensure that coding and billing are based on medical record documentation. Particular attention should be paid to issues of appropriate diagnosis codes and individual Medicare Part B claims (including documentation guidelines for evaluation and management services).[22] A physician practice can also institute a policy that the coder and/or physician review all rejected claims pertaining to diagnosis and procedure codes. This step can facilitate a reduction in similar errors.

b. Reasonable and Necessary Services. A practice's compliance program may provide guidance that claims are to be submitted only for services that the physician practice finds to be reasonable and necessary in the particular case. The OIG recognizes that physicians should be able to order any tests, including screening tests, they believe are appropriate for the treatment of their patients. However, a physician practice should be aware that Medicare will only pay for services that meet the Medicare definition of reasonable and necessary.[23]

Medicare (and many insurance plans) may deny payment for a service that is not reasonable and necessary according to the Medicare reimbursement rules. Thus, when a physician provides services to a Medicare beneficiary, he or she should only bill those services that meet the Medicare standard of being reasonable and necessary for the diagnosis and treatment of a patient. A physician practice can bill in order to receive a denial for services, but only if the denial is needed for reimbursement from the secondary payor. Upon request, the physician practice should be able to provide documentation, such as a patient's medical records and

[10] Physician practices seeking additional guidance on potential risk areas can review the OIG's Work Plan to identify vulnerabilities and risk areas on which the OIG will focus in the future. In addition, physician practices can also review the OIG's semiannual reports, which identify program vulnerabilities and risk areas that the OIG has targeted during the preceding six months. All of these documents are available on the OIG's webpage at http://www.hhs.gov/oig.

[11] Appendix A of this document lists additional risk areas that a physician practice may want to review and incorporate into their practice standards and procedures.

[12] For example, Dr. X, an ophthalmologist, billed for laser surgery he did not perform. As one element of proof, he did not even have laser equipment or access to such equipment at the place of service designated on the claim form where he performed the surgery.

[13] Billing for services, supplies and equipment that are not reasonable and necessary involves seeking reimbursement for a service that is not warranted by a patient's documented medical condition. See 42 U.S.C. 1395l(a)(1)(A) ("no payment may be made under part A or part B [of Medicare] for any expenses incurred for items or services which * * * are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of the malformed body member"). *See also:* Appendix A for further discussion on this topic.

[14] Double billing occurs when a physician bills for the same item or service more than once or another party billed the Federal health care program for an item or service also billed by the physician. Although duplicate billing can occur due to simple error, the knowing submission of duplicate claims—which is sometimes evidenced by systematic or repeated double billing—can create liability under criminal, civil, and/or administrative law.

[15] For example, Dr. Y bills Medicare using a covered office visit code when the actual service was a non-covered annual physical. Physician practices should remember that "necessary" does not always constitute "covered" and that this example is a misrepresentation of services to the Federal health care programs.

[16] An example of this is when the practice bills for a service performed by Dr. B, who has not yet been issued a Medicare provider number, using Dr. A's Medicare provider number. Physician practices need to bill using the correct Medicare provider number, even if that means delaying billing until the physician receives his/her provider number.

[17] Unbundling is the practice of a physician billing for multiple components of a service that must be included in a single fee. For example, if dressings and instruments are included in a fee for a minor procedure, the provider may not also bill separately for the dressings and instruments.

[18] A modifier, as defined by the CPT–4 manual, provides the means by which a physician practice can indicate a service or procedure that has been performed has been altered by some specific circumstance, but not changed in its definition or code. Assuming the modifier is used correctly and appropriately, this specificity provides the justification for payment for those services. For correct use of modifiers, the physician practice should reference the appropriate sections of the *Medicare Provider Manual. See Medicare Carrier Manual* Section 4632. For general information on the correct use of modifiers, a physician practice can consult the National Correct Coding Initiative (NCCI). See Appendix F for information on how to download the NCCI edits. The NCCI coding edits are updated on a quarterly basis and are used to process claims and determine payments to physicians.

[19] This is the practice of coding/charging one or two middle levels of service codes exclusively, under the philosophy that some will be higher, some lower, and the charges will average out over an extended period (in reality, this overcharges some patients while undercharging others).

[20] Upcoding is billing for a more expensive service than the one actually performed. For example, Dr. X intentionally bills at a higher evaluation and management (E&M) code than what he actually renders to the patient.

[21] The official coding guidelines are promulgated by HCFA, the National Center for Health Statistics, the American Hospital Association, the American Medical Association and the American Health Information Management Association. *See* International Classification of Diseases, 9th Revision, Clinical Modification (ICD–9–CM)(and its successors); 1998 Health Care Financing Administration Common Procedure Coding System (HCPCS) (and its successors); and Physicians' CPT. In addition, there are specialized coding systems for specific segments of the health care industry. Among these are ADA (for dental procedures), DSM IV (psychiatric health benefits) and DMERCs (for durable medical equipment, prosthetics, orthotics and supplies).

[22] The failure of a physician practice to: (i) document items and services rendered; and (ii) properly submit the corresponding claims for reimbursement is a major area of potential erroneous or fraudulent conduct involving Federal health care programs. The OIG has undertaken numerous audits, investigations, inspections and national enforcement initiatives in these areas.

[23] "[A]ny * * * [or the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." 42 U.S.C. 1395y(a)(1)(A).

physician's orders, to support the appropriateness of a service that the physician has provided.

c. Documentation. Timely, accurate and complete documentation is important to clinical patient care. This same documentation serves as a second function when a bill is submitted for payment, namely, as verification that the bill is accurate as submitted. Therefore, one of the most important physician practice compliance issues is the appropriate documentation of diagnosis and treatment. Physician documentation is necessary to determine the appropriate medical treatment for the patient and is the basis for coding and billing determinations. Thorough and accurate documentation also helps to ensure accurate recording and timely transmission of information.

i. Medical Record Documentation. In addition to facilitating high quality patient care, a properly documented medical record verifies and documents precisely what services were actually provided. The medical record may be used to validate: (a) The site of the service; (b) the appropriateness of the services provided; (c) the accuracy of the billing; and (d) the identity of the care giver (service provider). Examples of internal documentation guidelines a practice might use to ensure accurate medical record documentation include the following:[24]

- The medical record is complete and legible;
- The documentation of each patient encounter includes the reason for the encounter; any relevant history; physical examination findings; prior diagnostic test results; assessment, clinical impression, or diagnosis; plan of care; and date and legible identity of the observer;
- If not documented, the rationale for ordering diagnostic and other ancillary services can be easily inferred by an independent reviewer or third party who has appropriate medical training;
- CPT and ICD–9–CM codes used for claims submission are supported by documentation and the medical record; and
- Appropriate health risk factors are identified. The patient's progress, his or her response to, and any changes in, treatment, and any revision in diagnosis is documented.

The CPT and ICD–9–CM codes reported on the health insurance claims form should be supported by documentation in the medical record and the medical chart should contain all necessary information. Additionally, HCFA and the local carriers should be able to determine the person who provided the services. These issues can be the root of investigations of inappropriate or erroneous conduct, and have been identified by HCFA and the OIG as a leading cause of improper payments.

One method for improving quality in documentation is for a physician practice to compare the practice's claim denial rate to the rates of other practices in the same specialty to the extent that the practice can obtain that information from the carrier. Physician coding and diagnosis distribution can be compared for each physician within the same specialty to identify variances.

ii. HCFA 1500 Form. Another documentation area for physician practices to monitor closely is the proper completion of the HCFA 1500 form. The following practices will help ensure that the form has been properly completed:

- Link the diagnosis code with the reason for the visit or service;
- Use modifiers appropriately;
- Provide Medicare with all information about a beneficiary's other insurance coverage under the Medicare Secondary Payor (MSP) policy, if the practice is aware of a beneficiary's additional coverage.

d. Improper Inducements, Kickbacks and Self-Referrals. A physician practice would be well advised to have standards and procedures that encourage compliance with the anti-kickback statute[25] and the physician self-referral law.[26] Remuneration for referrals is illegal because it can distort medical decision-making, cause overutilization of services or supplies, increase costs to Federal health care programs, and result in unfair competition by shutting out competitors who are unwilling to pay for referrals. Remuneration for referrals can also affect the quality of patient care by encouraging physicians to order services or supplies based on profit rather than the patients' best medical interests.[27]

In particular, arrangements with hospitals, hospices, nursing facilities, home health agencies, durable medical equipment suppliers, pharmaceutical manufacturers and vendors are areas of potential concern. In general the anti-kickback statute prohibits knowingly and willfully giving or receiving anything of value to induce referrals of Federal health care program business. It is generally recommended that all business arrangements wherein physician practices refer business to, or order services or items from, an outside entity should be on a fair market value basis.[28] Whenever a physician practice intends to enter into a business arrangement that involves making referrals, the arrangement should be reviewed by legal counsel familiar with the anti-kickback statute and physician self-referral statute.

In addition to developing standards and procedures to address arrangements with other health care providers and suppliers, physician practices should also consider implementing measures to avoid offering inappropriate inducements to patients.[29] Examples of such inducements include routinely waiving coinsurance or deductible amounts without a good faith determination that the patient is in financial need or failing to make reasonable efforts to collect the cost-sharing amount.[30]

Possible risk factors relating to this risk area that could be addressed in the practice's standards and procedures include:

- Financial arrangements with outside entities to whom the practice

[24] For additional information on proper documentation, physician practices should also reference the *Documentation Guidelines for Evaluation and Management Services*, published by HCFA. Currently, physicians may document based on the 1995 or 1997 E&M Guidelines, whichever is most advantageous to the physician. A new set of draft guidelines were announced in June 2000, and are undergoing pilot testing and revision, but are not in current use.

[25] The anti-kickback statute provides criminal penalties for individuals and entities that knowingly offer, pay, solicit, or receive bribes or kickbacks or other remuneration in order to induce business reimbursable by Federal health care programs. *See* 42 U.S.C. 1320a–7b(b). Civil penalties, exclusion from participation in the Federal health care programs, and civil False Claims Act liability may also result from a violation of the prohibition. *See* 42 U.S.C. 1320a–7a(a)(5), 42 U.S.C. 1320a–7(b)(7), and 31 U.S.C. 3729–3733.

[26] The physician self-referral law, 42 U.S.C. 1395nn (also known as the "Stark law"), prohibits a physician from making a referral to an entity with which the physician or any member of the physician's immediate family has a financial relationship if the referral is for the furnishing of designated health services, unless the financial relationship fits into an exception set forth in the statute or implementing regulations.

[27] *See* Appendix B for additional information on the anti-kickback statute.

[28] The OIG's definition of "fair market value" excludes any value attributable to referrals of Federal program business or the ability to influence the flow of such business. *See* 42 U.S.C. 1395nn(h)(3). Adhering to the rule of keeping business arrangements at fair market value is not a guarantee of legality, but is a highly useful general rule.

[29] *See* 42 U.S.C. 1320a–7a(a)(5).

[30] In the OIG Special Fraud Alert "Routine Waiver of Part B Co-payments/Deductibles" (May 1991), the OIG describes several reasons why routine waivers of these cost-sharing amounts pose concerns. The Alert sets forth the circumstances under which it may be appropriate to waive these amounts. *See also* 42 U.S.C. 1320a–7a(a)(5).

* **A4556** Electrodes, (e.g., apnea monitor), per pair N
If "incident to" a physician's service, do not bill.

* **A4557** Lead wires, (e.g., apnea monitor), per pair Qp Qh N
If "incident to" a physician's service, do not bill.

* **A4558** Conductive gel or paste, for use with electrical device (e.g., TENS, NMES), per oz N
If "incident to" a physician's service, do not bill.

* **A4559** Coupling gel or paste, for use with ultrasound device, per oz N
If "incident to" a physician's service, do not bill.

