ExamWorks

Claimant : Bayani Dillard

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Flushing Hospital and Medical Center

Job Description & Performance Evaluation

Employee Information

Name: Bagani Dillard

Employee ID#: 21070.

Position Title: EMT

Department: PREHOSPITAL CARE

Cost Center Number: 6601

FLSA Status: Union Non-Exempt

Date of Hire: 3-5-03

Date Appointed to Current Title:

Period Covered by Evaluation: June 1, 2016 - June 1, 2017

Type of Evaluation: ANNUAL

REQUIRED LICENSES/CERTIFICATIONS

New York State Department of Health EMT Card
Driver License issued by New York, New Jersey, Pennsylvania, or Connecticut.

JOB HAZARDS / PHYSICAL DEMANDS

Extended periods of listening concentration
Fine motor dexterity required
Shifting and changing priorities.
Heavy lifting, pulling, pushing, stretching, or physical exertion is required.
Ability to lift, carry, and balance up to 125 pounds (250 pounds with assistance), using patient moving equipment required.
Ability to be unaffected by loud noises and flashing lights required.
Ability to calculate weight and volume ratios as applicable.
Possesses good manual dexterity with ability to perform all tasks related to the highest quality patient care.
Ability to bend, stoop and crawl on uneven terrain as required.
Ability to withstand varied environmental conditions such as extreme heat, cold, and moisture required.
Ability to work in low light situation and confined spaces required.

	☐	☐	☐

Core Responsibilities	*(Check only one box per line)*		
	Does Not Meet Standards	Meets Standards	Exceeds Standards
Uses prescribed techniques and equipment to assess patients and obtain vital signs.	☐	☑	☐
Provides all necessary treatment following established protocols.	☐	☑	☐
Asks for medical direction from medical control physician and carries out medical control orders as appropriate.	☐	☑	☐
Provides additional emergency care following established protocols.	☐	☑	☐
Selects appropriate carry device and mode of movement to the vehicle and assists with lifting, carrying and safely loading patient into ambulance.	☐	☑	☐
Determines appropriate medical facility to which patient will be transported.	☐	☑	☐
Transports patient to medical facility providing ongoing medical care as necessary enroute.	☐	☑	☐
Follows proper procedures for hospital notification and transition of care, safely transferring patient to receiving facility.	☐	☑	☐
Complies with regulations in handling deceased, notifies authorities and arranges for protection of property and evidence at scene.	☐	☑	☐
Replaces supplies, properly disposes of medical waste.	☐	☑	☐
Properly cleans contaminated equipment according to established guidelines.	☐	☑	☐
Safeguards vehicle and equipment and responsible for reporting any lost, stolen, or broken equipment to a Supervisor immediately	☐	☑	☐
Completes all paperwork in a neat, accurate, and timely manner, including, but not limited to ePCR's, medication logs, gas receipts, incident reports, UAL's, and required statements.	☐	☑	☐
Adheres to all hospital rules and regulation, Departmental policy and FDNY-EMS rules and regulations relating to voluntary hospital ambulance departments.	☐	☑	☐
Maintains up to date certifications and licenses without lapses. Reports immediately to a supervisor any loss of driver's license and/or	☐	☑	☐

Uses appropriate communication channels, consults with supervisor about actual or potential issues.	☐	☑	☐
Communicates and shares information in a timely manner.	☐	☑	☐
Answers telephone calls timely in a caring and respectful manner, and adheres to the established telephone answering protocols.	☐	☑	☐
Works effectively with people/groups across organizational boundaries, maintaining excellent working relationships with co-workers, superiors, and the public.	☐	☑	☐
OVERALL RATING:	Does Not Meet Standards	Meets Standards	Exceeds Standards
	☐	☑	☐

Supervisor's Comments: Note successes or trouble spots and any plans for improvement, if required.

Customer Service	*(Check only one box per line)*		
	Does Not Meet Standards	Meets Standards	Exceeds Standards
Engages in behavior that is conducive to the achievement of the Medical Center's customer service goals.	☐	☑	☐
Provides service in a manner that fosters excellent outcomes.	☐	☑	☐
Interacts with customers (i.e. patients, residents, families, visitors, and staff members), in a way that projects a desire to be helpful and makes the customers feel that their concerns or issues have been understood and will be acted upon.	☐	☑	☐
Grooming and attire projects a professional image and is appropriate and consistent with the dress code policy for the position held.	☐	☑	☐
Conduct/behavior is professional, courteous, tactful, respectful, and is appropriate and consistent with the Medical Center's anti-disruptive behavior policies.	☐	☑	☐
OVERALL RATING:	Does Not Meet Standards	Meets Standards	Exceeds Standards
	☐	☑	☐

Educational/Professional Development	*(Check only one box per line)*	
	Does Not Meet Standards	Meets Standards
Utilizes learning resources and attends mandatory workshops and seminars consistent with job duties and responsibilities.	☐	☑
Meets regulatory, licensure and/or annual health assessment requirements.	☐	☑
Self-identifies his/her learning needs.	☐	☑
Participates in the development of other staff members as required or as appropriate. (teamwork)	☐	☑
If not meeting standards, indicate plan of correction and follow-up date:		

Corporate Compliance	*(Check only one box per line)*	
	Does Not Meet Standards	Meets Standards
Adheres to the Medical Center's Code of Conduct and Compliance Program, including HIPAA Policies and Procedures.	☐	☑
Adheres to the Medical Center's Policies and Procedures addressing the Organization's commitment to compliance and specific policies addressing areas of potential fraud and abuse, as well as all regulatory requirements.	☐	☑
Decisions are based on the highest ethical standards, and a culture of trust and respect for others is fostered by fair and ethical behavior towards others.	☐	☑
Completes required re-orientation and corporate compliance training prior to due date for completion.	☐	☑
If not meeting standards, indicate plan of correction and follow-up date:		

Overall Evaluation

Performance Factors	*For each performance factor, please check the box which corresponds with the overall rating in the performance assessment section of the evaluation.*		
	Does Not Meet Standards	Meets Standards	Exceeds Standards
Core Responsibilities	☐	☑	☐
Productivity	☐	☑	☐
Communication / Relationships	☐	☑	☐

Age Specific Competencies
(For staff who assess, treat, or provide care to patients of different ages)
(Check all patient populations served)

☐ Neonatal/Infants (0-1 year)	☐ Pediatric/Childhood (1-12 years)	☐ Adolescent (13-18 years)
☐ Adult (18 – 65 years)	☐ Geriatric (65+ years)	☑ All Age Groups

Age Specific Competencies	Does Not Meet Standards	Meets Standards
Effectively communicates using age-appropriate techniques. Method of Validation: ☑ DO ☐ PR ☐ CR ☐ CT ☐ OTHER _____	☐	☑
Maintains a safe environment appropriate to patient age. Method of Validation: ☑ DO ☐ PR ☐ CR ☐ CT ☐ OTHER _____	☐	☑
Assures that procedures/treatments are appropriate for age and/or weight of patient. Method of Validation: ☑ DO ☐ PR ☐ CR ☐ CT ☐ OTHER _____	☐	☑
Uses equipment appropriate to the age and/or weight of the patient. Method of Validation: ☑ DO ☐ PR ☐ CR ☐ CT ☐ OTHER _____	☐	☑
☐ *ASSESSMENT OF AGE SPECIFIC COMPETENCIES IS NOT REQUIRED FOR THIS POSITION.*		

METHODS OF VALIDATION:
- DO: Direct Observation
- PR: Peer Review
- CR: Chart Review

ACTION PLAN

AREAS NEEDING IMPROVEMENT (Knowledge, Behavior, Skills)	PLAN FOR IMPROVEMENT	TARGET DATE

EMPLOYEE SIGNATURE: _____ DATE: _____

DEPARTMENT HEAD/
DESIGNEE SIGNATURE: _____ DATE: 0-27-17

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS
----------X

Index No.: 708782/2022

BAYANI DILLARD,

Plaintiff,

-against-

MILLER SYSTEMS, LTD d/b/a MCDONALD'S RESTAURANT, ALLIED ENTERPRISES NY, LLC, ALLIED ENTERPRISE CO., and MCDONALD'S CORPORATION,

Defendants,
----------X

VERIFIED BILL OF PARTICULARS

Plaintiff, **BAYANI DILLARD**, by his attorneys, EPSTEIN SHAKH, LLP, responding to the demands of Defendants, **MILLER SYSTEMS, LTD d/b/a MCDONALD'S RESTAURANT** and **MCDONALD'S CORPORATION**, for a Verified Bill of Particulars, dated May 26, 2022 and December 9, 2022, allege(s), upon information and belief:

1. The date of the occurrence is June 11, 2021at approximately 2:30 p.m.

2. The location of the subject occurrence is 160-11 Willets Point Boulevard, Flushing, New York 11357, premises commonly known as McDonalds Restaurant. Specifically, the men's bathroom located therein.

3. Plaintiff was caused to slip and fall on a wet surface in the men's bathroom at the defendants' premises.

4. The aforesaid occurrence was caused wholly and solely by the negligence of answering defendants by and through its agents, servants and/or employees, in the ownership, operation, management, maintenance, construction, control, and inspection of the aforesaid premises, and specifically the floor surfaces located at the above-referenced location; in causing, allowing, and permitting said premises to be, become and remain for a period of time after notice, either actual or constructive, in a slippery floor, dangerous and/or hazardous condition; in causing, allowing and permitting a trap to exist at the aforesaid premises; in failing to restore/repair/replace and/or maintain the floor surfaces free of slipping hazards at the aforesaid premises to a reasonably safe and proper condition; in failing to maintain, repair said premises; in failing to maintain said floor; in causing, allowing and permitting an obstruction to plaintiffs safe passage at said location; in causing; allowing and permitting the existence of conditions which constituted a trap, nuisance, menace and danger to lawful pedestrians, including the plaintiff herein; in failing to have taken necessary steps and measures to have prevented the above mentioned location from being used while in said dangerous condition; in failing to ensure that the defendants' premises are adequately illuminated; in failing to give plaintiff adequate and timely signal, notice, or warning of said dangerous and defective condition; in negligently and carelessly causing and permitting the above location to be and remain in said

dangerous and defective condition for an unreasonable length of time, resulting in a foreseeable hazard to the plaintiff and others; in failing to take suitable and necessary precautions for the safety of persons at said location; in failing to erect barricades, barriers, or warning signs at said location; and in failing to maintain the floor of said location in a safe condition.

5. It is alleged that the defendants violated Chapters 3, 4 and Chapter 5 of the 2020 Property Management Code of the State of New York, and specifically: Section 305.1; Section 402.3; Section 503.4.

6. Plaintiff claims that the defendants were negligent in allowing a dangerous/hazardous condition to exist upon the subject premises, and same consisted of wet and slippery condition; presence of liquid/fluid upon the floor at the premises; defective plumbing; floor slip resistance below the acceptable threshold; defective flooring surfaces. The condition complained of herein was present in the men's bathroom, located upon the defendants' premises.

7. Plaintiff objects to the inquiry demanding the identification of the alleged defect as one of "defect is one of design, materials, installation, inspection, maintenance, repair or other" is improper for a bill of particulars in that same is an interrogatory, seeks expert opinion, and/or seeks evidentiary material beyond the scope of CPLR §3043(a), (*See* Harris v. Ariel Transportation Corp., 37 A.D.3d 308 (1st Dept. 2007); *see also* Patterson v. Jewish Hospital and Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194 (Sup. Ct. Kings Cty. 1978).

8. Plaintiff claims that the defendants, their agents, servants, and/or employees caused the said defect(s). Plaintiff reserves the right to amend and/or supplement this response upon completion of defendants' depositions.

9. Plaintiff objects to the inquiry demanding the identification of duration/length of time the subject defect existed as improper for a bill of particulars in that same is an interrogatory, seeks expert opinion, and/or seeks evidentiary material beyond the scope of CPLR §3043(a), (*See* Harris v. Ariel Transportation Corp., 37 A.D.3d 308 (1st Dept. 2007); *see also* Patterson v. Jewish Hospital and Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194 (Sup. Ct. Kings Cty. 1978).

10. Plaintiff objects to the inquiry demanding the identification of the defect as latent or paten, as same is an interrogatory, seeks expert opinion, and/or seeks evidentiary material beyond the scope of CPLR §3043(a), (*See* Harris v. Ariel Transportation Corp., 37 A.D.3d 308 (1st Dept. 2007); *see also* Patterson v. Jewish Hospital and Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194 (Sup. Ct. Kings Cty. 1978).

11. Plaintiff objects to the inquiry demanding a statement describing "how said defect was instrumental in producing the Plaintiff's injuries" as improper for a bill of particulars in that same is an interrogatory,

seeks expert opinion, and/or seeks evidentiary material beyond the scope of CPLR §3043(a), (*See* Harris v. Ariel Transportation Corp., 37 A.D.3d 308 (1st Dept. 2007); *see also* Patterson v. Jewish Hospital and Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194 (Sup. Ct. Kings Cty. 1978).

12. The defendants, their servants, agents and/or employees had actual notice of the said dangerous, defective, and unsafe condition. Without in any way conceding that actual notice is a necessary prerequisite to suit herein, plaintiff claims that the defendant, its agents, servants and/or employees, the exact identities of whom are not presently known or available to the plaintiff, and subject to further discovery proceedings, had actual notice of the said dangerous, unguarded, defective and unsafe conditions and did create said dangerous, unguarded and defective conditions, and were present upon said premises by their servants, agents and/or employees, and actual notice was given to the defendant, their servants, agents and/or employees prior to this accident. Furthermore, actual notice is presumed and is imputed to the defendant herein by virtue of the subject defective condition having been created by the said defendant. Plaintiff reserves the right to further respond to this demand upon completion of further discovery proceedings and depositions. Constructive notice is claimed in that the alleged defective/dangerous condition existed for such a substantial period of time that the defendants, their agents, servants and/or employees should have known such a defect/dangerous condition existed and/or if the defendants had routinely inspected the above-mentioned location, the above defect and/or dangerous condition would have/should have been easily discovered. It will be further alleged that, at the very least, the above mentioned dangerous/defective condition existed for a substantial period of time continuing and up to and including the date and time of the subject accident.

13. Plaintiff objects to the inquiry demanding a statement describing whether plaintiff "had been on the premises prior to the time of the incident including the number of times, the dates thereof, the duration of said visits, the last time" as improper for a bill of particulars in that same is an interrogatory, seeks expert opinion, and/or seeks evidentiary material beyond the scope of CPLR §3043(a), (*See* Harris v. Ariel Transportation Corp., 37 A.D.3d 308 (1st Dept. 2007); *see also* Patterson v. Jewish Hospital and Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194 (Sup. Ct. Kings Cty. 1978).

14. Plaintiff objects to the inquiry demanding a statement describing "lighting conditions in the vicinity of the incident at the time of the incident and if any defect with regard to lighting is to be claimed against the defendants" as improper for a bill of particulars in that same is an interrogatory, seeks expert opinion, and/or seeks evidentiary material beyond the scope of CPLR §3043(a), (*See* Harris v. Ariel Transportation Corp., 37 A.D.3d 308 (1st Dept. 2007); *see also* Patterson v. Jewish Hospital and Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194 (Sup. Ct. Kings Cty. 1978).

15. Plaintiff objects to the inquiry demanding a statement describing "whether conditions were a factor in causing the incident alleged in the Complaint, and, if so, specify those weather conditions which plaintiff will claim contributed to the incident" as improper for a bill of particulars in that same is an interrogatory, seeks expert opinion, and/or seeks evidentiary material beyond the scope of CPLR §3043(a), (*See* Harris v. Ariel Transportation Corp., 37 A.D.3d 308 (1st Dept. 2007); *see also* Patterson v. Jewish Hospital and Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194 (Sup. Ct. Kings Cty. 1978).

16. Plaintiff objects to the inquiry demanding a statement as to whether "one or more prior incidents resulted from such defect, specify the date, time, circumstances, and names and addresses of persons involved in each prior incident" as improper for a bill of particulars in that same is an interrogatory, seeks expert opinion, and/or seeks evidentiary material beyond the scope of CPLR §3043(a), (*See* Harris v. Ariel Transportation Corp., 37 A.D.3d 308 (1st Dept. 2007); *see also* Patterson v. Jewish Hospital and Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194 (Sup. Ct. Kings Cty. 1978).

17. Plaintiff was walking at the moment of the incident.

18. As a result of the subject accident, the plaintiff sustained the following injuries:

RIGHT KNEE:

a. Internal derangement of the right knee joint;

b. Stiffness and clicking in the knee;

c. Weakness, crepitus, swelling, tightness and stiffness of the knee;

d. Posttraumatic edema in subcutaneous tissues;

e. Fluid surrounding the popliteus tendon at the postlateral corner;

f. Tear on the undersurface of the mid body of the medial meniscus and partial anterior subluxation of the anterior horn of the medial meniscus ventral to the margin of the medial tibial plateau;

g. Antalgic gait;

h. ***Surgery***: Right knee arthroscopic surgery, partial medial meniscectomy, chondroplasty pf patella, chondroplasty of femoral trochlea, chondroplasty of medial femoral condyle, chondroplasty of medial tibial plateau, and major synovectomy of the right knee, performed on January 10, 2022, by Gus Katsigiorgis, M.D., at Long Island Jewish Hospital Valley Stream;

i. Postoperative scarring;

j. Recommendation for knee replacement surgery;

k. Permanent loss of range of motion in the right knee;

l. Need for knee bracing;

m. Need for use of ambulatory devices;

n. Severe pain and suffering.

Upon information and belief, all of the above injuries are permanent and continuing in nature, except those of a superficial nature that may have healed at the present time. All of the aforementioned injuries, resulting disabilities, aggravations, exacerbations and involvements are associated with further soft tissue injuries to the areas traumatically affected, including: injury, tearing, derangement and damage to the associated muscle groups, ligaments, tendons, cartilage, blood tissue, epithelial tissue, all concomitant to the specific injuries and related to the specific portions mentioned herein above, with resultant scarring, hemorrhage, pain, ecchymosis, deformity and disability; stiffness, weakness and partial restriction and limitation of motion, pain on motion and loss of use of the above-mentioned parts; and atrophy. If it is claimed by Defendants that any of the above stated injuries are pre-existing and/or degenerative in nature, it is hereby alleged that said injuries were activated, aggravated and/or exacerbated as a result of the complained of incident. It is claimed that these injuries have weakened those parts of the body and rendered them more susceptible to future trauma so that they have prevented and will in the future prevent Plaintiff from engaging in some or all physical activities involving movements of those injured parts of Plaintiff's body, and including, but not limited to physical exercise for health or pleasure, sports and business activities which Plaintiff formerly engaged in, and limitations of movement involved in the course of daily living. Inactivity is detrimental to the Plaintiff's health and well-being. It is further claimed that these injuries have and will diminish Plaintiff s future earning capacity, will deprive Plaintiff of future earning capacity, future earning opportunities, business opportunities, raises, promotions, advancements, fringe benefits, health, dental and/or vision benefits, contributions to retirement and/or other benefits, social security retirement income, pension and/or other income, training and experience which could benefit the Plaintiff in retaining and obtaining future positions or business opportunities. Plaintiff intends to make a claim for the value of household services, including household cleaning, laundry, shopping, food preparation, caring for children or adults, household repairs and servicing the needs of others in or about the home as part of the loss sustained due to the injuries suffered herein, Plaintiff suffered, still suffers, and upon information and belief, will continue to suffer pain, discomfort and limited movement of the injured portions of his body, including the adjacent and surrounding muscles, tendons, nerves, joints, fascia, vessels and soft tissues. Plaintiff reserves the right to prove any and all further consequences and any and all further and future medical expenses.

19. All plaintiff's providers are identified under a cover titled plaintiff's Response to Demand for Authorizations.

20. As a result of the subject accident, the plaintiff was confined to:

a. Hospital – one (1) day;
b. Bed – one (1) day;
c. Home – two (2) weeks.

21. At the time of the subject accident, the plaintiff was 45 years old. Plaintiff's date of birth is [redacted] 1976. Plaintiff's Social Security Number is [redacted]-9312. Plaintiff's residence address is 52 Charles Street, Malverne, New York 11565. Plaintiff is married.

22. Plaintiff was disabled from work for thirteen (13) months. Plaintiff was employed as a New York State Emergency Medical Technician (EMT) by Flushing Hospital Medical Center, 4500 Parsons Boulevard, Flushing, New York 11355. Plaintiff's base annual income is $58,840.00, not inclusive of union benefits afforded through SEIU 1199. Plaintiff was partially reimbursed for loss of income by New York State Insurance Fund (plaintiff's employer's workers compensation carrier) in the amount of $38,362.27. Accordingly, plaintiff sustained economic loss in the amount of $20,477.73.

23. Not Applicable. Plaintiff was not a student at the time of the subject accident.

24. Plaintiff made a claim for worker's compensation benefits through New York State Insurance Fund, under Claim No.: 73141129-110 (WCB No.: G3051719).

25. Not Applicable.

26. Plaintiff is not claiming special damages associated with costs for medical treatment or services. However, plaintiff claims as special damages $56,394.07, which has been asserted as a lien by the New York State Insurance Fund.

27. See Item 26.

28. Not Applicable.

29. Improper demand.

PLEASE TAKE FURTHER NOTICE, that the plaintiff reserves the right to serve an Amended and/or Supplemental Bill of Particulars in connection with all claims including those of continuing Special Damages and disabilities.

Dated: February 26, 2023
Melville, New York

EPSTEIN SHAKH, LLP
Attorneys for Plaintiff

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ATTORNEY CERTIFICATION

I, **DEBORAH J. EPSTEIN, ESQ**., hereby certify under penalty of perjury and as an officer of the court that, to the best of my knowledge, information, and belief, formed after an inquiry reasonable under the circumstances, the presentation of the attached paper or the contentions therein are not frivolous as defined in subsection (c) of section 130-1.1 of 22 NYCRR.

Dated: February 26, 2023
Melville, New York

Deborah J. Epstein
DEBORAH J. EPSTEIN, ESQ.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS
----------X

Index No.: 708782/2022

BAYANI DILLARD,

Plaintiff,

-against-

MILLER SYSTEMS, LTD d/b/a MCDONALD'S RESTAURANT, ALLIED ENTERPRISES NY, LLC, ALLIED ENTERPRISE CO., and MCDONALD'S CORPORATION,

Defendants,
----------X

ATTORNEY VERIFICATION

STATE OF NEW YORK)
} ss.:
COUNTY OF SUFFOLK)

DEBORAH J. EPSTEIN, an attorney duly admitted to practice law in the Courts of the State of New York, hereby affirms to the truth under the penalties of perjury:

That I am a member of the law firm of **EPSTEIN SHAKH, LLP**, the attorneys of record for the plaintiff(s) in the within action; that affirmant has read the foregoing **VERIFIED BILL OF PARTICUALRS** and knows the contents thereof; that the same is true to affirmant's own knowledge, except as to those matters therein stated to be alleged on information and belief and that those matters affirmant believes to be true. Affirmant further says that the reason this affirmation is made by affirmant not by plaintiff(s) is that plaintiff(s) do not reside within the County wherein affirmant maintains his office.

The grounds of affirmant's belief as to all matters not stated upon affirmant's knowledge are as follows: statements of the plaintiff(s), and affirmant's own general investigation into the facts and circumstances of this action.

Dated: February 26, 2023
Melville, New York

Deborah J. Epstein
DEBORAH J. EPSTEIN

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS
----------X

Index No.: 708782/2022

BAYANI DILLARD,

Plaintiff,

-against-

MILLER SYSTEMS, LTD d/b/a MCDONALD'S RESTAURANT, ALLIED ENTERPRISES NY, LLC, ALLIED ENTERPRISE CO., and MCDONALD'S CORPORATION,

Defendants,
----------X

VERIFIED BILL OF PARTICULARS

Plaintiff, **BAYANI DILLARD**, by his attorneys, EPSTEIN SHAKH, LLP, responding to the demands of Defendant, **ALLIED ENTERPRISES NY, LLC**, for a Verified Bill of Particulars, dated September 21, 2022, allege(s), upon information and belief:

1. Plaintiff's residence address is 52 Charles Street, Malverne, New York 11565.

2. At the time of the subject accident, the plaintiff was 45 years old. Plaintiff's date of birth is [redacted] 1976. Plaintiff's Social Security Number is [redacted]-9312.

3. The date of the occurrence is June 11, 2021at approximately 2:30 p.m.

4. The location of the subject occurrence is 160-11 Willets Point Boulevard, Flushing, New York 11357, premises commonly known as McDonalds Restaurant. Specifically, the men's bathroom located therein.

5. The aforesaid occurrence was caused wholly and solely by the negligence of answering defendants by and through its agents, servants and/or employees, in the ownership, operation, management, maintenance, construction, control, and inspection of the aforesaid premises, and specifically the floor surfaces located at the above-referenced location; in causing, allowing, and permitting said premises to be, become and remain for a period of time after notice, either actual or constructive, in a slippery floor, dangerous and/or hazardous condition; in causing, allowing and permitting a trap to exist at the aforesaid premises; in failing to restore/repair/replace and/or maintain the floor surfaces free of slipping hazards at the aforesaid premises to a reasonably safe and proper condition; in failing to maintain, repair said premises; in failing to maintain said floor; in causing, allowing and permitting an obstruction to plaintiffs safe passage at said location; in causing; allowing and permitting the existence of conditions which constituted a trap, nuisance, menace and danger to lawful pedestrians, including the plaintiff herein; in failing to have taken necessary steps and measures to have prevented the above mentioned location from being used while in said dangerous condition; in failing to ensure that the defendants' premises are adequately illuminated; in failing to give plaintiff adequate and timely signal, notice, or warning of said dangerous and defective condition; in negligently and carelessly causing and permitting the above location to be and remain in said

dangerous and defective condition for an unreasonable length of time, resulting in a foreseeable hazard to the plaintiff and others; in failing to take suitable and necessary precautions for the safety of persons at said location; in failing to erect barricades, barriers, or warning signs at said location; and in failing to maintain the floor of said location in a safe condition.

6. Plaintiff was caused to slip and fall on a wet surface in the men's bathroom at the defendants' premises.

7. Not Applicable.

8. The defendants, their servants, agents and/or employees had actual notice of the said dangerous, defective, and unsafe condition. Without in any way conceding that actual notice is a necessary prerequisite to suit herein, plaintiff claims that the defendant, its agents, servants and/or employees, the exact identities of whom are not presently known or available to the plaintiff, and subject to further discovery proceedings, had actual notice of the said dangerous, unguarded, defective and unsafe conditions and did create said dangerous, unguarded and defective conditions, and were present upon said premises by their servants, agents and/or employees, and actual notice was given to the defendant, their servants, agents and/or employees prior to this accident. Furthermore, actual notice is presumed and is imputed to the defendant herein by virtue of the subject defective condition having been created by the said defendant. Plaintiff reserves the right to further respond to this demand upon completion of further discovery proceedings and depositions. Constructive notice is claimed in that the alleged defective/dangerous condition existed for such a substantial period of time that the defendants, their agents, servants and/or employees should have known such a defect/dangerous condition existed and/or if the defendants had routinely inspected the above-mentioned location, the above defect and/or dangerous condition would have/should have been easily discovered. It will be further alleged that, at the very least, the above mentioned dangerous/defective condition existed for a substantial period of time continuing and up to and including the date and time of the subject accident.

9. Plaintiff objects to the inquiry demanding the identification of the "names and addresses of any person(s) by whom notice was given/supplied" is improper for a bill of particulars in that same is an interrogatory, seeks expert opinion, and/or seeks evidentiary material beyond the scope of CPLR §3043(a), (*See* Harris v. Ariel Transportation Corp., 37 A.D.3d 308 (1st Dept. 2007); *see also* Patterson v. Jewish Hospital and Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194 (Sup. Ct. Kings Cty. 1978).

10. Plaintiff objects to the inquiry demanding the identification of duration/length of time the subject defect existed as improper for a bill of particulars in that same is an interrogatory, seeks expert opinion, and/or seeks evidentiary material beyond the scope of CPLR §3043(a), (*See* Harris v. Ariel Transportation Corp., 37 A.D.3d 308

(1st Dept. 2007); *see also* Patterson v. Jewish Hospital and Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194 (Sup. Ct. Kings Cty. 1978).

11. As a result of the subject accident, the plaintiff sustained the following injuries:

RIGHT KNEE:

a. Internal derangement of the right knee joint;

b. Stiffness and clicking in the knee;

c. Weakness, crepitus, swelling, tightness and stiffness of the knee;

d. Posttraumatic edema in subcutaneous tissues;

e. Fluid surrounding the popliteus tendon at the postlateral corner;

f. Tear on the undersurface of the mid body of the medial meniscus and partial anterior subluxation of the anterior horn of the medial meniscus ventral to the margin of the medial tibial plateau;

g. Antalgic gait;

h. ***Surgery***: Right knee arthroscopic surgery, partial medial meniscectomy, chondroplasty pf patella, chondroplasty of femoral trochlea, chondroplasty of medial femoral condyle, chondroplasty of medial tibial plateau, and major synovectomy of the right knee, performed on January 10, 2022, by Gus Katsigiorgis, M.D., at Long Island Jewish Hospital Valley Stream;

i. Postoperative scarring;

j. Recommendation for knee replacement surgery;

k. Permanent loss of range of motion in the right knee;

l. Need for knee bracing;

m. Need for use of ambulatory devices;

n. Severe pain and suffering.

Upon information and belief, all of the above injuries are permanent and continuing in nature, except those of a superficial nature that may have healed at the present time. All of the aforementioned injuries, resulting disabilities, aggravations, exacerbations and involvements are associated with further soft tissue injuries to the areas traumatically affected, including: injury, tearing, derangement and damage to the associated muscle groups, ligaments, tendons, cartilage, blood tissue, epithelial tissue, all concomitant to the specific injuries and related to the specific portions mentioned herein above, with resultant scarring, hemorrhage, pain, ecchymosis, deformity and disability; stiffness, weakness and partial restriction and limitation of motion, pain on motion and loss of use of the above-mentioned parts; and atrophy. If it is claimed by Defendants that any of the above stated injuries are pre-existing and/or degenerative in nature, it is hereby alleged that said injuries were activated, aggravated and/or

exacerbated as a result of the complained of incident. It is claimed that these injuries have weakened those parts of the body and rendered them more susceptible to future trauma so that they have prevented and will in the future prevent Plaintiff from engaging in some or all physical activities involving movements of those injured parts of Plaintiff's body, and including, but not limited to physical exercise for health or pleasure, sports and business activities which Plaintiff formerly engaged in, and limitations of movement involved in the course of daily living. Inactivity is detrimental to the Plaintiff's health and well-being. It is further claimed that these injuries have and will diminish Plaintiff s future earning capacity, will deprive Plaintiff of future earning capacity, future earning opportunities, business opportunities, raises, promotions, advancements, fringe benefits, health, dental and/or vision benefits, contributions to retirement and/or other benefits, social security retirement income, pension and/or other income, training and experience which could benefit the Plaintiff in retaining and obtaining future positions or business opportunities. Plaintiff intends to make a claim for the value of household services, including household cleaning, laundry, shopping, food preparation, caring for children or adults, household repairs and servicing the needs of others in or about the home as part of the loss sustained due to the injuries suffered herein, Plaintiff suffered, still suffers, and upon information and belief, will continue to suffer pain, discomfort and limited movement of the injured portions of his body, including the adjacent and surrounding muscles, tendons, nerves, joints, fascia, vessels and soft tissues. Plaintiff reserves the right to prove any and all further consequences and any and all further and future medical expenses.

12. All plaintiff's providers are identified under a cover titled plaintiff's Response to Demand for Authorizations.

13. Plaintiff was employed as a New York State Emergency Medical Technician (EMT) by Flushing Hospital Medical Center, 4500 Parsons Boulevard, Flushing, New York 11355. Plaintiff's base annual income is $58,840.00, not inclusive of union benefits afforded through SEIU 1199. Plaintiff was partially reimbursed for loss of income by New York State Insurance Fund (plaintiff's employer's workers compensation carrier) in the amount of $38,362.27. Accordingly, plaintiff sustained economic loss in the amount of $20,477.73.

14. See Item 13.

15. See Item 11.

16. Plaintiff objects to the inquiry demanding a statement as to whether "the incident in question exacerbated and/or aggravated any physical condition of the plaintiff" is improper for a bill of particulars in that same is an interrogatory, seeks expert opinion, and/or seeks evidentiary material beyond the scope of CPLR

§3043(a), (*See* Harris v. Ariel Transportation Corp., 37 A.D.3d 308 (1st Dept. 2007); *see also* Patterson v. Jewish Hospital and Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194 (Sup. Ct. Kings Cty. 1978).

17. Plaintiff objects to the inquiry demanding a statement as to whether "plaintiff claims any limitation of motion, loss of use, or loss of function as a result of the injuries alleged, and if so, state the nature, extent and degree of permanency thereof" is improper for a bill of particulars in that same is an interrogatory, seeks expert opinion, and/or seeks evidentiary material beyond the scope of CPLR §3043(a), (*See* Harris v. Ariel Transportation Corp., 37 A.D.3d 308 (1st Dept. 2007); *see also* Patterson v. Jewish Hospital and Medical Center of Brooklyn, 94 Misc.2d 680, 405 N.Y.S.2d 194 (Sup. Ct. Kings Cty. 1978).

18. As a result of the subject accident, the plaintiff was confined to:

a. Hospital – one (1) day;
b. Bed – one (1) day;
c. Home – two (2) weeks.

19. (Numbered as 16) – Plaintiff was disabled from work for thirteen (13) months. Plaintiff was employed as a New York State Emergency Medical Technician (EMT) by Flushing Hospital Medical Center, 4500 Parsons Boulevard, Flushing, New York 11355. Plaintiff's base annual income is $58,840.00, not inclusive of union benefits afforded through SEIU 1199. Plaintiff was partially reimbursed for loss of income by New York State Insurance Fund (plaintiff's employer's workers compensation carrier) in the amount of $38,362.27. Accordingly, plaintiff sustained economic loss in the amount of $20,477.73.

20. (Numbered as 17) – See Item 19.

21. (Numbered as 18) – Not Applicable.

22. (Numbered as 19) - Plaintiff is not claiming special damages associated with costs for medical treatment or services. However, plaintiff claims as special damages $56,394.07, which has been asserted as a lien by the New York State Insurance Fund.

23. (Numbered as 20) - It is alleged that the defendants violated Chapters 3, 4 and Chapter 5 of the 2020 Property Management Code of the State of New York, and specifically: Section 305.1; Section 402.3; Section 503.4

24. (Numbered as 21) – See Item 23.

25. (Numbered as 22) - Plaintiff claims that the defendants were negligent in allowing a dangerous/hazardous condition to exist upon the subject premises, and same consisted of wet and slippery condition; presence of liquid/fluid upon the floor at the premises; defective plumbing; floor slip resistance below the acceptable

threshold; defective flooring surfaces. The condition complained of herein was present in the men's bathroom, located upon the defendants' premises.

26. (Numbered as 23) – See Item 5.

27. (Numbered as 24) – See Item 25.

PLEASE TAKE FURTHER NOTICE, that the plaintiff reserves the right to serve an Amended and/or Supplemental Bill of Particulars in connection with all claims including those of continuing Special Damages and disabilities.

Dated: February 26, 2023
Melville, New York

EPSTEIN SHAKH, LLP
Attorneys for Plaintiff

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TO:

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MILLER SYSTEMS, LTD and
MCDONALD'S CORPORATION
505 Eighth Avenue, Suite 2302
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T. (212) 231-2220
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File No.: 31056

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Buffalo, New York 14202
T. (716) 402-5848
E.: tflascher@gerberciano.com

ATTORNEY CERTIFICATION

I, **DEBORAH J. EPSTEIN, ESQ**., hereby certify under penalty of perjury and as an officer of the court that, to the best of my knowledge, information, and belief, formed after an inquiry reasonable under the circumstances, the presentation of the attached paper or the contentions therein are not frivolous as defined in subsection (c) of section 130-1.1 of 22 NYCRR.

Dated: February 26, 2023
Melville, New York

Deborah J. Epstein
DEBORAH J. EPSTEIN, ESQ.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF QUEENS
----------X

Index No.: 708782/2022

BAYANI DILLARD,

Plaintiff,

-against-

MILLER SYSTEMS, LTD d/b/a MCDONALD'S RESTAURANT, ALLIED ENTERPRISES NY, LLC, ALLIED ENTERPRISE CO., and MCDONALD'S CORPORATION,

Defendants,
----------X

ATTORNEY VERIFICATION

STATE OF NEW YORK)
} ss.:
COUNTY OF SUFFOLK)

DEBORAH J. EPSTEIN, an attorney duly admitted to practice law in the Courts of the State of New York, hereby affirms to the truth under the penalties of perjury:

That I am a member of the law firm of **EPSTEIN SHAKH, LLP**, the attorneys of record for the plaintiff(s) in the within action; that affirmant has read the foregoing **VERIFIED BILL OF PARTICUALRS** and knows the contents thereof; that the same is true to affirmant's own knowledge, except as to those matters therein stated to be alleged on information and belief and that those matters affirmant believes to be true. Affirmant further says that the reason this affirmation is made by affirmant not by plaintiff(s) is that plaintiff(s) do not reside within the County wherein affirmant maintains his office.

The grounds of affirmant's belief as to all matters not stated upon affirmant's knowledge are as follows: statements of the plaintiff(s), and affirmant's own general investigation into the facts and circumstances of this action.

Dated: February 26, 2023
Melville, New York

Deborah J. Epstein
DEBORAH J. EPSTEIN

Workers' Compensation Board

State of New York - Workers' Compensation Board

First Report of Injury
Report Type (MTC) 02-Change

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Pursuant to 12 NYCRR §300.22, when the claim administrator is changing the Agreement to Compensate Code from Without Liability to With Liability, this notice must be served on the claimant and his or her attorney or licensed representative, if any, within one business day of the date it is filed electronically with the chair.

Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719

Date of Injury 06/11/2021

Claim Administrator Claim Number 73141129-163

Maintenance Type Code Date 05/11/2023

Claim Type

WCB Received Date 05/11/2023

Agreement to Compensate

INSURER INFORMATION

Insurer Name

FEIN xxxxx3200

Insurer Type

Insurer ID W204002

CLAIM ADMINISTRATOR INFORMATION

Name

Info/Attn

Address

City

State

Postal Code

Country

FEIN xxxxx3200

Claim Admin ID W204002

Late Reason

Claim Representative Name

Claim Representative Business Phone Number

Claim Representative E-mail Address

FULL DENIAL REASONS

Full Denial Effective Date

EMPLOYEE INFORMATION

First Name Bayani **Middle Name/Initial**

Last Name Dillard **Suffix**

Mailing Address

City **State**

Postal Code **Country**

Phone Number **Gender**

Date of Birth 11/05/1976 **Date of Hire**

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx9312

Occupation Description

CLAIM INFORMATION

Time of Injury **Date Employer Had Knowledge of the Injury**

Employment Status 2 - Part-time Employee **Date Claim Administrator Had Knowledge of the Injury**

Wage Period **Initial Date Employer Had Knowledge of Date of Disability**

Estimated Wage **Current Date Employer had Knowledge of Current Date of Disability**

Work Week Type **Number of Days Worked Per Week**

Date of Denial Rescission **Work Days Scheduled** (S-Scheduled N-Non Scheduled)

S	M	T	W	T	F	S

EMPLOYEE INJURY

Full Wages Paid for Date of Injury **Employer Paid Salary in Lieu of Compensation**

Death Result of Injury **Date of Death** **Number of Dependents**

Nature of Injury

Part of Body

Part of Body Injured Location	Part of Body Injured	Part of Body Injured Fingers/Toes Location

Cause of Injury

Type of Loss

Accident/Injury Description

WORK STATUS

Initial Date Last Day Worked _____

Initial Date Disability Began _____

Initial RTW Date _____

Latest RTW Type Code _____

Latest RTW/Status Date _____

Current Date Disability Began _____

Initial RTW Type Code _____

Initial RTW Physical Restrictions _____

Initial RTW With Same Employer _____

Latest RTW Physical Restrictions _____

Latest RTW With Same Employer _____

Current Date Last Day Worked _____

First Day of Disability After the Waiting Period _____

ACCIDENT LOCATION AND WITNESSES

Premises _____

Organization Name _____

Street _____ State _____

City _____ Postal Code _____

County/Parish _____ Country _____

Location Narrative _____

Witnesses	Business Phone Number

MEDICAL TREATMENT

Initial Treatment _____

Managed Care Org. _____

Managed Care Org. ID _____

EMPLOYER INFORMATION

Name _____ **Employer FEIN** xxxxx1781

Industry Code _____ **UI Number** _____

Manual Classification _____

Info/Attn _____

Mailing Address _____ 8900 VAN WYCK EXPRESSWAY 5K

City _____ **State** _____

Postal Code _____ **Country** _____

Physical Addr _____

City _____ **State** _____

Postal Code _____ **Country** _____

Contact Name _____

Contact Business Phone Number _____

INSURED INFORMATION

Insured Name _____ **Insured FEIN** _____

Insured Type _____ **Insured Location ID** _____

Policy Number ID _____

Policy Effective Date _____ **Policy Expiration Date** _____

CHANGE DATA ELEMENTS

Change Data Element/Segment Number	Change Reason Code
0169 - Employer Mailing Secondary Address	U - Update
0058 - Employment Status Code	U - Update

Workers' Compensation Board

State of New York - Workers' Compensation Board

First Report of Injury
Report Type (MTC) 02-Change

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Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719

Date of Injury 06/11/2021

Claim Administrator Claim Number 73141129-163

Maintenance Type Code Date 04/14/2023

Claim Type

WCB Received Date 04/14/2023

Agreement to Compensate

INSURER INFORMATION

Insurer Name

FEIN xxxxx3200

Insurer Type

Insurer ID W204002

CLAIM ADMINISTRATOR INFORMATION

Name

Info/Attn

Address

City

State

Postal Code

Country

FEIN xxxxx3200

Claim Admin ID W204002

Late Reason

Claim Representative Name Charles Termini

Claim Representative Business Phone Number 9147016268

Claim Representative E-mail Address ctermini@nysif.com

FULL DENIAL REASONS

Full Denial Effective Date

EMPLOYEE INFORMATION

First Name Bayani **Middle Name/Initial**

Last Name Dillard **Suffix**

Mailing Address

City **State**

Postal Code **Country**

Phone Number **Gender**

Date of Birth 11/05/1976 **Date of Hire**

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx9312

Occupation Description

CLAIM INFORMATION

Time of injury **Date Employer Had Knowledge of the Injury**

Employment Status **Date Claim Administrator Had Knowledge of the Injury**

Wage Period **Initial Date Employer Had Knowledge of Date of Disability**

Estimated Wage **Current Date Employer had Knowledge of Current Date of Disability**

Work Week Type **Number of Days Worked Per Week**

Date of Denial Rescission **Work Days Scheduled** (S-Scheduled N-Non Scheduled)

S	M	T	W	T	F	S

EMPLOYEE INJURY

Full Wages Paid for Date of Injury **Employer Paid Salary in Lieu of Compensation**

Death Result of Injury **Date of Death** **Number of Dependents**

Nature of Injury

Part of Body

Part of Body Injured Location	Part of Body Injured	Part of Body Injured Fingers/Toes Location

Cause of Injury

Type of Loss

Accident/Injury Description

WORK STATUS

Initial Date Last Day Worked _____

Initial Date Disability Began _____

Initial RTW Date _____

Latest RTW Type Code _____

Latest RTW/Status Date _____

Current Date Disability Began _____

Initial RTW Type Code _____

Initial RTW Physical Restrictions _____

Initial RTW With Same Employer _____

Latest RTW Physical Restrictions _____

Latest RTW With Same Employer _____

Current Date Last Day Worked _____

First Day of Disability After the Waiting Period _____

ACCIDENT LOCATION AND WITNESSES

Premises _____

Organization Name _____

Street _____

State _____

City _____

Postal Code _____

County/Parish _____

Country _____

Location Narrative _____

Witnesses	Business Phone Number

MEDICAL TREATMENT

Initial Treatment _____

Managed Care Org. _____

Managed Care Org. ID _____

EMPLOYER INFORMATION

Name _____ **Employer FEIN** xxxxx1781

Industry Code _____ **UI Number** _____

Manual Classification _____

Info/Attn _____

Mailing Address _____

City _____ **State** _____

Postal Code _____ **Country** _____

Physical Addr _____

City _____ **State** _____

Postal Code _____ **Country** _____

Contact Name _____

Contact Business Phone Number _____

INSURED INFORMATION

Insured Name _____ **Insured FEIN** _____

Insured Type _____ **Insured Location ID** _____

Policy Number ID _____

Policy Effective Date _____ **Policy Expiration Date** _____

CHANGE DATA ELEMENTS

Change Data Element/Segment Number	Change Reason Code
0138 - Claim Administrator Claim Representative Email Address	U - Update
0140 - Claim Administrator Claim Representative Name	U - Update
0137 - Claim Administrator Claim Representative Business Phone Number	U - Update

Workers' Compensation Board

State of New York - Workers' Compensation Board

First Report of Injury
Report Type (MTC) 02-Change

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Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719

Date of Injury 06/11/2021

Claim Administrator Claim Number 73141129-163

Maintenance Type Code Date 03/10/2023

Claim Type

WCB Received Date 03/10/2023

Agreement to Compensate

INSURER INFORMATION

Insurer Name

FEIN xxxxx3200

Insurer Type

Insurer ID W204002

CLAIM ADMINISTRATOR INFORMATION

Name

Info/Attn

Address

City

State

Postal Code

Country

FEIN xxxxx3200

Claim Admin ID W204002

Late Reason

Claim Representative Name Peter Henderson

Claim Representative Business Phone Number 9147016265

Claim Representative E-mail Address phenders@nysif.com

FULL DENIAL REASONS

Full Denial Effective Date

EMPLOYEE INFORMATION

First Name Bayani **Middle Name/Initial**

Last Name Dillard **Suffix**

Mailing Address

City **State**

Postal Code **Country**

Phone Number **Gender**

Date of Birth 11/05/1976 **Date of Hire**

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx9312

Occupation Description

CLAIM INFORMATION

Time of injury **Date Employer Had Knowledge of the Injury**

Employment Status **Date Claim Administrator Had Knowledge of the Injury**

Wage Period **Initial Date Employer Had Knowledge of Date of Disability**

Estimated Wage **Current Date Employer had Knowledge of Current Date of Disability**

Work Week Type **Number of Days Worked Per Week**

Date of Denial Rescission **Work Days Scheduled** (S-Scheduled N-Non Scheduled) S M T W T F S

EMPLOYEE INJURY

Full Wages Paid for Date of Injury **Employer Paid Salary in Lieu of Compensation**

Death Result of Injury **Date of Death** **Number of Dependents**

Nature of Injury

Part of Body

Part of Body Injured Location	Part of Body Injured	Part of Body Injured Fingers/Toes Location

Cause of Injury

Type of Loss

Accident/Injury Description

WORK STATUS

Initial Date Last Day Worked _____

Initial Date Disability Began _____

Initial RTW Date _____

Latest RTW Type Code _____

Latest RTW/Status Date _____

Current Date Disability Began _____

Initial RTW Type Code _____

Initial RTW Physical Restrictions _____

Initial RTW With Same Employer _____

Latest RTW Physical Restrictions _____

Latest RTW With Same Employer _____

Current Date Last Day Worked _____

First Day of Disability After the Waiting Period _____

ACCIDENT LOCATION AND WITNESSES

Premises _____

Organization Name _____

Street _____ State _____

City _____ Postal Code _____

County/Parish _____ Country _____

Location Narrative _____

Witnesses	Business Phone Number

MEDICAL TREATMENT

Initial Treatment _____

Managed Care Org. _____

Managed Care Org. ID _____

EMPLOYER INFORMATION

Name _____ **Employer FEIN** xxxxx1781

Industry Code _____ **UI Number** _____

Manual Classification _____

Info/Attn _____

Mailing Address _____ _____

City _____ **State** _____

Postal Code _____ **Country** _____

Physical Addr _____ _____

City _____ **State** _____

Postal Code _____ **Country** _____

Contact Name _____

Contact Business Phone Number _____

INSURED INFORMATION

Insured Name _____ **Insured FEIN** _____

Insured Type _____ **Insured Location ID** _____

Policy Number ID _____

Policy Effective Date _____ **Policy Expiration Date** _____

CHANGE DATA ELEMENTS

Change Data Element/Segment Number	Change Reason Code
0138 - Claim Administrator Claim Representative Email Address	U - Update
0140 - Claim Administrator Claim Representative Name	U - Update
0137 - Claim Administrator Claim Representative Business Phone Number	U - Update
0015 - Claim Administrator Claim Number (Key Match)	U - Update

WORKERS' COMPENSATION BOARD

State of New York - Workers' Compensation Board

First Report of Injury
Report Type (MTC) 02-Change

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Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719

Date of Injury 06/11/2021

Claim Administrator Claim Number 73141129-110

Maintenance Type Code Date 11/10/2021

Claim Type I - Indemnity for Lost Time

WCB Received Date 11/10/2021

Agreement to Compensate L - With Liability

INSURER INFORMATION

Insurer Name New York State Insurance Fund

FEIN xxxxx3200

Insurer Type

Insurer ID W204002

CLAIM ADMINISTRATOR INFORMATION

Name New York State Insurance Fund

Info/Attn

Address 199 Church Street, NYC, NY 100071100

City New York City

State NY

Postal Code 10007-1100

Country US - UNITED STATES

FEIN xxxxx3200

Claim Admin ID W204002

Late Reason

FULL DENIAL REASONS

Full Denial Effective Date

Full Denial Reason

Denial Reason Narrative

EMPLOYEE INFORMATION

First Name	Bayani	**Middle Name/Initial**	
Last Name	Dillard	**Suffix**	
Mailing Address	52 Charles Street		
City	MALVERNE	**State**	NY
Postal Code	11565	**Country**	
Phone Number		**Gender**	M - Male
Date of Birth	11/05/1976	**Date of Hire**	
Employee ID Type	S - Employee Social Security Number	**Employee ID**	xxxxx9312
Occupation Description	EMT		

CLAIM INFORMATION

Time of injury		**Date Employer Had Knowledge of the Injury**	06/11/2021
Employment Status	1 - Regular/Full-time Employee	**Date Claim Administrator Had Knowledge of the Injury**	06/14/2021
Wage Period	01 - Weekly	**Date Employer Had Knowledge of Date of Disability**	06/14/2021
Estimated Wage	$1,362.31	**Number of Days Worked Per Week**	5
Work Week Type	F - Fixed Work Week	**Work Days Scheduled** (S-Scheduled N-Non Scheduled)	S M T W T F S N N S S S S S

Date of Denial Rescission

EMPLOYEE INJURY

Full Wages Paid for Date of Injury	Yes	**Employer Paid Salary in Lieu of Compensation**	
Death Result of Injury		**Date of Death**	
Number of Dependents			
Nature of Injury	52 - Strain or Tear		
Part of Body	53 - Knee		
Cause of Injury	60 - Strain or Injury By - Strain or Injury By, NOC		
Type of Loss	01 - Traumatic Injury		

Accident/Injury Description

While stepping out van, felt pain in right knee later that day. Additional Body Parts:Knee, Right

WORK STATUS

Initial Date Last Day Worked		**Return To Work Type**	
Initial Date Disability Began	06/12/2021	**Physical Restrictions**	
Initial Return to Work Date		**Return To Work Same Employer**	

ACCIDENT LOCATION AND WITNESSES

Premises X - Other

Organization Name

Street **State**

City **Postal Code**

County/Parish QUEENS - Queens **Country**

Location Narrative offiste

Witnesses **Business Phone Number**

MEDICAL TREATMENT

Initial Treatment 3 - Emergency Evaluation, Diagnostic Testing, and Medical Procedures

Managed Care Org.

Managed Care Org. ID

EMPLOYER INFORMATION

Name FLUSHING HOSPITAL & MEDICAL CENTER **Employer FEIN** xxxxx1781

Industry Code 622110 **UI Number**

Manual Classification 7380 - Drivers And Helpers Noc-Commercial

Info/Attn

Mailing Address %KATHY SHELDON-JAMAICA HOSP MED CTR 8900 VANWYCK EXPRESSWAY 5L

City JAMAICA **State** NY

Postal Code 11418 **Country**

Physical Addr 4500 PARSONS BOULEVARD

City FLUSHING **State** NY

Postal Code 11355 **Country**

Contact Name

Contact Business Phone Number

INSURED INFORMATION

Insured Name FLUSHING HOSPITAL & MEDICAL CENTER

Insured FEIN xxxxx1781

Insured Type I - Insured

Insured Location ID

Policy Number ID 12345112

Policy Effective Date 06/02/2000

Policy Expiration Date

WORKERS' COMPENSATION BOARD

State of New York - Workers' Compensation Board

First Report of Injury
Report Type (MTC) 02-Change

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Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719

Date of Injury 06/11/2021

Claim Administrator Claim Number 73141129-110

Maintenance Type Code Date 11/09/2021

Claim Type I - Indemnity for Lost Time

WCB Received Date 11/09/2021

Agreement to Compensate L - With Liability

INSURER INFORMATION

Insurer Name New York State Insurance Fund

FEIN xxxxx3200

Insurer Type

Insurer ID W204002

CLAIM ADMINISTRATOR INFORMATION

Name New York State Insurance Fund

Info/Attn

Address 199 Church Street, NYC, NY 100071100

City New York City

State NY

Postal Code 10007-1100

Country US - UNITED STATES

FEIN xxxxx3200

Claim Admin ID W204002

Late Reason

FULL DENIAL REASONS

Full Denial Effective Date

Full Denial Reason

Denial Reason Narrative

EMPLOYEE INFORMATION

First Name	Bayani	**Middle Name/Initial**	
Last Name	Dillard	**Suffix**	
Mailing Address	52 Charles Street		
City	MALVERNE	**State**	NY
Postal Code	11565	**Country**	
Phone Number		**Gender**	M - Male
Date of Birth	11/05/1976	**Date of Hire**	
Employee ID Type	S - Employee Social Security Number	**Employee ID**	xxxxx9312
Occupation Description	EMT		

CLAIM INFORMATION

Time of injury		**Date Employer Had Knowledge of the Injury**	06/11/2021
Employment Status	1 - Regular/Full-time Employee	**Date Claim Administrator Had Knowledge of the Injury**	06/14/2021
Wage Period	01 - Weekly	**Date Employer Had Knowledge of Date of Disability**	06/14/2021
Estimated Wage	$1,362.31	**Number of Days Worked Per Week**	7
Work Week Type	F - Fixed Work Week	**Work Days Scheduled** (S-Scheduled N-Non Scheduled)	S M T W T F S S S S S S S S

Date of Denial Rescission

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

Employer Paid Salary in Lieu of Compensation

Death Result of Injury

Date of Death

Number of Dependents

Nature of Injury 52 - Strain or Tear

Part of Body 53 - Knee

Cause of Injury 60 - Strain or Injury By - Strain or Injury By, NOC

Type of Loss 01 - Traumatic Injury

Accident/Injury Description

While stepping out van, felt pain in right knee later that day. Additional Body Parts Knee, Right

WORK STATUS

Initial Date Last Day Worked

Return To Work Type

Initial Date Disability Began 06/12/2021

Physical Restrictions

Initial Return to Work Date

Return To Work Same Employer

ACCIDENT LOCATION AND WITNESSES

Premises X - Other

Organization Name

Street **State**

City **Postal Code**

County/Parish QUEENS - Queens **Country**

Location Narrative offiste

Witnesses **Business Phone Number**

MEDICAL TREATMENT

Initial Treatment 3 - Emergency Evaluation, Diagnostic Testing, and Medical Procedures

Managed Care Org.

Managed Care Org. ID

EMPLOYER INFORMATION

Name FLUSHING HOSPITAL & MEDICAL CENTER **Employer FEIN** xxxxx1781

Industry Code 622110 **UI Number**

Manual Classification 7380 - Drivers And Helpers Noc-Commercial

Info/Attn

Mailing Address %KATHY SHELDON-JAMAICA HOSP MED CTR 8900 VANWYCK EXPRESSWAY 5L

City JAMAICA **State** NY

Postal Code 11418 **Country**

Physical Addr 4500 PARSONS BOULEVARD

City FLUSHING **State** NY

Postal Code 11355 **Country**

Contact Name

Contact Business Phone Number

INSURED INFORMATION

Insured Name FLUSHING HOSPITAL & MEDICAL CENTER

Insured FEIN xxxxx1781

Insured Type I - Insured

Insured Location ID

Policy Number ID 12345112

Policy Effective Date 06/02/2000

Policy Expiration Date

WORKERS' COMPENSATION BOARD

F8024-47

State of New York - Workers' Compensation Board

First Report of Injury
Report Type (MTC) 02-Change

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Pursuant to 12 NYCRR §300.22, when the claim administrator is changing the Denial Reason, this notice must be served on the claimant and his or her attorney or licensed representative, if any, within one business day of the date it is filed electronically with the chair.

Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719

Date of Injury 06/11/2021

Claim Administrator Claim Number 73141129-110

Maintenance Type Code Date 06/23/2021

Claim Type I - Indemnity for Lost Time

WCB Received Date 06/23/2021

Agreement to Compensate L - With Liability

INSURER INFORMATION

Insurer Name New York State Insurance Fund

FEIN xxxxx3200

Insurer Type

Insurer ID W204002

CLAIM ADMINISTRATOR INFORMATION

Name New York State Insurance Fund

Info/Attn

Address 199 Church Street, NYC, NY 100071100

City New York City

State NY

Postal Code 10007-1100

Country US - UNITED STATES

FEIN xxxxx3200

Claim Admin ID W204002

Late Reason

FULL DENIAL REASONS

Full Denial Effective Date

Full Denial Reason

Denial Reason Narrative

EMPLOYEE INFORMATION

First Name Bayani
Middle Name/Initial
Last Name Dillard
Suffix
Mailing Address 52 Charles Street
City MALVERNE
State NY
Postal Code 11565
Country
Phone Number
Gender M - Male
Date of Birth 11/05/1976
Date of Hire
Employee ID Type S - Employee Social Security Number
Employee ID xxxxx9312
Occupation Description EMT

CLAIM INFORMATION

Time of injury
Date Employer Had Knowledge of the Injury 06/11/2021
Employment Status 1 - Regular/Full-time Employee
Date Claim Administrator Had Knowledge of the Injury 06/14/2021
Wage Period 01 - Weekly
Date Employer Had Knowledge of Date of Disability 06/14/2021
Estimated Wage $1,362.31
Number of Days Worked Per Week 3
Work Week Type F - Fixed Work Week
Work Days Scheduled (S-Scheduled N-Non Scheduled)

S	M	T	W	T	F	S
N	N	S	N	S	S	N

Date of Denial Rescission

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes
Employer Paid Salary in Lieu of Compensation
Death Result of Injury
Date of Death
Number of Dependents
Nature of Injury 52 - Strain or Tear
Part of Body 53 - Knee
Cause of Injury 60 - Strain or Injury By - Strain or Injury By, NOC
Type of Loss 01 - Traumatic Injury

Accident/Injury Description

While stepping out van, felt pain in right knee later that day. Additional Body Parts Knee, Right

WORK STATUS

Initial Date Last Day Worked
Return To Work Type
Initial Date Disability Began 06/12/2021
Physical Restrictions
Initial Return to Work Date
Return To Work Same Employer

ACCIDENT LOCATION AND WITNESSES

Premises X - Other

Organization Name

Street **State**

City **Postal Code**

County/Parish QUEENS - Queens **Country**

Location Narrative offiste

Witnesses **Business Phone Number**

MEDICAL TREATMENT

Initial Treatment 3 - Emergency Evaluation, Diagnostic Testing, and Medical Procedures

Managed Care Org.

Managed Care Org. ID

EMPLOYER INFORMATION

Name FLUSHING HOSPITAL & MEDICAL CENTER **Employer FEIN** xxxxx1781

Industry Code 622110 **UI Number**

Manual Classification 7380 - Drivers And Helpers Noc-Commercial

Info/Attn

Mailing Address %KATHY SHELDON-JAMAICA HOSP MED CTR 8900 VANWYCK EXPRESSWAY 5L

City JAMAICA **State** NY

Postal Code 11418 **Country**

Physical Addr 4500 PARSONS BOULEVARD

City FLUSHING **State** NY

Postal Code 11355 **Country**

Contact Name

Contact Business Phone Number

INSURED INFORMATION

Insured Name FLUSHING HOSPITAL & MEDICAL CENTER

Insured FEIN xxxxx1781

Insured Type I - Insured

Insured Location ID

Policy Number ID 12345112

Policy Effective Date 06/02/2000

Policy Expiration Date

WORKERS' COMPENSATION BOARD

State of New York - Workers' Compensation Board

First Report of Injury
Report Type (MTC) 00-Original

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719 **Date of Injury** 06/11/2021

Claim Administrator Claim Number 73141129-110 **Maintenance Type Code Date** 06/14/2021

Claim Type I - Indemnity for Lost Time **WCB Received Date** 06/14/2021

Agreement to Compensate L - With Liability

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Insurer Name New York State Insurance Fund **FEIN** xxxxx3200

Insurer Type **Insurer ID** W204002

CLAIM ADMINISTRATOR INFORMATION

Name New York State Insurance Fund

Info/Attn

Address 199 Church Street, NYC, NY 100071100

City New York City **State** NY

Postal Code 10007-1100 **Country** US - UNITED STATES

FEIN xxxxx3200 **Claim Admin ID** W204002

Late Reason

EMPLOYEE INFORMATION

First Name Bayani **Middle Name/Initial**

Last Name Dillard **Suffix**

Mailing Address 52 Charles Street

City MALVERNE **State** NY

Postal Code 11565 **Country**

Phone Number **Gender** M - Male

Date of Birth 11/05/1976 **Date of Hire**

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx9312

Occupation Description EMT

CLAIM INFORMATION

Time of injury

Date Employer Had Knowledge of the Injury 06/11/2021

Employment Status 1 - Regular/Full-time Employee

Date Claim Administrator Had Knowledge of the Injury 06/14/2021

Wage Period 01 - Weekly

Date Employer Had Knowledge of Date of Disability 06/14/2021

Estimated Wage $1,219.62

Number of Days Worked Per Week 3

Work Week Type F - Fixed Work Week

Work Days Scheduled (S-Scheduled N-Non Scheduled)

S	M	T	W	T	F	S
N	N	S	N	S	S	N

Date of Denial Rescission

EMPLOYEE INJURY

Full Wages Paid for Date of Injury No

Employer Paid Salary in Lieu of Compensation

Death Result of Injury

Date of Death

Number of Dependents

Nature of Injury 52 - Strain or Tear

Part of Body 53 - Knee

Cause of Injury 60 - Strain or Injury By - Strain or Injury By, NOC

Type of Loss 01 - Traumatic Injury

Accident/Injury Description

While stepping out van, felt pain in right knee later that day. Additional Body Parts:Knee, Right

WORK STATUS

Initial Date Last Day Worked

Return To Work Type

Initial Date Disability Began 06/14/2021

Physical Restrictions

Initial Return to Work Date

Return To Work Same Employer

ACCIDENT LOCATION AND WITNESSES

Premises X - Other

Organization Name

Street

State

City

Postal Code

County/Parish Unknown

Country

Location Narrative offiste

Witnesses

Business Phone Number

MEDICAL TREATMENT

Initial Treatment 3 - Emergency Evaluation, Diagnostic Testing, and Medical Procedures

Managed Care Org.

Managed Care Org. ID

EMPLOYER INFORMATION

Name FLUSHING HOSPITAL & MEDICAL CENTER **Employer FEIN** xxxxx1781

Industry Code 622110 **UI Number**

Manual Classification 7380 - Drivers And Helpers Noc-Commercial

Info/Attn

Mailing Address %KATHY SHELDON-JAMAICA HOSP MED CTR 8900 VANWYCK EXPRESSWAY 5L

City JAMAICA **State** NY

Postal Code 11418 **Country**

Physical Addr 4500 PARSONS BOULEVARD

City FLUSHING **State** NY

Postal Code 11355 **Country**

Contact Name

Contact Business Phone Number

INSURED INFORMATION

Insured Name FLUSHING HOSPITAL & MEDICAL CENTER **Insured FEIN** xxxxx1781

Insured Type I - Insured **Insured Location ID**

Policy Number ID 12345112

Policy Effective Date 06/02/2000 **Policy Expiration Date**

FLUSHING HOSPITAL MEDICAL CENTER | JAMAICA HOSPITAL MEDICAL CENTER | BROOKDALE HOSPITAL MEDICAL CENTER

RECEIVED JUL 26 2023 By

DEPARTMENT of PREHOSPITAL CARE

INCIDENT REPORT

FACILITY Flushing Hospital PAGE 1 OF 1

ON DUTY SUPERVISOR: Tiffany Santos NOTIFIED (Yes) No

DATE OF OCCURRENCE: 6/11/2021 TIME OF OCCURRENCE: 8:12 Am

UNIT(S): 52F2 LOCATION: 146 st / 26 Ave

CAD# 0910 ACR# PD. REPORT # (if applicable)

CREW(S) INVOLVED: switch

DRIVER B. Dillard SHIELD 7228 TECH T Reuben SHIELD 6414

DRIVER SHIELD: TECH SHIELD

DESCRIPTION/COMMENTS: While getting off ambulance to clockon a female PT not Answering her medic alert. I jumped off jump kit and felt pain in Right knee. I went to lift PT off floor in Residence walking around felt Right knee was hurting took an aleve. I continued my shift with slight pain. Then our ambulance was going for Fun Charge I went to use the bathroom and lost strength in my Right Knee and fell the floor. I got up and felt pain to Right inner thigh and swelling and heavy feeling developed while I rested my leg trying to see if would go away. Our Ambulance was clear due to truck not stopping and driven I met with Tiffany Santos your 3 supervisor I explained my Right knee was bruised and swollen. I went to be evaluated and was seen in the Emergency Room - 7228

* I was sent home by MD to Rest ice and elevate my Right knee. I will feedback tuesday for work 7228.

I affirm that all the facts set forth above are true, complete and correct to the best of my knowledge and belief. I am providing a true account of the matter(s) under consideration. The facts that I have provided are mine and were provided without being influenced by any other party or person. I understand this statement will be used for administrative purposes, and the information shall be subject to verification.

SUBMITTED BY Dayani Dillard SHIELD 7228 DATE 6/11/2021

WITNESS SHIELD DATE

SUPERVISOR T Santos SHIELD 6913 DATE 6/11/21

THIS DOCUMENT IS PRIVILEDGED AND CONFIDENTIAL PURSUANT TO NYS PUBLIC HEALTH LAW 2805j THROUGH m AND NYS EDUCATION LAW 6527 AND IN ACCORDANCE WITH THE HOSPITAL WIDE QUAILITY ASSURANCE/PERFORMANCE IMPROVEMENT PROGRAM

Supervisor's Report Of Employee Incident

Establishment: THE FLUSHING HOSPITAL MEDICAL CENTER - FHMC Report Nbr: 3

Incident Date: 06/11/21 Incident Time: 08:12 AM Date/Time/Reported To Supervisor: 06/11/21 05:10 PM

Employee Name(Last,First,MI):DILLARD, BAYANI Sex: M Employee ID: 21070 DOB:11/05/7

Employee Home Address: 52 CHARLES STREET, MALVERNE, NY 11565 Home Phone#:718-658-044

Department: PRE-HOSPITAL CARE Shift: DAY Job Title: EMT

Date of Hire: 03/05/03 STD Hours: 40.00

Cost Center: 6601 Work Phone#: 7182068300 Cell#: 9173865380

Exact Location where incident occured(Bldg, Fl, Room# Office): N/A

WAS MEDICAL TREATMENT AT OUR MEDICAL CENTER OFFERED? YES DATE: 06/11/21

Brief Description of Incident (Employee's own words):

WHILE ON SCENE OF A CALL, I STEPPED OFF THE AMBULANCE AND FELT PAIN TO MY RIGHT KNOEE. LATER THAT DAY WHILE AT MCDONALDS MY NEE GAVE WAY AND I FELL AGAIN

Was Proper Protective Equipment Used? YES Equipment: MASK, GLOVES

PPE Explanation:

Were There Any Witnesses? YES Witness Name:TOM REARDON

Witness Dept: PHC Witness Phone#: 3472562193

==========

PRIMARY INCIDENT TYPE: SLIP, TRIP AND/OR FALL CAUSE: DRY FLOOR

Body Part: KNEE-RIGHT

*** FRAUDULENT STATEMENTS WILL RESULT IN DISMISSAL OF EMPLOYMENT AND/OR PROSECUTION. ***

Employee's Signature _____ Today's Date _____ Returned To Work: NO Phone#: 7182068300 Dept:6601

TIFFANY SANTOS

Name Of Supervisor _____ Signature _____ Today's Date: _____

Supervisor's Phone:9172993882 Supervisor's Dept:6601

==========

ER Chart Number _____

EMERGENCY DEPARTMENT PHYSICIAN'S REPORT

==========

Date Of Treatment: / / Treatment Time: _____ AM [ ] PM [ ] Patients Complaint: _____

Diagnosis and Part of Body Affected (Specify right or Left):

Nature Of Treatment (Please check box):

[ ] First Aid Only [ ] Post Exposure Prophylaxis [ ] Refused Exam/Treatment

[ ] Medical Treatment [ ] X-rays [ ] Other _____

DISPOSITION (Please check box)
[ ] Hospitalize [ ] Returned to Work
[ ] Sent home for one day and advised to report to EHS/OHS for Follow-up ASAP

FOLLOW UP (Please check box) [ ] Not Required [ ] Refer to Workers Comp MD
[ ] Return to EHS/OHS on (Date) / / [ ] Refer to Private MD

THE JAMAICA HOSPITAL MEDICAL CENTER

JHMC_____ TRUMP NH_____ DTC_____ TJH_____ MEDISYS_____ OTHER X FLUSHING

EMPLOYEE INCIDENT REPORT

SUPERVISOR'S REPORT OF EMPLOYEE INCIDENT

DATE OF INCIDENT: 6/11/2021	TIME OF INCIDENT: 8:11 ☒ AM ☐ PM	DATE/TIME REPORTED TO SUPERVISOR: 6/11/2021 4:00 ☐ AM ☒ PM	
EMPLOYEE NAME (Last, First, MI): Dillard, Bayani	SEX: M ☒ F ☐	SOCIAL SECURITY NUMBER: 166-70-9312	DATE OF BIRTH: 11/5/1976
EMPLOYEE HOME ADDRESS (Street, City, Zip Code): 52 Charles Street Malverne, NY 11565			HOME PHONE: 917 38[illegible]5350
DEPARTMENT: PRehospital Care	Unit: 52F2	Shift: 2	JOB TITLE: EMT
COST CENTER	WORK EXT.		
EXACT LOCATION where incident occurred (Bldg. Fl. Room # Offsite)		WAS MEDICAL TREATMENT AT OUR MEDICAL CENTER OFFERED? YES ☒ NO ☐ REFUSED ☐ DATE 6/11/21	
NATURE OF INJURY OR ILLNESS: RT knee pain	BODY PART - Left ☐ Right ☒: RT knee		

BRIEF DESCRIPTION OF INCIDENT (Use employee's own words as possible): While working going to a call and stepping off ambulance to check on a pt not responding to not answering medic alert. I jumped off the ambulance and felt pain in Right knee. I lifted pt and worked the remainder of the shift with slight pain. Then walking into the bathroom at McDonalds my Right knee gave out I fell to floor on bathroom group and took Aleve. I was waiting for the bus to be exchange with tow truck and I met tour 3 Supervisor Tiffany and told her my RT leg was swelling and not [illegible] 8 [illegible] 72.

WAS PROPER PROTECTIVE EQUIPMENT USED? YES___ NO___ IF YES, NAME EQUIPMENT_____

WERE THERE ANY WITNESSES? YES ☒ NO ☐ IF YES, NAME, DEPT. AND PHONE NUMBER

INCIDENT TYPE: CHECK BOX AND IDENTIFY SUBSTANCE OR ITEM. (Include size/weight where applicable.)

- ☐ BURN_____ (Heat related 1st, 2nd, 3rd, degree. If known specify)
- ☐ CAUGHT ON OR IN/BETWEEN_____ (Object, elevator, pinched/crushed, etc. Specify)
- ☐ CUT BY_____ (Sharps: tool, tests tube, etc. Specify)
- ☐ ELECTRICAL SHOCK_____ (Specify)
- ☐ EQUIPMENT RELATED_____ (Specify)
- ☐ FOREIGN BODY IN EYE_____ (Specify)
- ☐ LIFTING PATIENT_____ (Transferring PT. repositioning, actual lifting, stretcher related. Specify)
- ☐ LIFTING MATERIAL_____ (Specify)
- ☐ NOISE_____ (Exposure to injurious noise levels. Specify)
- ☐ NEEDLE/SHARPS INJURY CONTAMINATED____/CLEAN____ (Size, gauge or type. Specify)_____
- ☐ PHYSICAL ASSAULT_____ (Patient, relative, visitor, etc. Specify)
- ☐ REPETITIVE MOTION/OTHER BODY MECHANICS_____ (Bending, stretching, pulling, pushing. Specify)
- ☐ RUBBED OR ABRADED_____ (Pressure, vibration, or friction – non-impact cases. Specify)
- ☐ SLIP AND/OR FALL_____ (Same level, elevation, wet floor, obstacle, rolling chair. Specify)
- ☐ STRUCK AGAINST_____ (Stationary object. Specify)
- ☐ STRUCK BY_____ (Door, object. Specify)
- ☐ TRANSIT_____ (Vehicle, Specify)
- ☒ OTHER Stepping off of ambulance and falling (Specify)
- ☐ EXPOSURE_____ (Communicable disease. Specify)
- ☐ EXPOSURE_____ (Potentially hazardous chemical, inhalation, contact, etc. Specify)
- ☐ EXPOSURE BLOOD/ BODY FLUIDS_____ (Splash, bite, spray to mucous membranes, eyes, nose, mouth, etc. Specify)
- ☐ WORKPLACE ALTERCATION_____ (Specify)

EMPLOYEE SIGNATURE: Bayani Dillard	TODAY'S DATE: 6/11/2021	RETURNED TO WORK: Y ☒ N ☐	PHONE#: 917 38[illegible]5350	DEPT.: PHC
NAME OF SUPERVISOR (Print): Tiffany Santos	SIGNATURE: [illegible]	TODAY'S DATE: 6/11/21	PHONE/BEEPER#: —	DEPT.: PHC

ER Chart Number # 661237

EMERGENCY DEPARTMENT PHYSICIAN'S REPORT

DATE OF TREATMENT: 6/11/21	TIME OF TREATMENT: 1:00 ☐ AM ☒ PM	PATIENT'S COMPLAINT: (R) knee pain

DIAGNOSIS AND PART OF BODY AFFECTED (Specify right or left side): (R) knee sprain

NATURE OF TREATMENT (Please check box)
- ☐ First Aid Only
- ☐ Medical Treatment
- ☒ Post Exposure Prophylaxis
- ☐ X-rays
- ☐ Refused Exam/Treatment
- ☐ Other_____

DISPOSITION (Please check box)
- ☐ Hospitalize
- ☒ Returned to Work
- ☐ Sent home for one day and advised to report to EHS/OHS for Follow-up ASAP

FOLLOW UP (Please check box)
- ☐ Not Required
- ☐ Return to EHS/OHS on (Date) __/__/____
- ☐ Refer to Workers' Comp MD_____
- ☐ Refer to Private MD_____

Comments: RICE f/u with ortho

NAME OF PHYSICIAN (Print name): Jane Chang, PA	SIGNATURE: [illegible]	DATE: 6/11/21

SEND ORIGINAL REPORT TO EMPLOYEE INCIDENTS DEPARTMENT

WHITE COPY- EMPLOYEE YELLOW COPY-OCCUPATIONAL HEALTH PINK-SAFETY

NEW YORK STATE | Workers' Compensation Board

PO Box 5205
Binghamton, NY 13902-5205

2000000007
Customer Service Toll-Free Line: 877-632-4996
Statewide Fax Line: 877-533-0337
www.wcb.ny.gov

COVER SHEET FOR REPORT OF INDEPENDENT MEDICAL EXAMINATION

A copy of each report of Independent Medical Examination shall be submitted on the same day and in the same manner to the Workers' Compensation Board, the insurance carrier or self-insured employer, the claimant's attending physician or other attending independent examiner, the claimant's representative, if any, and the claimant.

CHECK ONE: ☑ PHYSICIAN ☐ PODIATRIST ☐ CHIROPRACTOR ☐ PSYCHOLOGIST

THIS EXAMINATION WAS REQUESTED BY: ☑ CARRIER/EMPLOYER ☐ CLAIMANT

WCB Case No.	Carrier Case No. (If Known)	Date of Injury/Illness	Injured Person's Social Security No.	Date of Examination
G3051719	73141129-110	6/11/2021		3/20/2023

Injured Person	FIRST NAME	MIDDLE INITIAL	LAST NAME	ADDRESS (Include Apt. No.)
	Bayani Dillard			52 Charles Street, Malverne, NY 11565
Insurance Carrier/ Self-Insured Employer	NYSIF			199 Church Street, New York, NY, 10007
Independent Examiner				
	Authorization No.			Date of Report of Independent Medical Examination
				3/24/2023
	Start Time of Patient Examination	End Time of Patient Examination		Total Time Spent Reviewing Records
	1:06 pm	1:23 pm		30 Minutes

IF EXAMINER CONDUCTED THIS EXAMINATION AS AN EMPLOYEE OF AN IME COMPANY, OR UNDER CONTRACT OR ARRANGEMENT WITH AN IME COMPANY, STATE NAME AND WORKERS' COMPENSATION BOARD REGISTRATION NUMBER OF IME COMPANY.

Attach Report of Independent Medical Examination

Report of Independent Medical Examination must include this cover sheet and a narrative report that includes the components listed below. If the examination concludes Schedule Loss of Use and/or Non-Schedule Permanent Partial Disability please include the IME-4.3A and/or IME-4.3B with the cover sheet and your medical narrative.

- A description of the examination;
- A list of all documents or information reviewed by the IME evaluator;
- The examiner's professional opinion; and
- A signed and dated certification at the end of the report of the independent medical examination as follows:
  - I hereby certify that this report is a full and truthful representation of my professional opinion with respect to the claimant's condition; that no person or entity has caused, directed or encouraged me to submit a report that differs substantially from my professional opinion; and I have reviewed the report and attest to its accuracy.
  - The signature and date must be below the required certification.

Any questionnaire or intake sheets completed by the claimant either before arriving or after arriving for the independent medical examination must be attached to this cover sheet with the report.

In certifying on the cover sheet, you are certifying to the entire contents of the Report of Independent Medical Examination.

I hereby certify that this report is a full and truthful representation of my professional opinion with respect to the claimant's condition; that no person or entity has caused, directed or encouraged me to submit a report that differs substantially from my professional opinion; and I have reviewed the report and attest to its accuracy.

Thomas E. Albus, M.D. — Independent Examiner's Name

3/24/2023 — Date

Thomas E. Albus — Independent Examiner's Signature

Thomas Albus, M.D.
American Board of Orthopedic Surgery
601 Franklin Avenue, Suite 215, Garden City, NY 11530

3090000097

March 20, 2023

Medex Analytic Services
3200 N University Dr.
Coral Springs, FL 33065

Claimant:	Bayani Dillard
Date of Loss:	6/11/2021
WCB#:	G3051719
Carrier Case#:	73141129-110
Case#:	48279
Employer:	Flushing Hospital & Medical Center
Exam Type:	Worker's Compensation IME
Specialty:	Orthopedic Surgery

To Whom It May Concern:

As per your request, I examined the above-referenced claimant for the purpose of an independent orthopedic evaluation on March 20, 2023, at the Garden City, office. The claimant presented a Driver's License for verification. The examination was performed in the presence of a medical assistant, Amanjot. Mr. Dillard drove himself to our office. There was no interpreter present at the time of the IME.

The findings of my examination are as follows:

INJURY HISTORY:

Mr. Bayani Dillard is a 46-year-old right-handed male, who alleges that he sustained injuries to the right knee as a result of a work-related accident on 6/11/2021. At the time of the incident, Mr. Dillard was employed as an EMT. He states that on the day of the incident while jumping off the EMS vehicle, he mis stepped and landed awkwardly on his right knee which caused severe pain.

Mr. Dillard went to the emergency room at Flushing Hospital immediately after the incident. X-rays and CT scans of the right knee were performed. Later that day, he was treated with medications for pain relief and was released home.

After the injury, the claimant followed up with an orthopedic surgeon and a pain management specialist. He reports that he was advised to start with physical therapy. Mr. Dillard has undergone further diagnostic testing with X-rays and MRIs of the right knee. Mr. Dillard denies receiving any injections. He underwent right knee arthroscopy on 1/10/2022. The claimant has no current treatment in place.

PRESENT COMPLAINTS:

Today, Mr. Dillard described pain in the right knee.

3090000007

PAST/UNRELATED MEDICAL & SURGICAL HISTORY:

Mr. Dillard mentions that he suffers from Asthma, Obesity, and Hypertension. Further, he denies undergoing any surgery. There is no history of work-related/MVA-related injury.

