

REQUEST FOR PROPOSAL



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

TABLE OF CONTENTS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

INSTRUCTIONS TO BIDDERS.....	1
1. SUBMITTAL RECEIPT AND OPENING	1
2. PRE-BID CONFERENCE	1
3. INFORMATION REQUESTS	1
4. SOLICITATION QUESTIONS	2
5. APPROVED ALTERNATES.....	2
6. ENVIRONMENTAL PROCUREMENT POLICY	2
7. PURCHASING WEB SITE	3
8. DOWNLOADING SOLICITATIONS	3
9. EMAIL NOTIFICATION	3
10. CITY OF SCOTTSDALE PROCUREMENT CODE	3
11. PROSPECTIVE BIDDER'S CONFERENCE.....	3
12. BIDDER'S PRESENTATION	4
13. INELIGIBLE BIDDER	4
14. OBLIGATIONS.....	4
15. NON COLLUSION AFFIDAVIT	4
16. IMMIGRATION LAW COMPLIANCE	4
17. LAWFUL PRESENCE IN THE UNITED STATES FOR PERSONS	5
18. TAXES/LICENSES.....	5
19. CONTRACTOR'S LICENSING REQUIREMENTS	7
20. LITIGATION	8
21. SUBCONTRACTOR'S LIST.....	8
22. SUBCONTRACTORS.....	8
23. CONFIDENTIAL INFORMATION.....	8
24. SMALL BUSINESS	9
25. TITLE VI NOTICE	9
26. INTERPRETATIONS, ADDENDA.....	9
27. SUBMITTAL PROCEDURE	10
28. AWARD DETERMINATION	11
29. REJECTION OF BIDS	11
30. PROTESTS.....	11
31. CONTRACT AWARD NOTIFICATION	13
32. AWARD OF CONTRACT.....	13
33. BID BOND.....	13
GENERAL TERMS AND CONDITIONS	14
1. ADDITIONAL SERVICE REQUESTED	14
2. ADVERTISING.....	14
3. ARIZONA LAW	14
4. ASSIGNMENT	14
5. ATTORNEY'S FEES.....	14
6. AUTHORITY	14
7. CANCELLATION OF CITY CONTRACTS	15
8. CAPTIONS/HEADINGS.....	15
9. CERTIFICATE OF INSURANCE	15
10. CHANGES IN THE WORK	15
11. CHEMICALS	16
12. COMPLIANCE WITH FEDERAL AND ARIZONA STATE IMMIGRATION LAWS.....	16
13. COMPLIANCE WITH FEDERAL AND STATE LAWS	17
14. CONFLICT OF INTEREST	17
15. CONTRACT ADMINISTRATOR DUTIES	17

16.	CONTRACTOR ON SITE SAFETY REPORTING REQUIREMENTS	18
17.	CO-OP USE OF CONTRACT	18
18.	COUNTERPARTS	18
19.	ENDANGERED HARDWOODS.....	18
20.	ENTIRE AGREEMENT	19
21.	EQUAL EMPLOYMENT OPPORTUNITY	19
22.	ESTIMATED QUANTITIES	19
23.	EXECUTION OF CONTRACT	19
24.	FORCE MAJEURE	19
25.	FUNDS APPROPRIATION	19
26.	INDEMNIFICATION	20
27.	INDEPENDENT CONTRACTOR	20
28.	INSURANCE REQUIREMENTS	20
	Insurance Representations and Requirements.....	20
	Required Coverage	22
29.	LITIGATION	23
30.	LOCAL CONDITIONS, RULES AND REGULATIONS	23
31.	MODIFICATIONS.....	24
32.	NO PREFERENTIAL TREATMENT OR DISCRIMINATION	24
33.	NO WAIVER.....	24
34.	ORDER OF PRECEDENCE	24
35.	PATENTS.....	25
36.	PAYMENT TERMS	25
37.	PRICE REDUCTION.....	25
38.	RECORDS AND AUDIT RIGHTS	25
39.	REGISTERED/LICENSES	26
40.	REQUEST FOR TAXPAYER I.D. NUMBER & CERTIFICATION IRS W-9 FORM.....	26
41.	RISK OF LOSS	26
42.	SCOTTSDALE CITY SEAL AND CITY SYMBOL	27
43.	SEVERABILITY.....	27
44.	SUCCESSORS AND ASSIGNS	27
45.	TERMINATION	27
46.	TESTING OF MATERIALS	28
47.	TIME IS OF THE ESSENCE	28
48.	WARRANTY.....	28
	SPECIAL TERMS AND CONDITIONS	30
1.	ACCEPTANCE / AGREEMENT	30
2.	INVOICING	30
3.	KEY PERSONNEL.....	30
4.	MULTIPLE AWARDS.....	31
5.	OWNERSHIP OF PROJECT DOCUMENTS	31
6.	PRICE ESCALATION	31
7.	PURCHASING PROCEDURE	32
8.	QUANTITY	32
9.	TERM OF AGREEMENT	32
10.	UNPREDICTABLE MARKET CHANGE.....	32
	SCOPE OF WORK.....	33
1.	GENERAL INFORMATION.....	33
2.	CONTRACT ADMINISTRATION	33
3.	GENERAL VENDOR QUALIFICATIONS.....	33
4.	BACKGROUND	34
5.	MINIMUM TECHNICAL REQUIREMENTS.....	35
5.1	PART ONE - WORKER'S COMPENSATION BILL PAYMENT SERVICES	35
5.2	PART TWO - WORKER'S COMPENSATION PHARMACY PROGRAM	38
	DATA SECURITY - SOLICITATION QUESTIONS	40
	SUBMITTAL REQUIREMENTS CHECKLIST.....	42
	EVALUATION CRITERIA.....	47
	OFFER AND ACCEPTANCE	49
	PRICE PROPOSAL FORM – PART 1 WORKMAN'S COMPENSATION BILL REVIEW PRICING	50

PRICE PROPOSAL FORM – PHARMACY SERVICES PRICING	53
REFERENCES	56
BIDDER GENERAL DISCLOSURE FORM	57
BIDDER LITIGATION DISCLOSURE FORM.....	73
EXHIBIT A – SAMPLE MEDICAL BILLS	74

INSTRUCTIONS TO BIDDERS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

The City of Scottsdale invites sealed submittals to contract for a medical bill review, reduction, and payment program and a pharmacy services program for its Worker's Compensation program.

SOLICITATION CRITICAL DATES

BID/PROPOSAL SUBMITTAL DUE: **2:00 P.M., LOCAL TIME, OCTOBER 21, 2015**

QUESTIONS DUE: **10:00 A.M. LOCAL TIME, OCTOBER 13, 2015**

1. SUBMITTAL RECEIPT AND OPENING

SEALED SOLICITATION SUBMITTALS WILL BE RECEIVED until **2:00 P.M., LOCAL TIME, OCTOBER 21, 2015**, at the Purchasing Department Front Desk located on the second floor of the Scottsdale Corporation Yard Building at 9191 E. San Salvador Dr., Scottsdale, AZ 85258. **All submittals must be date and time stamped at the Purchasing Department front desk on or before the submittal receipt time and date. LATE SUBMITTALS WILL NOT BE ACCEPTED.** To allow staff to complete required internal administrative functions, submittals will be opened, read and the name of each bidder recorded, as a matter of public information, within thirty (30) minutes after the receipt time and date have past.

No Submittal will be considered unless it is submitted on the forms contained herein. **All submittals must be presented in a sealed envelope or box.** The outside of the submittal must be clearly marked with the solicitation number, solicitation title and the submitting company's name. This includes envelopes delivered by Fed Ex, UPS, DHL or other carrier.

2. PRE-BID CONFERENCE

(Not Applicable)

3. INFORMATION REQUESTS

Requests for additional information relating to this bid should be directed to:

Karie Ingles, CPPB
Bid & Contract Specialist
480-312-5744
kingles@scottsdaleaz.gov

INSTRUCTIONS TO BIDDERS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

4. SOLICITATION QUESTIONS

The Bidder shall submit all questions, requests for clarification and inquiries in regards to this Solicitation to Karie Ingles, no less than eight (8) days prior to the original Solicitation opening date. It is preferred that all questions be submitted via email to the appropriate purchasing staff, kingles@scottsdaleaz.gov, where possible. When submitting any questions the Bidder should indicate the page number, Section Number/Clause Title and if possible paragraph number that is being questioned.

It is your responsibility to give notice, in the form of written questions before the bid opening on any item or issue in this solicitation that you believe should not be included or contained in any amendment to this solicitation or that the City failed to include in this solicitation that should have been included, and by your notice, the City could have cured the problem if the item or issue had been timely raised or objected to.

Failure to give notice may constitute a waiver of your right to object to the inclusion or lack of inclusion of the item or issue in this solicitation in any subsequent protest filed by you.

All questions, regardless of the method they are communicated (email, regular mail or hand delivered), must be clearly marked as "Solicitation Questions" and state the Solicitation number in the subject line of the email or on the outside of the envelope. If questions are not submitted via email, the submittal envelope **MUST** be clearly marked with Solicitation number and words "SOLICITATION QUESTIONS", or it may be mistaken as an actual bid submittal and not be opened immediately.

All Solicitation questions **MUST** be received by the Purchasing Division by **10:00 A.M., LOCAL TIME, OCTOBER 13, 2015**. Any inquiries received after the specified time will be reviewed on an individual basis by the Purchasing staff to determine if a response would be advantageous for the City.

5. APPROVED ALTERNATES

(Not Applicable)

6. ENVIRONMENTAL PROCUREMENT POLICY

The City has established an Environmental Procurement Policy which encourages the inclusion of environmentally responsible products and services available to meet the intended purpose. We encourage the offer of alternatives that broaden the range of environmentally responsible products or services that will meet the performance requirements of this solicitation. IF YOU WISH TO SUBMIT AN ALTERNATIVE, follow the procedures specified in the Instructions to Bidders, Approved Alternate Section of this document., unless the approved alternate clause has been deemed not applicable.

INSTRUCTIONS TO BIDDERS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

7. PURCHASING WEB SITE

The Purchasing web site provides a wide variety of information; including the capability to download solicitations and plan sheets (if applicable), how to introduce your products, a list of the Buyer's commodity lines, etc. The web site can be accessed at <http://www.scottsdaleaz.gov/purchasing>. Registering and downloading a solicitation will also provide the supplier with notices of all addenda that are issued.

8. DOWNLOADING SOLICITATIONS

All solicitation documents; plan sheets/drawings if applicable and addenda are available for download in .pdf format. Bidders may print their own copies of these documents or provide the files to any reprographics/copy center in their area. Bidders will no longer be able to pick-up these documents at the Purchasing Department and plan shipments will no longer be available. There will be one set of plan sheets/drawings (if applicable) available for onsite review only at the Purchasing Office located at 9191 E. San Salvador Dr., Scottsdale, AZ 85258.

It is imperative that you download the solicitation from the Purchasing web site at <https://eservices.scottsdaleaz.gov/eservices/solicitations/> in order to be notified of associated addenda.

9. EMAIL NOTIFICATION

The City of Scottsdale does not maintain a Bidder list; however, on the Purchasing web site, lower right side, see "Subscribe to Solicitation Opportunities", enter your email address and click subscribe to receive a notification of Solicitation Opportunities twice weekly at <http://www.scottsdaleaz.gov/purchasing>.


10. CITY OF SCOTTSDALE PROCUREMENT CODE

All procurement activities, conducted by the City of Scottsdale, are in conformance with the rules and regulations of the Scottsdale Procurement Code. A copy of the Code is available for review in the Office of the City Clerk located at City Hall, 3939 Drinkwater Boulevard and the Purchasing Office, located at 9191 E. San Salvador Drive, Scottsdale, Arizona. A copy of the Code is also available from the Purchasing website at <http://www.scottsdaleaz.gov/purchasing>.

A hard copy of the Code is available for purchase, for a fee of \$10.00, at the Purchasing Office.

11. PROSPECTIVE BIDDER'S CONFERENCE

A prospective bidder's conference may be held. If scheduled, the date and time of this conference will be indicated on the cover page of this document. The purpose of this conference will be to clarify the contents of this Solicitation in order to prevent any misunderstanding of the City's position. This conference will also give Bidders an opportunity to submit any questions and discuss any questions previously submitted.

INSTRUCTIONS TO BIDDERS	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>

12. BIDDER'S PRESENTATION

Bidders may be invited to make a presentation. If invited, Bidders will be notified of the date and time of the presentation by the City of Scottsdale Purchasing Department.

13. INELIGIBLE BIDDER

The preparer of the bid specifications is not eligible to submit a bid or proposal on the solicitation for which they prepared the specification, nor is the preparer eligible to supply any product to a bidder or Offeror on the solicitation for which they prepared the specification.

14. OBLIGATIONS

The issuance of this Solicitation does not obligate the City to pay any costs incurred in the preparation and submission of proposals.

15. NON COLLUSION AFFIDAVIT

By signing the Offer Form/Signature Page of the solicitation, or other official contract form, the Bidder certifies that:

In connection with the performance of this solicitation or any resulting Contract, the Bidder is stating and certifying that the Contractor/Company has not either directly, or indirectly, entered into any agreement, participated in any collusion, or otherwise taken any action in restraint of free competitive proposing in connection with the preparation or submission of its Submittal in response to this solicitation or any potential resulting Contract.

If any company is jointly owned or associated through common officers/employees with another company(s) that is/are responding to the same solicitation, both/all of those companies must take all precautions so as to make sure the preparation of their bid or proposal submittal is done completely independent of the other company(s) or individual(s). Specifically, any individual working on preparation, approving or signing one submittal can have no knowledge of or interaction with any other bid or proposal submission from a different company for that same solicitation.

If the subject matter of this solicitation is construction, the bidder shall submit a completed and Notarized Non Collusion Affidavit, stating and certifying that said Bidder/Company has not either directly, or indirectly, entered into any agreement, participated in any collusion, or otherwise taken any action in restraint of free competitive proposing in connection with the preparation or submission of its Submittal in response to this solicitation or any potential resulting Contract. The Bidder is to return the completed and notarized Non Collusion Affidavit with their submittal.

16. IMMIGRATION LAW COMPLIANCE

By signing the Offer Form/Signature Page of this solicitation, the Bidder certifies and warrants that for all solicitations for services (including construction services) it has complied with the E-Verify Program as required by ARS §23-214(A) or will have complied with the requirements of the E-Verify Program before award. Failure to comply with the E-Verify Program may result in the automatic disqualification of the Submittal as being non-responsive or the termination of any contract awarded and the possible forfeiture of any applicable bond.

INSTRUCTIONS TO BIDDERS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

16. IMMIGRATION LAW COMPLIANCE – CONT'D

The City will include specific "Compliance with Federal and Arizona State Immigration Laws" language in any contract or subcontract it enters into with the successful Bidder. In addition, this language must be included in any subcontracts that the successful bidder enters into with its subcontractors.

17. LAWFUL PRESENCE IN THE UNITED STATES FOR PERSONS

Arizona State law A.R.S. §1-502 (H.B. 2008) requires that all PERSONS who will be awarded a contract and apply for public benefit must demonstrate through a signed affidavit and the presentation of a copy of documentation that they are lawfully present in the United States.

A PERSON is defined as all NATURAL PERSONS/INDIVIDUALS/SOLE PROPRIETORSHIPS as indicated by your W9 Filing. *(This law does not apply to LLP's, LLC's, PLLC's, Corporations, Limited Partnerships or General Partnerships)*

By submitting your quote, bid or proposal to the City you are agreeing that if you are selected as the awardee and meet the criteria as a PERSON you will abide by this law and sign and submit an AFFIDAVIT DEMONSTRATING LAWFUL PRESENCE IN THE UNITED STATES and attach the appropriate copy of your documentation in proof of that statement. Types of acceptable documentation copies are an Arizona Driver's License issued after 1996, Arizona nonoperating identification license, U.S. birth certificate, U.S. Passport, I-94 Form with photograph and several others that are all listed on the Affidavit form that the City will send to you for your completion prior to issuing any contract.

If you have previously done business with the City and already have filed the above Affidavit with copies of an acceptable documentation please indicate when you submitted it. If your acceptable Affidavit is already on file with the City that will be sufficient to meet this requirement.

If you fail to complete and provide a completed Affidavit and accompanying acceptable copy of your documentation, or not advise us of your prior filing within 10 calendar days of being requested by then you may be considered non responsive and disqualified from that award consideration. You can obtain the complete Affidavit form from the Purchasing Department at (480) 312-5700 or the Purchasing web site at <http://www.scottsdaleaz.gov/Purchasing> on the lower right side of the page under Forms.


18. TAXES/LICENSES

Federal Excise Taxes:

The City of Scottsdale is exempt from certain federal excise taxes. The most common areas where the City is exempt from Federal excise taxes are:

1. Fuel that is used by the City
2. Communication
3. Heavy trucks, trailers and tractors
4. Certain Superfund activity

If there is a specific circumstance that is in doubt you should contact the City to resolve that status of that Federal Excise tax and its applicability.

INSTRUCTIONS TO BIDDERS	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>

18. TAXES/LICENSES – CONT'D

Transaction Privilege (Sales) Taxes on the City:

The City of Scottsdale is not exempt from being charged the appropriate Arizona State, County, and City privilege (sales) taxes on the goods and services that we procure. For suppliers within the state of Arizona the City expects to be charged the appropriate privilege taxes on the invoice. For out of state suppliers that do not have the ability to collect Arizona State privilege taxes the City will self-accrue such Arizona State and City use taxes for collection and payment to the State of Arizona and City of Scottsdale.

Transaction Privilege (Sales) Taxes on the Supplier / Contractor: Certain Business Services and Activities may have a City of Scottsdale Privilege (sales) tax liability. To determine the City of Scottsdale tax treatment please visit the following website and view the City of Scottsdale Tax Code and other Privilege and Use tax resources.

Questions pertaining to the applicability of taxes shall be directed to the City of Scottsdale Tax & License Section at 480-312-2400. The Contractor shall be responsible for payment of all applicable taxes due on contract income whether or not such taxes are specifically separated in the bid amount.

<http://www.scottsdaleaz.gov/taxes/>

Certain Business Services and Activities may have a State Privilege (sales) tax liability. To determine the State tax treatment, please visit the following website or contact the Arizona Department of Revenue at 602-716-6578 or 602-716-6657.

<http://azleg.state.az.us/ArizonaRevisedStatutes.asp?Title=42>

To obtain a State of Arizona Privilege (Sales) Tax License Application, please go to the following website:


<http://www.azdor.gov/Business.aspx>

The City of Scottsdale requires a license for service-oriented businesses located in Scottsdale that do not have a City of Scottsdale transaction privilege (sales) tax liability. This includes all activities or acts including, but not limited to service, professionals, trades and occupations, personal or corporate. To engage or continue in business the owner must obtain a Business, Occupational and Professional license. Service oriented businesses located outside the City limits are NOT required to obtain a Business, Occupational and Professional License from the City of Scottsdale.

Please visit the following website for the City of Scottsdale Transaction Privilege & Use Tax License and the Business, Occupational and Professional License applications:

<http://www.scottsdaleaz.gov/taxes>

Bidder is solely responsible for any and all tax obligations which may result out of the bidder's performance of this contract. The City has no obligation to pay any amounts for taxes, of any type incurred by the bidder.

INSTRUCTIONS TO BIDDERS	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>

18. TAXES/LICENSES – CONT'D

Construction Related Transaction Privilege (Sales) Taxes Responsibility of the Contractor:

The Contractor shall be responsible for payment of all applicable State of Arizona and City of Scottsdale transaction privilege (sales) taxes due on construction income whether or not such taxes are specifically separated in the bid amount. The taxes are to be reported on either a progressive billing (accrual) basis or cash receipts basis, depending on the method chosen at the time application was made for the Privilege (sales) Tax License.

City Privilege (sales) tax exemptions/deductions may be applicable to certain projects. We advise you to consider this as you prepare your bid. Please review, in detail, Sections 415, 465, and 110 of the Scottsdale Revised City Code, Appendix C to determine if exemptions/deductions are applicable. For tax guidance, please reference the City Code and other tax resources at the following website:

<http://www.scottsdaleaz.gov/taxes/>

The State of Arizona has similar exemptions; please reference ARS Title 42 at the following website:

<http://www.azleg.state.az.us/ArizonaRevisedStatutes.asp?Title=42>


To determine tax treatment of design/build contracts, please contact the Arizona Department of Revenue at 602-255-2060 and the City of Scottsdale Tax Audit Section at 480-312-2629.

Construction bids will be evaluated and recommended for award based on the total bid cost including tax.

19. CONTRACTOR'S LICENSING REQUIREMENTS

If applicable, the Contractor shall state his Arizona State Contractor's License Number and Classification on the Bid Form as evidence that he is licensed to contract the work indicated in the specifications at the time of bid submittal.

In accordance with Article 3, Regulation 32-1151 of the Arizona Registrar of Contractors Statutes and Rules, it is unlawful for any person, firm, partnership, corporation, association or other organization, or a combination of any of them, to engage in the business of, submit a bid or respond to a request for qualification/quotation or a request for proposals for construction services as, act or offer to act in the capacity of or purport to have the capacity of a contractor without having a contractor's license in good standing in the name of the person, firm, partnership, corporation, association or other organization at the time of bid submittal, if such licensing is a requirement of the Arizona Registrar of Contractors.

INSTRUCTIONS TO BIDDERS	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>

20. LITIGATION

The Bidder will disclose any issue or potential issue that may have a material bearing on the financial condition, solvency or credit worthiness of the organization. Disclosure includes any material contingent liabilities or uninsured potential losses, involuntary contract terminations in other jurisdictions and any voluntary or involuntary bankruptcy filings over the past 7 years. The Bidder will also disclose any litigation in which the Bidder has been involved in, either as a plaintiff or defendant, within the past 3 years, and the Bidder shall agree to notify the City within 24 hours of any litigation or significant potential for litigation of which the Bidder becomes aware. Further, the Bidder will be required to warrant that it will disclose in writing to the City all litigation involving the Bidder, the Bidder's related organization, owners and key personnel.

21. SUBCONTRACTOR'S LIST

If, at the time of bidding, any bidder intends to subcontract any portion of this contract, the bidder must complete the information required on the Subcontractor's List preceding the Bid Form and include this list with bid submittal documents.

22. SUBCONTRACTORS

During the performance of the Contract, the Contractor may engage any additional Subcontractors as may be required for the timely completion of this Contract, unless specifically prohibited by the specification. The addition of any Subcontractors must first receive the approval of the City. The awarded Contractor may relieve Subcontractors of City Tax liability by providing them with a completed Subcontractor Written Declaration form.


In the event of subcontracting, the sole responsibility for fulfillment of all terms and conditions of this Contract rests with the Contractor. The Contractor assumes responsibility for the proper performance of the work of Subcontractors and any acts and omissions in connection with such performance. Nothing in the Contract Documents is intended or deemed to create any legal or contractual relationship between the City and any Subcontractor or Sub-Subcontractor, including but not limited to any third-party beneficiary rights.

23. CONFIDENTIAL INFORMATION

Requests for nondisclosure of confidential information such as trade secrets and other proprietary data must be made known to the City within the bid submittal.

Bidders are instructed to clearly identify any proprietary information that may be submitted, and, if feasible, package such information in a separate, sealed envelope labeled "Confidential" or "Proprietary".

The City is subject to Arizona statutes and City Charter provisions that permit the inspection of public records. The City cannot insure confidentiality of any portion of a submittal document in the event a public inspection request is made.

INSTRUCTIONS TO BIDDERS	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>

23. CONFIDENTIAL INFORMATION – CONT'D

However, in accordance with Section R2-188.23 pertaining to Request for Proposals and Section R2-188.6 pertaining to Invitation for Bids, of the City's Procurement Code, the City shall examine the portions of your proposal noted as "Confidential" and/or "Proprietary". If a determination to disclose the information is made, you shall be so informed.

This is the only notification concerning confidential information that will be given to potential bidders, and this provision should be taken into consideration prior to submitting a bid.

After contract award, and unless otherwise instructed by the bidder, the City shall destroy all information identified as confidential or proprietary in accordance with public records retention requirements.

24. SMALL BUSINESS

Small, minority owned businesses (MBE/WBE/DBE) are encouraged to respond to City of Scottsdale solicitations.

25. TITLE VI NOTICE

"The City of Scottsdale, in accordance with the provisions of Title VI of the Civil Rights Act of 1964 (78 Stat. 252.42 U.S.C. §§ 2000d-4) and the Regulations, hereby notifies all bidders that it will affirmatively ensure that for any contract entered into pursuant to this advertisement, disadvantaged business enterprises will be afforded full and fair opportunity to submit bids in response to this invitation and will not be discriminated against on the grounds of race, color, or national origin in consideration for an award."

26. INTERPRETATIONS, ADDENDA

THE CITY OF SCOTTSDALE WILL NOT BE RESPONSIBLE FOR BIDDERS ADJUSTING THEIR SUBMITTAL BASED ON ORAL INSTRUCTIONS BY ANY MEMBER OF THE CITY STAFF OR BY THE CITY'S CONTRACTED CONSULTANT OR AGENT. SUBMITTALS DEVIATING FROM THE SPECIFICATIONS CONTAINED HEREIN BY ANY MEANS OTHER THAN AN AUTHORIZED ADDENDUM BY THE PURCHASING DIVISION WILL BE SUBJECT TO REJECTION.

Should a Bidder find an ambiguity, inconsistency or error in the Plans if applicable or Specifications, or should he be in doubt as to their meaning, he shall at once notify the contact person listed on page one of this solicitation, who will prepare a written addendum. The City will not be responsible for oral instructions or information.

All questions shall be submitted as per the Solicitations Questions Clause.

Any addenda issued by the City will become a part of the Contract. By signing and submitting a bid or proposal, the Bidder/Proposer is acknowledging that they will abide by all addenda issued prior to the opening of the bids/proposals and agreeing that all pricing takes into account all such addenda.

INSTRUCTIONS TO BIDDERS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

26. INTERPRETATIONS, ADDENDA – CONT'D

A Notice of Addenda will be emailed to those who have registered as a downloader and provided their email address; or provided by other appropriate means to each bidder, person or firm recorded on the Plan Holder's list. The bidder/proposer can return to the City's website under Solicitation Opportunities to verify how many addenda have been issued against a specific solicitation. If they feel they are missing any addenda, they can register again as a downloader to obtain access to all issued addenda. A viewing copy of the addenda will also be available wherever the Solicitation Documents are kept. It is the responsibility of the bidder/proposer to be aware of ALL addenda before submitting their final bid/proposal. The City takes no responsibility for any addenda that a bidder/proposer has failed to address in their submittal, and will hold the bidder/proposer responsible that their pricing encompasses all issued addenda.

27. SUBMITTAL PROCEDURE

No submittal will be considered unless it is submitted on the bid forms contained herein (or as otherwise requested). Faxed or emailed submittals will not be considered. Erasures, interlineations or other modifications in the submittal shall be initialed by the authorized person signing the Offer & Acceptance/Proposal Signature Page document.

The Bid Form/Pricing Proposal page (if applicable) containing the pricing must be completed. The name of the Contractor/Company must be listed on the page.

To be considered responsive, the Offer and Acceptance Form/Proposal Signature page must be signed and dated by an authorized person(s) eligible to sign contract documents for the contractor and is part of the original bid/proposal submittal due at the stated date and time indicated in the solicitation. Consortiums, joint ventures, or teams entering submittals will not be considered responsive unless it is established that all contractual responsibility rests solely with one bidder or one legal entity. The Submittal must indicate the responsible entity.

Submitters should be aware that joint responsibility and liability will attach to any resulting contract and failure of one party in a joint venture to perform will not relieve the other party or parties of total responsibility for performance.


If you wish to mail your submittal please note that it is the submitter's responsibility to ensure the submittal is received at the Front Desk of the Purchasing Office with enough time to have it time and date stamped on or before the solicitation receipt date and time. Faxed or emailed submittals will not be accepted. **LATE SUBMITTALS WILL NOT BE CONSIDERED.**

Submittals received after the time and date specified will be returned to the bidder unopened. A submittal may be withdrawn prior to the time set for opening submittals.

No submittal may be withdrawn for a period of one hundred and twenty (120) days after the date set for receipt of submittals.

At any time prior to the specified solicitation due time and date a Bidder may withdraw the bid. Faxed withdrawals will not be considered.

Submittals received by the City with the signed Offer on the Offer and Acceptance form/Proposal Signature document constitutes a legally binding offer by the contractor.

INSTRUCTIONS TO BIDDERS	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>

27. SUBMITTAL PROCEDURE – CONT'D

All submittals are to be completed on City of Scottsdale (COS) forms without any alterations; failure to do so may result in your submittal being rejected.

28. AWARD DETERMINATION

Responsive proposals will be evaluated based on the evaluation criteria established within the solicitation document. Various elements of the proposal submittal will be reviewed and evaluated against the solicitation requirements. There may or may not be a requested presentation from the top proposals to further understand their proposal and how it responds to the solicitation requirements. Proposers should not assume there will be an opportunity for presentations and should therefore make their proposal submittals comprehensive in response to the solicitation requirements.

Upon conclusion of all of the evaluations, a recommendation is made to award to the proposer that best meets the City's needs and provides the best value to the City.

Notwithstanding any other provision of the Request for Proposal, the City expressly reserves the right to:

- (1). Waive any immaterial defect or informality; or
- (2). Reject any or all Proposals, or portions thereof; or
- (3). Reissue a Request for Proposal.
- (4). To award by individual line item, by group of line items, or as a total, whichever is deemed most advantageous to the City.


29. REJECTION OF BIDS

The Purchasing Director or City Council reserves the right, as the interest of the City requires, to reject any or all submittals, to waive any informality in submittals received, to award a contract by accepting or rejecting any alternate submittal(s) (additive or subtractive) and reserves the right to reject the submittal(s) of any bidder who has previously failed to perform competently in any contract with the City.

30. PROTESTS

Pursuant to the City of Scottsdale Procurement Code Section 2-213 an aggrieved person may protest any aspect of a solicitation prior to award of a contract. As used herein, the phrase "any aspect of a solicitation" shall be limited in its interpretation to mean an alleged violation of the City's Procurement Code as it relates to the bid solicitation, its evaluation, or its award.

A protest must be filed within ten (10) calendar days after the protestor, exercising reasonable diligence, knew or should have known of facts and circumstances upon which the protest is based. Failure to protest any issue, fact or circumstance the protestor knew or should have known upon the exercise of reasonable diligence within said ten (10) calendar day period shall forever preclude a hearing based upon that issue, fact or circumstance.

INSTRUCTIONS TO BIDDERS	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>

30. PROTESTS – CONT'D

Notice of Awards will be given either through the City Council Meeting Agendas for those contracts being awarded by City Council (i.e. ,for construction and professional services) or through a Notice of Intent to Award posting, seven (7) calendar days prior to award, on the Purchasing section of the City's Internet Web Site for all administratively awarded contracts. Award of contracts shall be final and no protest pursuant to this section may be filed after award.

A protest must be in writing and shall:
State the name and address of the aggrieved person.
Identify the contracting activity and the number of the solicitation.

Contain a statement of all the grounds for the protest that the protestor then knows or should know based upon the exercise of reasonable diligence. Include supporting exhibits, evidence or documents to substantiate any claims unless not available within the filing time in which case the expected availability date shall be indicated.

Material submitted by a protestor shall not be withheld from an interested party except to the extent that the withholding of information is permitted or required by law or as determined pursuant to code provisions for confidential material.

If the protestor believes the protest contains material that should be withheld, a statement advising the Director of this fact shall accompany the protest submission.

The written protest must be filed with the Purchasing Director at the following address:

City of Scottsdale
Purchasing Services Department
9191 E San Salvador Dr.
Scottsdale, AZ 85258
Attn: James Flanagan, Purchasing Director

The Director may dismiss a protest, upon a written determination, before scheduling a hearing if:

The protest does not state a valid basis for protest; or

The protest is untimely pursuant to Procurement Code Section 2-213.

If the director determines a hearing is appropriate under the circumstances, the director shall notify the protestor of the time and place set for a hearing on the protest. The director may also give notice of the hearing to any other persons involved in the solicitation whose interests may be affected by the ruling requested from the director. Any person whose interest is affected shall be permitted to intervene and participate in such hearing.

Nothing contained herein shall require that the protest hearing be held prior to the award, if evidence from the solicitation, its evaluation or its award cannot be released to the public until after the award in order to protect the competitive process or in the best interests of the City.

INSTRUCTIONS TO BIDDERS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

31. CONTRACT AWARD NOTIFICATION

Intent to Award notices for contracts conducted as formal solicitations will be posted on Purchasing's website on the Intent to Award listing. Informal solicitations will be posted to the Award listing upon award. Intent to Award and award information can be found at the link provided below:

<https://eservices.scottsdaleaz.gov/eServices/Solicitations/Awards.aspx?CID=0>

The City Council must approve award of contracts for construction and professional services exceeding the formal procurement limit. Any contract award going to City Council for approval is not binding on the City until after approval by the City Council, even if previously signed by the Contractor and a City representative. All other contracts exceeding the formal procurement limit may be administratively awarded by the Purchasing Director.

It is the submitter's responsibility to access this information from the City of Scottsdale Purchasing website link provided above. This is the only notification you will receive regarding the posting of Notices of Intent to Award and Award.

32. AWARD OF CONTRACT

By signing the Offer portion of the Offer/Acceptance Form as a part of the Response to the Solicitation, the contractor is making a non-contingent offer to contract with the City strictly based upon the terms, conditions, and specifications contained in the City's solicitation. The City is under no obligation to accept any identified exceptions. These Bid or Proposal offers do not become contracts until after the Purchasing Director has signed the Acceptance portion of the Offer/Acceptance Form. The contract is then considered awarded to the successful contractor, eliminating the signing of a separate contract.

For that reason, all of the terms, conditions and specifications of the procurement contract are contained in the solicitation, unless any of the terms, conditions or specifications are modified by an addendum to the solicitation, a contract amendment, or by mutually agreed written terms and conditions in the Contract documents.

The effective date of this contract shall be the date the Purchasing Director signs the Offer and Acceptance form, unless another date is specifically stated as the effective date.

The Contractor is cautioned not to begin any billable work or provide any materials or services under this contract until the contractor receives a purchase order document or separate Notice to Proceed.

Once the City has awarded the contract by signing the acceptance portion of the Offer/Acceptance Form, Notice of Contract Award and presenting it to the Contractor, the Contractor is required to provide all additional Bonds and/or Insurance Certificates, and other documentation required to issue the purchase order or Notice to Proceed; within ten (10) calendar days after the date of this Acceptance of Offer or Notice of Contract Award. If the Contractor fails to furnish the required documents within the stated 10 calendar days they may be considered in default and may risk forfeiture of any applicable required Bid Bond. All required documents shall be sent to the Purchasing Representative listed in the solicitation.

33. BID BOND

(Not Applicable)

GENERAL TERMS AND CONDITIONS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

1. **ADDITIONAL SERVICE REQUESTED**

Any service requested which is not specifically authorized by the Contract or written adjustments thereto, requires the issue of a separate purchase order by the City for authorization to perform, and separate billing by the Contractor for payment.

2. **ADVERTISING**

No advertising or publicity concerning the City using the Contractor's services shall be undertaken without prior written approval of such advertising or publicity by the City of Scottsdale Contract Administrator and by the City Attorney.

3. **ARIZONA LAW**

The Contract and all Contract Documents are considered to be made under, and will be construed in accordance with and governed by the laws of the State of Arizona without regard to the conflicts or choice of law provisions. Any action to enforce any provision of this Contract or to obtain any remedy under this Contract will be brought in the Superior Court, Maricopa County, Arizona, and for this purpose, each party expressly and irrevocably consents to the jurisdiction and venue of this Court.

4. **ASSIGNMENT**

Services covered by this Contract may not be assigned or sublet in whole or in part without first obtaining the written consent of the Purchasing Director and Contract Administrator.

5. **ATTORNEY'S FEES**

In the event either party brings any action for any relief, declaratory or otherwise, arising out of this Contract, or on account of any breach or default hereof, the prevailing party shall be entitled to receive from the other party reasonable attorneys' fees and reasonable costs and expenses, determined by the court sitting without a jury, which shall be deemed to have accrued on the commencement of such action and shall be enforceable whether or not such action is prosecuted to judgment.

6. **AUTHORITY**

Each party hereby warrants and represents that it has full power and authority to enter into and perform this Contract, and that the person signing on behalf of each has been properly authorized and empowered to enter this Contract. Each party further acknowledges that it has read this Contract, understands it, and agrees to be bound by it.

GENERAL TERMS AND CONDITIONS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

7. CANCELLATION OF CITY CONTRACTS

The City may cancel any contract or agreement, without penalty or obligation, if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of the City's departments or agencies is, at any time while the contract or any extension of the contract is in effect, an employee of any other party of the contract in any capacity or a consultant to any other party of the contract with respect to the subject matter of the contract. The cancellation shall be effective when written notice from the City is received by all other parties to the contract, unless the notice specifies a later time (A.R.S. 38-511).

8. CAPTIONS/HEADINGS

The headings used in the Contract Documents are for ease of reference only and will not in any way be construed to limit or alter the meaning of any provision.

The captions used in this Contract are solely for the convenience of the parties, do not constitute a part of this Contract and are not to be used to construe or interpret this Contract.

9. CERTIFICATE OF INSURANCE

The successful vendor(s) will be required to furnish the City of Scottsdale a Certificate of Insurance on a standard insurance industry ACORD™ form or its equivalent when separate insurance requirements are listed under clause #28-Insurance Requirements. The ACORD™ form must be issued by an insurance company authorized to transact business in the State of Arizona. A sample of a standard insurance industry ACORD™ form with the required additional insured language can be found on the Purchasing web site under forms at: <http://www.scottsdaleaz.gov/Purchasing>. Failure to provide a Certificate of Insurance with the appropriate verbiage will result in rejection of your certificate and/or may be cause for Contract default. Additionally, Certificates of Insurance submitted without referencing the solicitation number will be subject to rejection and discarded.

10. CHANGES IN THE WORK

The City may at any time, as the need arises, order changes within the scope of the work without invalidating the contract. If such changes increase or decrease the amount due under the contract documents, or in the time required for performance of the work, an equitable adjustment shall be authorized by written Change Order.

The City will execute a formal Change Order based on detailed written quotations from the Contractor for work related changes and/or a time of completion variance. All Change Orders are subject to approval by the City.

Contract Change Orders are subject to the Rules and Procedures within the City's Procurement Code. Change orders to contracts may be executed, according to established rules, when provided for in the original contract.

GENERAL TERMS AND CONDITIONS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

10. CHANGES IN THE WORK – CONT'D

The Contractor will not perform any additional services without a written Change Order approved by the City. If the Contractor performs additional services without a Change Order, the Contractor will not receive any additional compensation.

11. CHEMICALS

Contractors must agree to provide Material Safety Data Sheets (MSDS) for all substances that are delivered to the City of Scottsdale, that come under the Federal requirements of 29CFR 1910 Subpart Z - Toxic and Hazardous Substances, which includes 29CFR 1910.1200 - Hazard Communication

All Contractors using chemicals on City of Scottsdale property shall use only the safest chemicals, with the least harmful ingredients. These chemicals shall be approved for use by a City of Scottsdale representative prior to bringing them on property.

Contractors shall make every attempt to apply approved chemicals with highly volatile organic compounds, outside of working hours. Adequate ventilation shall be used at all times during the application of these approved chemicals.

In conjunction with the Occupational Safety and Health Standards, Subpart-Z Toxic and Hazardous Substances, and Section 1910.1200 Hazard Communication, Contractors are hereby informed of the presence of (or possible presence) of chemicals in the area where the work requested will be performed. It is the responsibility of all selected Contractors to contact the City of Scottsdale for specific information relative to the type of chemicals present and location of appropriate material safety data sheets.

12. COMPLIANCE WITH FEDERAL AND ARIZONA STATE IMMIGRATION LAWS

Under the provisions of A.R.S. §41-4401, the Bidder warrants to the City that the Bidder and all its subcontractors will comply with all Federal Immigration laws and regulations that relate to their employees and that the Bidder and all its subcontractors now comply with the E-Verify Program under A.R.S. §23-214(A).

A breach of this warranty by the Bidder or any of its subcontractors will be considered a material breach of this Contract and may subject the Bidder or Subcontractor to penalties up to and including termination of this Contract or any subcontract.