* **A4561** Pessary, rubber, any type Qp Qh N

* **A4562** Pessary, non rubber, any type Qp Qh N

↩ * **A4565** Slings Qp Qh N

⊘ **A4566** Shoulder sling or vest design, abduction restrainer, with or without swathe control, prefabricated, includes fitting and adjustment E

⊘ **A4570** Splint E
IOM: 100-02, 6, 10; 100-02, 15, 100; 100-04, 4, 240

⊘ **A4575** Topical hyperbaric oxygen chamber, disposable E
IOM: 100-03, 1, 20.29

⊘ **A4580** Cast supplies (e.g. plaster) E
IOM: 100-02, 6, 10; 100-02, 15, 100; 100-04, 4, 240

⊘ **A4590** Special casting material (e.g. fiberglass) E
IOM: 100-02, 6, 10; 100-02, 15, 100; 100-04, 4, 240

○ **A4595** Electrical stimulator supplies, 2 lead, per month (e.g. TENS, NMES) Qh N
If "incident to" a physician's service, do not bill.
IOM: 100-03, 2, 160.13

* **A4600** Sleeve for intermittent limb compression device, replacement only, each E

↩ * **A4601** Lithium ion battery, rechargeable, for non-prosthetic use, replacement E

▶ * **A4602** Replacement battery for external infusion pump owned by patient, lithium, 1.5 volt, each N1 N

* **A4604** Tubing with integrated heating element for use with positive airway pressure device Qh N
DMEPOS Modifier(s): NU

* **A4605** Tracheal suction catheter, closed system, each Qh N
DMEPOS Modifier(s): NU

* **A4606** Oxygen probe for use with oximeter device, replacement Qp Qh N

* **A4608** Transtracheal oxygen catheter, each N

Supplies for Respiratory and Oxygen Equipment

⊘ **A4611** Battery, heavy duty; replacement for patient owned ventilator Qp Qh E
Medicare Statute 1834(a)(3)(a)
DMEPOS Modifier(s): NU, RR, UE

⊘ **A4612** Battery cables; replacement for patient-owned ventilator Qh E
Medicare Statute 1834(a)(3)(a)
DMEPOS Modifier(s): NU, RR, UE

⊘ **A4613** Battery charger; replacement for patient-owned ventilator Qh E
Medicare Statute 1834(a)(3)(a)
DMEPOS Modifier(s): NU, RR, UE

* **A4614** Peak expiratory flow rate meter, hand held Qp Qh N
If "incident to" a physician's service, do not bill.

○ **A4615** Cannula, nasal N
If "incident to" a physician's service, do not bill.
IOM: 100-03, 2, 160.6; 100-04, 20, 100.2

○ **A4616** Tubing (oxygen), per foot N
If "incident to" a physician's service, do not bill.
IOM: 100-03, 2, 160.6; 100-04, 20, 100.2

○ **A4617** Mouth piece N
If "incident to" a physician's service, do not bill.
IOM: 100-03, 2, 160.6; 100-04, 20, 100.2

○ **A4618** Breathing circuits Qh N
If "incident to" a physician's service, do not bill.
IOM: 100-03, 2, 160.6; 100-04, 20, 100.2
DMEPOS Modifier(s): NU, RR, UE

▶ New ↩ Revised ✔ Reinstated ~~deleted~~ Deleted ⊘ Not covered or valid by Medicare
○ Special coverage instructions * Carrier discretion B Bill local carrier D Bill DME MAC

Exhibit 4

FIRST COAST
SERVICE OPTIONS, INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

CAREERS EMPLOYEES VENDORS

THE LEADER IN MEDICARE ADMINISTRATION

HOME WHO WE ARE WHAT WE DO OUR STAKE

WELCOME TO FIRST COAST SERVICE OPTIONS, INC.

First Coast has proudly served as one of the nation's largest Medicare administrators for 50 years, and is the current Medicare Administrative Contractor (MAC) for Jurisdiction N (JN), which includes Florida, Puerto Rico and the U.S. Virgin Islands. As our name suggests, we are headquartered on Florida's beautiful first coast, home to the nation's oldest city, St. Augustine.

First Coast's mission is strongly linked to the Medicare program and the beneficiaries it serves. We contract with the Centers for Medicare & Medicaid Services (CMS) to provide quality Medicare administrative services to the beneficiaries in Florida, Puerto Rico and the U.S. Virgin Islands and the health care providers who serve them. These services include claims processing, customer service, provider audit and reimbursement, provider enrollment, and various education and outreach activities. First Coast also performs financial management functions for CMS that help ensure the appropriateness of the Medicare benefit payments we issue.

Everything First Coast does is guided by our company's values:
the right things, the right way.



MEDICARE PROVIDERS

- In English
- En español
- Electronic Services

STAY INFORMED -- SIGNUP FOR ENEWS

Join First Coast's eNews Listserv to receive up-to-date information you need as a health care provider. Sign up now, and you'll receive automatic email notifications whenever urgent or critical Medicare information is posted to **medicare.fcso.com** or **medicareespanol.fcso.com**, First Coast's Medicare provider websites.

Click here to signup and pick your topics of interest, in either English or Spanish.

Exhibit 5

FIRST COAST
SERVICE OPTIONS, INC.

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

CAREERS EMPLOYEES VENDORS

MEDICARE ADMINISTRATION

HOME WHO WE ARE WHAT WE DO OUR STAKE

FIRST COAST IS COMMITTED TO PROVIDING VALUE FOR OUR CUSTOMERS.

First Coast Service Options, Inc. (First Coast) is committed to providing value for our customers. By that, we mean meeting customer expectations at the best possible price. Our primary customer, the Centers for Medicare & Medicaid Services (CMS), has very clear expectations: process Medicare claims timely and accurately, meet the service needs of Medicare beneficiaries and providers and diligently manage Medicare program finances. CMS properly expects that all this be done at the best possible price.

CLAIMS PROCESSING

As the primary traditional Medicare administrator in Florida, Puerto Rico and the U.S. Virgin Islands, we process millions of claims. We focus on the efficiency of our key business processes to continually improve transactional productivity for claims and inquiry processes every year. This improvement is driven by an organization-wide effort to ensure every aspect of claims processing facilitates accurate claims payment.

CUSTOMER SERVICE

First Coast is proud to serve America's seniors and people with disabilities as well as physicians and health care providers who care for them in Florida, Puerto Rico and the U.S. Virgin Islands. First Coast responds to inquiries mainly through our telephone call center in Jacksonville, Fla. To reinforce the critical role providers play in filing claims correctly, First Coast's nationally-recognized education and training department uses various methods, such as creative and high-tech curricula design, to reach our large, diverse health care providers' population throughout the nation.

GOOD STEWARDSHIP

Having nearly 50 years of experience in Florida, a state highly susceptible to Medicare fraud, has taught First Coast a lot about good stewardship. Over the years, First Coast has employed a wide range of payment safeguard tools that have saved billions of Medicare trust fund dollars, including playing a key role in fighting infusion drug and other fraud in South Florida, resulting in billions of Medicare program dollars saved.

CONTACT US SITE MAP

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Find fee schedules – fee schedule lookup

Complete this form to obtain Medicare fee-for-service allowances. You must select a fee schedule and enter a procedure code, location, and date of service.

*Required

Select fee schedule * Please select
Procedure code * A4556
Date of service * 5/11/2016
Location - locality * Please select

Submit Reset

More Information

- Help guide
- ASC payment indicators
- MPFS policy indicator definitions
- PDF, text, or Excel fee schedules
- Recent fee schedule news
- Search for LCDs
- National physician fee schedule lookup on CMS.gov
- Seasonal influenza vaccines pricing on CMS.gov

Results

Fee Schedule	MPFS	Procedure Code	A4556	Date Of Service	5/11/2016
State	FL	Locality	99	Modifier	
Record Effective Date	01/01/2016	Description	Electrodes, pair		

NON OPPS		OPPS	
NON FAC PAR	0.00	NON FAC PAR	0.00
NON FAC NON PAR	0.00	NON FAC NON PAR	0.00
NON FAC LC	0.00	NON FAC LC	0.00
NON FAC eRx LC	N/A	NON FAC eRx LC	N/A
NON FAC EHR LC	N/A	NON FAC EHR LC	N/A
NON FAC PQRS LC	N/A	NON FAC PQRS LC	N/A
NON FAC EHR PQRS LC	N/A	NON FAC EHR PQRS LC	N/A
NON FAC 2014 eRx/EHR LC	N/A	NON FAC 2014 eRx/EHR LC	N/A
NON FAC 2014 eRx/EHR PQRS LC	N/A	NON FAC 2014 eRx/EHR PQRS LC	N/A
FAC PAR	0.00	FAC PAR	0.00
FAC NON PAR	0.00	FAC NON PAR	0.00
FAC LC	0.00	FAC LC	0.00
FAC eRx LC	N/A	FAC eRx LC	N/A
FAC EHR LC	N/A	FAC EHR LC	N/A
FAC PQRS LC	N/A	FAC PQRS LC	N/A
FAC EHR PQRS LC	N/A	FAC EHR PQRS LC	N/A
FAC 2014 eRx/EHR LC	N/A	FAC 2014 eRx/EHR LC	N/A
FAC 2014 eRx/EHR PQRS LC	N/A	FAC 2014 eRx/EHR PQRS LC	N/A

Policy Indicators

Status	P	Conversion Factor	0.0
Global Surgery	XXX	Update Factor	0.0
Facility Pricing	9	Work RVU	0.0
PC/TC	9	FAC PE RVU	0.0
Preoperative Percentage	0.0	NON FAC PE RVU	0.0
Intraoperative Percentage	0.0	Malpractice RVU	0.0
Postoperative Percentage	0.0	Work GPCI	1.0
Multiple Surgery	9	Practice GPCI	0.96
Bilateral Surgery	9	Malpractice GPCI	1.315
Assistant At Surgery	9	MPPR	0.00
Two Surgeons	9	Anti-markup Test Indicator	9
Team Surgery	9		
Endoscopic Base			

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CMS

FIRST COAST
SERVICE OPTIONS, INC.

Last Modified: 4/4/2020 Location: FL, PR, USVI Business: Part B

Medicare physician fee schedule payment policy indicators

The information that follows provides definitions of national policy indicators for each procedure code (and modifier, where applicable) described by specific fields on the Centers for Medicare & Medicaid Services' (CMS) Medicare physician fee schedule database (MPFSDB).

- HCPC
- Modifier
- Code status
- Global surgery
- Preoperative, intraoperative, and postoperative percentages
- Professional component/technical component indicator (PC/TC)
- Multiple procedure - modifier 51
- Bilateral surgery - modifier 50
- Assistant at surgery
- Co-surgeons - modifier 62
- Team surgeons - modifier 66
- Physician supervision of diagnostic procedures
- Facility pricing
- Anti-markup test indicator

HCPC

This is the Current Procedural Terminology (CPT®) code assigned by the American Medical Association (AMA) or the Healthcare Common Procedure Coding System (HCPCS) code assigned by CMS for the procedure.

Modifier

For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components:

26 -- Professional component

TC -- Technical component

For services other than those with a professional and/or technical component, this field is blank with one exception: the presence of CPT® modifier 53 which indicates that separate relative value units (RVUs) and a fee schedule amount have been established for procedures which the physician terminated before completion. This modifier is used only with colonoscopy through stoma CPT® code 44388, colonoscopy CPT® code 45378 and screening colonoscopy codes G0105 and G0121. Any other codes billed with modifier 53 are subject to carrier medical review and priced by individual consideration.

> **Modifier 53** -- Discontinued procedure - Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.

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Code status

This field provides the fee schedule status of each code.

A -- Active code. These codes are separately paid under the physician fee schedule if covered. There are relative value units (RVUs) and payment amounts for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B -- Payment for covered services is always bundled into payment for other services not specified. There are no RVUs or payment amounts for these codes and no separate payment is ever made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).

C -- Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.

D* -- Deleted/discontinued codes.

E -- Excluded from physician fee schedule by regulation. These codes are for items and/or services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs or payment amounts are shown and no payment may be made under the fee schedule for these codes. Payment for them, when covered, continues under reasonable charge procedures.

F -- Deleted/discontinued codes. (Code not subject to a 90 day grace period.) These codes are deleted effective with the beginning of the year and are never subject to a grace period. This indicator is no longer effective with the 2005 fee schedule as of January 1, 2005.

G -- Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code subject to a 90-day grace period.) This indicator is no longer effective with the 2005 fee schedule as of January 1, 2005.

H* -- Deleted modifier. For 2000 and later years, either the technical component (TC) or professional component (PC) shown for the code has been deleted and the deleted component is shown in the data base with the H status.

I -- Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Code not subject to a 90-day grace period.)

J -- Anesthesia services (no relative value units or payment amounts for anesthesia codes on the database, only used to facilitate the identification of anesthesia services.)

L -- Local codes. Carriers will apply this status to all local codes in effect on January 1, 1998 or subsequently approved by central office for use. Carriers will complete the RVUs and payment amounts for these codes.

M -- Measurement codes, used for reporting purposes only.

N -- Non-covered service. These codes are carried on HCPCS as non-covered services.

P -- Bundled/excluded codes. There are no RVUs and no payment amounts for these services. No separate payment is made for them under the fee schedule.

If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician service).

If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (for example, colostomy supplies) and is paid under the other payment provision of the Social Security Act.

Q -- Therapy functional information code, used for required reporting purposes only. This indicator is no longer effective with the 2020 fee schedule as of January 1, 2020.

R -- Restricted coverage. Special coverage instructions apply.

T -- There are RVUs and payment amounts for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made.

X -- Statutory exclusion. These codes represent an item or service that is not in the statutory definition of "physician services" for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

* Codes with these indicators had a 90 day grace period before January 1, 2005.

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Global surgery

This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service.

000 -- Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.

010 -- Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable.

090 -- Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.

MMM -- Maternity codes; usual global period does not apply.

XXX -- Global concept does not apply

YYY -- Carrier determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.