SUBSEQUENT ACCIDENTS/INJURIES:

Mr. Dillard has not suffered any subsequent MVA or Worker's related injuries.

PRESENT MEDICATIONS:

Mr. Dillard's current medications include Percocet. The claimant says that he took these medications prior to IME.

OCCUPATIONAL STATUS:

At the time of the incident, Mr. Dillard was employed as an EMT. He reports missing approximately 1 year due to the date of loss injury. He states that he is working full-time in the same position.

DAILY ACTIVITIES:

The claimant is able to independently perform all daily activities.

MEDICAL RECORDS AVAILABLE FOR REVIEW:

- IME report dated 5/19/2022 by Louis Romeo, M.D.
- IME report dated 8/26/2021 by Louis Romeo, M.D.
- Procedure note of right knee arthroscopic surgery, partial medial meniscectomy, chondroplasty of the patella, chondroplasty of the femoral trochlea, chondroplasty of the medial femoral condyle, chondroplasty of the medial tibial plateau, the major synovectomy of right knee dated 1/10/2022 by Gus Katsgiorgis, D.O.
- X-ray of the right knee dated 7/23/2021 submitted by Gus Katsgiorgis, D.O. Impression: Degenerative changes present. Reveal no fractures.
- X-ray of the right knee dated 6/22/2021 submitted by Mathew Diament, M.D. Impression: Patellar enthesopathy. Tricompartmental osteoarthritis is most pronounced in the medial tibiofemoral compartment. If clinical symptoms persist consider further imaging with MRI, provided there are no medical contraindications.
- Ultrasound of the right knee dated 6/22/2021 submitted by Mathew Diament, M.D. Impression: The source of pain was not elucidated on this exam. If clinical symptoms persist consider further imaging with MRI, provided there are no medical contraindications.
- MRI of the right knee dated 6/21/2021 submitted by James McCleavey, M.D.

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Impression: Osseous structures are intact. Superficial chondral erosions on the medial femoral condyle. Oblique tear on the undersurface of the mid-body of the medial meniscus and partial anterior subluxation of the anterior horn of the medial meniscus ventral to the margin of the medial tibial plateau. Chondral erosion is a discrete subcentimeter degenerative osteochondral lesion on the anterior superior margin of the lateral femoral condyle at articulation with the lateral patella facet. The fluid surrounds the popliteus tendon at the posterolateral corner. Lateral patellar tilt. Attenuated diameter of the medial patellar retinaculum and medial patellofemoral ligament. Moderate joint effusion with fluid extending into the suprapatellar bursa. Mild edema in subcutaneous tissues ventral to the knee.

- Physical therapy progress notes dated 8/2/2021, 8/4/2021, 8/6/2021, 8/12/2021, 8/13/2021, 8/14/2021, 8/17/2021, 8/18/2021, 8/20/2021, 8/24/2021, 8/25/2021, 8/27/2021, 9/2/2021, 9/3/2021, 9/4/2021, 9/8/2021, 9/9/2021, 9/10/2021, 9/13/2021, 9/15/2021, 9/17/2021, 9/20/2021, 9/22/2021, 9/25/2021, 9/28/2021, 9/29/2021, 9/30/2021, 10/4/2021, 10/11/2021, 10/14/2021, 10/15/2021, 10/16/2021, 10/18/2021, 10/20/2021, 10/22/2021, 10/27/2021, 11/1/2021, 11/2/2021, 11/3/2021, 11/8/2021, 11/11/2021, 11/15/2021, 11/18/2021, 11/23/2021, 1/26/2022, 2/3/2022, 2/14/2022, 2/15/2022, 2/24/2022, 3/1/2022 and 3/2/2022 from (Valley) Island Musculoskeletal Care, M.D, P.C.
- Follow-up notes dated 7/23/2021, 9/13/2021, 11/15/2021, 1/26/2022, 3/23/2022, 4/27/2022, 5/20/2022, 7/6/2022, 10/3/2022 and 1/11/2023 by Gus Katsgiorgis, D.O.
- Chiropractic progress notes dated 6/22/2021 from NewYork Medical & Diagnostic.
- Follow-up notes dated 6/18/2021, 6/19/2021, 7/2/2021, 7/21/2021 and 7/28/2021 by Appasahed Naik, M.D.

PHYSICAL EXAMINATION:

General Examination:

Mr. Dillard is a 46-year-old right-handed male with dark brown eyes. He stands 6'00" tall and weighs 320 pounds.

All Range of Motion measurements were taken with the aid of a standard hand-held goniometer. All Units are measured in degrees. When appropriate, the range of motion was measured 3 times. Range of Motion normal values are in accordance with the New York State Workers Compensation guidelines and AMA 5th edition for evaluation of permanent impairment.

Examination of Knees:
There was no heat redness or swelling noted. There was no medial or lateral joint line pain/tenderness elicited upon palpation. Patella was located centrally. There was no ligament instability seen. The Anterior Drawer test, Posterior Drawer test, and Lachman test were all negative for the right as well as left knee. Healed arthroscopic portals were

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noted on the right knee.

Range of Motion	Normal	Left	Right
Flexion	140	120	100
Extension	0	0	0

Examination of all non-orthopedic complaints is deferred to their respective specialty.

IMPRESSION/DIAGNOSIS:

- Right knee, postoperative arthroscopy 01/10/2022, 14 months postoperative. The underlying diagnosis is that of multicompartmental arthritis of the knee.

CAUSALITY:

After reviewing the medical records, taking a history, and performing a physical examination, there is a causal relationship between the knee strain and the date of loss/injury. The multicompartmental arthritis of the knee is pre-existing.

MMI:

Based on the findings of my examination today, in my opinion, the claimant has attained maximum medical improvement.

SLU:

Based on today's examination, the claimant has a 26% scheduled loss of use of the Right knee (with 26% for defect of flexion and 0% for defect of extension). The SLU is calculated with the contralateral knee as a baseline. Reference chapter 7, page 42, table 7.4. Workers' Compensation Guidelines for Determining Impairment First Edition, November 22, 2017.

However it should be noted that the SLU is influenced by underlying osteoarthritis. This does not depict the claimant's clinical status.

TREATMENT AND RECOMMENDATIONS:

Based upon evaluation as well as a review of medical records, the claimant would not benefit from additional medical treatment, physical therapy, diagnostic testing, evaluations, or surgery. There is no need for further treatment at this time. A self-directed home exercise program is reasonable at this stage.

The past treatment was reasonable, related, and necessary.

PROGNOSIS:

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The prognosis is good for the claimant returning to pre-injury work at full duty.

ABILITY TO WORK:

The claimant has returned to work full-time. He can continue to work in the same position as tolerated.

All opinions expressed are made with a reasonable degree of medical certainty

There was no doctor-patient relationship established during today's encounter. There was no existing doctor-patient relationship.

My assessment is in accordance with the New York State Workers' Compensation Board Guidelines effective 11/1/2021. Treatment Guidelines, the New York State Guidelines for Determining Permanent Impairment and Loss of Wage-Earning Capacity, January 2012, as well as the New York State Workers' Compensation Guidelines for Determining Impairment effective 1/1/18.

Pursuant to CPLR 2106, I, Thomas Albus, MD, a Diplomate of the American Board of Orthopedic Surgeons are duly licensed to practice medicine in the State of New York. I affirm, under the penalties of perjury, that the information contained within this document was prepared and is the work product of the undersigned, and is true to the best of my knowledge and information.

This report is a full and truthful representation of my professional opinion with respect to the claimant's condition in accordance with Workers' Compensation Law Sections 13-a (4)(e)(i), 13-k (3)(e)(i),13-l (3)(e)(i) or 13-m (4)(e)(i), as appropriate. No person or entity has caused, directed, or encouraged me to submit a report that differs substantially from my professional opinion. I have reviewed the report and attest to its accuracy.

If any additional information is made available for my review, I will be happy to re-evaluate my position at that time.

Sincerely,

Thomas Albus, MD
Board Certified in Orthopedics
License# 290960

PATEL KAO PAIN & REHAB ASSOCIATES, LLC

3098000007

IME Identification Form

Name: Bayani Dillard

Date: 3/20/23

Doctor: Albus

Location: Garden City

Medical Assistant: Aman

Start Time: 12:10

Interpreter: Y___ N✓ Name(If yes):_____

End Time: _____

Legal Rep: Y___ N✓ Name (If yes):_____

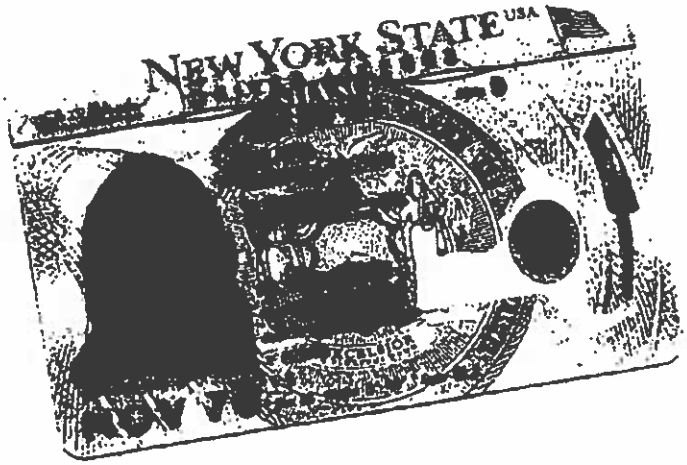
Vendor: Medex

Videographer: Y___ N✓ Name (If yes):_____

Other: Y___ N✓ Name (If yes):_____ Relationship(If yes):_____

Comments: _____

Photo Identification



PKPR GROUP

Provider's Name: [redacted]
3090000007

PERSONAL INFORMATION: (Circle wherever applicable)

Today's Date: 3/20/22 Patient Name: MR. BAYANI Dillard

Gender: Male Female Date of Birth Nov 5, 1976 Right-handed Left-handed

Height: 6 Weight: 320 Hair Color: Black Eye Color: Dark Brown Age: 46

How did you arrive at today's exam? Drove Myself Someone drove Taxi Bus/Train

ACCIDENT DETAILS

Date of Accident: 6/14/21

Briefly describe the incident: Slipped and fell wet floor in bathroom

For Motor Vehicle Accidents: (Circle appropriate)

Were you a Pedestrian Bicyclist Driver Passenger If Passenger Front Back

Were you wearing a seatbelt? Yes No Did the airbags deploy? Yes No

Did you lose consciousness? Yes No Any Cut? Yes No Any Stitches? Yes No

The car you were in was hit from: Front Back Driver side Passenger Side

Which Body parts were injured at the time of the accident? (Circle appropriate)

Head Neck Mid Back Lower back

Right shoulder Right elbow Right wrist Right hand Right hip Right knee Right ankle Right foot

Left shoulder Left elbow Left wrist Left hand Left hip Left knee Left ankle Left foot

Other:

HOSPITAL VISIT: (Circle wherever applicable)

Did you go to the Hospital? Yes No How? Ambulance With someone By Myself

When? Immediately After ___ Days Were you admitted? Yes No Did you lose consciousness ? Yes NO

When were you discharged? Same day After ___ Days

Describe the test performed: X-ray CT scan MRI

Which Body Part: Head Neck Back Shoulder Knee Other:

What treatment did you get: Medication Cane–Crutches–Sling–Neck collar–Knee brace–Bandage

Other: Are you still using it? Yes No

Today' Date:_____ Name:_____

INITIAL CARE: (Circle wherever applicable)

3090000007

When did you first go to the doctor (After the hospital visit): 6/14/21

To whom? *Orthopedic surgeon* *Pain management* *Neurology* *Internal Medicine* *PCP*

What was the treatment started? *Physical therapy* *Chiropractic* *Acupuncture* *Massage*

Any other specialty/doctor have you seen since the accident?

Orthopedic surgeon *Pain management* *Neurology* *Internal Medicine* *PCP* *Other*

Which Tests were performed?

X-ray Head Neck Lower back Shoulder R L Knee R L Other:_____

MRI Head Neck Lower back Shoulder R L Knee R L Other:_____

CT scan Head Neck Lower back Shoulder R L Knee R L Other:_____

EMG/NCV Upper Limbs Lower Limbs

Have you received any Injection? Yes No Which body part? _____

Have you received any Surgery? Yes No Which body part? R Knee Date 1/10/22

Has injection/surgery helped you? Yes No

CURRENT CARE:

Are you receiving any treatment at present? Yes No Is treatment helping? Yes No

Physical therapy_____/week Acupuncture_____/week Chiropractic_____/week

Are you taking any medications? Yes No If yes, please list Simvastatin, Xanax, Prozac

Did you take any medications today? Yes Regulation Nuvia and blood pressure Hypertension Meds

CURRENT COMPLAINTS OF PAIN IN:

Head *Neck* *Mid Back* *Lower back*

Right shoulder *Right elbow* *Right wrist* *Right hand* *Right hip* *Right knee* *Right ankle* *Right foot*

Left shoulder *Left elbow* *Left wrist* *Left hand* *Left hip* *Left knee* *Left ankle* *Left foot*

Other:_____

OCCUPATIONAL HISTORY

On the date of the accident were you employed? Yes No Occupation: EMT / Nursing Home

Job Description: Emergency Medical Technician

Did you lose any time from work? Yes No If Yes how long? 1 year

Are you working right now? Yes No Where? Same Job Different Job

Why are you not working (if not)? Pain Covid-19 Retired Changed job

If working: Full time Restricted What are the restriction if any? _____

Today' Date:_____ Name:_____

PAST MEDICAL HISTORY

3090000007

Do you have any illness? Yes No

Circle: Hypertension Diabetes Heart Disease Stroke Cancer Asthma Arthritis Other: Hypertension (HTN)

Did you undergo any surgery unrelated to this accident? Yes No Describe:_____

Any other injury? Yes No If yes: Worker's comp Motor vehicle Other When:?_____

Do you? Smoke cigarette NO Drink alcohol NO

SUBSEQUENT INJURY

Have you suffered any injury after the accident? Yes No

If yes, When? _____ Injured body part: _____ Treatment: _____

ACTIVITIES OF DAILY LIVING

1. How far can you walk? No limit Half mile One mile One block Two Blocks
2. How long can you stand continuously? No limit Two hours One hour 30 min 10 min
3. How long can you sit before you have to change position because of pain?
   No limit Two hours One hour 30 minutes 10 minutes
4. Does anyone help you with daily activities? Yes No If yes: Who? _____
5. What activities are you not able to do because of your injury? Run at full speed and go down and upstairs as quick but is due with discomfort and sometimes pain by applying strength.
6. What are your typical activities during the day? Moving around stretching knee leg and doing normal daily routines. -S.

Claimant Signature Bonya Dulemal Date:_____

NEW YORK STATE Workers' Compensation Board

PO Box 5205
Binghamton, NY 13902-5205

Customer Service Toll-Free Line: (877) 632-4996
Statewide Fax Line: (877) 533-0337
www.wcb.ny.gov

IME-4.3A 5-18

ATTACHMENT FOR REPORT OF INDEPENDENT MEDICAL EXAMINATION SCHEDULED LOSS OF USE

Please utilize this form as an attachment to the IME report, where there is an injury to a scheduled body part. These attachments will be considered part of the IME report, and must be served together with the IME-4.

Claimant's Name (LAST, FIRST, MI): Bayani Dillard

Social Security No.:

WCB Case No.: G3051719

Date of Injury/Illness: 6/11/2021

Date of Examination: 3/20/2023

A. Permanent Partial Disability

If the claimant has a permanent partial impairment, **complete A1** for all body parts and conditions for which a schedule award is appropriate (schedule loss of use). Use Form IME-4.3B for all body parts and conditions for which a non-schedule award (classification) is appropriate.

A1. Schedule Loss of Use of Member:

Body Part

Please include all the information in the bullet points below in the table on this page or attach a medical narrative with your report. The medical narrative should include the following information:

- Affected body part (include left or right side) and identify Guideline chapter (when special consideration exist).
- Measured Active Range of Motion (ROM) (3 measurements for injured body part, and use the greatest ROM. If not, please explain why.
- Measurement of contralateral body part ROM, or explain why inapplicable
- Previously received scheduled losses of use to same body part(s), if known
- Special considerations
- Loading for Digits and Toes

	Body Part/Measurement	Body Part/Measurement	Body Part/Measurement	Body Part/Measurement	Body Part/Measurement	Body Part/Measurement
	1 Right knee	2	3	4	5	6
	☐ Left ☐ Right	☐ Left ☐ Right	☐ Left ☐ Right	☐ Left ☐ Right	☐ Left ☐ Right	☐ Left ☐ Right
Range of Motion (3 measures)	See attached reports					
Contralateral ROM	See attached reports					
Contralateral Applicable Y/N If No, please explain below	Y					
Special Considerations (Chapter)						
Impairment %	26%					

Details:

13-10504

FDNY EMS
NOTICE OF INFRACTION

Date	Time	Location of Infraction	Borough
3/12/19	0752	Van Wyck Exp/Astoria Ave	Queens

Operator	Shield #	Title	Unit
Dillard Baim	7228	EMT	5262

Technician	Shield #	Title	Unit
Reardon, Thomas	6911	EMT	5262

Voluntary Hospital: Flushing Hospital 33

INFRACTION OF:

- [x] EMS OGP
- [ ] NYS DMV
- [ ] NYS EMS DOH PART 800
- [ ] SECURITY STICKER
- [ ] REMAC PROTOCOLS (non-patient care)
- [ ] OTHER _____

DESCRIPTION OF INFRACTION

AT 0615 hours unit placed out of service equipment light bar. Responded to 97 Ave 138 St for repair. At 0751 hours BIS investigator observed unit on CAD map traveling 10-62 at Astoria Ave/138 Street. Light bar repaired & left repair location. BIS inv sent Queens East Dispatcher a message to have the unit go 10-98. Dispatcher never called unit. At 0758 hours unit moved 10-98 at Van Wyck Exp/Rudsevelt Ave on CAD map. Unit traveled 7.0 miles from repair location. Unit failed to update their status.

Vincent Orchiano — Print Name
Inv — Rank
BITS — Station
_____ — Division

Signature
3/12/19 — Date

VOLUNTARY HOSPITAL AMBULANCE COPY

EMS 102.12.01 (1/13)

FLUSHING HOSPITAL MEDICAL CENTER
4500 Parsons Blvd
Flushing NY 11355-2205

Dillard, Bayani
MRN: 661237, DOB: 11/5/1976, Sex: M
Adm: 6/11/2021, D/C: 6/11/2021

Patient Demographics

Address	Phone	E-mail Address
52 CHARLES STREET MALVERNE NY 11565	917-386-5380 (Home) 917-386-5380 (Mobile) *Preferred*	bdillard_2000@yahoo.com

Basic Information

Date Of Birth	Legal Sex	Race	Preferred Language
11/5/1976	Male	American Indian or Alaskan Native, Black or African American, Filipino	English

Admission Information

Arrival Date/Time:	06/11/2021 1926	Admit Date/Time:	06/11/2021 1947	IP Adm. Date/Time:	
Admission Type:	Emergency	Point of Origin:	Self Referral	Admit Category:	
Means of Arrival:	Walk In	Primary Service:	Emergency Medicine	Secondary Service:	N/A
Transfer Source:	Home	Service Area:	FLUSHING HOSPITAL MEDICAL CENTER	Unit:	FHMC EMERGENCY ROOM
Admit Provider:		Attending Provider:	Paas Holland, Piret, MD	Referring Provider:	Chong, Jane, PA

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
06/11/2021 2051	Home/self Care	Home	None	FHMC EMERGENCY ROOM

Events

ED Arrival at 6/11/2021 1926

Unit: FHMC EMERGENCY ROOM
User: Labarca, Nicole, RN

Admission at 6/11/2021 1947

Unit: FHMC EMERGENCY ROOM — Room: FD-16A — Bed: 16A
User: Provenzano, Donna, RN — Patient class: Emergency — Service: Emergency Medicine

ED Roomed at 6/11/2021 1947

Unit: FHMC EMERGENCY ROOM — Room: FD-16A — Bed: 16A
User: Provenzano, Donna, RN — Patient class: Emergency — Service: Emergency Medicine

Discharge at 6/11/2021 2051

Unit: FHMC EMERGENCY ROOM — Room: FD-16A — Bed: 16A
User: Brady, Jeannine, RN — Patient class: Emergency — Service: Emergency Medicine

Discharge at 6/11/2021 2051

Unit: FHMC EMERGENCY ROOM — Room: FD-16A — Bed: 16A
User: Brady, Jeannine, RN — Patient class: Emergency — Service: Emergency Medicine

Allergies as of 6/11/2021

Review status set to Review Complete by Paas Holland, Piret, MD on 6/11/2021

	Noted	Reaction Type	Reactions
Asa [aspirin]	**10/18/2012**	**Allergy**	**Rash**
Motrin [ibuprofen] Rash	04/10/2015		
Seafood Rash	04/10/2015		

Immunizations

Name	Date
(Pfizer)Purple Cap (FH ONLY) SARS-COV-2(COVID-19)Vaccine,Pres Free,30 Mcg/0.3ml Dose	02/07/22
(Pfizer)Purple Cap (FH ONLY) SARS-COV-2(COVID-19)Vaccine,Pres Free,30 Mcg/0.3ml Dose	08/30/21
(Pfizer)Purple Cap (FH ONLY) SARS-COV-2(COVID-19)Vaccine,Pres Free,30 Mcg/0.3ml Dose	08/09/21

Medical as of 6/11/2021

Past Medical History

Medical as of 6/11/2021 (continued)

Diagnosis	Date	Comments	Source
Arthritis [M19.90]	—	—	Provider
Asthma [J45.909]	—	—	Provider
Hypertension [I10]	—	—	Provider

Problem List as of 6/11/2021 Reviewed: **6/11/2021 8:00 PM by Paas-Holland, Piret, MD**

None

ED Records

ED Arrival Information

Expected	Arrival	Acuity	Means of arrival	Escorted by	Service	Admission type
-	6/11/2021 19:26	Urgent	Walk In	Self	Emergency Medicine	Emergency

Arrival complaint
Knee pain

ED Disposition

ED Disposition	Condition	Comment
Discharge	--	Bayani Dillard discharge to home/self care. Condition at discharge: Stable

ED Notes

ED Provider Notes by Chong, Jane, PA at 6/11/2021 8:01 PM

Author: Chong, Jane, PA
Filed: 6/11/2021 8:37 PM
Editor: Chong, Jane, PA (Physician Assistant)

Service: —
Date of Service: 6/11/2021 8:01 PM

Author Type: Physician Assistant
Status: Attested
Cosigner: Paas Holland, Piret, MD at 6/11/2021 8:42 PM

Attestation signed by Paas Holland, Piret, MD at 6/11/2021 8:42 PM

I reviewed the notes, assessments by PA-C Jane Chong, I concur with her documentation of this patient, and I collaborated in the management of this patient.

.First Provider Evaluation Time: File (06/11/21 1954)

History

Chief Complaint

Patient presents with

- Knee Pain

  R knee x8 hours after jumping out of ambulace, as per pt knee feels tight

44 yo male with pmh htn, asthma, arthritis came in for right knee pain. Pt states he jumped off the ambulance - felt a little pain but continued to work. Pt states when he went to go to bathroom afterwards he felt stiffness in the knee and fell onto it. Pt denies any injucy to head or loc. Pt states he took aleve with relief.

The history is provided by the patient. No language interpreter was used.

Illness

Location: **Right knee pain**
Severity: **Moderate**
Onset quality: **Sudden**
Duration: **1 day**
Timing: **Constant**
Progression: **Unchanged**
Chronicity: **New**
Associated symptoms: **no fever**

Past Medical History:

Diagnosis	Date
Arthritis	
Asthma	
Hypertension	

History reviewed. No pertinent surgical history.

No family history on file.

Social History

Tobacco Use

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance Use Topics

- Alcohol use: No
- Drug use: No

Review of Systems
Constitutional: Negative for chills and fever.
Musculoskeletal: Positive for arthralgias.
All other systems reviewed and are negative.

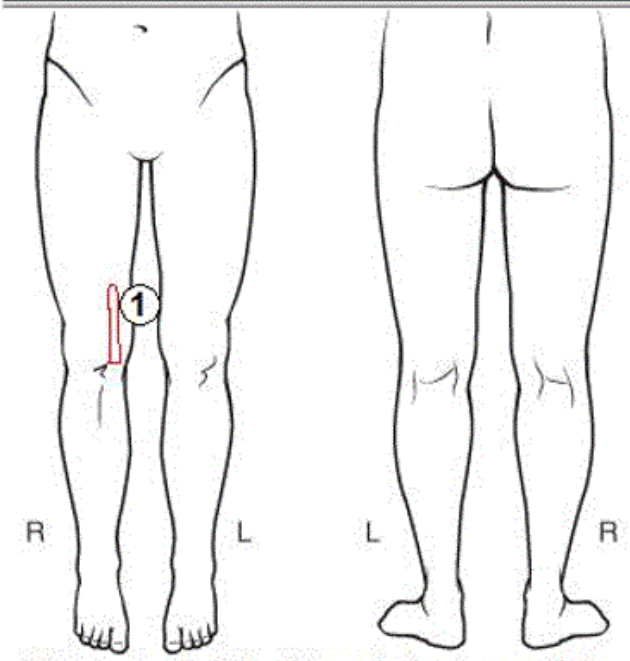
Physical Exam

BP (!) 162/94 Comment: pt states he has HTN, took his medication today | Pulse 102 | Temp 98.8 °F (37.1 °C) (Oral) | Resp 20 | Ht 5' 11" (1.803 m) | Wt (!) 345 lb (156.5 kg) | SpO2 95% | BMI 48.12 kg/m²

Physical Exam
Vitals reviewed.
Constitutional:
General: He is not in acute distress.
Appearance: Normal appearance. He is obese. He is not ill-appearing, toxic-appearing or diaphoretic.
HENT:
Head: Normocephalic and atraumatic.
Neck:
Vascular: No carotid bruit.
Pulmonary:
Effort: Pulmonary effort is normal.
Musculoskeletal:
Cervical back: Normal range of motion and neck supple. No rigidity or tenderness.
Right knee: Tenderness present over the medial joint line.
Legs:

ED Notes (continued)

ED Provider Notes by Chong, Jane, PA at 6/11/2021 8:01 PM (continued)



1: Ecchymosis noted of medial aspect extending upwards to thigh - with from - tenderness to touch

Lymphadenopathy:
Cervical: No cervical adenopathy.
Skin:
General: Skin is warm and dry.
Coloration: Skin is not jaundiced or pale.
Findings: No bruising, erythema, lesion or rash.
Neurological:
General: No focal deficit present.
Mental Status: He is alert and oriented to person, place, and time. Mental status is at baseline.

Assessment

Acute right knee pain

Plan

Ct right knee

ED Course

Pt was stable during stay here.
2040 - no fx noted - advised to RICE and take aleve prn. F/u with ortho clinic.

Procedures

MDM

Number of Diagnoses or Management Options
Acute pain of right knee: new and requires workup

Amount and/or Complexity of Data Reviewed
Tests in the radiology section of CPT®: reviewed and ordered

Risk of Complications, Morbidity, and/or Mortality
Presenting problems: moderate
Diagnostic procedures: low
Management options: low

Patient Progress
Patient progress: stable

Jane Chong, PA
06/11/21 2037

Piret Paas Holland, MD
06/11/21 2042

Electronically Signed by Paas Holland, Piret, MD on 6/11/2021 8:42 PM

ED Notes by Brady, Jeannine, RN at 6/11/2021 8:05 PM

Author: Brady, Jeannine, RN | Service: — | Author Type: Registered Nurse
Filed: 6/11/2021 8:05 PM | Date of Service: 6/11/2021 8:05 PM | Status: Signed
Editor: Brady, Jeannine, RN (Registered Nurse)

Patient sent for CT scan, safety maintained, will continue to monitor.

Electronically Signed by Brady, Jeannine, RN on 6/11/2021 8:05 PM

ED Notes by Brady, Jeannine, RN at 6/11/2021 7:52 PM

Author: Brady, Jeannine, RN | Service: — | Author Type: Registered Nurse
Filed: 6/11/2021 7:53 PM | Date of Service: 6/11/2021 7:52 PM | Status: Signed
Editor: Brady, Jeannine, RN (Registered Nurse)

Received patient awake and alert x 3, no acute distress noted. C/o injuring right knee this morning. Swelling

ED Notes (continued)

ED Notes by Brady, Jeannine, RN at 6/11/2021 7:52 PM (continued)

and ecchymosis to right knee noted, patient is having difficulty bearing weight. Awaiting MD eval, safety and fall risks maintained.

Electronically Signed by Brady, Jeannine, RN on 6/11/2021 7:53 PM

Discharge Instructions - Encounter Notes

Discharge Instructions by Chong, Jane, PA at 6/11/2021 8:35 PM

Author: Chong, Jane, PA
Filed: 6/11/2021 8:35 PM
Editor: Chong, Jane, PA (Physician Assistant)
Electronically signed by Chong, Jane, PA on 6/11/2021 8:35 PM

Service: —
Date of Service: 6/11/2021 8:35 PM

Author Type: Physician Assistant
Status: Written

ED Patient verbalize discharge instructions - Encounter Notes

ED Patient verbalize discharge instructions by Brady, Jeannine, RN at 6/11/2021 8:44 PM

Author: Brady, Jeannine, RN
Filed: 6/11/2021 8:44 PM
Editor: Brady, Jeannine, RN (Registered Nurse)

Service: —
Date of Service: 6/11/2021 8:44 PM

Author Type: Registered Nurse
Status: Signed

Patient verbalized understanding of discharge instructions.

Electronically signed by Brady, Jeannine, RN on 6/11/2021 8:44 PM

Discharge Instructions

Dillard, Bayani (MRN 661237)

None

FLUSHING HOSPITAL MEDICAL CENTER
4500 Parsons Blvd
Flushing NY 11355-2205

Dillard, Bayani
MRN: 661237, DOB: 11/5/1976, Sex: M
Adm: 6/11/2021, D/C: 6/11/2021

Imaging - All Orders and Results

CT knee right without contrast [63208220]

Electronically signed by: **Chong, Jane, PA on 06/11/21 2000**
Status: **Completed**
Ordering user: Chong, Jane, PA 06/11/21 2000
Ordering provider: Chong, Jane, PA
Authorized by: Paas Holland, Piret, MD
Frequency: Once 06/11/21 2000 - 1 occurrence
Indications of use: Knee trauma, dislocation suspected (Age >= 5y)

Questionnaire

Question	Answer
Clinical History:	ECCHYOMSIS/PAIN OF MEDIAL ASPECT - R/O FX AND LIGAMENT DAMAGE
Is this exam being performed on an Inpatient or ER patient requiring IV contrast ?	No

CT knee right without contrast [153469453]

Electronically signed by: **Chong, Jane, PA on 06/11/21 2000**
Status: **Completed**
This order may be acted on in another encounter.
Ordering user: Chong, Jane, PA 06/11/21 2000
Ordering provider: Chong, Jane, PA
Authorized by: Paas Holland, Piret, MD
Indications of use: Knee trauma, dislocation suspected (Age >= 5y)

Questionnaire

Question	Answer
Clinical History:	ECCHYOMSIS/PAIN OF MEDIAL ASPECT - R/O FX AND LIGAMENT DAMAGE
Is this exam being performed on an Inpatient or ER patient requiring IV contrast ?	No

CT knee right without contrast [153469453]

Resulted: 06/11/21 2021, Result status: Final result

Order status: Completed
Resulted by: Choi, Jai H, MD
Performed: 06/11/21 2011 - 06/11/21 2012
Accession number: 6095847
Resulting lab: RADIOLOGY
Narrative:
Clinical history: Pain and ecchymosis.

Noncontrast CT scan of the right knee was performed and reconstructed at 2.5-mm axial images.
Coronal and sagittal reformations were obtained.

Findings:
Bones: No fractures or dislocations are noted.
Mild spurring at the tibial spine and superior patella is noted.
Joints: The joint space with subchondral sclerosis is worse at the medial compartment and at the patellofemoral joint..
Soft tissues: There is distention of the suprapatellar bursa.
There is edema in the anterior subcutaneous fat with overlying skin stranding. A small calcification is noted along the subcutaneous tissues at the anteromedial aspect.

Impression:
Impression: No fractures.
Mild degeneration.
There is distention of the suprapatellar bursa.

Any questions or concerns about this report may be addressed to me at 718-670-3116 or JCHOI.FLUSHING@jhmc.org

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
22 - RADIOLOGY	RADIOLOGY	Unknown	Unknown	02/23/11 2220 - Present

Medications

All Meds and Administrations

(There are no med orders for this encounter)

Care Plan

Encounter Problems (Active)

There are no active problems.

Patient Education

Education

Title: Pain Management (Not Started)

Points For This Title

Point: Pain Control (Not Started)

Description:
Encourage the patient to contact staff for pain medication before the pain becomes intolerable or if pain medication is not working.

Learner Progress: Not documented in this visit.

Point: Pain Rating Scale (Not Started)

Description:
Provide patient with information on the Pain Rating Scale. Explain the rating scale of 0 to 10.

Learner Progress: Not documented in this visit.

Point: Patient Controlled Analgesia (Not Started)

Description:
Give the patient written information on Patient Controlled Analgesia. Explain how the pump works. Demonstrate pushing the button to give pain medicine to the patient. Caution the patient and other family/visitors that only the patient should press the PCA button for pain relief to decrease the chance of getting too much pain medicine.

Learner Progress: Not documented in this visit.

Point: Epidural Information (Not Started)

Description:
Give the patient written information on Epidural Analgesia. Explain why an epidural is used, how the epidural is placed and how the medication is given. If the epidural is PCA, demonstrate pushing the button to give pain medicine to the patient.
Caution the patient and other family/visitors that only the patient should press the button for pain relief to decrease the chance of getting too much pain medicine.

Learner Progress: Not documented in this visit.

Flowsheets (all recorded)

Custom Formula Data - Fri June 11, 2021

Row Name	2049	1932	1928
OTHER			
BSA (Calculated - sq m)	—	—	2.8 sq meters -NL
Pre Gravida Weight	—	—	-1 oz (-0.028 kg) -NL
BSA (Calculated - sq m)	—	—	2.8 sq meters -NL
BMI (Calculated)	—	—	48.1 -NL
IBW/kg (Calculated) Male	—	—	75.3 kg -NL
Low Range Vt 6cc/kg MALE	—	—	451.8 mL -NL
Adult Moderate Range Vt 8cc/kg MA	—	—	602.4 mL -NL
Adult High Range Vt 10cc/kg MALE	—	—	753 mL -NL
IBW/kg (Calculated) FEMALE	—	—	70.8 kg -NL
Low Range Vt 6cc/kg FEMALE	—	—	424.8 mL -NL
Adult Moderate Range vt 8cc/kg FEMALE	—	—	566.4 mL -NL
BMI (Calculated)	—	—	48.2 -NL
Percent Weight Change Since Birth	—	—	0 -NL
IBW/kg (Calculated)	—	—	75.3 -NL
Low Range Vt 6cc/kg	—	—	451.8 mL -NL
Adult Moderate Range Vt 8cc/kg	—	—	602.4 mL -NL
Adult High Range Vt 10cc/kg	—	—	753 mL -NL
Systolic BP	160 -JB	—	162 -NL
Risk Level	—	NO RISK -NL	—
Relevant Labs and Vitals			
Temp (in Celsius)	36.9 -JB	—	37.1 -NL
Minor Risk Factors			
OB BMI>30KG/M2	—	—	48.1 -NL
OB BMI>30KG/M2 Value	—	—	1 -NL
VTE Minor Score	—	—	1 -NL

Screening - Fri June 11, 2021

Row Name	1928
Travel/Communicable diseases screening	
Travel in the past month?	No -NL
Coronavirus	
Do you have any of these symptoms?	None of these symptoms -NL
Have you been in contact with someone that is positive for covid in the last 14 days?	No -NL
Have you been advised by health department/professional to self-quarantine?	No -NL
Have you recently been tested for the Coronavirus?	No -NL

HIV Test - Fri June 11, 2021

Row Name	1932
HIV Test	
Do you want to be tested for HIV?	No -NL

Triage Plan - Fri June 11, 2021

Row Name	1932

Patient Education (continued)

Flowsheets (all recorded) (continued)

Triage Plan

ESI	3 -NL
Destination	Main -NL
Triage Complete	Triage Complete -NL

Vaccination - Fri June 11, 2021

Row Name	1932
Vaccination	
Vaccinations Up To Date	No -NL

Human Trafficking - Fri June 11, 2021

Row Name	1932
Human Trafficking	
Are there any indicators or telltale signs of human trafficking?	No -NL

Vital Signs - Fri June 11, 2021

Row Name	2049	1928
Vital Signs		
Temp	98.4 °F (36.9 °C) -JB	98.8 °F (37.1 °C) -NL
Temp src	Oral -JB	Oral -NL
Pulse	89 -JB	102 -NL
Heart Rate Source	Monitor -JB	Monitor -NL
Resp	20 -JB	20 -NL
BP	160/90 -JB	**162/94** ! pt states he has HTN, took his medication today -NL
BP Location	Right arm -JB	Right arm -NL
BP Method	Automatic -JB	Automatic -NL
SpO2	97 % -JB	95 % -NL
O2 Device	None (Room air) -JB	None (Room air) -NL
Patient Position	Lying -JB	Sitting -NL
Pain Assessment	0-10 (VVAS) -JB	0-10 (VVAS) -NL
Sepsis Screening Criteria		
Neuromuscular Disease	—	No -NL
Invasive Devices	—	None -NL
Alteration in Mental Status	—	No -NL
Immunocompromise (AIDS, Cancer, Organ Transplant)	—	No -NL
Height and Weight		
Height	—	5' 11" (1.803 m) -NL
Height Method	—	Stated -NL
Weight	—	**345 lb (156.5 kg)** ! -NL
Weight Method	—	Stated -NL
OTHER		
Pain Score	—	Three -NL
Shock Index	0.56 -JB	0.63 -NL

COVID Vaccine - Fri June 11, 2021

Row Name	1928
Covid Vaccination	
Have you been vaccinated against COVID-19?	No -NL

Respiratory - Fri June 11, 2021

Patient Education (continued)

Flowsheets (all recorded) (continued)

Row Name	1951
Respiratory	
Respiratory (WDL)	WDL -JB

HEENT - Fri June 11, 2021

Row Name	1951
HEENT	
HEENT (WDL)	WDL -JB

Skin Color/Condition - Fri June 11, 2021

Row Name	1951
Skin Color/Condition	
Skin Color/Condition (WDL)	X -JB
Skin Color	Ecchymosis right knee -JB

Gastrointestinal - Fri June 11, 2021

Row Name	1951
Abdominal	
Gastrointestinal (WDL)	WDL -JB

Musculoskeletal - Fri June 11, 2021

Row Name	1951
Musculoskeletal	
Musculoskeletal (WDL)	X -JB
RLE	Limited movement;Swelling;Injury/trauma -JB

Cardiac Assessment - Fri June 11, 2021

Row Name	1951
Cardiac	
Cardiac (WDL)	WDL -JB
Cardiac Monitoring	
Cardiac Monitor On	No -JB
Cardiac Monitor Audible	No -JB
Alarms Set	No -JB

Arrival Documentation - Fri June 11, 2021

Row Name	1926
Notification	
Notification	No -NL
Triage Call	
Triage Call	Call 1x -NL
Healthcare Facility	
Did patient arrive from another healthcare facility?	No -NL
Prehospital Treatment	
Prehospital Treatment	No -NL
Prehospital Medication	No -NL

Abuse Indicators - Fri June 11, 2021

Row Name	1932
Screening	

Patient Education (continued)

Flowsheets (all recorded) (continued)

Screening (WDL)	WDL -NL

Departure Condition - Fri June 11, 2021

Row Name	2049
Pain	
Pain Score	Two -JB

Ortho Devices - Fri June 11, 2021

Row Name	2136
Ortho Devices	
Ortho Devices	Ace wrap -JB
Patient Given Instruction	Yes -JB
Return Demonstration by Patient	Yes -JB
Patient Verbalized Understanding	Yes -JB

First Provider Evaluation - Fri June 11, 2021

Row Name	1954
First Provider Evaluation Time	
First Provider Evaluation Time	File -JC

Vitals Reassessment - Fri June 11, 2021

Row Name	2049	1928
Vitals Assessment		
Restart Vitals Timer	Yes -JB	Yes -NL

Neurological - Fri June 11, 2021

Row Name	1951
Neurological	
Neuro (WDL)	WDL -JB

Language Doc-AMB/ED - Fri June 11, 2021

Row Name	1930
Language Documentation	
What is the patient's preferred language?	English -NL
Reason for Documentation	Collecting clinical information -NL
Is the patient deaf/hard of hearing?	No -NL

Fall Risk Assessment (READ ONLY) - Fri June 11, 2021

Row Name	1932
Fall Risk Assessment (READ ONLY)	
History of Falls	No -NL
Hendrich II Fall Risk Assessment (READ ONLY)	
Confusion/Disorientation /Impulsivity	0 -NL
Depression	0 -NL
Altered Elimination	0 -NL
Dizziness or Vertigo	0 -NL
Male Gender	1 -NL
Administered Antiepileptics	0 -NL
Administered Benzodiazepines	0 -NL
Get-Up-And-Go Test	0 -NL

Patient Education (continued)

Flowsheets (all recorded) (continued)

Hendrich II Fall Risk Score	1 -NL
Reviewed:	Yes -NL

Columbia-Suicide Severity Rating Scale-(C-SSRS)-Initial Screening - Fri June 11, 2021

Row Name	1932

C-SSRS Initial Screening Instructions: Questions 1, 2 and 6 are required of all patients. Questions 3, 4 and 5 are required if a patient answers "YES" to question 2. IF "NO" to questions 1, 2 and 6 = NO RISK

1) Within the past month, have you wished you were dead or wished you could go to sleep and not wake up?	No -NL
2) Within the past month, have you actually had any thoughts about killing yourself?	No -NL

C-SSRS Initial Risk Score

Risk Level	NO RISK -NL

Adult GCS - Fri June 11, 2021

Row Name	1930

Glasgow Coma Scale

Eye Opening	4 -NL
Best Verbal Response	5 -NL
Best Motor Response	6 -NL
Glasgow Coma Scale Score	15 -NL

User Key (r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
JC	Chong, Jane, PA	05/25/21 - 12/07/21
JB	Brady, Jeannine, RN	06/30/15 -
NL	Labarca, Nicole, RN	05/25/21 - 05/03/23

Flowsheet Notes

No notes of this type exist for this encounter.