The City retains the legal right to inspect the papers of any employee of the Bidder or any subcontractor who works on this Contract to ensure that the Bidder or any subcontractor is complying with the warranty given above.

The City may conduct random verification of the employment records of the Bidder and any of its subcontractors to ensure compliance with this warranty. The Bidder agrees to indemnify, defend and hold the City harmless for, from and against all losses and liabilities arising from any and all violations of these statutes.

GENERAL TERMS AND CONDITIONS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

12. COMPLIANCE WITH FEDERAL AND ARIZONA STATE IMMIGRATION LAWS – CONT'D

The City will not consider the Bidder or any of its subcontractors in material breach of this Contract if the Bidder and its subcontractors establish that they have complied with the employment verification provisions prescribed by 8 USCA §1324(a) and (b) of the Federal Immigration and Nationality Act and the E-Verify requirements prescribed by A.R.S. §23-214(A). The "E-Verify Program" means the employment verification pilot program as jointly administered by the United States Department of Homeland Security and the Social Security Administration or any of its successor programs.

The provisions of this Article must be included in any contract the Bidder enters into with any and all of its subcontractors who provide services under this Contract or any subcontract. "Services" are defined as furnishing labor, time or effort in the State of Arizona by a contractor or subcontractor. Services include construction or maintenance of any structure, building or transportation facility or improvement to real property. The Contractor will take appropriate steps to assure that all subcontractors comply with the requirements of the E-Verify Program. The Contractor's failure to assure compliance by all its' subcontractors with the E-Verify Program may be considered a material breach of this Contract by the City.

13. COMPLIANCE WITH FEDERAL AND STATE LAWS

The City has entered into this Contract with the Bidder relying on his knowledge and expertise to provide the services contracted for. As a part of that reliance, the Bidder represents that he knows and understands the relevant and applicable federal and state laws that apply to the services provided through this Contract, and agrees to comply with these relevant and applicable federal and state laws.


The Bidder understands and acknowledges the applicability to it of the American with Disabilities Act, the Immigration Reform and Control Act of 1986 and the Drug Free Workplace Act of 1989. The following is only applicable to construction contracts: The Bidder must also comply with A.R.S. § 34-301, "Employment of Aliens on Public Works Prohibited", and A.R.S. § 34-302, as amended, "Residence Requirements for Employees".

14. CONFLICT OF INTEREST

The City may cancel any contract or agreement, without penalty or obligation, if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of the City's departments or agencies is, at any time while the contract or any extension of the contract is in effect, an employee of any other party of the contract with respect to the subject matter of the contract. The cancellation shall be effective when written notice from the City is received by all parties to the contract, unless the notice specifies a later time (A.R.S. 38-511).

15. CONTRACT ADMINISTRATOR DUTIES

The Contract Administrator shall be responsible to audit the billings, approve payments, establish delivery schedules, approve addenda, and assure Certificates of Insurance are in City's possession and are current and conform to the contract requirements.

GENERAL TERMS AND CONDITIONS	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>

16. CONTRACTOR ON SITE SAFETY REPORTING REQUIREMENTS

For any non-construction City supplier whose service contract(s) (either singular or in aggregate) results in the contractor working 500 or more hours on site at a City of Scottsdale location(s) in any one calendar quarter, the following documentation must be provided by the contractor to the Contract Administrator (CA):

- the contractor's most recent OSHA 300A (if applicable);
- all accident reports for injuries that occurred in the city under the contract during the most recent review period;
- the contractor's current worker's compensation experience modifier;
- the above information is to be provided to the CA initially and every February thereafter as long as the contract is in force;
- the CA will provide this information to Risk Management when requested.

17. CO-OP USE OF CONTRACT

In addition to the City of Scottsdale, this Agreement may be extended for use by other municipalities, government agencies and governing bodies, including the Arizona Board of Regents, and political subdivisions of the State. Any such usage by other entities must be in accord with the ordinances, charter and/or rules and regulations of the respective entity and the approval of the Contractor.


18. COUNTERPARTS

This contract may be executed in one or more counterparts, and each originally executed duplicate counterpart of this Contract shall be deemed to possess the full force and effect of the original.

19. ENDANGERED HARDWOODS

Any construction, building addition or alteration project which is financed by monies of this state or its political subdivisions shall not use endangered tropical hardwood unless an exemption is granted by the Director of the State of Arizona, Department of Administration.

The Director shall only grant an exemption if the use of endangered tropical hardwood is deemed necessary for historical restoration or to repair existing facilities and the use of any substitute material is not practical. Any lease-purchase agreement entered into by this state or its political subdivisions for construction shall specify that no endangered tropical hardwood may be used in the construction unless an exemption is granted by the Director. As used in this subsection, "endangered tropical hardwood" includes ebony, lauan, mahogany or teak hardwood.

GENERAL TERMS AND CONDITIONS	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>

20. ENTIRE AGREEMENT

This Contract constitutes the entire understanding of the parties and supersedes all previous representations, written or oral, with respect to the services specified herein. This Contract may not be modified or amended except by a written document, signed by authorized representatives of each party.

21. EQUAL EMPLOYMENT OPPORTUNITY

During the performance of this contract the Bidder will follow the Federal government's guidelines to ensure that employees or applicants applying for employment will not be discriminated against because of race, color, religion, sex or national origin. The City of Scottsdale Diversity Office can be reached at 480-312-2727.

22. ESTIMATED QUANTITIES

All Quantities referenced in this solicitation document are subject to adjustment dictated by City requirements. Quantities at variance with stated bid quantities may be purchased as required.

23. EXECUTION OF CONTRACT

The Contractor shall provide all the required documentation, which can include but may not be limited to, applicable bonds, insurance certificates, IRS W-9 form and other documentation required to issue the purchase order or notice to proceed within ten (10) calendar days after the date of the Acceptance of Offer or Notice of Contract Award by the City. If a separate City Contract is required, the Contractor must execute it within ten (10) calendar days and return it to the City. Failure to complete these requirements within ten (10) calendar days may place the Contractor in default.

24. FORCE MAJEURE

The City shall not be held responsible for acceptance of all or any part of the materials tendered for delivery under this Agreement due to federal, state or municipal action, statute, ordinance or regulation, strike or other labor trouble, fire, windstorm or other incidents outside of the City's control which shall make such acceptance impossible or impractical.

Neither party shall be responsible for delays or failures in performance resulting from acts beyond their control. Such acts shall include, but not be limited to, acts of God, riots, acts of war, epidemics, governmental regulations imposed after the fact, fire, communication line failures, or power failures.

25. FUNDS APPROPRIATION

If the City Council does not appropriate funds to continue this Contract and pay for required charges, the City may terminate this Contract at the end of the current fiscal period. The City agrees to give written notice to the Contractor at least 30 days before the end of its current fiscal period and will pay the Contractor for all approved charges incurred through the end of this period.

GENERAL TERMS AND CONDITIONS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

26. INDEMNIFICATION

To the fullest extent permitted by law, Bidder, its successors, assigns and guarantors, shall defend, indemnify and hold harmless the City of Scottsdale, its agents, representatives, officers, directors, officials and employees from and against all allegations, demands, proceedings, suits, actions, claims, damages, losses, expenses, including but not limited to, attorney fees, court costs, and the cost of appellate proceedings, and all claim adjusting and handling expense, related to, arising from or out of, or resulting from any negligent or willful actions, acts, errors, mistakes or omissions by Bidder relating to work or services performed under this Contract, including but not limited to, any Subcontractor or anyone directly or indirectly employed by any of them or anyone for whose acts any of them may be liable and any injury or damages claimed by any of Bidder's and Subcontractor's employees.

Insurance provisions set forth in this agreement, if any, are separate and independent from the indemnity provisions of this paragraph and shall not be construed in any way to limit the scope and magnitude of the indemnity provisions. The indemnity provisions of this paragraph shall not be construed in any way to limit the scope and magnitude and applicability of the insurance provisions.

27. INDEPENDENT CONTRACTOR

The services Contractor provides under the terms of this Contract to the City are that of an Independent Contractor, not an employee, or agent of the City. The City will report the value paid for these services each year to the Internal Revenue Service (I.R.S.) using Form 1099.

City shall not withhold income tax as a deduction from contractual payments. As a result of this, Contractor may be subject to I.R.S. provisions for payment of estimated income tax. Contractor is responsible for consulting the local I.R.S. office for current information on estimated tax requirements.


28. INSURANCE REQUIREMENTS

Insurance Representations and Requirements

General

Contractor agrees to comply with all applicable City ordinances and state and federal laws and regulations.

Without limiting any obligations or liabilities of Contractor, must purchase and maintain, at its own expense, this Contract's stipulated minimum insurance with insurance companies properly licensed by the State of Arizona (admitted insurer) with an AM Best, Inc. rating of B ++ 6 or above or an equivalent qualified unlicensed insurer by the State of Arizona (non-admitted insurer) with policies and forms satisfactory to City of Scottsdale. Failure to maintain insurance as specified may result in termination of this Contract at City of Scottsdale's option.

GENERAL TERMS AND CONDITIONS	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>

28. INSURANCE REQUIREMENTS – CONT'D

Insurance Representations and Requirements – Cont'd

No Representation of Coverage Adequacy

By requiring the insurance stated in this Contract, the City of Scottsdale does not represent that coverage and limits will be adequate to protect Contractor. City of Scottsdale reserves the right to review any and all of the insurance policies and/or endorsements required by this Contract, but have no obligation to do so. Failure to demand any evidence of full compliance with the insurance requirements stated in this Contract or failure to identify any insurance deficiency does not relieve Contractor from, nor be construed or considered a waiver of, its obligation to maintain the required insurance at all times during the performance of this Contract.

Coverage Term

All insurance required by this Contract must be maintained in full force and effect until all work or services required to be performed under the terms of this Contract are satisfactorily performed, completed and formally accepted by the City of Scottsdale, unless specified otherwise in this Contract.

Claims Made

In the event any insurance policies required by this Contract are written on a "claims made" basis, coverage shall continue uninterrupted throughout the term of this Contract by keeping coverage in force using the effective date of this Contract as the retroactive date on all "claims made" policies. The retroactive date for exclusion of claims must be on or before the effective date of this Contract, and can never be after the effective date of this Contract. Upon completion or termination of this Contract, the "claims made" coverage shall be extended for an additional three (3) years using the original retroactive date, either through purchasing an extended reporting option; or by continued renewal of the original insurance policies. Submission of annual Certificates of Insurance, citing the applicable coverages and provisions specified herein, shall continue for three (3) years past the completion or termination of this Contract.

Policy Deductibles and or Self-Insured Retentions

The policy requirements may provide coverage which contains deductibles or self-insured retention amounts. Any deductibles or self-insured retention are not applicable to the policy limits provided to City of Scottsdale. Contractor is solely responsible for any deductible or self-insured retention amount. City of Scottsdale, at its option, may require Contractor to secure payment of any deductible or self-insured retention by a surety bond or irrevocable and unconditional Letter of Credit.

Use of Subcontractors

If any work under this Contract is subcontracted in any way, Contractor must execute a written agreement with Subcontractor containing the same Indemnification Clause and Insurance Requirements as stated in this Contract protecting City of Scottsdale and Contractor. Contractor will be responsible for executing the agreement with Subcontractor and obtaining Certificates of Insurance verifying the insurance requirements.

GENERAL TERMS AND CONDITIONS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

28. INSURANCE REQUIREMENTS – CONT'D

Insurance Representations and Requirements – Cont'd

Evidence of Insurance and Required Endorsements

Before starting any work or services under this Contract, Contractor must furnish City of Scottsdale with Certificate(s) of Insurance, or formal endorsements as required by this Contract, issued by Contractor's insurer(s) as evidence that policies are placed with acceptable insurers as specified in this Contract and provide the required coverage, conditions, and limits of coverage and that this coverage and the provisions are in full force and effect. If a Certificate of Insurance is submitted as verification of coverage, City of Scottsdale will reasonably rely upon the Certificate of Insurance as evidence of coverage but this acceptance and reliance will not waive or alter in any way the insurance requirements or obligations of this agreement. If any of the above cited policies expire during the life of this Contract, it is Contractor's responsibility to forward renewal Certificates within ten (10) days after the renewal date containing all the aforementioned insurance provisions. Certificates must specifically cite the following provisions endorsed to the Contractor's policy:

1. City of Scottsdale, its agents, representatives, officers, directors, officials and employees must be named an Additional Insured under the following policies:
 - a) Commercial General Liability
 - b) Auto Liability
 - c) Excess Liability - Follow Form to underlying insurance as required.
2. Contractor's insurance must be primary insurance as respects performance of subject contract.
3. All policies, except Professional Liability insurance, if applicable, waive rights of recovery (subrogation) against City of Scottsdale, its agents, representatives, officers, directors, officials and employees for any claims arising out of work or services performed by Contractor under this Contract.
4. If the Contractor receives notice that any of the required policies of insurance are materially reduced or cancelled, it will be Contractor's responsibility to provide prompt notice of same to the City, unless such coverage is immediately replaced with similar policies.

Required Coverage

Commercial General Liability

Contractor must maintain "occurrence" form Commercial General Liability insurance with a limit of not less than \$1,000,000 for each occurrence, \$2,000,000 Products and Completed Operations Annual Aggregate, and a \$2,000,000 General Aggregate Limit. The policy must cover liability arising from premises, operations, independent contractors, products-completed operations, personal injury and advertising injury. If any Excess insurance is utilized to fulfill the requirements of this section, the Excess insurance must be "follow form" equal or broader in coverage scope than underlying.

GENERAL TERMS AND CONDITIONS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

28. INSURANCE REQUIREMENTS – CONT'D

Required Coverage – Cont'd

Vehicle Liability

If any vehicle is used in the performance of the scope of work that is the subject of this contract, the Contractor must maintain Business Automobile Liability insurance with a limit of \$1,000,000 each occurrence on Contractor's owned, hired, and non-owned vehicles assigned to or used in the performance of the Contractor's work or services under this Contract. If any hazardous material, as defined by any local, state or federal authority, is the subject, or transported, in the performance of this contract, an MCS 90 endorsement is required providing \$5,000,000 per occurrence limits of liability for bodily injury and property damage. If any Excess insurance is utilized to fulfill the requirements of this section, the Excess insurance must be "follow form" equal or broader in coverage scope than underlying.

Worker's Compensation Insurance

Contractor must maintain Worker's Compensation insurance to cover obligations imposed by federal and state statutes having jurisdiction of Contractor's employees engaged in the performance of work or services under this Contract and must also maintain Employers' Liability Insurance of not less than \$100,000 for each accident, \$100,000 disease for each employee and \$500,000 disease policy limit.

Professional Liability


If the Contract is the subject of any professional services or work, or if Contractor engages in any professional services or work adjunct or residual to performing the work under this Contract, Contractor must maintain Professional Liability insurance covering errors and omissions arising out of the work or services performed by Contractor or anyone employed by Contractor or anyone for whose acts, mistakes, errors and omissions Contractor is legally liable, with a liability insurance limit of \$1,000,000 each claim and \$2,000,000 all claims.

29. LITIGATION

The Bidder will disclose any issue or potential issue that may have a material bearing on the financial condition, solvency or credit worthiness of the organization. Disclosure includes any material contingent liabilities or uninsured potential losses, involuntary contract terminations in other jurisdictions and any voluntary or involuntary bankruptcy filings over the past 7 years. The Bidder will also disclose any litigation in which the Bidder has been involved in, either as a plaintiff or defendant, within the past 3 years, and the Bidder shall agree to notify the City within 24 hours of any litigation or significant potential for litigation of which the Bidder becomes aware. Further, the Bidder will be required to warrant that it will disclose in writing to the City all litigation involving the Bidder, the Bidder's related organization, owners and key personnel.

30. LOCAL CONDITIONS, RULES AND REGULATIONS

The Bidder shall familiarize himself with the nature and extent of the Contract documents, work to be performed, all local conditions, and federal, state and local laws, ordinances, rules and regulations that in any manner may affect cost, progress or performance of the work.

GENERAL TERMS AND CONDITIONS	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>

31. MODIFICATIONS

Any adjustments, alterations, additions, deletions, or modifications in the terms and/or conditions of this contract must be made by written Change Authorization approved by the Contract Administrator, Purchasing Director and the Contractor.

If Contractor performs any modification without written Change Authorization, the City shall not be obligated to accept said modification.

32. NO PREFERENTIAL TREATMENT OR DISCRIMINATION

In accordance with the provisions of Article II, Section 36 of the Arizona Constitution, the City will not grant preferential treatment to or discriminate against any individual or group on the basis of race, sex, color, ethnicity or national origin. The City of Scottsdale Diversity Office can be reached at 480-312-2727.

33. NO WAIVER

The failure of either party to enforce any of the provisions of the Contract Documents or to require performance of the other party of any of the provisions of this Contract will not be construed to be a waiver of those provisions, nor will it affect the validity of the Contract Documents, or the right of either party to enforce each and every provision.

No delay or failure of either party in exercising any right hereunder, and no partial or single exercise thereof, shall be deemed to constitute a waiver of such right or any other rights hereunder. All waivers must be in writing and signed by the party to be charged. Any waiver by either party of any requirement hereunder shall be deemed to be a specific limited waiver, and shall not be deemed to be a continuing waiver nor a waiver of any other requirement hereof.

34. ORDER OF PRECEDENCE

In the event of a conflict in the provisions of this solicitation or resulting contract, as accepted by the City and as they may be amended, the following shall prevail in the order set forth below:

1. Signed and fully executed separate Contract or Offer and Acceptance Sheet
2. Special Terms & Conditions of the solicitation
3. General Terms & Conditions of the solicitation
4. Statement or Scope of Work (SOW)
5. Specifications
6. Attachments
7. Exhibits
8. Instructions to Bidders
9. Other documents referenced or included in the solicitation or contract

GENERAL TERMS AND CONDITIONS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

35. PATENTS

The Contractor agrees upon receipt of notification to promptly assume full responsibility for the defense of any suit or proceeding which is, has been, or may be brought against the City of Scottsdale and its agents or bidders for alleged patent and/or copyright infringement, as well as for the alleged unfair competition resulting from similarity in design, trademark or appearance of goods by reason of the use or sale of any goods furnished under this contract and the Contractor further agrees to indemnify the City against any and all expenses, losses, royalties, profits and damages including court costs and attorney's fees resulting from the bringing of such suit or proceedings including any settlement or decree of judgment entered therein.

The City may be represented by and actively participate through its own counsel in any such suit or proceedings if it so desires.

36. PAYMENT TERMS

The City of Scottsdale's payment terms are payment within thirty (30) days except in Title 34 circumstances where payment is required within fourteen (14) days. Payment may be sooner where cash discounts are offered for early payment, however, cash discounts offered will not be considered in determining lowest bidder. In no event will payment be made prior to receipt of an original invoice containing invoice and Purchase Order numbers and receipt of purchased item. The City is not liable for delays in payment caused by failure of the vendor or contractor to send invoice to the address specified below:


CITY OF SCOTTSDALE
ACCOUNTS PAYABLE
7447 E. INDIAN SCHOOL ROAD, #210
SCOTTSDALE, ARIZONA 85251-4468

37. PRICE REDUCTION

If Contractor's, manufacturer, or supplier at any time during the course of this contract, makes a general price decrease, to the Contractor, the Contractor shall promptly notify the City in writing and extend such decrease to the City effective on the date of such general price decrease.

38. RECORDS AND AUDIT RIGHTS

Bidder's and Subcontractor's books, records, correspondence, accounting procedures and practices, and any other supporting evidence relating to this Contract (all the foregoing hereinafter referred to as "Records") shall be open to inspection and subject to audit and/or reproduction during normal working hours by the City of Scottsdale, or its authorized representative, to the extent necessary to adequately permit evaluation and verification of any invoices, payments or claims based on Bidder's or Subcontractor's actual costs (including direct and indirect costs and overhead allocations) incurred, or units expended directly in the performance of work under this Contract. For the purpose of evaluating or verifying such actual or claimed costs or units expended, the City of Scottsdale or its authorized representative shall have access to said Records from the effective date of this Contract for the duration of the work and until three (3) years after the date of final payment by the City of Scottsdale to Bidder pursuant to this Contract.

GENERAL TERMS AND CONDITIONS	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>

38. RECORDS AND AUDIT RIGHTS – CONT'D

The City of Scottsdale or its authorized representative shall have access, during normal working hours, to all necessary Bidder and Subcontractor facilities, and shall be provided adequate and appropriate work space, in order to conduct audits in compliance with the provisions of this Article. The City of Scottsdale shall give Bidder or Subcontractor reasonable advance notice of intended audits.

Bidder shall require Subcontractors to comply with the provisions of this Article by insertion of the requirements hereof in any subcontract pursuant to this Contract.

If an audit in accordance with this article, discloses overcharges, of any nature, by the Contractor to the City in excess of one percent (1%) of the total contract billings, the actual cost of the City's audit shall be reimbursed to the City by the Contractor. Any adjustments and/or payments which must be made as a result of any such audit or inspection of the Contractor's invoices and/or records shall be made within a reasonable amount of time (not to exceed 90 days) from presentation of City's findings to Contractor.

39. REGISTERED/LICENSES

To be considered responsive, Contractors must be registered/licensed in the State of Arizona, if such registration/license is normally a requirement.

40. REQUEST FOR TAXPAYER I.D. NUMBER & CERTIFICATION IRS W-9 FORM

Upon request, the Contractor shall provide the required I.R.S. W-9 FORM which is available from the IRS website at www.IRS.gov under their forms section.

41. RISK OF LOSS

Contractor agrees to bear all risks of loss, injury or destruction of goods and materials ordered as a result of this Invitation for Bid which occur prior to delivery to the City; and such loss, injury, or destruction shall not release Contractor from any obligation hereunder.

The Contractor agrees upon receipt of notification to promptly assume full responsibility for the defense of any suit or proceeding which is, has been, or may be brought against the City of Scottsdale and its agents or vendors for alleged patent and/or copyright infringement, as well as for the alleged unfair competition resulting from similarity in design, trademark or appearance of goods by reason of the use or sale of any goods furnished under this contract and the Contractor further agrees to indemnify the City against any and all expenses, losses, royalties, profits and damages including court costs and attorney's fees resulting from the bringing of such suit or proceedings including any settlement or decree of judgment entered therein.

The City may be represented by and actively participate through its own counsel in any such suit or proceedings if it so desires.

GENERAL TERMS AND CONDITIONS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

42. SCOTTSDALE CITY SEAL AND CITY SYMBOL

The Scottsdale City seal (as defined in S.R.C. § 2-1) and the City symbol are registered marks and are reserved solely for the City's use. Any other use or reproduction of the City's registered marks in any print, digital, or other media and without the City's express, written consent is prohibited. As a breach of this prohibition may impair the City's reputation, dilute its mark(s), or otherwise cause the City irreparable harm, the City shall be entitled to an immediate injunction enjoining such use in addition to any other legal or equitable remedies.

43. SEVERABILITY

If any provision of the Contract Documents or the application of them to any person or circumstance is invalid, illegal or unenforceable to any extent, the remainder of the Contract Documents and their application will not be affected and are enforceable to the fullest extent permitted by law.

44. SUCCESSORS AND ASSIGNS

No right or interest covered by this Contract shall be assigned in whole or in part without the prior written consent of the City.

The CONTRACTOR and the City agree that the provisions of the Contract Documents are binding upon the parties, their employees, agents, heirs and assigns. This Contract extends to and is binding upon the CONTRACTOR, its successors and assigns, including any individual, company, partnership or other entity with or into which the CONTRACTOR merges, consolidates or is liquidated, or any person, corporation, partnership or other entity to which the CONTRACTOR sells its assets.

45. TERMINATION

Termination for Convenience: City reserves the right to terminate this contract or any part hereof for its sole convenience with thirty (30) days written notice. In the event of such termination, Contractor shall immediately stop all work hereunder, and shall immediately cause any of its suppliers and subcontractors to cease such work. Contractor shall be paid a reasonable termination charge consisting of a percentage of the order price reflecting the percentage of the work performed prior to the notice of termination, plus actual direct costs resulting from termination.

Contractor shall not be paid for any work done after receipt of the notice of termination, nor for any costs incurred by Contractor's suppliers or subcontractors which Contractor could reasonably have avoided. Contractor shall not unreasonably anticipate the requirements of this contract.

Cancellation for Cause: City may also terminate this contract or any part hereof with seven (7) days' notice for cause in the event of any default by the Contractor, or if the Contractor fails to comply with any of the terms and conditions of this contract. Late deliveries, deliveries of products which are defective or do not conform to this contract, unsatisfactory performance as judged by the Contract Administrator, and failure to provide City, upon request, with adequate assurances of future performance shall all be causes allowing City to terminate this contract for cause.

GENERAL TERMS AND CONDITIONS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

45. TERMINATION – CONT'D

Cancellation for Cause – Cont'd

In the event of termination for cause, City shall not be liable to Contractor for any amount, and Contractor shall be liable to City for any and all damages sustained by reason of the default which gave rise to the termination. If it should be determined that City has improperly terminated this contract for default, such termination may be deemed a termination for convenience.

In the event Contractor is in violation of any Federal, State, County or City law, regulation or ordinance, the City may terminate this contract immediately upon giving notice to the Contractor.

46. TESTING OF MATERIALS

When required in the course of any service or contract the procedures and methods used to sample and test material will be determined by the City. Unless otherwise specified, samples and test will be made in compliance with the following: The City of Scottsdale Minimum Sampling Frequency Guide, The City of Scottsdale Material Testing Manual and the standard methods of AASHTO or ASTM, DSPM and MAG supplements.

The City will provide a pre-qualified City or Independent Testing Laboratory and will pay directly for initial City Acceptance Testing. When the first and subsequent tests indicate noncompliance with the specifications, the cost associated with that noncompliance will be paid for by the Contractor. When the first and subsequent tests indicate noncompliance with the specifications, all retesting will be performed by the same testing agency.


Rejected materials shall be immediately removed and shall not be used in any form for any other part of the work.

47. TIME IS OF THE ESSENCE

The City and the CONTRACTOR mutually agree that time is of the essence with respect to the dates and times contained in the Contract Documents.

48. WARRANTY

Contractor expressly warrants that all goods or services furnished under this agreement shall conform to all specifications and appropriate standards, will be new, and will be free from defects in material or workmanship. Contractor warrants that all such goods or services will conform to any statements made on the containers or labels or advertisements for such goods, or services, and that any goods will be adequately contained, packaged, marked and labeled. Contractor warrants that all goods or services furnished hereunder will be merchantable, and will be safe and appropriate for the purpose for which goods or services of that kind are normally used. If Contractor knows or has reason to know the particular purpose for which City intends to use the goods or services, Contractor warrants that such goods or services will be fit for such particular purpose. Contractor warrants that goods or services furnished will conform in all respect to samples. Inspection, test, acceptance of use of the goods or services furnished hereunder shall not affect the Contractor's obligation under this warranty, and such warranties shall survive inspection, test, acceptance and use.

GENERAL TERMS AND CONDITIONS	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>

48. WARRANTY – CONT'D

Contractor's warranty shall run to City, its successors, and assigns. Contractor agrees to replace or correct defects of any goods or services not conforming to the foregoing warranty promptly, without expense to City, when notified of such nonconformity by City, provided City elects to provide Contractor with the opportunity to do so. In the event of failure of Contractor to correct defects in or replace nonconforming goods or services promptly, City, after reasonable notice to Contractor, may make such corrections or replace such goods and services and charge Contractor for the cost incurred by City in doing so. Contractor recognizes that City's requirements may require immediate repairs or reworking of defective goods, without notice to the Contractor. In such event, Contractor shall reimburse City for the costs, delays, or other damages which City has incurred.

SPECIAL TERMS AND CONDITIONS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

1. **ACCEPTANCE / AGREEMENT**

Contractor shall act under the authority and approval of the Contract Administrator for the City, further named herein, to provide the services required by this Contract.

Any Contract/Agreement made pursuant to this solicitation must be accepted in writing by the Offeror. If for any reason the Offeror should fail to accept in writing, any conduct by Offeror which recognizes the existence of a Contract/ Agreement pertaining to the subject matter hereof shall constitute acceptance by Offeror of the Contract/Agreement and all of its terms and conditions. Any terms proposed in Offeror's acceptance of City's Contract which adds to, varies from or conflicts with the terms herein are hereby objected to. Any such proposed terms shall be void and the terms herein shall constitute the complete and exclusive statement of the terms and conditions of the Contract/Agreement between the parties and may hereafter be modified only by written instrument executed by the authorized representatives of both parties.

2. **INVOICING**

The Contractor shall submit One (1) legible copy of their detailed invoice prior to approval of any payments. At a **MINIMUM**, the invoice(s) **MUST** provide the following information:

- Company name, address and contact
- Xxx bill-to name and contact information
- Contract Serial Number
- Xxx purchase order number
- Invoice number and date
- Payment terms
- Date of service
- Contract Item number(s)
- Description of Services provided endeavor
- Pricing per unit of service
- Extended price
- Total Amount Due

The Contractor shall submit invoices with all supporting documentation within thirty (30) days after the service/work is completed and approved by the Contract Administrator.

3. **KEY PERSONNEL**

The Contractor shall provide an adequate staff of experienced personnel capable of and devoted to the successful accomplishment of Contract work. The Contractor shall assign the specific individuals identified in its proposal to key positions. The Contract is predicated, in part and among other considerations, on the utilization of the specific individual(s) and/or personnel qualification(s) identified and/or described in the Contractor's offer. Therefore, no substitution of such specified individuals and/or personnel shall be made without prior written approval of the CA. Any substitution of personnel under this Contract shall be equal or better than those identified in the Contract. The City's approval of a personnel substitution shall not be construed as an acceptance of the substitution's performance potential. No approval shall be unreasonably withheld of a proposed substitution of personnel. The Contractor shall bear all transitional expenses incurred for any costs associated with removing or replacing Key Personnel who are performing work under the contract.

SPECIAL TERMS AND CONDITIONS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

4. MULTIPLE AWARDS

If deemed to be in the City of Scottsdale's best interests, the City reserves the right to award multiple Contracts as a result of the solicitation process. While multiple awards are possible, the preferred procedure is to make a single award for each commodity or category of commodity.

5. OWNERSHIP OF PROJECT DOCUMENTS

All documents, including but not limited to notes, records, data compilations, studies, and reports in any format, including but not limited to, written or electronic media, prepared in the performance of this Contract will remain the property of the City and must be delivered to the Contract Administrator before final payment is made to the Consultant.

When the work detail covers only the preparation of preliminary reports or documents, there will be no limitations upon the City concerning use of the ideas or recommendations in the reports or documents. The City will release the Consultant from any liability for the preparation and use of preliminary reports or documents.

Any use of the project documents for purposes other than intended under this Contract will be at the sole risk of the City, and the Consultant will not be liable for any losses or injuries arising out of that use.

6. PRICE ESCALATION

Price increases may only be requested by the Contractor, thirty (30) days prior to the anniversary date of the Agreement. Failure to do so may result in the denial of any increase requested.

A requested price increase will become effective only after approval by the Contract Administrator and the Purchasing Director. Once approved the price increase will be adjusted into a new base price for the remainder of the contract period. Any future requested price increases to the base price will only be reviewed at annual renewal time and require the approval of the Contract Administrator and Purchasing Director.

Approved price increases will be applied to the unit pricing in the Agreement as a percentage increase.

The increased rate shall be based upon mutual consent of the Contractor and the Contract Administrator; however, the Contract Administrator shall evaluate the Contractor's performance, services and records documentation to determine the appropriateness of the increase requested.

The percentage increase in the unit pricing may not exceed the percent in the U.S. City Average "Consumer Price Index" (C.P.I.) All Items, 1982-84=100 for All Urban Consumers for the Percentage Change from the previous twelve (12) months, as published by the U. S. Department of Labor Bureau of Labor Statistics.

SPECIAL TERMS AND CONDITIONS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

7. PURCHASING PROCEDURE

All orders require a City of Scottsdale purchase order that will be communicated by phone, fax or e-mail. No parts or commodities or work shall be rendered/are to be delivered without the issuance of a City of Scottsdale purchase order. Any invoices received from the Contractor without a City of Scottsdale purchase order number, referenced on the invoice, may remain unpaid.

8. QUANTITY

All Quantities referenced in this solicitation document are subject to adjustment dictated by City requirements. Quantities at variance with stated bid quantities may be purchased as required.

9. TERM OF AGREEMENT


The term of this Contract shall be for a one (1) year period of the Acceptance of Offer/Notice of Award.

The City and Contractor may mutually agree to extend this Contract for four (4) additional one (1) year periods, upon the recommendation of the Contract Administrator, concurrence of the Purchasing Director.

10. UNPREDICTABLE MARKET CHANGE

In the event of an unpredictable change in the market, which affects the then current contract price, Contractor may submit justification for a price adjustment. Contract Administrator and Purchasing Director shall review justification and determine applicable price adjustment. Upon return to normal market conditions, the price will be adjusted to the price established by the original contract terms.

The Purchasing Director shall be the final authority on any price adjustment due to unpredictable market change.

SCOPE OF WORK	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>

1. **GENERAL INFORMATION**

- 1.1 The City of Scottsdale desires to contract for medical bill review, reduction, and payment program (Part 1) for its Worker's Compensation program. In addition, the City also desires to examine the possibility of an additional pharmacy plan(s) for worker compensation prescriptions as well (identified as Part 2)
- 1.2 The Offeror is encouraged to read the Solicitation documents very carefully, as the City shall not be responsible for errors and omissions on the part of the Offeror. The Offeror is also encouraged to carefully review their final submittal documents, as the Evaluation Committee is not required to make interpretations or correct detected errors in calculations.
- 1.3 Offeror shall familiarize themselves with the nature and extent of the solicitation and contract documents, work to be performed, all local conditions, and federal, state and local laws, ordinances, rules and regulations that may in any manner affect cost, progress or performance of the work.

2. **CONTRACT ADMINISTRATION**

- 2.1 The Contract Administrator shall be the Worker's Compensation Claims Adjuster or designee. The Contract Administrator shall audit the billings, approve payments, establish delivery schedules, approve addenda to the contract, and generally be responsible for overseeing the execution of the contract.

3. **GENERAL VENDOR QUALIFICATIONS**

- 3.1 The Contractor shall be in compliance with all applicable Federal, State, Local, ANSI, and O.S.H.A. laws, rules, and regulations and all other applicable regulations for the term of this contract.
- 3.2 The Contractor, without additional expense to the City, shall be responsible for obtaining and maintaining any necessary licenses and permits required in connection with the completion of the required services herein.
- 3.3 The Contractor may not subcontract any segment or services covered herein, without prior approval of the Contract Administrator. All subcontracted services shall be warranted by and be the responsibility of the Contractor.
- 3.4 Offeror shall have a **MINIMUM** of two (2) consecutive years' of experience in Worker's Compensation bill review. Offeror is preferred to have a **MINIMUM** of two (2) consecutive years' of experience in pharmacy programs.

SCOPE OF WORK



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

4. BACKGROUND


- 4.1 The City of Scottsdale has a current contract for workman's compensation (WC) medical bill review for cost containment. The City has approximately 2700 employees. This includes all administrative staff, including Police and Fire personnel.
- 4.2 For historical purposes, the City has calculated the total amount of workman's compensation initial bill charges and the actual number of bills, as provide below. The actual number of bills in future years may be more or less, the City makes no guarantee.

FISCAL YEAR	NUMBER OF WC BILLS	TOTAL ANNUAL WC CHARGES
2013 - 2014	2,508	\$ 3,187,227
2012 - 2013	2,457	\$ 3,311,559
2011 – 2012	2,237	\$ 2,768,890

- 4.3 In addition to the WC medical bill review, it is the City of Scottsdale's desires to examine pharmacy plans for its worker compensation prescriptions. If appropriate savings and benefits are available, the City (at its option) may select and implement a pharmacy program as requested herein (Part 2).
- 4.3.1 The City of Scottsdale does not currently have a said pharmacy plan for Worker's Compensation. The current WC medical bill review provider has been modifying prescription billings to the state fees schedule and paying the vendors. The chart below provides the actual number of bills and charges from historical documentation.

FISCAL YEAR	NUMBER OF WC PHARMACY BILLS	TOTAL CHARGES
2013 – 2014	488	\$160,482
2012 – 2013	610	\$175,603

- 4.4 Actual service requests referenced above for future years may be more or less, and therefore any quantities listed herein should be used for information purposes only.

SCOPE OF WORK	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>


5. MINIMUM TECHNICAL REQUIREMENTS

The scope of this work covered by this contract shall include, but not be limited to:

5.1 PART ONE - WORKER'S COMPENSATION BILL PAYMENT SERVICES

5.1.1 WC BILL PAYMENT CONTRACTOR RESPONSIBILITIES

- 1) Review individual WC medical bills and identify charges in excess of the Arizona Industrial Commission Physician Fee Schedule.
- 2) Review individual WC medical bills and identify improperly coded medical procedures.
- 3) Review individual WC medical bills and identify medical procedures not covered by the Industrial Commission Physician Fee Schedule.
- 4) Review WC medical bills, and discard duplicates
- 5) Review WC medical bills not covered under the Fee Schedule and reduce to Usual and Customary fees using defensible methodology. If using an outside source for database, please give full details regarding the source and identify who is liable in the event of their error. If an outside source is used, that source must provide an indemnity agreement in favor of the City of Scottsdale and a general liability insurance certificate
- 6) The Contractor shall review, as part of their job regular job duties, each WC medical bill within a maximum of seven (7) calendar day turnaround time, from the date the bill is made available to the Contractor, considering that all supporting documentation is also available at that time
- 7) Arrange for the pick-up and return of approved medical bill(s) and related documentation in a manner and frequency that is acceptable to the City
- 8) Make payment on behalf of the City of Scottsdale to various providers for all bills transferred to the Contractor for review and payment.
- 9) Provide individual bill copies and documentation on amounts paid via electronic means that will interface and upload to the individual claims in Risk Master Software (Version XR7, 13.1 & 14.1) Medical Bill Review (MBR) platform. This includes changing the affected financial files for each claim to reflect paid amounts and entries into payment history.
- 10) Provide or propose a means for the City of Scottsdale to cumulatively reimburse for bills paid as well as pay contractors fees.
- 11) Contractor shall provide a quality assurance representative that will assist in the handling of problems, disputes and workflow challenges. This representative shall be available to the City during normal working hours of Monday through Friday, 7:30 AM (MST) to 5:00 PM (MST) via dedicated phone, dedicated hotline preferred, or e-mail.

SCOPE OF WORK	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>

5. MINIMUM TECHNICAL REQUIREMENTS – CONT'D


5.1 **PART ONE - WORKER'S COMPENSATION BILL PAYMENT SERVICES – CONT'D**

5.1.1 **WC BILL PAYMENT CONTRACTOR RESPONSIBILITIES – CONT'D**

- 5.1.1.2 Contractor shall resolve any conflicts or complaints from medical providers concerning bill audits, modifications or amounts.
- 5.1.1.3 Contractor shall make records available, including but not limited to check copies, within 2 business days of request
- 5.1.1.4 After utilization review is complete, the Contractor shall prepare checks for medical services provided. Contractor shall provide the City with a grand total of the bills to be paid and a subtotal of the bills into specific categories (as determined by the City of Scottsdale). Line item detail and a summary report will be submitted within three (3) working days.
- 5.1.1.5 Contractor shall provide regular audits of utilization review adjustments and checking account activity (at least quarterly).

5.1.2 **WC BILL PAYMENT SPECIFICATIONS AND REQUIREMENTS**

- 1) The contracted services shall include, but not be limited to, check writing; summary reports; electronic transfer of payment information compatible with RiskMaster XR7, 13.1 & 14.1 and monthly bank reconciliation reports.
- 2) For each payment batch, the Contractor shall provide the City with a grand total of the bills to be paid and a subtotal per claim and vendor. Checks will be available to be issued no more than fourteen (14) days from receipt of the medical bills.
- 3) The Contractor shall transfer all payment information, invoice copies, and audit amounts via the Risk Master interface to electronically attach to the specific claim file and record the amount paid in the financial section of the individual claim.
- 4) The Contractor shall provide electronic summary reports on a **MINIMUM** monthly basis, with biweekly preferred. The reports shall include a **MINIMUM** of, but not be limited to, payment detail; check numbers; employee names; vendor names; dates of service; and total billed and total amounts paid.
- 5) Contractor shall complete pricing including discounted bill charge and vendor charge for service for each of the medical bills provided in Exhibit A.
- 6) The Contractor shall provide monthly bank statements and reconciliation ledgers (paper or electronic) to the City of Scottsdale if payments for medical bills are drafted out of a City of Scottsdale account.