ZZZ -- Code related to another service and is always included in the global period of the other service. (Note: Physician work is associated with intra-service time and in some instances the post-service time.)

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Preoperative, intraoperative, and postoperative percentages

- Preoperative percentage - modifier 56

  This field contains the percentage for the preoperative portion of the global package.

- Intraoperative percentage - modifier 54

  This field contains the percentage for the intraoperative portion of the global package including postoperative work in the hospital.

- Postoperative percentage - modifier 55

  This field contains the percentage for the postoperative portion of the global package that is provided in the office after discharge from the hospital.

The total of preoperative, intraoperative, and postoperative percentages will usually equal one. Any variance is slight and results from rounding.

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Professional component/technical component indicator (PC/TC)

0 -- Physician service codes: This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 and TC cannot be used with these codes. The total RVUs include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.

1 -- Diagnostic tests or radiology services: This indicator identifies codes that describe diagnostic tests (e.g., pulmonary function tests), or therapeutic radiology procedures (e.g., radiation therapy). These codes generally have both a professional and technical component. Modifiers 26 and TC can be used with these codes.

The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense.

The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component.

2 -- Professional component only codes: This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test.

An example of a professional component only code is 93010, Electrocardiogram; interpretation and report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.

3 -- Technical component only codes: This indicator identifies stand alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only.

An example of a technical component code is CPT® code 93005, Electrocardiogram, tracing only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes.

The total RVUs for technical component only codes include values for practice expense and malpractice expense only.

4 -- Global test only codes: This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined.

5 -- Incident to codes: This indicator identifies codes that describe services covered incident to a physicians service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision.

Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes.

6 -- Laboratory physician interpretation codes: This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense.

7 -- Physical therapy service: Payment may not be made if the service is provided to either a hospital outpatient or inpatient by an independently practicing physical or occupational therapist.

8 -- Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies only to code 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate.

No payment is recognized for code 85060 furnished to hospital outpatients or non- hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.

9 -- Concept of a professional/technical component does not apply.

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Multiple procedure - modifier 51

This field indicates which payment adjustment rule for multiple procedures applies to the service.

0 -- No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure.

1 -- Standard payment adjustment rules in effect before January 1, 1996, or multiple procedures apply. In the 1996 MPFSDB, this indicator only applies to codes with procedure status of "D." If a procedure is reported on the same day as another procedure with an indicator of 1,2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 25 percent, 25 percent, 25 percent, and by

report). Payment is based on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

2 -- Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Payment is based on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

3 -- Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure).

Multiple endoscopy rules are applied to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure).

If an endoscopic procedure is reported with only its base procedure, carriers do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy.

4 -- Subject to 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006, through June 30, 2010). Subject to 50% reduction of the TC diagnostic imaging (effective for services July 1, 2010, and after). Subject to 25% reduction of the PC of diagnostic imaging (effective for services January 1, 2012, and after). Subject to 5% reduction of the PC of diagnostic imaging (effective for services January 1, 2017, and after).

5 -- Subject to 20% reduction of the practice expense component for certain therapy services (effective for services January 1, 2011, through March 31, 2013). Subject to 50% reduction of the practice expense component for certain therapy services (effective for services April 1, 2013, and after).

6 -- Subject to 25% reduction of the TC diagnostic cardiovascular services (effective for services January 1, 2013, and after).

7 -- Subject to 20% reduction of the TC diagnostic ophthalmology services (effective for services January 1, 2013, and after).

9 -- Concept does not apply.

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Bilateral surgery - modifier 50

This field provides an indicator for services subject to a payment adjustment.

0 -- 150 percent payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base payment for the two sides on the lower of: (a) the total actual charge for both sides or (b) 100 percent of the fee schedule amount for a single code.

Example: The fee schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100 and XXXXX-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200).

The bilateral adjustment is inappropriate for codes in this category because of (a) physiology or anatomy or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.

1 -- 150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), contractors base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code

If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules.

2 -- 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers with a 2 in the units field), contractors base payment for both sides on the lower of (a) the total actual charges by the physician for both sides or (b) 100 percent of the fee schedule amount for a single code.

Example: The fee schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100. Payment would be based on the fee schedule amount ($125) since it is lower than the total actual charges for the left and right sides ($200).

The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure.

3 -- The usual payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), contractors base payment for each side or organ or site of a paired organ on the lower of: (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side. If procedure is reported as a bilateral procedure and with other procedure codes on the same day, contractors determine the fee schedule amount for a bilateral procedure before applying eny applicable multiple procedure rules.

Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures.

9 -- Concept does not apply.

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Assistant at surgery

This field provides an indicator for services where an assistant at surgery is never paid for per the CMS Internet-only manual.

0 -- Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.

1 -- Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.

2 -- Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.

9 -- Concept does not apply.

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Co-surgeons - modifier 62

This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid.

0 -- Co-surgeons not permitted for this procedure.

1 -- Co-surgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure.

2 -- Co-surgeons permitted; no documentation required if two specialty requirements are met.

9 -- Concept does not apply.

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Team surgeons - modifier 66

This field provides an indicator for services for which team surgeons may be paid.

0 -- Team surgeons not permitted for this procedure.

1 -- Team surgeons could be paid; supporting documentation required to establish medical necessity of a team; pay by report.

2 -- Team surgeons permitted; pay by report.

9 -- Concept does not apply.

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Physician supervision of diagnostic procedures

This field provides levels of physician supervision required for diagnostic tests payable under the physician fee schedule.

General supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

Direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

Personal supervision means a physician must be in attendance in the room during the performance of the procedure.

01 -- Procedure must be performed under the general supervision of a physician.

02 -- Procedure must be performed under the direct supervision of a physician.

03 -- Procedure must be performed under the personal supervision of a physician.

04 -- Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist; otherwise must be performed under the general supervision of a physician.

05 -- Not subject to supervision when furnished personally by a qualified audiologist, physician or nonphysician practitioner. Direct supervision by a physician is required for those parts of the test that may be furnished by a qualified technician when appropriate to the circumstances of the test.

06 -- Procedure must be performed by a physician or a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under state law.

21 -- Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician.

22 -- May be performed by a technician with on-line real-time contact with physician.

66 -- May be performed by a physician or by a physical therapist with ABPTS certification and certification in this specific procedure.

6A -- Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill.

77 -- Procedure must be performed by a PT with ABPTS certification or by a PT without certification under direct supervision of a physician, or by a technician with certification under general supervision of a physician.

7A -- Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT, but only the PT with ABPTS certification may bill.

09 -- Concept does not apply.

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Facility pricing

Facility fees are calculated at a national level with a reduced practice expense because of reduced physician overhead associated with services provided in a facility.

Place of service (POS) codes to be used to identify facilities are:

19 -- Off campus-outpatient hospital

21 -- Inpatient hospital

22 -- On campus-outpatient hospital

23 -- Emergency room-hospital

24 -- Ambulatory surgical center - In a Medicare approved ASC, for an approved procedure on the ASC list, Medicare pays the lower facility fee to physicians. Beginning with dates of service January 1, 2008, in a Medicare approved ASC, for procedures NOT on the ASC list of approved procedures, contractors will also pay the lower facility fee to physicians.

26 -- Military treatment facility

31 -- Skilled nursing facility

34 -- Hospice

41 -- Ambulance -- land

42 -- Ambulance air or water

51 -- Inpatient psychiatric facility

52 -- Psychiatric facility partial hospitalization

53 -- Community mental health center

56 -- Psychiatric residential treatment facility

61 -- Comprehensive inpatient rehabilitation facility

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Anti-markup test indicator

This field providers an indicator for anti-markup test codes.

1-- Anti-markup test HCPCS.

9 -- Concept does not apply.

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Source: CR 11453

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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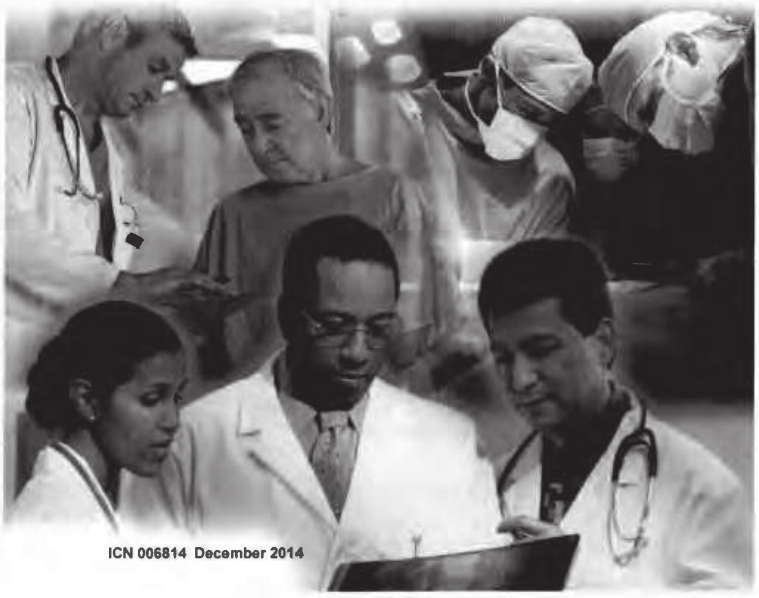
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official Information Health Care Professionals Can Trust

Medicare Physician Fee Schedule

PAYMENT SYSTEM FACT SHEET SERIES



ICN 006814 December 2014

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

This publication provides the following information about the Medicare Physician Fee Schedule (PFS):

- Physician services;
- Medicare PFS payment rates; and
- Resources.

Physician Services

Medicare Part B pays for physician services based on the Medicare PFS, which lists the more than 7,400 unique covered services and their payment rates. Physicians' services include the following:

- Office visits;
- Surgical procedures;
- Anesthesia services; and
- A range of other diagnostic and therapeutic services.

Physicians' services are furnished in all settings including:

- Physicians' offices;
- Hospitals;
- Ambulatory Surgical Centers;
- Skilled Nursing Facilities and other post-acute care settings;
- Hospices;
- Outpatient dialysis facilities;
- Clinical laboratories; and
- Beneficiaries' homes.

Medicare PFS Payment Rates

Payment rates for an individual service are based on the following components as shown in the Medicare PFS payment rates formula on page 3:

1) Relative Value Units (RVUs);
   - Work RVU;
   - Practice Expense (PE) RVU; and
   - Malpractice (MP) RVU;
2) Conversion Factor (CF); and
3) Geographic Practice Cost Indices (GPCIs).

Exhibit 6

Medicare PFS Payment Rates Formula

Each component of the Medicare PFS payment rates formula is discussed in more detail below.

1) Relative Value Units (RVUs)

Three separate RVUs are associated with the calculation of a payment under the Medicare PFS:

- **The Work RVU** reflects the relative time and intensity associated with furnishing a Medicare PFS service and accounts for approximately 50 percent of the total payment associated with a service;
- **The PE RVU** reflects the costs of maintaining a practice (such as renting office space, buying supplies and equipment, and staff costs); and
- **The MP RVU** reflects the costs of malpractice insurance.

2) Conversion Factor (CF)

To determine the payment rate for a particular service, each of the three separate RVUs is adjusted by the corresponding GPCI. The sum of the geographically adjusted RVUs is multiplied by a dollar CF. The statute specifies the formula by which the CF is updated on an annual basis.

The formula specifies that the update for a year is equal to the Medicare Economic Index (MEI) adjusted up or down depending on how actual expenditures compare to a target rate called the Sustainable Growth Rate (SGR). The MEI is a measure of inflation faced by physicians with respect to their practice costs and general wage levels.

The SGR is calculated based on:

- Medical inflation;
- Projected growth in the domestic economy;
- Projected growth in the number of beneficiaries in Fee-For-Service Medicare; and
- Changes in law or regulation.

However, in recent years, Congress took action to establish a specific update amount.

3) Geographic Practice Cost Indices (GPCIs)

GPCIs are adjustments that are applied to each of the three relative values used in calculating a physician payment, as described above. The purpose of these adjustments is to account for geographic variations in the costs of practicing medicine in different areas within the country.

You can use the Physician Fee Schedule Search Tool located at http://www.cms.gov/apps/physician-fee-schedule on the Centers for Medicare & Medicaid Services (CMS) website to obtain national and local payment rates. The Medicare Learning Network® (MLN) publication titled "How to Use The Searchable Medicare Physician Fee Schedule (MPFS)" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How_to_MPFS_Booklet_ICN901344.pdf on the CMS website provides information on how to use the Physician Fee Schedule Search Tool.

Resources

The chart below provides Medicare PFS resource information.