Encounter-Level Documents on 06/11/2021:

Document on 6/11/2021 8:44 PM: ED After Visit Summary (below)

AFTER VISIT SUMMARY

Bayani Dillard MRN: 661237 | 6/11/2021 | FHMC EMERGENCY ROOM 718-670-5494

Instructions

Read the attached information
Acute Knee Pain Adult Easy-to-Read (English)

Schedule an appointment with FHMC Orthopedic Outpatient Clinic as soon as possible for a visit
Specialty: Orthopedic Medicine
Contact: 4500 Parsons Blvd
Flushing New York 11355
718-670-5486

What's Next

You currently have no upcoming appointments scheduled.

Preferred Pharmacy Info

Pharmacy
FLUSHING RX - FLUSHING, NY - 146-01 45TH AVENUE

IF YOU ARE INTERESTED IN THE COVID-19 VACCINE
WALK-IN'S WELCOME
8900 Van Wyck Expressway
Jamaica, NY 11418
C Bldg, Cellar Level

MONDAY- FRIDAY 7AM-3PM

OUTSIDE OF THESE HOURS: **Scan code or email your Name, Date of birth and phone number to COVID@jhmc.org**

SCAN ME

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Today's Visit

You were seen by Piret Paas-Holland, MD and Jane Chong, PA

Reason for Visit
Knee Pain

Diagnosis
Acute pain of right knee

Imaging Tests
CT knee right without contrast

Blood Pressure 162/94	Temperature (Oral) 98.8 °F
Pulse 102	Respiration 20
Oxygen Saturation 95%	

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Send messages to your doctor, view your test results, renew your prescriptions, schedule appointments, and more.

Go to https://mychart.medisys.org/mychart/, click "Sign Up Now", and enter your personal activation code: KMJSF-SWT95-P2DQ5. Activation code expires 9/9/2021.

Bayani Dillard (MRN: 661237) • Printed by Jeannine Brady, RN at 6/11/21 8:44 PM

Page 1 of 6 Epic

Your Medication List

ASK your doctor about these medications

ASK **Albuterol HFA** inhaler Commonly known as: VENTOLIN	Inhale 2 puffs into the lungs every 6 (six) hours as needed for Wheezing.
ASK **DULERA IN**	Inhale into the lungs.
ASK **Edarbi** 80 MG Tabs Generic drug: Azilsartan Medoxomil	Take by mouth.
ASK **SINGULAIR PO**	Take by mouth.

Healthix Disclaimer

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This notice is to inform patients who have been treated in our Emergency Department that their Protected Health Information may have been accessed through Healthix in a very limited number of situations while they were being treated in our Emergency Department.

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If you wish to request an audit log as to whether such "Break the Glass" access occurred when you were a patient in our Emergency Department, please contact:

Flushing Hospital Privacy Officer
Phone: 718 206-7892

Patient Education (continued)

Encounter-Level Documents on 06/11/2021: (continued)

If you are uninsured, Flushing Hospital may be able to help you obtain insurance or offer you a discount on your bill. Please contact the Financial Office at (718) 670-5588, or email us at enroll.flushing@jhmc.org for more information regarding our financial assistance program.

Patient Signature: _____ Date: _____

Patient Education (continued)

Encounter-Level Documents on 06/11/2021: (continued)

Attached Information

Acute Knee Pain Adult Easy-to-Read (English)

Acute Knee Pain, Adult

Many things can cause knee pain. Sometimes, knee pain is sudden (*acute*) and may be caused by damage, swelling, or irritation of the muscles and tissues that support your knee.

The pain often goes away on its own with time and rest. If the pain does not go away, tests may be done to find out what is causing the pain.

Follow these instructions at home:

Pay attention to any changes in your symptoms. Take these actions to relieve your pain.

If you have a knee sleeve or brace:

- Wear the sleeve or brace as told by your doctor. Remove it only as told by your doctor.
- Loosen the sleeve or brace if your toes:
  - Tingle.
  - Become numb.
  - Turn cold and blue.
- Keep the sleeve or brace clean.
- If the sleeve or brace is not waterproof:
  - **Do not** let it get wet.
  - Cover it with a watertight covering when you take a bath or shower.

Activity

- Rest your knee.
- **Do not** do things that cause pain.
- Avoid activities where both feet leave the ground at the same time (*high-impact activities*). Examples are running, jumping rope, and doing jumping jacks.
- Work with a physical therapist to make a safe exercise program, as told by your doctor.

Managing pain, stiffness, and swelling

- If told, put ice on the knee:
  - Put ice in a plastic bag.
  - Place a towel between your skin and the bag.
  - Leave the ice on for 20 minutes, 2–3 times a day.
- If told, put pressure (*compression*) on your injured knee to control swelling, give support, and help with discomfort. Compression may be done with an elastic bandage.

General instructions

- Take all medicines only as told by your doctor.
- Raise (*elevate*) your knee while you are sitting or lying down. Make sure your knee is higher than your heart.
- Sleep with a pillow under your knee.
- **Do not** use any products that contain nicotine or tobacco. These include cigarettes, e-cigarettes, and chewing tobacco. These products may slow down healing. If you need help quitting, ask your doctor.
- If you are overweight, work with your doctor and a food expert (*dietitian*) to set goals to lose weight. Being overweight can make your knee hurt more.
- Keep all follow-up visits as told by your doctor. This is important.

Contact a doctor if:

- The knee pain does not stop.
- The knee pain changes or gets worse.
- You have a fever along with knee pain.
- Your knee feels warm when you touch it.
- Your knee gives out or locks up.

Get help right away if:

- Your knee swells, and the swelling gets worse.
- You cannot move your knee.
- You have very bad knee pain.

Summary

- Many things can cause knee pain. The pain often goes away on its own with time and rest.
- Your doctor may do tests to find out the cause of the pain.
- Pay attention to any changes in your symptoms. Relieve your pain with rest, medicines, light activity, and use of ice.
- Get help right away if you cannot move your knee or your knee pain is very bad.

Patient Education (continued)

Encounter-Level Documents on 06/11/2021: (continued)

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Document Revised: 05/30/2019 Document Reviewed: 05/30/2019
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Document on 6/11/2021 8:42 PM: ED After Visit Summary (below)

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Bayani Dillard MRN: 661237 — 6/11/2021 — FHMC EMERGENCY ROOM 718-670-5494

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What's Next

You currently have no upcoming appointments scheduled.

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FLUSHING RX - FLUSHING, NY - 146-01 45TH AVENUE

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Bayani Dillard (MRN: 661237) • Printed by Jeannine Brady, RN at 6/11/21 8:42 PM — Page 1 of 6 Epic

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Scan on 6/11/2021: D/C (below)

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Notice to Patients About Access to Protected Health Information in an Emergency

Flushing Hospital Medical Center participates in the health information exchange operated by Healthix. Healthix is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law.

This notice is to inform patients who have been treated in our Emergency Department that their Protected Health Information may have been accessed through Healthix in a very limited number of situations while they were being treated in our Emergency Department.

This emergency access is called "Breaking the Glass". Access to a patient's records in Healthix is allowed without the patient's consent only when an authorized staff member of the Flushing Hospital Medical Center attests that (i) an emergency condition exists; (ii) the patient is in immediate need of medical attention; (iii) an attempt to secure consent to access Healthix would result in delay of treatment which would increase the risk to the patient's life or health; and (iv) in his or her reasonable judgment, the information that may be held by or accessible via Healthix may be material to emergency treatment.

If you wish to request an audit log as to whether such "Break the Glass" access occurred when you were a patient in our Emergency Department, please contact:

Flushing Hospital Privacy Officer
Phone: 718 206-7892

If you are uninsured, Flushing Hospital may be able to help you obtain insurance or offer you a discount on your bill. Please contact the Financial Office at (718) 670-5588, or email us at enroll.flushing@jhmc.org for more information regarding our financial assistance program.

Patient Signature: Bayani Dillard Date: 6/11/2021

Attached Information

Acute Knee Pain Adult Easy-to-Read (English)

Acute Knee Pain, Adult

Many things can cause knee pain. Sometimes, knee pain is sudden (*acute*) and may be caused by damage, swelling, or irritation of the muscles and tissues that support your knee.

The pain often goes away on its own with time and rest. If the pain does not go away, tests may be done to find out what is causing the pain.

Follow these instructions at home:

Pay attention to any changes in your symptoms. Take these actions to relieve your pain.

If you have a knee sleeve or brace:

- Wear the sleeve or brace as told by your doctor. Remove it only as told by your doctor.
- Loosen the sleeve or brace if your toes:
  - Tingle.
  - Become numb.
  - Turn cold and blue.
- Keep the sleeve or brace clean.
- If the sleeve or brace is not waterproof:
  - **Do not** let it get wet.
  - Cover it with a watertight covering when you take a bath or shower.

Activity

- Rest your knee.
- **Do not** do things that cause pain.
- Avoid activities where both feet leave the ground at the same time (*high-impact activities*). Examples are running, jumping rope, and doing jumping jacks.
- Work with a physical therapist to make a safe exercise program, as told by your doctor.

Managing pain, stiffness, and swelling

- If told, put ice on the knee:
  - Put ice in a plastic bag.
  - Place a towel between your skin and the bag.
  - Leave the ice on for 20 minutes, 2–3 times a day.
- If told, put pressure (*compression*) on your injured knee to control swelling, give support, and help with discomfort. Compression may be done with an elastic bandage.

General instructions

- Take all medicines only as told by your doctor.
- Raise (*elevate*) your knee while you are sitting or lying down. Make sure your knee is higher than your heart.
- Sleep with a pillow under your knee.
- **Do not** use any products that contain nicotine or tobacco. These include cigarettes, e-cigarettes, and chewing tobacco. These products may slow down healing. If you need help quitting, ask your doctor.
- If you are overweight, work with your doctor and a food expert (*dietitian*) to set goals to lose weight. Being overweight can make your knee hurt more.
- Keep all follow-up visits as told by your doctor. This is important.

Contact a doctor if:

- The knee pain does not stop.
- The knee pain changes or gets worse.
- You have a fever along with knee pain.
- Your knee feels warm when you touch it.
- Your knee gives out or locks up.

Get help right away if:

- Your knee swells, and the swelling gets worse.
- You cannot move your knee.
- You have very bad knee pain.

Summary

- Many things can cause knee pain. The pain often goes away on its own with time and rest.
- Your doctor may do tests to find out the cause of the pain.
- Pay attention to any changes in your symptoms. Relieve your pain with rest, medicines, light activity, and use of ice.
- Get help right away if you cannot move your knee or your knee pain is very bad.

This information is not intended to replace advice given to you by your health care provider. Make sure you discuss any questions you have with your health care provider.

Document Revised: 05/30/2019 Document Reviewed: 05/30/2019
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Order-Level Documents:

There are no order-level documents.

Encounter-Level E-Signatures:

FHMC NYS EXTERNAL APPEALS (E-SIG) - Received on 6/11/2021

Patient Name: Dillard,Bayani
Patient MRN: 661237

PATIENT CONSENT TO THE RELEASE OF RECORDS FOR NEW YORK STATE EXTERNAL APPEAL

The patient, the patient's designee, and the patient's provider have a right to an external appeal of certain adverse determinations made by health plans.

When an external appeal is filed, a consent to the release of medical records, signed and dated by the patient, is necessary. An external appeal agent assigned by the New York State Department of Financial Services will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against my health plan.

If the patient or the patient's designee submits this application, by signing the Patient Consent to the Release of Records for New York State External Appeal, the patient attests that the information provided in this application is true and accurate to the best of his or her knowledge.

Signature of patient is required below. If the patient is a minor, the document must be signed by their parent or legal guardian. If the patient is deceased, the document must be signed by the patient's healthcare proxy or executor. If signed by a guardian, healthcare proxy or executor, a copy of the legal supporting document should be included.

Patient Education (continued)

Encounter-Level E-Signatures: (continued)

Sign

Signature: Signature captured at 6/11/2021 07:36 PM

Print Name: BAYANI D

Date: (required) 06/11/21

On behalf of (if applicable):

Age: 44

Patient's Health Plan ID#: W/C

FHMC LIMITED POWER OF ATTORNEY (E-SIG) - Received on 6/11/2021

LIMITED POWER OF ATTORNEY TO PURSUE PAYMENT AND APPEALS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION ("LIMITED POWER OF ATTORNEY")

By signing this document, I give the Health Care Provider, identified below, a Limited Power of Attorney to pursue payment from my health insurer, health maintenance organization, self-insurance plan, governmental program, or other payer for medical services provided to me by the Health Care Provider, and I authorize the release of medical information.

I, the undersigned Patient/Principal, appoint Flushing Hospital Medical Center ("Health Care Provider"), located at 45th Avenue at Parsons Blvd, Flushing New York 11355 my Attorney-In-Fact and authorized representative to act in any way which I myself could do, if I was personally present, and to take all reasonable action, as determined by the Health Care Provider, to pursue payment from my Health Plan and/or pursue any appeals available to me under my Health Plan's policies or procedures and all applicable law, including but not limited to External Appeals under all State and Federal laws, relating to health care services provided by the Health Care Provider. The Health Care Provider, as my agent, may pursue payment and/or appeal, only when my Health Plan has denied payment based on medical necessity. The Health Care Provider will not charge me for its services in pursuing payment and/or an appeal on my behalf. I agree that my Health Plan will pay any amount owed directly to the Health Care Provider for these services. In pursuing such payment and/or an appeal:

I authorize the Health Care provider and my Health Plan to release all relevant medical information, including (if applicable) any HIV-related information, mental health treatment information, or alcohol/substance abuse treatment information, relating to my treatment which is necessary to pursue payment from my Health Plan. I understand that this information may be released, but only as necessary, to my Health Plan, an external appeal agent, arbitrator, court of law, and/or other third party reviewer ("Independent Reviewer") responsible for deciding if the Health Care Provider's claim for services should be paid. I understand that my Health Plan and/or the Independent Reviewer will use this information to make a decision about payment to the Health Care Provider. I also understand that the decision by the Independent Reviewer will be final and binding on me, the Health Care Provider, and the Health Plan, and:

I authorize the Health Care Provider to complete, execute, acknowledge, seal and to deliver any consent, demand, request, application, agreement, authorization or other documents necessary, to request, on my behalf, payment and/or appeal to my Health Plan and, if applicable, to the Independent Reviewer, the New York State Department of Health, the State Insurance Department, the U.S. Department of Health and Human Services, the U.S. Department of Labor, and/or any other applicable agency or body.

Patient Education (continued)

Encounter-Level E-Signatures: (continued)

This Limited Power of Attorney shall not be affected by my subsequent disability or incompetence and MAY BE REVOKED BY ME AT ANY TIME upon prior notice to the Health Care Provider. This Limited Power of Attorney, including authorization for release of medical information, will terminate one (1) year from today's date unless I agree to extend it beyond that date.
Any person or entity receiving this document may rely on a copy as if it were and executed original.

IN WITNESS WHEREOF, I have signed my name on 06/11/21

YOU SIGN HERE:

Signature captured at 6/11/2021 07:36 PM

PRINTED NAME: Dillard,Bayani

ADDRESS: 52 CHARLES STREET

MEDICAL RECORD#: 661237

WITNESS:

PRINT NAME/TITLE: BJE R EG

ADDRESS: 4500 Parsons Boulevard, Flushing, NY 11355

END OF REPORT

CT knee right without contrast

Status: Final result

Study Result

Narrative & Impression
Clinical history: Pain and ecchymosis.

Noncontrast CT scan of the right knee was performed and reconstructed at 2.5-mm axial images.
Coronal and sagittal reformations were obtained.

Findings:
Bones: No fractures or dislocations are noted.
Mild spurring at the tibial spine and superior patella is noted.
Joints: The joint space with subchondral sclerosis is worse at the medial compartment and at the patellofemoral joint..
Soft tissues: There is distention of the suprapatellar bursa.
There is edema in the anterior subcutaneous fat with overlying skin stranding. A small calcification is noted along the subcutaneous tissues at the anteromedial aspect.

IMPRESSION:
Impression: No fractures.
Mild degeneration.
There is distention of the suprapatellar bursa.

Any questions or concerns about this report may be addressed to me at 718-670-3116 or JCHOI.FLUSHING@jhmc.org

Imaging

CT knee right without contrast (Order: 153469453) - 6/11/2021

Result History

Admission Diagnoses (coded)

Dx Code	Diagnosis
M25.561	Pain in right knee

Resulting Physicians

Reading	Signing	Date/Time	Phone	Pager
CHOI, JAI H	**CHOI, JAI H**	6/11/2021 20:21	718-670-5447	

Exam Information

Status	Exam Begun	Exam Ended
Final [99]	6/11/2021 20:11	6/11/2021 20:12

View study in PACS

(Link Unavailable) Show images for CT knee right without contrast

Dillard, Bayani

MRN: 661237

ED 6/11/2021 (1 hours)
Status: Discharged
FHMC EMERGENCY ROOM

Last attending: Piret Paas Holland, MD • with Treatment team
Primary impression: Acute pain of right knee
Chief complaint: Knee Pain

ED Provider Notes

Jane Chong, PA (Physician Assistant) • Emergency Medicine

Cosigned by: Piret Paas Holland, MD at 6/11/2021 8:42 PM

Attestation signed by Piret Paas Holland, MD at 6/11/2021 8:42 PM

I reviewed the notes, assessments by PA-C Jane Chong, I concur with her documentation of this patient, and I collaborated in the management of this patient.

.First Provider Evaluation Time: File (06/11/21 1954)

History

Chief Complaint
Patient presents with
- Knee Pain
  R knee x8 hours after jumping out of ambulace, as per pt knee feels tight

44 yo male with pmh htn, asthma, arthritis came in for right knee pain. Pt states he jumped off the ambulance - felt a little pain but continued to work. Pt states when he went to go to bathroom afterwards he felt stiffness in the knee and fell onto it. Pt denies any injucy to head or loc. Pt states he took aleve with relief.

The history is provided by the patient. No language interpreter was used.
Illness
Location: **Right knee pain**
Severity: **Moderate**
Onset quality: **Sudden**
Duration: **1 day**
Timing: **Constant**
Progression: **Unchanged**
Chronicity: **New**
Associated symptoms: **no fever**

Past Medical History:

Diagnosis	Date
• Arthritis	
• Asthma	
• Hypertension	

History reviewed. No pertinent surgical history.

No family history on file.

Social History

Tobacco Use
- Smoking status: Never Smoker
- Smokeless tobacco: Never Used

Substance Use Topics
- Alcohol use: No
- Drug use: No

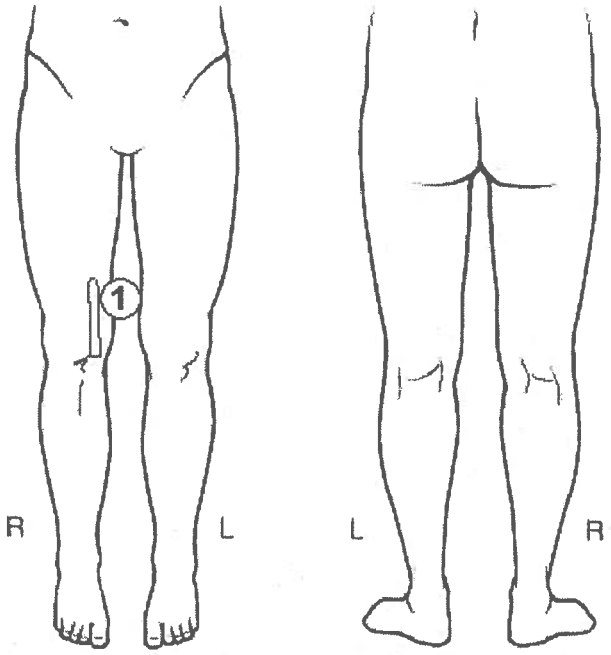
Review of Systems
Constitutional: Negative for chills and fever.
Musculoskeletal: Positive for arthralgias.
All other systems reviewed and are negative.

Physical Exam

BP (!) 162/94 Comment: pt states he has HTN, took his medication today | Pulse 102 | Temp 98.8 °F (37.1 °C) (Oral) | Resp 20 | Ht 5' 11" (1.803 m) | Wt (!) 345 lb (156.5 kg) | SpO2 95% | BMI 48.12 kg/m²

Physical Exam
Vitals reviewed.
Constitutional:
General: He is not in acute distress.
Appearance: Normal appearance. He is obese. He is not ill-appearing, toxic-appearing or diaphoretic.
HENT:
Head: Normocephalic and atraumatic.
Neck:
Vascular: No carotid bruit.
Pulmonary:
Effort: Pulmonary effort is normal.
Musculoskeletal:
Cervical back: Normal range of motion and neck supple. No rigidity or tenderness.
Right knee: Tenderness present over the medial joint line.

Legs:



1: Ecchymosis noted of medial aspect extending upwards to thigh - with from - tenderness to touch

Lymphadenopathy:
Cervical: No cervical adenopathy.
Skin:
General: Skin is warm and dry.
Coloration: Skin is not jaundiced or pale.
Findings: No bruising, erythema, lesion or rash.
Neurological:
General: No focal deficit present.
Mental Status: He is alert and oriented to person, place, and time. Mental status is at baseline.

Assessment
Acute right knee pain

Plan
Ct right knee

ED Course
Pt was stable during stay here.
2040 - no fx noted - advised to RICE and take aleve prn. F/u with ortho clinic.

Procedures

MDM

Number of Diagnoses or Management Options
Acute pain of right knee: new and requires workup

Amount and/or Complexity of Data Reviewed
Tests in the radiology section of CPT®: reviewed and ordered

Risk of Complications, Morbidity, and/or Mortality
Presenting problems: moderate
Diagnostic procedures: low
Management options: low
Patient Progress
Patient progress: stable

Jane Chong, PA
06/11/21 2037

Piret Paas Holland, MD
06/11/21 2042

Other Notes

All notes

ED Notes from Jeannine Brady, RN ED Notes from Jeannine Brady, RN

Additional Orders and Documentation

Results Meds Orders Flowsheets
Imaging

Encounter Info: History, Allergies, Detailed Report

Media

From this encounter

Electronic signature on 6/11/2021 7:36 PM - E-signed

Electronic signature on 6/11/2021 7:36 PM - 1 of 2 e-signatures recorded

Scan on 6/11/2021 8:52 PM by Beverley Adams: D/C

Clinical Impressions

Primary: **Acute pain of right knee** M25.561

Disposition

Discharge

Bayani Dillard discharge to home/self care.

Condition at discharge: Stable

ED After Visit Summary (Printed 6/11/2021)

Follow-Ups: Schedule an appointment with FHMC Orthopedic Outpatient Clinic (Orthopedic Medicine)

Medication Changes

As of 6/11/2021 8:51 PM

None

Care Timeline

1926 Arrived
2012 CT knee right without contrast
2051 Discharged

Alcohol Testing Form (Non-DOT)

(The instructions for completing this form are on the back of Copy 3)

STEP 1: TO BE COMPLETED BY ALCOHOL TECHNICIAN

A: Employee Name (Print) (First, M.I., Last): BAYANI DILLARD

B: SSN or Employee ID No.: # 21070

C: Employer Name: Flushing Hospital

Street: 4500 Parsons blvd

City, ST ZIP: Flushing, NY 11358

DER Name and Telephone No.: P. Diorio (DER Name) 718-206-8300 (DER (Area Code & Phone Number))

D: Reason for Test: [X] Random [ ] Reasonable Susp. [ ] Post-Accident [ ] Return to Duty [ ] Follow-up [ ] Pre-employment

STEP 2: TO BE COMPLETED BY EMPLOYEE

I certify that I am about to submit to alcohol testing and that the identifying information provided on the form is true and correct.

Bayani Dillard — Signature of Employee — Date: 10/13/22 (Month / Day / Year)

STEP 3: TO BE COMPLETED BY ALCOHOL TECHNICIAN

(If the technician conducting the screening test is not the same technician who will be conducting the confirmation test, each technician must complete their own form. I certify that I have conducted alcohol testing on the above named individual, that I am qualified to operate the testing device(s) identified, and that the results are as recorded.

TECHNICIAN: [X] BAT [ ] STT DEVICE: [ ] SALIVA [ ] BREATH* 15-Minute Wait: [ ] Yes [ ] No

SCREENING TEST: *For BREATH DEVICE* write in the space below only if the testing device is not designed to print.*

Test #	Testing Device Name	Device Serial # OR Lot # & Exp. Date	Activation Time	Reading Time	Result
Alcomate					Neg

CONFIRMATION TEST: *Results MUST be affixed to each copy of this form or printed directly onto the form.*

REMARKS: Negative

EMMC/OH — Alcohol Technician's Company

OCCUPATIONAL HEALTH SERVICE
FLUSHING HOSPITAL MEDICAL CENTER
45th AVENUE AT PARSONS BLVD.
FLUSHING, NY 11355

Company Street Address

PRINT Alcohol Technician's Name (First, M.I., Last)

Company City, State, Zip

Phone Number (Area Code & Number)

Signature of Alcohol Technician — Date: 10/13/22 (Month / Day / Year)

STEP 4: TO BE COMPLETED BY EMPLOYEE IF TEST RESULT IS POSITIVE

I certify that I have submitted to the alcohol test, the results of which are accurately recorded on this form. I understand that I must not drive, perform safety-sensitive duties, or operate heavy equipment because the results are positive.

Signature of Employee — Date (Month / Day / Year)

COPY 1 - ORIGINAL - FORWARD TO THE EMPLOYER

471-FS-C3 (Rev. 1/07) 6363

Accidental [illegible] line [illegible]

Screening Results Here

RBT IV# 027036
DATE 10-13-22
TEST NO. 0011
ID#
21070
AS IV# 118704
CONFIRMATION
G/210L TIME
.000 BLANK
.000 MAN 10:18

Affix With Tamper Evident Tape

RBT IV# 027036
DATE 10-13-22
TEST NO. 0011
ID#
21070
AS IV# 118704
CONFIRMATION
G/210L TIME
.000 BLANK
.000 MAN 10:18

Affix Confirmation Results Here

RBT IV# 027036
DATE 10-13-22
TEST NO. 0011
ID#
21070
AS IV# 118704
CONFIRMATION
G/210L TIME
.000 BLANK
.000 MAN 10:18

Affix With Tamper Evident Tape

Affix Additional Test Results Here

Affix With Tamper Evident Tape

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

1218079964

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 7/23/2021 1:34:45 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Gus Katsiglorgis, DO

Gender: MALE
Phone: (917)386-5380

History of Present Illness

The patient presents for evaluation. He works as an EMS worker. While performing his work activities he was in McDonald's bathroom, slipped on the floor landing on his right knee. He states there was water/urine on the floor, causing him to fall, twisting his knee and shoulder and landed on the right knee. Denies any prior injuries or problems before to the right knee. He is 44 years of age. He is not working now because of his injury. He went to Flushing hospital and then saw a Dr. Guillaume in the office that ordered an MRI. He had an MRI performed. I discussed the results with him. He has difficulty about the right knee with clicking, popping, swelling, giving way sensations.

Past Medical History: Asthma, High blood pressure.
No Known Drug Allergies

Physical Exam

Note:: Examination of the Right Knee: There is patellofemoral pain. There is tenderness. Positive McMurray's sign. Swelling/Effusion. Neurovascularly intact. Restricted range of motion fve degrees shy of full extension, 100 degrees of flexion.

X-RAYS
X-rays of the Right Knee/ 3 views: Degenerative changes present. Reveal no fractures.

Assessment

Right knee meniscus tear. Mechanical symptoms.
Other tear of medial meniscus, current injury, right knee, initial encounter (S83.241A)
Encounter for examination and observation following work accident (Z04.2)

Plan

Physical therapy. I went over risks, benefits and alternatives of right knee arthroscopy with possible arthrotomy, possible meniscectomy, possible meniscal repair with the patient. I discussed if meniscal repair is carried out, the patient may need further surgery with regards to meniscectomy if the meniscus does not heal. I discussed if partial meniscectomy is performed, that only the damaged portion of the meniscus will be removed. I discussed possible complications including, but not limited to, infection, bleeding, nerve damage, stiffness, pain, implant loosening, hardware loosening, skin breakdown, keloid formation, neuroma formation and further surgery for this, post-operative RSD, post-operative DVT, PE, MI, possible loss of limb or life, persistence of symptoms and possible need for further surgery in the future. No guarantees were made. All questions were answered. The patient does want to proceed with surgery. I am requesting authorization for right knee arthroscopy, possible arthrotomy, possible meniscectomy, possible meniscal repair.

In my opinion the incident that the patient describes is the competent medical cause of this injury.
The patients complaints are consistent with their history of injury.
The patients history of illness is consistent with my objective findings.
The patient has a 100% temporary impairment.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

1218079964

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
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Check In Date/Time: 7/23/2021 1:34:45 PM
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Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Gus Katsigiorgis, DO

Gender: MALE
Phone: (917)386-5380

The patient has a 100% temporary impairment.

This note is being transcribed from dictation of 07/23/2021

Electronically signed by Gus Katsigiorgis, DO at 09:43 AM, AUGUST 02, 2021

1218079964

ISLAND MUSCULOSKELETAL CARE, M.D., P.C.
P.O. BOX 360
HEWLETT, NEW YORK 11557

ROBERT L. HECHT, M.D., F.A.A.P.M.R
PHYSICAL MEDICINE & REHABILITATION

RUSSELL WEINSTEIN, M.D.
MARK J. DECKER, M.D.
RADIOLOGISTS

BARRY D. JUPITER, M.D., F.A.A.O.S.
GUS KATSIGIORGIS, D.O.
NABIL FARAKH, D.O.
ORTHOPEDIC SURGEONS

X-RAY REPORT

07/23/2021

Re: Dillard, Bayani

X-RAYS
X-rays of the Right Knee/ 3 views: Degenerative changes present. Reveal no fractures.

Gus Katsigiorgis, DO

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 9/13/2021 3:18:49 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Gus Katsigiorgis, DO

Gender: MALE
Phone: (917)386-5380

History of Present Illness

The patient presents for follow up. He has difficulty and pain about the right knee with clicming, popping and locking. MRI pergormed. I discussed the results with him.

Physical Exam

Note:: Examination of the Right Knee: There is patellofemoral pain. There is tenderness. Positive McMurray's sign. Swelling/Effusion. Neurovascularly intact. Restricted range of motion five degrees shy of full extension, 90 degrees of flexion.

Assessment

Right knee meniscus tear. Mechanical symptoms.
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Plan

Physical therapy. I went over risks, benefits and alternatives of right knee arthroscopy with possible arthrotomy, possible meniscectomy, possible meniscal repair with the patient. I discussed if meniscal repair is carried out, the patient may need further surgery with regards to meniscectomy if the meniscus does not heal. I discussed if partial meniscectomy is performed, that only the damaged portion of the meniscus will be removed. I discussed possible complications including, but not limited to, infection, bleeding, nerve damage, stiffness, pain, implant loosening, hardware loosening, skin breakdown, keloid formation, neuroma formation and further surgery for this, post-operative RSD, post-operative DVT, PE, MI, possible loss of limb or life, persistence of symptoms and possible need for further surgery in the future. No guarantees were made. All questions were answered. The patient does want to proceed with surgery. I am requesting authorization for right knee arthroscopy, possible arthrotomy, possible meniscectomy, possible meniscal repair.

In my opinion the incident that the patient describes is the competent medical cause of this injury.
The patients complaints are consistent with their history of injury.
The patients history of illness is consistent with my objective findings.
The patient has a 100% temporary impairment.

This note is being transcribed from dictation of 09/13/2021

Electronically signed by Gus Katsigiorgis, DO at 02:23 PM, SEPTEMBER 21, 2021

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
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Physician: Gus Katsiglorgis, DO

Gender: MALE
Phone: (917)386-5380

Gus Katsigiorgis, DO

264184

ISLAND MUSCULOSKELETAL CARE, M.D., P.C.
REVIEW OF SYSTEMS

NAME: Dillard, Bayani

DATE: 09/13/21

ARE THERE ANY CHANGES SINCE YOUR LAST VISIT? _____YES _____NO

IF YES, PLEASE NOTE AND MARK BELOW:

GENERAL-
- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Fever or Chills
- ☐ Weakness
- ☐ Trouble Sleeping

SKIN-
- ☐ Rashes
- ☐ Lumps
- ☐ Itching
- ☐ Dryness
- ☐ Color Changes
- ☐ Hair and Nails changes

HEAD-
- ☐ Headache
- ☐ Head injury
- ☐ Neck pain

EYES-
- ☐ Vision Loss/Changes
- ☐ Glasses or contacts
- ☐ Pain
- ☐ Redness
- ☐ Blurry or double vision
- ☐ Flashing lights
- ☐ Specks
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Last eye exam

NOSE-
- ☐ Stuffiness
- ☐ Discharge
- ☐ Itching
- ☐ Hay Fever
- ☐ Nosebleeds
- ☐ Sinus pain

THROAT-
- ☐ Bleeding
- ☐ Dentures
- ☐ Sore tongue
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Thrush
- ☐ Non-healing sores

NECK-
- ☐ Lumps
- ☐ Swollen Glands
- ☐ Pain
- ☐ Stiffness

BREASTS-
- ☐ Lumps
- ☐ Pain
- ☐ Discharge
- ☐ Self-exams
- ☐ Breast-feeding

RESPIRATORY-
- ☐ Cough
- ☐ Sputum
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Painful breathing

CARDIOVASCULAR-
- ☐ Chest pain or discomfort
- ☐ Tightness
- ☐ Palpitations
- ☐ Shortness of Breath with activity
- ☐ Difficulty breathing lying down
- ☐ Swelling
- ☐ Sudden awakening from sleep with shortness of breath

GASTROINTESTINAL-
- ☐ Swallowing difficulties
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Nausea
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Yellow eyes or skin

URINARY-
- ☐ Frequency
- ☐ Urgency
- ☐ Burning or pain
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Change in urinary strength

VASCULAR-
- ☐ Calf pain with walking
- ☐ Leg cramping

MUSCULOSKELETAL-
- ☐ Muscle or joint pain
- ☐ Stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma

NEUROLOGIC-
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor

HEMATOLOGIC-
- ☐ Ease of bruising
- ☐ Ease of bleeding

ENDOCRINE-
- ☐ Head or cold intolerance
- ☐ Sweating
- ☐ Frequent urination
- ☐ Thirst
- ☐ Change in appetit

PSYCHIATRIC-
- ☐ Nervousness
- ☐ Stress
- ☐ Depression
- ☐ Memory Loss

PATIENT SIGNATURE: _____

PHYSICIAN SIGNATURE: _____

☐ Dr. Brett Sliverman NPI: 1083620355
☐ Dr. Michael Trepeta NPI: 1164584553
☐ Dr. Gus Katsigiorgis NPI: 1033105564
☐ Dr. Nabil Farakh NPI: 1699932186
☐ Dr. Kanwarpaul Grewal NPI: 1144497033
☐ Dr. Steven Goodman NPI: 1477530285
☐ Dr. Robert Drazic NPI: 1578559001
☐ Dr. Paul Kublak NPI: 1396739777
☐ Dr. Robert Hecht NPI: 1669468120
☐ Dr. Elizabeth Mathew NPI: 1447571393

ThermoCare PLUS

FAX TO: 516-500-9508

PRESCRIPTION AND PHYSICIANS CERTIFICATE OF MEDICAL NECESSITY

Patient Name Bayani Dillard Date of Surgery/Injury 10/7/21

ICD 10 Primary Code S83.241A ICD 10 Secondary _____ Other ICD 10 Code _____

Medical Condition Rt Knee Meniscus tear Other ICD 10 Codes _____

PLEASE CIRCLE BELOW: RIGHT or LEFT AND AFFECTED BODY PART:
Right or Left | Foot Ankle Knee Back Shoulder Elbow Wrist Hip Neck

EQUIPMENT ORDERED: Thermo Plus System, Cold, Pneumatic Compression, and Mechanical DVT Prophylaxis Unit

EXPLANATION OF COLD AND COMPRESSION THERAPY

The Thermo Plus System/Vascutherm (VT4) is a portable, integrated ice-less, temperature regulated therapy device clinically proven to control post-operative pain and edema, reduce swelling, stimulate blood flow and increase speed functional recovery, thus reducing health care costs. The combination of these therapies ultimately increases muscle strength and range of motion. Post-operative swelling and its complications are the most common cause of extended recovery time. Temperature regulated therapy devices substantially reduce the risk of frostbite associated with ice or units that circulate ice water. The benefits of cold and compression therapy are thought to be most effective if applied almost immediately after injury or at the conclusion of an operative procedure. In many cases, the role of cold compression in the management of musculoskeletal injuries and orthopedic operative procedures may also reduce the need for pain reducing narcotics. Therefore, I am prescribing the Thermo Plus System for the above-named patient to assist during post-op treatment.

Physician Initials _____

COLD THERAPY INSTRUCTIONS

Frequency: 60 minutes 3 times per day or as much as patient desires, but no less.
Duration: 21 days **Setting:** 46 Degrees F

COMPRESSION THERAPY INSTRUCTONS

Frequency: 60 minutes 3 times per day or as much as patient desires, but no less.
Duration: 21 days

DEEP VEIN THROMBOSIS (DVT) MECHANICAL PREVENTION

A Thermo Plus portable therapy system is being prescribed for the above named patient. After a surgical procedure the use of intermittent pneumatic compression machine combined with other therapies, may reduce the risk of clot formation, and complications of DVT post phlebitic syndrome. Intermittent compression devices apply pressure that is similar to walking. An intermittent compression machine used following surgery has been clinically proven to help reduce the overall rate of DVT occurence and serious events associated with DVT. The Thermo Plus System is designed to provide this type of therapy.

Physician Initials _____

DVT THERAPY INSTRUCTIONS

Based on the below risk assessment, the patient should use DVT prevention.
Duration: 21 days

DVT RISK ASSESSMENT: A total of 3 points indicates HIGH RISK of DVT (as per AAOS guidelines)

BMI 35.26

____Age 41-59 1 pt; Age 60-74 2 pts; Age 75+ 3 pts
____Smoker 3 pts
____Arthroscopic surgery 2 pts
____Major surgery lasting 30 minutes or more 2 pts
____Add one point for each of the following: bed rest, restricted mobility, leg currently swollen, varicose veins, overweight/obese, past heart attack, serious infection

____Family history of blood clotting disorders 3 pts
____Birth Control pills 3 pts
____Serious trauma within last month 5 pts
____Broken hip, pelvis or leg within last month 5 pts
____Joint replacement surgery 5 pts

DVT ASSESSMENT TOTAL _____

_____
Physicians Signature

Gus Katsigiorgis D.O., FAOAO
Physicians Name

1033105564
Physicians NPI Number (not groups NPI)

9/20/2021
Date of script

REV 06/04/18)

ISLAND MUSCULOSKELETAL CARE, M.D., P.C.