SCOPE OF WORK	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>

5. MINIMUM TECHNICAL REQUIREMENTS – CONT'D


5.1.2 WC BILL PAYMENT SPECIFICATIONS AND REQUIREMENTS – CONT'D

- 7) The Contractor shall be capable of issuing checks and transferring payment information on a **MINIMUM** of a weekly basis. During calendar year 2013, the City of Scottsdale processed approximately twelve thousand (12,000) billed lines and twenty-six hundred (2,600) checks. The actual number of checks requiring processing by the City of Scottsdale for subsequent years may be more or less. The Contractor should use this figure for internal planning purposes only.
- 8) The Contractor shall be prepared to provide a **MINIMUM** of forty (40) hours of staff support annually at no additional charge to the City. This support may be provided via the telephone or on-site depending on the circumstances.

5.1.3 WC BILL PAYMENT REPORTING REQUIREMENTS

The Contractor shall submit an electronically comprehensive Monthly Savings Report in Word, Excel or in an agreed upon format, within thirty (30) days of each month end to the Risk Management Department. Stated report shall include the following reporting categories:

- a) Total dollar amount of bills submitted for audit.
- b) Bill review reductions related to Fee Schedule
- c) Usual and Customary Reductions
- d) PPO reductions
- e) Recommended allowance
- f) Gross savings
- g) Gross percentage of savings
- h) Total monthly fee for service
- i) Overall net savings
- j) Net percentage of savings

SCOPE OF WORK	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>

5. MINIMUM TECHNICAL REQUIREMENTS – CONT'D


5.2 **PART TWO - WORKER'S COMPENSATION PHARMACY PROGRAM**

5.2.1 PHARMACY PROGRAM OBJECTIVES

The City of Scottsdale desires to contract for Pharmacy Benefits to supplement our Worker's Compensation program. We are looking for cost savings in addition to any ICA cost reductions. We would like a first program allows injured workers to submit and fill prescriptions in a timely manner. We prefer a program where the contractor does not have to call our adjusters for permission to fill each time. We would like a 'first fill program that would be available extended hours and on weekends. We are looking for a partner to assist us in controlling the use of pain medications.

5.2.2 PHARMACY PROGRAM CONTRACTOR RESPONSIBILITIES

- 1) Contractor shall provide a contact for pharmacy inquiries for worker eligibility and prescription authorization seven (7) days per week during normal pharmacy hours of operation, Monday through Friday. A determination on authorization must be made within 30 minutes of the pharmacy request.
- 2) Contractor shall provide a means for injured employees to refill medications seamlessly, with a minimal authorization delay. A 'first fill' program is preferred.
- 3) Contractor shall make arrangements for all authorized prescription charges to be submitted directly to them. Additionally, provide a means where the City of Scottsdale Risk management staff may submit unauthorized prescription documentation for examination, possible reduction and payment. This is in anticipation of items not captured by the program.
- 4) Pharmacy program shall discount prescription charges per the Arizona Industrial Commission Physician Fee Schedule, Contractor Formulary, or Reasonable and Customary Charges.
- 5) Contractor shall review prescriptions to identify those not related to the injured workers medical treatment.
- 6) Contractor shall review prescriptions to identify duplications, and early re-fills, and possible abuse.
- 7) Contractor shall track prescription usage for potential abuse, and notify the prescribing physician of potential problems in writing.
- 8) If Contractor utilizes an outside source or database to reduce prescription charges via formulary or to Usual and Customary fees, please give full details regarding the source and identify who is liable in the event of their error. If an outside source is used, that source must provide an indemnity agreement in favor of the City of Scottsdale and a general liability insurance certificate.
- 9) Contractor shall make payment on behalf of the City of Scottsdale to various providers for all prescriptions transferred to the Contractor.

SCOPE OF WORK	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>

5.0 MINIMUM TECHNICAL REQUIREMENTS – CONT'D

5.2 PART TWO - WORKER'S COMPENSATION PHARMACY PROGRAM – CONT'D

5.2.2 PHARMACY PROGRAM CONTRACTOR RESPONSIBILITIES – CONT'D

- 10) Contractor shall provide individual bill copies and documentation on amounts paid via electronic means that will interface Risk Master Software Medical Bill Review (MBR) version XR7, 13.1 & 14.1.
- 11) Contractor will provide or propose a means for the City of Scottsdale to cumulatively reimburse for bills paid as well as pay contractors fees.
- 12) The Contractor shall transfer all payment information, invoice copies, and audit amounts via the Risk Master interface to electronically attach to the specific claim file and record the amount paid in the financial section of the individual claim.
- 13) Contractor shall provide a listing of in-network pharmacies in the greater phoenix area
- 14) Contractor will disclose any drug rebate program.

5.2.3 PHARMACY PROGRAM REPORTING REQUIREMENTS

- 1) The Contractor shall submit quarterly reports on the Pharmacy program including these categories:
 - a) Total number of prescription and total billed amount
 - b) Generic utilization
 - c) Network Penetration
 - d) Therapeutic class rankings
 - e) Copies of letters sent to prescribing physicians from the previous cycle.
 - f) Top 10 prescribing physicians, with counts for each including the % of opioid use
 - g) Top 20 injured works receiving most prescriptions and including opioid use
 - h) List of opioids filled with date of injury older than four months
 - i) Drug utilization report ranking by largest cost
- 2) The contractor shall assist the City of Scottsdale with audit requests including but not limited to copies of payments issued within 2 business days.



PROPOSAL #16RP009
WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

DATA SECURITY - SOLICITATION QUESTIONS

DATA SECURITY - SOLICITATION QUESTIONS



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

If your firm plans to download or store City data onto a non-City computer system you must answer the following questions within your proposal submittal:

1. Describe your current physical security and how it protects the City as a user and our data, including any third party datacenter or additional SaaS solution to provide the service, data storage or processing.
2. Describe what backup or replication procedures you use to protect the City's data and the associated costs or what other means you use for this purpose.
3. Describe what process you use to assure prompt and available access and uptime to your storage sites.
 - 3A – Provide a copy of your disaster recovery plan (DRP) with your proposal submission? How often do you test your DRP?
 - 3B - Do you have redundant data centers? If so how many and of what size, configuration, capacity?
4. Describe what storage process you currently use, explain how data is secured at rest and in transit.
5. Describe what security methods you employ to protect data from a cyber-attack.
6. Describe how you receive / store / process and transmit encrypted data that is provided to your software by the City. If you do not store encrypted data please indicate so in your response.
7. Describe how exchange of information (data) uses standard SSL (Secure Socket Layer) or TLS (Transport Layer Security), or if the one of the preceding is not used explain what method of data security is utilized.
8. Describe the method, condition and format you use to destroy City data upon expiration or cessation of the provided service.

SUBMITTAL REQUIREMENTS CHECKLIST



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

It is preferred that all submittals be prepared on 8½" X 11" paper and printed on one (1) side only. Foldout pages should be kept to a minimum. Offerors are reminded that the Evaluation Committee's ability to evaluate the proposals is dependent upon the organization, detail and readability of the submittal documents. A clear, complete and adequate response is very important. Please format your response to correspond with the areas listed below in the order they are listed below.

Bidder may bid on Part 1 – Workman's Comp Medical Bill Review and/or Part 2 – Pharmacy Services. Bidders wishing to bid on both Part 1 and Part 2 need to present them separately. Offer shall properly describe proposal pricing document and whether any cost savings are provided.

To constitute a valid responsive proposal by the Offeror to this solicitation, the Offeror's submittal **MUST** include a **MINIMUM** of the following items:

- ☐ **Offer/Acceptance Document (COS Form)** – Complete Offer portion of the document, signed in ink.
- ☐ **Solicitation Questions**
Offeror **MUST** provide answers to the questions posed if applicable to services as requested. Refer to section of the solicitation titled DATA SECURITY - SOLICITATION QUESTIONS. These must be included in the proposal response and they must be clearly labeled as such.
- ☐ **Supplemental Questions** – Fully completed Supplemental questionnaire.
- ☐ **Reference List (COS Form)** – Fully completed Reference List.
- ☐ **General Disclosure Form (COS Form)** – Fully completed General Disclosure Form, signed in ink.
- ☐ **Litigation Disclosure Form (COS Form)** – Fully completed Litigation Disclosure Form, signed in ink.
- ☐ **Firm Qualifications** - The Offeror shall submit a Firm Qualification summary to illustrate the Offeror's understanding of the objectives of this Solicitation, as well as the qualifications, experience, training and other credentials that illustrate the Offeror and employee's abilities to successfully complete the scope of work represented in this Solicitation. The Firm Qualifications document shall include, at a **MINIMUM**, of the following items:
 - Offeror's document shall contain a synopsis of the firm's history, including a statement indicating the length of time the Offeror has been doing business in the Phoenix Metropolitan area.
 - Company Name, Main office business address, local office business address (if different), Office phone, fax and email address and Company web page address (if available), and Office hours.
 - Offeror's document shall identify who answers calls and who responds to questions.
 - Offeror's document shall define the telephone information system to monitor performance (i.e. hold time, busy signal, inquiry response time, hang-ups).
 - Offeror's document shall demonstrate previous experience performing work similar to the size and scope of the work identified herein, within the last five (5) years.
 - Offeror's document shall identify the key issues and potential obstacles with respect to the scope of work identified herein. Offer's documents should provide a basic methodology to address and overcome all identified issues and obstacles
 - Offeror's document shall contain a comprehensive description of all services that shall be provided.
 - Offer's document shall provide full details of the vendors HIPPA program.

SUBMITTAL REQUIREMENTS CHECKLIST – CONT'D



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

- ☐ **Key Personnel Qualifications and Resumes** – Offeror's proposal shall include the qualifications of the key personnel that will be involved in projects covered by the scope of this solicitation. The qualifications provided shall include resumes, academic credentials, applicable training classes, certifications, professional association memberships, etc.
- Offeror's document shall contain an organizational chart that identifies key project personnel by name and title.
 - Offeror's document shall provide composition of firms Medical Bill Review staff/ per location associated with this contract. Offeror shall provide all positions, including position titles and all associates.
 - Include relevant experience and expertise for the last two (2) years.

Each location shall identify key personnel who will perform auditing, authorizations or re-pricing for the City of Scottsdale account

Resumes of all key project personnel which will be serving the City of Scottsdale account shall be submitted separately at the end of the Offeror's proposal. All resumes shall include a brief summary of past accomplishment, training, academic credentials, certifications, memberships, etc.).

- ☐ **Sub-Consultants** - Offeror's document shall list all sub-consultants (if any) that will be used in the completion of services and projects identified herein, and the sub-consultants envisioned role in each service or project.
- ☐ **Workload Delegation Including Implementation** – Offeror should provide a statement that identifies the portions of the Scope of Work that will be accomplished by the Offeror , by its direct employees and by others or sub-contractors. The Offeror shall also include a statement of the scope of work specifically assigned to Scottsdale City Staff 1) for implementation, training and startup of operations and 2) day to day functions.
- ☐ **General Submission Requirements (Applicable Separately to each Part 1 & Part 2)**
Offeror's document shall summarize the Offeror's understanding of the objectives of this Request for Proposal, as well as outlining a detailed project approach description which integrates the City's proposed Scope of Work.

This section of the Offeror's proposal should cover a **MINIMUM** of the following items:

- a. Offeror's available network(s) coverage and size for medical bill review (Part 1) and/or Pharmacy Service (Part 2)
- b. Offeror's processing turnaround time for each bill and audit review
- c. Offeror's ability to generate requested reports
- d. The number staff dedicated to review/audit bills/customer service pharmacy for each program - Part 1 & 2 respectively
- e. Volume of bills the Offeror currently processes per month. Offeror's current capacity in regards to bill processing. Future plans in regards to expansion of bill processing capacity
- f. Offeror's grievance procedure to resolve complaints

SUBMITTAL REQUIREMENTS CHECKLIST – CONT'D



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

General Submission Requirements – Cont'd

Offeror's document shall:

- g. Offeror's document shall describe the implementation process you would employ for a seamless transition of our cost containment operations to your organization and address all aspects including account setup, EDI development, history transfer, etc. Provide the name of your Implementation Manager who will be assigned to the City of Scottsdale and his/her related professional experience.
- h. Describe your provider inquiries department and how you address provider complaints. What specific (uniqueness) can you offer about your handling of provider inquiries that will ensure the number of provider complaints received by the City of Scottsdale staff is minimized?
- i. List any affiliated PPO providers, provider networks or other providers who will be utilized on the COS account which offer discounted programs
- j. Elaborate on other methods your firm will provide to allow for further reductions in addition to the reductions based upon the Arizona Fee Schedule
- k. Describe in detail what would be needed set up the account for the program including all banking requirements and responsibilities:
- l. Specifically describe information and money transactions & transfers in a flow chart format
- m. Specify in detail all means and methods of required electronic interface; including but not limited to, information transfer, software hardware, data file specifications, etc.
- n. Provide a flow chart to describe the timing on all information, vendor payments and City payments to vendor.
- o. Thoroughly describe the implementation process and timing from a Vendor's prospective including any fees; as well as the implementation process, responsibilities and recommended timing for City implementation: (This must be very specific regarding means of electronic interface, software hardware, data files, information timing and transfer)
- p. Describe all data transfer process including intake and return, file types and timing needed for administration of the program. Please include vendors and city's responsibilities.
- q. Outline all fees and costs (i.e. Annual Charge, Monthly Charges, Per Billing Charge, Percentage of Bill Reduction to ICA Schedule/Savings, Percentage of bill savings below ICA to Reasonable and Customary, all Charges for Data Feeds, Check writing charges Per check, Per Vendor).
- r. Describe Offerors physical and electronic data security and controls used to limit unauthorized access to information/
- s. Outline any proposed performance guarantees or audit guarantees.
- t. Include sample reports.
- u. Address any changes in pricing assuming a one year contract is renewed each year over a three (3) to five (5) year period.
- v. Any additional information Offeror feels is relevant to their services, systems and other programs not addressed above.

SUBMITTAL REQUIREMENTS CHECKLIST – CONT'D



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

PART SPECIFIC REQUIREMENTS

☐ **PART 1 – Workman's Compensation Medical Bill Review**

Offeror's document shall:

1. Provide a description and detail on the system in place to identify and eliminate charges to the City for duplicate bills, erroneous bills, any adjustments and savings.
2. Provide a detailed description of their system to obtain additional savings on medical bills as respects Usual and Customary Charge Programs or Provider Network Programs.
3. Include specifics on network size and coverage.
4. Provide a description and detail on the system in place for review of doctor and hospital bills to prevent miss-coding.
5. Provide a description, detail, frequency, and samples of the reports that will be provided by the Offeror.
6. Provide a copy of their written internal audit guidelines and procedures for monitoring contract performance.
7. Describe any performance guarantee and percentage of or flat amount of vendor's fee to be returned if the guarantee is not met.
8. Include a description of their plan to change from ICD9 to ICD10 coding if it has not already done so.

☐ **PART 2 - Pharmacy Program Plan**

Offeror's document shall:

1. Identify in detail processes the city of Scottsdale will be required to perform in order to use the vendor's pharmacy service plan
2. Identify in detail any access requirements to the City's Risk Master Software and Data Base
3. What do you require for an eligibility file? (include transmission detail and frequency)
4. Describe it's pharmacy program mechanics and implementation plan
5. Describe it's Pharmacy system integration with Risk Master and projected implementation timeline
6. List your customers currently using Risk Master Software? Are you compatible with its MBR Interface as previously noted? If not please describe your mechanism for file transfers with other customers that you might recommend.
7. Describe Offeror's ability to timely approve prescription requests, including first fill. Include how first fill is attained.
8. Describe in detail all steps for the set up implementation of a pharmacy program including City's responsibilities. Please include timeframes and any setup or implementation costs.
9. Describe in detail all benefits of its pharmacy program to the city and to its workers.
10. Provide a description of any informational material available for the education of injured employees.
11. Describe in detail the prescription or fill tracking features of their pharmacy program and how the information is to be use by the City.
12. Address their process to reduce physicians filling prescriptions in office.

SUBMITTAL REQUIREMENTS CHECKLIST – CONT'D



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

PART 2 - Pharmacy Program Plan – Cont'd

13. Include a detailed description of how its pharmacy program works. Include a flow chart if necessary.
14. Describe in detail pharmacy services including but not limited to prescription cards, first fills, formulary recommended, and ability to customize formulary.
15. Provide list of all participating pharmacies.
16. Provide details on your ability to discount all medications
17. Do you offer a custom formulary? Is the formulary or discount program used subject to a contract renewal in the next 2-5 years?
18. Include an opinion of the Worker's Compensation pharmacy programs greatest challenges and a description of strategies to overcome them.
19. Provide a description, detail, frequency, and samples of the reports that will be provided by the Offeror.
20. Provide a copy of their written internal audit guidelines and procedures for monitoring contract performance.
21. Describe any performance guarantee and percentage of or flat amount of vendor's fee to be returned if the guarantee is not met.

- ☐ **Fee Structure** – Offeror shall provide a complete schedule of all fees for each element of work and identify all expenses.

- Fees associated with performing the required tasks by percentage of savings and line item billing. Indicate specific fees for layers of reduction - specifically, fees charged to reduce to ICA Fee Schedule, fees charged for further penetration into PPO(s) and/ or out-of-network providers, and maximum fee to be imposed per bill. It is expected that each proposal will identify a maximum fee to be imposed in anticipation of, or in the case of, significant medical services described in a single bill, such as hospital or surgical bills.


Completion of Price Proposal.

- ☐ **Exceptions** – Offeror shall include all exceptions taken in regards to the terms and conditions as specified in this solicitation document, any award documents, or attached contracts. All exceptions taken by the Offeror shall be clearly defined and the changes requested clearly identified in their submittal document. Exceptions taken by the Offeror shall be used in the evaluation process. If the Offeror does not indicate exceptions in their submittal document this will signify to the City that the Offeror is in full agreement with all areas of the solicitation document, attached award documents and contracts, and agree to all terms as stated.

- ☐ **Proposal Copies** – Identify and submit one (1) **unbound original** and four (4) copies of the Offeror's proposal (Proposal copies can be bound if the Offeror so desires). In addition, Offeror is requested to provide an electronic copy of the Offeror's **complete** proposal. This electronic copy shall be **one (1) file**, on a Compact Disc (CD) or other media device, in Adobe® Acrobat format (PDF), and be an electronic representation of the Offeror's complete proposal document (signature page, quotation page, sample documents, all attachments, brochures, pamphlets, etc.).

"Please **do not** return a copy of the solicitation/addenda(s) with your proposal/submittal. Return only the required documents as referenced on the Submittal Checklist."

All submittals are to be completed on the City of Scottsdale (**COS**) forms without any alterations; failure to do so may result in your submittal being rejected.

EVALUATION CRITERIA	
	WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES RFP # 16RP009

GENERAL

After receipt of all proposals, each submittal shall be screened to determine if any shall be deemed non-responsive. Unsigned proposals, incomplete proposals, non-conformance with mandatory requirements, etc., may result in the determination of non-responsive.

Subsequent to the initial review, all remaining proposals shall be reviewed by the Proposal Evaluation Committee.

PROPOSAL EVALUATION (Part 1 & Part 2 Services shall be rated separately)

All responsive proposals shall be evaluated by the Proposal Evaluation Committee using the weighting and criteria listed below. The recommendation for contract award will be made to the responsible Offeror whose proposal is determined to be the most advantageous to the City when applying the following criteria and weighting.

The following is the weighting of criteria that will be used to review the proposals:

PROPOSAL EVALUATION CRITERIA	WEIGHT
General Submission Requirements	35%
Fee Structure / Cost Savings	30%
Firm & Staff Qualifications / Key Personnel / Subs	15%
Workload Delegation / Exceptions	20%

The following items may be used by the Proposal Evaluation Committee to evaluate each proposal submitted:

1. Cost factors associated with implementing and performing the work required by the contract.
2. The Offeror's demonstrated experience on similar types of projects, including satisfactory reference checks relating to past work relationships, past performance on projects of similar scope and size, level of knowledge, reliability, flexibility and ability to meet project deadlines.
3. The ability and willingness of the Offeror to meet or exceed the specifications and standards of this Solicitation and Offeror's understanding and perceived perception of the scope of work contained herein.
4. The ability of the Offeror to meet the RiskMaster compatibility requirement.
5. Staff Size, experience, qualifications, and location of the personnel to be assigned to this project.
6. The content and quality of the Offeror's proposal and other presentation materials.
7. The effect of any contract exceptions.
8. The amount of internal staff time needed for operation of the program.

EVALUATION CRITERIA – CONT'D



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

Each proposal will be reviewed in entirety and assigned a score with respect to each of the criteria. The proposals will be ranked by the evaluation committee according to their total weighted ranking.

The evaluation committee may establish a short list of those proposals considered most advantageous to the City of Scottsdale. If a short list occurs, selected Offerors may be invited to make a presentation, but Offeror should not rely on a possible presentation to present their qualifications and offered services. If invited, the Offeror will be notified of the date and time of the presentation by the Contract Administrator. Results of any presentation may be used to determine the contract award.

At the conclusion of all presentations, an overall ranking of proposals will be performed, combining the results of the proposal evaluations and the presentations.

**OFFER AND ACCEPTANCE**

City of Scottsdale
Purchasing Division
9191 E. San Salvador Dr.
Scottsdale, AZ 85258
Phone: 480-312-5700 – Fax: 480-312-5701

SOLICITATION #	16RP009	SOLICITATION TITLE:	Worker's Compensation Medical Bill Review and Pharmacy Services
-----------------------	----------------	----------------------------	--

OFFER**TO THE CITY OF SCOTTSDALE:**

The undersigned hereby offers and agrees, in accordance with the undersigned's written offer submitted in response to this solicitation, to furnish the material and/or service(s) in compliance with all terms, conditions, specifications, scope of work, and addendums in the solicitation listed above, including written exceptions that are subject to the approval of the City prior to acceptance. The undersigned agrees that the entire solicitation listed above is hereby incorporated by reference as if fully set forth herein.

The Offeror's signature on this OFFER form certifies that he has read, understands and will comply with all terms, conditions and specifications stated in all documents constituting the solicitation. The bidder also certifies it is in compliance with the Non Collusion and all Federal and Arizona State Immigration Laws.

OFFER MADE - COMPANY INFORMATION		FOR CLARIFICATION OF THIS OFFER, CONTACT:	
Company Name		Printed Name	
Address		Title	
City	State	Zip	Phone
Signature for Offeror	Date	Fax	E Mail
Printed Name and Title of Authorized Signatory		Address (if different from Company info)	
Federal Employer Tax ID # or SSN as per W9 Statement		City, State, Zip (if different from Company info)	

ACCEPTANCE OF OFFER, NOTICE OF CONTRACT AWARD
(for City of Scottsdale Use Only)

The contractor's offer is hereby accepted by the City of Scottsdale. The Contractor is now bound to sell the materials and/or service(s) and perform based upon the above solicitation , including all terms, conditions, specifications, scope of work, and addendums contained in the Solicitation, as well as any written exceptions that have been separately accepted by the City.

This contract shall henceforth be referred to as **Contract # 16RP009**

The contract consists of the following documents: 1) Solicitation # 16RP009 and all addendums (if applicable) as issued by the City; 2) The Contractor's Response to the City's solicitation; 3) This signed offer and acceptance and any other applicable contractual agreements, 4) All written exceptions and/or modifications to the solicitation requirements as agreed to by the City and the Contractor as per attachment _____, dated _____.

The Contractor is hereby cautioned not to commence any billable work or provide any material or service under this contract until the Contractor receives a purchase order document from the City.

The Contractor must provide the following checked items within ten (10) calendar days from the date of this Acceptance of Offer, Notice of Contract Award in order for the City to issue the required Purchase Order : ☐ Payment Bond ☐ Performance Bond, ☐ Insurance Certificate(s), ☐ I.R.S. Form W-9/Taxpayer ID No. & Certification, ☐ other documentation as identified.

If the Contractor fails to furnish the required documents within the stated ten (10) calendar days they may be considered in default and may be at risk of forfeiture of any applicable Bid Bond posted. All required documents are to be sent to the Bid & Contract Specialist listed in the solicitation.

This document has been approved as to form on the 22nd day of July, 2012 by the City Attorney and is on file with the City Clerk. It need not be submitted to the City Attorney for approval unless the form document is altered.

City of Scottsdale, a municipal corporation
Offer Accepted and Awarded this _____ day
of _____, 201__

Risk Management issues reviewed and approved as to form _____, 201__
by City of Scottsdale Risk Management Director

Recommended award approved _____, 201__
by City of Scottsdale Contract Administrator

J. E. Flanagan
Or Designee _____
As City of Scottsdale Purchasing Director

PRICE PROPOSAL FORM – PART 1 WORKMAN’S COMPENSATION BILL REVIEW PRICING



WORKER’S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

PART ONE - BILL REVIEW PRICING

Offerors must propose a firm, fixed, fully-loaded rate per service category listed on the pricing proposal form below.

1.0 Administrative Fees

Please note in detail any addition to set up and implementation noted above how your service will be paid for: If the item does not apply, please note with N/A

DESCRIPTION	ESTIMATED QUANTITIES	FLAT FEE	ANNUAL COST
Administration fees and basis	1	\$ _____	\$ _____
Network Access Fee:	1	\$ _____	\$ _____
Implementation Fee	1	\$ _____	\$ _____
Other Required Services/fees, if any not specifically requested in the RFP		\$ _____	\$ _____
Other:		\$ _____	\$ _____
SUB TOTAL COST			\$ _____

2.0 Item Pricing

DESCRIPTION	ESTIMATED QUANTITIES	UNIT PRICE OR / FLAT FEE	ANNUAL COST
Bill Review Charge / Per Bill	2500	\$ _____ per _____	\$ _____
Bill Review Charge / Per Line	2500	\$ _____ per _____	\$ _____
Check Issuance Charge/ Per Check	500	\$ _____ per _____	\$ _____
SUB TOTAL COST			\$ _____
GRAND TOTAL (Total Amount of 1.0 Admin Fees + 2.0 Item Pricing)			\$ _____

COMPANY NAME: _____

PRICE PROPOSAL FORM – PART 1 WORKMAN’S COMPENSATION BILL REVIEW PRICING – CONT’D



WORKER’S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

PART ONE - SAMPLE WORKER’S COMPENSATION BILL REVIEW PRICING

DESCRIPTION	A. Provider Bill Total Charge	B. Total savings from state capitation	C. Additional Savings(PPO, URL) after capitation via PPO, URL (Please also note percentage of additional savings	D. Additional Savings (Other sources as described below)	E. Final total amount owned to vendor \$ (A-B-C-D)	F. Total fees per example including check issuance & line item review, <u>but</u> excluding any annual or implementation fee:
Scotts Sample 1	\$954.30	\$ _____	\$ _____ _____ % Savings	\$ _____	\$ _____	\$ _____
Scotts Sample 2	\$17,120.30	\$ _____	\$ _____ _____ % Savings	\$ _____	\$ _____	\$ _____
Scotts Sample 3	\$3,930.38	\$ _____	\$ _____ _____ % Savings	\$ _____	\$ _____	\$ _____
Scotts Sample 4	\$44,490.81	\$ _____	\$ _____ _____ % Savings	\$ _____	\$ _____	\$ _____
Scotts Sample 5	\$2,307.20	\$ _____	\$ _____ _____ % Savings	\$ _____	\$ _____	\$ _____
Scotts Sample 6	\$624.83	\$ _____	\$ _____ _____ % Savings	\$ _____	\$ _____	\$ _____
Scotts Sample 7	\$39,782.00	\$ _____	\$ _____ _____ % Savings	\$ _____	\$ _____	\$ _____
Scotts Sample 8	\$186.68	\$ _____	\$ _____ _____ % Savings	\$ _____	\$ _____	\$ _____

COMPANY NAME: _____

PRICE PROPOSAL FORM – PART 1 WORKMAN’S COMPENSATION BILL REVIEW PRICING – CONT’D



WORKER’S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

PART ONE - SAMPLE WORKER’S COMPENSATION BILL REVIEW PRICING – CONT’D

DESCRIPTION	A. Provider Bill Total Charge	B. Total savings from state capitation	C. Additional Savings(PPO, URL) after capitation via PPO, URL (Please also note percentage of additional savings	D. Additional Savings (Other sources as described below)	E. Final total amount owned to vendor \$ (A-B-C-D)	F. Total fees per example including check issuance, but excluding any annual or implementation fee:
Scotts Sample 9	\$22,658.00	\$ _____	\$ _____ _____ % Savings	\$ _____	\$ _____	\$ _____
Scotts Sample 10	\$150.00	\$ _____	\$ _____ _____ % Savings	\$ _____	\$ _____	\$ _____
Scotts Sample 11	\$279.00	\$ _____	\$ _____ _____ % Savings	\$ _____	\$ _____	\$ _____
Scotts Sample 12	\$139.56	\$ _____	\$ _____ _____ % Savings	\$ _____	\$ _____	\$ _____
Scotts Sample 13	\$166.00	\$ _____	\$ _____ _____ % Savings	\$ _____	\$ _____	\$ _____
Scotts Sample 14	\$152.53	\$ _____	\$ _____ _____ % Savings	\$ _____	\$ _____	\$ _____
Scotts Sample 15	\$95.00	\$ _____	\$ _____ _____ % Savings	\$ _____	\$ _____	\$ _____
Scotts Sample 16	\$197.16	\$ _____	\$ _____ _____ % Savings	\$ _____	\$ _____	\$ _____
Scotts Sample 17	\$157.95	\$ _____	\$ _____ _____ % Savings	\$ _____	\$ _____	\$ _____
TOTAL						\$ _____

COMPANY NAME: _____

PRICE PROPOSAL FORM – PHARMACY SERVICES PRICING



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

PART TWO - PHARMACY PROGRAM PRICING

Offerors must propose a firm, fixed, fully-loaded rate per service category listed on the pricing proposal form below:

1.0 Pharmacy Administrative Fees – Fixed Pricing

DESCRIPTION	ESTIMATED QUANTITIES	FLAT FEE	ANNUAL COST
Administration fees and basis	1	\$ _____	\$ _____
Network Access Fee:	1	\$ _____	\$ _____
Implementation Fee	1	\$ _____	\$ _____
Other Required Services/fees, if any not specifically requested in the RFP		\$ _____	\$ _____
Note the affect if any rebates or other credits that may be issued		\$ _____	\$ _____
SUB TOTAL COST			\$ _____

2.0 Pharmacy Item Pricing

DESCRIPTION	ESTIMATED QUANTITIES	UNIT PRICE OR / FLAT FEE	ANNUAL COST
Per Prescription Fee	400	\$ _____ per _____	\$ _____
Per Fill Fee	400	\$ _____ per _____	\$ _____
Pharmacy Payment Check Issuance Charge/ Per Check	400	\$ _____ per _____	\$ _____
Note the affect if any rebates or other credits that may be issued		\$ _____	\$ _____
Other incremental charges		\$ _____	\$ _____
SUB TOTAL COST			\$ _____
GRAND TOTAL (Total Amount of 2.0 Admin Fees + 2.0 Item Pricing)			\$ _____

COMPANY NAME: _____

PRICE PROPOSAL FORM – PHARMACY SERVICES PRICING – CONT'D



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

PART TWO - PHARMACY PROGRAM – SAMPLE PRESCRIPTION PRICING

ITEM	Prescription 30 day supply	A. Manufacturer Suggested Retail	B. Contractors Fill Cost	C. Return of Rebate (if applicable)	D. All applicable fees for this prescription and payment	Total Cost to City Per Prescription (B-C+D)
1.	Tramadol ER 150	\$ _____	\$ _____		\$ _____	\$ _____
2.	Gabapentin 300 mg	\$ _____	\$ _____		\$ _____	\$ _____
3.	Meloxicam 7.5 mg	\$ _____	\$ _____		\$ _____	\$ _____
4.	Morphine Sulfate Cap ER 80mg	\$ _____	\$ _____		\$ _____	\$ _____
5.	Morphine Sulfate tab 15mg	\$ _____	\$ _____		\$ _____	\$ _____
6.	Lunesta tab 3 mg	\$ _____	\$ _____		\$ _____	\$ _____
7.	Duloxetine cap 60mg	\$ _____	\$ _____		\$ _____	\$ _____
8.	Celebrex cap 200mg	\$ _____	\$ _____		\$ _____	\$ _____
9.	Senna tab 8.6mg	\$ _____	\$ _____		\$ _____	\$ _____
10.	Duloxetine HCL Cap 60 mg.	\$ _____	\$ _____		\$ _____	\$ _____
TOTAL COST FOR PRESCRIPTIONS						\$ _____

COMPANY NAME: _____

PRICE PROPOSAL FORM – PHARMACY SERVICES PRICING – COND'T**WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES****RFP # 16RP009****SUMMARY OF COSTS****PART ONE**

WC BILL REVIEW PRICING COSTS	TOTAL PROPOSED
1.0 Administrative Fees	\$ _____
2.0 Item Pricing	\$ _____
Sample WC Bill Review Total	\$ _____
	\$ _____
	\$ _____
GRAND TOTAL COST	\$ _____

PART TWO

PHARMACY PROGRAM COSTS	TOTAL PROPOSED
1.0 Administrative Fees Total	\$ _____
2.0 Pharmacy Item Pricing Total	\$ _____
Sample Prescription Pricing Total	\$ _____
	\$ _____
	\$ _____
GRAND TOTAL COST	\$ _____

****TAXES**

1. Do not include any use, or federal excise tax in your bid. The City is exempt from the payment of federal excise tax and will add use tax as applicable.

ADDENDA

The Bidder hereby acknowledges that his bid/proposal pricing is based on all of the addenda that were issued by the City prior to opening of this bid/proposal.

NO BID: If no bid please state reason:

COMPANY NAME: _____

REFERENCES



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

List minimum of three (3) Arizona customers, for whom your company has provided service(s) of a similar scope as this Invitation for Bid, during the past three years. Include the length of any contracts listed. *Offerors may make multiple copies of this document as needed.*

The following questions are asked to enable the evaluation team to assess the qualifications of Offerors under consideration for final award. This information may or may not be a determining factor in award of this Solicitation.

Company Name: _____

Company Address: _____

City/State/Zip: _____

Contact Person: _____ Telephone #: _____

Email: _____ Date of Service: _____

Type of Service Provided: _____

Company Name: _____

Company Address: _____

City/State/Zip: _____

Contact Person: _____ Telephone #: _____

Email: _____ Date of Service: _____

Type of Service Provided: _____

Company Name: _____

Company Address: _____

City/State/Zip: _____

Contact Person: _____ Telephone #: _____

Email: _____ Date of Service: _____

Type of Service Provided: _____

YOUR COMPANY NAME: _____

BIDDER GENERAL DISCLOSURE FORM



WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES

RFP # 16RP009

Bidder shall respond to each of the questions below by checking the appropriate box and provide supplemental information as needed. Failure to fully and truthfully disclose the information required by this disclosure form may result in the disqualification of your submittal from consideration or termination of the contract, once awarded.

Debarment / Suspension Information – Has the Respondent or any of its principals been debarred or suspended from contracting with any public entity?

☐ YES

☐ NO

If "YES", in an attachment to this form identify the public entity and the name and current phone number of a representative of the public entity familiar with the debarment or suspension, and state the reason for or circumstances surrounding the debarment or suspension, including but not limited to the period of time for such debarment or suspension.

Surety Information – Has the Respondent or any of its principals ever had a bond or surety cancelled or forfeited?

☐ YES

☐ NO

If "YES", in an attachment to this form identify the name of the bonding company, date, amount of bond and reason for such cancellation or forfeiture.

Bankruptcy Information – Has the Respondent or any of its principals ever been declared bankrupt or filed for protection from creditors under State or Federal proceeding in the last seven (7) years?

☐ YES

☐ NO

If "YES", in an attachment to this form identify the date, court, jurisdiction, case number, amount of liabilities and amount of assets.

Signature

Title

Printed Name

Date

COMPANY NAME: _____

BIDDER LITIGATION DISCLOSURE FORM**WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES****RFP # 16RP009**

Bidder shall respond to each of the questions below by checking the appropriate box and provide supplemental information as needed. Failure to fully and truthfully disclose the information required by this disclosure form may result in the disqualification of your submittal from consideration or termination of the contract, once awarded.

Have you or any member of your Firm or Team to be assigned to this contract ever been indicted or convicted of a felony or a misdemeanor involving theft or moral turpitude in the last five (5) years?

☐ YES☐ NO

Have you or any member of your Firm or Team to be assigned to this contract ever been terminated (for cause or otherwise) from any work being performed for the City of Scottsdale or any other Federal, State or Local Government?


☐ YES☐ NO

Have you or any member of your Firm or Team to be assigned to this contract ever been involved in any claim or litigation with the City of Scottsdale or any other Federal, State or Local Government during the last ten (10) years?

☐ YES☐ NO

If you answered "YES", to any of the above questions, in an attachment to this form, please indicate the name(s) of the person(s), the nature, and status and/or outcome of the information, indictment, conviction, termination, claim or litigation, as applicable.

Signature_____
Title_____
Printed Name_____
Date**COMPANY NAME:** _____

EXHIBIT A – SAMPLE MEDICAL BILLS	
	<p>WORKER'S COMPENSATION MEDICAL BILL REVIEW AND PHARMACY SERVICES</p> <p>RFP # 16RP009</p>

The following exhibit is included for reference.

- **Exhibit A: Sample Medical Bills**

- Sample 1 (1 pages)
- Sample 2 (5 pages)
- Sample 3 (2 pages)
- Sample 4 (7 pages)
- Sample 5 (12 pages)
- Sample 6 (3 pages)
- Sample 7 (6 pages)
- Sample 8 (3 pages)
- Sample 9 (4 pages)
- Sample 10 (3 pages)
- Sample 11 (4 pages)
- Sample 12 (4 pages)
- Sample 13 (3 pages)
- Sample 14 (5 pages)
- Sample 15 (2 pages)
- Sample 16 (4 pages)
- Sample 17 (4 pages)

The following 72 pages are in order as listed above.
The Samples are marked and numbered in the top right hand corner only.

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

RECEIVED

MAR 18 2014

BY: RISK MGMT.