Medicare Physician Fee Schedule Resources

For More Information About...	Resource
Medicare Physician Fee Schedule	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched on the CMS website
Medicare Physician Fee Schedule Proposed and Final Rules	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html on the CMS website
All Available MLN Products	"MLN Catalog" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLN Catalog.pdf on the CMS website or scan the Quick Response (QR) code on the right
Provider-Specific Medicare Information	MLN publication titled "MLN Guided Pathways: Provider Specific Medicare Resources" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website
Medicare Information for Beneficiaries	http://www.medicare.gov on the CMS website

This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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Your feedback is important to us and we use your suggestions to help us improve our educational products, services and activities and to develop products, services and activities that better meet your educational needs. To evaluate Medicare Learning Network® (MLN) products, services and activities you have participated in, received, or downloaded, please go to http://go.cms.gov/MLNProducts and in the left-hand menu click on the link called '*MLN* Opinion Page' and follow the instructions. Please send your suggestions related to MLN product topics or formats to MLN@cms.hhs.gov.

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Check out CMS on:

CY 2015 Final Rule
Physician Fee Schedule
(CMS-1612-FC)
Direct Practice Expense Inputs Used To Create
Resource-Based Practice Expense Relative Value Units

This document contains descriptions of the various inputs used in the calculation of the practice expense (PE) relative value units (RVUs) that appear in the Final Rule (CMS-1612-FC) for CY 2015.[1] There are three different types of direct PE inputs: clinical labor, disposable medical supplies, and medical equipment valued at $500 or more.

The sources of these direct PE inputs are from one of the following:

1. Clinical Practice Expert Panels (CPEPs) convened in 1995 to develop estimates of the different types of resource inputs necessary to perform medical services;
2. A crosswalk to a related service developed based upon a clinical opinion by CMS;
3. The AMA's Relative Value Update Committee (RUC);
4. Refinement of the CPEP inputs by the AMA's Practice Expense Advisory Committee (PEAC) or the Practice Expense Review Committee (PERC) (which replaced the PEAC in September 2004) or the RUC Practice Expense Subcommittee (which took over the PERC's role in September 2007);
5. CMS; or
6. A medical specialty society.

DATA FILES

The five direct PE data files are the most current files available and are subject to change based upon CMS and RUC analysis. Each file is provided in both Microsoft Excel and comma separated value formats.

The data files contain one separate and unique record for each procedure code, including the resource input type (clinical labor, medical supplies, and medical equipment).

Three of the files contain the direct PE inputs for:

1. *Clinical Labor*;
2. *Medical Supplies*; and
3. *Medical Equipment*.

The fourth file contains the *Summary DPEI Output Table* contains summary cost information from each direct input data file for every CPT code, including when filled with modifiers TC, 26, or 53, for the non-facility and facility setting, as appropriate.

[1] In previous years, we have displayed recommended inputs even when these inputs are not used in the calculation of the PE RVUs. We note that we are no longer displaying such inputs in these public use files since they are not used in the calculation of the PE RVUs that appear in the final rule.

There is also a fifth file included for this final rule, which provides a detailed breakout of the clinical labor tasks for the clinical labor inputs. As discussed in II.A.3.c of the final rule, we have revised the direct PE input database to include task-level clinical labor time information for every code in the database. We are displaying this information as we attempt to increase the transparency of the direct PE database. This modification will enable us to more accurately allocate equipment minutes to clinical labor tasks in a more consistent and efficient manner for procedure codes reviewed for CY 2015 and after.

DATA ELEMENTS

The following tables provide data definitions for the various data elements included in the first four direct PE input tables described above.

1) The *Clinical Labor* file contains the following data elements:

PFS CY 2015 Data Elements	Description
HCPCS	The CPT or alpha-numeric HCPCS number for the service.
Source	Identifies the source of the resource inputs: the PEAC, RUC, CMS, a crosswalk by CMS, or a medical specialty society.
Labor Code	The code for the type of clinical labor.
Description	Specific description of the type of clinical labor.
Rate per Minute	Rate per minute for the type of clinical labor.
NF Pre Svc	Clinical labor time associated with pre-service period when the service is performed in a non-facility setting.
NF Svc	Clinical labor time associated with the service period when the service performed in a non-facility setting.
NF Post Svc	Clinical labor time associated with the post-service period when the service is performed in a non-facility setting.
F Pre Svc	Clinical labor time associated with pre-service period when the service is performed in a facility setting.
F Svc	Clinical labor time associated with the service period when the service performed in a facility setting.
F Post Svc	Clinical labor time associated with the post-service period when the service is performed in a facility setting.
Global	The global period associated with the service.
Reference Code	Identifies a reference code used to crosswalk practice expense inputs for the service.
RUC Meeting	Identifies the RUC meeting date or RUC Recommendation year when the code/service was refined.
RUC Tab	Identifies the associated tab of the RUC Recommendation book when code/service was refined.

Exhibit 7

2) The *Medical Supplies* file contains the following data elements:

PFS CY 2015 Data Elements	Description
HCPCS	The CPT or alpha-numeric HCPCS number for the service.
Source	Identifies the source of the resource inputs: the PEAC, RUC, CMS, a crosswalk by CMS, or a medical specialty society.
Category	General description of the medical supply category.
CMS Code	The CMS code identifying the specific type of medical supply.
Description	Specific description of the medical supply.
Unit	Unit of measure for the medical supply.
Price	Invoice or other validated price.
NF Quantity	Quantity of the medical supply used for the service in the non-facility setting.
F Quantity	Quantity of the medical supply used for the service in the facility setting.
Global	The global period associated with the service.
Reference Code	Identifies a reference code used to crosswalk practice expense inputs for the service.
RUC Meeting	Identifies the RUC meeting date or RUC Recommendation year when the code/service was refined.
RUC Tab	Identifies the associated tab of the RUC Recommendation book when code/service was refined.

3) The *Medical Equipment* file contains the following data elements:

PFS CY 2015 Data Elements	Description
HCPCS	The CPT or alpha-numeric HCPCS number for the service.
Source	Identifies the source of the resource inputs: the PEAC, RUC, CMS, a crosswalk by CMS, or a medical specialty society.
Category	General description of the medical equipment category.
CMS Code	The CMS code identifying the specific type of medical equipment.
Description	Specific description of the medical equipment.
Useful Life	Useful life of the medical equipment.
Price	Invoice or other validated price.
NF Time	The time associated with use of the medical equipment in the non-facility setting.
F Time	The time associated with use of the medical equipment in the facility setting.
Global	The global period associated with the service.
Reference Code	Identifies a reference code used to crosswalk practice expense inputs for the service.
RUC Meeting	Identifies the RUC meeting date or RUC Recommendation year when the code/service was refined.
RUC tab	Identifies the associated tab of the RUC Recommendation book when code/service was refined.

4) The *Summary DPEI Output Table* file contains the following data elements:

PFS CY 2015 Data Elements	Description
HCPCS	The CPT or alpha-numeric HCPCS number for the service.
Modifier	TC, 26, or 53 modifier associated with the service.
HCPCSMOD	Combination of the HCPCS and Modifier.
Need PE	Indicates whether the service requires a practice expense RVU.
Need NF PE	Indicates whether the service requires a practice expense RVU in the non-facility setting.
Need F PE	Indicates whether the service requires a practice expense RVU in the facility setting.
NF Pre Svc Cost	The total cost of the clinical labor time associated with pre-service period when the service is performed in a non-facility setting.
NF Svc Cost	The total cost of the clinical labor time associated with the service period when the service performed in a non-facility setting.
NF Post Svc Cost	The total cost of the clinical labor time associated with the post-service period when the service is performed in a non-facility setting.
F Pre Svc Cost	The total cost of the clinical labor time associated with pre-service period when the service is performed in a facility setting.
F Svc Cost	The total cost of the clinical labor time associated with the service period when the service performed in a facility setting.
F Post Svc Cost	The total cost of the clinical labor time associated with the post-service period when the service is performed in a facility setting.
NF Supply Cost	The total cost of the medical supplies associated with the service when performed in the non-facility setting.
F Supply Cost	The total cost of the medical associated with the service when performed in the facility setting.
NF Equipment Cost	The total cost of the medical equipment associated with the service when performed in the non-facility setting.
F Equipment Cost	The total cost of the medical equipment associated with the service when performed in the facility setting.

5) The *Clinical Labor Task Detail* file contains the following data elements:

PFS CY 2015 Data Elements	Description
HCPCS Code	The CPT or alpha-numeric HCPCS number for the service.
HCPCS Code Description	Specific HCPCS short-descriptor for the service performed.

Period	Shows the clinical labor tasks performed within each phase of the service period: Pre-Service Period Service Period: Pre-Service Service Period: Intra-Service Service Period: Post-Service Post-Service Period
Labor Code	The code for the type of clinical labor.
Description	Specific description of the type of clinical labor.
Labor Code Cost Per Minute	Rate per minute for the type of clinical labor.
Labor Activity	Detailed description of the clinical labor task performed.
Non-facility Minutes	Clinical labor time associated with the described clinical labor task when the service is performed in a non-facility setting.
Facility Minutes	Clinical labor time associated with the described clinical labor task when the service is performed in a facility setting.

NOTE: CPT codes and descriptions only are copyright 2014 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

hcpcs	source	category	cms_ code	description	unit	price	nf_ quantity	f_ quantity	global_ period	reference _code	ruc_ meeting	ruc_tab
G0281	RUC	Office Supply, Grocery	SK068	razor	item	0.389	1		XXX			
G0283	RUC	Gown, Drape	SB022	gloves, non-sterile	pair	0.084	1		XXX			
G0283	RUC	Accessory, Procedure	SD055	electrode, electrical stimulation	item	1.312	2		XXX			
G0283	RUC	Wound Care, Dressings	SG079	tape, surgical paper 1in (Micropore)	inch	0.002	6		XXX			
G0283	RUC	Pharmacy, NonRx	SJ024	electrolyte coupling gel	ml	0.016	1		XXX			
G0283	RUC	Pharmacy, NonRx	SJ053	swab-pad, alcohol	item	0.013	1		XXX			
G0283	RUC	Office Supply, Grocery	SK068	razor	item	0.389	1		XXX			
G0329	RUC	Gown, Drape	SB044	underpad 2ft x 3ft (Chux)	item	0.23	1		XXX			

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

Table of Contents
(Rev. 3096, 10-17-14)

Those requiring "By Report" payment or carrier pricing; and

Those that are not included in the definition of physicians' services.

For services with national codes but for which national relative values have not been provided, carriers must establish local relative values (to be multiplied, in the carrier system, by the national CF), as appropriate, or establish a flat local payment amount. Carriers may choose between these options.

The "By Report" services (with national codes or modifiers) include services with codes ending in 99, team surgery services, unusual services, pricing of the technical component for positron emission tomography reduced services, and radio nuclide codes A4641 and 79900. The status indicators of the Medicare fee schedule database identify these specific national codes and modifiers that carriers are to continue to pay on a "By Report" basis. Carriers may not establish RVUs for them. Similarly, carriers may not establish RVUs for "By Report" services with local codes or modifiers.

Additionally, carriers do not establish fees for noncovered services or for services always bundled into another service. The MPFSDB identifies noncovered national codes and codes that are always bundled.

A. Diagnostic Procedures and Other Codes With Professional and Technical Components

For diagnostic procedure codes and other codes describing services with both professional and technical components, relative values are provided for the global service, the professional component, and the technical component. The CMS makes the determination of which HCPCS codes fall into this category.

B. No Special RVUs for Limited License Practitioners

There are no special RVUs for limited license physicians, e.g., optometrists and podiatrists. The fee schedule RVUs apply to a service regardless of whether a medical doctor, doctor of osteopathy, or limited license physician performs the service. Carriers may not restrict either physicians, independently practicing physical therapists, and/or other providers of covered services by the use of these codes.

20.3 - Bundled Services/Supplies

(Rev. 147, 04-23-04)

There are a number of services/supplies that are covered under Medicare and that have HCPCS codes, but they are services for which Medicare bundles payment into the payment for other related services. If carriers receive a claim that is solely for a service or supply that must be mandatorily bundled, the claim for payment should be denied by the carrier.

A. Routinely Bundled

Exhibit 8

Separate payment is never made for routinely bundled services and supplies. The CMS has provided RVUs for many of the bundled services/supplies. However, the RVUs are not for Medicare payment use. Carriers may not establish their own relative values for these services.

B. Injection Services

Injection services (codes 90782, 90783, 90784, 90788, and 90799) included in the fee schedule are not paid for separately if the physician is paid for any other physician fee schedule service rendered at the same time. Carriers must pay separately for those injection services only if no other physician fee schedule service is being paid. In either case, the drug is separately payable. If, for example, code 99211 is billed with an injection service, pay only for code 99211 and the separately payable drug. (See section 30.6.7.D.) Injection services that are immunizations with hepatitis B, pneumococcal, and influenza vaccines are not included in the fee schedule and are paid under the drug pricing methodology as described in Chapter 17.

C. Global Surgical Packages

The MPFSDB lists the global charge period applicable to surgical procedures.

D. Intra-Operative and/or Duplicate Procedures

Chapter 23 and §30 of this chapter describe the correct coding initiative (CCI) and policies to detect improper coding and duplicate procedures.