ORTHOPEDICS, PHYSIATRY & PAIN MANAGEMENT

125 FRANKLIN AVENUE, VALLEY STREAM, NY 11580

PHONE: 516-887-1787 FAX: 516-887-2059

9/20/21

LETTER OF MEDICAL NECESSITY

Patient Name: Bayani Dillard
Date of Service: 10/7/21
DOB:11/5/76
Tax ID#: 113292487
DX: S83.241A right knee meniscus tear

The above patient will have surgery on 10/7/21, I find that the patient will benefit from cold, compression therapy with DVT. Cold and compression is necessary for post-operative care, the Vascutherm Unit will help the patient symptomatically as well as help decrease swelling to the area. The pain will be decreased from the usage of the Vascutherm Unit and the patient will be less inclined to need stronger pain medication.

SCDs is to prevent blood clots as the patient will be mostly immobilized from s/p surgery. With any type of immobilization patient is at a greater risk of DVT development, especially with a combination of any type of underlying medical condition. SCDs will promote circulation while the patient is immobilized and will prevent any blood clots which could be very dangerous and life threatening.

Sincerely,

Dr. Gus Katsigiorgis, DO

9/20/2021 2:29:00PM

PATIENT DEMOGRAPHICS SHEET

DEMOGRAPHICS

Acct #	264184	Phone (Res)	(917)386-5380	
Name	Dillard, Bayani	Phone (Work)		Ext.
Address	52 Charles Street Malverne, NY 11565	Phone (Cell)		
		SS #	000-00-93'2	Sex M
Email		DOB	11/05/1976	

Default Physician Gus Kalsigiorgis
Default Ref. Doctor Phone: Fax:
Marital Status
Language
Race
Ethnicity

Active Yes
Date of death

Emergency :
Contact WC: 6/11/21
Phone
Relationship

Additional Ref. Doctors
Chronic Diagnosis
1. S83.241A *Cfh tear of medial meniscus, current injury, r knee, init* 3.
2. 4.

Primary Carrier (Major Medical)

WCOFFICE	Policy #	DOI: 6/11/21	Relationship	Self
	Grp #		Copay	
Hewlett, NY 11557	Effective Date	From to	Deductible	
Ext: Ext:				

Primary Carrier (Workman Compensation)

State Insurance Fund	Policy #	73141129-110	Relationship	Self
	Grp #		Copay	
Po Box 66699 Albany, NY 12206	Effective Date	From to	Deductible	
607-741-3906 Ext: Ext:				

EMPLOYER

Name	Flushing Hospital Medical Center	Phone	
Address	4500 Parsons Blvd, Flushing, , NY 11355	Fax	
		Contact	Yogesh Patel Ph: (631) 756-4176 FX:(631)756-4074

Pharmacies

RITE AID-198 WEST MERRICK ROA 10620,198 WEST MERRICK ROAD,VALLEY STREAM,NY,115805512

All above information is correct _____

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 45 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check In Date/Time: 11/15/2021 10:47:45 AM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Gus Katsigiorgis, DO

Gender: MALE
Phone: (917)386-5380

History of Present Illness

The patient presents for follow up. He has difficulty and pain about the right knee with clicking, popping and locking.

Physical Exam

Note:: Examination of the Right Knee: There is patellofemoral pain. There is joint line tenderness. Positive McMurray's sign. Neurovascularly intact. Restricted range of motion.

Assessment

Right knee meniscus tear. Mechanical symptoms.
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Plan

Physical therapy. I went over risks, benefits and alternatives of right knee arthroscopy with possible arthrotomy, possible meniscectomy, possible meniscal repair with the patient. I discussed if meniscal repair is carried out, the patient may need further surgery with regards to meniscectomy if the meniscus does not heal. I discussed if partial meniscectomy is performed, that only the damaged portion of the meniscus will be removed. I discussed possible complications including, but not limited to, infection, bleeding, nerve damage, stiffness, pain, implant loosening, hardware loosening, skin breakdown, keloid formation, neuroma formation and further surgery for this, post-operative RSD, post-operative DVT, PE, MI, possible loss of limb or life, persistence of symptoms and possible need for further surgery in the future. No guarantees were made. All questions were answered. The patient does want to proceed with surgery. I am requesting authorization for right knee arthroscopy, possible arthrotomy, possible meniscectomy, possible meniscal repair.

In my opinion the incident that the patient describes is the competent medical cause of this injury.
The patients complaints are consistent with their history of injury.
The patients history of illness is consistent with my objective findings.
The patient has a 100% temporary impairment.

This note is being transcribed from dictation of 11/15/2021

Electronically signed by Gus Katsigiorgis, DO at 09:47 AM, NOVEMBER 23, 2021

Gus Katsigiorgis, DO

264184

ISLAND MUCULOSKELETAL CARE, M.D., P.C.

PATIENT NAME: Dillard, Bayani

DATE OF EXAM: 11/15/21

HEAD&NECK	ROM	Right	Left
	Flex (0-60)	FULL	
	Ext (0-50)	FULL	
	LatFlex (0-40)	FULL	FULL
	Rot (0-80)	FULL	FULL

UPPER EXTREMITY	ROM	Right	Left
Shoulder	ABD (0-180)	FULL	FULL
	FowFlex (0-180)	FULL	FULL
	IntRot (0-90)	FULL	FULL
	ExtRot (0-90)	FULL	FULL
Elbow	Flex (0-150)	FULL	FULL
	Ext (0)	FULL	FULL
	Sup (0-90)	FULL	FULL
	Pron (0-90)	FULL	FULL
Wrist	Flex (0-80)	FULL	FULL
	Ext (0-70)	FULL	FULL
	RadialDev (0-20)	FULL	FULL
	UlnarDev (0-30)	FULL	FULL

UPPER EXTREMITY MMT	Right	Left
Deltoid (C5,6; Axillary N)	5/5	5/5
Biceps (C5,6; Musculocut N)	5/5	5/5
Triceps (C6,7,8; Radial N)	5/5	5/5
Wrist Ext (C6,7,8; Radial N)	5/5	5/5
Wrist Flex (C6,7,8,T1; Med&Uln)	5/5	5/5

UPPER EXTREMITY DTR	Right	Left
Biceps (C5,6)	2/4	2/4
Triceps (C6,7)	2/4	2/4
Brachioradialis (C6,7)	2/4	2/4
Finger Jerk (C7,T1)	2/4	2/4

UPPER EXTREMITY SENSATION	Right	Left
Light Touch	Y / N	Y / N
Pain	Y / N	Y / N

BACK	ROM	Right	Left
	Flex (0-90)	FULL	
	Ext (0-30)	FULL	
	LatFlex (0-20)	FULL	FULL
	Rot (0-30)	FULL	FULL

LOWER EXTREMITY	ROM	Right	Left
HIP	Flex (0-120)	FULL	FULL
	EXT (0-120)	FULL	FULL
	Abd (0-50)	FULL	FULL
	IntRot (0-45)	FULL	FULL
	ExtRot (0-30)	FULL	FULL
Knee	Flex (0-135)	FULL	FULL
	Ext (0)	FULL	FULL
Ankle	DorsiFlex (0-20)	FULL	FULL
	PlantFlex (0-50)	FULL	FULL
	Inver (0-45)	FULL	FULL
	Ever (0-20)	FULL	FULL

LOWER EXTREMITY MMT	Right	Left
Iliopsoas (L1,2,3; Femoral N)	5/5	5/5
Quads (L2,3,4; Femoral N)	5/5	5/5
Hamstring (L5,S1,2; Sciatic N)	5/5	5/5
Tibialis Ant (L4,5; Deep Peron N)	5/5	5/5
Gastrocnemius (S1,2; Tibial N)	5/5	5/5
EHL (L5,S1; Deep Peron N)	5/5	5/5

LOWER EXTREMITY DTR	Right	Left
Patella (L3,4)	2/4	2/4
Achilles (L5,S1)	2/4	2/4

LOWER EXTREMITY SENSATION	Right	Left
Light Touch	Y / N	Y / N
Pain	Y / N	Y / N

Gait/Station: Nml / Antalgic / Other Assistive Device: N / Y _____ Brace: N / Y _____

General Appearance: Alert, NAD, Oriented to time/Place Y / N _____

Pulses: RUE: Nml / Abnml LUE: Nml / Abnml RLE: Nml / Abnml LLE: Nml / Abnml

REVIEW OF IMAGES: X-RAY MRI REVIEW OF EMGS

PHYSICAN SIGNATURE _____

264184

ISLAND MUSCULOSKELETAL CARE, M.D., P.C.

REVIEW OF SYSTEMS-

NAME: Dillard, Bayani

DATE: 11/15/21

ARE THERE ANY CHANGES SINCE YOUR LAST VISIT? ✓ YES ____ NO

IF YES, PLEASE NOTE AND MARK BELOW:

GENERAL-
- ☐ Weight loss or gain
- ☐ Fatigue
- ☐ Fever or Chills
- ☐ Weakness
- ☐ Trouble Sleeping

SKIN-
- ☐ Rashes
- ☐ Lumps
- ☐ Itching
- ☐ Dryness
- ☐ Color Changes
- ☐ Hair and Nails changes

HEAD-
- ☐ Headache
- ☐ Head injury
- ☐ Neck pain

EYES-
- ☐ Vision Loss/Changes
- ☐ Glasses or contacts
- ☐ Pain
- ☐ Redness
- ☐ Blurry or double vision
- ☐ Flashing lights
- ☐ Specks
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Last eye exam

NOSE-
- ☐ Stuffiness
- ☐ Discharge
- ☐ Itching
- ☐ Hay Fever
- ☐ Nosebleeds
- ☐ Sinus pain

THROAT-
- ☐ Bleeding
- ☐ Dentures
- ☐ Sore tongue
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Thrush
- ☐ Non-healing sores

NECK-
- ☐ Lumps
- ☐ Swollen Glands
- ☐ Pain
- ☐ Stiffness

BREASTS-
- ☐ Lumps
- ☐ Pain
- ☐ Discharge
- ☐ Self-exams
- ☐ Breast-feeding

RESPIRATORY-
- ☐ Cough
- ☐ Sputum
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Painful breathing

CARDIOVASCULAR-
- ☐ Chest pain or discomfort
- ☐ Tightness
- ☐ Palpitations
- ☐ Shortness of Breath with activity
- ☐ Difficulty breathing lying down
- ☐ Swelling
- ☐ Sudden awakening from sleep with shortness of breath

GASTROINTESTINAL-
- ☐ Swallowing difficulties
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Nausea
- ☐ Change in bowel habits
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Yellow eyes or skin

URINARY-
- ☐ Frequency
- ☐ Urgency
- ☐ Burning or pain
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Change in urinary strength

VASCULAR-
- ☐ Calf pain with walking
- ☐ Leg cramping

MUSCULOSKELETAL-
- ☐ Muscle or joint pain
- ☒ Stiffness
- ☐ Back pain
- ☐ Redness of joints
- ☐ Swelling of joints
- ☐ Trauma

NEUROLOGIC-
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor

HEMATOLOGIC-
- ☐ Ease of bruising
- ☐ Ease of bleeding

ENDOCRINE-
- ☐ Head or cold intolerance
- ☐ Sweating
- ☐ Frequent urination
- ☐ Thirst
- ☐ Change in appetite

PSYCHIATRIC-
- ☐ Nervousness
- ☐ Stress
- ☐ Depression
- ☐ Memory loss

PATIENT SIGNATURE: Bayani Dillard

PHYSICIAN SIGNATURE: ✓

☐ Dr. Brett Silverman NPI: 1083620855

☐ Dr. Michael Trepeta NPI: 1164584553

☒ Dr. Gus Katsigiorgis NPI: 1033105564

☐ Dr. Nabil Farakh NPI: 1699932186

☐ Dr. Kanwarpaul Grewal NPI: 1144497033

☐ Dr. Steven Goodman NPI: 1477530285

☐ Dr. Robert Drazic NPI: 1578559001

☐ Dr. Paul Koblak NPI: 1396739777

☐ Dr. Robert Hecht NPI: 1668468120

☐ Dr. Elizabeth Mathew NPI: 1447571393

SUFFOLK
20 Grand Ave.
Shirley, NY
11967

QUEENS
109-07 Jamaica Ave.
Richmond Hill, NY
11418

BROOKLYN
2569 Ocean Ave.
Brooklyn, NY
11229

BRONX
2475 Pastchester Rd.
Bronx, NY
10469

ISLAND MUSCULOSKELETAL CARE, M.D. P.C.

(516) 887-1787
(718) 627-3342
(631) 242-8172

2641184
WC

NASSAU
125 Franklin Avenue
Valley Stream, NY
11580

SUFFOLK
1993 Deer Park Ave.
Deer Park, NY
11729

SUFFOLK
485 No. Ocean Ave.
Patchogue, NY
11772

QUEENS
108-25 Jamaica Ave.
Richmond Hill, NY
11418

PHYSICAL THERAPY LETTER OF MEDICAL NECESSITY/RX

Today's Date: 11/15/21

Patient's Name: Dillard, Bryant Age: _____

Diagnosis: RT/Knee

Precaution: _____

Frequency of Treatment: 3x Duration of Treatment: 8 wks

REDUCE SWELLING, INFLAMMATION

- ☐ Ultrasound
- ☐ Phonophoresis
- ☐ Whirlpool
- ☐ Hot/Cold Pack

REDUCE PAIN/STRESS: MUSCLE RE-EDUCATION

- ☐ Electro-Stimulation
- ☐ Traction (manual)
- ☐ Massage
- ☐ Iontophoresis
- ☐ TENS

INCREASE STRENGTH/MOTION

- ☐ Range of Motion
  - ☐ active ☐ passive ☐ active assisted
- ☐ Kinetic activities (back/neck)
- ☐ Kinetic activities (extremities)
- ☐ Closed Kinetic Chain Exercises
- ☐ Proprioceptive training
- ☐ Flexibility Exercises
- ☐ Theraband Exercises

FUNCTIONAL PROGRAM

- ☐ ADL ☐ Instruct in home program
  - ☐ Functional Training
- ☐ Gait Training

Weight Bearing Status

- ☐ full weight bearing
- ☐ partial weight bearing starting _____
- ☐ and progress to FWB by _____
- ☐ non-weight bearing
- ☐ assistive devices
  - ☐ crutches ☐ cane ☐ knee immobilizer
  - ☐ brace
  - use until _____

ADDITIONAL ORDERS:

_____

GOALS:

- ☐ Increase Strength
- ☐ Decrease Pain
- ☐ Increase ROM
- ☐ Decrease Swelling

_____
Physician's Signature

- ☐ Dr. Barry Jupiter NPI: 1295721405
- ☐ Dr. Gus Katsigiorgis NPI: 1833105564
- ☐ Dr. Nabil Farakh NPI: 1699932186
- ☐ Dr. Robert Hecht NPI: 1669468120
- ☐ Dr. Stephen Wade NPI: 1114067261

Received by WCB Email on 11/24/2021 10:48:19 AM

Acct # 264184 WC

NORTHWELL HEALTH

LONG ISLAND JEWISH VALLEY STREAM

900 FRANKLIN AVENUE, VALLEY STREAM, NEW YORK 11580 (516) 256-6000 FAX: (516) 256-6503

29881 12
29876 3

PATIENT NAME: DILLARD, BAYANI
DATE OF OPERATION: 01/10/2022
MEDICAL RECORD #: 10381388
ENCOUNTER #: 21180750
SURGEON: GUS KATSIGIORGIS FR004057
DATE OF BIRTH: 11/05/1976

S83.231D 1
M94.261 2
M65.861 3

OPERATIVE REPORT

ASSISTANT: DR. LUCAS BARLETT, ORTHOPEDIC RESIDENT.

PREOPERATIVE DIAGNOSIS: Right knee internal derangement.

POSTOPERATIVE DIAGNOSES: Right knee medial meniscus tear, marked synovitis of right knee, chondromalacia of patella grade 3, femoral trochlea grade 3, chondromalacia of medial femoral condyle grade 3, medial tibial plateau grade 3.

NATURE OF OPERATION: Right knee arthroscopic surgery, partial medial meniscectomy, chondroplasty of patella, chondroplasty of femoral trochlea, chondroplasty of medial femoral condyle, chondroplasty of medial tibial plateau, major synovectomy of right knee.

ANESTHESIA: General.

ESTIMATED BLOOD LOSS: Minimal.

COMPLICATIONS: No complications occurred.

INDICATIONS: Prior to surgery, I had a lengthy discussion with the patient with regard to risks, benefits, and alternatives of right knee arthroscopy, partial arthrotomy, and meniscectomy. Among risks and complications, I did discuss infection, bleeding, nerve damage, stiffness, pain, possible need for further surgery in the future including total knee replacement, postoperative DVT, PE, MI, and possible loss of limb or life. I did discuss weight loss to patient prior to surgery. The patient did wish to proceed with surgery. No guarantees were made. All questions were answered.

PROCEDURE: Prior to surgery, the patient received preoperative antibiotics. General anesthesia was administered. Right knee was examined under general anesthesia. The patient was noted to have no signs of instability. The right lower

PHYSICIAN'S COPY

NORTHWELL HEALTH

LONG ISLAND JEWISH VALLEY STREAM

900 FRANKLIN AVENUE, VALLEY STREAM, NEW YORK 11580 (516) 256-6000 FAX: (516) 256-6503

PATIENT NAME: DILLARD, BAYANI
MEDICAL RECORD #: 10381388
DATE OF BIRTH: 11/05/1976

extremity was prepped and dressed in sterile manner. One arthroscopic portal was made lateral to the suprapatellar tendon to enter the joint space. The arthroscope was introduced in the suprapatellar region. Synovitis was present. No patellar maltracking was present. Chondromalacia was noted about the undersurface of the patella, about the femoral trochlea, grade 3. The lateral gutter was inspected, no pathology of the lateral gutter. The medial gutter was inspected, no pathology of the medial gutter. A medial arthroscopic portal was made under direct visualization to avoid injury to medial meniscus. Probing of the medial meniscus was performed. Complex tearing of the posterior horn of the medial meniscus extending into the body, nonrepairable was noted. Chondromalacia was noted about the medial femoral condyle, medial tibial plateau grade 3. Chondroplasty was performed. Synovitis was noted. Synovectomy was performed. Using arthroscopic duckbill and shaving instruments, partial medial meniscectomy was performed to a smooth stable contour. Further probing of the medial meniscus revealed no further tears and the meniscus was noted to be stable. The intercondylar notch was inspected. Synovitis was noted. Synovectomy was performed. The lateral joint space was inspected. Synovitis was noted. Synovectomy was performed. No lateral meniscus tear was present. The anterior and posterior cruciate ligaments were noted to be intact with no tears. The suprapatellar region was addressed. Synovectomy was performed. Chondroplasty was performed about the undersurface of the patella, about the femoral trochlea. No patellofemoral maltracking was present. No loose bodies about the knee were present. Thorough irrigation was performed. Two arthroscopic portals were closed with 3-0 nylon simple interrupted sutures. A sterile dressing was applied. At the end of the procedure, the patient was noted to have capillary refill less than 2 seconds, good dorsalis pedis, and posterior tibial pulse. The patient was transferred to the recovery room in stable condition.

Electronically Signed by: GUS KATSIGIORGIS 01/11/2022 12:08:28 PM

DICT: GUS KATSIGIORGIS, DO (FR004057) 01/10/2022 1049
TRANS: HT_01_SAP/HT_03_BMH 01/10/2022 2103
JOB: 7081976

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 45 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 1/26/2022 9:35:18 AM Physician: Gus Katsigiorgis, DO
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

History of Present Illness
The patient presents for follow up. He has difficulty and pain about the right knee with clicking, popping and locking.

Physical Exam
Note:: Examination of the Right Knee: There is patellofemoral pain. There is joint line tenderness. Positive McMurray's sign. Neurovascularly intact. Restricted range of motion.

Assessment
Right knee meniscus tear. Mechanical symptoms.
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)
H/O arthroscopy of right knee (Z98.890)

Plan
Physical therapy. Patient walks with antalgic gait.

In my opinion the incident that the patient describes is the competent medical cause of this injury.
The patients complaints are consistent with their history of injury.
The patients history of illness is consistent with my objective findings.
The patient has a 100% temporary impairment.

This note is being transcribed from dictation of 1/26/2022

Electronically signed by Gus Katsigiorgis, DO at 10:24 AM, FEBRUARY 03, 2022

Gus Katsigiorgis, DO

26484.

ISLAND MUCULOSKELETAL CARE, M.D., P.C.

PATIENT NAME: Dillard, Bayani DATE OF EXAM: 01/26/22

HEAD&NECK	ROM	Right	Left
	Flex (0-60)	FULL	
	Ext (0-50)	FULL	
	LatFlex (0-40)	FULL	FULL
	Rot (0-80)	FULL	FULL

UPPER EXTREMITY	ROM	Right	Left
Shoulder	ABD (0-180)	FULL	FULL
	FowFlex (0-180)	FULL	FULL
	IntRot (0-90)	FULL	FULL
	ExtRot (0-90)	FULL	FULL
Elbow	Flex (0-150)	FULL	FULL
	Ext (0)	FULL	FULL
	Sup (0-90)	FULL	FULL
	Pron (0-90)	FULL	FULL
Wrist	Flex (0-80)	FULL	FULL
	Ext (0-70)	FULL	FULL
	RadialDev (0-20)	FULL	FULL
	UlnarDev (0-30)	FULL	FULL

UPPER EXTREMITY MMT	Right	Left
Deltoid (C5,6; Axillary N)	5/5	5/5
Biceps (C5,6; Musculocut N)	5/5	5/5
Triceps (C6,7,8; Radial N)	5/5	5/5
Wrist Ext (C6,7,8; Radial N)	5/5	5/5
Wrist Flex (C6,7,8,T1; Med&Uln)	5/5	5/5

UPPER EXTREMITY DTR	Right	Left
Biceps (C5,6)	2/4	2/4
Triceps (C6,7)	2/4	2/4
Brachioradialis (C6,7)	2/4	2/4
Finger Jerk (C7,T1)	2/4	2/4

UPPER EXTREMITY SENSATION	Right	Left
Light Touch	Y / N	Y / N
Pain	Y / N	Y / N

BACK	ROM	Right	Left
	Flex (0-90)	FULL	
	Ext (0-30)	FULL	
	LatFlex (0-20)	FULL	FULL
	Rot (0-30)	FULL	FULL

LOWER EXTREMITY	ROM	Right	Left
HIP	Flex (0-120)	FULL	FULL
	EXT (0-120)	FULL	FULL
	Abd (0-50)	FULL	FULL
	IntRot (0-45)	FULL	FULL
	ExtRot (0-30)	FULL	FULL
Knee	Flex (0-135)	FULL	FULL
	Ext (0)	FULL	FULL
Ankle	DorsiFlex (0-20)	FULL	FULL
	PlantFlex (0-50)	FULL	FULL
	Inver (0-45)	FULL	FULL
	Ever (0-20)	FULL	FULL

LOWER EXTREMITY MMT	Right	Left
Iliopsoas (L1,2,3; Femoral N)	5/5	5/5
Quads (L2,3,4; Femoral N)	5/5	5/5
Hamstring (L5,S1,2; Sciatic N)	5/5	5/5
Tiblalis Ant (L4,5; Deep Peron N)	5/5	5/5
Gastrocnemius (S1,2; Tibial N)	5/5	5/5
EHL (L5,S1; Deep Peron N)	5/5	5/5

LOWER EXTREMITY DTR	Right	Left
Patella (L3,4)	2/4	2/4
Achilles (L5,S1)	2/4	2/4

LOWER EXTREMITY SENSATION	Right	Left
Light Touch	Y / N	Y / N
Pain	Y / N	Y / N

Gait/Station: Nml / Antalgic / Other Assistive Device: N / Y _____ Brace: N / Y _____

General Appearance: Alert, NAD, Oriented to time/Place N / N _____

Pulses: RUE: Nml / Abnml LUE: Nml / Abnml RLE: Nml / Abnml LLE: Nml / Abnml

REVIEW OF IMAGES: X-RAY MRI REVIEW OF EMGS

PHYSICAN SIGNATURE _____

SUFFOLK
20 Grand Ave.
Shirley, NY
11967

QUEENS
109-07 Jamaica Ave.
Richmond Hill, NY
11418

BROOKLYN
2569 Ocean Ave.
Brooklyn, NY
11229

BRONX
2475 Eastchester Rd.
Bronx, NY
10469

ISLAND MUSCULOSKELETAL CARE, M.D. P.C.

(516) 887-1787
(718) 627-3342
(631) 242-8172

2604184
WC

NASSAU
125 Franklin Avenue
Valley Stream, NY
11580

SUFFOLK
1993 Deer Park Ave.
Deer Park, NY
11729

SUFFOLK
485 No. Ocean Ave.
Patchogue, NY
11772

QUEENS
108-25 Jamaica Ave.
Richmond Hill, NY
11418

PHYSICAL THERAPY LETTER OF MEDICAL NECESSITY/RX

Today's Date: 3/23/22

Patient's Name: Dinardi, Bayani Age: _____

Diagnosis: S/P (R) (a) p

Precaution: _____

Frequency of Treatment: 3 Duration of Treatment: 8

REDUCE SWELLING, INFLAMMATION

- ☑ Ultrasound
- ☐ Phonophoresis
- ☐ Whirlpool
- ☐ Hot/Cold Pack

REDUCE PAIN/STRESS; MUSCLE RE-EDUCATION

- ☐ Electro-Stimulation
- ☑ Traction (manual)
- ☑ Massage
- ☐ Iontophoresis
- ☐ TENS

INCREASE STRENGTH/MOTION

- ☐ Range of Motion
  - ☐ active ☐ passive ☐ active assisted
- ☐ Kinetic activities (back/neck)
- ☑ Kinetic activities (extremities)
- ☐ Closed Kinetic Chain Exercises
- ☐ Proprioceptive training
- ☐ Flexibility Exercises
- ☐ Theraband Exercises

FUNCTIONAL PROGRAM

- ☐ ADL ☐ Instruct in home program
  - ☐ Functional Training
- ☐ Gait Training

Weight Bearing Status

- ☐ full weight bearing
- ☐ partial weight bearing starting _____
- ☐ and progress to FWB by _____
- ☐ non-weight bearing
- ☐ assistive devices
  - ☐ crutches ☐ cane ☐ knee immobilizer
  - ☐ brace

use until _____

ADDITIONAL ORDERS:

_____

GOALS:

- ☐ Increase Strength
- ☐ Decrease Pain
- ☐ Increase ROM
- ☐ Decrease Swelling

Physician's Signature

☐ Dr. Barry Jupiter NPI: 1295721405 ☐ Dr. Gus Katsigiorgis NPI: 1033105564 ☐ Dr. Nabil Farakh NPI: 1699932186 ☐ Dr. Robert Hecht NPI: 1669468120 ☐ Dr. Stephen Wade NPI: 1114067261

Received by WCB Email on 4/11/2022 6:22:45 PM

264184

ISLAND MUCULOSKELETAL CARE, M.D., P.C.

PATIENT NAME: Dillard, Bayani DATE OF EXAM: 03/23/22

HEAD&NECK	ROM	Right	Left
	Flex (0-60)	FULL	
	Ext (0-50)	FULL	
	LatFlex (0-40)	FULL	FULL
	Rot (0-80)	FULL	FULL

UPPER EXTREMITY	ROM	Right	Left
Shoulder	ABD (0-180)	FULL	FULL
	FowFlex (0-180)	FULL	FULL
	IntRot (0-90)	FULL	FULL
	ExtRot (0-90)	FULL	FULL
Elbow	Flex (0-150)	FULL	FULL
	Ext (0)	FULL	FULL
	Sup (0-90)	FULL	FULL
	Pron (0-90)	FULL	FULL
Wrist	Flex (0-80)	FULL	FULL
	Ext (0-70)	FULL	FULL
	RadialDev (0-20)	FULL	FULL
	UlnarDev (0-30)	FULL	FULL

UPPER EXTREMITY MMT	Right	Left
Deltoid (C5,6; Axillary N)	5/5	5/5
Biceps (C5,6; Musculocut N)	5/5	5/5
Triceps (C6,7,8; Radial N)	5/5	5/5
Wrist Ext (C6,7,8; Radial N)	5/5	5/5
Wrist Flex (C6,7,8,T1; Med&Uln)	5/5	5/5

UPPER EXTREMITY DTR	Right	Left
Biceps (C5,6)	2/4	2/4
Triceps (C6,7)	2/4	2/4
Brachioradialis (C6,7)	2/4	2/4
Finger Jerk (C7,T1)	2/4	2/4

UPPER EXTREMITY SENSATION	Right	Left
Light Touch	Y / N	Y / N
Pain	Y / N	Y / N

BACK	ROM	Right	Left
	Flex (0-90)	FULL	
	Ext (0-30)	FULL	
	LatFlex (0-20)	FULL	FULL
	Rot (0-30)	FULL	FULL

LOWER EXTREMITY	ROM	Right	Left
HIP	Flex (0-120)	FULL	FULL
	EXT (0-120)	FULL	FULL
	Abd (0-50)	FULL	FULL
	IntRot (0-45)	FULL	FULL
	ExtRot (0-30)	FULL	FULL
Knee	Flex (0-135)	FULL	FULL
	Ext (0)	FULL	FULL
Ankle	DorsiFlex (0-20)	FULL	FULL
	PlantFlex (0-50)	FULL	FULL
	Inver (0-45)	FULL	FULL
	Ever (0-20)	FULL	FULL

LOWER EXTREMITY MMT	Right	Left
Iliopsoas (L1,2,3; Femoral N)	5/5	5/5
Quads (L2,3,4; Femoral N)	5/5	5/5
Hamstring (L5,S1,2; Sciatic N)	5/5	5/5
Tibialis Ant (L4,5; Deep Peron N)	5/5	5/5
Gastrocnemius (S1,2; Tibial N)	5/5	5/5
EHL (L5,S1; Deep Peron N)	5/5	5/5

LOWER EXTREMITY DTR	Right	Left
Patella (L3,4)	2/4	2/4
Achilles (L5,S1)	2/4	2/4

LOWER EXTREMITY SENSATION	Right	Left
Light Touch	Y / N	Y / N
Pain	Y / N	Y / N

Gait/Station: Nml / Antalgic / Other Assistive Device: N / Y _____ Brace: N / Y _____

General Appearance: Alert, NAD, Oriented to time/Place Y / N _____

Pulses: RUE: Nml / Abnml LUE: Nml / Abnml RLE: Nml / Abnml LLE: Nml / Abnml

REVIEW OF IMAGES: X-RAY MRI REVIEW OF EMGS

PHYSICAN SIGNATURE _____

Received by WCB Email on 4/11/2022 6:22:45 PM

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 45 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 3/23/2022 9:37:48 AM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WC - State Insurance Fund [73141129-110]

Acc No: 264184
DOB: 11/05/1976
Physician: Gus Katsigiorgis, DO

Inj. Date: 06/11/2021
Gender: MALE
Phone: (917)386-5380

History of Present Illness

The patient presents for follow up. He has difficulty and pain about the right knee. He notes improvement with therapy.

Physical Exam

Note:: Examination of the Right Knee: There is patellofemoral pain. There is joint line tenderness. Negative McMurray's sign. Neurovascularly intact. Restricted range of motion. No palpable cords.

Assessment

Right knee meniscus tear. Mechanical symptoms.
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Plan

Physical therapy. Home exercise program. Patient walks with antalgic gait. Follow up in four weeks duration.

In my opinion the incident that the patient describes is the competent medical cause of this injury.
The patients complaints are consistent with their history of injury.
The patients history of illness is consistent with my objective findings.
The patient has a 100% temporary impairment.

This note is being transcribed from dictation of 3/23/2022

Electronically signed by Gus Katsigiorgis, DO at 02.33 PM, APRIL 01, 2022

Gus Katsigiorgis, DO

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Inj. Date: 06/11/2021

Patient Name: **Dillard, Bayani**
Acc No: 264184
Gender: MALE
Age: 45 Year(s)
DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565,
Phone: (917)386-5380
Check in Date/Time: 4/27/2022 10:00:10 AM
Physician: Gus Katsigiorgis, DO
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WC - State Insurance Fund [73141129-110]

History of Present Illness

The patient presents for follow up. Status post right knee arthroscopic surgery. In the past therapy helped. He would like to continue.

Physical Exam

Note:: Examination of the Right Knee: There is patellofemoral pain. No signs of instability. Negative McMurray's sign.

Assessment

Right knee status post surgery.
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)
H/O arthroscopy of right knee (Z98.890)

Plan

Physical therapy. Patient walks with antalgic gait. Follow up in three weeks duration.

In my opinion the incident that the patient describes is the competent medical cause of this injury.
The patients complaints are consistent with their history of injury.
The patients history of illness is consistent with my objective findings.
The patient has a 100% temporary impairment.

This note is being transcribed from dictation of 4/27/2022

Electronically signed by Gus Katsigiorgis, DO at 09:31 AM, MAY 10, 2022

Gus Katsigiorgis, DO

204184

ISLAND MUCULOSKELETAL CARE, M.D., P.C.

PATIENT NAME: Dillard, Bayani DATE OF EXAM: 4/27/22

HEAD&NECK

ROM	Right	Left
Flex (0-60)	FULL	
Ext (0-50)	FULL	
LatFlex (0-40)	FULL	FULL
Rot (0-80)	FULL	FULL

UPPER EXTREMITY

	ROM	Right	Left
Shoulder	ABD (0-180)	FULL	FULL
	FowFlex (0-180)	FULL	FULL
	IntRot (0-90)	FULL	FULL
	ExtRot (0-90)	FULL	FULL
Elbow	Flex (0-150)	FULL	FULL
	Ext (0)	FULL	FULL
	Sup (0-90)	FULL	FULL
	Pron (0-90)	FULL	FULL
Wrist	Flex (0-80)	FULL	FULL
	Ext (0-70)	FULL	FULL
	RadialDev (0-20)	FULL	FULL
	UlnarDev (0-30)	FULL	FULL

UPPER EXTREMITY MMT	Right	Left
Deltoid (C5,6; Axillary N)	5/5	5/5
Biceps (C5,6; Musculocut N)	5/5	5/5
Triceps (C6,7,8; Radial N)	5/5	5/5
Wrist Ext (C6,7,8; Radial N)	5/5	5/5
Wrist Flex (C6,7,8,T1; Med&Uln)	5/5	5/5

UPPER EXTREMITY DTR	Right	Left
Biceps (C5,6)	2/4	2/4
Triceps (C6,7)	2/4	2/4
Brachioradialis (C6,7)	2/4	2/4
Finger Jerk (C7,T1)	2/4	2/4

UPPER EXTREMITY SENSATION	Right	Left
Light Touch	Y / N	Y / N
Pain	Y / N	Y / N

BACK

ROM	Right	Left
Flex (0-90)	FULL	
Ext (0-30)	FULL	
LatFlex (0-20)	FULL	FULL
Rot (0-30)	FULL	FULL

LOWER EXTREMITY

	ROM	Right	Left
HIP	Flex (0-120)	FULL	FULL
	EXT (0-120)	FULL	FULL
	Abd (0-50)	FULL	FULL
	IntRot (0-45)	FULL	FULL
	ExtRot (0-30)	FULL	FULL
Knee	Flex (0-135)	FULL	FULL
	Ext (0)	FULL	FULL
Ankle	DorsiFlex (0-20)	FULL	FULL
	PlantFlex (0-50)	FULL	FULL
	Inver (0-45)	FULL	FULL
	Ever (0-20)	FULL	FULL

LOWER EXTREMITY MMT	Right	Left
Iliopsoas (L1,2,3; Femoral N)	5/5	5/5
Quads (L2,3,4; Femoral N)	5/5	5/5
Hamstring (L5,S1,2; Sciatic N)	5/5	5/5
Tibialis Ant (L4,5; Deep Peron N)	5/5	5/5
Gastrocnemius (S1,2; Tibial N)	5/5	5/5
EHL (L5,S1; Deep Peron N)	5/5	5/5

LOWER EXTREMITY DTR	Right	Left
Patella (L3,4)	2/4	2/4
Achilles (L5,S1)	2/4	2/4

LOWER EXTREMITY SENSATION	Right	Left
Light Touch	Y / N	Y / N
Pain	Y / N	Y / N

Gait/Station: Nml / Ataxic / Other Assistive Device: N / Y _____ Brace: N / Y _____

General Appearance: Alert, NAD, Oriented to time/Place Y / N _____

Pulses: RUE: Nml / Abnml LUE: Nml / Abnml RLE: Nml / Abnml LLE: Nml / Abnml

REVIEW OF IMAGES: X-RAY MRI REVIEW OF EMGS

PHYSICAN SIGNATURE _____

264184

G3051719

ISLAND MUSCULOSKELETAL CARE MD PC

125 FRANKLIN AVE
VALLEY STREAM
N.Y. 11580

108-25 JAMAICA AVE
RICHMOND HILL
N.Y. 11418

2569 OCEAN AVE
BROOKLYN
N.Y. 11229

2475 EASTCHESTER RD
BRONX, NY 10469

1993 DEER PARK AVE
DEER PARK, NY 11729

485 N. OCEAN AVE
PATCHOGUE, NY 11772

20 GRAND AVE SUITE A
SHIRLEY, NY 11967

DATE: 4/27/22

THIS IS TO CERTIFY THAT Dillard, Bayani

IS UNDER MY CARE/TREATMENT FOR: W.C. 6/11/21

THE PATIENT WAS LAST SEEN ON: 4/27/22

✓ RECEIVED TREATMENT TODAY

✓ IS TOTALLY DISABLED AT THIS TIME

___ IS PARTIALLY DISABLED AT THIS TIME

___ CAN RETURN TO FULL DUTY WORK ON ___

___ CAN RETURN TO LIGHT DUTY WORK ON ___

___ PATIENT MAY PARTICIPATE IN ALL GYM/ACTIVITIES

___ PATIENT MAY NOT PARTICIPATE IN ALL GYM/ACTIVITIES

NEXT APPOINTMENT: 5/20/22

ISLAND MUSCULOSKELETAL
CARE, M.D., P.C.
125 FRANKLIN AVE.
VALLEY STREAM, NY 11580

ADDITIONAL NEEDS:

___ USE OF ELEVATOR IN SCHOOL

___ ALLOW EXTRA TIME TO EACH CLASS

___ CRUTHES/WHEELCHAIR FOR AMBULATION

___ STUDENT TO OBTAIN EXTRA SET OF TEXT BOOKS

SPECIFIC INSTRUCTIONS: estimated return to work date 6/6/22. patient is out of work on 5/1/22 as well.

DOCTORS SIGNATURE: ___

☐ Dr. Robert Hecht NPI: 1669468320
☐ Dr. Gus Katsigiorgis NPI: 1033105564
☐ Dr. Nabil Farakh NPI: 1659932186
☐ Dr. Barry Jupiter NPI: 1295721405
☐ Dr. Stephen Wade NPI: 1114067263

Received by WCB Fax on 4/27/2022 10:14:54 AM

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 45 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 5/20/2022 3:27:08 PM Physician: Gus Katsigiorgis, DO
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

History of Present Illness

The patient presents for follow up. Status post right knee arthroscopic surgery. He was doing therapy and it was helping.

Physical Exam

Note:: Examination of the Right Knee: There is patellofemoral pain. No signs of instability. Negative McMurray's sign. Crepitus.

Assessment

Right knee status post surgery.
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)
Chondromalacia, right knee (M94.261)
Other synovitis and tenosynovitis, right lower leg (M65.861)
H/O arthroscopy of right knee (Z98.890)

Plan

Physical therapy. Home exercise program. Patient walks with antalgic gait. Follow up in three weeks duration.

In my opinion the incident that the patient describes is the competent medical cause of this injury.
The patients complaints are consistent with their history of injury.
The patients history of illness is consistent with my objective findings.
The patient has a 0% temporary impairment.

This note is being transcribed from dictation of 5/20/2022

Electronically signed by Gus Katsigiorgis, DO at 10:40 AM, JUNE 02, 2022

Gus Katsigiorgis, DO

264184

ISLAND MUCULOSKELETAL CARE, M.D., P.C.