City of Scottsdale
7447 E Indian School
Scottsdale, AZ 85251

RECEIVED PHOENIX

MAR 27 2014

CORVELMEDCHECK

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		Name, First Name, Middle Initial	
3. PATIENT'S BIRTH DATE MM DD YY		SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	
5. PATIENT'S ADDRESS (No., Street)		INSURED'S ADDRESS (No., Street)	
CITY		STATE	
Gilbert		AZ	
ZIP CODE		TELEPHONE (Include Area Code)	
85233		()	
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)	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
c. EMPLOYER'S NAME OR SCHOOL		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
11. INSURED'S POLICY GROUP OR FECA NUMBER			
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.			
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
14. DATE OF CURRENT: MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
12-16-2010		08/24/2012	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
Weston Montrose		FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE	
1. 724.2		ORIGINAL REF. NO.	
2. 724.4		23. PRIOR AUTHORIZATION NUMBER	
3. 847.1			
24. A. DATE(S) OF SERVICE From To		B. PLACE OF SERVICE	
MM DD YY MM DD YY		EMG	
C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	
N476218070805		F. \$ CHARGES	
03-12-14 03-12-14 11 N 99070		644.40 60	
N431722022205		G. DAYS OR UNITS	
03-12-14 03-12-14 11 N 99070		119.70 90	
N429300012410		H. (SPOT) FEE	
03-12-14 03-12-14 11 N 99070		190.20 60	
		I. ID. QUAL.	
		J. RENDERING PROVIDER ID. #	
		1G Tramadol ER-150	
		1619998168	
		1G Gabapentin 300mg	
		1619998168	
		1G Meloxicam 7.5MG	
		1619998168	
		NPI	
		NPI	
		NPI	
25. FEDERAL TAX I.D. NUMBER		26. PATIENT'S ACCOUNT NO.	
27-4021610		GRADAR0001	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		28. TOTAL CHARGE	
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		\$ 954.30	
29. AMOUNT PAID		30. BALANCE DUE	
\$ 0.00		\$ 954.30	
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.)		32. SERVICE AUTHORITY, EDUCATION INFORMATION	
Scott, Jeffrey D, MD		Andoloris Medical PLLC	
03142014		3417 N 32nd St Suite B	
1851693527		Phoenix, AZ 85018	
TJ274021610		Los Angeles, CA 90074-2706	

NUCC Instruction Manual available at: www.nucc.org

WCMS-1500CS

APPROVED OMB 0938-0359 PDR CMS-1500 (08/05)

Corvel Scan Date: 3/27/2014

1 SCOTTSDALE HLTH TPK 7400 E THOMPSON PEAK PKWY SCOTTSDALE, AZ 852554109 4808826776										2 SCOTTSDALE HLTH TPK P.O. BOX 29399 PHOENIX, AZ 85038										3 C1403030036 C0000105411 000C 860181654										4 TYPE OF BILL 0131 ID 013114																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
PATIENT NAME										PATIENT ADDRESS										AZ																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																									
BIRTH DATE										SEX										ADMISSION DATE										CONVENTION CODES										HOP																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																					
01 OCCURRENCE CODE										02 OCCURRENCE DATE										03 OCCURRENCE DATE										04 OCCURRENCE DATE										05 OCCURRENCE DATE										06 OCCURRENCE DATE										07 OCCURRENCE DATE										08 OCCURRENCE DATE										09 OCCURRENCE DATE										10 OCCURRENCE DATE										11 OCCURRENCE DATE										12 OCCURRENCE DATE										13 OCCURRENCE DATE										14 OCCURRENCE DATE										15 OCCURRENCE DATE										16 OCCURRENCE DATE										17 OCCURRENCE DATE										18 OCCURRENCE DATE										19 OCCURRENCE DATE										20 OCCURRENCE DATE										21 OCCURRENCE DATE										22 OCCURRENCE DATE										23 OCCURRENCE DATE										24 OCCURRENCE DATE										25 OCCURRENCE DATE										26 OCCURRENCE DATE										27 OCCURRENCE DATE										28 OCCURRENCE DATE										29 OCCURRENCE DATE										30 OCCURRENCE DATE										31 OCCURRENCE DATE										32 OCCURRENCE DATE										33 OCCURRENCE DATE										34 OCCURRENCE DATE										35 OCCURRENCE DATE										36 OCCURRENCE DATE										37 OCCURRENCE DATE										38 OCCURRENCE DATE										39 OCCURRENCE DATE										40 OCCURRENCE DATE										41 OCCURRENCE DATE										42 OCCURRENCE DATE										43 OCCURRENCE DATE										44 OCCURRENCE DATE										45 OCCURRENCE DATE										46 OCCURRENCE DATE										47 OCCURRENCE DATE										48 OCCURRENCE DATE										49 OCCURRENCE DATE										50 OCCURRENCE DATE										51 OCCURRENCE DATE										52 OCCURRENCE DATE										53 OCCURRENCE DATE										54 OCCURRENCE DATE										55 OCCURRENCE DATE										56 OCCURRENCE DATE										57 OCCURRENCE DATE										58 OCCURRENCE DATE										59 OCCURRENCE DATE										60 OCCURRENCE DATE										61 OCCURRENCE DATE										62 OCCURRENCE DATE										63 OCCURRENCE DATE										64 OCCURRENCE DATE										65 OCCURRENCE DATE										66 OCCURRENCE DATE										67 OCCURRENCE DATE										68 OCCURRENCE DATE										69 OCCURRENCE DATE										70 OCCURRENCE DATE										71 OCCURRENCE DATE										72 OCCURRENCE DATE										73 OCCURRENCE DATE										74 OCCURRENCE DATE										75 OCCURRENCE DATE										76 OCCURRENCE DATE										77 OCCURRENCE DATE										78 OCCURRENCE DATE										79 OCCURRENCE DATE										80 OCCURRENCE DATE										81 OCCURRENCE DATE										82 OCCURRENCE DATE										83 OCCURRENCE DATE										84 OCCURRENCE DATE										85 OCCURRENCE DATE										86 OCCURRENCE DATE										87 OCCURRENCE DATE										88 OCCURRENCE DATE										89 OCCURRENCE DATE										90 OCCURRENCE DATE										91 OCCURRENCE DATE										92 OCCURRENCE DATE										93 OCCURRENCE DATE										94 OCCURRENCE DATE										95 OCCURRENCE DATE										96 OCCURRENCE DATE										97 OCCURRENCE DATE										98 OCCURRENCE DATE										99 OCCURRENCE DATE										100 OCCURRENCE DATE										101 OCCURRENCE DATE										102 OCCURRENCE DATE										103 OCCURRENCE DATE										104 OCCURRENCE DATE										105 OCCURRENCE DATE										106 OCCURRENCE DATE										107 OCCURRENCE DATE										108 OCCURRENCE DATE										109 OCCURRENCE DATE										110 OCCURRENCE DATE										111 OCCURRENCE DATE										112 OCCURRENCE DATE										113 OCCURRENCE DATE										114 OCCURRENCE DATE										115 OCCURRENCE DATE										116 OCCURRENCE DATE										117 OCCURRENCE DATE										118 OCCURRENCE DATE										119 OCCURRENCE DATE										120 OCCURRENCE DATE										121 OCCURRENCE DATE										122 OCCURRENCE DATE										123 OCCURRENCE DATE										124 OCCURRENCE DATE										125 OCCURRENCE DATE										126 OCCURRENCE DATE										127 OCCURRENCE DATE										128 OCCURRENCE DATE										129 OCCURRENCE DATE										130 OCCURRENCE DATE										131 OCCURRENCE DATE										132 OCCURRENCE DATE										133 OCCURRENCE DATE										134 OCCURRENCE DATE										135 OCCURRENCE DATE										136 OCCURRENCE DATE										137 OCCURRENCE DATE										138 OCCURRENCE DATE										139 OCCURRENCE DATE										140 OCCURRENCE DATE										141 OCCURRENCE DATE										142 OCCURRENCE DATE										143 OCCURRENCE DATE										144 OCCURRENCE DATE										145 OCCURRENCE DATE										146 OCCURRENCE DATE										147 OCCURRENCE DATE										148 OCCURRENCE DATE										149 OCCURRENCE DATE										150 OCCURRENCE DATE										151 OCCURRENCE DATE										152 OCCURRENCE DATE										153 OCCURRENCE DATE										154 OCCURRENCE DATE										155 OCCURRENCE DATE										156 OCCURRENCE DATE										157 OCCURRENCE DATE										158 OCCURRENCE DATE										159 OCCURRENCE DATE										160 OCCURRENCE DATE										161 OCCURRENCE DATE										162 OCCURRENCE DATE										163 OCCURRENCE DATE										164 OCCURRENCE DATE										165 OCCURRENCE DATE										166 OCCURRENCE DATE										167 OCCURRENCE DATE										168 OCCURRENCE DATE										169 OCCURRENCE DATE										170 OCCURRENCE DATE										171 OCCURRENCE DATE										172 OCCURRENCE DATE										173 OCCURRENCE DATE										174 OCCURRENCE DATE										175 OCCURRENCE DATE										176 OCCURRENCE DATE										177 OCCURRENCE DATE										178 OCCURRENCE DATE										179 OCCURRENCE DATE										180 OCCURRENCE DATE										181 OCCURRENCE DATE										182 OCCURRENCE DATE										183 OCCURRENCE DATE										184 OCCURRENCE DATE										185 OCCURRENCE DATE										186 OCCURRENCE DATE										187 OCCURRENCE DATE										188 OCCURRENCE DATE										189 OCCURRENCE DATE										190 OCCURRENCE DATE										191 OCCURRENCE DATE										192 OCCURRENCE DATE										193 OCCURRENCE DATE										194 OCCURRENCE DATE										195 OCCURRENCE DATE										196 OCCURRENCE DATE										197 OCCURRENCE DATE										198 OCCURRENCE DATE										199 OCCURRENCE DATE										200 OCCURRENCE DATE										201 OCCURRENCE DATE										202 OCCURRENCE DATE										203 OCCURRENCE DATE										204 OCCURRENCE DATE										205 OCCURRENCE DATE										206 OCCURRENCE DATE										207 OCCURRENCE DATE										208 OCCURRENCE DATE										209 OCCURRENCE DATE										210 OCCURRENCE DATE										211 OCCURRENCE DATE										212 OCCURRENCE DATE										213 OCCURRENCE DATE										214 OCCURRENCE DATE										215 OCCURRENCE DATE										216 OCCURRENCE DATE										217 OCCURRENCE DATE										218 OCCURRENCE DATE										219 OCCURRENCE DATE										220 OCCURRENCE DATE										221 OCCURRENCE DATE										222 OCCURRENCE DATE										223 OCCURRENCE DATE										224 OCCURRENCE DATE										225 OCCURRENCE DATE										226 OCCURRENCE DATE										227 OCCURRENCE DATE									

SCOTTSDLE HLTH TPK 7400 E THOMPSON PEAK PKWY SCOTTSDALE, AZ 852554109 4808826776										SCOTTSDLE HLTH TPK P.O. BOX 29399 PHOENIX, AZ 85038										13 Prt Cld # C1403030036 14 Mod Rec # C0000105411 15 Fed Tax # 000C 16 Stamp Covers From 013014 Through 013114 17 ID 18 860181654										19 TYPE OF S:L 0131 20 AZ 21 HOP																																																																															
PATIENT NAME										PATIENT ADDRESS																																																																																																			
BIRTHDATE										SEX										ADMISSION DATE										18 DHR										17 STAT										CONDITION CODES										20 AGI										21 HOP																																							
01301409										1										1										18										01																																																																					
OCCURRENCE CODE										OCCURRENCE DATE										OCCURRENCE CODE										OCCURRENCE DATE										OCCURRENCE CODE										OCCURRENCE DATE										OCCURRENCE CODE										OCCURRENCE DATE										OCCURRENCE CODE										OCCURRENCE DATE																			
04										013014																																																																																																			
VALUE CODES										VALUE CODES										VALUE CODES										VALUE CODES										VALUE CODES										VALUE CODES										VALUE CODES										VALUE CODES										VALUE CODES																													
CODE										AMOUNT										CODE										AMOUNT										CODE										AMOUNT										CODE										AMOUNT										CODE										AMOUNT																			
REV CD										DESCRIPTION										HCPCS/RATE/PPS CODE										SERV. DATE										SERV. UNITS										TOTAL CHARGES										NON-COVERED CHARGES																																																	
0636										DRUGS/DETAIL CODE										J2270										013014										6										464 40																																																											
0636										DRUGS/DETAIL CODE										J2405										013014										12										289 50																																																											
0636										DRUGS/DETAIL CODE										Q9967										013014										100										27 00																																																											
0636										DRUGS/DETAIL CODE										J2270										013114										1										79 90																																																											
0636										DRUGS/DETAIL CODE										J2405										013114										4										96 50																																																											
0637										SELF ADMINISTERED DRUGS										013014										6										26 20																																																																					
0637										SELF ADMINISTERED DRUGS										013114										11										66 90																																																																					
0762										OBSERVATION ROOM										013014										1										2944 00																																																																					
0940										OTHER THERAPEUTIC SERVICE										9637659										013014										6										1362 00																																																											
0940										OTHER THERAPEUTIC SERVICE										96376										013114										2										454 00																																																											
0001										Page 2 of 2										CREATION DATE										021214										TOTALS										17120 30																																																											
PAYER NAME										HEALTH PLAN ID										PROR PAYMENTS										EST AMOUNT DUE										NPI										1417152745																																																											
CITY OF SCOTTSDALE ICA										999999999										Y Y										1712030										860181654																																																																					
INSURED'S NAME										INSURED'S UNIQUE ID										GROUP NAME										INSURANCE GROUP NO.																																																																															
										20 CLMNB131404-WC-182										CITY OF SCOTTS										526559315																																																																															
TREATMENT AUTHORIZATION CODES										DOCUMENT CONTROL NUMBER										EMPLOYER NAME																																																																																									
NOTIFIED																				CITY OF SCOTTSDALE																																																																																									
80704										U86121										UV1582										U																																																																															
80704										78652										E8849										E8493										E0000																																																																					
PRINCIPAL PROCEDURE										OTHER PROCEDURE										OTHER PROCEDURE										OTHER PROCEDURE										OTHER PROCEDURE										OTHER PROCEDURE										OTHER PROCEDURE																																																	
CODE										DATE										CODE										DATE										CODE										DATE										CODE										DATE																																							
CITY OF SCOTTSDALE										B3282N00000X																																																																																																			
CITY OF SCOTTSDALE																																																																																																													
7447 E INDIAN SCHOOL 225																																																																																																													
SCOTTSDALE AZ 85251																																																																																																													



Patient Accounts Customer Service
(602) 445-3370

FEI # 86-0181654

DO NOT PAY THIS STATEMENT.
THIS IS NOT A BILL. THE INFORMATION
PROVIDED BELOW IS FOR INFORMATION
PURPOSES ONLY

PATIENT:

[REDACTED]

ACCOUNT NUMBER

C1403030036

DATE ADMITTED

01/30/14

DATE DISCHARGED

01/31/14

PATIENT TYPE

HOP

PAGE NO.

1 of 3

REFER TO THIS NUMBER ON ALL CORRESPONDENCE

ATTENTION:

[REDACTED]

☐ MasterCard ☐ VISA

☐ Other

Card No. _____ Expiration Date _____

Signature _____

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

INSURANCE PAYMENTS:

Scottsdale Healthcare
P.O. BOX 29399
Phoenix, AZ 85038

CLAIMS AND BILLING INFORMATION THAT REQUIRE A RESPONSE:

Scottsdale Healthcare
P.O. Box 1270
Scottsdale, AZ 85252

MEDICAL RECORDS REQUEST:

Scottsdale Healthcare Osborn
Medical Records Department
7400 E. Osborn Road
Scottsdale, AZ 85251

Scottsdale Healthcare Shea
Medical Records Department
9003 E. Shea Boulevard
Scottsdale, AZ 85260

Scottsdale Healthcare Thompson Peak
Medical Records Department
7400 E. Thompson Peak Parkway
Scottsdale, AZ 85255

ATTENTION: MEDICARE PATIENTS

These charges have been billed to Medicare. When the Hospital receives payment, you will receive an Explanation of Benefits (EOB) from Medicare. These EOB's are sent to the PATIENT ONLY. The hospital does not receive copies of these EOB's. Copies can be obtained by calling Medicare at 800-633-4227 or online at www.medicare.gov

DATE OF SERVICE		ITEM NO.	DESCRIPTION	QTY.	ITEM PRICE	TOTAL CHARGES
01/30/14	18	1590	SODIUM CHLORIDE PF SYRINGE	1	1.50	1.50
01/30/14	24	1590	SODIUM CHLORIDE PF SYRINGE	3	1.50	4.50
01/30/14	28	1590	SODIUM CHLORIDE PF SYRINGE	2	1.50	3.00
01/30/14	31	1590	SODIUM CHLORIDE PF SYRINGE	1	1.50	1.50
01/31/14	47	1590	SODIUM CHLORIDE PF SYRINGE	1	1.50	1.50
			TOTAL PHARMACY			12.00
01/30/14	19	2547	SODIUM CHLORIDE 0.9% 1000ML	1	128.00	128.00
			TOTAL PHARMACY IV SOLUTIONS			128.00
01/30/14	8	11717	SLEEVE SCD KNEE	1	71.36	71.36
			TOTAL NONSTERILE SUPPLY			71.36
01/30/14	3	10627	DRESSING TRANSPARENT 2 X 3	1	2.30	2.30
01/31/14	14	10630	DRESSING TRANSPARENT IV GARD	1	3.34	3.34
			TOTAL STERILE SUPPLY			5.64

NOTE: AMOUNTS INDICATED TO BE PAID BY THIRD PARTIES ARE ESTIMATED BY HOSPITAL. HOWEVER, THE PATIENT AND / OR RESPONSIBLE PARTY HAVE PERSONALLY GUARANTEED PAYMENT AND ARE RESPONSIBLE FOR THE TOTAL CHARGES ON THIS STATEMENT.

CONTINUED

Corvel Scan Date: 2/24/2014



P.O. BOX 29399
Phoenix, AZ 85038

Patient Accounts Customer Service
(480) 882-6776

DO NOT PAY THIS STATEMENT.
THIS IS NOT A BILL. THE INFORMATION
PROVIDED BELOW IS FOR INFORMATION
PURPOSES ONLY

PATIENT:

ACCOUNT NUMBER

DATE ADMITTED

DATE DISCHARGED

PATIENT TYPE

PAGE NO.

C1403030036

01/30/14

01/31/14

HOP

2 of 3

REFER TO THIS NUMBER ON ALL CORRESPONDENCE

DATE OF SERVICE		ITEM NO.	DESCRIPTION	QTY.	ITEM PRICE	TOTAL CHARGES
01/30/14	1	83324	METABOLIC PANEL, BASIC IONIZ	1	250.00	250.00
01/31/14	34	83326	METABOLIC PANEL BASIC	1	232.00	232.00
			TOTAL CHEMISTRY			482.00
01/30/14	1	84085	HEMATOCRIT	1	50.00	50.00
01/30/14	1	84088	HEMOGLOBIN	1	45.00	45.00
01/31/14	33	84010	CBC AUTOMATED (PLATELET & DI	1	137.00	137.00
			TOTAL HEMATOLOGY			232.00
01/31/14	39	70052	CHEST PORTABLE	1	467.00	467.00
			TOTAL CHEST X-RAY			467.00
01/30/14	13	71099	CT THORAX WITH CONTRAST	1	1,841.00	1,841.00
01/30/14	13	71206	CT ABD & PELVIS WITH CONTRAS	1	3,405.00	3,405.00
			TOTAL CT SCAN, BODY SCAN			5,246.00
01/31/14	36	63403	PT ASSESSMENT (IP)-15 MIN	1	216.00	216.00
			TOTAL PHYSICAL THERAPY			216.00
01/30/14	2	66011	ED INTENSIVE	1	3,029.00	3,029.00
01/30/14	53	66083	INJ THER/PROPH/DIAG, ADD-ON	2	227.00	454.00
01/30/14	55	66085	INJECTION-INTRAVENTOUS	1	227.00	227.00
01/30/14	4	66088	IV INFUSION, HYDRATION, EA A	1	313.00	313.00
01/30/14	57	66098	IV PUSH, REPEATED DRUG.	1	227.00	227.00
			TOTAL EMERGENCY DEPT.			4,250.00
01/30/14	10	64153	OXIMETRY, SINGLE	1	125.00	125.00
			TOTAL PULMONARY FUNCTION			125.00
01/30/14	23	267	MORPHINE 10MG AMPULE	1	74.90	74.90
01/30/14	25	267	MORPHINE 10MG AMPULE	1	79.90	79.90
01/30/14	26	267	MORPHINE 10MG AMPULE	1	79.90	79.90
01/30/14	27	267	MORPHINE 10MG AMPULE	1	79.90	79.90
01/30/14	15	5944	ONDANSETRON 2MG/ML INJ-2ML	1	96.50	96.50
01/30/14	22	5944	ONDANSETRON 2MG/ML INJ-2ML	1	96.50	96.50
01/30/14	30	5944	ONDANSETRON 2MG/ML INJ-2ML	1	96.50	96.50
01/30/14	12	71480	OMNIPAQUE 300-100ML-CT.	100	0.27	27.00
01/30/14	20	7758	HYDROMORPHONE 2MG/ML	1	74.90	74.90
01/30/14	16	7830	MORPHINE 5MG/ML VIAL	1	74.90	74.90
01/30/14	17	7830	MORPHINE 5MG/ML VIAL	1	74.90	74.90
01/31/14	40	267	MORPHINE 10MG AMPULE	1	79.90	79.90
01/31/14	45	5944	ONDANSETRON 2MG/ML INJ-2ML	1	96.50	96.50

NOTE: AMOUNTS INDICATED TO BE PAID BY THIRD PARTIES ARE ESTIMATED BY HOSPITAL. HOWEVER, THE PATIENT AND / OR RESPONSIBLE PARTY HAVE PERSONALLY GUARANTEED PAYMENT AND ARE RESPONSIBLE FOR THE TOTAL CHARGES ON THIS STATEMENT.

CONTINUED

Corvel Scan Date: 2/24/2014



P.O. BOX 29399
Phoenix, AZ 85038

Patient Accounts Customer Service
(480) 882-6776

DO NOT PAY THIS STATEMENT.
THIS IS NOT A BILL. THE INFORMATION
PROVIDED BELOW IS FOR INFORMATION
PURPOSES ONLY

PATIENT:

ACCOUNT NUMBER

DATE ADMITTED

DATE DISCHARGED

PATIENT TYPE

PAGE NO.

C1403030036

01/30/14

01/31/14

HOP

3 of 3

REFER TO THIS NUMBER ON ALL CORRESPONDENCE

DATE OF SERVICE		ITEM NO.	DESCRIPTION	QTY.	ITEM PRICE	TOTAL CHARGES
			TOTAL DRUGS/DETAIL CODE			1,032.20
01/30/14	29	1669	NORCO 5-325 MG TABLETS	2	7.40	14.80
01/30/14	32	2890	SENNA 187MG TAB	2	1.40	2.80
01/30/14	21	3579	ACETAMINOPHEN/OXYCODONE 5MG	2	4.30	8.60
01/31/14	46	1107	PANTOPRAZOLE 40MG TABLET	1	2.10	2.10
01/31/14	41	1669	NORCO 5-325 MG TABLETS	2	7.40	14.80
01/31/14	42	1669	NORCO 5-325 MG TABLETS	2	7.40	14.80
01/31/14	43	1669	NORCO 5-325 MG TABLETS	2	7.40	14.80
01/31/14	44	1669	NORCO 5-325 MG TABLETS	2	7.40	14.80
01/31/14	49	686	CYCLOBENZAPRINE HCL 10MG TAB	1	1.40	1.40
01/31/14	48	858	DIAZEPAM 5MG TAB	1	4.20	4.20
			TOTAL SELF-ADMIN DRUGS-NO DET CODING			93.10
01/30/14	58	39150	3RD FLOOR MED/SURG HOP	32	92.00	2,944.00
			TOTAL OBSERVATION ROOM			2,944.00
01/30/14	52	57456	IV PUSH, REPEATED DRUG	6	227.00	1,362.00
01/31/14	50	57456	IV PUSH, REPEATED DRUG	2	227.00	454.00
			TOTAL OTHER THERAPEUTIC SERVICES			1,816.00
			TOTAL CHARGES			17,120.30
			TOTAL PAYMENTS/ADJUSTMENTS			0.00
			ESTIMATED PATIENT BALANCE DUE			0.00

NOTE: AMOUNTS INDICATED TO BE PAID BY THIRD PARTIES ARE ESTIMATED BY HOSPITAL, HOWEVER, THE PATIENT AND / OR RESPONSIBLE PARTY HAVE PERSONALLY GUARANTEED PAYMENT AND ARE RESPONSIBLE FOR THE TOTAL CHARGES ON THIS STATEMENT.

**UNPAID
BALANCE**

17,120.30

Corvel Scan Date: 2/24/2014



Patient Accounts Customer Service
(602) 445-3370

FEI # 86-0181654

Corvel Scan Date: 1/31/2014

DO NOT PAY THIS STATEMENT.
THIS IS NOT A BILL. THE INFORMATION
PROVIDED BELOW IS FOR INFORMATION
PURPOSES ONLY

PATIENT:

ACCOUNT NUMBER DATE ADMITTED DATE DISCHARGED PATIENT TYPE PAGE NO.
A1401210053 01/12/14 01/12/14 ED 1 of 2
REFER TO THIS NUMBER ON ALL CORRESPONDENCE

ATTENTION:

☐ MasterCard ☐ VISA

☐ Other

Card No. _____ Expiration Date _____

Signature _____

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

INSURANCE PAYMENTS:

Scottsdale Healthcare
P.O. BOX 29679
Phoenix, AZ 85038

CLAIMS AND BILLING INFORMATION THAT REQUIRE A RESPONSE:

Scottsdale Healthcare
P.O. Box 1270
Scottsdale, AZ 85252

MEDICAL RECORDS REQUEST:

Scottsdale Healthcare Osborn
Medical Records Department
7400 E. Osborn Road
Scottsdale, AZ 85251

Scottsdale Healthcare Shea
Medical Records Department
9003 E. Shea Boulevard
Scottsdale, AZ 85260

Scottsdale Healthcare Thompson Peak
Medical Records Department
7400 E. Thompson Peak Parkway
Scottsdale, AZ 85255

ATTENTION: MEDICARE PATIENTS

These charges have been billed to Medicare. When the Hospital receives payment, you will receive an Explanation of Benefits (EOB) from Medicare. These EOB's are sent to the PATIENT ONLY. The hospital does not receive copies of these EOB's. Copies can be obtained by calling Medicare at 800-633-4227 or online at www.medicare.gov.

DATE OF SERVICE		ITEM NO.	DESCRIPTION	QTY.	ITEM PRICE	TOTAL CHARGES
01/12/14	14	2468	ALBUTEROL 0.5% - 0.1-1ML SOL	1	14.80	14.80
01/12/14	13	6000	IPRATROPIUM 0.02% SOLN 2.5ML	1	1.50	1.50
			TOTAL PHARMACY			16.30
01/12/14	12	2547	SODIUM CHLORIDE 0.9% 1000ML	2	64.00	128.00
			TOTAL PHARMACY IV SOLUTIONS			128.00
01/12/14	2	10834	NEBULIZER SMALL VOLUME	1	3.28	3.28
			TOTAL STERILE SUPPLY			3.28
01/12/14	8	83326	METABOLIC PANEL BASIC	1	232.00	232.00
			TOTAL CHEMISTRY			232.00
01/12/14	6	83068	CRP.	1	83.00	83.00
			TOTAL IMMUNOLOGY			83.00
01/12/14	5	84010	CBC AUTOMATED (PLATELET & DI	1	137.00	137.00

NOTE: AMOUNTS INDICATED TO BE PAID BY THIRD PARTIES ARE ESTIMATED BY HOSPITAL, HOWEVER, THE PATIENT AND / OR RESPONSIBLE PARTY HAVE PERSONALLY GUARANTEED PAYMENT AND ARE RESPONSIBLE FOR THE TOTAL CHARGES ON THIS STATEMENT.

CONTINUED

Corvel Scan Date: 1/31/2014



P.O. BOX 29679
Phoenix, AZ 85038

Patient Accounts Customer Service
(480) 882-6776

DO NOT PAY THIS STATEMENT.
THIS IS NOT A BILL. THE INFORMATION
PROVIDED BELOW IS FOR INFORMATION
PURPOSES ONLY

PATIENT:



ACCOUNT NUMBER

A1401210053

DATE ADMITTED

01/12/14

DATE DISCHARGED

01/12/14

PATIENT TYPE

ED

PAGE NO.

2 of 2

REFER TO THIS NUMBER ON ALL CORRESPONDENCE

DATE OF SERVICE	ITEM NO.	DESCRIPTION	QTY.	ITEM PRICE	TOTAL CHARGES
01/12/14	7 84139	SED RATE	1	104.00	104.00
		TOTAL HEMATOLOGY			241.00
01/12/14	9 85046	CULTURE, BLOOD	1	324.00	324.00
01/12/14	1 87103	ZZ INFLUENZA B VIRUS	1	89.00	89.00
01/12/14	1 87104	ZZ INFLUENZA A VIRUS	1	89.00	89.00
		TOTAL BACTERIOLOGY & MICROBIOLOGY			502.00
01/12/14	2 64146	SVN,(SM VOLUME NEB)-INITIAL	1	129.00	129.00
		TOTAL RESPIRATORY SERVICES			129.00
01/12/14	19 66005	ED INTERMEDIATE	1	905.00	905.00
01/12/14	18 66083	INJ THER/PROPH/DIAG, ADD-ON	1	227.00	227.00
01/12/14	21 66085	INJECTION-INTRAVENTOUS	1	227.00	227.00
01/12/14	20 66088	IV INFUSION, HYDRATION, EA A	3	313.00	939.00
		TOTAL EMERGENCY DEPT.			2,298.00
01/12/14	10 3259	METHYLPRDNISOLONE NA 125MG/2	1	105.10	105.10
01/12/14	17 7800	HEP FLUSH 100UNITS/ML 5ML	1	96.20	96.20
01/12/14	11 945	DIPHENHYDRAMINE 50MG/ML INJ	1	96.50	96.50
		TOTAL DRUGS/DETAIL CODE			297.80
		TOTAL CHARGES			3,930.38
		TOTAL PAYMENTS/ADJUSTMENTS			0.00
		ESTIMATED PATIENT BALANCE DUE			0.00

NOTE: AMOUNTS INDICATED TO BE PAID BY THIRD PARTIES ARE ESTIMATED BY HOSPITAL, HOWEVER, THE PATIENT AND / OR RESPONSIBLE PARTY HAVE PERSONALLY GUARANTEED PAYMENT AND ARE RESPONSIBLE FOR THE TOTAL CHARGES ON THIS STATEMENT.

**UNPAID
BALANCE**

3,930.38

13357019003706890027

1 SCOTSDLE HLTH SHEA 9003 E. SHEA BOULEVARD SCOTTSDALE, AZ 852606709 4808826776										2 SCOTSDLE HLTH SHEA PO BOX 29689 PHOENIX, AZ 85038										34 Pat Cnt # B1332820027 35 Mod Rec # B0000920415 36 Fed Tax # 000B 860181654										4 TYPE OF BILL 0111 5 Statement Covers From 112413 Through 112713 7 ID																													
PATIENT NAME										PATIENT ADDRESS										AZ 85331																																							
BIRTHDATE										SEX										ADMISSION DATE										CONDITION CODES																													
M										11241308										1										14																													
04										080111																																																	
02										0.0080										3.00																																							
0110										ROOM AND BED PRIVATE GEN										1470 00										3																													
0250										PHARMACY																				9																													
0258										PHARMACY IV SOLUTIONS																				4																													
0271										NONSTERILE SUPPLY																				1																													
0272										STERILE SUPPLY																				27																													
0278										SUPPLY/IMPLANTS																				1																													
0301										CHEMISTRY																				6																													
0302										IMMUNOLOGY																				6																													
0305										HEMATOLOGY																				10																													
0306										BACTERIOLOGY & MICROBIOLC																				28																													
0324										CHEST X-RAY																				1																													
0361										OPERATING ROOM-MINOR SURG																				1																													
0370										ANESTHESIA																				2																													
0402										ULTRASOUND																				1																													
0420										PHYSICAL THERAPY																				6																													
0450										EMERGENCY DEPT																				1																													
0490										AMBULATORY SURGICAL CARE																				1																													
0610										MRI																				1																													
0636										DRUGS/DETAIL CODE																				18																													
0637										SELF ADMINISTERED DRUGS																				23																													
0710										RECOVERY ROOM																				7																													
0730										EKG/ECG																				1																													
0001										Page 1 of 1										CREATION DATE 120613										TOTALS																													
50 PAYER NAME										51 HEALTH PLAN ID										53 Rels										54 PRIOR PAYMENTS										55 EST AMOUNT DUE																			
CITY OF SCOTTSDALE ICA										99999										Y										Y										4449081																			
AETNA PPO/MC/HLTH FUND/										60054										Y										Y										4449081																			
58 INSURED'S NAME										59 P. REL										60 INSURED'S UNIQUE ID										61 GROUP NAME										62 INSURANCE GROUP NO.																			
										20										080907WC022										CITY OF SCOTTS										999999																			
										18										W121084322										CITY OF SCOTTS										088353001200001																			
53 TREATMENT AUTHORIZATION CODES										54 DOCUMENT CONTROL										55 EMPLOYER NAME																																							
VERBAL AUTH																				CITY OF SCOTTSDALE																																							
01135697																				CITY OF SCOTTSDALE																																							
56 DX										57										58										59																													
99859										Y53081										Y72789										Y71590										Y																			
59 Admt DX										60 Patient Reason DX										61 PPS CODE										62 ECI										63																			
99859																				858										E8784																													
74 CODE										75 CODE										76 CODE										77 ATTENDING										78																			
8311										112413										8391										112413										NPI 1336120666										Quasi									
77 OPERATING										NPI 1548340839										Quasi										FIRST										MICHAEL																			
78 OTHER										NPI										Quasi										FIRST										FRANK																			
79 OTHER										NPI										Quasi										FIRST																													
80 OTHER										NPI										Quasi										FIRST																													
81 OTHER										NPI										Quasi										FIRST																													
CITY OF SCOTTSDALE										B3282N00000X																																																	
CITY OF SCOTTSDALE																																																											
7447 E INDIAN SCHOOL 225																																																											
SCOTTSDALE AZ 85251																																																											

Corvel Scan Date: 12/23/2013



Patient Accounts Customer Service
(602) 445-3370

FEI # 86-0181654

DO NOT PAY THIS STATEMENT.
THIS IS NOT A BILL. THE INFORMATION
PROVIDED BELOW IS FOR INFORMATION
PURPOSES ONLY

PATIENT:	ACCOUNT NUMBER	DATE ADMITTED	DATE DISCHARGED	PATIENT TYPE	PAGE NO.
[REDACTED]	B1332820027	11/24/13	11/27/13	IP	1 of 6
REFER TO THIS NUMBER ON ALL CORRESPONDENCE					

ATTENTION:

☐ MasterCard ☐ VISA
☐ Other _____

Card No. _____ Expiration Date _____

Signature _____

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

INSURANCE PAYMENTS:

Scottsdale Healthcare
P.O. BOX 29689
Phoenix, AZ 85038

CLAIMS AND BILLING INFORMATION THAT REQUIRE A RESPONSE:

Scottsdale Healthcare
P.O. Box 1270
Scottsdale, AZ 85252

MEDICAL RECORDS REQUEST:

Scottsdale Healthcare Osborn
Medical Records Department
7400 E. Osborn Road
Scottsdale, AZ 85251

Scottsdale Healthcare Shea
Medical Records Department
9003 E. Shea Boulevard
Scottsdale, AZ 85260

Scottsdale Healthcare Thompson Peak
Medical Records Department
7400 E. Thompson Peak Parkway
Scottsdale, AZ 85255

ATTENTION: MEDICARE PATIENTS

These charges have been billed to Medicare. When the Hospital receives payment, you will receive an Explanation of Benefits (EOB) from Medicare. These EOB's are sent to the PATIENT ONLY. The hospital does not receive copies of these EOB's. Copies can be obtained by calling Medicare at 800-633-4227 or online at www.medicare.gov

DATE OF SERVICE		ITEM NO.	DESCRIPTION	QTY.	ITEM PRICE	TOTAL CHARGES
11/24/13	10	33152	ROOM 5319 F	1	1,470.00	1,470.00
11/25/13	46	33152	ROOM 5319 F	1	1,470.00	1,470.00
11/26/13	96	33152	ROOM 5319 F	1	1,470.00	1,470.00
			TOTAL ROOM AND BED PRIVATE GEN CLASS			4,410.00
11/24/13	15	1590	SODIUM CHLORIDE PF SYRINGE	1	1.50	1.50
11/25/13	49	1590	SODIUM CHLORIDE PF SYRINGE	1	1.50	1.50
11/25/13	120	2344	GLYCOPYRROLATE 0.2MG/ML INJ	3	32.27	96.80
11/25/13	121	2575	ROCURONIUM 10MG/ML VIAL	1	98.10	98.10
11/25/13	123	338	BUPIVACAINE HCL 0.25%-30ML S	1	118.50	118.50
11/25/13	125	341	BUPIVACAINE HCL 0.5%-30ML SD	1	104.60	104.60
11/25/13	126	348	BUPIVACAINE 0.5%/EPIN 30ML S	1	104.90	104.90
11/25/13	128	5537	PROPOFOL 10MG/ML-20ML AMP	1	104.90	104.90
11/25/13	53	7365	DOUBLES IRRIGATION 3 LITERS	1	137.00	137.00
			TOTAL PHARMACY			767.80
11/25/13	59	2548	SODIUM CHLORIDE 0.9% 500ML I	1	128.00	128.00

NOTE: AMOUNTS INDICATED TO BE PAID BY THIRD PARTIES ARE ESTIMATED BY HOSPITAL, HOWEVER, THE PATIENT AND / OR RESPONSIBLE PARTY HAVE PERSONALLY GUARANTEED PAYMENT AND ARE RESPONSIBLE FOR THE TOTAL CHARGES ON THIS STATEMENT.

CONTINUED

Corvel Scan Date: 12/23/2013



P.O. BOX 29689
Phoenix, AZ 85038

Patient Accounts Customer Service
(480) 882-6776

DO NOT PAY THIS STATEMENT.
THIS IS NOT A BILL. THE INFORMATION
PROVIDED BELOW IS FOR INFORMATION
PURPOSES ONLY

PATIENT:

ACCOUNT NUMBER
B1332820027

DATE ADMITTED
11/24/13

DATE DISCHARGED
11/27/13

PATIENT TYPE
IP

PAGE NO.
2 of 6

REFER TO THIS NUMBER ON ALL CORRESPONDENCE

DATE OF SERVICE	ITEM NO.	DESCRIPTION	QTY.	ITEM PRICE	TOTAL CHARGES
11/25/13	54 796	DEX 5% NACL 0.45% KCL 20 100	1	97.90	97.90
11/25/13	55 796	DEX 5% NACL 0.45% KCL 20 100	1	97.90	97.90
11/26/13	134 5215	SODIUM CHLORIDE 0.9% 50ML IN	1	128.00	128.00
		TOTAL PHARMACY IV SOLUTIONS			451.80
11/27/13	170 1537	PRESCRIPTION PAD - NO CHARGE	50	0.00	0.00
		TOTAL DRUGS/OTHER			0.00
11/26/13	95 12060	BOOT ORTHOSIS LARGE	1	141.54	141.54
		TOTAL NONSTERILE SUPPLY			141.54
11/24/13	23 10627	DRESSING TRANSPARENT 2 X 3	1	2.30	2.30
11/24/13	24 10855	SENSOR OXIMETER DIGIT DISP	1	54.74	54.74
11/25/13	71 10010	STAPLER SKIN 35 WIDE FIXED	1	41.26	41.26
11/25/13	80 10372	BANDAGE ESMARK STRL LF 6IN X	1	11.85	11.85
11/25/13	66 10695	DRESSING PETROL XEROFORM ST	1	2.61	2.61
11/25/13	78 10751	KIT DRAIN HEMO 1/8 TUBING-10	1	45.98	45.98
11/25/13	79 10877	PAD ELECTROSURGICAL GROUNDIN	1	13.09	13.09
11/25/13	75 10998	SPONGE 18X18 LAP	1	1.40	1.40
11/25/13	82 11009	SPONGE 4X8 12 PLY ST	2	0.54	1.08
11/25/13	67 11091	TUBE SUCTION YANKAUER HIGH C	1	2.85	2.85
11/25/13	83 11220	DRAIN PENROSE 1/4X12 ST	2	1.84	3.68
11/25/13	88 11299	BLADE CLIPPER ASSEMBLY PREM-	1	17.55	17.55
11/25/13	81 11466	BANDAGE ELASTIC NS 6IN	2	7.63	15.26
11/25/13	73 11474	BANDAGE ELASTIC ST LF COBAN	1	19.13	19.13
11/25/13	64 11476	PADDING CAST WEBRIL 4IN	1	3.51	3.51
11/25/13	72 11476	PADDING CAST WEBRIL 4IN	2	3.51	7.02
11/25/13	85 11547	STOCKINETTE IMPERVIOUS XLG-1	1	20.74	20.74
11/25/13	77 11880	COVER WARMING CONVECTIVE UPP	1	35.93	35.93
11/25/13	69 22198	NDL MAYO CATGUT 1/2 CIRCLE-2	1	13.18	13.18
11/25/13	68 29647	ADHESIVE LIQUID MASTISOL-296	1	9.75	9.75
11/25/13	86 48306	SUTURE LEVEL 2	1	20.00	20.00
11/25/13	76 48312	SUTURE LEVEL 5	1	60.00	60.00
11/25/13	65 48316	SUTURE LEVEL 6	1	100.00	100.00
11/25/13	70 89974	GOWN KIT FLEX STD BPBAW-8997	1	106.48	106.48
11/26/13	47 11126	KIT CATH URINARY CLOSED SYS	1	13.23	13.23
11/27/13	141 36479	COVER PROBE ULTRASOUND	1	31.74	31.74
11/27/13	140 88065	DRAPE MAX BARRIER W CHG DISK	1	97.41	97.41
		TOTAL STERILE SUPPLY			751.77
11/27/13	137 97315	CATH PICC DUAL LUMEN SAPIEN	1	884.00	884.00
		TOTAL OTHER IMPLANTS			884.00

NOTE: AMOUNTS INDICATED TO BE PAID BY THIRD PARTIES ARE ESTIMATED BY HOSPITAL, HOWEVER, THE PATIENT AND / OR RESPONSIBLE PARTY HAVE PERSONALLY GUARANTEED PAYMENT AND ARE RESPONSIBLE FOR THE TOTAL CHARGES ON THIS STATEMENT.