E. EKG Interpretations

For services provided between January 1, 1992, and December 31, 1993, carriers must not make separate payment for EKG interpretations performed or ordered as part of, or in conjunction with, visit or consultation services. The EKG interpretation codes that are bundled in this way are 93000, 93010, 93040, and 93042. Virtually, all EKGs are performed as part of or ordered in conjunction with a visit, including a hospital visit.

If the global code is billed for, i.e., codes 93000 or 93040, carriers should assume that the EKG interpretation was performed or ordered as part of a visit or consultation. Therefore, they make separate payment for the tracing only portion of the service, i.e., code 93005 for 93000 and code 93041 for 93040. When the carrier makes this assumption in processing a claim, they include a message to that effect on the Medicare Summary Notice (MSN).

For services provided on or after January 1, 1994, carriers make separate payment for an EKG interpretation.

20.4 - Summary of Adjustments to Fee Schedule Computations

(Rev. 1931, Issued: 03-12-10, Effective: 06-14-10, Implementation: 06-14-10)

subject to the assistant-at-surgery policy. Accordingly, pay claims for procedures with these modifiers only if the services of an assistant-at-surgery are authorized.

Medicare's policies on billing patients in excess of the Medicare allowed amount apply to assistant-at-surgery services. Physicians who knowingly and willfully violate this prohibition and bill a beneficiary for an assistant-at-surgery service for these procedures may be subject to the penalties contained under §1842(j)(2) of the Social Security Act (the Act.) Penalties vary based on the frequency and seriousness of the violation.

20.4.4 - Supplies

(Rev. 1, 10-01-03)

B3-15900.2

Carriers make a separate payment for supplies furnished in connection with a procedure only when one of the two following conditions exists:

A. HCPCS code A4300 is billed in conjunction with the appropriate procedure in the Medicare Physician Fee Schedule Data Base (place of service is physician's office). However, A4550, A4300, and A4263 are no longer separately payable as of 2002. Supplies have been incorporated into the practice expense RVU for 2002. Thus, no payment may be made for these supplies for serviced provided on or after January 1, 2002.

B. The supply is a pharmaceutical or radiopharmaceutical diagnostic imaging agent (including codes A4641 through A4647); pharmacologic stressing agent (code J1245); or therapeutic radionuclide (CPT code 79900). Other agents may be used which do not have an assigned HCPCS code. The procedures performed are:

- Diagnostic radiologic procedures (including diagnostic nuclear medicine) requiring pharmaceutical or radiopharmaceutical contrast media and/or pharmacologic stressing agent;
- Other diagnostic tests requiring a pharmacologic stressing agent;
- Clinical brachytherapy procedures (other than remote after-loading high intensity brachytherapy procedures (CPT codes 77781 through 77784) for which the expendable source is included in the TC RVUs); or
- Therapeutic nuclear medicine procedures.

Drugs are not supplies, and may be paid incidental to physicians' services as described in Chapter 17.

20.4.5 - Allowable Adjustments

(Rev. 1, 10-01-03)

Medicare Claims Processing Manual
Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Table of Contents
(Rev. 3196, 02-13-15)

Transmittals for Chapter 20

Skilled Nursing Facilities, CORFs, OPTs, and hospitals bill the FI for prosthetic/orthotic devices, supplies, and covered outpatient DME and oxygen (refer to §40). The HHAs may bill Durable Medical Equipment (DME) to the RHHI, or may meet the requirements of a DME supplier and bill the DME MAC. This is the HHA's decision. Fiscal Intermediaries (FIs) other than RHHIs will receive claims only for the class "Prosthetic and Orthotic Devices."

Unless billing to the FI is required as outlined in the preceding paragraph, claims for implanted DME, implanted prosthetic devices, replacement parts, accessories and supplies for the implanted DME must be billed to the local carriers/MACs and not the DME MAC. The Healthcare Common Procedure Coding System (HCPCS) codes that describe these categories of service are updated annually in late spring. All other DMEPOS items are billed to the DME MAC. See the Medicare Claims Processing Manual, Chapter 23, §20.3 for additional information.

Parenteral and enteral nutrition, and related accessories and supplies, are covered under the Medicare program as a prosthetic device. See the Medicare Benefit Policy Manual, Chapter 15, for a description of the policy. All Parenteral and Enteral (PEN) services furnished under Part B are billed to the DME MAC. If a provider (see §01) provides PEN items under Part B it must qualify for and receive a supplier number and bill as a supplier. Note that some PEN items furnished to hospital and SNF inpatients are included in the Part A PPS rate and are not separately billable. (If a service is paid under Part A it may not also be paid under Part B.)

10.1 - Definitions
(Rev. 1, 10-01-03)
A3-3313.1, B3-2100.1, HHA-220.1, HO-235.1, SNF-264.1

10.1.1 - Durable Medical Equipment (DME)
(Rev. 1, 10-01-03)

DME is covered under Part B as a medical or other health service (§1861(s)(6) of the Social Security Act [the Act]) and is equipment that:

a. Can withstand repeated use;

b. Is primarily and customarily used to serve a medical purpose;

c. Generally is not useful to a person in the absence of an illness or injury; and

d. Is appropriate for use in the home.

All requirements of the definition must be met before an item can be considered to be durable medical equipment.

A SNF normally is not considered a beneficiary's home. However, a SNF can be considered a beneficiary's home for Method II home dialysis purposes. See the Program Integrity Manual, Chapter 5, for guidelines on when a SNF may be considered a home.

Exhibit 9

Chapter 9 Contents

Introduction

In this chapter, you will find information regarding DMEPOS benefit categories, the DME MAC Medical Review Department, medical policies, Advance Determination of Medicare Coverage (ADMC) process, and Prior Authorization of Power Mobility Equipment. In order for any item to be covered by the DME MAC, it must fall into one of the benefit categories defined below. The medical policies used by the DME MAC to make coverage determinations may be either national or local. The national policies can be found on the CMS website in the ***Medicare National Coverage Determinations Manual*** and in the ***Medicare Benefit Policy Manual***. Both of these manuals can be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html. The local policies can be found in Local Coverage Determinations (LCDs), which are available at http://www.cgsmedicare.com/jc/coverage/LCDinfo.html. See the "Medical Policies" section below for more specific information.

1. DMEPOS Benefit Categories

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, §§60.6.1-60.6 &110-140
CMS Manual System, Pub. 100-03, *Medicare National Determinations Manual*, Chapter 1, §180

All Medicare Part B covered services processed by the DME MAC fall into one of the following benefit categories specified in the Social Security Act (§1861(s)):

1. Durable medical equipment (DME)
2. Prosthetic devices (including nutrition)
3. Leg, arm, back and neck braces (orthoses) and artificial leg, arm and eyes, including replacement (prostheses)
4. Surgical dressings
5. Immunosuppressive drugs
6. Therapeutic shoes for diabetics
7. Oral anticancer drugs
8. Oral antiemetic drugs (replacement for intravenous antiemetics)
9. Intravenous immune globulin

General definitions and coverage issues relating to the preceding categories are listed below.

Durable Medical Equipment (DME)

Durable medical equipment is equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an illness or injury, and (d) is appropriate for use in the home.

Supplies and accessories that are necessary for the effective use of medically necessary DME are covered. Supplies may include drugs and biologicals that must be put directly into the equipment in order to achieve the therapeutic benefit of the DME or to assure the proper functioning of the equipment.

Repairs, skilled maintenance, and replacement of medically necessary DME are covered.

Prosthetic Devices

Prosthetic devices are items which replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ. The test of permanence is considered met if the medical record, including the judgment of the attending physician, indicates that the condition is of long and indefinite duration.

In addition to artificial arms and legs, coverage under this benefit includes, but is not limited to, breast prostheses, eye prostheses, parenteral and enteral nutrition, ostomy supplies, urological supplies in patients with permanent urinary incontinence, and glasses or contact lenses in patients with aphakia or pseudophakia.

Enteral and Parenteral Nutrition therapy is covered under the prosthetic device benefit provision, which requires that the patient must have a permanently inoperative internal body organ or function thereof.

Supplies that are necessary for the effective use of a medically necessary prosthetic device are covered. Equipment, accessories, and supplies (including nutrients) which are used directly with an enteral or parenteral nutrition device to achieve the therapeutic benefit of the prosthesis or to assure the proper functioning of the device are covered.

Repairs, adjustments, and replacement of medically necessary prosthetic devices are covered.

Dental prostheses (i.e., dentures) are excluded from coverage. Claims for internal prostheses (e.g., intraocular lens, joint implants, etc.) are not processed by the DME MAC.

Braces (Orthotics)

A brace is a rigid or semi-rigid device that is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. The orthotic benefit for braces is limited to leg, arm, back, and neck, and used independently, rather than in conjunction with, or as components of, other medical or non-medical equipment. Accessories used in conjunction with, and necessary for the full functioning of, durable medical equipment fall under the durable medical equipment benefit. You must not use L-codes or miscellaneous codes to bill for items that are components of, or used in conjunction with, wheelchairs. These items are correctly billed using the appropriate wheelchair accessory codes.

Repairs, adjustments, and replacement of medically necessary braces are covered.

Exhibit 10

Chapter 5 Contents

Introduction – DMEPOS Fee Schedule Categories

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30

Reimbursement for most durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) is established by fee schedules. Payment is limited to the lower of the actual charge or the fee schedule amount. See Chapter 10 of this manual for more information about fee schedules and pricing.

The fee schedule classifies most DMEPOS into one of the six categories explained below:

- Inexpensive or other routinely purchased DME (IRP)
- Items requiring frequent and substantial servicing
- Customized items
- Other prosthetic and orthotic devices
- Capped rental items
- Oxygen and oxygen equipment

To determine in which category a specific HCPCS code is classified, see *Appendix-A HCPCS* at the end of this manual.

1. Inexpensive or Other Routinely Purchased DME (IRP)

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.1

Payment for this type of equipment is made for rental or lump sum purchase, depending on the beneficiary's choice. The total payment amount may not exceed the actual charge or the fee for a purchase.

- Inexpensive DME
  This category is defined as equipment whose purchase price does not exceed $150.

guidelines specified in Local Coverage Determination. It is important to note that just because a beneficiary qualified for oxygen under a Medicare Advantage Plan does not necessarily mean that he or she will qualify for oxygen under FFS. These instructions apply whether a beneficiary voluntarily returns to FFS or if he/she involuntarily returns to FFS because their Medicare Advantage Plan no longer participates in the Medicare+Choice program.

You should maintain open communication with beneficiaries and determine, prior to delivery of an item or continued rental, whether there has been a change in enrollment from a Medicare Advantage Plan to FFS Medicare. You may contact our Interactive Voice Response (IVR) unit at 866.238.9650 to determine if a beneficiary is enrolled in a Medicare Advantage Plan.

8. Supplies and Accessories Used with Beneficiary-Owned Equipment

For supplies and accessories used with beneficiary-owned equipment (equipment that is owned by the beneficiary, but was not paid for by the DME MAC/fee-for-service Medicare), all of the following information must be submitted with the initial claim in Item 19 on the CMS-1500 claim form or in the NTE segment for electronic claims:

- HCPCS code of base equipment
- A notation that this equipment is beneficiary-owned
- Date the patient obtained the equipment

Claims for supplies and accessories must include all three pieces of information listed above. Claims lacking any one of the above elements will be denied for missing information.

Medicare requires that supplies and accessories only be provided for equipment that meets the existing coverage criteria for the base item. In addition, if the supply or accessory has additional, separate criteria, these must also be met. In the event of a documentation request from the DME MAC or a redetermination request, you should provide information justifying the medical necessity for the base item and the supplies and/or accessories. Refer to the applicable Local Coverage Determination(s) and related Policy Article(s) for information on the relevant coverage, documentation, and coding requirements at http://www.cgsmedicare.com/jc/coverage/LCDinfo.html.

9. Repairs, Maintenance, and Replacement

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, §§110.2(A) – 110.2(C)

Under the circumstances specified below, payment may be made for repair, maintenance, and replacement of medically required DME, including equipment which had been in use before the beneficiary enrolled in Part B of the Medicare program. **Payments for repair and maintenance may not include payment for parts and labor covered under a manufacturer's or supplier's warranty.**

A – Repairs

To repair means to fix or mend and to put the equipment back in good condition after damage or wear. Repairs to equipment which a beneficiary owns are covered when necessary to make the equipment serviceable. If the expense for repairs exceeds the estimated expense of purchasing or

Exhibit 11

Level II HCPCS Codes

The following is a list of Level II HCPCS codes. The list includes the code descriptions, payment category (also known as "fee schedule category"—see Chapter 5 of this manual for information), and DME MAC Certificate of Medical Necessity (CMN) or DME MAC Information Form (DIF) number required where applicable. The appearance of a code below does not necessarily indicate that the item is covered by Medicare.