PATIENT NAME: Dillard, Bayani DATE OF EXAM: 05/20/22

HEAD&NECK ROM	Right	Left
Flex (0-60)	FULL	
Ext (0-50)	FULL	
LatFlex (0-40)	FULL	FULL
Rot (0-80)	FULL	FULL

UPPER EXTREMITY ROM		Right	Left
Shoulder	ABD (0-180)	FULL	FULL
	FowFlex (0-180)	FULL	FULL
	IntRot (0-90)	FULL	FULL
	ExtRot (0-90)	FULL	FULL
Elbow	Flex (0-150)	FULL	FULL
	Ext (0)	FULL	FULL
	Sup (0-90)	FULL	FULL
	Pron (0-90)	FULL	FULL
Wrist	Flex (0-80)	FULL	FULL
	Ext (0-70)	FULL	FULL
	RadialDev (0-20)	FULL	FULL
	UlnarDev (0-30)	FULL	FULL

UPPER EXTREMITY MMT	Right	Left
Deltoid (C5,6; Axillary N)	5/5	5/5
Biceps (C5,6; Musculocut N)	5/5	5/5
Triceps (C6,7,8; Radial N)	5/5	5/5
Wrist Ext (C6,7,8; Radial N)	5/5	5/5
Wrist Flex (C6,7,8,T1; Med&Uln)	5/5	5/5

UPPER EXTREMITY DTR	Right	Left
Biceps (C5,6)	2/4	2/4
Triceps (C6,7)	2/4	2/4
Brachioradialis (C6,7)	2/4	2/4
Finger Jerk (C7,T1)	2/4	2/4

UPPER EXTREMITY SENSATION	Right	Left
Light Touch	Y / N	Y / N
Pain	Y / N	Y / N

BACK ROM	Right	Left
Flex (0-90)	FULL	
Ext (0-30)	FULL	
LatFlex (0-20)	FULL	FULL
Rot (0-30)	FULL	FULL

LOWER EXTREMITY ROM		Right	Left
HIP	Flex (0-120)	FULL	FULL
	EXT (0-120)	FULL	FULL
	Abd (0-50)	FULL	FULL
	IntRot (0-45)	FULL	FULL
	ExtRot (0-30)	FULL	FULL
Knee	Flex (0-135)	FULL	FULL
	Ext (0)	FULL	FULL
Ankle	DorsiFlex (0-20)	FULL	FULL
	PlantFlex (0-50)	FULL	FULL
	Inver (0-45)	FULL	FULL
	Ever (0-20)	FULL	FULL

LOWER EXTREMITY MMT	Right	Left
Iliopsoas (L1,2,3; Femoral N)	5/5	5/5
Quads (L2,3,4; Femoral N)	5/5	5/5
Hamstring (L5,S1,2; Sciatic N)	5/5	5/5
Tibialis Ant (L4,5; Deep Peron N)	5/5	5/5
Gastrocnemius (S1,2; Tibial N)	5/5	5/5
EHL (L5,S1; Deep Peron N)	5/5	5/5

LOWER EXTREMITY DTR	Right	Left
Patella (L3,4)	2/4	2/4
Achilles (L5,S1)	2/4	2/4

LOWER EXTREMITY SENSATION	Right	Left
Light Touch	Y / N	Y / N
Pain	Y / N	Y / N

Gait/Station: Nml / Antalgic / Other Assistive Device: N / Y _____ Brace: N / Y _____

General Appearance: Alert, NAD, Oriented to time/Place Y / N _____

Pulses: RUE: Nml / Abnml LUE: Nml / Abnml RLE: Nml / Abnml LLE: Nml / Abnml

REVIEW OF IMAGES: X-RAY MRI REVIEW OF EMGS

PHYSICAN SIGNATURE _____

G3051719

Received by WCB Fax on 6/6/2022 4:40:30 PM

264184

DATE: 5/20/22

THIS IS TO CERTIFY THAT Dillard, Bayone

IS UNDER MY CARE/TREATMENT FOR W.C. Case 6/1/21

THE PATIENT WAS LAST SEEN ON 5/20/22

___ SUSPENDED TREATMENT TODAY

___ IS EQUALLY DISABLED AT THIS TIME

___ IS PARTIALLY DISABLED AT THIS TIME

___ CAN RETURN TO FULL DUTY WORK ON 6/6/22

___ CAN RETURN TO LIGHT DUTY WORK ON _____

___ PATIENT MAY PARTICIPATE IN ALL GYM/ACTIVITIES

___ PATIENT MAY NOT PARTICIPATE IN ALL GYM/ACTIVITIES

NEXT APPOINTMENT: _____

ADDITIONAL NEEDS:

___ USE OF ELEVATOR IN SCHOOL

___ ALLOW EXTRA TIME IN EACH CLASS

___ CRUTCHES/WHEELCHAIR/OR AMBULATION

___ STUDENT TO OBTAIN EXTRA SET OF TEXT BOOKS

SPECIFIC INSTRUCTIONS: _____

DOCTORS SIGNATURE: _____

Dr. Stephen Wolk

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Inj. Date: 06/11/2021

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 45 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 7/6/2022 9:22:40 AM Physician: Gus Katsigiorgis, DO
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WC - State Insurance Fund [73141129-110]

History of Present Illness

The patient is here for a follow up visit. The patient is doing well. He notes that physical therapy is helping.

Physical Exam

Note:: Examination of the Right Knee: Patient has mild range of motion. There is mild tenderness about the knee. Negative McMurray. Crepitus noted. No laxity noted. No effusion noted. No signs of infection. Calf is soft and non tender with a negative Homan sign. No signs of instability.
Sensory and motor are grossly intact lower extremities.

Assessment

Status post right knee arthroscopy. OA.
Chondromalacia, right knee (M94.261)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)
Other synovitis and tenosynovitis, right lower leg (M65.861)
H/O arthroscopy of right knee (Z98.890)

Plan

Physical therapy. Home exercise. Pain medication as needed. Hinged knee brace for support. The patient is currently working. Follow up two months. 0% impairment.

In my opinion the incident that the patient describes is the competent medical cause of this injury.
The patients complaints are consistent with their history of injury.
The patients history of illness is consistent with my objective findings.
The patient has a 0% temporary impairment.

This note is being transcribed from dictation of 07-06-22.

Giovanni Pinello, PA

Electronically signed by Gus Katsigiorgis, DO at 04:47 PM, AUGUST 01, 2022

Gus Katsigiorgis, DO

SUFFOLK
20 Grand Ave.
Shirley, NY
11967

QUEENS
109-07 Jamaica Ave.
Richmond Hill, NY
11418

BROOKLYN
2569 Ocean Ave.
Brooklyn, NY
11229

BRONX
2475 Eastchester Rd.
Bronx, NY
10469

ISLAND MUSCULOSKELETAL CARE, M.D. P.C.

(516) 887-1787
(718) 627-3342
(631) 242-8172

NASSAU
125 Franklin Avenue
Valley Stream, NY
11580

SUFFOLK
1993 Deer Park Ave.
Deer Park, NY
11729

SUFFOLK
485 No. Ocean Ave.
Patchogue, NY
11772

QUEENS
108-25 Jamaica Ave.
Richmond Hill, NY
11418

244184
WC

PHYSICAL THERAPY LETTER OF MEDICAL NECESSITY/RX

Today's Date: 7/6/22

Patient's Name: Dillard, Bayani Age: _____

Diagnosis: Right Knee

Precaution: _____

Frequency of Treatment: 3X Duration of Treatment: 8 wks

REDUCE SWELLING, INFLAMMATION

- ☐ Ultrasound
- ☐ Phonophoresis
- ☐ Whirlpool
- ☐ Hot/Cold Pack

REDUCE PAIN/STRESS; MUSCLE RE-EDUCATION

- ☐ Electro-Stimulation
- ☐ Traction (manual)
- ☐ Massage
- ☐ Iontophoresis
- ☐ TENS

INCREASE STRENGTH/MOTION

- ☑ Range of Motion
  - ☐ active ☑ passive ☐ active assisted
- ☐ Kinetic activities (back/neck)
- ☐ Kinetic activities (extremities)
- ☑ Closed Kinetic Chain Exercises
- ☐ Proprioceptive training
- ☐ Flexibility Exercises
- ☐ Theraband Exercises

FUNCTIONAL PROGRAM

- ☐ ADL ☑ Instruct in home program
  - ☐ Functional Training
- ☐ Gait Training

Weight Bearing Status

- ☐ full weight bearing
- ☐ partial weight bearing starting _____
- ☐ and progress to FWB by _____
- ☐ non-weight bearing
- ☐ assistive devices
  - ☐ crutches ☐ cane ☐ knee immobilizer
  - ☐ brace

use until _____

ADDITIONAL ORDERS:

_____

GOALS:

- ☐ Increase Strength
- ☐ Decrease Pain
- ☐ Increase ROM
- ☐ Decrease Swelling

Physician's Signature

☐ Dr. Barry Jupiter NPI: 1295721405
☒ Dr. Gus Katsigiorgis NPI: 1033105564
☐ Dr. Nabil Farakh NPI: 1699932186
☐ Dr. Robert Hecht NPI: 1669468120
☐ Dr. Stephen Wade NPI: 1114067261

264184

ISLAND MUCULOSKELETAL CARE, M.D., P.C.

PATIENT NAME: Dillard, Bayani

DATE OF EXAM: 7/6/22

HEAD&NECK	ROM	Right	Left
	Flex (0-60)	FULL	
	Ext (0-50)	FULL	
	LatFlex (0-40)	FULL	FULL
	Rot (0-80)	FULL	FULL

UPPER EXTREMITY	ROM	Right	Left
Shoulder	ABD (0-180)	FULL	FULL
	FowFlex (0-180)	FULL	FULL
	IntRot (0-90)	FULL	FULL
	ExtRot (0-90)	FULL	FULL
Elbow	Flex (0-150)	FULL	FULL
	Ext (0)	FULL	FULL
	Sup (0-90)	FULL	FULL
	Pron (0-90)	FULL	FULL
Wrist	Flex (0-80)	FULL	FULL
	Ext (0-70)	FULL	FULL
	RadialDev (0-20)	FULL	FULL
	UlnarDev (0-30)	FULL	FULL

UPPER EXTREMITY MMT	Right	Left
Deltoid (C5,6; Axillary N)	5/5	5/5
Biceps (C5,6; Musculocut N)	5/5	5/5
Triceps (C6,7,8; Radial N)	5/5	5/5
Wrist Ext (C6,7,8; Radial N)	5/5	5/5
Wrist Flex (C6,7,8,T1; Med&Uln)	5/5	5/5

UPPER EXTREMITY DTR	Right	Left
Biceps (C5,6)	2/4	2/4
Triceps (C6,7)	2/4	2/4
Brachioradialis (C6,7)	2/4	2/4
Finger Jerk (C7,T1)	2/4	2/4

UPPER EXTREMITY SENSATION	Right	Left
Light Touch	Y / N	Y / N
Pain	Y / N	Y / N

BACK	ROM	Right	Left
	Flex (0-90)	FULL	
	Ext (0-30)	FULL	
	LatFlex (0-20)	FULL	FULL
	Rot (0-30)	FULL	FULL

LOWER EXTREMITY	ROM	Right	Left
HIP	Flex (0-120)	FULL	FULL
	EXT (0-120)	FULL	FULL
	Abd (0-50)	FULL	FULL
	IntRot (0-45)	FULL	FULL
	ExtRot (0-30)	FULL	FULL
Knee	Flex (0-135)	FULL	FULL
	Ext (0)	FULL	FULL
Ankle	DorsiFlex (0-20)	FULL	FULL
	PlantFlex (0-50)	FULL	FULL
	Inver (0-45)	FULL	FULL
	Ever (0-20)	FULL	FULL

LOWER EXTREMITY MMT	Right	Left
Iliopsoas (L1,2,3; Femoral N)	5/5	5/5
Quads (L2,3,4; Femoral N)	5/5	5/5
Hamstring (L5,S1,2; Sciatic N)	5/5	5/5
Tibialis Ant (L4,5; Deep Peron N)	5/5	5/5
Gastrocnemius (S1,2; Tibial N)	5/5	5/5
EHL (L5,S1; Deep Peron N)	5/5	5/5

LOWER EXTREMITY DTR	Right	Left
Patella (L3,4)	2/4	2/4
Achilles (L5,S1)	2/4	2/4

LOWER EXTREMITY SENSATION	Right	Left
Light Touch	Y / N	Y / N
Pain	Y / N	Y / N

Gait/Station: Nml / Antalgic / Other Assistive Device: N / Y _____ Brace: N / Y _____

General Appearance: Alert, NAD, Oriented to time/Place Y / N _____

Pulses: RUE: Nml / Abnml LUE: Nml / Abnml RLE: Nml / Abnml LLE: Nml / Abnml

REVIEW OF IMAGES: X-RAY MRI REVIEW OF EMGS

PHYSICAN SIGNATURE _____

NEW YORK STATE | Workers' Compensation Board

PRIOR AUTHORIZATION REQUEST: MTG CONFIRMATION

Listed below are details of a Prior Authorization Request (PAR) that was submitted to request confirmation that the proposed treatment(s)/test(s) are based on a correct application of the Medical Treatment Guidelines. The claim administrator has denied all or part of the request; please carefully review all items.

To the health care provider: For any treatment/test that was **Granted In Part** or **Denied**, if Denial Category is **Medical**, you may request review by the Medical Director's Office using OnBoard no later than 09/06/2022 OR convert the request to an MTG Variance.

To the claimant: For any treatment/test that was **Denied**, if Denial Category is **Administrative** or **Jurisdiction** you or your legal representative may request review by filing *Request for Assistance by Injured Worker* (Form RFA-1W) or *Request for Further Action by Legal Counsel* (Form RFA-1LC) respectively. These forms are available under the "Forms" section of the WCB's website: www.wcb.ny.gov. If you do not have access to the internet, please call (877) 632-4996 or visit our nearest Customer Service Center to obtain a copy of the form.
Note: If present, a Level 2 Insurer Response supersedes a Level 1 Insurer Response.

CLAIM INFORMATION

WCB Case #	Date of Injury	Claim Admin Claim #
G3051719	06/11/2021	73141129-110

Patient Name Dillard, Bayani
Address 52 Charles Street
MALVERNE, NY 11565
SSN XXX-XX-9312 **DOB** 11/05/1976 **Gender** Male

Employer Name FLUSHING HOSPITAL AND MEDICAL
Address %KATHY SHELDON-JAMAICA HOSP ME, D CTR 8900 VANWYCK EXPRESSWAY
JAMAICA, NY 11418

Insurer Name STATE INSURANCE FUND **Insurer ID** W204002
Address 199 CHURCH ST - 7TH FLOOR
NEW YORK, NY 10007-1173

Claim Admin Name STATE INSURANCE FUND **Claim Admin ID** W204002
Address 199 CHURCH ST - 7TH FLOOR
NEW YORK, NY 10007-1173

HEALTH CARE PROVIDER INFORMATION

Name KATSIGIORGIS, GUS

Address ISLAND MUSCULOSKELETLA CARE MD, PO BOX 360

HEWLETT, NY 11557

Type Physician

WCB Auth # 234244-2 **NPI** 1033105564

PRIOR AUTHORIZATION REQUEST DETAILS

	Body Part	MTG Reference Code and Description	CPT Code and Description
1.	Right Knee	Knee - D.6.f: Rehabilitation - Therapeutic Exercise - Knee Injury	97110: Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
2.	Right Knee	Knee - D.6.s: Rehabilitation - Mobilization (Soft Tissue) - Knee Injury	97140: Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
3.	Right Knee	Knee - D.6.u: Rehabilitation - Superficial Heat/Cold Therapy - Knee Injury	97010: Application of a modality to 1 or more areas; hot or cold packs
4.	Right Knee	Knee - D.6.y: Rehabilitation - Ultrasound - Knee Injury	97035: Application of a modality to 1 or more areas; ultrasound, each 15 minutes
5.	Right Knee	Knee - D.6.j: Rehabilitation - Electrical Stimulation (Physician/Therapist Applied) - Knee Injury	97014: Application of a modality to 1 or more areas; electrical stimulation (unattended)

NEW YORK STATE | Workers' Compensation Board

PRIOR AUTHORIZATION REQUEST: MTG CONFIRMATION

STATEMENT OF MEDICAL NECESSITY / SUPPORTING MEDICAL DOCUMENTATION

Statement of Medical Necessity: 3 TIMES PER WEEK FOR 8 WEEKS - PLEASE SEE THE ATTACHED NOTES.

Supporting documentation was provided as a part of this request.

PROVIDER'S ATTESTATION

By submission of this request for prior authorization, I certify that my statements are true and correct, and I do not have a substantially similar request pending.

Provider Name KATSIGIORGIS, GUS **Date** 08/16/2022

LEVEL 1 INSURER RESPONSE

	Authorization Requested		Insurer Response	
1.	**Body Part**	Right Knee	**Insurer Response**	Deny
	MTG Reference Code and Description	Knee - D.6.f: Rehabilitation - Therapeutic Exercise - Knee Injury	**Denial Category**	Medical Reasons
	CPT Code and Description	97110: Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	**Denial Reason**	MTGs - treatment not consistent with
			Rationale	Claimant received about 97 sessions of physical therapy from 06/19/21 to 07/13/22.
2.	**Authorization Requested**		**Insurer Response**	
	Body Part	Right Knee	**Insurer Response**	Deny
	MTG Reference Code and Description	Knee - D.6.s: Rehabilitation - Mobilization (Soft Tissue) - Knee Injury	**Denial Category**	Medical Reasons
	CPT Code and Description	97140: Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	**Denial Reason**	MTGs - treatment not consistent with
			Rationale	Claimant received about 97 sessions of physical therapy from 06/19/21 to 07/13/22.

LEVEL 1 INSURER RESPONSE

	Authorization Requested		Insurer Response	
3.	Body Part	Right Knee	Insurer Response	Deny
	MTG Reference Code and Description	Knee - D.6.u: Rehabilitation - Superficial Heat/Cold Therapy - Knee Injury	Denial Category	Medical Reasons
	CPT Code and Description	97010: Application of a modality to 1 or more areas; hot or cold packs	Denial Reason	MTGs - treatment not consistent with
			Rationale	Claimant received about 97 sessions of physical therapy from 06/19/21 to 07/13/22.
4.	Authorization Requested		Insurer Response	
	Body Part	Right Knee	Insurer Response	Deny
	MTG Reference Code and Description	Knee - D.6.y: Rehabilitation - Ultrasound - Knee Injury	Denial Category	Medical Reasons
	CPT Code and Description	97035: Application of a modality to 1 or more areas; ultrasound, each 15 minutes	Denial Reason	MTGs - treatment not consistent with
			Rationale	Claimant received about 97 sessions of physical therapy from 06/19/21 to 07/13/22.
5.	Authorization Requested		Insurer Response	
	Body Part	Right Knee	Insurer Response	Deny
	MTG Reference Code and Description	Knee - D.6.j: Rehabilitation - Electrical Stimulation (Physician/Therapist Applied) - Knee Injury	Denial Category	Medical Reasons
	CPT Code and Description	97014: Application of a modality to 1 or more areas; electrical stimulation (unattended)	Denial Reason	MTGs - treatment not consistent with
			Rationale	Claimant received about 97 sessions of physical therapy from 06/19/21 to 07/13/22.

Claim Apportioned No

Name of the Reviewer Yogesh Patel

Date 08/17/2022

Reviewer Title L1 Reviewer

Note: A Level 2 Insurer Response supersedes a Level 1 Insurer Response.

LEVEL 2 INSURER RESPONSE

1.	Authorization Requested		Insurer Response	
	Body Part	Right Knee	**Insurer Response**	Deny
	MTG Reference Code and Description	Knee - D.6.f: Rehabilitation - Therapeutic Exercise - Knee Injury	**Denial Category**	Medical Reasons
	CPT Code and Description	97110: Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	**Denial Reason**	Other
			Other Reason	see rationale
			Rationale	New York Medical Treatment Guidelines note physical therapy is recommended to improve function, including range of motion and strength. Total numbers of visits may be as few as two to three for mild patients or up to 12 to 15 with documentation of objective functional improvement. In this case, the patient is greater than seven months following arthroscopic right knee surgery. It appears that appropriate physical therapy has already been performed. The total number of completed sessions of treatment is unclear. The reviewed records do not indicate any functional benefit related to prior therapy and/or exacerbated clinical symptoms. The request for 24 additional sessions of treatment exceeds the guideline recommendations. As such, CPT 97110 is denied.

LEVEL 2 INSURER RESPONSE

2.	Authorization Requested		Insurer Response	
	Body Part	Right Knee	**Insurer Response**	Deny
	MTG Reference Code and Description	Knee - D.6.s: Rehabilitation - Mobilization (Soft Tissue) - Knee Injury	**Denial Category**	Medical Reasons
	CPT Code and Description	97140: Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	**Denial Reason**	Other
			Other Reason	see rationale
			Rationale	New York Medical Treatment Guidelines note physical therapy is recommended to improve function, including range of motion and strength. Total numbers of visits may be as few as two to three for mild patients or up to 12 to 15 with documentation of objective functional improvement. In this case, the patient is greater than seven months following arthroscopic right knee surgery. It appears that appropriate physical therapy has already been performed. The total number of completed sessions of treatment is unclear. The reviewed records do not indicate any functional benefit related to prior therapy and/or exacerbated clinical symptoms. The request for 24 additional sessions of treatment exceeds the guideline recommendations. As such, CPT 97140 is denied.

LEVEL 2 INSURER RESPONSE

3.	Authorization Requested		Insurer Response	
	Body Part	Right Knee	**Insurer Response**	Deny
	MTG Reference Code and Description	Knee - D.6.u: Rehabilitation - Superficial Heat/Cold Therapy - Knee Injury	**Denial Category**	Medical Reasons
	CPT Code and Description	97010: Application of a modality to 1 or more areas: hot or cold packs	**Denial Reason**	Other
			Other Reason	see rationale
			Rationale	New York Medical Treatment Guidelines note physical therapy is recommended to improve function, including range of motion and strength. Total numbers of visits may be as few as two to three for mild patients or up to 12 to 15 with documentation of objective functional improvement. In this case, the patient is greater than seven months following arthroscopic right knee surgery. It appears that appropriate physical therapy has already been performed. The total number of completed sessions of treatment is unclear. The reviewed records do not indicate any functional benefit related to prior therapy and/or exacerbated clinical symptoms. The request for 24 additional sessions of treatment exceeds the guideline recommendations. As such, CPT 97010 is denied.

LEVEL 2 INSURER RESPONSE

4.	Authorization Requested		Insurer Response	
	Body Part	Right Knee	**Insurer Response**	Deny
	MTG Reference Code and Description	Knee - D.6.y: Rehabilitation - Ultrasound - Knee Injury	**Denial Category**	Medical Reasons
	CPT Code and Description	97035: Application of a modality to 1 or more areas; ultrasound, each 15 minutes	**Denial Reason**	Other
			Other Reason	see rationale
			Rationale	New York Medical Treatment Guidelines note physical therapy is recommended to improve function, including range of motion and strength. Total numbers of visits may be as few as two to three for mild patients or up to 12 to 15 with documentation of objective functional improvement. In this case, the patient is greater than seven months following arthroscopic right knee surgery. It appears that appropriate physical therapy has already been performed. The total number of completed sessions of treatment is unclear. The reviewed records do not indicate any functional benefit related to prior therapy and/or exacerbated clinical symptoms. The request for 24 additional sessions of treatment exceeds the guideline recommendations. As such, CPT 97035 is denied.

LEVEL 2 INSURER RESPONSE

5.	Authorization Requested		Insurer Response	
	Body Part	Right Knee	**Insurer Response**	Deny
	MTG Reference Code and Description	Knee - D.6.j: Rehabilitation - Electrical Stimulation (Physician/Therapist Applied) - Knee Injury	**Denial Category**	Medical Reasons
	CPT Code and Description	97014: Application of a modality to 1 or more areas; electrical stimulation (unattended)	**Denial Reason**	Other
			Other Reason	see rationale
			Rationale	New York Medical Treatment Guidelines note physical therapy is recommended to improve function, including range of motion and strength. Total numbers of visits may be as few as two to three for mild patients or up to 12 to 15 with documentation of objective functional improvement. In this case, the patient is greater than seven months following arthroscopic right knee surgery. It appears that appropriate physical therapy has already been performed. The total number of completed sessions of treatment is unclear. The reviewed records do not indicate any functional benefit related to prior therapy and/or exacerbated clinical symptoms. The request for 24 additional sessions of treatment exceeds the guideline recommendations. As such, CPT 97014 is denied.

Claim Apportioned No

Supporting documentation was provided as a part of this request.

Name of the Reviewer Douglas Lurie **Date** 08/25/2022

Reviewer Title L2 Reviewer, MD

NEW YORK STATE | Workers' Compensation Board

PRIOR AUTHORIZATION REQUEST: MTG CONFIRMATION

Listed below are details of a Prior Authorization Request (PAR) that was submitted to request confirmation that the proposed treatment(s)/test(s) are based on a correct application of the Medical Treatment Guidelines. Upon identification of the claim administrator, they will be required to respond within 8 business days; parties will be notified of the outcome.

CLAIM INFORMATION

WCB Case #	Date of Injury	Claim Admin Claim #
G3051719	06/11/2021	73141129-110

Patient Name Dillard, Bayani

Address 52 Charles Street
MALVERNE, NY 11565

SSN XXX-XX-9312 **DOB** 11/05/1976 **Gender** Male

Employer Name FLUSHING HOSPITAL AND MEDICAL CENTER

Address %KATHY SHELDON-JAMAICA HOSP ME, D CTR 8900 VANWYCK EXPRESSWAY
JAMAICA, NY 11418

Insurer Name State Insurance Fund **Insurer ID** W204002

Address 199 CHURCH ST - 7TH FLOOR
NEW YORK, NY 10007-1173

Claim Admin Name State Insurance Fund **Claim Admin ID** W204002

Address 199 CHURCH ST - 7TH FLOOR
NEW YORK, NY 10007-1173

HEALTH CARE PROVIDER INFORMATION

Name KATSIGIORGIS, GUS

Address ISLAND MUSCULOSKELETLA CARE MD, PO BOX 360
HEWLETT, NY 11557

Type Physician

WCB Auth # 234244-2 **NPI** 1033105564

PRIOR AUTHORIZATION REQUEST DETAILS

	Body Part	MTG Reference Code and Description	CPT Code and Description
1.	Right Knee	Knee - D.6.f: Rehabilitation - Therapeutic Exercise - Knee Injury	97110: Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
2.	Right Knee	Knee - D.6.s: Rehabilitation - Mobilization (Soft Tissue) - Knee Injury	97140: Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
3.	Right Knee	Knee - D.6.u: Rehabilitation - Superficial Heat/Cold Therapy - Knee Injury	97010: Application of a modality to 1 or more areas; hot or cold packs
4.	Right Knee	Knee - D.6.y: Rehabilitation - Ultrasound - Knee Injury	97035: Application of a modality to 1 or more areas; ultrasound, each 15 minutes
5.	Right Knee	Knee - D.6.j: Rehabilitation - Electrical Stimulation (Physician/Therapist Applied) - Knee Injury	97014: Application of a modality to 1 or more areas; electrical stimulation (unattended)

STATEMENT OF MEDICAL NECESSITY / SUPPORTING MEDICAL DOCUMENTATION

Statement of Medical Necessity: 3 TIMES PER WEEK FOR 8 WEEKS - PLEASE SEE THE ATTACHED NOTES.

Supporting documentation was provided as a part of this request.

PROVIDER'S ATTESTATION

By submission of this request for prior authorization, I certify that my statements are true and correct, and I do not have a substantially similar request pending.

Provider Name KATSIGIORGIS, GUS **Date** 08/16/2022

Case Number: PA-00-0482-868

08/25/2022

New York State Insurance Fund
15 Computer Drive West
Albany, NY 12205

Claimant: Bayani Dillard
WCB Case #: G3051719
Claim Admin Claim #: 73141129-110

Clinical Summary:
This is a 45-year-old male with a history of occupational claim from 06/11/2021. The patient was seen on 07/06/2022. The patient reported physical therapy was helping. There was a diagnosis of right knee arthroscopy, osteoarthritis, chondromalacia, medial meniscal tear, and synovitis. Examination demonstrated mild tenderness at the knee. There was no motor weakness or sensory change. A hinged knee brace was provided for support. Additional physical therapy was recommended. The patient was seen for physical therapy on 07/13/2022. The patient was status post arthroscopic right knee surgery on 01/10/2022. Examination noted 0-110° of right knee motion. Additional therapy was recommended. A request was submitted on 08/16/2022 for additional physical therapy three times per week for eight weeks for the right knee.

Code: 97110: Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to developstrength and endurance, range of motion and flexibility

Rationale:
New York Medical Treatment Guidelines note physical therapy is recommended to improve function, including range of motion and strength. Total numbers of visits may be as few as two to three for mild patients or up to 12 to 15 with documentation of objective functional improvement. In this case, the patient is greater than seven months following arthroscopic right knee surgery. It appears that appropriate physical therapy has already been performed. The total number of completed sessions of treatment is unclear. The reviewed records do not indicate any functional benefit related to prior therapy and/or exacerbated clinical symptoms. The request for 24 additional sessions of treatment exceeds the guideline recommendations. As such, CPT 97110 is denied.

Code: 97140: Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes

Rationale:
New York Medical Treatment Guidelines note physical therapy is recommended to improve function, including range of motion and strength. Total numbers of visits may be as few as two to three for mild patients or up to 12 to 15 with documentation of objective functional improvement. In this case, the patient is greater than seven months following arthroscopic right knee surgery. It appears that appropriate physical therapy has already been performed. The total number of completed sessions of treatment is unclear. The reviewed records do not indicate any functional benefit related to prior therapy and/or exacerbated clinical symptoms. The request for 24 additional sessions of treatment exceeds the guideline recommendations. As such, CPT 97140 is denied.

Code: 97010: Application of a modality to 1 or more areas; hot or cold packs

Rationale:
New York Medical Treatment Guidelines note physical therapy is recommended to improve function, including range of motion and strength. Total numbers of visits may be as few as two to three for mild patients or up to 12 to 15 with documentation of objective functional improvement. In this case, the patient is

greater than seven months following arthroscopic right knee surgery. It appears that appropriate physical therapy has already been performed. The total number of completed sessions of treatment is unclear. The reviewed records do not indicate any functional benefit related to prior therapy and/or exacerbated clinical symptoms. The request for 24 additional sessions of treatment exceeds the guideline recommendations. As such, CPT 97010 is denied.

Code: 97035: Application of a modality to 1 or more areas; ultrasound, each 15 minutes

Rationale:
New York Medical Treatment Guidelines note physical therapy is recommended to improve function, including range of motion and strength. Total numbers of visits may be as few as two to three for mild patients or up to 12 to 15 with documentation of objective functional improvement. In this case, the patient is greater than seven months following arthroscopic right knee surgery. It appears that appropriate physical therapy has already been performed. The total number of completed sessions of treatment is unclear. The reviewed records do not indicate any functional benefit related to prior therapy and/or exacerbated clinical symptoms. The request for 24 additional sessions of treatment exceeds the guideline recommendations. As such, CPT 97035 is denied.

Code: 97014: Application of a modality to 1 or more areas; electrical stimulation (unattended)

Rationale:
New York Medical Treatment Guidelines note physical therapy is recommended to improve function, including range of motion and strength. Total numbers of visits may be as few as two to three for mild patients or up to 12 to 15 with documentation of objective functional improvement. In this case, the patient is greater than seven months following arthroscopic right knee surgery. It appears that appropriate physical therapy has already been performed. The total number of completed sessions of treatment is unclear. The reviewed records do not indicate any functional benefit related to prior therapy and/or exacerbated clinical symptoms. The request for 24 additional sessions of treatment exceeds the guideline recommendations. As such, CPT 97014 is denied.

References:
New York MTG Knee Injury (effective May 1, 2022)

Attestation:
ProPeer's clinical reviewer states the following:

Credentials, Knowledge & Experience
I do possess the scope of licensure or certification that typically manages the medical condition, procedure, treatment or issue under review.

I also possess the relevant experience and /or knowledge to render an opinion or determination for this case.

I also have had a minimum of 5 years, Full-Time Equivalent, providing direct patient care.

Financial Incentives
I attest I am NOT to receive any financial incentive that is dependent in any way on my recommendation to ProPeer or the referring entity, or the outcome of this case.

Independence
I attest that I have had no involvement with this case (episode of care) prior to the referring entity's initial referral of this case to ProPeer, with the exception of "re-consideration" requested by ProPeer's client.

Conflict of Interest
I, the clinical reviewer, do hereby attest that I do not have a conflict of interest in this case.
For the purposes of this peer review, Conflict of Interest is defined as:

I am free of any material professional, familial or financial conflict of interest with any of the following:

- The referring entity (ProPeer's client);
- The health carrier;
- Any officer, director or management employee of the health carrier;
- Any group health plan administrator, plan fiduciary or plan employee;
- The covered person/injured worker or their authorized representative;
- The attending provider or any other health care provider previously involved in this case, the provider's medical group or independent practice association recommending the health care service or treatment that is the subject of his peer review;
- The facility at which the recommended health care service or treatment would be provided; **or**
- The developer or manufacturer of the principal drug, device, procedure, or the therapy being recommended for the covered person.

I attest that I hold appropriate licensure/credentials that typically manages the medical condition, procedure, treatment, or issues under review and maintain current knowledge to render a determination. I received my medical degree from the Medical College of Wisconsin. I completed my Physical Medicine and Rehabilitation Residency at the University of Pittsburgh Medical Center. I hold an active and unrestricted Wisconsin license. I have experience producing Peer Reviews supported by evidence-based medicine and have experience with worker's compensation claims. I am Board Certified in Physical Medicine & Rehabilitation.

The opinions rendered herein are based solely upon review of the written records and information submitted by the client for review and evaluation. No verbal information whatsoever is obtained or used during the review and evaluation process. ProPeer Resources cannot be responsible for the accuracy of the information submitted for review. It is the sole responsibility of the client to provide ProPeer all information necessary for a thorough and objective review and opinion. A reconsideration of an opinion may be warranted and undertaken if the information submitted was incomplete, inaccurate or certain circumstances have changed. UCR database quotations are data-based and not contingent upon physician review.

This review was requested by and provided to a ProPeer client as consultatory information for use in conjunction with other relevant information; i.e., policy language including definitions, terms and provisions, and limitations and exclusions, that is available to and needed by the client in the adjudication of a claim. **Final responsibility for the adjudication of a claim remains solely with the client.**

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NEW YORK STATE | Workers' Compensation Board

PRIOR AUTHORIZATION REQUEST: MTG VARIANCE

Listed below are details of a Prior Authorization Request (PAR) that was submitted to request treatments/tests that vary from the Medical Treatment Guidelines. The claim administrator has granted the request.

To the claimant: This is a copy for your records. No action is required at this time; if you have any questions, please follow up with GUS KATSIGIORGIS.

Note: If present, a Level 2 Insurer Response supersedes a Level 1 Insurer Response.

CLAIM INFORMATION

WCB Case #	Date of Injury	Claim Admin Claim #
G3051719	06/11/2021	73141129-110

Patient Name Dillard, Bayani

Address 52 Charles Street
MALVERNE, NY 11565

SSN XXX-XX-9312 **DOB** 11/05/1976 **Gender** Male

Employer Name FLUSHING HOSPITAL AND MEDICAL

Address %KATHY SHELDON-JAMAICA HOSP ME, D CTR 8900 VANWYCK EXPRESSWAY
JAMAICA, NY 11418

Insurer Name STATE INSURANCE FUND **Insurer ID** W204002

Address 199 CHURCH ST - 7TH FLOOR
NEW YORK, NY 10007-1173

Claim Admin Name STATE INSURANCE FUND **Claim Admin ID** W204002

Address 199 CHURCH ST - 7TH FLOOR
NEW YORK, NY 10007-1173

HEALTH CARE PROVIDER INFORMATION

Name KATSIGIORGIS, GUS

Address ISLAND MUSCULOSKELETLA CARE MD, PO BOX 360
HEWLETT, NY 11557

Type Physician

WCB Auth # 234244-2 **NPI** 1033105564

PRIOR AUTHORIZATION REQUEST DETAILS

	Body Part	MTG Reference Code and Description	CPT Code and Description
1.	Right Knee	Knee - D.6.f: Rehabilitation - Therapeutic Exercise - Knee Injury	97110: Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
2.	Right Knee	Knee - D.6.s: Rehabilitation - Mobilization (Soft Tissue) - Knee Injury	97140: Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
3.	Right Knee	Knee - D.6.u: Rehabilitation - Superficial Heat/Cold Therapy - Knee Injury	97010: Application of a modality to 1 or more areas; hot or cold packs
4.	Right Knee	Knee - D.6.y: Rehabilitation - Ultrasound - Knee Injury	97035: Application of a modality to 1 or more areas; ultrasound, each 15 minutes
5.	Right Knee	Knee - D.6.j: Rehabilitation - Electrical Stimulation (Physician/Therapist Applied) - Knee Injury	97014: Application of a modality to 1 or more areas; electrical stimulation (unattended)

STATEMENT OF MEDICAL NECESSITY / SUPPORTING MEDICAL DOCUMENTATION

Statement of Medical Necessity: 3 TIMES PER WEEK FOR 8 WEEKS PLEASE SEE THE ATTACHED NOTES

Supporting documentation was provided as a part of this request.

PROVIDER'S ATTESTATION

By submission of this request for prior authorization, I certify that my statements are true and correct, and I do not have a substantially similar request pending.

Provider Name KATSIGIORGIS, GUS **Date** 09/13/2022

LEVEL 1 INSURER RESPONSE

1.	Authorization Requested		Insurer Response	
	Body Part	Right Knee	**Insurer Response**	Deny
	MTG Reference Code and Description	Knee - D.6.f: Rehabilitation - Therapeutic Exercise - Knee Injury	**Denial Category**	Medical Reasons
			Denial Reason	Other
			Other Reason	Duplicate same denied on 8/25/22. Also, not according to Knee MTG.
	CPT Code and Description	97110: Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	**Rationale**	Duplicate same denied on 8/25/22. Also, not according to Knee MTG.

2.	Authorization Requested		Insurer Response	
	Body Part	Right Knee	**Insurer Response**	Deny
	MTG Reference Code and Description	Knee - D.6.s: Rehabilitation - Mobilization (Soft Tissue) - Knee Injury	**Denial Category**	Medical Reasons
			Denial Reason	Other
			Other Reason	Duplicate same denied on 8/25/22. Also, not according to Knee MTG.
	CPT Code and Description	97140: Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	**Rationale**	Duplicate same denied on 8/25/22. Also, not according to Knee MTG.

LEVEL 1 INSURER RESPONSE

	Authorization Requested		Insurer Response	
3.	Body Part	Right Knee	Insurer Response	Deny
	MTG Reference Code and Description	Knee - D.6.u: Rehabilitation - Superficial Heat/Cold Therapy - Knee Injury	Denial Category	Medical Reasons
			Denial Reason	Other
			Other Reason	Duplicate same denied on 8/25/22. Also, not according to Knee MTG.
	CPT Code and Description	97010: Application of a modality to 1 or more areas; hot or cold packs	Rationale	Duplicate same denied on 8/25/22. Also, not according to Knee MTG.
4.	Authorization Requested		Insurer Response	
	Body Part	Right Knee	Insurer Response	Deny
	MTG Reference Code and Description	Knee - D.6.y: Rehabilitation - Ultrasound - Knee Injury	Denial Category	Medical Reasons
			Denial Reason	Other
			Other Reason	Duplicate same denied on 8/25/22. Also, not according to Knee MTG.
	CPT Code and Description	97035: Application of a modality to 1 or more areas; ultrasound, each 15 minutes	Rationale	Duplicate same denied on 8/25/22. Also, not according to Knee MTG.
5.	Authorization Requested		Insurer Response	
	Body Part	Right Knee	Insurer Response	Deny
	MTG Reference Code and Description	Knee - D.6.j: Rehabilitation - Electrical Stimulation (Physician/Therapist Applied) - Knee Injury	Denial Category	Medical Reasons
			Denial Reason	Other
			Other Reason	Duplicate same denied on 8/25/22. Also, not according to Knee MTG.
	CPT Code and Description	97014: Application of a modality to 1 or more areas; electrical stimulation (unattended)	Rationale	Duplicate same denied on 8/25/22. Also, not according to Knee MTG.

Claim Apportioned No

Name of the Reviewer Yogesh Patel

Reviewer Title L1 Reviewer

Date 09/16/2022

Note: A Level 2 Insurer Response supersedes a Level 1 Insurer Response.