CONTINUED

Corvel Scan Date: 12/23/2013



P.O. BOX 29689
Phoenix, AZ 85038

Patient Accounts Customer Service
(480) 882-6776

DO NOT PAY THIS STATEMENT.
THIS IS NOT A BILL. THE INFORMATION
PROVIDED BELOW IS FOR INFORMATION
PURPOSES ONLY

PATIENT:

ACCOUNT NUMBER

DATE ADMITTED

DATE DISCHARGED

PATIENT TYPE

PAGE NO.

B1332820027

11/24/13

11/27/13

IP

3 of 6

REFER TO THIS NUMBER ON ALL CORRESPONDENCE

DATE OF SERVICE	ITEM NO.	DESCRIPTION	QTY.	ITEM PRICE	TOTAL CHARGES
11/24/13	1	83326 METABOLIC PANEL BASIC	1	232.00	232.00
11/25/13	20	83326 METABOLIC PANEL BASIC	1	232.00	232.00
11/25/13	25	83601 WHOLE BLOOD GLUCOSE, REAGENT	1	25.00	25.00
11/26/13	94	83142 CPK	1	74.00	74.00
11/27/13	135	83142 CPK	1	74.00	74.00
11/27/13	153	83487 VANCOMYCIN TROUGH LEVEL	1	188.00	188.00
		TOTAL CHEMISTRY			825.00
11/24/13	6	83069 CRP HIGHLY SENSITIVE	1	68.00	68.00
11/24/13	8	86004 ABO GROUP	1	102.00	102.00
11/24/13	9	86048 ANTIBODY SCREEN INCUBATION.	1	163.00	163.00
11/24/13	9	86050 ANTIBODY SCREEN ANTIGLOBULIN	1	163.00	163.00
11/24/13	8	86082 RH TYPE..	1	85.00	85.00
11/25/13	21	83068 CRP.	1	83.00	83.00
		TOTAL IMMUNOLOGY			664.00
11/24/13	2	84010 CBC AUTOMATED (PLATELET & DI	1	137.00	137.00
11/24/13	3	84127 PROTHROMBIN TIME	1	105.00	105.00
11/24/13	4	84130 PTT	1	167.00	167.00
11/24/13	5	84139 SED RATE	1	104.00	104.00
11/25/13	18	84010 CBC AUTOMATED (PLATELET & DI	1	137.00	137.00
11/25/13	19	84139 SED RATE	1	104.00	104.00
11/26/13	61	84010 CBC AUTOMATED (PLATELET & DI	1	137.00	137.00
11/26/13	89	84127 PROTHROMBIN TIME	1	105.00	105.00
11/26/13	90	84130 PTT	1	167.00	167.00
11/27/13	136	84010 CBC AUTOMATED (PLATELET & DI	1	137.00	137.00
		TOTAL HEMATOLOGY			1,300.00
11/25/13	29	85002 AFB CULTURE AND STAIN	1	310.00	310.00
11/25/13	33	85002 AFB CULTURE AND STAIN	1	310.00	310.00
11/25/13	37	85002 AFB CULTURE AND STAIN	1	310.00	310.00
11/25/13	41	85002 AFB CULTURE AND STAIN	1	310.00	310.00
11/25/13	143	85042 CONCENTRATION FOR INFEC AGEN	1	60.00	60.00
11/25/13	144	85042 CONCENTRATION FOR INFEC AGEN	1	60.00	60.00
11/25/13	145	85042 CONCENTRATION FOR INFEC AGEN	1	60.00	60.00
11/25/13	146	85042 CONCENTRATION FOR INFEC AGEN	1	60.00	60.00
11/25/13	26	85076 CULTURE, TISSUE AEROBIC	1	232.00	232.00
11/25/13	34	85076 CULTURE, TISSUE AEROBIC	1	232.00	232.00
11/25/13	30	85085 CULTURE, AEROBIC SWAB	1	232.00	232.00
11/25/13	38	85085 CULTURE, AEROBIC SWAB	1	232.00	232.00
11/25/13	27	85088 CULTURE, ANAEROBIC	1	305.00	305.00
11/25/13	31	85088 CULTURE, ANAEROBIC	1	305.00	305.00

NOTE: AMOUNTS INDICATED TO BE PAID BY THIRD PARTIES ARE ESTIMATED BY HOSPITAL, HOWEVER, THE PATIENT AND / OR RESPONSIBLE PARTY HAVE PERSONALLY GUARANTEED PAYMENT AND ARE RESPONSIBLE FOR THE TOTAL CHARGES ON THIS STATEMENT.

CONTINUED

Corvel Scan Date: 12/23/2013



P.O. BOX 29689
Phoenix, AZ 85038

Patient Accounts Customer Service
(480) 882-6776

DO NOT PAY THIS STATEMENT.
THIS IS NOT A BILL. THE INFORMATION
PROVIDED BELOW IS FOR INFORMATION
PURPOSES ONLY

PATIENT:

ACCOUNT NUMBER
B1332820027

DATE ADMITTED
11/24/13

DATE DISCHARGED
11/27/13

PATIENT TYPE
IP

PAGE NO.
4 of 6

REFER TO THIS NUMBER ON ALL CORRESPONDENCE

DATE OF SERVICE		ITEM NO.	DESCRIPTION	QTY.	ITEM PRICE	TOTAL CHARGES
11/25/13	35	85088	CULTURE, ANAEROBIC	1	305.00	305.00
11/25/13	39	85088	CULTURE, ANAEROBIC	1	305.00	305.00
11/25/13	28	85097	CULTURE, FUNGUS, OTHER SOURC	1	288.00	288.00
11/25/13	32	85097	CULTURE, FUNGUS, OTHER SOURC	1	288.00	288.00
11/25/13	36	85097	CULTURE, FUNGUS, OTHER SOURC	1	288.00	288.00
11/26/13	40	85097	CULTURE, FUNGUS, OTHER SOURC	1	288.00	288.00
11/25/13	29	85950	AFB STAIN.	1	115.00	115.00
11/25/13	33	85950	AFB STAIN.	1	115.00	115.00
11/25/13	37	85950	AFB STAIN.	1	115.00	115.00
11/25/13	41	85950	AFB STAIN.	1	115.00	115.00
11/26/13	42	85965	GRAM STAIN.	1	106.00	106.00
11/25/13	43	85965	GRAM STAIN.	1	106.00	106.00
11/25/13	44	85965	GRAM STAIN.	1	106.00	106.00
11/25/13	45	85965	GRAM STAIN.	1	106.00	106.00
			TOTAL BACTERIOLOGY & MICROBIOLOGY			5,664.00
11/24/13	11	70052	CHEST PORTABLE	1	467.00	467.00
			TOTAL CHEST X-RAY			467.00
11/27/13	138	62625	PICC INSERTION	1	2,119.00	2,119.00
			TOTAL MINOR SURGERY			2,119.00
11/25/13	74	61200	ANES GENERAL LEVEL 1-1ST HR	1	1,290.00	1,290.00
11/25/13	62	61205	ANES GENERAL LEVEL 1-ADDL 1/	1	322.50	322.50
			TOTAL ANESTHESIA			1,612.50
11/24/13	13	73334	US EXT SOFT TIS LTD LT	1	400.00	400.00
			TOTAL ULTRASOUND			400.00
11/28/13	91	63401	GAIT TRAINING	1	157.00	157.00
11/26/13	92	63403	PT ASSESSMENT (IP)-15 MIN	1	216.00	216.00
11/27/13	147	63401	GAIT TRAINING	1	157.00	157.00
11/27/13	149	63406	THERAPEUTIC EXERCISE	1	157.00	157.00
11/27/13	148	63437	THERAPEUTIC ACTIVITY	1	157.00	157.00
11/27/13	151	63437	THERAPEUTIC ACTIVITY	1	157.00	157.00
			TOTAL PHYSICAL THERAPY			1,001.00
11/24/13	22	66009	ED IMMEDIATE	1	1,585.00	1,585.00
			TOTAL EMERGENCY DEPT.			1,585.00
11/25/13	84	60681	ORTHO MINOR PROCEDURE-1 1/4	1	11,585.00	11,585.00
			TOTAL AMBULATORY SURGICAL CARE			11,585.00

NOTE: AMOUNTS INDICATED TO BE PAID BY THIRD PARTIES ARE ESTIMATED BY HOSPITAL, HOWEVER, THE PATIENT AND / OR RESPONSIBLE PARTY HAVE PERSONALLY GUARANTEED PAYMENT AND ARE RESPONSIBLE FOR THE TOTAL CHARGES ON THIS STATEMENT.

CONTINUED

Corvel Scan Date: 12/23/2013



P.O. BOX 29689
Phoenix, AZ 85038

Patient Accounts Customer Service
(480) 882-6776

DO NOT PAY THIS STATEMENT.
THIS IS NOT A BILL. THE INFORMATION
PROVIDED BELOW IS FOR INFORMATION
PURPOSES ONLY

PATIENT:

ACCOUNT NUMBER

DATE ADMITTED

DATE DISCHARGED

PATIENT TYPE

PAGE NO.

B1332820027

11/24/13

11/27/13

IP

5 of 6

REFER TO THIS NUMBER ON ALL CORRESPONDENCE

DATE OF SERVICE	ITEM NO.	DESCRIPTION	QTY.	ITEM PRICE	TOTAL CHARGES
11/24/13	12 74330	MRI LWR EXT JT W/O LT	1	2,607.00	2,607.00
		TOTAL MRI			2,607.00
11/25/13	119 2206	FENTANYL 50MCG/ML INJ	2	40.15	80.30
11/25/13	124 3390	NEOSTIGMINE 1-1000 INJ	1	104.90	104.90
11/25/13	127 5369	MIDAZOLAM HCL 1MG/ML INJ	2	37.45	74.90
11/25/13	58 5395	VANCOMYCIN HCL 1000MG INJ	2	62.90	125.80
11/25/13	97 5944	ONDANSETRON 2MG/ML INJ-2ML	1	96.50	96.50
11/25/13	129 7758	HYDROMORPHONE 2MG/ML	1	74.90	74.90
11/25/13	60 7830	MORPHINE 5MG/ML VIAL	1	74.90	74.90
11/25/13	130 7842	MEPERIDINE 50MG/ML 1ML SDV	1	75.00	75.00
11/25/13	50 8013	ACETAMINOPHEN IV 10 MG/ML	1	58.20	58.20
11/25/13	56 8029	CEFEPIME 1 GRAM IVPB	2	126.60	253.20
11/25/13	57 8029	CEFEPIME 1 GRAM IVPB	1	126.60	126.60
11/26/13	133 1474	DAPTOMYCIN 500MG INJECTION	1	1,081.60	1,081.60
11/26/13	107 7830	MORPHINE 5MG/ML VIAL	1	74.90	74.90
11/26/13	108 7830	MORPHINE 5MG/ML VIAL	1	74.90	74.90
11/26/13	109 7830	MORPHINE 5MG/ML VIAL	1	74.90	74.90
11/26/13	110 7830	MORPHINE 5MG/ML VIAL	1	74.90	74.90
11/26/13	111 7830	MORPHINE 5MG/ML VIAL	1	74.90	74.90
11/26/13	100 901	ENOXAPARIN 40MG/0.4ML INJECT	1	54.60	54.60
		TOTAL DRUGS/DETAIL CODE			2,655.90
11/24/13	16 1669	NORCO 5-325 MG TABLETS	1	7.40	7.40
11/24/13	17 1669	NORCO 5-325 MG TABLETS	1	7.40	7.40
11/24/13	14 2890	SENNA 187MG TAB	2	1.40	2.80
11/25/13	118 1065	LIDOCAINE HCL 4% TOPICAL SOL	1	8.60	8.60
11/25/13	122 2679	OPHTHALMIC LUBRICANT 1GM UD	1	8.30	8.30
11/25/13	48 2890	SENNA 187MG TAB	2	1.40	2.80
11/26/13	112 1040	TAMSULOSIN 0.4MG CAPSULE	1	9.50	9.50
11/26/13	116 1092	CALCIUM CARBONATE 500MG CHEW	1	1.40	1.40
11/26/13	117 1092	CALCIUM CARBONATE 500MG CHEW	1	1.40	1.40
11/26/13	98 1107	PANTOPRAZOLE 40MG TABLET	1	2.10	2.10
11/26/13	101 1195	PEG WITH ELECTROLYTES 17GM P	1	4.80	4.80
11/26/13	99 2890	SENNA 187MG TAB	2	1.40	2.80
11/26/13	113 3594	PHENAZOPYRIDINE HCL 100MG TA	2	1.50	3.00
11/26/13	115 3594	PHENAZOPYRIDINE HCL 100MG TA	1	1.50	1.50
11/27/13	158 1041	MAGNESIUM HYDROXIDE SUSP	1	2.10	2.10
11/27/13	154 1107	PANTOPRAZOLE 40MG TABLET	1	2.10	2.10
11/27/13	159 1195	PEG WITH ELECTROLYTES 17GM P	1	4.80	4.80
11/27/13	155 1669	NORCO 5-325 MG TABLETS	1	7.40	7.40

NOTE: AMOUNTS INDICATED TO BE PAID BY THIRD PARTIES ARE ESTIMATED BY HOSPITAL. HOWEVER, THE PATIENT AND / OR RESPONSIBLE PARTY HAVE PERSONALLY GUARANTEED PAYMENT AND ARE RESPONSIBLE FOR THE TOTAL CHARGES ON THIS STATEMENT.

CONTINUED

Corvel Scan Date: 12/23/2013



P.O. BOX 29689
Phoenix, AZ 85038

Patient Accounts Customer Service
(480) 882-6776

DO NOT PAY THIS STATEMENT.
THIS IS NOT A BILL. THE INFORMATION
PROVIDED BELOW IS FOR INFORMATION
PURPOSES ONLY

PATIENT:



ACCOUNT NUMBER

B1332820027

DATE ADMITTED

11/24/13

DATE DISCHARGED

11/27/13

PATIENT TYPE

IP

PAGE NO.

6 of 6

REFER TO THIS NUMBER ON ALL CORRESPONDENCE

DATE OF SERVICE	ITEM NO.	DESCRIPTION	QTY.	ITEM PRICE	TOTAL CHARGES
11/27/13	156 1669	NORCO 5-325 MG TABLETS	1	7.40	7.40
11/27/13	157 1669	NORCO 5-325 MG TABLETS	1	7.40	7.40
11/27/13	171 1692	NORCO 7.5-325 MG TABLET	1	7.50	7.50
11/27/13	160 3594	PHENAZOPYRIDINE HCL 100MG TA	1	1.50	1.50
11/27/13	161 3594	PHENAZOPYRIDINE HCL 100MG TA	1	1.50	1.50
		TOTAL SELF-ADMIN DRUGS-NO DET CODING			105.50
11/25/13	87 47001	RECOVERY ROOM 1ST HOUR	1	1,658.00	1,658.00
11/25/13	83 47005	RECOVERY ROOM ADD'L-1/4 HOUR	6	414.50	2,487.00
		TOTAL RECOVERY ROOM			4,145.00
11/24/13	7 64610	FULL EKG-ED ONLY	1	348.00	348.00
		TOTAL EKG/ECG			348.00
		TOTAL CHARGES			44,490.81
		TOTAL PAYMENTS/ADJUSTMENTS			0.00
		ESTIMATED PATIENT BALANCE DUE			0.00

NOTE: AMOUNTS INDICATED TO BE PAID BY THIRD PARTIES ARE ESTIMATED BY HOSPITAL, HOWEVER, THE PATIENT AND / OR RESPONSIBLE PARTY HAVE PERSONALLY GUARANTEED PAYMENT AND ARE RESPONSIBLE FOR THE TOTAL CHARGES ON THIS STATEMENT.

**UNPAID
BALANCE**

44,490.81

Corvel Scan Date: 12/23/2013

Corvel Scan Date: 2/16/2015



Patient Accounts Customer Service
(602) 445-3370

FEI # 86-0181654

DO NOT PAY THIS STATEMENT.
THIS IS NOT A BILL. THE INFORMATION
PROVIDED BELOW IS FOR INFORMATION
PURPOSES ONLY

PATIENT:

ACCOUNT NUMBER DATE ADMITTED DATE DISCHARGED PATIENT TYPE PAGE NO.
A1501810160 01/18/15 01/18/15 ED 1 of 1

REFER TO THIS NUMBER ON ALL CORRESPONDENCE

ATTENTION:

☐ MasterCard ☐ VISA

☐ Other

Card No. _____ Expiration Date _____

Signature _____

PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE

INSURANCE PAYMENTS:

Scottsdale Healthcare
P.O. BOX 29679
Phoenix, AZ 85038

CLAIMS AND BILLING INFORMATION THAT REQUIRE A RESPONSE:

Scottsdale Healthcare
P.O. Box 1270
Scottsdale, AZ 85252

MEDICAL RECORDS REQUEST:

Scottsdale Healthcare Osborn
Medical Records Department
7400 E. Osborn Road
Scottsdale, AZ 85251

Scottsdale Healthcare Shea
Medical Records Department
9003 E. Shea Boulevard
Scottsdale, AZ 85260

Scottsdale Healthcare Thompson Peak
Medical Records Department
7400 E. Thompson Peak Parkway
Scottsdale, AZ 85255

ATTENTION: MEDICARE PATIENTS

These charges have been billed to Medicare. When the Hospital receives payment, you will receive an Explanation of Benefits (EOB) from Medicare. These EOB's are sent to the PATIENT ONLY. The hospital does not receive copies of these EOB's. Copies can be obtained by calling Medicare at 800-633-4227 or online at www.medicare.gov

DATE OF SERVICE	ITEM NO.	DESCRIPTION	QTY.	ITEM PRICE	TOTAL CHARGES
01/18/15	2 50508	ANKLE COMPLETE RT.	1	686.00	686.00
01/18/15	3 50550	FOOT 3 VIEWS RT.	1	656.00	656.00
		TOTAL RADIOLOGY, DIAGNOSTIC			1,342.00
01/18/15	66005	ED INTERMEDIATE	1	950.00	950.00
		TOTAL EMERGENCY DEPT.			950.00
01/18/15	5 3579	ACETAMINOPHEN/OXYCODONE 5MG	2	5.20	10.40
01/18/15	4 5033	IBUPROFEN 200MG TAB	3	1.60	4.80
		TOTAL SELF-ADMIN DRUGS-NO DET CODING			15.20
		TOTAL CHARGES			2,307.20
		TOTAL PAYMENTS/ADJUSTMENTS			0.00
		ESTIMATED PATIENT BALANCE DUE			0.00

NOTE: AMOUNTS INDICATED TO BE PAID BY THIRD PARTIES ARE ESTIMATED BY HOSPITAL, HOWEVER, THE PATIENT AND / OR RESPONSIBLE PARTY HAVE PERSONALLY GUARANTEED PAYMENT AND ARE RESPONSIBLE FOR THE TOTAL CHARGES ON THIS STATEMENT.

**UNPAID
BALANCE**

2,307.20

Corvel Scan Date: 2/16/2015

Scottsdale Healthcare Osborn
7400 E. Osborn Rd.
Scottsdale, AZ. 85251
480-882-4060

Patient Name: [REDACTED]
Med. Rec. #: 0001088038
Pt. Acct: A1501810160
Ordering: CONNIE BELSKUS..., PA-C
Admitting: NA PHYSICIAN A

DOB: [REDACTED]
Sex: M
Exam Date: 01/18/2015
Patient Type: ED

HISTORY:
R ANKLE PAIN - R ANKLE PAIN

Accession #	Code	Exam Reason
7465085	50508 ANKLE COMPLETE RT 50508	ANKLE PAIN

THREE-VIEW RIGHT ANKLE 01/18/2015

HISTORY
Pain.

COMPARISON
None.

TECHNIQUE AND FINDINGS
Three views.

Osseous structures are in anatomic alignment. Specifically, the ankle mortise is symmetric. There is fragmentation along the lateral base of the fifth metatarsal, age indeterminate. Dedicated foot films may better evaluate this area. Osseous structures otherwise appear intact. Tiny Achilles spur is present.

IMPRESSION
Age indeterminate fragmentation along the base of the fifth metatarsal. Correlate with focal tenderness.

DD: 01/18/2015 17:36 - Job#: 152825
DT: 01/18/2015 23:49 - sld
Doc# - 68327769

cc: Connie Belskus..., PA-C;

READ BY: MICHELLE LAI DUBES, MD
SIGNED BY: MICHELLE LAI DUBES, MD
SIGNED DATE/TIME: 01/19/2015 08:42 PM

Scottsdale Healthcare Osborn
7400 E. Osborn Rd.
Scottsdale, AZ. 85251
480-882-4060

Patient Name: [REDACTED]
Med. Rec. #: 0001088038
Pt. Acct: A1501810160
Ordering: CONNIE BELSKUS..., PA-C
Admitting: NA PHYSICIAN A

DOB: [REDACTED]
Sex: M
Exam Date: 01/18/2015
Patient Type: ED

HISTORY:

R ANKLE PAIN - R ANKLE PAIN

Accession #	Code	Exam Reason
7465102	50550 FOOT 3 VIEWS RT 50550	FOOT PAIN

THREE VIEW RIGHT FOOT 01/18/2015

HISTORY

Ankle pain.

COMPARISON

Ankle radiographs obtained earlier in the evening.

TECHNIQUE AND FINDINGS

Three views.

The fragment identified on the ankle films along the lateral base of the fifth metatarsal is not definitely appreciated on the foot films. This may be related to projection. No definitive fractures are identified. Joint spaces are preserved.

IMPRESSION

No definitive fracture. Correlate with focal tenderness along the base of the fifth metatarsal as there did appear to be a fragment based on oblique films obtained as part of ankle series earlier in the evening.

DD: 01/18/2015 18:03 - Job#: 152851
DT: 01/19/2015 04:09 - zpr
Doc# - 68327788

cc: Connie Belskus..., PA-C;

READ BY: MICHELLE LAI DUBES, MD
SIGNED BY: MICHELLE LAI DUBES, MD
SIGNED DATE/TIME: 01/19/2015 08:42 PM

SHC Osborn
EMERGENCY FLOW SHEET RECORD

Name: [REDACTED] Age: [REDACTED] MR: 0001088038 Acct: 1501810160

VITAL SIGNS	JHEL	JHEL
TIME	1/18/2015 18:42	1/18/2015 17:02
BP	159/80	168/88
PULSE	75	82
RESP	18	18
TEMP		97.8
PAIN	2	6
O2 SAT	98 on RA	98 on RA

Name: [REDACTED] Age: [REDACTED] MR: 0001088038 Acct: 1501810160
Prepared: Sun Jan 18, 2015 23:50:16 by Interface Page: 1

SHC OSBORN ED RECORD

DOB: [REDACTED]
Wt/Ht: 113.40 Kg 182.88 cm.
MedRec: 0001088038
AcctNum: 1501810160

Patient Data

Complaint: R ANKLE PAIN
Triage Time: Sun Jan 18, 2015 17:07
Urgency: ESI 4
Bed: ED TEAM-D
Initial Vital Signs: 1/18/2015 17:02
BP: 168/88
P: 82
O2 sat: 98 on RA

ED Attending: Castro-Marin, MD, Franco
Primary RN: Helman, RN, Jonathan

R: 18
T: 97.8
Pain: 6

ADMIN

DIGITAL SIGNATURE: Belskus, PA, Connie. (23:47 CBEI)

PRESENTING PROBLEM (Sun Jan 18, 2015 17:07 JHEL)

Presenting problems: Foo/Ankle/Toe Injury-Pain-Swelling.

TRIAGE (18:24)

PATIENT:

AGE: [REDACTED] GENDER: male, DOB: [REDACTED] TIME OF GREET: Sun Jan 18, 2015 17:01,
PREFERRED LANGUAGE: English, KG WEIGHT: 113.40, HEIGHT/LENGTH: 182.88cm, BMI: 33.90,
MEDICAL RECORD NUMBER: 0001088038, ACCOUNT NUMBER: 1501810160, Attending: A, NA,
PCP: OCCUPATIONAL HEALTH, DEPT. (Sun Jan 18, 2015 17:07 JHEL)

PHONE:

ADMISSION: URGENCY: ESI 4, TRANSPORT: Self, BED: TEAM-D 31. (Sun Jan 18, 2015 17:07 JHEL)

PROVIDERS: TRIAGE NURSE: Jonathan Helman, RN. (Sun Jan 18, 2015 17:07 JHEL)

COMPLAINT: R ANKLE PAIN. (Sun Jan 18, 2015 17:07 JHEL)

TRIAGE NOTES: Pt presents with R ankle pain while stepping out of fire truck. Pt states he rolled his ankle and felt a "pop" on the aspect of ankle. Pt is a Scottsdale firefighter. (Sun Jan 18, 2015 17:07 JHEL)

SAFETY SCREENING: Does the patient have complaint of an emotional or behavioral disorder? NO, Does the patient express any suicidal/homicidal thoughts/ideations? NO, Does the patient have any weapons in their possession currently? NO, Do you have any safety concerns with your home environment? NO. (17:08 JHEL)

TRAVEL SCREENING: No fever 100.4F or greater, Has not traveled within the past 21 days to Sierra Leone, Liberia, Guinea or Mali, Has not been in contact with a confirmed Ebola patient within the last 21 days. (17:08 JHEL)

GCS: The GCS total is 15. (17:08 JHEL)

VITAL SIGNS: BP 168/88, Pulse 82, Resp 18, Temp 97.8, Pain 6, O2 Sat 98, on RA, Time 1/18/2015 17:02. (17:02 JHEL)

ALLERGY (17:07 JHEL)

No Known Drug Allergies

KNOWN ALLERGIES

No Known Drug Allergies

CURRENT MEDICATIONS (17:07 JHEL)

None

HPI ANKLE (23:40 CBEI)

HISTORY OF PRESENT ILLNESS: this is a [REDACTED]-year-old male who presents emergency room with right ankle pain. The patient is a fire fighter and was stepping out of the fire truck when he inverted his ankle and felt a pop. He now has increased pain with movement. He has some swelling to his ankles. Because of his discomfort he came to the emergency room for evaluation.

CHIEF COMPLAINT: Patient presents for evaluation of pain.

Prepared: Sun Jan 18, 2015 23:50 by Interface Page: 1 of 6

SHC OSBORN ED RECORD

Wt/Ht: 113.40 Kg 182.88 cm.
MedRec: 0001088038
AcctNum: 1501810160

HISTORIAN: History provided by patient.
MECHANISM OF INJURY: Mechanism of injury: Body motion, inversion.
LOCATION: Symptoms are generalized.
QUALITY: Pain is dull in nature.
TIME COURSE: Sudden onset of symptoms, Symptoms are worsening.
ASSOCIATED WITH: Associated with foot pain, on the right, Associated with pain with ambulation.
EXACERBATED BY: Patient's condition exacerbated by walking.
RELIEVED BY: Patient's condition relieved by nothing.

PAST MEDICAL HISTORY

MEDICAL HISTORY: No past medical history. (17:08 JHEL)
SURGICAL HISTORY: Patient has no surgical history. (17:08 JHEL)
PSYCHIATRIC HISTORY: No previous psychiatric history. (17:08 JHEL)
SOCIAL HISTORY: Patient consumes alcohol socially, Patient was never a smoker, Denies drug abuse, Marital Status: Married, Lives at home with family, Patient does not have advanced directives. (17:08 JHEL)
NOTES: Nursing records reviewed. (23:42 CBEL)

EVENTS

ATTENDING: Patient care initiated. (17:37 BDAM)
DOCTOR EXTENDER: Patient care initiated. (17:24 CBEL)
TRANSFER: Triage to Emergency Team D 31. (Sun Jan 18, 2015 17:07 JHEL)
Removed from Emergency Team D 31. (18:44 JHEL)

ROS (23:42 CBEL)

CONSTITUTIONAL: Historian denies chills, Historian denies fever, Historian denies weakness.
EYES: Historian denies eye pain, Historian denies eye redness, Historian denies eye discharge.
CARDIOVASCULAR: Historian denies chest pain, no radiation, Historian denies diaphoresis.
RESPIRATORY: Historian denies cough, Historian denies shortness of breath, Historian denies wheezing.
MUSCULOSKELETAL: Historian reports fall, Historian reports joint stiffness, Historian reports joint swelling, Historian denies back pain.
SKIN: Historian denies pruritis, Historian denies rash, Historian denies skin changes.
NEUROLOGIC: Historian denies dizziness, Historian denies headache, Historian denies paresthesias.
HEMO/LYMPHATIC: Historian denies easy bruising, Historian denies gum bleeding, Historian denies petechiae.
PSYCHIATRIC: Negative psychiatric review of systems.
NOTES: All systems were reviewed and are negative except as described above.

PHYSICAL EXAM (23:42 CBEL)

CONSTITUTIONAL: Vital signs reviewed, Patient afebrile, Pulse normal, Blood pressure normal, Respiratory rate normal, Patient appears non toxic, Patient alert and oriented to person, place and time.
HEAD: Head exam included findings of head atraumatic, normocephalic.
EYES: Eye exam included findings of eyelids normal to inspection, Extraocular muscles intact, Conjunctiva normal, Sclera normal.
NECK: Neck exam included findings of normal range of motion, Trachea midline.
RESPIRATORY CHEST: Respiratory exam included findings of no respiratory distress, Breath sounds clear, Chest exam included findings of chest movement symmetrical.
CARDIOVASCULAR: Cardiovascular exam included findings of heart rate regular rate and

Prepared: Sun Jan 18, 2015 23:50 by Interface Page: 2 of 6

SHC OSBORN ED RECORD

Wt/Ht: 113.40 Kg 182.88 cm.
MedRec: 0001088038
AcctNum: 1501810160

rhythm, Heart sounds normal.

UPPER EXTREMITY: Upper extremity exam included findings of inspection normal, Range of motion normal.

LOWER EXTREMITY: Left Ankle:, Ankle ecchymosis, Ankle swelling, Ankle tenderness, Lateral malleolar region, Ankle active range of motion limited, Ankle passive range of motion limited, distal pulses intact, capillary refill less than 2 seconds, distal motor intact, distal sensory intact, Ankle stable.

NEURO: Neuro exam findings include patient oriented to person, place and time, Speech normal, Memory normal.

SKIN: Skin exam included findings of skin warm, dry, and normal in color.

PSYCHIATRIC: Psychiatric exam included findings of patient oriented to person place and time, Normal affect, Insight normal.

DOCTOR NOTES/ MEDICAL DECISION MAKING

TEXT: I agree with the documentation performed by the scribe. Ben Damari, and have performed the history, physical exam, all consultations, and medical decision-making pertaining to this patient. (17:45 FCAS)

this is a [REDACTED]-year-old male who presents emergency room with right ankle pain. The patient inverted his ankle when he was getting out of a fire truck today. He complains of pain and discomfort. He has difficulty with weightbearing. On exam he does have edema to his lateral malleolus and into his foot. His chest palpation over the distal end of the lateral malleolus and into the fifth metatarsal bone. Range of motion is slightly limited due to pain and discomfort.

I ordered an x-ray of the ankle. The x-ray of the ankle shows no fracture to the ankle itself. There is a possible chip fracture to the fifth metatarsal bone. He is tender with palpation of the area. The x-ray actually looks like this is an old corticated fracture. I ordered a foot x-ray for verification. The foot x-ray does not show any fracture dislocation.

This could be a new fracture to the proximal end of the fifth metatarsal bone. He is having significant amount of pain and discomfort. I will place the patient in a AFO boot and give crutches. I will encourage patient to keep his leg elevated. Followup with orthopedic surgeon for reevaluation. Return to emergency room if increased discomfort. (23:45 CBEL)

EMERGENCY DEPARTMENT COURSE (17:38 BDAM)

TEXT: The attending note was documented by Ben Damari acting as a scribe for Dr.

Castro-Marin The history, physical exam, and any procedure were performed by Connie Belskus PA. All medical decisions were performed by Dr. Castro-Marin.

This patient met fast tract criteria. The physician was available for consultation but was not actively involved in his care.

ATTENDING

ATTENDING NOTE:

The patient is revisited at this time and is resting comfortably in the bed. Patient is a 39 y/o male who presents to the ED w/c/o R ankle pain. The pt reports that earlier today he rolled his ankle and has since had persistent pain. The pt has requested pain medication at this time.. The pt demonstrates understanding and agreement with our treatment plan. All other questions and concerns have been answered. (17:37 BDAM)

The pt is revisited at this time and is resting comfortably in the bed. He is told we will place his R foot into a boot for further management of symptoms. We will obtain additional plain films at this time=. The pt demonstrates understanding and agreement with our treatment plan. All other questions and concerns have been answered. (17:49 BDAM)

RADIOLOGY INTERPRETATION (23:43 CBEL)

LOWER EXTREMITIES: Ankle films, old chip fracture. Other findings: Old chip Fx at the base of the 5th MT. Foot films negative, on the left, no fracture, no dislocation, no foreign body, no bony lesion.

Prepared: Sun Jan 18, 2015 23:50 by Interface Page: 3 of 6

SHC OSBORN ED RECORD

Wt/Ht: 113.40 Kg 182.88 cm.
MedRec: 0001088038
AcctNum: 1501810160

DIAGNOSIS (17:59 CBEL)

FINAL: PRIMARY: Ankle sprain, ADDITIONAL: Metatarsal fracture – closed.

DISPOSITION

PATIENT: Disposition: Discharge Home. (17:59 CBEL)

Patient left the department. (18:44 BBEL)

PRESCRIPTION (17:59 CBEL)

Motrin: TABLET : 600 mg : ORAL : Quantity: *** 1 *** Unit: tab(s) Route: ORAL Schedule: 1 to 3 times a day Dispense: *** 30 ***

May substitute. Refills: *** No Refills ***.

Percocet: TABLET : 5 mg-325 mg : ORAL : Quantity: *** 1-2 *** Unit: tab(s) Route: ORAL Schedule: 1 to 4 times a day Dispense: *** 20 ***

May substitute. Refills: *** No Refills ***.

INSTRUCTION (18:00 CBEL)

DISCHARGE: ANKLE SPRAIN, FOOT FRACTURE.

FOLLOWUP: Fishler, Thomas Christopher, Surg – Orthopedic, Sonoran Orthopaedic

Trauma Surgeons, 3126 N Civic Center Plaza, Scottsdale AZ 852515648, 4808742040, Follow up with Specialist in 2-3 days.

SPECIAL: Tylenol or Advil for Pain.

MEDICATION ADMINISTRATION SUMMARY

Drug Name	Dose Ordered	Route	Status	Time
*Percocet	10 mg	PO (Oral)	Given	18:02 1/18/2015
*Motrin	600 mg	PO (Oral)	Given	17:11 1/18/2015

*Additional information available in notes. Detailed record available in Medication Service section.

VITAL SIGNS

VITAL SIGNS: BP: 168/88, Pulse: 82, Resp: 18, Temp: 97.8, Pain: 6, O2 sat: 98 on RA, Time: 1/18/2015 17:02. (17:02 BBEL)

BP: 159/80, Pulse: 75, Resp: 18, Pain: 2, O2 sat: 98 on RA, Time: 1/18/2015 18:42. (18:42 BBEL)

ORDERS

ANKLE COMPLETE RT.: Ordered for: Belskus, PA, Connie

Status: Active

Reason: Ankle Pain. (17:13 BBEL)

FOOT 3 VIEWS RT.: Ordered for: Belskus, PA, Connie

Status: Active

Reason: Foot Pain. (17:30 CBEL)

Crutches: Ordered for: Belskus, PA, Connie

Status: Done by: Lopez, PCT 2, Raymond – Sun Jan 18, 2015 18:34. (17:55 CBEL)

Splint/Immobilize extremity >>: Ordered for: Belskus, PA, Connie

Status: Done by: Lopez, PCT 2, Raymond – Sun Jan 18, 2015 18:34. (17:55 CBEL)

MEDICATION SERVICE

Motrin: Order: Motrin (ibuprofen) – Dose: 600 mg : PO (Oral)

Notes: Verbal order, Read back and verified

Ordered by: Connie Belskus, PA

Entered by: Jonathan Helman, RN Sun Jan 18, 2015 17:11

Documented as given by: Jonathan Helman, RN Sun Jan 18, 2015 17:11

Patient, Medication, Dose, Route and Time verified prior to administration.

Prepared: Sun Jan 18, 2015 23:50 by Interface Page: 4 of 6

SHC OSBORN ED RECORD

Wt/Ht: 113.40 Kg 182.88 cm.
MedRec: 0001088038
AccNum: 1501810160

Site: Medication administered P.O., Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration.

Percocet: Order: Percocet (oxycodone HCl/acetaminophen) – Dose: 10 mg : PO
(Oral)

Notes: Verbal order, Read back and verified

Ordered by: Franco Castro–Marin, MD

Entered by: Jonathan Helman, RN Sun Jan 18, 2015 18:01 ,

Acknowledged by: Jonathan Helman, RN Sun Jan 18, 2015 18:01

Documented as given by: Jonathan Helman, RN Sun Jan 18, 2015 18:02

Patient, Medication, Dose, Route and Time verified prior to administration.

Site: Medication administered P.O.

NURSING ASSESSMENT: EXTREMITY LOWER (17:14 JHEL)

STANDARD CARE STATEMENT: Orthopedic/Musculoskeletal Emergencies, No relevant co-morbidities noted.

CONSTITUTIONAL: Complex assessment performed, Patient arrives ambulatory, Unsteady gait, Patient required no assistance to get on the stretcher, History obtained from patient, ED visit related to an injury, Date of injury 01/18/2015, Patient appears, in distress due to pain, Patient cooperative, Patient alert, Oriented to person, place and time, Skin warm, Skin dry, Skin normal in color, Mucous membranes pink, moist. Capillary refill is < 2 seconds, Patient is well-groomed.

PAIN: Pain radiates, Lateral lower leg., on a scale 0–10 patient rates pain as 6, R ankle.

LEFT LOWER EXTREMITY: Left lower extremity assessment findings include capillary refill less than 2 seconds, Skin color normal, Skin temperature warm, Distal sensation intact, Inspection findings include no swelling.

RIGHT LOWER EXTREMITY: Right lower extremity assessment findings include capillary refill less than 2 seconds, Skin color normal, Skin temperature warm, Distal sensation intact, Muscle tone normal, Inspection findings include swelling, to Lateral R ankle, Notes: Pt states he "rolled" his ankle 20 mins ago.

NOTES: Notes: Pt assigned to room. Assessed by RN and MD. Orders, treated per orders.

Will continue to monitor pt closely, according to condition.

SAFETY: Side rails up, Cart/Stretcher in lowest position, Call light within reach, Hospital ID band on.

NURSING PROCEDURE: DISCHARGE NOTE

DISCHARGE: Patient discharged to home, ambulating with crutches, friend driving.

Wheelchair discharge recommended to patient, patient refused wheelchair discharge, Other, Patient accompanied by Other fire department members., Discharge instructions printed, Discharge instructions given to patient, Simple or moderate discharge teaching performed, Prescriptions given and instructions on side effects given, Above person(s) verbalized understanding of discharge instructions and follow-up care. (18:42 JHEL)

BELONGINGS: Belongings and valuables with patient at time of discharge include:, Belongings remain with patient, Valuables remain with patient. (18:42 JHEL)

NOTES: Notes: CMS intact post splint application. pt understands CMS checks and safe splint

USC. (18:44 JHEL)

VITAL SIGNS: BP: 159 / 80, Pulse: 75, Resp: 18, Pain: 2, O2 sat: 98, on RA. (18:42 JHEL)

NURSING PROCEDURE: SPLINTING (18:34 RL,OP)

PATIENT IDENTIFIER: Patient's identity verified by patient stating name, Patient's identity verified by patient stating birth date, Patient's identity verified by hospital ID bracelet.