NOTE: Although a CMN may not be required for certain supplies, a CMN may be required for the related piece of equipment. Please refer to the Documentation Requirements in the appropriate Local Coverage Determination (LCD) for more information regarding CMN requirements.

Use the following hyperlinks for easy navigation to each HCPCS section:

HCPCS A

Top

The following chart contains definitions of the category numbers listed with the HCPCS codes below.

Payment Category					
1	Capped Rental	8	Parenteral/Enteral Supplies and Kits	15	Nebulizer Drugs
2	Freq. & Substantial Serv. DME	9	Parenteral/Enteral Pumps	16	Therapeutic Shoes for Diabetics
3	Customized DMEPOS	10	Immunosuppressive Drugs	17	Individual Consideration
4	Prosthetics/Orthotics	11	Ostomy, Trach., & Urologicals	18	Epoetin (EPO)
5	Inexp. & Routinely Purch. DME	12	Surgical Dressings	19	Dialysis Supplies & Equipment
6	Oxygen and Oxygen Equipment	13	Supplies	20	Oral Antiemetic Drugs
7	Parenteral/Enteral Nutrients	14	Not Otherwise Classified		

A4535	Disposable liner/shield for incontinence, each (Eff. Date 1/1/2003) (Deleted eff. 12/31/2004)		
A4536	Protective underwear, washable, any size, each (Eff. Date 1/1/2003) (Deleted eff. 12/31/2004)		
A4537	Under pad, reusable/washable, any size, each (Eff. Date 1/1/2003) (Deleted eff. 12/31/2004)		
A4538	Diaper, reusable, provided by a diaper service, each diaper (Eff. Date 1/1/2003) (Deleted eff. 12/31/2004)		
A4550	Surgical trays		
A4554	Disposable underpads, all sizes		
A4555	Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only (Eff. 01/01/2014)	13	
A4556	Electrodes, (e.g., apnea monitor), per pair (not valid for Medicare as of 11/1/1996)	13	
A4557	Lead wires, (e.g., apnea monitor), per pair	13	
A4558	Conductive paste or gel (not valid for Medicare as of 11/1/1996)	13	
A4559	Coupling gel or paste, for use with ultrasound device, per oz (Eff. date 1/1/2007)		
A4560	Pessary (Deleted eff. 12/31/2000)	04	
A4561	Pessary, rubber, any type (Deleted eff. 12/31/2001)	04	
A4562	Pessary, non rubber, any type (Deleted eff. 12/31/2001)	04	
A4565	Slings (Deleted eff. 3/1/1998) (Eff. Date 3/1/1998 changed to local carrier jurisdiction)		
A4566	Shoulder sling or vest design, abduction restrainer, with or without swathe control, prefabricated, includes fitting and adjustment (Eff. Date 1/1/2011)		
A4570	Splint (Deleted eff. 7/1/2001)		
A4572	Rib belt (Deleted eff.12/31/2002)		
A4575	Topical hyperbaric oxygen chamber, disposable		
A4580	Cast supplies (e.g. plaster)		
A4581	Supplies risser jacket (Deleted eff. 12/31/1996)		
A4590	Special casting material (e.g. fiberglass)		
A4595	Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES)	13	
A4600	Sleeve for intermittent limb compression device, replacement only, each	05	

Exhibit 12

2015 - 1st Half Florida DMEPOS Fee Schedule

HCPCS:	Mod 1:	Mod 2:	Category:	Fee Schedule:
A4556			SU	$12.02

CATEGORY KEY

CR = Capped Rental Items
FS = Frequently Serviced Items
IN = Inexpensive and Other Routinely Purchased Items
OS = Ostomy, Tracheostomy & Urological Items
OX = Oxygen and Oxygen Equipment
PE = Parenteral and Enteral Nutrition
PO = Prosthetics & Orthotics
SD = Surgical Dressings
SU = Supplies
TE = Transcutaneous Electrical Nerve Stimulators
TS = Therapeutic Shoes

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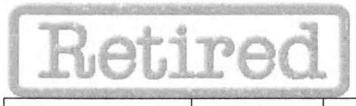
Exhibit 13

LCD for Transcutaneous Electrical Nerve Stimulators (TENS) (L5031)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Archive site.

Please Note: This is a Retired LCD.

Contractor Information



CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
CGS Administrators, LLC	DME MAC	18003 - DME MAC	Jurisdiction C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi New Mexico North Carolina Oklahoma Puerto Rico South Carolina Tennessee Texas Virgin Islands Virginia West Virginia

LCD Information

LCD ID
L5031

LCD Title
Transcutaneous Electrical Nerve Stimulators (TENS)

Source Proposed LCD
N/A

AMA CPT / ADA CDT / AHA NUBC Copyright Statement
CPT codes, descriptions and other data only are copyright 2019 American Medical Association. All Rights Reserved. Applicable FARS/HHSARS apply.

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CMS National Coverage Policy
CMS Manual System, Pub. 100-03, (Medicare National Coverage Determinations Manual), Chapter 1, Section 10.2, 160.7.1, 160.13, 160.27

Date Information

Original Effective Date
For services performed on or after 10/01/1993

Revision Effective Date
For services performed on or after 10/31/2014

Exhibit 14

Revision Ending Date
09/30/2015

Retirement Date
09/30/2015

Notice Period Start Date
08/01/1993

Notice Period End Date
N/A

Coverage Guidance

Coverage Indications, Limitations and/or Medical Necessity
For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this local coverage determination, the criteria for "reasonable and necessary", based on Social Security Act §1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

Medicare does not automatically assume payment for a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) item that was covered prior to a beneficiary becoming eligible for the Medicare Fee For Service (FFS) program. When a beneficiary receiving a DMEPOS item from another payer (including Medicare Advantage plans) becomes eligible for the Medicare FFS program, Medicare will pay for continued use of the DMEPOS item only if all Medicare coverage, coding and documentation requirements are met. Additional documentation to support that the item is reasonable and necessary, may be required upon request of the DME MAC.

A transcutaneous electrical nerve stimulator (TENS) (E0720, E0730) requires a written order prior to delivery (WORD). Refer to the DOCUMENTATION REQUIREMENTS section of this LCD and to the NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section of the related Policy Article for information about WOPD prescription requirements.

The physician ordering the TENS unit and related supplies must be the treating physician for the disease or condition justifying the need for the TENS unit.

A TENS is covered for the treatment of beneficiaries with chronic, intractable pain or acute post-operative pain when one of the following coverage criteria, I-III, are met.

I. Acute Post-operative Pain
TENS is covered for acute post-operative pain. Coverage is limited to 30 days (one month's rental) from the day of surgery. Payment will be made only as a rental.
A TENS unit will be denied as not reasonable and necessary for acute pain (less than three months duration) other than for post-operative pain.

II. Chronic Pain Other than Low Back Pain
TENS is covered for chronic, intractable pain other than chronic low back pain when all of the following criteria must be met:
- The presumed etiology of the pain must be a type that is accepted as responding to TENS therapy. Examples of conditions for which TENS therapy is not considered to be reasonable and necessary are (not all-inclusive):
  - headache
  - visceral abdominal pain
  - pelvic pain
  - temporomandibular joint (TMJ) pain
- The pain must have been present for at least three months
- Other appropriate treatment modalities must have been tried and failed

TENS therapy for chronic pain that does not meet these criteria will be denied as not reasonable and necessary.

III. Chronic Low Back Pain (CLBP)
TENS therapy for CLBP is only covered when all of the following criteria are met:
- The beneficiary has one of the diagnosis codes listed in the Diagnosis Codes that Support Medical Necessity section below.
- The beneficiary is enrolled in an approved clinical study that meets all of the requirements set out in NCD §160.27 (CMS Internet Only Manual 100-03, Chapter 1). Refer to the APPENDICES section for additional information about approved clinical studies.
  TENS therapy for CLBP that does not meet these criteria will be denied as not reasonable and necessary.

General Requirements for chronic pain (II) and CLBP (III)

When used for the treatment of chronic, intractable pain described in section II, the TENS unit must be used by the beneficiary on a trial basis for a minimum of one month (30 days), but not to exceed two months. The trial period will be paid as a rental. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating the pain. For coverage of a purchase, the physician must determine that the beneficiary is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time.

A 4-lead TENS unit may be used with either 2 leads or 4 leads, depending on the characteristics of the beneficiary's pain. If it is ordered for use with 4 leads, the medical record must document why 2 leads are insufficient to meet the beneficiary's needs.

TENS used for CLBP as described in section III does not require a trial rental period or an assessment of effectiveness by the treating physician. Upon the beneficiary's enrollment into an approved study, the TENS is eligible for purchase.

Supplies

Separate allowance will be made for replacement supplies when they are reasonable and necessary and are used with a covered TENS. Usual maximum utilization is:

- 2 TENS leads - a maximum of one unit of A4595 per month
- 4 TENS leads - a maximum of two units of A4595 per month.

If the use of the TENS unit is less than daily, the frequency of billing for the TENS supply code should be reduced proportionally.

Replacement of lead wires (A4557) more often than every 12 months would rarely be reasonable and necessary.

A conductive garment (E0731) used with a TENS unit is rarely reasonable and necessary, but is covered only if all of the following conditions are met:

- It has been prescribed by the treating physician for use in delivering covered TENS treatment
- One of the medical indications outlined below is met:
  - The beneficiary cannot manage without the conductive garment because
    - There is such a large area or so many sites to be stimulated and
    - The stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires
  - The beneficiary cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires
  - The beneficiary has a documented medical condition, such as skin problems, that preclude the application of conventional electrodes, adhesive tapes, and lead wires
  - The beneficiary requires electrical stimulation beneath a cast to treat chronic intractable pain.

A conductive garment is not covered for use with a TENS device during the trial period unless:

- The beneficiary has a documented skin problem prior to the start of the trial period; and
- The TENS is reasonable and necessary for the beneficiary.

If the criteria above are not met for E0731, it will be denied as not reasonable and necessary.

Reimbursement for supplies is contingent upon use with a covered TENS unit. Claims for TENS supplies provided when there is no covered TENS unit will be denied as not reasonable and necessary.

Effective for claims with dates of service on or after June 8, 2012 supplies provided for use with a previously covered TENS unit used for CLBP (not as part of an approved study) are not eligible for reimbursement. These supply claims will be denied as not reasonable and necessary.

REFILL REQUIREMENTS

For Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items and supplies provided on a recurring basis, billing must be based on prospective, not retrospective use. For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes or modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier

must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized. (CMS Program Integrity Manual, Internet-Only Manual, CMS Pub. 100-08, Chapter 5, Section 5.2.6).

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary or caregiver/designee prior to dispensing a new supply of items. Suppliers must not deliver refills without a refill request from a beneficiary. Items delivered without a valid, documented refill request will be denied as not reasonable and necessary.

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients. Suppliers must verify with the ordering physicians that any changed or atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a 3-month quantity at a time.

Coding Information

Retired

Bill Type Codes

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type.Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

Revenue Codes

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

N/A

CPT/HCPCS Codes

Group 1 Paragraph:

The appearance of a code in this section does not necessarily indicate coverage.

HCPCS MODIFIERS:

EY - No physician or other licensed health care provider order for this item or service

GA – Waiver of liability statement issued as required by payer policy, individual case

GZ – Item or service expected to be denied as not reasonable and necessary

KX - Requirements specified in the medical policy have been met

Q0 (zero) - Investigational clinical service provided in a clinical research study that is in an approved clinical research study

HCPCS CODES:

EQUIPMENT

Group 1 Codes:

CODE	DESCRIPTION
E0720	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, TWO LEAD, LOCALIZED STIMULATION
E0730	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, FOUR OR MORE LEADS, FOR MULTIPLE NERVE STIMULATION
E0731	FORM FITTING CONDUCTIVE GARMENT FOR DELIVERY OF TENS OR NMES (WITH CONDUCTIVE FIBERS SEPARATED FROM THE PATIENT'S SKIN BY LAYERS OF FABRIC)

Group 2 Paragraph:

SUPPLIES

Group 2 Codes:

CODE	DESCRIPTION
A4557	LEAD WIRES, (E.G., APNEA MONITOR), PER PAIR

CODE	DESCRIPTION
A4595	ELECTRICAL STIMULATOR SUPPLIES, 2 LEAD, PER MONTH, (E.G. TENS, NMES)

ICD-9 Codes that Support Medical Necessity

Group 1 Paragraph:

For TENS (E0720, E0730) used for CLBP when the approved clinical study (criterion III) requirements are met.