LEVEL 2 INSURER RESPONSE

	Authorization Requested		Insurer Response	
1.	**Body Part**	Right Knee	**Insurer Response**	Grant
	MTG Reference Code and Description	Knee - D.6.f: Rehabilitation - Therapeutic Exercise - Knee Injury		
	CPT Code and Description	97110: Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility		
2.	**Body Part**	Right Knee	**Insurer Response**	Grant
	MTG Reference Code and Description	Knee - D.6.s: Rehabilitation - Mobilization (Soft Tissue) - Knee Injury		
	CPT Code and Description	97140: Manual therapy techniques (eg. mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes		
3.	**Body Part**	Right Knee	**Insurer Response**	Grant
	MTG Reference Code and Description	Knee - D.6.u: Rehabilitation - Superficial Heat/Cold Therapy - Knee Injury		
	CPT Code and Description	97010: Application of a modality to 1 or more areas; hot or cold packs		

LEVEL 2 INSURER RESPONSE

	Authorization Requested		Insurer Response	
4.	**Body Part**	Right Knee	**Insurer Response**	Grant
	MTG Reference Code and Description	Knee - D.6.y: Rehabilitation - Ultrasound - Knee Injury		
	CPT Code and Description	97035: Application of a modality to 1 or more areas; ultrasound, each 15 minutes		
5.	**Authorization Requested**		**Insurer Response**	
	Body Part	Right Knee	**Insurer Response**	Grant
	MTG Reference Code and Description	Knee - D.6.j: Rehabilitation - Electrical Stimulation (Physician/Therapist Applied) - Knee Injury		
	CPT Code and Description	97014: Application of a modality to 1 or more areas; electrical stimulation (unattended)		

Claim Apportioned No

Supporting documentation was provided as a part of this request.

Name of the Reviewer Douglas Lurie **Date** 09/28/2022

Reviewer Title L2 Reviewer, DO

NEW YORK STATE | Workers' Compensation Board

PRIOR AUTHORIZATION REQUEST: MTG VARIANCE

Listed below are details of a Prior Authorization Request (PAR) that was submitted to request treatments/tests that vary from the Medical Treatment Guidelines. Upon identification of the claim administrator, they will be required to respond within 15 calendar days (final day will move to the next business day if it falls on a weekend/holiday); parties will be notified of the outcome.

CLAIM INFORMATION

WCB Case #	Date of Injury	Claim Admin Claim #
G3051719	06/11/2021	73141129-110

Patient Name Dillard, Bayani

Address 52 Charles Street
MALVERNE, NY 11565

SSN XXX-XX-9312 **DOB** 11/05/1976 **Gender** Male

Employer Name FLUSHING HOSPITAL AND MEDICAL CENTER

Address %KATHY SHELDON-JAMAICA HOSP ME, D CTR 8900 VANWYCK EXPRESSWAY
JAMAICA, NY 11418

Insurer Name State Insurance Fund **Insurer ID** W204002

Address 199 CHURCH ST - 7TH FLOOR
NEW YORK, NY 10007-1173

Claim Admin Name State Insurance Fund **Claim Admin ID** W204002

Address 199 CHURCH ST - 7TH FLOOR
NEW YORK, NY 10007-1173

HEALTH CARE PROVIDER INFORMATION

Name KATSIGIORGIS, GUS

Address ISLAND MUSCULOSKELETLA CARE MD, PO BOX 360
HEWLETT, NY 11557

Type Physician

WCB Auth # 234244-2 **NPI** 1033105564

PRIOR AUTHORIZATION REQUEST DETAILS

	Body Part	MTG Reference Code and Description	CPT Code and Description
1.	Right Knee	Rehabilitation - Therapeutic Exercise - Knee Injury	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
2.	Right Knee	Rehabilitation - Mobilization (Soft Tissue) - Knee Injury	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
3.	Right Knee	Rehabilitation - Superficial Heat/Cold Therapy - Knee Injury	Application of a modality to 1 or more areas; hot or cold packs
4.	Right Knee	Rehabilitation - Ultrasound - Knee Injury	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
5.	Right Knee	Rehabilitation - Electrical Stimulation (Physician/Therapist Applied) - Knee Injury	Application of a modality to 1 or more areas; electrical stimulation (unattended)

STATEMENT OF MEDICAL NECESSITY / SUPPORTING MEDICAL DOCUMENTATION

Statement of Medical Necessity: 3 TIMES PER WEEK FOR 8 WEEKS PLEASE SEE THE ATTACHED NOTES

Supporting documentation was provided as a part of this request.

PROVIDER'S ATTESTATION

By submission of this request for prior authorization, I certify that my statements are true and correct, and I do not have a substantially similar request pending.

Provider Name KATSIGIORGIS, GUS **Date** 09/13/2022

Case Number: PA-00-0540-724

09/27/2022

New York State Insurance Fund
15 Computer Drive West
Albany, NY 12205

Claimant: Dillard, Bayani
WCB Case #: PA-00-0540-724
Claim Admin Claim #: 73141129-110

Clinical Summary: This case involves a now 48-year-old male with a history of an occupational claim from 06/11/2021. The clinical note dated 07/13/2022 states the claimant is complaining of right knee pain. The claimant received 12 visits of skilled PT dated 03/30/2022 to 07/13/2022. Patient continues to show significant improvement with decreased in pain from 4/10 to 2/10 and with increased in ROM by 10 degrees and muscle strength from 3+/5 to 4-/5. Patient reports of improvement in function and ADL's. The claimant is still c/o intermittent aching pain on the right knee with stiffness and increased knee pain at the end of his shift even with medications, knee brace and activity restrictions. The physical examination of the right knee reports Pain, Weakness, Clicking, Swelling, Soreness, Tightness and Stiffness in the right knee. The treatment plan includes physical therapy for the right knee three times per week for eight weeks.

Code: 97110: Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

Rationale: The New York Medical Treatment Guidelines recommend up to 12-15 weeks of physical therapy for knee injuries with documentation of ongoing functional improvement. The claimant continues to experience intermittent aching pain on the right knee with stiffness and increased knee pain at the end of his shift even with medications, knee brace and activity restrictions. The pervious course of physical therapy sessions showed a decrease in pain, increased range of motion and strength, function and activities of daily living. Given the above, the request for code 97110: Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility for 12 sessions is granted.

Code: 97140: Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes

Rationale: The New York Medical Treatment Guidelines recommend up to 12-15 weeks of physical therapy for knee injuries with documentation of ongoing functional improvement. The claimant continues to experience intermittent aching pain on the right knee with stiffness and increased knee pain at the end of his shift even with medications, knee brace and activity restrictions. The pervious course of physical therapy sessions showed a decrease in pain, increased range of motion and strength, function and activities of daily living. Given the above, the request for code 97140: Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes for 12 sessions is granted.

Code: 97010: Application of a modality to 1 or more areas; hot or cold packs

Rationale: The New York Medical Treatment Guidelines recommend up to 12-15 weeks of physical therapy for knee injuries with documentation of ongoing functional improvement. The claimant continues to experience intermittent aching pain on the right knee with stiffness and increased knee pain at the end of his shift even with medications, knee brace and activity restrictions. The pervious course of physical therapy sessions showed a decrease in pain, increased range of motion and strength, function and activities of daily

living. Given the above, the request for code 97010: Application of a modality to 1 or more areas; hot or cold packs for 12 sessions is granted.

Code: 97035: Application of a modality to 1 or more areas; ultrasound, each 15 minutes

Rationale: The New York Medical Treatment Guidelines recommend up to 12-15 weeks of physical therapy for knee injuries with documentation of ongoing functional improvement. The claimant continues to experience intermittent aching pain on the right knee with stiffness and increased knee pain at the end of his shift even with medications, knee brace and activity restrictions. The pervious course of physical therapy sessions showed a decrease in pain, increased range of motion and strength, function and activities of daily living. Given the above, the request for code: 97035: Application of a modality to 1 or more areas; ultrasound, each 15 minutes for 12 sessions is granted.

Code: 97014: Application **of a modality to 1 or more areas; electrical stimulation**

Rationale: The New York Medical Treatment Guidelines recommend up to 12-15 weeks of physical therapy for knee injuries with documentation of ongoing functional improvement. The claimant continues to experience intermittent aching pain on the right knee with stiffness and increased knee pain at the end of his shift even with medications, knee brace and activity restrictions. The pervious course of physical therapy sessions showed a decrease in pain, increased range of motion and strength, function and activities of daily living. Given the above, the request for code 97014: Application of a modality to 1 or more areas; electrical stimulation for 12 sessions is granted.

References: New York Medical Treatment Guidelines, Knee Injury, effective May 02, 2022

Attestation:
ProPeer's clinical reviewer states the following:

Credentials, Knowledge & Experience
I do possess the scope of licensure or certification that typically manages the medical condition, procedure, treatment or issue under review.

I also possess the relevant experience and /or knowledge to render an opinion or determination for this case.

I also have had a minimum of 5 years, Full-Time Equivalent, providing direct patient care.

Financial Incentives
I attest I am NOT to receive any financial incentive that is dependent in any way on my recommendation to ProPeer or the referring entity, or the outcome of this case.

Independence
I attest that I have had no involvement with this case (episode of care) prior to the referring entity's initial referral of this case to ProPeer, with the exception of "re-consideration" requested by ProPeer's client.

Conflict of Interest
I, the clinical reviewer, do hereby attest that I do not have a conflict of interest in this case.
For the purposes of this peer review, Conflict of Interest is defined as:
I am free of any material professional, familial or financial conflict of interest with any of the following:

- The referring entity (ProPeer's client);
- The health carrier;
- Any officer, director or management employee of the health carrier;
- Any group health plan administrator, plan fiduciary or plan employee;

- The covered person/injured worker or their authorized representative;
- The attending provider or any other health care provider previously involved in this case, the provider's medical group or independent practice association recommending the health care service or treatment that is the subject of his peer review;
- The facility at which the recommended health care service or treatment would be provided; **or**
- The developer or manufacturer of the principal drug, device, procedure, or the therapy being recommended for the covered person.

I attest that I hold appropriate licensure/credentials that typically manages the medical condition, procedure, treatment, or issues under review and maintain current knowledge to render a determination. I received my medical degree from Touro University College of Osteopathic Medicine. I completed my Physical Medicine & Rehabilitation Residency and my Pain Medicine fellowship at the University of Texas Health Science Center San Antonio. I hold an active and unrestricted California and Texas license. I have experience producing Peer Reviews supported by evidence-based medicine and have experience with worker's compensation claims. I am Board Certified in Physical Medicine & Rehabilitation and Pain Medicine.

The opinions rendered herein are based solely upon review of the written records and information submitted by the client for review and evaluation. No verbal information whatsoever is obtained or used during the review and evaluation process. ProPeer Resources cannot be responsible for the accuracy of the information submitted for review. It is the sole responsibility of the client to provide ProPeer all information necessary for a thorough and objective review and opinion. A reconsideration of an opinion may be warranted and undertaken if the information submitted was incomplete, inaccurate or certain circumstances have changed. UCR database quotations are data-based and not contingent upon physician review.

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(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 45 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 10/3/2022 2:40:53 PM Physician: Gus Katsigiorgis, DO
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

History of Present Illness

The patient presents for follow up. Difficulty and pain about the right knee.

Physical Exam

Note:: Examination of the Right Knee: Patellofemoral pain. There is tenderness. Positive Swelling. Negative McMurray. No signs of instability.
Range of motion zero to 110.

Assessment

Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Plan

Therapy. Home exercise program. The patient is working.

In my opinion the incident that the patient describes is the competent medical cause of this injury.
The patients complaints are consistent with their history of injury.
The patients history of illness is consistent with my objective findings.
The patient has a 0% temporary impairment.

This note is being transcribed from dictation of 12/30/2022

Electronically signed by Gus Katsigiorgis, DO at 09:05 AM, JANUARY 19, 2023

Gus Katsigiorgis, DO

NEW YORK STATE | Workers' Compensation Board

Doctor's Report of MMI/Permanent Impairment

C-4.3

Use this form: 1. When rendering an opinion on MMI and/or permanent impairment; or 2. In response to a request by the Workers' Compensation Board to render a decision on MMI and/or permanent impairment.

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the patient, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date Examination: 01/11/2023 WCB Case #: G3051719 Claim Admin Claim Number 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI) 2. Date of Birth: 11/05/1976 3. SSN: 000-00-9312

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Home phone # (917)386-5380 6. Date of Injury/Illness: 06/11/2021 7. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Gus (First) Katsigiorgis (Last) (MI) 2. WCB Authorization #: 234244-2W

3. WCB Rating Code: OPCOS 4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN

5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)

6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE

7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)

8. Office phone #: 516-887-1787 9. Billing phone #: 516-374-6838 10. Treating Provider's NPI # 1033105564

C. Billing Information

1. Employer's Insurance carrier: STATE INSURANCE FUND 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

Enter ICD10 Code:	ICD10 Descriptor:
(1) M23.8X1	Other internal derangements of right knee
(2) M94.261	Chondromalacia, right knee
(3)	
(4)	

5. Billing (CPT) Code: 99455 6. Charge ($) 650.00 7. Zip Code: 11580-2108

C-4.3 5-22

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/illness: 06/11/2021

D. Maximum Medical Improvement

1. Has the patient reached Maximum Medical Improvement? ☒ Yes ☐ No If yes, provide the date patient reached MMI: 01/11/2023
If No, describe why the patient has not reached MMI and the proposed treatment plan (attach additional documentation, if necessary).

E. Permanent Partial Impairment

1. Is there permanent partial impairment? ☒ Yes ☐ No

2. List the body parts and conditions you treated the patient for related to the date of injury listed in Section A, Question 6.

right leg/knee 27.5

Complete Permanent Partial Disability, Attachment A and/or Attachment B, as indicated based on the patient's condition. Attachment A and/or Attachment B must be completed for each body part and/or condition which you treated the patient for on the date of injury listed in Section A, Question 6

- For a permanent partial impairment where schedule award (schedule loss of use) is appropriate, complete Attachment A, except for serious facial disfigurement, vision, or hearing loss.

Hearing Loss:
- Occupational Loss of Hearing - C-72.1 should be utilized.
- Traumatic Hearing Loss - C4.3 with an attached narrative.

Vision Loss:
- Attending Ophthalmologist's Report (Form C-5), or
- C-4.3 with an attached narrative.

Serious Facial Disfigurement
- C-4.3 with an attached narrative.

- For a non-schedule award (classification), complete Attachment B.

Sign below and submit to the Board only the pages of the form that apply to this report.

This form is signed under penalty of perjury.
Board Authorized Health Care Provider signature:

Gus Kalyiorgis DO		PHYSICIAN	01/03/2023
Name	Signature	Specialty	Date

C-4.3 5-22

Patient's Name: Dillard Bayard ; Date of Injury/Illness: 06/11/2021

Last First MI

C-4.3 5-22

Permanent Partial Disability - Attachment A

Schedule Loss of Use of Member

If the patient has a permanent partial impairment, complete Attachment A for all body parts and conditions for which a schedule award is appropriate (schedule loss of use). You must c this attachment for all body parts and conditions for which you treated the patient for the date of injury listed in Section A, Question 6. Attach additional sheets if needed

Body Part

Please include all the information in the bullet points below in the table on this page or attach a medical narrative with your report. The medical narrative should include the following information:

- Affected body part (include left or right side) and identify Guideline chapter (when special consideration exist).
- Measured Active Range of Motion (ROM) (3 measurements for injured body part, and use the greatest ROM). If not, please explain why.
- Measurement of contralateral body part ROM, or explain why inapplicable
- Previously received scheduled losses of use to same body part(s), if known, stating the specificity the percentage loss of use you believe to be attributable solely to the injury being evaluated (and why), versus the percentage(s) of loss of use to the same body part(s) attributed to prior injury(ies)
- Special considerations
- Loading for Digits and Toes

	Body Part/Measurement	Body Part/Measurement	Body Part/Measurement	Body Part/Measurement	Body Part/Measurement	Body Part/Measurement
	1 Knee/Leg	2	3	4	5	6
	☐ Left ☒ Right	☐ Left ☐ Right	☐ Left ☐ Right	☐ Left ☐ Right	☐ Left ☐ Right	☐ Left ☐ Right
Range of Motion (3 measures)	See Report					
Contralateral Applicable Y/N If No, please explain below						
Contralateral ROM	See Report					
Special Considerations (Chapter)						
Impairment %	27.5					

Details:

The patient has a scheduled loss of use of the right knee/leg of 27.5%; 20% SLU for the loss of range of motion in flexion and 7.5% SLU for chondromalacia.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Inj. Date: 06/11/2021

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 46 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check In Date/Time: 1/11/2023 11:00:06 AM Physician: Gus Katsigiorgis, DO
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WC - State Insurance Fund [73141129-110]

History of Present Illness

Schedule Loss of Use:

The patient presents for evaluation. Patient involved in a work injury suffering injury to his right knee 6/11/2021. Because of the injury he underwent surgery. Overall, surgery improved his symptoms. He is not interested in further intervention at this time.

Physical Exam

Note:: Examination of the Right Knee: No signs of infection. There is tenderness. Restricted range of motion. No calf tenderness. No palpable cords. Negative McMurray. Mild swelling. No signs of instability. Range of motion zero to 110, zero to 105, zero to 110.

Comparison Left Knee: Full motion. No tenderness.

Range of motion was measured using a goniometer three times passively.

Assessment

Right knee derangement.
Other internal derangements of right knee (M23.8X1)
Chondromalacia, right knee (M94.261)

Plan

Home exercise program. The patient has a schedule loss of use of the right leg of 27.5%; 20% SLU for loss of range of motion in flexion and 7.5% SLU for chondromalacia.

This note is being transcribed from dictation of 1/11/2023

Electronically signed by Gus Katsigiorgis, DO at 01:34 PM, FEBRUARY 03, 2023

Gus Katsigiorgis, DO

NEW YORK MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167)
80-46 KEW GARDENS RD
KEW GARDENS, NY 114151145
718-261-1000
Today's date: June 24, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976

Friday June 18, 2021 Provider: APPASAHED NAIK MD EXAM

NPI#: 1992822019

Date of Exam: 06-18-21

Name of Patient: Bayani Dillard
File#: 51372
DOI: Friday, June 11, 2021

The following progress note was done by Louis Guillaume, Orthopedic SA, and signed electronically by Dr. Appasaheb Naik, MD.

Presenting Chief Complaints: Right knee pain.
History of straining of the right knee when he missed a step from an ambulance and developed progressive right knee pain along with weakness and stiffness. Pain has improved with Advil. He was seen in the ER of Flushing Hospital.

Level of Disability: Moderate to severe

Patient's Symptoms: Pain, stiffness, pain with movement, worse with standing and walking.

Describe Onset: Acute

Cause: Due to a work related injury.

Description: Slightly improved

Rate of Change: Slightly

Pain Quality: Dull, stiff, throbbing, sore

Pain scale: 8/10

Patient's pain interferes with daily functional activities.

History: The patient is a 44 year-old right handed male who was involved in a work related accident on 06-11-21.

NEW YORK MEDICAL & DIAGNOSTIC CENTER 80-46 KEW GARDENS RD KEW GARDENS, NY
114151145
Encounter dated 06/18/2021 for Bayani L Dillard #51372
DOB:11/05/1976 Today's date: 06/24/2021

Weight: 343 lbs Height: 5' 11"

Past Medical History: Obesity, Asthma

Surgical History: None

Allergies: Seafood

Current Medications: None

Family History: Non-contributory

Social History: No smoking, no alcohol, no drugs.

Review of Systems:

General:	Denies weakness, fatigue, weight loss or gain, poor appetite, anorexia fever, chills, night sweats
Cardiac:	Denies precordial pain at rest, dyspnea, orthoapnea, wheeze, edema, heart murmur, nocturia, syncope, cyanosis.
Vascular:	Denies Phlebitis, varicosities, claudication, Raynauds
Neurological:	Denies headaches, dizziness, seizure, syncope, Tics, vertigo, weakness, tremor
Endocrin:	Denies heat or cold intolerance, weight gain or loss, change in hair distribution, goiter, change in voice, Polyuria, breast discharge.
Gastro-Intestinal:	Denies anorexia, nausea, vomiting, constipation, dysphagia, heartburn, bloody stool, abdominal pain, hemorrhoids, Jaundice, diarrhea.
Psychiatric:	Denies nervousness, depression, insomnia, emotional stability.

Current Complaints:
Right knee pain that increases with movement, weight bearing, climbing stairs and proceeding downstairs.
Weakness of right knee.

Physical Examination:
General Appearance: normal
HEENT: normal
Neck: normal
Thyroid: normal
Lungs: CTA
Heart: normal
Pulses: normal
Abdomen, soft non tender

Musculoskeletal Exam:

R Knee: + tenderness medial and lateral joint line.

Ecchymosis medial aspect of right knee seen.
ROM of the right knee shows flexion 95°/0 painful.

Mcmurray + R
Valgus stress test + R
Varus stress test negative
Lachman negative
Negative crepitus right knee

Muscle Testing: wnl
DTR's symmetrical
Sensation intact
Gait antalgic

Diagnostic Testing to date:
None

Disability Status: 100% disabled.

Clinical Impression:
Right Knee Derangement r/o MMT
MCL Ligament Injury

Plan:
X-ray right knee
US right knee
MRI right knee

Physical therapy 3 x week for 6 weeks. Physical therapist to provide services as patient's condition allows. Type of therapy: ADL training in selfcare activities, hot and cold packs, EMS, MR, ROM, ultrasound therapy, therapeutic exercises.
Goal is to decrease pain, increase mobility, improve ADL, reduce inflammation, reduce effusion, reduce muscle pain.

In addition to the above procedures, any other procedures that the physical therapist finds appropriate for the patient on each visit.

Follow up 4-6 weeks.

Abbreviations:
ADL: activities of daily living

ROM: range of motion

NEW YORK MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167)
80-46 KEW GARDENS RD
KEW GARDENS, NY 114151145
718-261-1000
Today's date: July 21, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Saturday June 19, 2021 Provider: APPASAHED NAIK MD EXAM

NPI#: 1992822019
Electronically signed by APPASAHED NAIK MD on 06/25/2021 at 12:41pm

Date of Procedure: 06-19-21

Name of Patient: Bayani Dillard
File#: 51372

HPI: 44 year-old male returns to the office today for an injection of steroids in the right knee and aspiration of the right knee. Patient suffers from right knee derangement.

Past medical history: Obesity, Sleep Apnea
Medication: None

Physical examination of the right knee shows tenderness to palpation. ROM shows limitation.

Assessment:
Right Knee Derangement

Treatment plan:
We discussed again the option of conservative treatment alone versus conservative treatment with an injection of steroids in the right knee.

Risks, benefits and side effects were detailed including but not limited to risk of local and general reaction to the products along with remote occurence of vasovagal reaction, risk of infection, risk of pain and discomfort in the site of injection as well as medical and metabolic risks associated with patient with comorbidities.

Patient decided to move forward and will receive this injection. A consent was signed.

Procedure: Right knee steroid injection and aspiration of fluid

Procedure code: 20610, 76942, J1030

Reason for procedure / diagnosis: Right knee Derangement

Diagnostic code: M23.91

Medication injected: 1cc Depomedrol and 3cc Lidocaine

Sedation medications used: none
Estimated blood loss: none
Pre-procedure pain score: 8/10
Post procedure pain score: 3/10
Complications: none

NEW YORK MEDICAL & DIAGNOSTIC CENTER 80-46 KEW GARDENS RD KEW GARDENS, NY 114151145
Encounter dated 06/19/2021 for Bayani L Dillard #51372
DOB:11/05/1976 Today's date: 07/21/2021

Description of procedure: Verbal and written consent were signed by patient after procedure was fully explained.

Time out was taken to identify the correct patient and site which was marked with a marking pen prior to starting the procedure. Patient was placed in the supine position and the site of procedure was exposed. The area was properly prepped and draped in the usual sterile fashion using Betadine. A local spray anesthetic agent of Ethyl Chloride was used to ease the discomfort felt with penetration of the needle. The area of injection anatomically is located in right knee suprapatellar pouch using a lateral approach.

Ultrasound image was used to confirm the site of injection and placement of the needle. An 18" gauge needle was introduced in the site with intermittent ultrasound image to verify proper placement of the needle in the right knee joint. 40cc yellowish fluid were aspirated from the knee and then 40mg Depomedrol mixed with 3cc Lidocaine were injected in the right knee. Patient tolerated the procedure well with no complications noted.

Blood pressure remained within normal limits before, during, after the procedure. He was instructed to apply local ice compress over the injection site for 20 minutes every 6 hours for the next 24 hours and will avoid physical therapy and straining. Patient instructed to contact us at NYMDC if there is any exacerbation of symptoms. A post procedure sheet was provided. Patient instructed to follow up 2-3 weeks at which point further recommendation options will be discussed.

.

End of note. Electronically signed by APPASAHED NAIK MD on 06/25/2021 at 12:41pm

Abbreviations:
ROM: range of motion

NEW YORK MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167)
80-46 KEW GARDENS RD
KEW GARDENS, NY 114151145
718-261-1000
Today's date: July 21, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Friday July 2, 2021 Provider: APPASAHED NAIK MD EXAM

NPI#: 1992822019

Date of Exam: 07-02-21

Name of Patient: Bayani Dillard Follow Up
File#: 51372
DOI: Friday, June 11, 2021

The following progress note was done by Louis Guillaume, Orthopedic SA, and signed electronically by Dr. Appasaheb Naik, MD.
==========

Presenting Chief Complaints: Right knee pain.
History of straining of the right knee when he missed a step from an ambulance and developed progressive right knee pain along with weakness and stiffness. Pain has improved with Advil. He was seen in the ER of Flushing Hospital. He is here to renew his PT sessions. Patient has not returned to work. MRI of the right knee shows chondral injury and tear of the meniscus.

Level of Disability: Moderate to severe

Patient's Symptoms: Pain, stiffness, pain with movement, worse with standing and walking.

Describe Onset: Acute

Cause: Due to a work related injury.

Description: Slightly improved

Rate of Change: Slightly

Pain Quality: Dull, stiff, throbbing, sore

Pain scale: 8/10

Patient's pain interferes with daily functional activities.

History: The patient is a 44 year-old right handed male who was involved in a work related accident on 06-11-21.

Weight: 343 lbs Height: 5' 11"

Past Medical History: Obesity, Asthma

Surgical History: None

Allergies: Seafood

Current Medications: None

NEW YORK MEDICAL & DIAGNOSTIC CENTER 80-46 KEW GARDENS RD KEW GARDENS, NY 114151145
Encounter dated 07/02/2021 for Bayani L Dillard #51372
DOB:11/05/1976 Today's date: 07/21/2021

Family History: Non-contributory

Social History: No smoking, no alcohol, no drugs.

Review of Systems:
General: Denies weakness, fatigue, weight loss or gain, poor appetite, anorexia fever, chills, night sweats
Cardiac: Denies precordial pain at rest, dyspnea, orthoapnea, wheeze, edema, heart murmur, nocturia, syncope, cyanosis.
Vascular: Denies Phlebitis, varicosities, claudication, Raynauds
Neurological: Denies headaches, dizziness, seizure, syncope, Tics, vertigo, weakness, tremor
Endocrin: Denies heat or cold intolerance, weight gain or loss, change in hair distribution, goiter, change in voice, Polyuria, breast discharge.
Gastro-Intestinal: Denies anorexia, nausea, vomiting, constipation, dysphagin, heartburn, bloody stool, abdominal pain, hemorrhoids, Jaundice, diarrhea.
Psychiatric: Denies nervousness, depression, insomnia, emotional stability.

Current Complaints:
Right knee pain that increases with movement, weight bearing, climbing stairs and proceeding downstairs. Weakness of right knee.

Physical Examination:
General Appearance: normal
HEENT: normal
Neck: normal
Thyroid: normal
Lungs: CTA
Heart: normal
Pulses: normal
Abdomen, soft non tender

Musculoskeletal Exam:

R Knee: + tenderness medial and lateral joint line.
Ecchymosis medial aspect of right knee seen.
ROM of the right knee shows flexion 95°/0 painful.

Mcmurray + R
Valgus stress test + R
Varus stress test negative
Lachman negative
Negative crepitus right knee

Muscle Testing: wnl
DTR's symmetrical
Sensation intact
Gait antalgic

Diagnostic Testing to date:
None

Disability Status: 100% disabled.

Clinical Impression:
Right Knee Derangement and evidence of MMT and chondral injury.

NEW YORK MEDICAL & DIAGNOSTIC CENTER 80-46 KEW GARDENS RD KEW GARDENS, NY 114151145
Encounter dated 07/02/2021 for Bayani L Dillard #51372
DOB:11/05/1976 Today's date: 07/21/2021

MCL Ligament Injury

Plan:
Continue physical therapy 3 x week for 6 weeks. Physical therapist to provide services as patient's condition allows. Type of therapy: ADL training in selfcare activities, hot and cold packs, EMS, MR, ROM, ultrasound therapy, therapeutic exercises.
Goal is to decrease pain, increase mobility, improve ADL, reduce inflammation, reduce effusion, reduce muscle pain.

In addition to the above procedures, any other procedures that the physical therapist finds appropriate for the patient on each visit.

Follow up 4-6 weeks.

Abbreviations:
ADL: activities of daily living
ROM: range of motion

NEW YORK MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167)
80-46 KEW GARDENS RD
KEW GARDENS, NY 114151145
718-261-1000
Today's date: August 3, 2021

1221055687

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Wednesday July 21, 2021 Provider: APPASAHED NAIK MD EXAM

NPI#: 1992822019

Date of Service: 07-21-2021

Patient's Name: Bayani Dillard
File#: 51372

Present Chief Complaints: Right knee pain.
Patient is an EMT worker who fell at work and injured his right knee on 06-11-21. Patient is not working since the episode.

Level of disability: Moderate-to-severe.

Patient's Symptoms: Pain, stiffness, pain with movement, worse with standing and walking.

Describe Onset: Acute.

Cause: Due to a work-related injury.

Description: Slightly improved.

Rate of Change: Slightly.

Pain Quality: Dull. Stiff. Throbbing. Sore.

Pain Scale: 8/10.

Patient's pain interferes with daily functional activities.

History: The patient is a 44-year-old right-handed male who was involved in a work related accident on 06-11-21.

WT: 343 lbs. HT: 5' 11"

Past Medical History: Obesity, asthma.

NEW YORK MEDICAL & DIAGNOSTIC CENTER 80-46 KEW GARDENS RD KEW GARDENS, NY 114151145

1221855687

Encounter dated 07/21/2021 for Bayani L Dillard #51372

DOB:11/05/1976 Today's date: 08/03/2021

Surgical History: None.

Family History: Noncontributory.

Allergies: Seafood.

Social History: No smoking, no alcohol, no drugs.

Medications: None.

Review of Systems:

Constitutional	Denies sweats, weight change, fever
HEENT	Denies dysphagia, blurry vision, tinnitus
Respiratory System	Denies SOB, fatigue
Cardiovascular System	Denies chest pain
Gastrointestinal System	Denies bloody/tarry stools, constipation
Genitourinary	Denies dysuria, blood in urine
Endocrine System	Denies heat/cold intolerance
Musculoskeletal System	Denies pain that awakens, progressive weakness
Integumentary System	Denies rash
Neurological System	Denies tremors, seizures, dizziness
Psychiatric	Denies suicidal/homicidal ideations, depressed, anxiety
Hematologic/Lymphatic System	Denies easy bleeding/bruising

Complaints:
Right knee pain that increases with movement, weightbearing, climbing stairs, and proceeding downstairs.
Weakness of right knee.

Physical Examination:
General Appearance: Normal
HEENT: Normal
Neck: Normal
Thyroid: Normal
Lungs: Normal
Heart: Normal
Pulses: Normal
Abdomen: Normal
Extremities: Normal
Neurologic: Normal
Back: Normal

Musculoskeletal Exam:

Right Knee: Positive medial joint line and lateral joint line tenderness. Ecchymosis medial aspect of right knee

seen.

Range of motion of the right knee shows flexion 95/130, extension 0.

McMurray's test is positive.
Valgus stress test is positive.
Varus stress is negative.
Lachman is negative.
Crepitus is negative.

Muscle Testing: Within normal limits.

Deep Tendon Reflexes: Symmetrical.

Sensory Exam: Sensation is intact.

Gait: Antalgic.

Diagnostic Testing:
MRI of the right knee shows chondral injury and tear of the meniscus.

Impression/Diagnosis:
1. Right knee derangement and evidence of MMT and chondral injury.
2. MCL ligament injury.

Disability Status: 100% disabled.

PLAN:
1. Advised arthroscopy versus stem cell injection.
2. Continue PT 3 x week for 6 weeks. Physical therapist to provide the following services as patient's condition allows. Type of Therapy: ADL training in self care activities, hot and cold packs, EMS, MR, ROM, ultrasound therapy, therapeutic exercises.
GOAL: Decrease pain, increase mobility, improve ADL, reduce inflammation, reduce effusion, reduce muscle pain.

In addition to the above procedures, any other procedures that the physical therapist finds appropriate for the patient on each visit.

Follow up in 4-6 weeks.

NEW YORK MEDICAL & DIAGNOSTIC CENTER 80-46 KEW GARDENS RD KEW GARDENS, NY 114151145

Encounter dated 07/21/2021 for Bayani L Dillard #51372 1221055687

DOB:11/05/1976 Today's date: 08/03/2021

Abbreviations:
ADL: activities of daily living
ROM: range of motion

264184

ISLAND MUCULOSKELETAL CARE, M.D., P.C.

DATE OF EXAM: 07/21/21.

1218079965

PATIENT NAME: Dilford, Brami

HEAD&NECK ROM	Right	Left
Flex (0-60)		FULL
Ext (0-50)		FULL
LatFlex (0-40)	FULL	
Rot (0-80)	FULL	FULL

UPPER EXTREMITY	ROM	Right	Left
Shoulder	ABD (0-180)	FULL	FULL
	FowFlex (0-180)	FULL	FULL
	IntRot (0-90)	FULL	FULL
	ExtRot (0-90)	FULL	FULL
Elbow	Flex (0-150)	FULL	FULL
	Ext (0)	FULL	FULL
	Sup (0-90)	FULL	FULL
	Pron (0-90)	FULL	FULL
Wrist	Flex (0-80)	FULL	FULL
	Ext (0-70)	FULL	FULL
	RadialDev (0-20)	FULL	FULL
	UlnarDev (0-30)	FULL	FULL

UPPER EXTREMITY MMT	Right	Left
Deltoid (C5,6; Axillary N)	S/S	S/S
Biceps (C5,6; Musculocut N)	S/S	S/S
Triceps (C6,7,8; Radial N)	S/S	S/S
Wrist Ext (C6,7,8; Radial N)	S/S	S/S
Wrist Flex (C6,7,8,T1; Med&Uln)	S/S	S/S

UPPER EXTREMITY DTR	Right	Left
Biceps (C5,6)	2/4	2/4
Triceps (C6,7)	2/4	2/4
Brachioradialis (C6,7)	2/4	2/4
Finger Jerk (C7,T1)	2/4	2/4

UPPER EXTREMITY SENSATION	Right	Left
Light Touch	Y / N	Y / N
Pain	Y / N	Y / N

BACK ROM	Right	Left
Flex (0-90)		FULL
Ext (0-30)		FULL
LatFlex (0-20)	FULL	
Rot (0-30)	FULL	FULL

LOWER EXTREMITY	ROM	Right	Left
HIP	Flex (0-120)	FULL	FULL
	EXT (0-120)	FULL	FULL
	Abd (0-50)	FULL	FULL
	IntRot (0-45)	FULL	FULL
	ExtRot (0-30)	FULL	FULL
Knee	Flex (0-135)	FULL	FULL
	Ext (0)	FULL	FULL
Ankle	DorsiFlex (0-20)	FULL	FULL
	PlantFlex (0-50)	FULL	FULL
	Inver (0-45)	FULL	FULL
	Ever (0-20)	FULL	FULL

LOWER EXTREMITY MMT	Right	Left
Iliopsoas (L1,2,3; Femoral N)	S/S	S/S
Quads (L2,3,4; Femoral N)	S/S	S/S
Hamstring (L5,S1,2; Sciatic N)	S/S	S/S
Tibialis Ant (L4,5; Deep Peron N)	S/S	S/S
Gastrocnemius (S1,2; Tibial N)	S/S	S/S
EHL (L5,S1; Deep Peron N)	S/S	S/S

LOWER EXTREMITY DTR	Right	Left
Patella (L3,4)	2/4	2/4
Achilles (L5,S1)	2/4	2/4

LOWER EXTREMITY SENSATION	Right	Left
Light Touch	Y / N	Y / N
Pain	Y / N	Y / N

Brace: N / Y _____

Assistive Device: N / Y _____

Gait/Station: Nml / Antalgic / Other

General Appearance: Alert, NAD, Oriented to time/Place Y / N _____

Pulses: RUE: Nml / Abnml LUE: Nml / Abnml RLE: Nml / Abnml LLE: Nml / Abnml

REVIEW OF IMAGES: X-RAY MRI REVIEW OF EMGS

PHYSICAN SIGNATURE _____

NEW YORK MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167)
80-46 KEW GARDENS RD
KEW GARDENS, NY 114151145
718-261-1000
1221055686
Today's date: August 3, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Wednesday July 28, 2021 Provider: APPASAHED NAIK MD EXAM

NPI#: 1992822019

Date of Service: 07-28-2021

Patient's Name: Bayani Dillard
File#: 51372
DOI: Friday, June 11, 2021

The following progress note was done by Louis Guillaume, Orthopedic SA, and signed electronically by Dr. Appasaheb Naik.

Present Chief Complaints: Right knee pain.
History of straining of the right knee when he missed a step from an ambulance and developed progressive right knee pain along with weakness and stiffness. Pain has improved with Advil. He was seen in the ER of Flushing Hospital. Patient continues to limp despite a steroid injection. He is considering surgery versus stem cell. He has not returned to work. He is receiving physical therapy. His injury is dated June 11, 2021.

Level of disability: Moderate-to-severe.

Patient's Symptoms: Pain, stiffness, pain with movement, worse with standing and walking.

Describe Onset: Acute.

Cause: Due to a work-related injury.

Description: Slightly improved.

Rate of Change: Slightly.

Pain Quality: Dull. Stiff. Throbbing. Sore.

Pain Scale: 8/10.

Patient's pain interferes with daily functional activities.

History of Accident: The patient is a 44-year-old right-handed male who was involved in a work related accident on 06-11-21.

WT: 343 lbs. HT: 5' 11"

Past Medical History: Obesity, asthma.

Surgical History: None.

Family History: Noncontributory.

Allergies: Seafood.

Social History: No smoking, no alcohol, no drugs.

Medications: None.

Review of Systems:
General: Denies weakness, fatigue, weight loss or gain, poor appetite, anorexia, fever, chills, night sweats.
Cardiac: Denies precordial pain at rest, dyspnea, orthopnea, wheeze, edema, murmur, nocturia, syncope, cyanosis.
Vascular: Denies phlebitis, varicosities, claudication, Raynaud's.
Neurological: Denies headache, dizziness, seizure, syncope, tics, vertigo, weakness, tremor.
Endocrine: Denies heat or cold intolerance, weight gain or loss, change in hair distribution, goiter, change in voice, polyuria, breast discharge.
Gastrointestinal: Denies anorexia, nausea, vomiting, constipation, dysphagia, heartburn, bloody stool, abdominal pain, hemorrhoids, jaundice, diarrhea.
Psychiatric: Denies nervousness, depression, insomnia, emotional instability.

Complaints: Right knee pain that increases with movement, weightbearing, climbing stairs, and proceeding downstairs. Weakness of right knee.

Physical Examination:
General Appearance: Normal
HEENT: Normal
Neck: Normal
Thyroid: Normal
Lungs: CTA
Heart: Normal
Pulses: Normal
Abdomen: Soft, nontender.
Extremities: Normal
Neurologic: Normal
Back: Normal

Musculoskeletal Exam:

Right Knee: Positive medial joint line and lateral joint line tenderness.
Ecchymosis medial aspect of right knee seen.

Range of motion of the right knee shows flexion 95/130, extension 0, painful.

McMurray's test is positive.
Valgus stress test is positive.
Varus stress is negative.
Lachman is negative.
Crepitus is negative.

Muscle Testing: Within normal limits.

Deep Tendon Reflexes: Symmetrical.

Sensory Exam: Sensation is intact.

Gait: Antalgic.

Diagnostic Testing:
MRI of the right knee shows chondral injury and tear of the meniscus.

Impression/Diagnosis:
1. Right knee derangement and evidence of MMT and chondral injury.
2. MCL ligament injury.

Disability Status: 100% disabled.

PLAN:
Continue physical therapy 3 x week for 6 weeks. Physical therapist to provide the following services as patient's condition allows. Type of Therapy: ADL training in self-care activities, hot and cold packs, EMS, MR, ROM, ultrasound therapy, therapeutic exercises.
GOAL: Decrease pain, increase mobility, improve ADL, reduce inflammation, reduce effusion, reduce muscle pain.

In addition to the above procedures, any other procedures that the physical therapist finds appropriate for the patient on each visit.

Follow up in 4-6 weeks.