SPLINTING: Splinting indicated for sprain care, Splinting indicated for pain control, Splint applied to, the right ankle, walker boot applied.

FOLLOW-UP: After procedure, ice therapy applied, After procedure, verbal instructions and a demonstration of the use of walking provided to patient, After procedure, patient returned

Prepared: Sun Jan 18, 2015 23:50 by Interface Page: 5 of 6

SHC OSBORN ED RECORD

Wt/Ht: 113.40 Kg 182.88 cm.
MedRec: 0001088038
AcctNum: 1501810160

demonstration of use of walking aid, Splint aftercare instructions given, MD/DO/PA/NP notified that splint application is completed, After procedure, capillary refill less than 2 seconds, After procedure, distal circulation intact, After procedure, distal motor function intact, After procedure, distal sensation intact, After procedure, distal pulses present.

SAFETY: Side rails up, Cart/Stretcher in lowest position, Call light within reach, Hospital ID band on.

ADMIN

PATIENT DATA CHANGE: Primary Nurse changed from (none) to Jonathan Helman, RN.

(17:07 JHEL)

Race: (none). (17:08 JHEL)

A02 176876825 by Interface. (17:10)

A08 176876942 by Interface, Name: [REDACTED] Self Admit MDs: (none), SSN: [REDACTED]

Zip Code: [REDACTED] Withdraw Consent: (none). (17:17)

Doctor Extender changed from (none) to Connie Belskus, PA. (17:24 CBEL)

Scribe changed from (none) to Ben Damari. (17:37 BDAM)

Name: [REDACTED] Self Admit MDs: (none), Attending: Franco Castro-Marin, MD. (17:38)

(17:46)

A08 176878028 by Interface, Name: [REDACTED] Self Admit MDs: (none). (18:28)

A08 176878104 by Interface, Phone: [REDACTED] Ethnicity: [REDACTED] Payment: ZZ

CITY OF SCOTTSDALE ICA 1500. (18:34)

A08 176878112 by Interface. (18:35)

A08 176878113 by Interface. (18:35)

A08 176878118 by Interface. (18:35)

A08 176878120 by Interface. (18:35)

IMAGING (18:46 RLOP)

DISCHARGE RECEIPT: Image captured from scanner.

Page 2 added. Image captured from scanner.

Key:

BDAM=Damari, Ben CBEL=Belskus, PA, Connie FCAS=Castro-Marin, MD, Franco JHEL=Helman, RN, Jonathan
RLOP=Lopez, PCT 2, Raymond

Prepared: Sun Jan 18, 2015 23:50 by Interface Page: 6 of 6



Name: [REDACTED]
 Age: [REDACTED] Y DOB: [REDACTED]
 Gender: M Wt: 113.40 kg Ht: 182.88 cm
 MedRec: 0001088038
 AcctNum: 1501810160
 Attending: FCAS
 Primary RN: JHEL
 Bed: ED TEAM-D

SHC OSBORN MEDICATION RECONCILIATION

You were seen in the Emergency Department on: Sun Jan 18, 2015

KNOWN ALLERGIES

No Known Drug Allergies

MEDICATIONS GIVEN WHILE IN THE EMERGENCY DEPARTMENT

Motrin (ibuprofen) -- Dose: 600 milligram(s) : PO (Oral)

Percocet (oxycodone HCl/acetaminophen) -- Dose: 10 milligram(s) : PO (Oral)

HOME MEDICATIONS

None

PRESCRIPTIONS (2)

Printed (2)

Motrin : TABLET : 600 mg : ORAL

Quantity: 1, Unit: tab(s), Route: ORAL, Schedule: 1 to 3 times a day, Dispense: 30

Percocet : TABLET : 5 mg-325 mg : ORAL

Quantity: 1-2, Unit: tab(s), Route: ORAL, Schedule: 1 to 4 times a day, Dispense: 20

Please bring this list of medications to your doctor on you next visit.

Favor de llevar esta lista de medicamentos a la proxima cita con su doctor.

Prepared: Sun Jan 18, 2015 23:50 by Interface 1 of 1

From: Thousand Cranes Fax: (800) 530-9132

To: O.K. TO PAY

Fax: +1 (480) 312-8023 Page 2 of 5 02/06/2015 12:51 PM

CITY OF SCOTTSDALE

JUDY BEREZA

7447 E INDIAN SCHOOL ROAD SUITE 225
SCOTTSDALE AZ 85251

FEB 06 2014

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

JUDY BEREZA

PICA

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (TRICARE/DoD) (Number ID) (ID) (ID) (ID) (ID)		1a. INSURED'S ID. NUMBER (For Program in Item 1) 141507-WC-003	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]		4. INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]	
3. PATIENT'S BIRTH DATE MM DD YY M [X] F []		5. INSURED'S ADDRESS (No., Street) [REDACTED]	
6. PATIENT'S ADDRESS (No., Street) [REDACTED]		7. INSURED'S ADDRESS (No., Street) [REDACTED]	
8. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [] Child [] Other []		8. CITY STATE AZ	
9. CITY STATE AZ		9. CITY STATE AZ	
10. ZIP CODE TELEPHONE (Include Area Code) [REDACTED]		10. ZIP CODE TELEPHONE (Include Area Code) [REDACTED]	
11. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]		11. INSURED'S POLICY GROUP OR FECA NUMBER [REDACTED]	
12. OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED]		12. INSURED'S DATE OF BIRTH MM DD YY M [X] F []	
13. RESERVED FOR NUCC USE FEB 06 2014		13. OTHER CLAIM ID (Designated by NUCC) [REDACTED]	
14. RESERVED FOR NUCC USE JUDY BEREZA		14. INSURANCE PLAN NAME OR PROGRAM NAME [REDACTED]	
15. INSURANCE PLAN NAME OR PROGRAM NAME [REDACTED]		15. IS THERE ANOTHER HEALTH BENEFIT PLAN? [] YES [X] NO If yes, complete Items 9, 9a and 9d.	
16. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.			
17. 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 02/06/2015		17. PATIENT'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	
18. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) 12/14 QUAL [REDACTED]		18. OTHER DATE MM DD YY QUAL [REDACTED]	
19. NAME OF REFERRING PROVIDER OR OTHER SOURCE [REDACTED]		19. NAME OF REFERRING PROVIDER OR OTHER SOURCE [REDACTED]	
20. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. [REDACTED] B. [REDACTED] C. [REDACTED] D. [REDACTED] E. [REDACTED] F. [REDACTED] G. [REDACTED] H. [REDACTED] I. [REDACTED] J. [REDACTED] K. [REDACTED] L. [REDACTED]		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. [REDACTED] B. [REDACTED] C. [REDACTED] D. [REDACTED] E. [REDACTED] F. [REDACTED] G. [REDACTED] H. [REDACTED] I. [REDACTED] J. [REDACTED] K. [REDACTED] L. [REDACTED]	
22. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. AB. AC. AD. AE. AF. AG. AH. AI. AJ. AK. AL. AM. AN. AO. AP. AQ. AR. AS. AT. AU. AV. AW. AX. AY. AZ. BA. BB. BC. BD. BE. BF. BG. BH. BI. BJ. BK. BL. BM. BN. BO. BP. BQ. BR. BS. BT. BU. BV. BW. BX. BY. BZ. CA. CB. CC. CD. CE. CF. CG. CH. CI. CJ. CK. CL. CM. CN. CO. CP. CQ. CR. CS. CT. CU. CV. CW. CX. CY. CZ. DA. DB. DC. DD. DE. DF. DG. DH. DI. DJ. DK. DL. DM. DN. DO. DP. DQ. DR. DS. DT. DU. DV. DW. DX. DY. DZ. EA. EB. EC. ED. EE. EF. EG. EH. EI. EJ. EK. EL. EM. EN. EO. EP. EQ. ER. ES. ET. EU. EV. EW. EX. EY. EZ. FA. FB. FC. FD. FE. FF. FG. FH. FI. FJ. FK. FL. FM. FN. FO. FP. FQ. FR. FS. FT. FU. FV. FW. FX. FY. FZ. GA. GB. GC. GD. GE. GF. GG. GH. GI. GJ. GK. GL. GM. GN. GO. GP. GQ. GR. GS. GT. GU. GV. GW. GX. GY. GZ. HA. HB. HC. HD. HE. HF. HG. HH. HI. HJ. HK. HL. HM. HN. HO. HP. HQ. HR. HS. HT. HU. HV. HW. HX. HY. HZ. IA. IB. IC. ID. IE. IF. IG. IH. II. IJ. IK. IL. IM. IN. IO. IP. IQ. IR. IS. IT. IU. IV. IW. IX. IY. IZ. JA. JB. JC. JD. JE. JF. JG. JH. JI. JJ. JK. JL. JM. JN. JO. JP. JQ. JR. JS. JT. JU. JV. JW. JX. JY. JZ. KA. KB. KC. KD. KE. KF. KG. KH. KI. KJ. KK. KL. KM. KN. KO. KP. KQ. KR. KS. KT. KU. KV. KW. KX. KY. KZ. LA. LB. LC. LD. LE. LF. LG. LH. LI. LJ. LK. LL. LM. LN. LO. LP. LQ. LR. LS. LT. LU. LV. LW. LX. LY. LZ. MA. MB. MC. MD. ME. MF. MG. MH. MI. MJ. MK. ML. MN. MO. MP. MQ. MR. MS. MT. MU. MV. MW. MX. MY. MZ. NA. NB. NC. ND. NE. NF. NG. NH. NI. NJ. NK. NL. NM. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TT. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UU. UV. UW. UX. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YY. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER.	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. AB. AC. AD. AE. AF. AG. AH. AI. AJ. AK. AL. AM. AN. AO. AP. AQ. AR. AS. AT. AU. AV. AW. AX. AY. AZ. BA. BB. BC. BD. BE. BF. BG. BH. BI. BJ. BK. BL. BM. BN. BO. BP. BQ. BR. BS. BT. BU. BV. BW. BX. BY. BZ. CA. CB. CC. CD. CE. CF. CG. CH. CI. CJ. CK. CL. CM. CN. CO. CP. CQ. CR. CS. CT. CU. CV. CW. CX. CY. CZ. DA. DB. DC. DD. DE. DF. DG. DH. DI. DJ. DK. DL. DM. DN. DO. DP. DQ. DR. DS. DT. DU. DV. DW. DX. DY. DZ. EA. EB. EC. ED. EE. EF. EG. EH. EI. EJ. EK. EL. EM. EN. EO. EP. EQ. ER. ES. ET. EU. EV. EW. EX. EY. EZ. FA. FB. FC. FD. FE. FF. FG. FH. FI. FJ. FK. FL. FM. FN. FO. FP. FQ. FR. FS. FT. FU. FV. FW. FX. FY. FZ. GA. GB. GC. GD. GE. GF. GG. GH. GI. GJ. GK. GL. GM. GN. GO. GP. GQ. GR. GS. GT. GU. GV. GW. GX. GY. GZ. HA. HB. HC. HD. HE. HF. HG. HH. HI. HJ. HK. HL. HM. HN. HO. HP. HQ. HR. HS. HT. HU. HV. HW. HX. HY. HZ. IA. IB. IC. ID. IE. IF. IG. IH. II. IJ. IK. IL. IM. IN. IO. IP. IQ. IR. IS. IT. IU. IV. IW. IX. IY. IZ. JA. JB. JC. JD. JE. JF. JG. JH. JI. JJ. JK. JL. JM. JN. JO. JP. JQ. JR. JS. JT. JU. JV. JW. JX. JY. JZ. KA. KB. KC. KD. KE. KF. KG. KH. KI. KJ. KK. KL. KM. KN. KO. KP. KQ. KR. KS. KT. KU. KV. KW. KX. KY. KZ. LA. LB. LC. LD. LE. LF. LG. LH. LI. LJ. LK. LL. LM. LN. LO. LP. LQ. LR. LS. LT. LU. LV. LW. LX. LY. LZ. MA. MB. MC. MD. ME. MF. MG. MH. MI. MJ. MK. ML. MN. MO. MP. MQ. MR. MS. MT. MU. MV. MW. MX. MY. MZ. NA. NB. NC. ND. NE. NF. NG. NH. NI. NJ. NK. NL. NM. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TT. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UU. UV. UW. UX. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YY. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.		24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z. AA. AB. AC. AD. AE. AF. AG. AH. AI. AJ. AK. AL. AM. AN. AO. AP. AQ. AR. AS. AT. AU. AV. AW. AX. AY. AZ. BA. BB. BC. BD. BE. BF. BG. BH. BI. BJ. BK. BL. BM. BN. BO. BP. BQ. BR. BS. BT. BU. BV. BW. BX. BY. BZ. CA. CB. CC. CD. CE. CF. CG. CH. CI. CJ. CK. CL. CM. CN. CO. CP. CQ. CR. CS. CT. CU. CV. CW. CX. CY. CZ. DA. DB. DC. DD. DE. DF. DG. DH. DI. DJ. DK. DL. DM. DN. DO. DP. DQ. DR. DS. DT. DU. DV. DW. DX. DY. DZ. EA. EB. EC. ED. EE. EF. EG. EH. EI. EJ. EK. EL. EM. EN. EO. EP. EQ. ER. ES. ET. EU. EV. EW. EX. EY. EZ. FA. FB. FC. FD. FE. FF. FG. FH. FI. FJ. FK. FL. FM. FN. FO. FP. FQ. FR. FS. FT. FU. FV. FW. FX. FY. FZ. GA. GB. GC. GD. GE. GF. GG. GH. GI. GJ. GK. GL. GM. GN. GO. GP. GQ. GR. GS. GT. GU. GV. GW. GX. GY. GZ. HA. HB. HC. HD. HE. HF. HG. HH. HI. HJ. HK. HL. HM. HN. HO. HP. HQ. HR. HS. HT. HU. HV. HW. HX. HY. HZ. IA. IB. IC. ID. IE. IF. IG. IH. II. IJ. IK. IL. IM. IN. IO. IP. IQ. IR. IS. IT. IU. IV. IW. IX. IY. IZ. JA. JB. JC. JD. JE. JF. JG. JH. JI. JJ. JK. JL. JM. JN. JO. JP. JQ. JR. JS. JT. JU. JV. JW. JX. JY. JZ. KA. KB. KC. KD. KE. KF. KG. KH. KI. KJ. KK. KL. KM. KN. KO. KP. KQ. KR. KS. KT. KU. KV. KW. KX. KY. KZ. LA. LB. LC. LD. LE. LF. LG. LH. LI. LJ. LK. LL. LM. LN. LO. LP. LQ. LR. LS. LT. LU. LV. LW. LX. LY. LZ. MA. MB. MC. MD. ME. MF. MG. MH. MI. MJ. MK. ML. MN. MO. MP. MQ. MR. MS. MT. MU. MV. MW. MX. MY. MZ. NA. NB. NC. ND. NE. NF. NG. NH. NI. NJ. NK. NL. NM. NO. NP. NQ. NR. NS. NT. NU. NV. NW. NX. NY. NZ. OA. OB. OC. OD. OE. OF. OG. OH. OI. OJ. OK. OL. OM. ON. OO. OP. OQ. OR. OS. OT. OU. OV. OW. OX. OY. OZ. PA. PB. PC. PD. PE. PF. PG. PH. PI. PJ. PK. PL. PM. PN. PO. PP. PQ. PR. PS. PT. PU. PV. PW. PX. PY. PZ. QA. QB. QC. QD. QE. QF. QG. QH. QI. QJ. QK. QL. QM. QN. QO. QP. QQ. QR. QS. QT. QU. QV. QW. QX. QY. QZ. RA. RB. RC. RD. RE. RF. RG. RH. RI. RJ. RK. RL. RM. RN. RO. RP. RQ. RR. RS. RT. RU. RV. RW. RX. RY. RZ. SA. SB. SC. SD. SE. SF. SG. SH. SI. SJ. SK. SL. SM. SN. SO. SP. SQ. SR. SS. ST. SU. SV. SW. SX. SY. SZ. TA. TB. TC. TD. TE. TF. TG. TH. TI. TJ. TK. TL. TM. TN. TO. TP. TQ. TR. TS. TT. TU. TV. TW. TX. TY. TZ. UA. UB. UC. UD. UE. UF. UG. UH. UI. UJ. UK. UL. UM. UN. UO. UP. UQ. UR. US. UT. UU. UV. UW. UX. UY. UZ. VA. VB. VC. VD. VE. VF. VG. VH. VI. VJ. VK. VL. VM. VN. VO. VP. VQ. VR. VS. VT. VU. VW. VX. VY. VZ. WA. WB. WC. WD. WE. WF. WG. WH. WI. WJ. WK. WL. WM. WN. WO. WP. WQ. WR. WS. WT. WU. WV. WW. WX. WY. WZ. XA. XB. XC. XD. XE. XF. XG. XH. XI. XJ. XK. XL. XM. XN. XO. XP. XQ. XR. XS. XT. XU. XV. XW. XX. XY. XZ. YA. YB. YC. YD. YE. YF. YG. YH. YI. YJ. YK. YL. YM. YN. YO. YP. YQ. YR. YS. YT. YU. YV. YW. YX. YY. YZ. ZA. ZB. ZC. ZD. ZE. ZF. ZG. ZH. ZI. ZJ. ZK. ZL. ZM. ZN. ZO. ZP. ZQ. ZR. ZS. ZT. ZU. ZV. ZW. ZX. ZY. ZZ.	
25. FEDERAL TAX ID. NUMBER SSN EIN 86-0505677 [] [X]		25. PATIENT'S ACCOUNT NO. BEN11319XX49285	
26. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) LEONETTI, WILLIAM DPM SIGNED 02/06/2015		26. SERVICE FACILITY LOCATION INFORMATION ARIZONA FOOT & ANKLE PC 3201 W PEORIA AVE STE A200 PHOENIX AZ 850294608	
27. ACCEPT ASSIGNMENT? [X] YES [] NO		27. TOTAL CHARGE 28. AMOUNT PAID 29. Paid for NUCC use \$ 624.83 \$ 0.00	
30. BILLING PROVIDER INFO & PH # (480) 559-4267 ARIZONA FOOT & ANKLE CARE PC 3201 W PEORIA AVE STE A200 PHOENIX AZ 850294608		30. BILLING PROVIDER INFO & PH # (480) 559-4267 ARIZONA FOOT & ANKLE CARE PC 3201 W PEORIA AVE STE A200 PHOENIX AZ 850294608	

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB 0938-1187 FORM 1500 (02-12)

WCMS-1500CS-12

PAGE 2/5 * RCVD AT 2/8/2015 12:51:33 PM [US Mountain Standard Time] * SVR:VMASCFAX01/5 * DNIS:29023 * CSID:6506558833

* DURATION (mm-ss):04-16

Corvel Scan Date: 2/16/2015

ARIZONA FOOT & ANKLE CARE PC
3201 W PEORIA AVE STE A200
PHOENIX, AZ 850294608
Phone:(602)843-3277 Fax:(602)843-3643

Date: 11/10/2014 PATIENT: [REDACTED] ACCOUNT #: [REDACTED]

Vitals

HR: 5 HT: 72 WT: 185 BP Diastolic: 96.9 BP Systolic: 96.9

PROBLEMS: [REDACTED] Prescribed: [REDACTED]

Ordered: [REDACTED] Injections: [REDACTED]

Note: [REDACTED]

WC - DOI: 07/02/2014

S: Patient seen for custom-made orthotics, right and left, for bilateral calcaneal fractures.

O: Evaluation, seen this date. Still has swelling, lymphedema, tenderness with weightbearing. Patient is in a flexible shoe, needs more support. Did casting for custom-made orthotics to stabilize heels bilaterally. Advised patient on palliative measures. Advised patient on home care. Not to overdo physical activities. To call if any questions or problems. Will contact patient when orthotics are ready to be dispensed. Continue with physical therapy and range of motion exercises to retard arthritic changes of the subtalar joint. In all probability, will recommend avoidance of steel-toe shoe gear in the future due to widening of both feet as a result of this injury. Prefer a hiking boot in lieu of a work boot for greater support and cushion.

A: Bilateral calcaneal fractures with subtalar joint involvement, abnormal gait, and loss of balance bilaterally.

P: Continue with home care. Continue with physical therapy. Prescribed custom-made orthotics bilaterally. To call if any questions or problems. Remains on a no-work status.

Electronically signed by
 LEONETTI, WILLIAM DPM
 11/16/2014 12:06:00 PM

[REDACTED]

From: Thousand Cranes Fax: (800) 530-9132

To:

Fax: +1 (480) 312-8023

Page 5 of 5 02/06/2015 12:51 PM

FAX ID#362638176

ACCOUNT NUMBER
LEON3201



1730 HOLDER LANE
NORTHFIELD, ILLINOIS
60093

INVOICE NUMBER
62811

ORTHOTIC CONSULTANT
JOHN N. BERGMANN D.P.M.

(800) 323-8267

CAST NUMBER
315 KP-ZONOV14

DEAR DOCTOR: THIS IS NOT A BILL, PLEASE PAY FROM MONTHLY STATEMENT

BILL TO:

SHIP TO:

ARIZONA FOOT & ANKLE CARE PC
DR WM J LEONETTI
3201 W PEOBIA
BLDG A200
PHOENIX, AZ 85029

ARIZONA FOOT & ANKLE CARE PC
DR WM J LEONETTI
3201 W PEOBIA
BLDG A200
PHOENIX, AZ 85029

Orthotic for Patient: [REDACTED]	Amount:
FLEXIBLE PLASTIC BALANCE ORTHOTIC FULL LENGTH-ONE PAIR	\$6.00
1/8" BLACK CLOTH TOP COVER-ONE PAIR	12.00
METATARSAL RAISE ON TOP OF ORTHOTIC	.50
FIT PLASTIC ORTHOTIC TO INSOLE PATTERN SENT	4.00
Shipped out to you via FEDEX GROUND	
Shipped to us via our First Class box label	7.00

INVOICE TOTAL : 109.50

~~O.K. TO PAY~~

~~FEB 06 2014~~

~~JUDY BEREZA~~

[illegible]

ED.052115.OP.PIMA.Final

Acct 4499
DOS 05.22.15City of
Scottsdale**SURGEON:** EDWARD J DOHRING, MD**ASSISTANT:** Bill Balogh, PA-C**ANESTHESIA:** General Endotracheal with no complications by Valley Anesthesia/ Kreitzman, MD**PREOPERATIVE DIAGNOSES:**

1. L2 spinal stenosis, central and left lateral recess, secondary to ligamentum flavum infolding and hypertrophy, facet capsular and bony hypertrophy, neuroforaminal narrowing secondary to disc space height loss and bulging, large extruded nucleus pulposus extrusion and reactive epidural fibrosis.
2. L3 spinal stenosis, central and left lateral recess, secondary to ligamentum flavum infolding and hypertrophy, facet capsular and bony hypertrophy, neuroforaminal narrowing secondary to disc space height loss and bulging, large extruded nucleus pulposus extrusion and reactive epidural fibrosis.
3. L4 spinal stenosis, central and left lateral recess, secondary to ligamentum flavum infolding and hypertrophy, facet capsular and bony hypertrophy, neuroforaminal narrowing secondary to disc space height loss and bulging, large extruded nucleus pulposus extrusion and reactive epidural fibrosis.
4. Left leg profound L3 radiculopathy with quadriceps weakness and atrophy.
5. Lesser Mechanical back pain.
6. Epidural fibrosis.

PROCEDURES:

1. L2 left unilateral MetRx tube minimally invasive spinal stenosis decompression: partial inferior laminectomy, partial facetectomy, partial foraminotomy, removal of extruded disc and associated epidural fibrosis, with decompression of cauda equina and L2 nerve root. (63047)
2. L3 left unilateral MetRx tube minimally invasive spinal stenosis decompression: hemi- laminectomy, partial facetectomy, partial foraminotomy, removal of extruded disc and associated epidural fibrosis, with decompression of cauda equina and L3 nerve root. (63048)
3. L4 left unilateral MetRx tube minimally invasive spinal stenosis decompression: partial superior laminectomy, partial facetectomy, partial foraminotomy, removal of extruded disc and associated epidural fibrosis, with decompression of cauda equina and L4 nerve root. (63048)
4. Microscopic lysis of neural and vascular adhesions. (69990)

INDICATIONS FOR THE PROCEDURE:

For the full indications for this surgery, please see the office notes.

██████████ is a ████████-year-old fireman for the City of Scottsdale who injured himself on 3/24/15 when he was putting away equipment and felt a sharp pain in his low back. He reports by the next day he had radiating pain into the left part of his thigh anteriorly. He also describes the sensation as a quivering, burning sensation. He also experienced numbness below his and over time has noted left leg weakness and quadriceps atrophy.

The patient has been treated conservatively with Vibhooti H. Davé D. O. and has undergone several ESIs as well as EMG/NCV study. He reports significant improvement in pain after the 1st ESI and more mild improvement after the 2nd ESI, but he has continued to note significant weakness and numbness in the leg.

Examination: Palpation of the spine reveals mild tenderness over the left lumbar paraspinal muscles. Range of motion is full with mild low back pain noted. Muscle strength is 5/5 in all muscle groups of the lower extremities bilaterally, except for left quad weakness 4/5 with inability fluidly to step up on a stool. There is obvious left quad atrophy when compared to the right. Sensation is decreased to light touch and pinprick in the L3 distribution on the left.

Diagnostic studies and procedures: 5/05/15 / EMG/NCV study / Vibhooti H. Davé D. O.: Consistent with acute left L3 radiculopathy. 4/21/15 & 5/01/15 / Left L3 and L4 TFESI / Allan L. Rowley M. D.: Pain

improvement but persistent numbness and significant weakness 4/14/15 / **SimonMed Imaging / MRI lumbar spine, reviewed:** This reveals a large disc extrusion spread out behind the L3 vertebral body, underlying the left cauda equina and the left L3 nerve root, causing severe left lateral recess and neural foraminal stenosis. There is some degenerative facet and ligamentum flavum change contributing to stenosis as well. 4/03/15 / **Spine Institute of Arizona / x-rays lumbar spine including flexion and extension, reviewed:** These reveal normal lumbar lordosis; disc space height is fairly well maintained.

Wilson has the diagnoses outlined above in the "Preoperative Diagnoses," confirmed on X-ray and MRI and EMG, and has corresponding symptoms and examination findings. The patient has residual back pain and radicular symptoms that have been refractory to multiple conservative approaches to pain, including activity restrictions, medications, and rehabilitation-based physical therapy, as well as injections. Indeed, these symptoms are worsening and interfering greatly with daily activities. At this point in time, after failing a conservative approach to the problems outlined above, the patient has elected to proceed with the surgery as outlined above.

CONSENT:

Lengthy detailed discussions have been held with the patient regarding the details of the indications for surgery and the alternatives to surgery, the details of the various possible surgical approaches to the problem at hand, the details of the risks and complications of the surgery, and the details of the anticipated procedure and post-operative course. The patient understands the FDA status of the procedure and implants being used.

Risks include, but are not limited to: infection, bleeding (possibly requiring transfusion), blood vessel injury, blood vessel clots and lung clots, lymphatic injury, nerve injury, paralysis, dural spinal fluid leak, urologic dysfunction, sexual dysfunction, surgical instrument failure, spinal instability, spinal vertebral fracture, need for further surgery, esophageal injury, difficulty swallowing, hoarseness or loss of vocalization ability, blindness, renal failure, pneumonia, heart attack, stroke, coma, and death.

It is well understood by the patient that the outcome of spine surgery such as this cannot be guaranteed. All questions have been answered to the patient's satisfaction, and the patient expressed excellent understanding of the above-mentioned concepts. Based on the above discussion, the patient elected to have the surgery as outlined above, and signed the Spine Institute of Arizona five-page spine surgery consent form.

FINDINGS:

Specific Findings/ Items of note include:

1. The primary finding was of a large disc extrusion, atypical in that it pieces of disc extended from the L2-3 disc level down to the L3-4 disc level, behind the body of L3, occupying the left lateral recess and L3-L4 foramen. There was one large disc fragment adherent to the left anterolateral cauda equina and the anterior aspect of the L3 nerve root from just below its take-off to the middle of the foramen, causing severe compression of the left L3 nerve root, but there were also additional smaller extruded disc fragments in the left lateral recess in the region of both the L2-3 and L3-4 discs, compressing the exiting left L2 root and the traversing left L4 root. There was no clear source of the disc herniation seen: there were no obvious left lateral L2-3 or L3-4 annular fissures or disc openings identified. Thus the extruded disc could have come from L2-3 or L3-4.
2. There was a fair amount of epidural fibrosis seen, likely in response to epidural venous bleeding at the time of the initial disc herniation / extrusion.
3. There were also findings contributing to degenerative spinal stenosis, including ligamentum flavum hypertrophy and facet capsular and bony hypertrophy.
4. The MRI indicated that the largest piece of extruded disc lay behind the body of L3 and directly in front of the L3 lamina, so the initial minimally invasive microscope-assisted tubular retractor approach to the extruded disc was through the left lamina of L3, which eventually required removal in its entirety in order to safely access and remove the multiple pieces of extruded disc. The required decompression extended cephalad past the L2-3 disc and caudad below the L3-4 disc. The pars interarticularis and facet joints were carefully preserved throughout the procedure.

5. Intra-canal decompression was performed using the microscope. Microscopic lysis of neural and vascular adhesions was performed using micro-instruments, including the Rhoton microscopic instruments (curettes and nerve hooks, etc.); the decompression was tedious because of the epidural fibrosis. The micro-instruments were used to perform fine dissection of the neural and vascular structures and epidural fibrosis adhesions. The microscope was necessary, as the neural and vascular structures dealt with, as well as the epidural fibrosis adhesions, were too small to be safely seen and operated without the microscope.
6. Thus the left L2, L3, and L4 nerve roots and associated cauda equina were seen to be compressed, and after the procedure were visualized as being decompressed.

PROCEDURE:

The surgical site was signed by the surgeon in the pre-op area. The patient was brought to the operating room, and general endotracheal anesthesia was administered. Bilateral TED hose and pneumatic hose were applied, and a Foley catheter was placed. The patient was then placed prone on the radiolucent operating table, with the shoulders and elbows at acute angles. Generous attention was paid to padding of all prominences. The chest and abdomen were free of obstruction or impingement. The cervical spine and upper extremities were mobilized throughout the case to prevent impingement. Perioperative antibiotics and IV hydrocortisone were administered. Surgical time-out to confirm patient identity, patient allergies, the anticipated procedure, and the use of antibiotics and DVT prophylaxis, was performed just prior to the procedure.

After sterile prep and drape, x-ray localization of anticipated surgical area was performed.

After proper initial pin placement was confirmed by fluoroscopic imaging, a slightly off-midline skin incision was made over the L3 vertebral body. Under fluoroscopic imaging, sequential muscle dilators were used until the minimally invasive MetRx tube cannula could be introduced. With minimally invasive exposure of the left L3 lamina now accomplished, subperiosteal paraspinous dissection was then performed, exposing the base of the spinous processes, the L3 lamina, the pars interarticularis, and the medial aspects of the L2-3 (and later L3-4) facet joints. The pars interarticularis and facet joints were carefully preserved. Hemostasis was maintained using electrocautery.

The microscope was brought in so that safe completion of the neural decompression could be performed. Intra-canal decompression was performed using the microscope. Microscopic lysis of neural and vascular adhesions was performed using micro-instruments, including the Rhoton microscopic instruments (curettes and nerve hooks, etc.). The micro-instruments were used to perform fine dissection of the neural and vascular structures and epidural fibrosis adhesions. The microscope was necessary, as the neural and vascular structures dealt with, as well as the epidural fibrosis adhesions, were too small to be safely seen and operated without the microscope.

First, a left L3 hemilaminectomy was performed. Using a combination of the high-speed diamond burr, Kerrison ronguers, and spinal micro-curettes and nerve hooks, left hemilaminectomy was performed sufficient to expose the distal aspect of the L2-3 ligamentum flavum and the proximal aspect of the L3-4 ligamentum flavum, safely resect these, and reveal the cauda equina dura below. Partial medial L2-3 facetectomy and L3-4 foramenotomy were then performed, exposing laterally enough to reveal the exiting L3 nerve root, which was visualized as being severely compressed and immobile, with significant epidural fibrosis initially preventing mobility.

There was epidural fibrosis adherent to the nerve root and cauda equina dura and to the surrounding soft tissue structures, including the L2-3 disc annulus itself. Tedious meticulous, but gentle, dissection of epidural fibrosis tissue from the neural elements was required in order to mobilize and decompress the cauda equina and L3 nerve root. With careful dissection and excision of fibrotic tissue, the cauda equina and nerve root were slowly mobilized.

At this point, the cauda equina dura was carefully retracted medially to expose the underlying L3 vertebral body. Epidural veins were cauterized with the bipolar, and the small amount of bleeding further controlled with Flo-seal and cottonoid patties. A large nucleus pulposus extrusion was identified on the left at L3, adherent to severely

compressing the L3 nerve root and extending from under it's axilla down into the foramen. After further careful dissection of epidural fibrosis, this large piece of extruded disc was removed using the pituitary, while gently retracting and protecting the cauda equina and exiting nerve root. The L3 root was also decompressed of posterior/posterolateral bony and soft tissue stenotic elements, sufficient to relieve all posterior / posterolateral elements of spinal stenosis affecting the nerve root.

The MetRx retractor tube was now re-directed, first cephalad and then later caudad, and the canal was explored with nerve hooks and other micro-instruments, and further pieces of adherent/ fibrosed disc fragments were found extending cephalad behind the body of L2 and caudad to the level of the L3-4 disc. Further partial laminectomy of inferior L2 and superior L4 were required to safely identify, isolate, and remove these disc fragments. These smaller fragments of disc in combination with mild degenerative elements of spinal stenosis (facet arthropathy and ligamentum flavum hypertrophy) were seen to be compressive of the L2 root in the L2-3 foramen, and the L4 root at it's take-off. There was a continuing plexus of epidural veins which was interwoven with the disc fragments and epidural fibrosis scar tissue. These veins were bipolar electrocauteried; hemostasis was also aided by the use of Flo-Seal. The L2 and L4 roots were also decompressed of posterior/ posterolateral bony and soft tissue stenotic elements, sufficient to relieve all posterior / posterolateral elements of spinal stenosis affecting the nerve root.

At the end of the decompression portion of the procedure, the neural elements were free and clear of compression and completely mobilizable, and the foramina were free and clear of compression, impingement, or obstruction.

Throughout the procedure, hemostasis was excellently maintained with thrombin and/or Flo-Seal, the excess of which was gently irrigated away. At the end of the surgery, Hemostasis was excellent and Valsalva maneuver in reverse Trendelenburg verified excellent hemostasis and revealed no evidence of CSF leak.

Morsellized pieces of fat and a small amount of Depo- Medrol were now placed about the neural elements. The wound was now closed, using 0 Vicryl for fascia, 3-0 PDS for subcutaneous tissue, and running 4-0 Monocryl for subcuticular skin closure. Dermabond and a sterile dressing were placed over the wound, followed by an abdominal binder.

All sponge, needle, gauze, and cottonoid counts were correct, and the patient was then taken to the PACU in stable condition.

Essential specific findings are as outlined above in "Findings," but findings contributing to the visualized left L2 and L3 and L4 nerve root compression and spinal stenosis included not only multiple fragments of extruded disc, but also ligament flavum infolding/ hypertrophy, and facet capsular and boney hypertrophy. Lumbar spinal stenosis and nerve root decompression of the L2 and L3 and L4 levels was performed by partial L2 and L4 and complete L3 left hemilaminectomies, partial facetectomies, and partial foraminotomies, as well as the excision of all neurologically compressive soft tissues, including excision of the extruded disc fragments. Throughout the laminectomy procedures, the pars interarticularis and facet joints were identified and carefully preserved.

In summary, the cauda equina and the left L2, L3, and L4 nerve roots were seen to be compressed, and after the procedure were visualized as being decompressed.

EDWARD J DOHRING, MD

Baxter**INVOICE**

CUSTOMER P.O. 62213MB

SHIP TO: 37702209

GLN:

SURGCENTER AT PARADISE VALLEY

DBA SURGCENTER AT DIMA CROSSING

8415 N PIMA RD STE 190

SCOTTSDALE AZ 85258

BILL TO: 37702209

GLN:

INVOICE NO:

40283605

INVOICE DATE:

05/29/13

ORDER NO /TYPE:

43964399 SO

ORDER DATE:

05/22/13

REMIT PAYMENTS TO:

BAXTER HEALTHCARE CORP

PO BOX 100714

PASADENA CA 91189-0003

00002370 1 SP 0460

TO: SURGCENTER AT PARADISE VALLEY

DBA SURGCENTER AT DIMA CROSSING

8415 N PIMA RD STE 190

SCOTTSDALE AZ 85258



PAYMENT TERMS:

0% Net 30 Days

ORDERED BY:

MICHELLE

DIRECT CUSTOMER INVOICE INQUIRIES TO:

GABRIELA FILIP

224-948-1232

**

QUANTITY	LOC	UNITS	CATALOG NO	SHIPMENT	ITEM DESCRIPTION	DATE	UNIT PRICE	AMOUNT
1	CA	6	1503350 50085412096105		FLOSEAL VHSD 5ML NDLFREE 6PK US HA130123	05/29/13	1,128.5100	1,128.51
					8.050 % SALES TAX			90.85
1	CA	6	1502186 50085412091001		FLOSEAL MALLEABLE & TRIMMABLE 6EA/CA HA130441	05/29/13	.0000	0.00
INVOICES PAID BEYOND NET TERMS ARE SUBJECT TO A LATE PAYMENT SERVICE FEE.								
Total = \$188.08								
SUBTOTAL:							1,128.51	
TOTAL TAX:							90.85	
TOTAL DUE:							1,219.36	

BAXTER HEALTHCARE CORPORATION
FEDERAL ID NO 38-2604143**RECEIVED**
6-3-13

Page 1 of 1

* Any discounts and rebates received by customer with respect to the products and services purchased from Baxter may be considered "discounts or other reductions in price" under the Anti-Kickback Statute (AKS) (42 U.S.C. § 1320a-7b(b)(3)(A)). To the extent required by the AKS or the Discount Safe Harbor regulations (42 C.F.R. § 1001.952(h) et seq.), customer shall fully and accurately disclose such discounts and other reductions in price according to the applicable state or federal cost reporting requirements. The total charges for the products and services purchased by customer shall be the contract price less any such discounts, rebates, and/or other reductions in price that may be applicable.

000000 000000 000000 000000



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/13

RECEIVED

JAN 29 2015

BY: RISK MGMT.