Group 1 Codes:

ICD-9 CODE	DESCRIPTION
353.4	LUMBOSACRAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
720.2	SACROILIITIS NOT ELSEWHERE CLASSIFIED
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY
721.42	SPONDYLOSIS WITH MYELOPATHY LUMBAR REGION
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
722.73	INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY LUMBAR REGION
722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
722.93	OTHER AND UNSPECIFIED DISC DISORDER OF LUMBAR REGION
724.02	SPINAL STENOSIS, LUMBAR REGION, WITHOUT NEUROGENIC CLAUDICATION
724.03	SPINAL STENOSIS, LUMBAR REGION, WITH NEUROGENIC CLAUDICATION
724.2	LUMBAGO
724.3	SCIATICA
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED
738.4	ACQUIRED SPONDYLOLISTHESIS
739.3	NONALLOPATHIC LESIONS OF LUMBAR REGION NOT ELSEWHERE CLASSIFIED
756.11	CONGENITAL SPONDYLOLYSIS LUMBOSACRAL REGION
756.12	SPONDYLOLISTHESIS CONGENITAL
805.4	CLOSED FRACTURE OF LUMBAR VERTEBRA WITHOUT SPINAL CORD INJURY
806.4	CLOSED FRACTURE OF LUMBAR SPINE WITH SPINAL CORD INJURY
846.0	LUMBOSACRAL (JOINT) (LIGAMENT) SPRAIN
846.1	SACROILIAC (LIGAMENT) SPRAIN
847.2	LUMBAR SPRAIN
953.2	INJURY TO LUMBAR NERVE ROOT

Revision History Number	Revision History Date	Revision History Explanation	Reason(s) for Change
		revision and no provider action is needed regarding this revision.	

Associated Documents

Attachments

TENS CMN - CMS 848 (DME MAC 06.03B) (41 KB) (Uploaded on 07/11/2006)

Related Local Coverage Documents

Article(s)

A37064 - Transcutaneous Electrical Nerve Stimulators (TENS) - Policy Article - Effective October 2014

Related National Coverage Documents

This LCD version has no Related National Coverage Documents.

All Versions

Updated on 09/30/2015 with effective dates 10/31/2014 - 09/30/2015

Updated on 05/14/2015 with effective dates 10/31/2014 - N/A

Updated on 03/14/2014 with effective dates 10/01/2013 - 10/30/2014

Updated on 08/16/2013 with effective dates 10/01/2013 - N/A

Updated on 08/09/2013 with effective dates 10/01/2013 - N/A

Updated on 10/12/2012 with effective dates 06/08/2012 - 09/30/2013

Updated on 03/08/2012 with effective dates 08/05/2011 - 06/07/2012

Updated on 08/04/2011 with effective dates 08/05/2011 - N/A

Updated on 02/25/2011 with effective dates 01/01/2011 - 08/04/2011

Updated on 08/28/2009 with effective dates 12/01/2009 - 12/31/2010

Updated on 03/12/2008 with effective dates 06/01/2007 - 11/30/2009

Updated on 02/19/2008 with effective dates 06/01/2007 - N/A

Updated on 08/03/2007 with effective dates 06/01/2007 - N/A

Updated on 03/09/2007 with effective dates 06/01/2007 - N/A

Updated on 12/15/2006 with effective dates 01/01/2007 - 05/31/2007

Updated on 03/01/2006 with effective dates 03/01/2006 - 12/31/2006

Updated on 11/15/2005 with effective dates 01/01/2006 - 02/28/2006

Additional Information

Keywords

N/A

Article for Transcutaneous Electrical Nerve Stimulators (TENS) - Policy Article - Effective October 2014 (A37064)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Archive site.

Please Note: This is a Retired Article.

Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
CGS Administrators, LLC	DME MAC	18003 - DME MAC	Jurisdiction C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi New Mexico North Carolina Oklahoma Puerto Rico South Carolina Tennessee Texas Virgin Islands Virginia West Virginia

Article Information

Article ID
A37064

Article Type
Article

Article Title
Transcutaneous Electrical Nerve Stimulators (TENS) - Policy Article - Effective October 2014

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Original Effective Date
01/01/2006

Revision Effective Date
10/31/2014

Revision Ending Date
09/30/2015

Retirement Date
09/30/2015

Article Guidance

Exhibit 15

Retired

Article Text

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. Information provided in this policy article relates to determinations other than those based on Social Security Act §1862(a)(1)(A) provisions (i.e. "reasonable and necessary").

Transcutaneous electrical nerve stimulation equipment is covered under the Durable Medical Equipment benefit (Social Security Act §1861(s)(6)). In order for a beneficiary's equipment to be eligible for reimbursement the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

During the rental of a TENS unit, supplies for the unit are included in the rental allowance; there is no additional allowance for electrodes, lead wires, batteries, etc. If a TENS unit (E0720 or E0730) is purchased, the allowance includes lead wires and one month's supply of electrodes, conductive paste or gel (if needed), and batteries.

Refer to the COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY section of the LCD for additional information about coverage criteria and associated documentation.

AFFORDABLE CARE ACT (ACA) 6407 REQUIREMENTS

ACA 6407 contains provisions that are applicable to specified items in this policy. In this policy the specified items are:

E0720	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, TWO LEAD, LOCALIZED STIMULATION
E0730	TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, FOUR OR MORE LEADS, FOR MULTIPLE NERVE STIMULATION
E0731	FORM FITTING CONDUCTIVE GARMENT FOR DELIVERY OF TENS OR NMES (WITH CONDUCTIVE FIBERS SEPARATED FROM THE PATIENT'S SKIN BY LAYERS OF FABRIC)

Face-to-Face Visit Requirements:

As a condition for payment, Section 6407 of the Affordable Care Act (ACA) requires that a physician (MD, DO or DPM), physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS) has had a face-to-face examination with a beneficiary that meets all of the following requirements:

- The treating physician must have an in-person examination with the beneficiary within the six (6) months prior to the date of the written order prior to delivery (WOPD).

- This examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered.

A new face-to-face examination is required each time a new prescription for one of the specified items is ordered. A new prescription is required by Medicare:

- For all claims for purchases or initial rentals
- When there is a change in the prescription for the accessory, supply, drug, etc.
- If a local coverage determination (LCD) requires periodic prescription renewal (i.e., policy requires a new prescription on a scheduled or periodic basis)
- When an item is replaced
- When there is a change in the supplier

The first bullet, "For all claims for purchases or initial rentals", includes all claims for payment of purchases and initial rentals for items not originally covered (reimbursed) by Medicare Part B. Claims for items obtained outside of Medicare Part B, e.g. from another payer prior to Medicare participation (including Medicare Advantage plans), are considered to be new initial claims for Medicare payment purposes.

Prescription Requirements:

A WOPD is a standard Medicare Detailed Written Order, which must be completed, including the prescribing physician's signature and signature date, and must be in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier's possession BEFORE the item is delivered. The WOPD must include all of the items below:

- Beneficiary's name
- Physician's name
- Date of the order and the start date, if start date is different from the date of the order
- Detailed description of the item(s)
- The prescribing practitioner's National Provider Identifier (NPI)
- The signature of the ordering practitioner
- Signature date

For any of the specified items provided on a periodic basis, including drugs, the written order must include, in addition to the above:

- Item(s) to be dispensed
- Dosage or concentration, if applicable
- Route of Administration, if applicable
- Frequency of use
- Duration of infusion, if applicable
- Quantity to be dispensed
- Number of refills

Note that prescriptions for these specified DME items require the National Provider Identifier to be included on the prescription. Prescriptions for other DMEPOS items do not have this NPI requirement. Suppliers should pay particular attention to orders that include a mix of items, to assure that these ACA order requirements are met.

The treating practitioner that conducted the face-to-face examination does not need to be the prescriber for the DME item. However the prescriber must:

- Verify that the in-person visit occurred within the 6-months prior to the date of their prescription, and
- Have documentation of the face-to-face examination that was conducted, and
- Provide the DMEPOS supplier with copies of the in-person visit records.

Date and Timing Requirements

There are specific date and timing requirements:

- The date of the face-to-face examination must be on or before the date of the written order (prescription) and may be no older than 6 months prior to the prescription date.
- The date of the face-to-face examination must be on or before the date of delivery for the item(s) prescribed.
- The date of the written order must be on or before the date of delivery.
- The DMEPOS supplier must have documentation of both the face-to-face visit and the completed WOPD in their file prior to the delivery of these items.

A date stamp (or similar) is required which clearly indicates the supplier's date of receipt of both the face-to-face record and the completed WOPD with the prescribing physician's signature and signature date. It is recommended that both documents be separately date-stamped to avoid any confusion regarding the receipt date of these documents.

Claim Denial

Claims for the specified items subject to ACA 6407 that do not meet the requirements specified above will be denied as statutorily non-covered – failed to meet statutory requirements.

If the supplier delivers the item prior to receipt of a written order, it will be denied as statutorily non-covered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

CODING GUIDELINES

A transcutaneous electrical nerve stimulator (TENS) (E0720, E0730) is a device that utilizes electrical current delivered through electrodes placed on the surface of the skin to decrease the patient's perception of pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins. A TENS unit must be distinguished from other electrical stimulators (e.g., neuromuscular stimulators) which are used to directly stimulate muscles and/or motor nerves.

A TENS supply allowance (A4595) includes electrodes (any type), conductive paste or gel (if needed, depending on the type of electrode), tape or other adhesive (if needed, depending on the type of electrode), adhesive remover, skin preparation materials, batteries (9 volt or AA, single use or rechargeable), and a battery charger (if rechargeable batteries are used).

Codes A4556 (Electrodes, [e.g., apnea monitor], per pair), A4558 (Conductive paste or gel), and A4630 (Replacement batteries, medically necessary TENS owned by patient) are not valid for claim submission to the DME MAC. A4595 should be used instead.

For code A4557, one unit of service is for lead wires going to two electrodes. If all the lead wires of a 4 lead TENS unit needed to be replaced, billing would be for two units of service.

There should be no billing and there will be no separate allowance for replacement electrodes (A4556), conductive paste or gel (A4558), replacement batteries (A4630), or a battery charger used with a TENS unit.

Other supplies, including but not limited to the following, will not be separately allowed: adapters (snap, banana, alligator, tab, button, clip), belt clips, adhesive remover, additional connecting cable for lead wires, carrying pouches, or covers.

Suppliers should contact the Pricing, Data Analysis and Coding (PDAC) Contractor for guidance on the correct coding of these items.

Coding Information

Retired

Bill Type Codes

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type.Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

Revenue Codes

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

N/A

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 Codes:

N/A

Covered ICD-9 Codes

Group 1 Paragraph:

N/A

Group 1 Codes:

N/A

Non-Covered ICD-9 Codes

Group 1 Paragraph:

N/A

Group 1 Codes:

N/A

Revision History Information

Revision History Table

Revision History Number	Revision History Date	Revision History Explanation
5	09/30/2015	This Article is being retired due to the ICD-10 transition.
4	10/31/2014	Revision Effective Date: 10/31/2014 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Removed: "When required by state law" from ACA new prescription requirements Revised: Face-to-Face Requirements for treating practitioner
3	07/01/2013	Revision Effective Date: 07/01/2013 (March 2014 Publication) NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Revised: ACA 6407 requirements
2	07/01/2013	Revision Effective Date: 07/01/2013 NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: ACA 6407 (CR 8304) F2F requirements

Revision History Number	Revision History Date	Revision History Explanation
1	08/05/2011	Revision Effective Date: 01/01/2011 NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: Preamble Added: Benefit category statement Revision Effective Date: 12/01/2009 CODING GUIDELINES: Changed: SADMERC to PDAC 03/01/2008 - In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC CIGNA Government Services (18003) Article A37064 from DME PSC TrustSolutions (77012) Article A37064 06/01/2007 - In accordance with Section 911 of the Medicare Modernization Act of 2003, Virginia and West Virginia were transitioned from DME PSC TriCenturion (77011) to DME PSC TrustSolutions (77012). 03/01/2006 - In accordance with Section 911 of the Medicare Modernization Act of 2003, this article was transitioned to DME PSC TrustSolutions (77012) from DMERC Palmetto GBA (00885). Effective Date: 01/01/2006 LMRP converted to an LCD and Policy Article 08/05/2011 - The Jurisdiction C contractor adopted a new business name. This LCD revision only includes the change from CIGNA Government Services to CGS Administrators, LLC. No coverage information was included in this revision and no provider action is needed regarding this revision.

Associated Documents

Related Local Coverage Documents

LCD(s)

L5031 - Transcutaneous Electrical Nerve Stimulators (TENS)

Related National Coverage Documents

This Article version has no Related National Coverage Documents.

Statutory Requirements URL(s)

N/A

Rules and Regulations URL(s)

N/A

CMS Manual Explanations URL(s)

N/A

Other URL(s)

N/A

All Versions

Updated on 09/30/15 with effective dates 10/31/2014 - 09/30/2015

Updated on 05/14/15 with effective dates 10/31/2014 - N/A

Updated on 03/14/14 with effective dates 07/01/2013 - 10/30/2014

Updated on 08/09/13 with effective dates 07/01/2013 - N/A

Updated on 08/04/11 with effective dates 08/05/2011 - 06/30/2013

Updated on 02/25/11 with effective dates 01/01/2011 - 08/04/2011

Updated on 08/28/09 with effective dates 12/01/2009 - 12/31/2010

Updated on 02/19/08 with effective dates 06/01/2007 - 11/30/2009

Updated on 08/10/07 with effective dates 06/01/2007 - N/A

Updated on 04/13/07 with effective dates 06/01/2007 - N/A

Updated on 03/01/06 with effective dates 03/01/2006 - 05/31/2007

Updated on 11/15/05 with effective dates 01/01/2006 - N/A

Additional Information

Keywords

N/A

2015 Jurisdiction List for DMEPOS HCPCS Codes

NOTE: Deleted codes are valid for dates of service on or before the date of deletion.