City of Scottsdale Risk Mgmt WC
7447 East Indian School Road
Suite 225
Scottsdale AZ 85251

141510-WC-141

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input checked="" type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) [REDACTED]																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]										3. PATIENT'S BIRTH DATE MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/> [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 <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) [REDACTED]																																							
CITY [REDACTED] STATE AZ										CITY [REDACTED] STATE [REDACTED]																																																	
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) [REDACTED]										10. IS PATIENT'S CONDITION RELATED TO: a. OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED] b. EMPLOYMENT? (Current or Previous) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> c. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> PLACE (State) [REDACTED] d. OTHER ACCIDENT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										11. INSURED'S POLICY GROUP OR FECA NUMBER [REDACTED]																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED] b. RESERVED FOR NUCC USE [REDACTED] c. RESERVED FOR NUCC USE [REDACTED] d. INSURANCE PLAN NAME OR PROGRAM NAME [REDACTED]										a. INSURED'S DATE OF BIRTH MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) Y4 141510WC141 c. INSURANCE PLAN NAME OR PROGRAM NAME City of Scottsdale Risk Mgmt WC d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, complete items 9, 9a, and 9d.																																																	
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 01 16 2015																				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) MM DD YY QUAL. 10/28/14										15. OTHER DATE MM DD YY QUAL. 439 10 28 2014										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN Armendariz Gustavo										17a. [REDACTED] 17b. NPI [REDACTED]										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> CHARGES RECEIVED PHOENIX																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9 A. 8242 B. [REDACTED] C. [REDACTED] D. [REDACTED] E. [REDACTED] F. [REDACTED] G. [REDACTED] H. [REDACTED] I. [REDACTED] J. [REDACTED] K. [REDACTED] L. [REDACTED]										22. RESUBMISSION CODE ORIGINAL FEB 16 2015										23. PRIOR AUTHORIZATION NUMBER RX20141211 CORVEL MEDCHECK																																							
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. EPST/Fancy Pen I. ID. QUAL J. RENDERING PROVIDER ID. #																																																	
1 01 05 2015 01 05 2015 11 N 97002 59 A 49 10 1 NPI										2 01 05 2015 01 05 2015 11 N 97110 A 103 50 3 NPI																																																	
3 01 05 2015 01 05 2015 11 N 97140 59 A 34 08 1 NPI										4 NPI																																																	
5 NPI										6 NPI																																																	
25. FEDERAL TAX I.D. NUMBER 860889959 SSN EIN [X]										26. PATIENT'S ACCOUNT NO. 0000208668										27. ACCEPT ASSIGNMENT? (For govt claims, see back) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										28. TOTAL CHARGE \$ 186 68										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.) Megan Onofray PT 01 16 2015										32. SERVICE FACILITY LOCATION INFORMATION Valley Rehab Associates 40th St 16620 N 40th St Suite 14 Phoenix AZ 85032										33. BILLING PROVIDER INFO & PH # (602) 788-1888 Industrial Solutions Network 7325 N 16th Street Suite 100 Phoenix AZ 85020																																							
SIGNED DATE										a. 1308921952 b.																																																	

Valley Physical Therapy - Paradise Valley
 16620 N 40th St, Suite 1-4
 Phoenix, AZ 85032-3348
 Phone: (480)502-5361
 Fax: (480)502-5369



Daily Note / Billing Sheet

Patient Name: [REDACTED]
 Date of Birth: [REDACTED]
 Referring Physician(s): Armendariz, Gustavo MD

Date of Daily Note: 01/05/2015
 Injury/Onset/Change of Status Date: 10/28/2014
 Diagnosis: ICD9: 824.2: Fracture of lateral malleolus, closed,
 845.00: Sprain of ankle, unspecified site
 Visit No.: 17
 Insurance Name: Industrial Solutions Network(ICA)

Date of Original Eval: 11/18/2014
 Treatment Diagnosis: ICD9: 719.46: Pain in joint, lower leg,
 781.2: Abnormality of gait
 Workers' Comp Claim: 0000208668

Subjective

Treatment Side: Right

Current Complaints / Gains: Pt notes that his calf gets tight from time to time, however for the most part he is doing fine. He is going to be very busy in the next weeks at work and is unable to return to therapy. Pt notes that he has a follow up with his MD next week and is confident that he will be released from care.

Pain Location: R calf/ankle

Pain Scale: Worst: 2 Best: 0 Current: 1 *Previous Findings as of 12/23/2014 - Worst:4 Best:0 Current:1

Pain Description: Dull/Achy

Pain Follow-up Plan: PT/HEP

Home Health Care: No

Medical History: See past medical history in EMR.

Mental Status/Cognitive Function Appears Impaired? No

Objective

CPT® Code	Direct Timed Codes	Units
97110	Therapeutic Exercise See Flowsheet (40 min)	3
97140	Manual Therapy STM, jt mobs, PROM, PNF DF/EV (15 min)	1
CPT® Code	Untimed Codes	Units
97002	PT Re-Evaluation	1

CPT copyright 2014 American Medical Association. All rights reserved.

Objective Findings

See discharge summary.

Assessment

Assessment/Diagnosis: Pt has been seen in therapy for 8 wks. He has only mild tightness to his calf remaining. He has been able to perform all exercises in the clinic well and without pain. He is working full time without restrictions. He will continue to benefit from use of his HEP to improve his flexibility and lateral ankle stability.

Patient Education: Pt advised on the benefit of continued therapy, as well as the benefit of continued use of his HEP.

Patient Demonstrates Compliance with Prescribed HEP

Rehab Potential: Good

Patient Problems:

- R ankle/calf injury 10/28/14
- R total hip replacement June 2014

Short Term Goals:

- 1: (1 Week) | Goal Met | I with initial HEP |
- 2: (2 Weeks) | Goal Met | Able to demo full ankle mobility without pain |
- 3: (2 Weeks) | Goal Met | Able to normalize gait with full heel strike and toe off without pain |
- 4: (3 Weeks) | Goal Met | Able to stand/walk > 1 hr without increased pain |
- 5: (4 Weeks) | Goal Met | Able to navigate stairs reciprocally without pain |

Long Term Goals:

- 1: (6 Weeks) | 85% | Able to return to light hiking without pain |
- 2: (8 Weeks) | Goal Met | Able to return to work full duty without pain or limitations. |

Plan

Instructions: Discharge

Valley Physical Therapy - Paradise Valley
16620 N 40th St, Suite 1-4
Phoenix, AZ 85032-3348
Phone: (480)502-5361
Fax: (480)502-5369

Patient Name: [REDACTED]
Date of Birth: [REDACTED]
Document Date: 01/05/2015

Daily Note / Billing Sheet

Pt's authorization is up on 1/9/15. He is unable to return to therapy again before 1/9/15 due to his work schedule. He is scheduled to return to see his MD on 1/12/15 and is expecting to be released from care.



Megan Onofray
License #8607
Completed by Megan Onofray on January 5, 2015 at 4:16 pm

1 METRO SURGERY CENTER 6790 W THUNDERBIRD ROAD PEORIA, AZ 85381-5207 (623) 979-1717										2 OP Report is Attached										33 PAY CNTRL # 50737 34 MED REC # 50737 35 FED TAX NO. 810587498 36 STATE/ENT COVERS PERIOD FROM 022015 THROUGH 022015 37 TYPE OF BILL 0831									
8 PATIENT NAME										9 PATIENT ADDRESS										10 BIRTH DATE									
11 SEX M										12 DATE 022015										13 HR 07									
14 TYPE 3										15 SRC 1										16 DMR 13									
17 STAT 01										18										19									
20										21										22									
23										24										25									
26										27										28									
29										30										31									
32										33										34									
35										36										37									
38										39										40									
41										42										43									
44										45										46									
47										48										49									
50										51										52									
53										54										55									
56										57										58									
59										60										61									
62										63										64									
65										66										67									
68										69										70									
71										72										73									
74										75										76									
77										78										79									
80										81										82									
83										84										85									
86										87										88									
89										90										91									
92										93										94									
95										96										97									
98										99										100									

DOE 2/08/15
141502-WC-236

O.K. TO PAY
MAR 04 2015

RECEIVED
MAR 02 2015
BY: RISK MGMT.

0001 PAGE 1 OF 1
JUDY BEREZA
WC CITY OF SCOTTSDALE

CREATION DATE 02/25/15 TOTALS 22,658.00 0.00

59 PRIOR 18 60 INSURED'S UR CODE 141502WC236
RECEIVED PHOENIX
MAR 11 2015

63 TREATMENT AUTHORIZATION CODES SX APPROVED
64 DOCUMENT CONTROL NUMBER CORVEL MEDCHECK
65 EMPLOYER NAME CITY OF SCOTTSDALE

76 ATTENDING NPI 1750305090 QUAL 1G T88241
LAST LEONETTI FIRST WILLIAM
77 OPERATING NPI 1750305090 QUAL 1G T88241
LAST LEONETTI FIRST WILLIAM
78 OTHER NPI
LAST
79 OTHER NPI
LAST

80 REMARKS WC CITY OF SCOTTSDALE
7447 E INDIAN SCHOOL RD #2
SCOTTSDALE, AZ 85251
261QA1903X

81 OCC
a
b
c
d

82
a
b
c
d

83
a
b
c
d

84
a
b
c
d

85
a
b
c
d

86
a
b
c
d

87
a
b
c
d

88
a
b
c
d

89
a
b
c
d

90
a
b
c
d

91
a
b
c
d

92
a
b
c
d

93
a
b
c
d

94
a
b
c
d

95
a
b
c
d

96
a
b
c
d

97
a
b
c
d

98
a
b
c
d

99
a
b
c
d

100
a
b
c
d

US-04 CMS-1430 APPROVED OAR NO. 0938-097 NUBC UC3810505 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL. ANY ARE LARKE A DAILY HEREOF Corvel Scan Date: 3/11/2015

METRO SURGERY CENTER, LLC
6790 West Thunderbird Road
Peoria, AZ 85381
Tel: (623) 979-1717 Fax: (623) 979-1707

OPERATIVE REPORT

PATIENT NAME: [REDACTED] **MEDICAL RECORD #:** 50737
SURGEON: WILLIAM LEONETTI, D.P.M. **DATE OF SERVICE:** 02/20/2015

5. Tenolysis of the peroneal longus and peroneal brevis tendons post trauma.
6. Application of a fiberglass posterior splint and compression bandage.

SURGEON: William Leonetti, D.P.M.
ASSISTANT SURGEON: Michael J. Leonetti, D.P.M.
ANESTHESIA: General.
ANESTHESIOLOGIST: Rebecca E. Dalmeida, M.D.

DISCUSSION: I met with the patient preoperatively and discussed the above surgical procedures. I met with patient and his wife. The patient understands the risks and complications. No guarantees given or implied. He understands the best surgical outcome. He may continue to have pain, tightness, limited range of motion, numbness, loss of feeling, loss of function, continued pain, continued problems, need for additional treatment or surgery at a later date, and development of arthritic changes. Reviewed consent and assent form, which were signed. IV was started. A 600 mg of clindamycin was provided.

DESCRIPTION OF PROCEDURE: The patient was brought to the operating room and placed in the supine position, where general anesthesia was provided. The patient was laid on a beanbag with appropriate padding. He was turned onto his left side with his right ankle facing dorsally. A thigh tourniquet was applied over several layers of Webril and the right leg was prepped and scrubbed in the usual sterile manner. Once the surgeon was scrubbed down and gloved, right leg was draped in the usual sterile manner. The leg was elevated. The tourniquet was inflated to 350 mmHg.

PROCEDURE #1: DIAGNOSTIC AND OPERATIVE ARTHROSCOPY WITH EXTENSIVE DEBRIDEMENT OF FIBROSIS AND SYNOVITIS USING PROPER ARTHROSCOPIC TECHNIQUE:

The anterior pouch of the ankle joint was inflated with 10 cc of sterile lactated Ringer's solution. A 2.7 camera and a 3.5 shaver were introduced into the anterior pouch taking care to avoid cartilaginous or bony surfaces. Inspection confirmed an abundance of hemorrhagic synovitis and fibrosis. There was a large adhesive band across the entire anterior pouch of the ankle joint. There were adhesions in the medial gutter and along the lateral aspect of the joint. Extensive debridement took place removing the adhesive bands crossing the anterior pouch, and the medial corner impingement was removed and curetted as well as debrided. The majority of the pathology was anterolaterally. Once the extensive debridement was completed, the joint was placed through range of motions and noted no impingement anteriorly or medially. The cartilaginous surface was inspected and noted low-grade chondral necrosis, but no blatant osteochondral lesions, fractures, or loose bodies identified. The joint was power flushed. The equipment was removed. The portals were closed.

METRO SURGERY CENTER, LLC
6790 West Thunderbird Road
Peoria, AZ 85381
Tel: (623) 979-1717 Fax: (623) 979-1707

OPERATIVE REPORT

PATIENT NAME: [REDACTED]

MEDICAL RECORD #: 50737

SURGEON: WILLIAM LEONETTI, D.P.M.

DATE OF SERVICE: 02/20/2015

PROCEDURE #2: OPEN ARTHROTOMY, SYNOVECTOMY, AND SHARP DISSECTION OF LATERAL IMPINGEMENT:

Attention was directed to the lateral ankle, where a 3 to 4 cm incision was made over the anterior crest of the fibula. Sharp dissection carried down through the subcutaneous tissues. Preoperatively, the lateral dorsal cutaneous nerve was marked to avoid impingement. Sharp dissection carried down to the capsular structures, which were noted to be severely attenuated. We entered the lateral joint just in front of the fibula and identified an abundance of hemorrhagic synovitis and adhesive bands between the talus and the fibula consistent with an impingement syndrome. It should be noted that the incision was extended dorsally just a bit to inspect these syndesmotomic ligaments. At this point, the joint was flushed and sharp dissection allowed this to remove the adhesions between the talus and the fibula. We dissected implying the appropriate lateral ligaments. The sutures were used to approximate the syndesmotomic ligament just above the joint to help with the syndesmotomic repair and the additional TightRope. Attention was directed to the anterior surface of the fibula, where a Smith & Nephew Bio-anchor was placed. The foot held in a neutral slightly everted position and the remnants of the anterior talofibular and anterior calcaneofibular were reached back to the fibula. This was prior to tightening these ligaments. The TightRope procedure was performed. A fibular incision was made. A pilot guidewire was placed from the fibula to the tibia with the use of the C-arm. This was followed by drill hole making sure that we did not damage the soft tissues on the medial side. The TightRope was placed from lateral to medial. The medial button was flattened and then with the foot held in neutral position and with the tibia and fibula compressed by the assistant, the TightRope was then tightened. At this point, the anterior talofibular and calcaneofibular ligament sutures were then tightened and then a vest-over-pants technique was used using a periosteum of the fibula to secure the lateral ligaments. The incisions of both ligament repairs were closed in appropriate layers and the 4-0 nylon was used to close the skin.

PROCEDURE #3:

Attention was directed to the peroneal brevis tendon, where an 8 cm curvilinear incision was made from above the fibula towards the fifth metatarsal base. Sharp dissection carried down through the subcutaneous tissues. Several veins were identified, ligated, and bovied. We identified a bulging tendon sheath over the peroneal brevis. This was incised the length of the incision, we identified a grossly flattened peroneal brevis tendon with a through-and-through longitudinal split tear. The total injury to the tendon was almost 7 cm in length. At this point, the tendon was completely attached to the synovial sheath. This was removed via sharp dissection with the use of a Bovie. The abnormal tendon tissue was removed via sharp dissection and then the tendon was tubularized with 5-0 Prolene. The tendon was identified to glide through the retinaculum without difficulty.

PROCEDURE #4: TENOLYSIS OF THE PERONEAL BREVIS AND PERONEAL LONGUS TENDON: The tendon was then completely tenolysed as well as the peroneal longus, brought out of the sheath, and severely attached. Due to hematoma formation, this was tenolysed, the length of the tendon, and the incision, the area was flushed with copious amounts of antibiotic solution. Appropriate closure was performed with 3-0 Vicryl and then 4-0 nylon on skin; silicone drain was placed in the incision distally. The incisions were cleaned, dried, and Steri-Stripped. The joint and the incisions were injected with Marcaine with epinephrine and dexamethasone. Adaptic soaked in Betadine was placed.

METRO SURGERY CENTER, LLC
6790 West Thunderbird Road
Peoria, AZ 85381
Tel: (623) 979-1717 Fax: (623) 979-1707

OPERATIVE REPORT

PATIENT NAME: [REDACTED]

MEDICAL RECORD #: 50737

SURGEON: WILLIAM LEONETTI, D.P.M.

DATE OF SERVICE: 02/20/2015

The joint was incorporated in the bandage. The tourniquet was let down. Compression bandage from the tips to toes to mid calf was completed followed by posterior splint. The patient was given Toradol postoperatively and let the operating room in excellent condition with normal neurovascular status.

X _____
William Leonetti, D.P.M.

JOB#: 416570
WL: med: psu/slk
DD: 02/22/2015
DT: 02/23/2015



RECEIVED

FEB 04 2015

BY: RISK MGMT.

CITY OF SCOTTSDALE
ATTN WORK COMP
7447 E INDIAN SCHOOL RD #225
SCOTTSDALE AZ 85251

B

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)		TRICARE <input type="checkbox"/> (ID#/DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input checked="" type="checkbox"/> (ID#)		1a. INSURED'S ID. NUMBER (For Program in Item 1) -WC-076	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]								3. PATIENT'S BIRTH DATE MM DD YY [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 <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) [REDACTED]			
CITY [REDACTED]				STATE AZ				8. RESERVED FOR NUCC USE				CITY [REDACTED]			
ZIP CODE 85050				TELEPHONE (Include Area Code) [REDACTED]				9. OTHER [REDACTED]				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]								11. INSURED'S POLICY GROUP OR FECA NUMBER [REDACTED]							
a. OTHER INSURED'S POLICY OR GROUP NUMBER FEB 10 2015 JUDY BEREZA								b. INSURED'S DATE OF BIRTH MM DD YY [REDACTED]							
b. RESERVED FOR NUCC USE								c. INSURANCE PLAN NAME OR PROGRAM NAME CITY OF SCOTTSDALE							
c. RESERVED FOR NUCC USE								d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 8a and 8d.							
d. INSURANCE PLAN NAME OR PROGRAM NAME								13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. [REDACTED]							
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 11/30/2011															
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 16 2013								15. OTHER DATE QUAL. MM DD YY 431							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE [REDACTED]								18. HOSPITALIZATION DATES REL. TO CURRENT SERVICES FROM MM DD YY TO MM DD YY [REDACTED]							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)								20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) A. V5843 B. C. D. E. F. G. H. I. J. K. L.								22. RESUBMISSION CODE ORIGINAL REF. NO. FEB 12 2015 CORVEL MEDCHECK							
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY 01092015 01092015								B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER 99213 E. DIAGNOSIS A F. \$ CHARGES 150.00 G. DAYS OR UNITS 1 H. ICD-9 G2 I. QUAL NPI J. RENDERING PROVIDER ID # 260152289 K. NPI 1750330130							
25. FEDERAL TAX ID. NUMBER [REDACTED]								26. PATIENT'S ACCOUNT NO. C51002ND							
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO								28. TOTAL CHARGE \$ 150.00							
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.) BRIAN L SHAFER MD SIGNED 01/29/2015								32. SERVICE FACILITY LOCATION INFORMATION BELL OFFICE 5620 E BELL ROAD SCOTTSDALE AZ 85254-5950							
33. BILLING PROVIDER INFO & PH # ORTHOPEDIC SPECIALISTS OF NOR 2355 E CAMELBACK RD STE 325 PHOENIX AZ 85016-3441 a. 1073835989 b. G22-60152289															

Patient: 309285 [REDACTED]
DOB: [REDACTED]
Date: 01/09/2015 08:15
Provider: Shafer, Brian L. MD
Encounter: ICA -follow up

ACTIVE PROBLEMS

- S/s Rotator Cuff (new)

CHIEF COMPLAINT

S/P Arth RCR 4 months post-op

HISTORY OF PRESENT ILLNESS

Doing well S/P:Arth RCR 4 months post-op. no c/o. ROM and pain are improving. PT is going well.

CURRENT MEDICATION

- Cytomel 5 MCG TABS, , 0 days, 0 refills
- NexIUM 10 MG PACK, , 0 days, 0 refills
- Synthroid TABS, , 0 days, 0 refills

Unchanged

PAST MEDICAL/SURGICAL HISTORY

Diagnoses:

Esophageal reflux
Arthroscopy Knee left.

Surgical:

- Thyroid surgery

unchanged

SOCIAL HISTORY

Behavioral: No tobacco use, not a current smoker, and smoking status: Never smoker.

Alcohol: Alcohol use.

Drug Use: Not using drugs.

unchanged

ALLERGIES

- No Known Allergies

Unchanged

FAMILY HISTORY

unchanged

Patient: 309285 - [REDACTED]
DOB: [REDACTED]
Date: 01/09/2015 08:15
Provider: Shafer, Brian L. MD
Encounter: ICA -follow up

REVIEW OF SYSTEMS

unchanged

PHYSICAL FINDINGS

L Shoulder exam reveals: FE: 180; ERS: 70; ERA: 90; IRA: 80. IRS L5 slightly decreased. 5/5 RC strength. Negative impingement signs. Negative speeds test. Negative Belly press.

In general the patient is well-appearing, alert and oriented and in no acute distress.

R Shoulder exam reveals: FE: 180; ERS: 70; ERA: 90; IRA: 80. 5/5 RC strength. Negative impingement signs. Negative speeds test. Negative Belly press. no TTP. skin intact

TESTS

None

ASSESSMENT

Doing well S/P above stated procedure

PLAN

- OTHER
WORK: work release
P.T.: Physical Therapy

Continue PT with the no restrictions. OK to continue unlimited strengthening. okay to return to full duty work at this time. F/U with me in 4 weeks

Brian L. Shafer MD

Electronically signed by: Brian Shafer Date: 01/09/2015 08:49



Invoice RECEIVED

CITY OF SCOTTSDALE
7447 E INDIAN SCHOOL RD
SUITE 225
SCOTTSDALE, AZ 85251

B

HEALTH INSURANCE CLAIM FORM

FEB 04 2015

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

BY: RISK MGMT.

-WC-179

PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)				MEDICAID <input type="checkbox"/> (Medicaid#)				TRICARE <input type="checkbox"/> (ID#DoD#)				CHAMPVA <input type="checkbox"/> (Member ID#)				GROUP HEALTH PLAN <input type="checkbox"/> (ID#)				FECA BLK LUNG <input type="checkbox"/> (ID#)				OTHER <input checked="" type="checkbox"/> (ID#)				1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																																			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)																3. PATIENT'S BIRTH DATE MM DD YY								SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>								4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																															
5. PATIENT'S ADDRESS (No., Street)																6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>																7. INSURED'S ADDRESS (No., Street)																																																															
CITY								STATE								CITY								STATE																																																																							
ZIP CODE								TELEPHONE (Include Area Code)								ZIP CODE								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																																																															
a. OTHER INSURED'S POLICY OR GROUP NUMBER																a. EMPLOYMENT? (Current or Previous)																a. INSURED'S DATE OF BIRTH MM DD YY																SEX M <input type="checkbox"/> F <input type="checkbox"/>																																															
b. RESERVED FOR NUCC USE																b. AUTO ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO																b. OTHER CLAIM ID (Designated by NUCC)																																																															
c. RESERVED FOR NUCC USE																c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																c. INSURANCE PLAN NAME OR PROGRAM NAME																																																															
d. INSURANCE PLAN NAME																10d. CLAIM CODES (Designated by NUCC)																d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9a, 9b, and 9d.																																																															
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.																																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																DATE 07 18 2013																SIGNATURE ON FILE																																																															
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)																15. OTHER DATE																16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION																																																															
04 30 2013 QUAL. 431																QUAL. MM DD YY																FROM MM DD YY TO MM DD YY																																																															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE																17a. NPI																18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																																																															
17b. NPI																FROM MM DD YY TO MM DD YY																																																																															
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																																																																																															
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																																																																																															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Refer to A-L to service line below (24E) ICD Ind. 9																																																																																															
A. 719 54 B. 782 3 C. 719 44 D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____																																																																																															
22. RESUBMISSION CODE ORIGINAL FEB 12 2015																																																																																															
23. PRIOR AUTHORIZATION NUMBER																																																																																															
CORVEL MEDCHECK																																																																																															
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. #																																																							
07182013 07182013								11				L3933				LT				ABC				279 00				1				NPI				1598875122																																																											
2																																																																																															
3																																																																																															
4																																																																																															
5																																																																																															
6																																																																																															
25. FEDERAL TAX I.D. NUMBER																26. PATIENT'S ACCOUNT NO.																27. ACCEPT ASSIGNMENT? (For govt. claims, see back)																28. TOTAL CHARGE																29. AMOUNT PAID																30. Rsvd for NUCC Use															
860087236																213956																<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO																\$ 279 00																\$ 0 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.)																32. SERVICE FACILITY LOCATION INFORMATION																33. BILLING PROVIDER INFO & PH #																																																															
LEONIE CHIN DUNCAN O																ARROWHEAD OT																602 2776211																																																															
3337 07 26 2013																6320 W UNION HILLS DR SUITE																THE ORTHOPEDIC CLINIC ASSOCIATION																																																															
																GLENDALE AZ 85308-1096																2222 EAST HIGHLAND AVE SUITE 300																																																															
																a. 1952427445																PHOENIX AZ 85016-4879																																																															
																b. 1003988338																																																																															

**THE ORTHOPEDIC CLINIC ASSOCIATION, P.C.**SERVING OUR PATIENTS THROUGH INNOVATIVE
AND COMPREHENSIVE ORTHOPEDIC CARE

Gustavo J. Armendariz Jr., M.D.
David S. Ballo, M.D.
Kraig M. Burgess, D.O.
Thomas R. Carter, M.D.
Anikar Chhabra, M.D., M.S.
P. Dean Cummings, M.D.
Sherwood K. Duhon, M.D.
Kostas Economopoulos, M.D.
Richard J. Emerson, D.O.
Earl L. Feng, M.D.
Joseph L. Haber, M.D.
Christopher W. Huston, M.D.
Steen Johnson, M.D.
Evan S. Lederman, M.D.
Amy Jo Overlin, M.D.
Grant D. Padley, D.O.
Josh C. Vella, M.D.
Jon Whisler, M.D.
Gerald N. Yacobucci, M.D.
Jon D. Zoltan, M.D.

ADMINISTRATION

Kendra T. Balazs, R.N., B.S.N., M.B.A.

ORTHOPEDIC SURGEONS FOR

Arizona State University

TEAM PHYSICIANS FORPhoenix Suns
Phoenix Mercury
Arizona Rattlers**OFFICES**2222 East Highland Avenue
Suite 300
Phoenix, AZ 85016
Tele (602) 277-62119377 East Bell Road
Suite 231
Scottsdale, AZ 85260
Tele (602) 277-62115002 South Mill Avenue
Tempe, AZ 85282
Tele (602) 277-621163208 West Union Hills Drive
Suite B1800
Glendale, AZ 85308
Tele (602) 277-62115845 E. Still Circle
Suite 106
Mesa, AZ 85206
Tele (602) 277-6211

Fed ID #88-0087236

www.TOCAMD.com
www.azcartilagerestoration.comRe: [REDACTED]
CLM# [REDACTED]
DOS 07/18/2013**INVOICE**CPT: L3933 – Finger Orthosis, Custom Fabricated w/o Joints

Aquaplast Supply	88.00
Soft Straps/Velcro	66.00
Stockinette/Soft Interface	50.00
Custom Fabrication with Fitting	75.00

TOTAL 279.00

**TOCA**

2222 E. Highland Ave #300 Phoenix, AZ 85016
 (602) 277-6211 Fax: (602) 277-1074

Page 1
 OT Visit

PID: 421847

Date of service: July 18, 2013

07/18/2013 - OT Visit: OT Vist Orthosis/Splint Eval
 Provider: Leonie Chin Duncan OT
 Location of Care: TOCA Arrowhead Hand

Orthosis/Splint Evaluation

Date: July 18, 2013

Referring Physician: Kraig Burgess DO

Physician Diagnosis: 816.01 FX MID/PROX PHALANX

DOI: April 29, 2013

DX: 719.54 hand/finger stiffness - left

DX 1: 719.44 joint pain-hand - left

DX: 782.3 Edema - left

Pain: 2

1-2 index and small

FUNCTIONAL OUTCOME SCORE:

Initial Quick DASH: 56.81

Hand Dominance: right

Hand Affected: left

Patient was fitted with a custom orthosis for the purpose of PIP extension

Type of orthosis/splint fabricated/issued: left small PIP jt extension

Code: L3933

See Treatment flow sheet for additional treatment information.

Patient Education Provided:

Patient was educated in wear/care/usage of Orthosis/splint

Patient was able to don/doff orthosis/splint independently prior to leaving treatment today

All questions were answered to the patient's reported satisfaction.

Comments: Pt present small PIP -25 deg extension. Pt reported not too much pain at small finger and better at index. as well, but not as strong. Pt was seen for MHP, soft tissue mob, u/s @ 0.8 w/cm2 x 12 mins to index and small, followed by gentle passive rom and gentle stretch to small PIP jt extn.

Tx time: 45 mins (ther ex 30 mins and fabrication of orthosis 15 mins)

Treating Therapist Leonie Chin Duncan O.T. License #3337

Physician: I have read the above summary:

☐ I agree with the therapist's recommendations

☐ I Request the following additions:



TOCA

2222 E. Highland Ave #300 Phoenix, AZ 85016
(602) 277-6211 Fax: (602) 277-1074

Page 2
OT Visit



PID: 421847

Date of service: July 18, 2013

Physician's Signature

Orders:

Added new Service order of Thera. Ex. 15 min (97110) - Signed

Added new Service order of FO S Finger Gutter, Figure 8 (L3933H) - Signed

Electronically signed by Leonie Chin Duncan OT on 07/18/2013 at 1:52 PM

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

RECEIVED

FEB 04 2015

BY: RISK MGMT.

City of Scottsdale Risk Mgmt WC
7447 East Indian School Road
Suite 225
Scottsdale AZ 85251

PICA

1. MEDICARE <input type="checkbox"/> (Medicare#)		MEDICAID <input type="checkbox"/> (Medicaid#)		TRICARE <input type="checkbox"/> (ID#DoD#)		CHAMPVA <input type="checkbox"/> (Member ID#)		GROUP HEALTH PLAN <input checked="" type="checkbox"/> (ID#)		FECA BLK LUNG <input type="checkbox"/> (ID#)		OTHER <input type="checkbox"/> (ID#)		INSURANCE NUMBER WC-196		(For Program in Item 1)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]								3. PATIENT'S BIRTH DATE MM DD YY [REDACTED] M <input checked="" type="checkbox"/> F <input type="checkbox"/>				4. INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]											
5. PATIENT'S ADDRESS (No., Street) [REDACTED]								6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) [REDACTED]											
CITY [REDACTED]						STATE AZ		8. RESERVED FOR NUCC USE						CITY [REDACTED]				STATE [REDACTED]					
ZIP CODE [REDACTED]				TELEPHONE (Include Area Code) () [REDACTED]				9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]						ZIP CODE [REDACTED]				TELEPHONE (Include Area Code) () [REDACTED]					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]								10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)				11. INSURED'S POLICY GROUP OR FECA NUMBER [REDACTED]											
a. OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED]								a. INSURED'S DATE OF BIRTH MM DD YY [REDACTED] M <input checked="" type="checkbox"/> F <input type="checkbox"/>				SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>											
b. RESERVED FOR NUCC USE								b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				c. OTHER CLAIMS (Designated by NUCC) Y4 [REDACTED] WC-196											
c. RESERVED FOR NUCC USE								c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				d. INSURANCE PLAN NAME OR PROGRAM NAME City of Scottsdale Risk Mgmt WC											
d. INSURANCE PLAN NAME OR PROGRAM NAME JUDY BEREZA								10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.											
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 [REDACTED] DATE 02 02 2015																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 [REDACTED]							
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 02/18/14 QUAL								15. OTHER DATE QUAL 439 12:12 2014								16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE ON Zangerle Kurt								17a. [REDACTED] 17b. NPI [REDACTED]								18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) 8472 ICD Ind. 9																22. RESUBMISSION CODE ORIGINAL REF. NO. FEB 12 2015							
23. PRIOR AUTHORIZATION NUMBER RX20141218																CORVEL MED CHECK							
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) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSOT (For Family Plan) I. ID QUAL J. PROVIDER ID. #																							
01 23 2015 01 23 2015 11 N 97002 59 A 49 10 1 NPI																							
01 23 2015 01 23 2015 11 N 97110 A 34 50 1 NPI																							
01 23 2015 01 23 2015 11 N 97140 59 A 34 08 1 NPI																							
01 23 2015 01 23 2015 11 N 97016 59 A 21 88 1 NPI																							
25. FEDERAL TAX I.D. NUMBER 860889959 SSN EIN 26. PATIENT'S ACCOUNT NO. 0000209014 27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ 139.56 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.) John A Elchert PT 02 02 2015 SIGNED DATE																32. SERVICE FACILITY LOCATION INFORMATION Contact PT Scottsdale 10304 N Hayden Road Suite 8 Scottsdale AZ 85258				33. BILLING PROVIDER INFORMATION Industrial Solutions Network (602) 788-1888 7325 N 16th Street Suite 100 Phoenix AZ 85020 1306921952			

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Corvel Scan Date: 2/12/2015



10304 N Hayden Rd, Suite 120
 Scottsdale, AZ 85258
 Phone: 480-429-5266
 Fax: 480-429-5297

Progress Note/Plan of Care

Patient Name: [REDACTED] Date Seen: 1/23/2015
 Date of Birth: [REDACTED] years old Patient ID: 3864
 Diagnosis: 847.2 Sprain lumbar Referring Physician: Kurt F Zangerle, M.D.
 724.2 Lower Back Pain

Visits: 9
 Cancels: 0 No Shows: 0

Assessment

[REDACTED] feels he is back to a prior level with his injury. He is doing well at work, and reports no pain lately with his work related activities and daily activities. He plans to return to his gym routine soon as well. Educated provided on proper progression. He will continue his hep for core strengthening. He will contact us if needed but at this time is discharged as he has reached his prior status.

Subjective

Subjective Findings

[REDACTED] and I discussed his work status, he feels he is back to that level prior to the injury for work. We discussed either continuing or discharging and based on this report we will discharge, he understands and agrees. Encouraged to seek MD if needed, continue hep.

Pain History

Pain Area	Current	Best	Worst
Lower back and posterior hip	0/10	0/10	1/10

Pain Area:

Area	Current	Best	Worst
Lower back and posterior hip	5/10	5/10	8-9/10

Lower back and left posterior hip, numbness in the buttock and burning in the lower back.

Objective

Today's Treatment

- PT Re-Evaluation Reviewed work related goals, made recommendations, and determined discharge
- Manual - Joint Mobilization long distraction of the hip, manual hamstring and quad stretches
- Physioball bridges at calf 20 repetitions, lifting into extension within pain tolerance.
- Supine Physioball Abdominal co-contraction, marches 20 repetitions, with 2-3 second holds. Then 20 reps of marches with abdominal stabilization.
- Upper back bridges. Rows on ball, Lat pull down on ball, Curl up march 20 to 30 repetitions of each except ball bridges/curl ups

Progress Note / Daily Note (1/23/2015) - [REDACTED]

Page 1

Corvel Scan Date: 2/12/2015



10304 N Hayden Rd, Suite 120
 Scottsdale, AZ 85258
 Phone: 480-429-5266
 Fax: 480-429-5297

only 5-10. Rows with 5 PL on CC. Lat pull down 10PL. Focusing on core stabilization today with the exercise.
 Game Ready min. compression, 55 degrees, lower back, supine with bolster.

Upper back was stiff from lifting child.

All exercises he performed today he can continue for HEP, full review completed.

Functional Testing

Test	Score	Impairment
Back Index	4	4

Observation

No noted rotation. Sacrum normal, unremarkable investigation.

L-Spine

L-Spine - Active Range Of Motion

Motion	12/23/2014		1/23/2015	
	AROM	Gross Strength	AROM	Gross Strength
Flexion	6 inches from floor, pushing on knees to return	4/5	5 inches from floor, pushing on knees to return	5/5 (upper) and 5/5 (lower)
	Percent		Percent	
Extension	25 Percent		100 Percent	
Sidebending Right	25 Percent		100 Percent	
Sidebending Left	25 Percent		100 Percent	
Rotation Right	50 Percent	4/5	75 Percent	5/5
Rotation Left	50 Percent	4/5	75 Percent	5/5

Lower abdomen showing improved strength.

L-Spine - Special Tests

Special Test	12/23/2014		1/23/2015	
	Right	Left	Right	Left
Straight Leg Raise	Positive	Positive	Negative	Negative
Prone Knee Bending	Negative	Negative	Negative	Negative
Slump Test (Lumbar)	Negative	Negative	Negative	Negative
Quadrant Test (L-Spine)	Positive	Positive	Negative	Negative

Lumbar: Palpation a dull pain to the left SI joint

Neuro

Hip flexor/abductor: 5/5 bilateral

Hip extension/adduction: 5/5, Knee: 5/5, Ankle, 5/5 Bilateral.

None noted to palpation today.

Palpation

Tenderness at Left SI joint



10304 N Hayden Rd, Suite 120
 Scottsdale, AZ 85258
 Phone: 480-429-5266
 Fax: 480-429-5297

Plan

Goals

Length	Status	Goal
Short Term	Met	1. Independent with home exercise program in 3 visits.
Long Term	Met	2. Patient able to participate in full recreational activities in 4 weeks to include return to work, ability to sit/lie without pain, and ambulate without pain
Short Term	partially met	2a. Increase ROM to WNL for lumbar flexion, extension, rotation, sidebend, and improve hamstring/quad flexibility
Short Term	partially met	2b. Increase strength to WNL 5/5 to hip flexor/abductor and trunk.
Long Term	partially met	3. Patient to report decreased pain during functional activities in 4 weeks to 0/10
Short Term	partially met	3a. Patient to report decreased pain measured by visual analog scale to 0/10
Short Term	Met	4. Back index improved to 30
Long Term	Met	5. Back index improved to 15
Long Term	Met	6. NEW goal, back index improved to 8

Treatment Plan

Recommend discharge with home exercise program 0 0 , with treatments to consist of:

Treatment Time

Timed Codes: 29 - Untimed Codes: 25 - Total Treatment Time: 54

John A Elchert, PT License #: 9801

(Document electronically signed by TheraOffice Documentation)

1/23/2015

A portion of this document was generated using Dragon voice recognition software. Syntax errors may occur.

To Be Completed By Physician

☐ I have no revisions to this plan of care

☐ Revise plan of care as follows

☐ Discharge Patient

Prognosis: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Continue ☐ times per ☐ for ☐ weeks/months

Physician Signature: _____ Date: _____

In signing this document, physician certifies that prescribed rehabilitation is a medical necessity.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

RECEIVED

FEB 04 2015

BY: RISK MGMT.

City Of Scottsdale Risk Management
7447 E. Indian School Rd. Suite 225
Scottsdale, AZ 85258

PICA

1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK/LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)				1a. INSURED'S I.D. NUMBER (For Program in Item 1) [REDACTED]			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]				3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>			
5. PATIENT'S ADDRESS (No., Street) [REDACTED]				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>			
CITY [REDACTED]		STATE AZ		CITY Scottsdale		STATE AZ	
ZIP CODE [REDACTED]		TELEPHONE (Include Area Code) ([REDACTED])		ZIP CODE 85251		TELEPHONE (Include Area Code) (480) 812-2642	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO b. ALCOHOL ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
a. OTHER INSURED'S POLICY OR GROUP NUMBER [REDACTED]				a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>			
b. RESERVED FOR NUCC USE O.K. TO PAY				b. OTHER CLAIM ID (Designated by NUCC) City Of Scottsdale			
c. RESERVED FOR NUCC USE FEB 10 2015				c. INSURANCE PLAN NAME OR PROGRAM NAME JUDY BEREZA			
d. INSURANCE PLAN NAME OR PROGRAM NAME JUDY BEREZA				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE [REDACTED]				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. [REDACTED]			
SIGNED SIGNATURE ON FILE DATE				SIGNED SIGNATURE ON FILE			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.				15. OTHER DATE MM DD YY QUAL.			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE [REDACTED]				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.				22. RESUBMISSION CODE ORIGINAL REF. NO.			
A. 844.9 B. C. D. E. F. G. H. I. J. K. L.				23. PRIOR AUTHORIZATION NUMBER			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	
1 01/27/15 01/27/15 11		99203		A		F. \$ CHARGES 166.00 G. DAYS OR UNITS 1.0 H. ICD-9-CM 9th Ed. NPI	
2						NPI	
3						NPI	
4						NPI	
5						NPI	
6						NPI	
25. FEDERAL TAX I.D. NUMBER 86-0181654 SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>				26. PATIENT'S ACCOUNT NO. 2011-406983			
27. ACCEPT ASSIGNMENT? (For gov't claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 166.00			
29. AMOUNT PAID \$ 0.00				30. Rsvd for NUCC Use 166.00			
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.) Palicia Trehame, MD 01/27/15				32. SERVICE FACILITY LOCATION INFORMATION Occupational Health Thompson Peak 20401 N. 73rd St., Ste. 255 Scottsdale A 85255			
33. BILLING PROVIDER INFO & PH# Scottsdale Healthcare Occupational Hlth P.O. Box 740137 Los Angeles CA 90074-0137 1396701454							

Scottsdale Healthcare Occupational Health Department

Osborn Office
Tele: 480-882-4770
Fax: 480-882-4391

Shea Office
Tele: 480-323-3818
Fax: 480-323-3238

Alrpark Office
Tele: 480-323-1880
Fax: 480-905-1136

Individual Encounter

Page: 1

Employee [REDACTED]
Department [REDACTED]

SSN/ID [REDACTED]

Date 01/27/15 Time 08:31a
Time Out 09:26a
Type Physician Assistant - ICA Init
Disposition Light Duty

Examiner Marilyn (Susie) Kuntz-Simpson, PA-C
Description Physician Assistant - ICA Initial Visit
Diagnosis 844.9 SPRAIN OF UNSPECIFIED SITE
Treatment

Narrative

S: [REDACTED] is a [REDACTED] y/o RHD female who has worked for the COS about [REDACTED] years. She is the [REDACTED]. Today she is here for evaluation of a new work injury. On 1/12/15 she was hiking on Quartz Trail just below Talliesin Overlook with a group of 4th graders. As she was coming down the trail she "tweaked" the right knee, twisting it quickly. She had sudden sharp pain, and then the right knee was very achy as she continued the hike. That night she treated with ibuprofen OTC, taking 2 tablets twice daily with food, taking Tumeric capsules, and using frozen peas over the area, protecting the skin. She also noticed swelling over the right knee, with swelling of the right foot toes on one occasion. She also hiked on 1/13/15, and 1/16/15. She continued with her ibuprofen and using cold packs. However, since the pain has not gone away she increased the ibuprofen to 2 tablets, three times a day with food. The patient also went to see her chiropractor on two occasions, 1/20 and 1/22/15. The chiropractor treated with an "activator" and stretches, which helped. She also went to her Yoga class once last week and this helped as well.

Initially, her pain scale was a 5/10, now it is an 8/10. Her right knee is worse at the end of the day, feels a little unstable when she first stands up and gets out of her car, as though it may give out. However, she has had no giveway or locking up. She has had no problems driving her car. She has had more discomfort with increased walking or hiking, bending her right knee. The pain kept her up last night and felt a little warm to the touch. Since it has not gone away she decided to come in for further evaluation and treatment. No prior right knee problems. No other injuries.

Other ROS (-): No fever, chills, redness, calf pain, hip or thigh pain. No chest pain, shortness of breath, dizziness, nausea, vomiting, abdominal pain, changes in bowel or bladder habits, or other symptoms.

PMH: (+) Shingles. PMH (-): Cardiopulmonary problems, cancer, seizures, blood or bone disorders, diabetes, hypertension, thyroid problems, acid reflux, liver disorders or other GI problems, kidney or other GU problems, blood or bone disorders, other musculoskeletal problems, depression/anxiety, other medical problems.

SH: No tobacco. Drinks alcohol socially, usually no more than two glasses of wine.

Medications: Valtrex
ALLERGIES: SULFAs

O: Alert and oriented. WDN female in NAD. Gait favors the right knee. Vital signs are normal (see vitals tab). Functions well. The patient demonstrates how she gets down on the floor to treat her sick pet, and has no problem kneeling. She does have difficulty coming up from a squatting or kneeling position, with discomfort in the medial aspect of the right knee. Hips: NT. FROM. Knees: Symmetric, no erythema, ecchymosis. There is swelling over the superior pole of the right knee. No palpable effusion. She also has multiple superficial varicose veins over both lower extremities, none tortuous. Right knee almost FROM, with limitation at end flexion and discomfort over the medial aspect. Left knee with FROM and no discomfort. No tenderness to palpation of either knee. Calf areas are soft and NT. No swelling. 2+ pedal pulses. Sensation grossly intact. Muscle strength and EHL are 5/5.

A: Right knee strain with worsening symptoms.

Plan:

1) The patient was advised she may switch from the ibuprofen to Aleve OTC, with food instead. She will stop the ibuprofen. I discussed anticipated results, potential adverse reactions, possible side effects

Scottsdale Healthcare Occupational Health Department

Osborn Office
Tele: 480-882-4770
Fax: 480-882-4391

Shea Office
Tele: 480-323-3818
Fax: 480-323-3238

Airpark Office
Tele: 480-323-1880
Fax: 480-905-1136

Individual Encounter

Page: 2

Employee
Department

SSN/ID

Date 01/27/15 Time 08:31a
Time Out 09:26a
Type Physician Assistant - ICA Init
Disposition Light Duty

Examiner Marilyn (Susie) Kuntz-Simpson, PA-C
Description Physician Assistant - ICA Initial Visit
Diagnosis 844.9 SPRAIN OF UNSPECIFIED SITE
Treatment

and potential adverse effects of not taking with medication as prescribed.

- 2) She was referred to SMIL today for a baseline x-ray of the right knee.
- 3) Since this injury occurred over 2 weeks ago, and the symptoms are worsening, a request for authorization for an MRI of the right knee without contrast was submitted.
- 4) Communication with SMIL was accomplished via the written order. The patient will hand carry the order to SMIL, and the results will be reported separately.
- 5) She is advised to continue with the use of cool packs over the right knee as needed with the skin protected, and elevate as much as possible.
- 6) Light duty: No kneeling, squatting, climbing or hiking. Walking as tolerated. Ice and elevate the right knee as needed.
- 7) Physical therapy is requested for the right knee, to evaluate and treat, twice a week for two weeks.
- 8) Follow up in about a week. RTC or ED sooner if worse or not better before then.

Susie Kuntz-Simpson, PA-C

Signed by SKUNTZ/Susie Kuntz-Simpson, PA on 1/27/2015 at 10:27am

ADDENDUM 1/27/15: Results from SMIL received. No acute fracture or dislocation. No definite effusion. (Please see scanned full x-ray report). The patient was notified by TC. She is re-considering physical therapy at this time. She will let me know if she prefers not to go ahead with this. The patient also will obtain her chiropractor's records to include in her file. She sees chiropractor for maintenance visits routinely when her back or shoulder are tight, and asked to see if they could also do something for her right knee as well when she was seen last week. SKSimpson, PA-C

Signed by SKUNTZ/Susie Kuntz-Simpson, PA on 1/27/2015 at 11:54am



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

RECEIVED
FEB 04 2015
BY: RISK MGMT.

City of Scottsdale Risk Mgmt WC
7447 East Indian School Road
Suite 225
Scottsdale AZ 85251

PICA

CARRIER

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input checked="" type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)				1a. INSURED'S I.D. NUMBER (For Program in Item 1) 131410-WC-076			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Desert Institute,				3. PATIENT'S BIRTH DATE MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>			
5. PATIENT'S ADDRESS (No., Street) CITY <input type="text"/> STATE <input type="text"/> ZIP CODE <input type="text"/>				4. INSURED'S NAME (Last Name, First Name, Middle Initial) 7. INSURED'S ADDRESS (No., Street) CITY <input type="text"/> STATE <input type="text"/> ZIP CODE <input type="text"/> TELEPHONE (Include Area Code) <input type="text"/>			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) JUDY BEREZA				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
11. INSURED'S POLICY OR FECA NUMBER Y4 131410 WC 076				12. INSURED'S DATE OF BIRTH MM DD YY M <input checked="" type="checkbox"/> F <input type="checkbox"/>			
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 DATE 01 28 2015				14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. 10/16/13			
15. OTHER DATE QUAL. 439 MM DD YY 10 16 2013				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN Shafer Brian				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9				22. RESUBMISSION CODE ORIGINAL REF. NO.			
23. PRIOR AUTHORIZATION NUMBER RX20150119				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) E. DIAGNOSIS POINTER			
25. FEDERAL TAX I.D. NUMBER 860889959 SSN EIN <input checked="" type="checkbox"/>				26. PATIENT'S ACCOUNT NO. 0000207919			
27. ACCEPT ASSIGNMENT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 152 53			
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.) Robb A Blackaby PT				32. SERVICE FACILITY LOCATION INFORMATION Desert Institute of PT 15953 N Greenway Hayden Suite A Scottsdale AZ 85260			
33. BILLING PROVIDER INFO & PH # (602) 788 1888 Industrial Solutions Network 7325 N 16th Street Suite 100 Phoenix AZ 85020				34. SIGNATURE OF PHYSICIAN OR SUPPLIER a. 1306921952			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

The Desert Institute of Physical Therapy
15953 N. Greenway-Hayden Loop, Ste #A
Scottsdale, AZ 85260-1765
Phone: (480)998-4848
Fax: (480)998-2207
www.desertinstituteoftpt.com

Physical Therapy Progress Note



Patient Name: [REDACTED]
Date of Birth: [REDACTED]
Injury/Onset/Change of Status Date: 10/01/2013
Diagnosis: ICD9: 727.61: Complete Rupture of Rotator Cuff, V58.78: Aftercare following surgery of the musculoskeletal system, NEC
Date of Original Eval: 09/15/2014
Treatment Diagnosis: ICD9: 727.61: Complete Rupture of Rotator Cuff, V58.78: Aftercare following surgery of the musculoskeletal system, NEC

Date of Progress Note: 01/20/2015
Patient #: 1
Referring Physician(s): SHAFER, BRIAN MD
Surgery: (Date/Type) 09/04/2014 Rotator cuff repair, debridement gh joint, labrum, biceps, capsule, subacromial decompression
Visit No.: 45

Subjective

Specific Physician Orders: Yes; No elevation above mouth level

History of Present Condition/Mechanism of Injury: This patient is a [REDACTED] year old male who works for Scottsdale Fire Department. Initial injury was in 2013 while doing an agility test. Conservative treatment failed which eventually lead to surgery to repair his right supraspinatus.

Current Complaints / Gains: Pt reports overall feels 93% improvement since beginning PT. He was released back onto the fire truck this last week. Shoulder feeling well and generally pain free, except for sharp lightening pain with some movements. Shoulder also feels slow when responding to quick movements.

Pain Location: R shoulder

Pain Scale: Worst: 8 Best: 0 Current: 0

Pain Description: Sharp

Pain Follow-up Plan: pain with only some mvmts, PT to increase end range mobility

Restrictions and Pain Alleviators:

Home Health Care: No

Medical History: History Of Cancer (Kidney cancer tumor, removed 9/2012)

Mental Status/Cognitive Function Appears Impaired? No

Current Medications: Prescription (Percocet), Over The Counter (Ibuprofen as needed)

Objective

Inspection

Comments Equal height B scapula in standing.

Range of Motion *Previous Findings as of 12/22/2014

Comments	Shoulder AROM: Flex: 150deg Abd: 135deg ER: 85 deg IR: 65 deg Ext: 78 deg	Shoulder AROM: Flex: 135deg Abd: 130deg ER: 75 deg IR: 55 deg Ext: 75 deg
----------	--	--

Strength *Previous Findings as of 12/22/2014

Comments	Shoulder Strength NT today slow with some proprioceptive responses to rhythmic stabilization	Shoulder Strength Flex: 4+/5 Abd: 4+/5 Ext: 4+/5 IR: 4+/5 ER: 4+/5 BI: 5-/5 Tri: 5-/5
----------	---	--

Palpation

The Desert Institute of Physical Therapy
 15953 N. Greenway-Hayden Loop, Ste #A
 Scottsdale, AZ 85260-1765
 Phone: (480)998-4848
 Fax: (480)998-2207
 www.desertinstituteofpt.com

Patient Name: [REDACTED]
 Patient #: 1
 Date of Birth: [REDACTED]
 Document Date: 01/20/2015

Physical Therapy Progress Note

Comments

Firm end feel with PROM stretching at end range flexion and abduction. Improving neuro muscular control through scapula and GH rhythm.

Palpation

Right Upper Trapezius

Tender with increased tissue tension

Assessment

Assessment/Diagnosis: Pt has made excellent gains with improved ROM, strength and function throughout R UE. Still with firm end feel at end ranges flexion and abduction. Will benefit from continued proprioceptive training for neuro feedback throughout R shoulder complex.

Patient Education: Recommended to pt to cont with pulleys at home x 3 ranges to stretch out end range of motion and mobilize scar tissue into end ranges.

Rehab Potential: Good

Patient Problems:

- Sharp 8/10 electric pain R shoulder complex, with some movements throughout the day
- Limited and firm end feel with end range flexion and abduction R UE
- Decreased proprioception and slow reaction time to neuro control through R shoulder complex

Long Term Goals:

1: (12 Weeks) | 95% | To decrease any shoulder pain and or inflammation.

To increase myofascial mobility where needed.

To promote the normalization of proper scapulohumeral rhythm.

To increase rotator cuff strength.

Patient independent with a home exercise program.

To maximize the patient's ability to perform functional and occupational activities as a Firefighter with minimal to zero complaints of pain. |

Summary/Recommendations: Cont PT 1x/wk x 4 weeks per MD recommendation to work on end range ROM, proprioception, strength and function needed for work activities and ADL's.

Plan

Frequency: 1 time a week

Duration: 4 weeks

Treatment to be provided:

Procedures

Therapeutic Activity, Neuromuscular Rehabilitation, Manual Therapy, Splinting/Taping, Patient Education

Modalities

To Improve (Pain Relief, Decrease Inflammation, Increase Blood Flow, Improve Tissue Healing)

Corrie Blackaby, PT, DPT

Corrie Blackaby, PT,DPT

License #5805

Completed by Corrie Blackaby, PT,DPT on January 20, 2015 at 1:52 pm

Powered by **WebPT**

Corvel Scan Date: 2/12/2015

The Desert Institute of Physical Therapy
15953 N. Greenway-Hayden Loop, Ste #A
Scottsdale, AZ 85260-1765
Phone: (480)998-4848
Fax: (480)998-2207
www.desertinstituteofpt.com

Daily Note / Billing Sheet



Patient Name: [REDACTED]
Date of Birth: [REDACTED]
Injury/Onset/Change of Status Date: 10/01/2013
Diagnosis: ICD9: 727.61: Complete Rupture of Rotator Cuff, V58.78: Aftercare following surgery of the musculoskeletal system, NEC
Date of Original Eval: 09/15/2014
Treatment Diagnosis: ICD9: 727.61: Complete Rupture of Rotator Cuff, V58.78: Aftercare following surgery of the musculoskeletal system, NEC
Workers' Comp Claim: 0000207919

Date of Daily Note: 01/20/2015
Patient #: 1
Referring Physician(s): SHAFER, BRIAN MD
Surgery: (Date/Type) 09/04/2014 Rotator cuff repair, debridement gh joint, labrum, biceps, capsule, subacromial decompression
Visit No.: 45
Insurance Name: INDUSTRIAL SOLUTIONS

Subjective

Specific Physician Orders: Yes; No elevation above mouth level

Current Complaints / Gains: Pt reports overall feels 93% improvement since beginning PT. He was released back onto the fire truck this last week. Shoulder feeling well and generally pain free, except for sharp lightening pain with some movements. Shoulder also feels slow when responding to quick movements.

Pain Location: R shoulder

Pain Scale: Worst: 8 Best: 0 Current: 0

Pain Description: Sharp

Pain Follow-up Plan: pain with only some mvmts, PT to increase end range mobility

Restrictions and Pain Alleviators:

Home Health Care: No

Medical History: History Of Cancer (Kidney cancer tumor, removed 9/2012)

Mental Status/Cognitive Function Appears Impaired? No

Objective

CPT® Code	Direct Timed Codes	Units
97112	Neuromuscular Re-Education See Flowsheet	1
97140	Manual Therapy	2
CPT® Code	Untimed Codes	Units
97002	PT Re-Evaluation	1

CPT copyright 2014 American Medical Association. All rights reserved.

Objective Findings

Performed RE required for insurance auth.

STM throughout R shoulder complex, pecs, fmxl release subscap. R GH jt mobs inf and post. PROM str R UE all planes. Stripping through post RTC in sidelying. Inf R 1st rib mobs with MET resisted inhalation to depress R 1st rib. Neuro: rhythmic stab R UE 90 deg flex both eyes open and closed.

Pt declined work out today as he already went to the gym this am and had to get to a work meeting.

Assessment

Assessment/Diagnosis: Pt has made excellent gains with improved ROM, strength and function throughout R UE. Still with firm end feel at end ranges flexion and abduction. Will benefit from continued proprioceptive training for neuro feedback throughout R shoulder complex.

Patient Education: Recommended to pt to cont with pulleys at home x 3 ranges to stretch out end range of motion and mobilize scar tissue into end ranges.

Rehab Potential: Good

Patient Problems:

- Sharp 8/10 electric pain R shoulder complex, with some movements throughout the day
- Limited and firm end feel with end range flexion and abduction R UE
- Decreased proprioception and slow reaction time to neuro control through R shoulder complex

Long Term Goals:

The Desert Institute of Physical Therapy
15953 N. Greenway-Hayden Loop, Ste #A
Scottsdale, AZ 85260-1765
Phone: (480)998-4848
Fax: (480)998-2207
www.desertinstituteofpt.com

Patient Name: [REDACTED]
Patient #: 1
Date of Birth: [REDACTED]
Document Date: 01/20/2015

Daily Note / Billing Sheet

1: (12 Weeks) | 95% | To decrease any shoulder pain and or inflammation.

To increase myofascial mobility where needed.

To promote the normalization of proper scapulohumeral rhythm.

To increase rotator cuff strength.

Patient independent with a home exercise program.

To maximize the patient's ability to perform functional and occupational activities as a Firefighter with minimal to zero complaints of pain. |

Plan

Instructions: Progressing Patient Next Visit

Corrie Blackaby, PT, DPT

Corrie Blackaby, PT, DPT

License #5805

Completed by Corrie Blackaby, PT, DPT on January 20, 2015 at 1:52 pm

2 of 2

Powered by **WebPT**

Corvel Scan Date: 2/12/2015



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

RECEIVED

FEB 04 2015

BY: RISK MGMT.

 City Of Scottsdale Risk Management
 7447 E. Indian School Rd. Suite 225
 Scottsdale, AZ 85258

B

CARRIER

PICA

141512-WC-196

PICA

1. MEDICARE (Medicare#) <input type="checkbox"/> MEDICAID (Medicaid#) <input type="checkbox"/> TRICARE (ID#/DoD#) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (ID#) <input type="checkbox"/> FECA BLK LUNG (ID#) <input type="checkbox"/> OTHER (ID#) <input type="checkbox"/>				1a. INSURED'S I.D. NUMBER (For Program in Item 1) [REDACTED]			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]				3. PATIENT'S BIRTH DATE MM DD YY [REDACTED]		4. INSURED'S NAME (Last Name, First Name, Middle Initial) City Of Scottsdale	
5. PATIENT'S ADDRESS (No., Street) [REDACTED]				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 7447 E Indian School Rd Suite	
CITY [REDACTED] STATE AZ		8. RESERVED FOR NUCC USE X		CITY Scottsdale STATE AZ		11. INSURED'S POLICY GROUP OR FECA NUMBER 85251	
ZIP CODE [REDACTED] TELEPHONE (Include Area Code) ([REDACTED])		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		12. INSURED'S DATE OF BIRTH MM DD YY a. INSURED'S DATE OF BIRTH MM DD YY b. OTHER CLAIM ID (Designated by NUCC) City Of Scottsdale	
d. INSURANCE PLAN NAME OR PROGRAM NAME JUDY BEREZA				10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.	
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				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) MM DD YY 12/18/14				15. OTHER DATE MM DD YY QUAL		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DOI 12/18/14				17a. NPI 17b. NPI		18. HOSPITALIZATION DATES RELAT TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		22. RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. 847.2 B. C. D. E. F. G. H. I. J. K. L.				ICD Ind.		23. PRIOR AUTHORIZATION NUMBER	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 01/14/15 01/14/15		B. PLACE OF SERVICE 11		C. EMG 99213		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER A	
E. DIAGNOSIS POINTER 95.00		F. \$ CHARGES 1.0		G. DAYS OR UNITS NPI		H. EPSDT Family Plan NPI	
I. RENDERING PROVIDER ID #		J.		K.		L.	
25. FEDERAL TAX I.D. NUMBER 86-0181654		SSN EIN <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 2011-405506		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	
28. TOTAL CHARGE \$ 95.00		29. AMOUNT PAID \$ 0.00		30. Rsvd for NUCC Use 95.00		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.) Patricia Trehame, MD 01/14/15	
32. SERVICE FACILITY LOCATION INFORMATION Occupational Health Thompson Peak 20401 N. 73rd St., Ste. 255 Scottsdale A 85255		33. BILLING PROVIDER INFO & PH # Scottsdale Healthcare Occupational Hlth P.O. Box 740137 Los Angeles CA 90074-0137 1396701454		34.		35.	

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Scottsdale Healthcare Occupational Health Department

Osborn Office
Tele: 480-882-4770
Fax: 480-882-4391

Shea Office
Tele: 480-323-3818
Fax: 480-323-3238

Airpark Office
Tele: 480-323-1880
Fax: 480-905-1136

Individual Encounter

Page: 1

Employee
Department

SSN/ID

Date 01/14/15 Time 09:36a
Time Out 10:13a
Type Physician Visit - ICA Follow U
Disposition Follow Up Needed - Full Duty

Examiner Jennifer Sosnowski, M.D.
Description Physician Visit - ICA Follow Up
Diagnosis 847.2 Lumbar Sprain
Treatment

Narrative

S: [REDACTED] is a [REDACTED] y/o male employed by COS, as a Police officer. He presents today for follow-up of his lumbar strain that occurred at work on 12/12/14. This is his 4th visit for this injury. He notes he is getting progressively better. He notes his PT advised him that he has his L SI joint is out of place and that he has core muscle weakness. He has continued with PT Biweekly for the most part. Just started more core strengthening on Friday and he is a bit more sore the day after the PT visits, but he is overall better. No pain with flexion or extension any longer - only with extended sitting or standing. He notes the pain is a dull ache - 1/10 usually, 2/10 day after PT. He has had no issue with the 20 lb lifting at work. He feels ready to return to full duty. He has PT Friday this week and then Tues, Fri next week.

O: VSS.

WNWD male in NAD, sitting comfortably in chair. rises to standing without discomfort. able to flex and extend to full AROM without discomfort. side bending and rotation without increase in pain and full ROM. mild tenderness to lower lumbar spine and L SI joint area to palpation. mild spasm L paraspinal muscles vs R.

A: lumbar strain - resolving

P: RTW full duty with f/u 1 1/2 -2 wks for reeval

1. may continue ibuprofen prn
2. Continue PT as above scheduled.

For the prescribed medication, Mr. [REDACTED] was advised on anticipated results, potential adverse reactions, possible side effects, and potential adverse effects of not taking the medication as prescribed.

Mr. [REDACTED] voiced understanding and is in agreement with treatment plan. f/u sooner if any worsening of pain with return to full duty.

Jennifer J Sosnowski, MD

Signed by JSOSNOWSKI/Jennifer Sosnowski, M.D. on 1/14/2015 at 10:21am



RECEIVED

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/15

FEB 09 2015

 CITY OF SCOTTSDALE
 7447 E INDIAN SCHOOL RD
 SUITE 225
 SCOTTSDALE AZ 85251

1415 12 - WC - 171

PICA ☐

1. MEDICARE <input type="checkbox"/> (Medicare) MEDICAID <input type="checkbox"/> (Medicaid) TRICARE <input type="checkbox"/> (ID# DoD) <input type="checkbox"/> (Number ID#) <input type="checkbox"/> (ID#) <input checked="" type="checkbox"/> (ID#)			2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]			3. PATIENT'S BIRTH DATE MM DD YY [REDACTED] SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F			4. INSURED'S NAME (Last Name, First Name, Middle Initial) CITY OF SCOTTSDALE		
5. PATIENT'S ADDRESS (No., Street) [REDACTED]			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input checked="" type="checkbox"/>			7. INSURED'S ADDRESS (No., Street) [REDACTED]			8. RESERVED FOR NUCC USE		
CITY [REDACTED] STATE AZ			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER		
ZIP CODE [REDACTED] TELEPHONE (Include Area Code) ([REDACTED])			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 due to myself or to the party who accepts assignment below. JUDY BEREZA			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. [REDACTED]			14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY 12 01 2014 QUAL 431		
15. OTHER DATE QUAL 304 MM DD YY 12 16 2014			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY [REDACTED] TO MM DD YY [REDACTED]			17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN GERALD YACOBUCCI MD			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY [REDACTED] TO MM DD YY [REDACTED]		
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9 A 171946 B _____ C _____ D _____ E _____ F _____ G _____ H _____ I _____ J _____ K _____ L _____			22. RESUBMISSION CODE _____ ORIGINAL _____		
23. PRIOR AUTHORIZATION NUMBER OKPERJUDYBEREZA			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) EPT/HCPCS MODIFIER F. CHARGES G. DAYS ON UNITS H. ESSENTIALITY I. ID. QUAL J. RENDERING PROVIDER ID. #			25. FEDERAL TAX I.D. NUMBER SSN EIN 860574338 <input type="checkbox"/> <input checked="" type="checkbox"/> C52000NJ			26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
28. TOTAL CHARGE \$ 197.16			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.) DANIELLE KROTIN PT, D PHOENIX AZ 85018-5500		
32. SERVICE FACILITY LOCATION INFORMATION STI THERAPY DIVISION 4840 E INDIAN SCHOOL 103 PHOENIX AZ 85053-2030			33. BILLING PROVIDER INFO & PH # (602) 5471836			34. 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.) DANIELLE KROTIN PT, D PHOENIX AZ 85018-5500			35. 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.) DANIELLE KROTIN PT, D PHOENIX AZ 85018-5500		

Patient: 76367 [REDACTED]
DOB: [REDACTED]
SSN: [REDACTED]

Date: 01/14/2015 09:00
Provider: Gonzales, Justin PTA
Encounter: Therapy Visit

NPI#1518925569

Clean # 14152 LWC 171

SUBJECTIVE

Diagnosis: R Knee Pain
Visit #: 10
Work Status: FT/FD

Patient states that he feels like his knee feels as good as it did before his injury. Patient states that though his legs are still not as strong as he would like, that he feels ready to strengthen his legs on his own and D/C from care.

OBJECTIVE

AREA TREATED: R knee

Activities listed below were performed in chronological order, both separately and distinctly.

Therapeutic exercise/procedure per flow sheet (60 min) to improve mobility, ROM, flexibility, strength, stabilization

Manual (15min) to (R knee) in (supine) STM of the posterior leg including the HS, gastroc, and ITB in prone; supine, STM of quad, and ITB all to improve tissue extensibility

IFC/IP to R knee in long sitting to decrease pain and inflammation.

Review of HEP/SCHM

ASSESSMENT

Patient demonstrates competence in recall of his ther ex program, performed today as he would in his HEP. Patient requires verbal cues to limit anterior translation with closed chain strengthening. Patient is able to identify compensatory technique and correct. Patient presents with minimal TTP and tissue hypertonicity along upper leg and surrounding knee.

PLAN

D/C from Care

Justin Gonzales PTA

Electronically signed by: Justin Gonzales PTA Date: 02/03/2015 13:26

2502963500

TRANSACTION REPORT

JAN/14/2015/WED 10:13 AM

FAX(TX)

#	DATE	START T.	RECEIVER	CON. TIME	PAGE	TYPE/NOTE	FILE
001	JAN/14	10:12AM	6022771074	10:00:39	3	MEMORY OK	SG3 3552



PROGRESS NOTE SUMMARY

1-14-2015

Patient Name: [REDACTED]

D.O.B.: [REDACTED]

Diagnosis: R knee pain

NPI#1518925569

Claim # 1415126X171

Dear Dr. Gerald Yacobucci:

Here is an updated progress report for your patient: [REDACTED] He is attending therapy at our STI Therapy Division Arcadia.

Compliance / Attendance:

- ☒ Excellent. Attended all authorized visits (100%).
☐ Good. Has attended at least 80% of scheduled appointments.
☐ Fair. Has attended 60% or more of scheduled appointments. (If used provide explanation)
☐ Poor. Has attended 60% or less of scheduled appointments. (If used provide explanation)
☐ Other. Explain:

Work Status: ☒ Full Duty ☐ Light/Modified ☐ Off work ☐ Unemployed ☐ Student ☐ Retired

SUBJECTIVE REPORT

Diagnosis: R knee pain

Visits since start of care#: 7

C/NS since date of evaluation: 0/0

Patient reports feeling very limited knee symptoms. Patient states that he feels strong enough to complete full simulated functional job duties in clinic today.

OBJECTIVE FINDINGS

AREA TREATED: R knee

Activities listed below were performed in chronological order, both separately and distinctly.

Therapeutic activity per flow sheet (60 min) to simulate all aspects of job with focus on techniques to decrease chance of re-injury.

Treatment / Therapy provided:

<input checked="" type="checkbox"/> Therapeutic modalities	<input checked="" type="checkbox"/> Manual Therapy	<input checked="" type="checkbox"/> Ultrasound	<input checked="" type="checkbox"/> Work Conditioning
<input checked="" type="checkbox"/> Therapeutic exercises	<input checked="" type="checkbox"/> Strength/Conditioning	<input checked="" type="checkbox"/> Gait Training	<input type="checkbox"/> Traction
<input type="checkbox"/> Orthopedic appliances	<input type="checkbox"/> Taping	<input checked="" type="checkbox"/> Neuromuscular Re-Ed	<input type="checkbox"/> Other:

ASSESSMENT

Patient is able to reverse hinge and carry unilateral and bilateral toolbox, each containing 40lbs. Patient completes simulated crouching, kneeling and hip hinging without compensation. To complete EMS portion, Patient successfully simulates gurney lift with 90lbs from floor to ground. In first fire fighter simulation with patient in full turnouts and gear, Patient completes hose related tasks. Patient is successful in dragging and pulling a hose attached to a sled with 150lbs. Charged line simulation also completed with sled and 150lbs, 10 reps for each task. Patient completes simulated forced entry with focus on pivot and rotational movement. Patient remains in turnouts for final fire fighter simulation. Patient completes simulated high rise training up stairs for 5 minutes with attached high rise packs. Patient is able to crawl in confined space simulation without pain during kneeling. Patient successfully simulates overhead ceiling breach simulation pushing and pulling 90 lbs x20 each. Patient finishes with waist to overhead lifts of 45lbs. Patient completes full program without c/o increased pain in knee. Patient continues to fatigue with activities and uses compensatory



460515

GOALS:

- Pt will demonstrate indep HEP/SCHM (75% met)
- Pt will sit x 60 min without c/o pain (met)
- Pt will perform squatting 100% depth without c/o increased pain and demonstrating correct technique (met)
- Pt will ascend/descend into fire truck without c/o increased pain (met)
- Pt will perform push/pull 150 lbs and lift/carry 75 lbs without c/o increased pain (met)
- Pt will perform activities related to job duties without c/o increased pain or stiffness (75% met)

SUMMARY, RECOMMENDATIONS and PLAN:

Continue with PT 3x/week x one more week; please advise with any change in POC. Thank you. Please advise and certify plan below. Thank you for your confidence in me and for the continued opportunity to work with Christian McDaniel.

Respectfully,

Danielle Krohn
Danielle Krohn PT #9643, DPT
NPI: 1841576402
ph: (602) 956-2850

Please kindly fax back to (602) 956-2877. Please call the clinic with any questions or inquiries. Thank You

PHYSICIAN CERTIFICATION: (TO BE COMPLETED BY PHYSICIAN)

Patient Name: [REDACTED] Next Physician Appt: 1/16/15 or ☐ N/A
RECOMMENDATIONS: ☒ Cont. as above: 1 x wk. x 1 wks. ☐ Revise treatment plan as follows:

I certify the needs for those services furnished under this plan of care.

Physician Signature: *Gerald Yacubov*

Gerald Yacubov MD

NPI: 1649267304

Date: 1-13-2015

Page 2

* 1/16/15 - MIMI**NPI#1518925569***Clear # 141512 WSC171*

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

RECEIVED

CITY OF SCOTTSDALE 0010
7447 E INDIAN SCHOOL
STE 225
SCOTTSDALE AZ 85251

B

PICA

PICA

1. MEDICARE (Medicare #) <input type="checkbox"/>		MEDICAID (Medicaid #) <input type="checkbox"/>		TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/>		CHAMPVA (Member ID) <input type="checkbox"/>		FECA BLK LUNG (SSN or ID) <input checked="" type="checkbox"/>		OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 050609-WC-074											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) [REDACTED]										SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial) [REDACTED]											
5. PATIENT'S ADDRESS (No., Street) [REDACTED]										6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) [REDACTED]											
CITY [REDACTED]				STATE AZ				CITY [REDACTED]				STATE AZ											
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) [REDACTED]										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE		11. INSURED'S POLICY GROUP OR FECA NUMBER DOI 9/1/05 a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME CITY OF SCOTTSDALE c. INSURANCE PLAN NAME OR PROGRAM NAME NO OTHER COVERAGE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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 [REDACTED] DATE 09 27 2014										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 [REDACTED]													
14. DATE OF CURRENT: MM DD YY [REDACTED]				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY [REDACTED]				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY [REDACTED]															
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DOI 9/01/05				17a. [REDACTED] 17b. NPI [REDACTED]				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY [REDACTED]															
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES [REDACTED]				22. MEDICARE RESUBMISSION CODE [REDACTED]															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 354.2 2. 729.5 3. [REDACTED] 4. [REDACTED]										23. PRIOR AUTHORIZATION NUMBER [REDACTED]													
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 OF WEEK		H. I.D. QUAL		J. RENDERING PROVIDER ID. #							
1 09/26/2014		11		99213		12		157.95		1		NPI		1750373718									
2												NPI											
3												NPI											
4												NPI											
5												NPI											
6												NPI											
25. FEDERAL TAX I.D. NUMBER 061650930				26. PATIENT'S ACCOUNT NO. 2793771				27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. TOTAL CHARGE \$ 157.95				29. AMOUNT PAID \$ 0.00				30. BALANCE DUE \$ 157.95			
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.) H62757 PETER K KUBITZ DO SIGNED 09 27 2014								32. SERVICE FACILITY LOCATION INFORMATION ARIZONA CENTER FOR PAIN RE 20950 N TATUM BLVD PHOENIX AZ 85050 a. 1437234465 b. [REDACTED]								33. BILLING PROVIDER INFO & PH. # (480) 222 7246 MARK J RUBIN MD PC 20950 N TATUM BLVD 300 PHOENIX AZ 85050 a. 1437234465 b. [REDACTED]							

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WC22826

WCMS-1500CS

Corvel Scan Date: 2/12/2015



Mark J. Rubin, MD * Aaron Rodarte, PA-C
 J. Julian Grove, MD * Brittany Jones, PA-C
 Peter K. Kubitz, DO * Micah Lasley, PA-C

20950 N TATUM BLVD, SUITE 300
 PHOENIX, AZ 85050
 Phone: (480) 222-7246
 Fax: (480) 222-7271
 www.azcpr.com

Patient #: WC22826

DOB: [REDACTED]

Date of Encounter: 09/26/2014 07:54 AM

History of Present Illness

The patient is a [REDACTED] year old female who presents for routine medical follow up. The pain is in the left elbow. Pain scores include a current pain level of 3/10, a minimum pain level of 2/10 and a maximum pain level of 5/10. Patient reports he/she is always compliant with prescribed treatment regimen. The patient has experienced some relief. Treatment side effects include: none reported. The patient's level of function has improved slightly. The character of the pain is described as no change. The patient's goal of today's visit is to make no changes to treatment at this time. The patient is not currently attending physical therapy at this time.

Ms. [REDACTED] returns to clinic today for a 6 month reevaluation for ongoing left elbow pain. She continues to find a significant management with her previously prescribed medications, which she takes on a regular basis. She is here today primarily for refills of her medications.

Past Medical History
 Medial epicondylitis
 Lesion of ulnar nerve
 Arm pain

Past Surgical
 No Surgeries

Allergies
 No Known Drug Allergies 04/02/2014

Medication History
 Medications Reconciled.

Family History
 Arthritis
 Heart Attack
 Diabetes

Social History
 Tobacco use: Current every day smoker
 Non Drinker/No Alcohol Use
 No Drug Use
 Current Work/Study Status: Full-time
 Living Situation: Lives with spouse
 Marital status: Married

Diagnostic Studies
Cervical Spine MRI (09/21/2007); 1. Straightening of the normal cervical lordosis.
 2. Mild bulging disc at C5-6.
 3. Mild bulging disc at C6-7.
 4. Tiny right paracentral disc protrusion at C7-T1.
 5. Otherwise, negative MRI of the cervical spine and cervical cord.

* Impression from report, please see scanned report for full details *

Patient #: WC22826

DOB: [REDACTED]

Thursday, February 5, 2015

Page 1 / 3

Corvel Scan Date: 2/12/2015

Review of Systems**General:** Present- **Night Sweats**. Not Present- Chills, Fatigue, Fever, Tiredness, Weight Gain and Weight Loss.**Skin:** Not Present- Itching and Rash.**HEENT:** Present- **Vertigo**. Not Present- Visual Disturbances, Ringing in the Ears and Seasonal Allergies.**Respiratory:** Not Present- Difficulty Breathing.**Cardiovascular:** Not Present- Chest Pain and Palpitations.**Gastrointestinal:** Not Present- Abdominal Pain, Constipation and Diarrhea.**Musculoskeletal:** Present- **Joint Pain**. Not Present- Joint Stiffness, Joint Swelling and Muscle Weakness.**Neurological:** Present- **Dizziness**. Not Present- Fainting, Headaches, Incontinence Stool, Incontinence Urine, Numbness, Trouble walking, Unsteadiness and Weakness.**Psychiatric:** Not Present- Anxiety, Depression, Insomnia, Memory Loss and Suicidal Ideation.**Hematology:** Present- **Easy Bruising**. Not Present- Abnormal Bleeding and Blood Clots.**Vital Signs****Weight:** 216 lb **Height:** 62 in**Body Mass Index:** 39.51 kg/m²**Physical Exam**

The physical exam findings are as follows:

General**Mental Status** - Alert. **General Appearance** - Alert and oriented X3, Well developed and well nourished, Cooperative, Well groomed and Consistent with stated age. Not in acute distress. **Orientation** - Oriented X3 and Oriented X4. **Build & Nutrition** - Well nourished and Well developed. **Posture** - Normal posture. **Hydration** - Well hydrated. **Voice** - Normal.**Integumentary****General Characteristics:** Overall examination of the patient's skin reveals - no rashes. **Color** - normal coloration of skin.**Head and Neck****Head****Head Shape** - Normocephalic and atraumatic..**Trachea** - midline.**Neurologic****GAIT** : - Normal.**MOBILITY AIDS:** - None.**SENSATION:** - Sensation is normal in the upper limbs to light touch.**STRENGTH UPPER LIMBS:** - Normal throughout.**Neuropsychiatric**

Mental status exam performed with findings of - able to articulate well with normal speech/language, rate, volume and coherence, thought content normal with ability to perform basic computations and apply abstract reasoning, associations are intact, no evidence of hallucinations, delusions, obsessions or homicidal/suicidal ideation, demonstrates appropriate judgment and insight, displays ability to recall recent and remote events and fund of knowledge is intact and attention span and ability to concentrate are normal.

Musculoskeletal*Similar tenderness over the left medial epicondyle and cubital tunnel with increased sensitivity rating down her forearm on the ulnar aspect towards the 4th and 5th digits with percussion over the cubital tunnel. Range of motion of the left elbow is not significantly impaired. Mild tenderness over the right medial epicondyle.*

Assessment & Plan
Arm pain

Lesion of ulnar nerve

Medial epicondylitis

- Started Lyrica 150MG, 1 (one) Capsule PO Q 12 HOURS, #60, 30 days starting 09/26/2014, Ref. x5.
- Started Diclofenac Sodium 75MG, 1 (one) Tablet DR PO Q 12 HOURS, #60, 30 days starting 09/26/2014, Ref. x5.
- Started Voltaren 1%, 1-2 grams 2-4 times daily to affected area, 2 Tube, 30 days starting 09/26/2014, Ref. x5.
- **Medication Plan:** No change to medications, continue to monitor for complications.
- **Return Visit:** Patient will follow up in 6 months to determine outcome and future treatment course. Patient advised to call with any questions or concerns.

I reviewed the options with the patient in detail today. She continues to have a great deal of tenderness over her left elbow and pain is elicited particularly with external and internal rotation. Based on her continued compliance, efficacy and lack of adverse side effects I'll refill her medications x6 months. I have reminded her of the importance of taking her diclofenac with food. We will plan on following up with her in 6 months or sooner if needed.

Over 15 minutes spent involved in patient encounter today, >50% in counseling and coordinating care.

****Dragon dictation software was used to generate this document. Grammatical and/or phonetic errors may be present.****

History & Physical Note


Chart Review Note (Peter K Kubitz, DO; 10/24/2014 11:40:18 AM)

I have reviewed the history and physical note and findings.

Completed and submitted for review by Micah Lasley, PA-C 10/24/2014 11:40:18 AM

Signed electronically by Peter K Kubitz, DO 10/24/2014 11:40:18 AM

Electronically signed by:



Peter K Kubitz DO