NOTE: Updated codes are in bold.

NOTE: The jurisdiction list includes codes that are not payable by Medicare. Please consult the Medicare contractor in whose jurisdiction a claim would be filed in order to determine coverage under Medicare.

HCPCS	DESCRIPTION	JURISDICTION
A4310 - A4358	Incontinence Supplies/ Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4360 - A4435	Urinary Supplies	If provided in the physician's office for a temporary condition, the item is incident to the physician's service & billed to the Local Carrier. If provided in the physician's office or other place of service for a permanent condition, the item is a prosthetic device & billed to the DME MAC.
A4450 - A4456	Tape; Adhesive Remover	Local Carrier if incident to a physician's service (not separately payable), or if supply for implanted prosthetic device. If other, DME MAC.
A4458-**A4459**	Enema Bag/**System**	DME MAC
A4461-A4463	Surgical Dressing Holders	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4465 - A4466	Non-elastic Binder and Elastic Garment	DME MAC
A4470	Gravlee Jet Washer	Local Carrier
A4480	Vabra Aspirator	Local Carrier
A4481	Tracheostomy Supply	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4483	Moisture Exchanger	DME MAC
A4490 - A4510	Surgical Stockings	DME MAC
A4520	Diapers	DME MAC
A4550	Surgical Trays	Local Carrier
A4554	Disposable Underpads	DME MAC
A4555 - A4558	Electrodes; Lead Wires; Conductive Paste	Local Carrier if incident to a physician's service (not separately payable). If other, DME MAC.
A4559	Coupling Gel	Local Carrier if incident to a physician's service

Exhibit 16

Symbols Legend

⊙=Modifier 51 Exempt
●=Moderate sedation
+=Add-on code
⁄=FDA approval pending
▲=Revised code
●=New code
○=Reinstated
#=Resequenced

Newsletters

A Comparative Look at the Physical Medicine and Rehabilitation Codes

With the creation of new codes for Physical Medicine and Rehabilitation, such as the addition of Evaluation and Reevaluation codes, comes the dilemma of identifying services that may be separately reported from other services provided. Although this is in no way an attempt to identify all circumstances that exist, the intent of this article is to summon a way of thinking for those professionals required to "sift through" the given facts to identify exactly what physical therapy procedures were performed, and what should be reported. This information includes responses to a variety of questions presented to *CPT Assistant* staff and should help in resolving some common issues encountered when using the codes.

Identification of Users for the Physical Medicine and Rehabilitation Codes

As with other sections of CPT, the codes in the physical medicine section are designed to identify physical medicine services. These codes are not restricted to use by a specific specialty group. Instead, these codes may be used by any provider who is qualified to perform the service represented by the specific code. No distinction is made concerning the licensure or professional credentials of the provider. Licensure and credentialing vary on a state-by-state and institutional basis. Appropriate state and institutional authorities should be consulted regarding the appropriate provision of these services by health care professionals.

Use of the 97001 - 97004 Codes

The physical medicine codes (97001 - 97004) were added to identify a dynamic process in which clinical judgements are made based on data gathered. These evaluations result in the development of a plan for management of a patient's problems as they relate to his or her disease or disability. These codes may be separately reported if, and only if, the patient's condition requires significant, separately identifiable E/M service, above and beyond the usual pre-service and post-service work associated with the procedure performed.

Since some of the physical medicine services include an evaluation component as part of pre-service work, use of these codes is dependent on whether the service being provided is a significant, separate service, or if it is simply a component of the more involved procedure. Since patient circumstances vary, identification of when these codes are used will be dependent on the specific patient encounter and identification of what was actually done. A vignette for each code has been provided for further clarification.

Modality Codes

One of the most commonly asked questions regarding the use of the modality codes involves the intended number of times these services may be reported for a given date. Both the supervised modality codes (97010-97028) and the constant attendance codes (97032-97039) include language in the descriptor that indicates ". . . Application of a modality to **one or more areas**. . ."

The constant attendance modality codes, however, also include a time component which defines these codes. The descriptor language for the constant attendance codes indicates that these codes are reported for

". . . each 15 minutes." Therefore, these codes may be reported once for each 15 minute period spent providing the service.

Time is **not** a factor in determining the use of the supervised modalities (ie, they do not include a time component in the descriptor), and therefore, are intended to be used only once during an encounter, regardless of the number of areas treated. When more than one modality is used during an encounter, whether supervised or constant attendance, or any combination, each modality provided should be reported.

Reporting Modalities

Supervised Modalities	Reporting Method
97010-97028	Once per encounter
Constant Attendance	Reporting Method
97032-97039	Report code for each 15 minutes of modality application

In addition, since the codes are divided into "supervised" and "constant attendance" sections, these codes are used according to whether direct (one-to-one) patient contact is provided (constant attendance), or whether the application of the modality does not require direct (one-on-one) patient contact by the provider.

The timeframes indicated in the descriptor language of the supervised modality codes describe the total time, ie, preservice, intraservice, and postservice time spent in performing this modality. Codes that do not include an increment of time in the descriptor do not utilize time as a component for determining the use of the code. The code is reported without regard to the length of time spent performing the service.

Therapeutic Procedures and Other Services

The therapeutic procedure codes identify a manner of effecting change through the application of clinical skills and/or service that attempt to improve function. Common components included as part of the therapeutic procedures include chart reviews for treatment, setup of activities and the equipment area, and review of previous documentation as needed. Also included is communication with other health care professionals (such as the social worker or nurse), discussions with the family, and calls to the referring physician for additional information or clarification. Subsequent to providing the therapeutic service, the treatment is recorded, and typically the progress is documented.

Other services may also be required to effectively administer the various treatments involved. Therefore, as was previously indicated, the use of the Physical Therapy Evaluation codes with a particular therapeutic procedure may be used when a significant, separately identifiable service is performed in addition to the therapeutic service being provided.

Exhibit 17

A more complete, separate description of each of the codes listed in this section of *CPT* is included in the Summer, 1995 *CPT Assistant* (Volume 5, Issue 2, pages 5-9).

Tests and Measurements

Code 97703, *Checkout for orthotic/prosthetic use, established patient, each 15* minutes, is an end-service that identifies the examination of an orthotic/prosthetic device to insure correct fit when using the orthotic or prosthetic during functional activities. An example of this is checking for skin integrity where the orthotic/prosthetic device may apply pressure. Any adjustments or repairs may be made to insure alignment and reinstruction may be given at this time as well.

This differs from use of code 97504, Orthotics fitting and training, upper and/or lower extremities, each 15 minutes, which is intended to be used to report orthotics fitting and training. This code was added in 1997 and identifies the fitting as well as the patient training (required to properly use the devices). The fabrication of the orthotic is not recognized as a distinct service, but rather a provision of materials and supplies that may be reported with a supply/material code (eg, CPT code 99070, or HCPCS Level II code).

Application of Cast and Strapping vs. Orthosis

Application of a cast or strapping device (listed in the 29000 series) is intended to be used when the desired effect is to provide total immobilization or restriction of movement. Strapping refers to the application of overlapping strips of adhesive plaster or tape to a body part to exert pressure on it and hold a structure in place. Strapping may be used to treat strains, sprains, dislocations, and some fractures.

Orthosis application differs from the purpose of an application of a cast or strapping device. Orthotics are used to support a weak or ineffective joint or muscle. They are generally used to provide support while the patient transitions through treatment (ie, provides mobility with support). Some examples of orthotic devices include shoe inserts and braces.

When code 97504 was added to *CPT*, a cross reference was added at the end of the Application of Casts and Strapping section notes to refer the reader to code 97504 to report orthotics fitting and training. "(For orthotics fitting and training, see 97504)" This cross reference and the addition of the new code (97504) was to make it clear that casting and strapping codes should not be reported for orthotics fitting and training. Also, the cross reference is intended to make clear that the casting and strapping codes should not be reported in addition to code 97504. When describing orthotic procedures, dynamic splints are considered orthotics and therefore the dynamic splint application service should be identified by code 97504.

Testing Physical Performance

Code 97750 identifies testing/measurement of physical performance of a select area or number of areas. As is indicated in the descriptor language, this code is used according to the time spent providing the service. In addition, it varies from the use of the 97001-97004 codes in that it requires a separately report from other evaluations that may be done.

Other Procedures

New acupuncture codes (97780-97781) were included in the physical medicine and rehabilitation section of *CPT 1998*. These codes are reported once per session regardless of the number of needles used and without regard to time. The difference in use depends on whether or not electrical stimulation is performed for the procedure. As was previously indicated *CPT* does not limit the use of the acupuncture codes to a particular specialty group. The acupuncture codes may be reported by any qualified provider according to any state and licensure requirements.

Clinical Vignettes

Physical Therapy Evaluation

Initial visit with 56-year-old female with right shoulder adhesive capsulitis. She has painful and limited range of motion with the inability to use her arm for the majority of activities at work. The medical history is significant for hypertension. She has had shoulder complaints for less than one month. The examination includes, but is not limited to, range of motion examination, joint integrity and mobility examination, muscle performance examination (including strength, power, and endurance), left/right comparison, respiration, heart rate, blood pressure assessment, and environmental (home or work barriers) examination.

Reevaluation of an 18-year-old female who had an ACL repair eight weeks ago. She has been undergoing conservative management and is not at the appropriate stage for progression of an open and modified closed chain rehabilitation program. Joint effusion continues to be a problem with irritation from the prescribed brace patient is wearing. Examination would include but not be limited to the following: range of motion examination; gait examination; joint integrity and mobility examination, girth measurement and muscle performance examination, and functional assessment.

This case involves an initial visit with a 42-year-old female with a diagnosis of multiple sclerosis. The patient is employed as a librarian. She shares in care- giver responsibilities of her two teenage children and in home maintenance tasks. Her chief complaints are lack of strength and endurance and sensory problems. The therapist designs an activity that parallels the physical requirements of the activities in which the patient has identified deficits. In addition to observing the completion of the activity, the therapist engages the patient in a discussion of other issues that the patient believes are interfering with her ability to function in her home and career. Based on the patient's self report and actual performance, the patient's deficits in the following performance components (see *Uniform Terminology for Occupational Therapy*, 3rd Edition) are evaluated: activities of daily living; work and productive activities; sensory awareness; sensory processing; neuro-musculoskeletal (eg, range of motion, muscle endurance, strength); motor (eg, gross coordination, bilateral integration, fine coordination, visual-motor integration).

The patient is a 49-year-old female who sustained a forearm fracture (distal end of the radius) in an automobile accident. She received treatment during and after casting to prevent edema, maintain range of motion, muscle strength and sensation, and assure safe return to daily activities. She was discharged to home three months ago with a maintenance program of exercises and gradual increase in daily home activities. She returned to work six weeks ago. During a recent physician visit, she complained that her ability to grasp and hold objects had not returned to normal and there was pain and a lack of strength associated with these activities. She was referred back to therapy, as these problems were interfering with hear ability to get dressed, prepare meals, and perform her job as a manicurist. The therapist reassesses her ability to perform tasks with the affected arm and retested muscle strength, using discharge data as a baseline, and explores compensatory methods which help to ameliorate the pain. Based on the patient's self report and actual performance, the patient's deficits in the following performance components (see *Uniform Terminology for Occupational Therapy*, 3rd Edition) are reevaluated: activities of daily living; work and productive activities; neuro-musculoskeletal; motor.

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Symbols Legend

⊙=Modifier 51 Exempt
⊕=Moderate sedation
✚=Add-on code
⌿=FDA approval pending
▲=Revised code
●=New code
○=Reinstated
#=Resequenced

Newsletters

Coding Consultation:Medicine

Medicine, 97010 (Q&A)

Question

We have been told that we can report multiple units of code 97010 when we use both cold and hot packs for therapy during a single treatment session. This is inconsistent with previous information we have received. Has the use of code 97010 changed?

AMA Comment

From a CPT coding perspective, codes 97010-97028 *(Application of a modality to one or more areas)* are intended to be reported only one time per modality, per treatment session. The length of a given treatment session is not stated in the CPT book; therefore, the therapist or physician would report each modality only one time for a given treatment session. If two separate treatment sessions are provided on the same date of service (eg, am and pm), then both may be reported. Code 97010 should be reported only one time for the use of both cold and hot packs during a single session.■

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Exhibit 18

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