Abbreviations:
ADL: activities of daily living
ROM: range of motion

JAMAICA HOSPITAL MEDICAL CENTER
8900 VAN WYCK EXPWY.
JAMAICA, N.Y. 11418

PROGRESS NOTES

Bayani, Dillard

RECEIVED
JUL 22 2023
By 31056

Date & Time	Start MD Notes Here ←	Start RN and all Other Notes Here ←
6.14.21 1pm	Employee states that on 6.11.21 at work, he slipped down from his ambulance & heard some click in his (R) knee, later on, during the same shift his (R) knee became v. swollen & tender. Employee went to FHC ER; CT scan (R) knee was done - DJD/ spurs were noted. Employee denies any prior problem with (R) knee - ever. At present, employee feels essentially the same; 12/10 pain in (R) knee during any activity which exceeds ADL and after medication; pain is moderate 5-6 out of 10; acute, sharp, diffuse over entire joint, nonradiating, stable, improved by prn medication.	
	PMHx: HTN, ASHD Med: Edarbi, Atenolol, Simvastatin NKDA PSHx: NO FHx: NC	→

JAMAICA HOSPITAL MEDICAL CENTER
JAMAICA, N.Y. 11418

Bayani Dillard

PROGRESS NOTES

Date & Time	Start MD Notes Here ←	Start RN and all Other Notes Here ←
6.14.21 cont	CC: AAOx3 ambulating v. slowly & with limp on (R) leg 2/2 pleurisy. BP 150/90 HR 84 RR 14 T 98.6 HEENT: WNL Lungs good air movement b/l. No wheezes CVS: S1 S2 + reg. rate no S3 S4. Abdn: soft BS (+) Ext: (R) knee - massive diffuse swelling, minimal mobility, reduced tenderness to palpation (+) hematoma over medial aspect. any manipulation was deferred due to pain.	
	A: 1) (R) knee derangement; DJD with likely meniscus/ligament lesion	
	- cont Motrin 600 mg po q8° w/ meals	
	- refer to on-call ortho - appointment date 6/23 9:00 am & options for other providers given	
	- off work	
	- RTO ER any time if needed	

RZESOFZ PERYK, M.D.
LIC #205021

JAMAICA HOSPITAL MEDICAL CENTER

OCCUPATIONAL HEALTH SERVICES

89-06 135 Street
Suite 5C
Jamaica, NY 11418
Tel#: 718-206-6813
Fax#: 718-206-8703

Date: 6.14.21

RE: Bayani Dillard

The above named employee was seen at Occupational Health Services on: 6.14.21

Disposition:

- o Full Duty
- o Full Duty Pending Lab Results
- ✓ No work

PMD Note Provided:

- ✓ Yes
- o No

Limitations: /

Next Scheduled Appointment: - orthopedics
- OHS any time if needed

Grzegorz Petryk, MD

GRZEGORZ PETRYK, M.D.
LIC #205221

Return to: ABAASKE@JHMC.ORG

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

OMB Control Number: 1235-0003
Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: Jamaica Hospital - Benefits Department 718-206-6700

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached:

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: Dillard _____ Bayan
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: RZEGORZ PETRYK, M.D. LIC #205221

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax:(_____) _____

Jamaica Hospital
Occupational Health Services
89-06 135th Street - Suite 5C
Jamaica, New York 11418
Tel: 718-206-6813
Fax: 718-206-8703

PART A: MEDICAL FACTS

1. Approximate date condition commenced: 6.11.21

Probable duration of condition: 2-6 weeks

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
__(No)__Yes. If so, dates of admission:

Date(s) you treated the patient for condition:
6-14-21

Will the patient need to have treatment visits at least twice per year due to the condition? __(No)__ Yes.

Was medication, other than over-the-counter medication, prescribed? __(No)__Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
____No ____(Yes). If so, state the nature of such treatments and expected duration of treatment:
ortho

2. Is the medical condition pregnancy? __(No)__Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____(Yes.)

If so, identify the job functions the employee is unable to perform:
lifting, walking

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

Employee developed (R) knee swelling, tenderness during his work on 6-11-21 - it was likely triggered by stepping down from his ambulance.

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: 2 - 6 weeks

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary?
   ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   N A

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; N A days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___No ___Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups?
   ____ No ____Yes. If so, explain:

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   Frequency : _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

CONTINUED ON NEXT PAGE

PRZEGORZ PETRYK, M.D.
LIC #2[illegible]221

Signature of Health Care Provider

6.14.21
Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

OCCUPATIONAL HEALTH SERVICES ALCOHOL AND CONTROLLED SUBSTANCE TESTING IDENTIFICATION FORM

EMPLOYEE NAME Bayani Dillard

SHIELD NUMBER 7228

EMPLOYEE ID NUMBER 21070

HOSPITAL AFFILIATION Flushing Hospital Medical Center

DEPARTMENT Prehospital Care

Test(s) to be performed:

B.A.T. Breath Alcohol Test or Swab (only) _____

Drug Test- **Random** ✓ **Test # 46405N** **Also Alcohol Test**

Post Accident _____ **Test # 39295N** **Also Alcohol Test**

Reasonable Suspicion: _____ **Test # 39295N** **Also Alcohol Test**

I CERTIFY THAT THE IDENTIFICATION INFORMATION ON THIS FORM IS TRUE AND CORRECT

EMPLOYEE Bayani Dillard **DATE** 10/13 **Arrival Time:** 959
(Signed at time of arrival of test site)

SUPERVISOR NOTIFYING Paul Singh **DATE** 10/13/22 **NotificationTime:** 9:46am

COLLECTED BY _____ **DATE** 10/13/22 **CompletionTime** 10:50AM
(Signed at completion of test(s))

If collected at an offsite, please Fax This Notice, copy of the Chain of Custody and Result of Alcohol Test to 718-206-8703

FORENSIC DRUG TESTING CUSTODY AND CONTROL FORM

Quest Diagnostics

201

800-877-748

www.questdiagnostics.com/mydrugte

14464617 5742061 SPECIMEN ID NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE LAB ACCESSION NO.

A. Employer Name, Address, I.D. No.
FLUSHING HOSPITAL
14614 45TH AVE
FLUSHING NY 11355
PH: 718-670-5630 FAX: --

B. MRO Name, Address, Phone and Fax No. FORM ID: SAPHS00020
GEORGE PETRYK, M.D.
CORPORATE HEALTH SERVICES
6906 135TH ST APT 5E
JAMAICA NY 11436
PH 718-206-8010 FAX: 718-206-8315

C. Donor SSN or Employee I.D. No.

D. Donor Name: Last: DILLARD First: BAYANI

E. Donor ID Verified: ☒ Photo ID ☐ Emp. Rep.

F. Reason for Test: ☐ Pre-employment (1) ☒ Random (3) ☐ Reasonable Suspicion/Cause (5) ☐ Post-Accident (2) ☐ Promotion (22) ☐ Return to Duty (6) ☐ Follow-up (23) ☐ Other (specify) (99)

G. Drug Tests to be Performed:
( ) 4640DN SAP 5-50+MDMA/600 ☒ 3374DN SAP 4/2K+6MD/MDMA5

H. Collection Site Name: FLUSHING HOSPITAL
Address: 14614 45TH AVE
City, State and Zip: FLUSHING NY 11355
Collection Site Code:
Collector Phone No.: 7186705630
Collector Fax No.: 7188860563

STEP 2: COMPLETED BY COLLECTOR

Read specimen temperature within 4 minutes. Is temperature between 90° and 100° F? ☒ Yes ☐ No, Enter Remark

Specimen Collection: ☒ Split ☐ Single ☐ None Provided (Enter Remark) ☐ Observed (Enter Remark)

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5.

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified in the certification section on Copy 1 of this form was collected, labeled, sealed, and released to the Delivery Service noted in accordance with applicable requirements.

X Signature of Collector — Time of Collection 10 AM PM

(Print) Collector's Name (First, MI, Last) — Date (Mo./Day/Yr.) 10/13/22

SPECIMEN BOTTLE(S) RELEASED TO: ☒ Quest Diagnostics Courier ☐ FedEx ☐ Other _____ Name of Delivery Service Transferring Specimen to Lab

RECEIVED AT LAB: X Signature of Accessioner

(Print) Accessioner's Name (First, MI, Last) — Date (Mo./Day/Yr.) / /

Primary Specimen Bottle Seal Intact ☐ Yes ☐ No, Enter Remark

SPECIMEN BOTTLE(S) RELEASED TO:

STEP 5: COMPLETED BY DONOR

I certify that I provided my specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information and numbers provided on this form and on the label affixed to each specimen bottle is correct.

X Signature of Donor — (PRINT) Donor's Name (First, MI, Last): BAYANI DILLARD — Date (Mo./Day/Yr.) 10/13/22

Daytime Phone No. (917) 386-3380 Evening Phone No. (917) 386-3380 Date of Birth 11/5/7. (Mo. Day Yr.)

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

In accordance with applicable requirements, my determination/verification is:

☐ NEGATIVE ☐ POSITIVE ☐ TEST CANCELLED ☐ REFUSAL TO TEST BECAUSE: ☐ DILUTE ☐ ADULTERATED ☐ SUBSTITUTED

REMARKS

X Signature of Medical Review Officer — (PRINT) Medical Review Officer's Name (First, MI, Last) — Date (Mo./Day/Yr.) / /

STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SECONDARY SPECIMEN

In accordance with applicable requirements, my determination/verification for the split specimen (if tested) is:

☐ RECONFIRMED ☐ FAILED TO RECONFIRM - REASON

X Signature of Medical Review Officer — (PRINT) Medical Review Officer's Name (First, MI, Last) — Date (Mo./Day/Yr.) / /

COPY 2 - MEDICAL REVIEW OFFICER COPY

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FORENSIC DRUG TESTING CUSTODY AND CONTROL FORM

Quest Diagnostic
202
800-877-74
www.questdiagnostics.com/mydrugte

10060617 5792061 SPECIMEN ID NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE LAB ACCESSION NO.

A. Employer Name, Address, I.D. No.
FLUSHING HOSPITAL
14614 45TH AVE
FLUSHING NY 11355
PH: 718-670-5630 FAX: --

B. MRO Name, Address, Phone and Fax No. FORM ID: 3APH500020
GRZEGORZ PETRYK, M.D.
CORPORATE HEALTH SERVICES
8906 135TH ST APT 5C
JAMAICA NY 11418
PH: 718-206-8810 FAX: 718-206-8915

C. Donor SSN or Employee I.D. No.

D. Donor Name: Last: DILLARD First: PAYANI

E. Donor ID Verified: ☒ Photo ID ☐ Emp. Rep.

F. Reason for Test: ☐ Pre-employment (1) ☒ Random (3) ☐ Reasonable Suspicion/Cause (5) ☐ Post-Accident (2) ☐ Promotion (22) ☐ Return to Duty (6) ☐ Follow-up (23) ☐ Other (specify) (99)

G. Drug Tests to be Performed:
( ) 4640SN SAP 5-50+MDMA/6AM ☒ 3374BN SAP 4/2K+6AM/MDMA5

H. Collection Site Name: FLUSHING HOSPITAL
Address: 14614 45TH AVE
City, State and Zip: FLUSHING NY 11355
Collection Site Code:
Collector Phone No.: 7186705630
Collector Fax No.: 7188860565

STEP 2: COMPLETED BY COLLECTOR

Read specimen temperature within 4 minutes. Is temperature between 90° and 100° F? ☒ Yes ☐ No, Enter Remark

Specimen Collection: ☒ Split ☐ Single ☐ None Provided (Enter Remark) ☐ Observed (Enter Remark)

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5.

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified in the certification section on Copy 1 of this form was collected, labeled, sealed, and released to the Delivery Service noted in accordance with applicable requirements.

X Signature of Collector — Time of Collection AM PM ▶
(Print) Collector's Name (First, MI, Last) — Date (Mo./Day/Yr.) ▶

SPECIMEN BOTTLE(S) RELEASED TO:
☐ Quest Diagnostics Courier ☐ FedEx
☐ Other
Name of Delivery Service Transferring Specimen to Lab

RECEIVED AT LAB: X Signature of Accessioner ▶
(Print) Accessioner's Name (First, MI, Last) — Date (Mo./Day/Yr.) ▶

Primary Specimen Bottle Seal Intact
☐ Yes
☐ No, Enter Remark

SPECIMEN BOTTLE(S) RELEASED TO:

STEP 5: COMPLETED BY DONOR

I certify that I provided my specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information and numbers provided on this form and on the label affixed to each specimen bottle is correct.

X Signature of Donor — (PRINT) Donor's Name (First, MI, Last): PAYANI DILLARD — Date (Mo./Day/Yr.): 10/13/22

Daytime Phone No. (917) 336-3210 Evening Phone No. (917) 336-3210 Date of Birth 11/5/77 (Mo. Day Yr.)

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COPY 3 - COLLECTOR COPY

COPY FROM FLUSHING HOSPITAL 10060617

FAX COPY TO 10058059

LABORATORY REPORT

Quest Diagnostics

10058059 AREA/ROUTE/STOP: XXXXXXX
GRZEGORZ PETRYK, M.D.
CORPORATE HEALTH SERVICES
8906 135TH ST APT 5C
JAMAICA, NY 11418

DONOR ID	DONOR NAME	SPECIMEN ID
9312	DILLARD, BAYANI	5792061

PAGE	REQUISITION NO	ACCESSION NO.	COLLECTION DATE & TIME	LOG-IN-DATE	REPORT DATE	& TIME
1	5792061	068358Z	10132022 10:00AM	10152022	10152022	03:51PM

REMARKS Client Site Location:
REASON FOR TEST: RANDOM
DONOR ID VERIFIED: PHOTO I.D.

REPORT STATUS FINAL

TEST	RESULTS IN RANGE	RESULTS OUT OF RANGE	UNITS	REFFERENCE RANGE	SITE CODE
Seals Intact: Yes					
Tests Ordered: 33748N (SAP 4/2K+6AM/MDMA5)					
Urine Substance Abuse Panel			Initial Test Level	MS Confirm Test Level	
AMPHETAMINES	Negative		500 ng/mL	250 ng/mL	
COCAINE METABOLITES	Negative		150 ng/mL	100 ng/mL	
MDA-ANALOGUES	Negative		500 ng/ml	250 ng/ml	
OPIATES	Negative		2000 ng/mL	2000 ng/mL	
6-ACETYLMORPHINE	Negative		10 ng/mL	10 ng/mL	
PHENCYCLIDINE	Negative		25 ng/mL	25 ng/mL	

CERTIFYING TECHNICIAN/SCIENTIST: KPSR01
SPECIMEN RECEIVED AND PROCESSED IN THE NORRISTOWN DHHS CERTIFIED LABORATORY.

LAB Quest Diagnostics-Norristown
400 Egypt Rd
Norristown PA 19403

>> END OF REPORT <<

FORENSIC DRUG TESTING CUSTODY AND CONTROL FORM

Quest Diagnostics®
800-877-7484
www.questdiagnostics.com/mydrugtest

10060622 4025625 SPECIMEN ID NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE LAB ACCESSION NO.

A. Employer Name, Address, I.D. No.
JAMAICA HOSPITAL CRP HLTH
3906 GREGORY PETRYK
3906 135TH ST APT 5C
JAMAICA NY 11419
PH: 718-206-8867 FAX: 718-206-8915

B. MRO Name, Address, Phone and Fax No. FORM ID: SAFH500821
GRZEGORZ PETRYK, M.D.
CORPORATE HEALTH SERVICES
3906 135TH ST APT 5C
JAMAICA NY 11419
PH: 718-206-8216 FAX: 718-206-8915

C. Donor SSN or Employee I.D. No. 21270

D. Donor Name: Last: DILLARD First: BAYANI

E. Donor ID Verified: ☒ Photo ID ☐ Emp. Rep.

F. Reason for Test: ☒ Pre-employment (1) ☐ Random (3) ☐ Reasonable Suspicion/Cause (5) ☐ Post-Accident (2) ☐ Promotion (22) ☒ Return to Duty (6) ☐ Follow-up (23) ☐ Other (specify) (99)

G. Drug Tests to be Performed:
☐ 59295N AMP COMP IV-A ☐ 40405N SAP 5-5D+MDMA/5AN

33748N

H. Collection Site Name: JAMAICA HOSP CRP HLTH
Address: 3906 135TH ST, STE 5C
City, State and Zip: JAMAICA NY 11419
Collection Site Code:
Collector Phone No.: 7182068867
Collector Fax No.: 7182068915

STEP 2: COMPLETED BY COLLECTOR

Read specimen temperature within 4 minutes. Is temperature between 90° and 100° F? ☒ Yes ☐ No, Enter Remark

Specimen Collection: ☐ Split ☒ Single ☐ None Provided (Enter Remark) ☐ Observed (Enter Remark)

REMARKS

STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 5.

STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified in the certification section on Copy 1 of this form was collected, labeled, sealed, and released to the Delivery Service noted in accordance with applicable requirements.

X [signature] — Signature of Collector
Time of Collection: 12 AM/PM
G. PETRYK — (Print) Collector's Name (First, MI, Last)
Date (Mo./Day/Yr.): 5/23/22

SPECIMEN BOTTLE(S) RELEASED TO:
☒ Quest Diagnostics Courier ☐ FedEx
☐ Other _____
Name of Delivery Service Transferring Specimen to Lab

RECEIVED AT LAB: X _____ Signature of Accessioner
(Print) Accessioner's Name (First, MI, Last)
Date (Mo./Day/Yr.) / /

Primary Specimen Bottle Seal Intact
☐ Yes
☐ No, Enter Remark _____

SPECIMEN BOTTLE(S) RELEASED TO:

STEP 5: COMPLETED BY DONOR

I certify that I provided my specimen to the collector; that I have not adulterated it in any manner; each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information and numbers provided on this form and on the label affixed to each specimen bottle is correct.

X [signature] — Signature of Donor
BAYANI DILLARD — (PRINT) Donor's Name (First, MI, Last)
5-23-22 — Date (Mo./Day/Yr.)

Daytime Phone No. (917) 286-5350
Evening Phone No. ( )
Date of Birth 11/5/1976 (Mo. Day Yr.)

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

In accordance with applicable requirements, my determination/verification is:

☐ NEGATIVE ☐ POSITIVE ☐ TEST CANCELLED ☐ REFUSAL TO TEST BECAUSE:
☐ DILUTE ☐ ADULTERATED ☐ SUBSTITUTED

REMARKS _____

X _____ Signature of Medical Review Officer
(PRINT) Medical Review Officer's Name (First, MI, Last)
Date (Mo./Day/Yr.) / /

STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SECONDARY SPECIMEN

In accordance with applicable requirements, my determination/verification for the split specimen (if tested) is:

☐ RECONFIRMED ☐ FAILED TO RECONFIRM - REASON _____

X _____ Signature of Medical Review Officer
(PRINT) Medical Review Officer's Name (First, MI, Last)
Date (Mo./Day/Yr.) / /

COPY 2 - MEDICAL REVIEW OFFICER COPY

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NEW YORK STATE | Workers' Compensation Board

PO Box 6806
Binghamton, NY 13902-6806
Customer Service Toll-Free Line: 877-632-4996
Statewide Fax Line: 877-533-0337
www.wcb.ny.gov

COVER SHEET FOR REPORT OF INDEPENDENT MEDICAL EXAMINATION

A copy of each report of Independent Medical Examination shall be submitted on the same day and in the same manner to the Workers' Compensation Board, the insurance carrier or self-insured employer, the claimant's attending physician or other attending independent examiner, the claimant's representative, if any, and the claimant.

CHECK ONE: [X] PHYSICIAN [ ] PODIATRIST [ ] CHIROPRACTOR [ ] PSYCHOLOGIST

THIS EXAMINATION WAS REQUESTED BY: [X] CARRIER/EMPLOYER [ ] CLAIMANT

WCB CASE NO	CARRIER CASE NO. (IF KNOWN)	DATE OF INJURY	INJURED PERSON'S SOCIAL SECURITY NUMBER	DATE OF EXAMINATION
G305 1719	73141129	8/11/2021	xxx-xx-9312	Thursday, August 26, 2021

Injured Person	(First Name) (Middle Initial) (Last Name) BAYANI DILLARD	ADDRESS (Include Apt. No.) 52 Charles Street Melverne, NY 11566
Insurance Carrier/Self-Insured Employer	Yogesh Patel State Insurance Fund-L.I.	PO BOX 66699 Albany, NY 12206
Independent Examiner	Louis Romeo, M.D.	2545 Hempstead Turnpike Ste 221 East Meadow, NY 11554
	Authorization No. 189682-81	Date of Report of Independent Medical Examination 8/26/21
	Start Time of Patient Examination: 1146	End Time of Patient Examination: 1151
	Total Time Spent Reviewing Records: 40m	

IF EXAMINER CONDUCTED THIS EXAMINATION AS AN EMPLOYEE OF AN IME COMPANY OR UNDER CONTRACT OR ARRANGEMENT WITH AN IME COMPANY, STATE NAME AND WORKERS' COMPENSATION BOARD REGISTRATION NUMBER OF IME COMPANY.

Richmond Disability Evaluation Group – Reg. #010026

Attach Report of Independent Medical Examination

Report of Independent Medical Examination must include this cover sheet and a narrative report that includes the components listed below. If the examination concludes Schedule Loss of Use and/or Non-Schedule Permanent Partial Disability please include the IME-4.3A and/or IME-4.3B with the cover sheet and your medical narrative.

- A description of the examination;
- A list of all documents or information reviewed by the IME evaluator;
- The examiner's professional opinion; and
- A signed and dated certification at the end of the report of the independent medical examination as follows:
  - I hereby certify that this report is a full and truthful representation of my professional opinion with respect to the claimant's condition; that no person or entity has caused, directed or encouraged me to submit a report that differs substantially from my professional opinion; and I have reviewed the report and attest to its accuracy.
  - The signature and date must be below the required certification.

Any questionnaire or intake sheets completed by the claimant either before arriving or after arriving for the independent medical examination must be attached to this cover sheet with the report.

In certifying on the cover sheet, you are certifying to the entire contents of the Report of Independent Medical Examination.

I hereby certify that this report is a full and truthful representation of my professional opinion with respect to the claimant's condition; that no person or entity has caused, directed or encouraged me to submit a report that differs substantially from my professional opinion; and I have reviewed the report and attest to its accuracy

Louis Romeo, M.D.
Independent Examiner's Name

8/27/21
Date

Independent Examiner's Signature

IME-4 (5-18)

IME-4 5-18

RICHMOND
DISABILITY
EVALUATION
GROUP
1890 CLOVE ROAD • STATEN ISLAND, NY 10304

Telephone (718) 720-8740
Fax (718) 981-1134
info@RichmondEvaluation.com

125181653

Claimant:	**BAYANI DILLARD**
WCB Case No.	**G305 1719**
Carrier Case No.	**73141129**
Date of Examination:	08/26/2021
Independent Examiner:	**Louis Romeo, M.D.**

Please be advised the attached Worker's Compensation IME Report has been submitted to the following parties and addresses in compliance with Section 137 via US Postal Service:

Worker's Compensation Board
P.O. Box 5205
Binghamton, New York 13902

BAYANI DILLARD
52 Charles Street
Malverne, NY 11565

Rex E. Zachofsky, PLLC
111 John Street, Room 1615
New York, NY 10038

Dr. Appasaheb Naik, Dr. Martin Gillman
80-46 Kew Gardens Road
Kew Gardens, NY 11415

Louis Romeo, M.D.
Diplomate American Board of Orthopedic Surgery

2545 Hempstead Tpke., Suite 221,
East Meadow, NY 11554

08/26/2021

Richmond Disability Eval. Group
1890 Clove rd.
Staten Island, NY 10304

Claimant: Dillard, Bayani
Richmond Disability Eval.
Group#:73141129
Claim#: 73141129
WCB#: G3051719
Emp. Name: Flushing Hospital
medical center
DOB: 11/05/1976
DOA: 06/11/2021

To Whom It May Concern:

As you requested, I have performed an orthopedic medical evaluation regarding the above-named claimant, Mr. Bayani Dillard, on 08/26/2021 in the Nassau, NY office. He reports that he drove himself to this examination. Mr. Dillard presented a valid photo identification prior to the evaluation.

My findings are as follows:

IDENTIFICATION:

Mr. Dillard is a 44-year-old right-handed male. His self-reported height is 5 feet 11 inches, weight is 357 pounds and he has black hair with dark brown eyes.

HISTORY OF ACCIDENT:

The history was obtained from Mr. Dillard who reports that while he was employed as an Emergency medical technician for Flushing Hospital medical center, he was involved in a work-related accident on 06/11/2021. The claimant explains that at the time of the accident he slipped on a wet floor and sustained an injury. Mr. Dillard states that he fell forward to the floor. He reports that he sustained injuries to his right knee.

Mr. Dillard states that he was not rendered unconscious as a result of the accident. He denies sustaining any fractures. The claimant reports sustaining left lower extremity lacerations which did not require stitches.

Mr. Dillard reports that he went to the emergency room of Flushing Hospital Medical Center that same day for an evaluation and treatment. The claimant states that X-rays of the right knee, and CT scans of the right knee were performed at the hospital. He was discharged without admission with advice to rest.

SUBSEQUENT TREATMENT:

Mr. Dillard reports that ten days later, he was under the care of Dr. Gus katsigiorgus, an orthopedist and Dr. Louis p Guillaume, an orthopedist for further assessment. He was referred for physical therapy, massage therapy, heat treatment, ice treatment and TENS unit. The treatment began at a frequency of three times a week. Mr. Dillard reports that the treatment provided only temporary relief of symptoms. He reports that he continues to receive the conservative treatment at a frequency of three times a week at the present time. Mr. Dillard states that additional diagnostic tests which consisted of X-rays of the right knee, MRI study of the right knee and CT scans of the right knee were performed.

The claimant states that he did not require the use of any assistive device as a result of this accident.

He denies undergoing any surgery as a result of this accident. The claimant reports receiving right knee injections in June 19, 2021.

Mr. Dillard states that he is scheduled to have right knee surgery on Waiting for approval. He denies any pending injections.

CURRENT COMPLAINTS:

At the time of this examination, Mr. Dillard states that he has a complaint of pain in the right knee.

The claimant reports that he feels sharp pain in the right knee and stiffness to the right knee.

He states that movement, inactivity, sleeping, overworking, stress, fatigue, lifting and carrying aggravates the pain.

SOCIAL STATUS:

Mr. Dillard reports that he was employed full time as an Emergency medical technician at the time of the accident. The claimant states that duties of his occupation entail: "Heavy lifting, climbing, running up down stairs, moving lifting carrying weights from 50-400 lbs. Treating Pt and moving and driving long hours standing and sitting for 1-2 hours and having heavy clothing to wear uniform".

He states that he missed three months from work due to the accident. Mr. Dillard states that currently, he is not working as a result of the accident. He states that he has not worked in any capacity since the accident. The claimant reports that he anticipates returning to work Unknown at this time.

The claimant's reported highest education level is: associate degree.

PAST MEDICAL HISTORY:

Mr. Dillard reports history of prior accident in 3/2004. The claimant reports sustaining lower back injuries at the time of the prior accident. The claimant reports history of high blood pressure and asthma.

medications: Edarbi, Proair and Singular.

ALLERGIES:

Mr. Dillard states that he is allergic to Sea food and Motrin.

SOCIAL HISTORY:

Mr. Dillard states that he does not smoke. He reports that he consumes alcohol occasionally.

ADL CAPABILITIES AS STATED BY THE CLAIMANT:

He states that he can walk for 1/2 mile. He can reportedly stand for 20 minutes before he has to sit due to pain. He can sit for 1 hour before he has to change positions because of pain.

Mr. Dillard states that he is unable to do the following activities because of his injury: gardening, sports, washing dishes, washing clothes, sweeping, tying your shoes, personal hygiene, shopping/running errands. The claimant also reports that he is unable to: "Right knee effects me doing everything need to slow down."

Mr. Dillard states that he does not participate in any volunteer activities.

Mr. Dillard states that his typical activities throughout the day and/or recreational activities since the accident: "Shower walking up down stairs getting out of car driving, laying in Bed. I get restless leg and bending hard to do using total upper body to move thing".

The claimant states that he is able to drive.

REVIEW OF RECORDS:

1. MRI report of the right knee, by James McCleavey, M.D., dated 06/21/2021. Impression: Osseous structures are intact. Superficial chondral erosions on the medial femoral condyle. Oblique tear on the undersurface of the mid body of the medial meniscus and partial anterior subluxation of the anterior horn of the medial meniscus ventral to the margin of the medial tibial plateau. Chondral erosion a discrete subcentimeter degenerative osteochondral lesion on the anterior superior margin of the lateral femoral condyle at articulation with the lateral patella facet. Fluid surrounding the popliteus tendon at the posterolateral corner. Lateral patellar tilt. Attenuated diameter of the medial patellar retinaculum and medial patellofemoral ligament. Moderate joint effusion with fluid extending into the suprapatellar bursa. Mild edema in subcutaneous tissues ventral to the knee.
2. X-ray report of the right knee, by Mathew Diament, M.D., dated 06/22/2021. Impression: Patellar enthesopathy. Tricompartmental osteoarthritis, most pronounced in the

medial tibiofemoral compartment. If clinical symptoms persist consider further imaging with MRI, provided there are no medical contraindications.

3. Ultrasound report of the right knee, dated 06/22/2021, by Mathew Diament, M.D., with the impression of source of pain not elucidated on this exam. If clinical symptoms persist consider further imaging with MRI, provided there are no medical contraindications.
4. SOAP progress notes from New York Medical and Diagnostic Center, dated 06/05/2021, 06/18/2021, 06/19/2021, 06/21/2021, 06/22/2021, 06/23/2021, 06/25/2021, 06/26/2021, 06/28/2021, 07/02/2021, 07/07/2021, 07/12/2021, 07/14/2021, 07/16/2021, 07/23/2021 and 07/28/2021.
5. MG-2 form dated 08/13/2021, by Gus Katsgiorgis, M.D. Request: Please review medical records for surgery right knee arthroscopy with possible meniscectomy.
6. Office visit report from Island Musculoskeletal Care, PC, dated 07/23/2021.
7. X-ray report of the right knee, by Gus Katsgiorgis, M.D., dated 07/23/2021. Impression: Degenerative changes present. Reveal no fractures.
8. C-3 form dated 07/27/2021.
9. MG-2 form dated 07/21/2021, by Appasaheb Naik, M.D. Request: Therapeutic exercise for the right knee 3 times a week for 8 weeks.
10. First report of injury (MTC) 00-original code dated 06/14/2021.

FINDINGS ON PHYSICAL EXAMINATION:

The claimant was in no way injured during the examination and left the examination room in no more discomfort than when entering the room.

The claimant ambulated with a limping gait.

The claimant uses no assistive devices to ambulate. The claimant is using strap brace on the right leg.

The claimant required no help getting on or off the examination table. The claimant was able to rise from the chair without difficulty.

The claimant reports taking Tylenol today prior to the examination.

All motions are measured with a hand held goniometer.

The ranges of motion noted are as compared to the AMA - Guidelines for Determining Permanent Impairment and Loss of Wage Earning Capacity, Fifth Edition.

RIGHT KNEE:

There is no heat, swelling, erythema or crepitus noted. There is effusion noted. There is complaint of tenderness noted on palpation over medial joint line. The claimant complains of pain at extremes of motions.

Ranges of motion:

	Claimant	Normal
Flexion	120 degrees	140 degrees
Extension	0 degrees	0 degrees

DIAGNOSIS:

In my professional opinion, based upon a comprehensive physical examination, case history and review of the claimant's file, my impression is:

1. Right Knee internal derangement.

DISABILITY:

There is a mild partial disability.

Upon completion of the examination, Mr. Dillard offers no complaints as a result of this examination and left the examining area stable and unchanged.

If you have any further questions regarding Mr. Dillard, please do not hesitate to contact me.

ATTESTATION:

Pursuant to CPLR 2106, I, Louis C. Romeo, MD hereby affirms under the penalties of perjury, that I am duly licensed to practice medicine in the State of New York. I affirm, under the penalties of perjury, that my assertions and conclusions contained in the above report are true.

I, Louis C. Romeo, MD being a doctor duly licensed to practice medicine in the State of New York, am not a party of the above entitled action, and hereby affirm the forgoing statements to be true, under penalty of perjury pursuant to the Civil Practice Law and Rules section 2106.

I, Louis C. Romeo, MD being a doctor duly licensed to practice medicine in the State of New York, pursuant to the applicable provisions of the Civil Practice Law and Rules section 2106, hereby affirms under the penalties of perjury that the statements contained herein are true and accurate.

I affirm to the best of my knowledge that I am unaware of a conflict of interest between me, the examiner, the claimant examinee or the claimant's healthcare provider(s).

Very truly yours,

Louis C. Romeo, FAAOS, FACS
IME Authorization #: 189682-8B
Available for testimony:

CLAIMANT'S QUESTIONAIRE FORM 51016533

PLEASE ANSWER ALL THE QUESTIONS AS ACCURATE AS POSSIBLE TO THE BEST OF YOUR KNOWLEDGE

FULL NAME: *DILLARD BAYANI* TODAY'S DATE: *08/26/2021* DATE OF ACCIDENT: *06/11/2021*

DATE OF BIRTH: *11/05/1976* AGE: *44* SEX: [X] MALE [] FEMALE

HEIGHT: *5 FEET 11 INCHES* WEIGHT: *357* YOU ARE: [X] RIGHT HANDED [] LEFT HANDED [] AMBIDEXTROUS

HAIR COLOR: *BLACK* EYE COLOR: *DARK BROWN*

SOCIAL SECURITY NUMBER: *9312*
CELL PHONE NUMBER: *1-917-386-5380*
EMAIL ADRESS: *BDILLARD_2000@YAHOO.COM*

IFYOU HAD SURGERY IN THE LAST 6 WEEKS - SPEAK WITH RECEPTIONIST IMMEDIATELY

**FEMALES ONLY- ARE YOU PREGNANT? [] YES [] NO IF YES- HOW MANY WEEKS?

WERE YOU PREGNANT AT THE TIME OF THE ACCIDENT? [] YES [] NO IF YES-HOW MANY WEEKS

DID ANYONE ACCOMPANY YOU TO THIS EXAM [] YES [X] NO RELATION: NAME:

DO YOU NEED A TRANSLATOR? [] YES [X] NO IF YES, WHAT LANGUAGE DO YOU SPEAK?

HOW DID YOU GET TO THIS OFFICE? [X] DROVE YOURSELF [] PUBLIC TRANSPORT [] TAXI [] RELATIVE [] OTHER:

DID YOU BRING A PHOTO ID WITH YOU TO THIS EXAM? [X] YES [] NO

IF YOU ANSWERED NO, DID YOU COMPLETE A "NO PHOTO ID FORM" [] YES [] NO

HOW DO YOU TRAVEL TO YOUR DOCTORS' APPOINTMENTS? *DRIVE YOURSELF*

TELL US ABOUT YOU WORK RELATED INJURY

NAME OF EMPLOYER AT THE TIME OF THE ABOVE MENTIONED INJURY DATE? *FLUSHING HOSPITAL MEDICAL CENTER*

WHAT WAS YOUR OCCUPATION: *EMERGENCY MEDICAL TECHNICIAN*

WHAT CAUSED YOUR INJURY/ HOW DID YOUR INJURY OCCUR? *SLIP AND FALL/TRIP AND FALL*

AT THE TIME OF THE ACCIDENT YOU: *SLIPPED* ON *WET FLOOR*

DID YOU FALL? [X] YES [] NO [X] FORWARD [] BACKWARDS [] TO THE RIGHT SIDE [] TO THE LEFT SIDE

DID YOU PREVENT A FALL BY HOLDING TO SOMETHING? [] YES [] NO

WHERE DID YOU FALL TO: [X] FLOOR [] GROUND [] DOWN STAIRS

PREVENTED A FALL BY HOLDING ON WITH:

DID YOU HIT YOUR HEAD AS A RESULT OF THE FALL: [] YES [] NO

WERE YOU ABLE TO FINISH YOUR SHIFT: [] YES [X] NO

DID YOU IMMEDIATELY FEEL PAIN: [X] YES [] NO

IMMEDIATELY AFTER THE ACCIDENT, WHERE DID YOU FEEL PAIN? PLEASE CHECK ALL THAT APPLY.

[] HEAD [] NECK [] MID-BACK [] LOW-BACK [] RIGHT SHOULDER [] LEFT SHOULDER [] RIGHT ELBOW

[] LEFT ELBOW [] RIGHT WRIST [] LEFT WRIST [] RIGHT HAND [] LEFT HAND [] RIGHT HIP [] LEFT HIP

[X] RIGHT KNEE [] LEFT KNEE [] RIGHT ANKLE [] LEFT ANKLE [] RIGHT FOOT [] LEFT FOOT

[]OTHER:

DID YOU LOSE CONSCIOUSNESS? [] YES [X] NO HOW LONG: DIZZINESS:

DID YOU SUSTAIN ANY FRACTURES? [] YES [X] NO

DID YOU SUSTAIN ANY CUTS THAT NEEDED STITCHES? [X] YES []NO

IF YES, WHERE ON YOUR BODY? *LEFT LOWER EXTREMITY*

HOW MANY STITCHES WERE APPLIED?

HOSPITAL TREATMENT HISTORY

DID YOU GO TO THE HOSPITAL? [X] YES [] NO

IF YES, WHICH HOSPITAL DID YOU GO TO? *FLUSHING HOSPITAL MEDICA CENTER*

DID YOU VISIT CLINIC OR PHYSICIAN: [] YES [] NO

HOW DID YOU GET TO THE HOSPITAL? [] BY AMBULANCE [] ON YOUR OWN [X] OTHER:

DID YOU GO TO THE HOSPITAL [X] THAT DAY [] NEXT DAY HOW MANY DAYS LATER?

WERE YOU ADMITTED? [] YES [X] NO IF YES, HOW LONG WERE YOU ADMITTED FOR?

DID YOU UNDERGO SURGERY WHILE AT HOSPITAL? []YES [] NO BODY PART:

PLEASE CHECK ALL TESTS THAT WERE PERFORMED, *WHILE YOU WERE AT THE HOSPITAL*: YES

[X] X-RAYS, BODY PARTS? *[CQF13973]*

[]MRI, BODY PARTS? ___

[X]CT SCAN, BODY PARTS? *RIGHT KNEE*

[] ULTRASOUND BODY PARTS?

WERE ANY MEDICATIONS PRESCRIBED TO YOU AT THE HOSPITAL? [] YES [X] NO

IF YES, PLEASE LIST MEDICATION AND DOSAGE (IF KNOWN):

TELL US, WHAT TYPE OF TREATMENT DID YOU RECEIVE AFTER THE ABOVE MENTIONED ACCIDENT / INCIDENT?

DID YOU RECEIVE ANY TREATMENT? [X] YES [] NO IF YES, CHECK ALL THAT APPLY:

[X] PHYSICAL THERAPY [] CHIROPRACTIC [] ACUPUNCTURE [X] MASSAGE THERAPY [X] HEAT [X] ICE [X] TENS UNIT HOW LONG AFTER THE ACCIDENT / INJURY DID YOU START TREATMENT? *TEN DAYS LATER*

HOW MANY TIMES A WEEK DID YOU INITIALLY RECEIVE TREATMENT? *THREE*

ARE THE TREATMENTS GIVING TEMPORARY RELIEF OR ARE YOU GETTING A SUSTAINED PROGRESSIVE IMPROVEMENT *TEMPORARY RELIEF*?

ARE YOU STILL RECEIVING TREATMENT? [X] YES [] NO

HOW MANY TIMES A WEEK DO YOU CURRENTLY RECEIVE TREATMENT? *THREE* TIMES PER WEEK

IF NO, WHAT WAS THE DATE OF YOUR LAST TREATMENT? WOULD YOU LIKE TO CONTINUE TREATMENT? [] YES [] NO

PLEASE LIST ALL DOCTORS THAT YOU HAVE TREATED WITH SINCE THE ACCIDENT

DOCTOR *GUS KATSIGIORGUS* SPECIALTY *AN ORTHOPEDIST* DOCTOR SPECIALTY

DOCTOR *LOUIS P GUILLAUME* SPECIALTY *AN ORTHOPEDIST* DOCTOR SPECIALTY

DOCTOR SPECIALTY DOCTOR SPECIALTY

DOCTOR SPECIALTY

WERE YOU REFERRED FOR ANY ADDITIONAL TESTS? [X] YES [] NO

[X] X-RAYS *RIGHT KNEE*

[X] MRI *RIGHT KNEE*

[X] CT SCAN *RIGHT KNEE*

[] EMG

DID YOUR TREATING DOCTOR PRESCRIBE : [] NECK BRACE [] BACK BRACE []WRIST BRACE [] ELBOW BRACE [] KNEE BRACE [] ANKLE/FOOT BRACE [] SLING [] CAST

DO YOU USE []A CANE [] CRUTCHES [] WALKER [] CAM BOOT []WHEELCHAIR ([]MOTORIZED OR []MANUAL)

WERE YOU SPECIALLY FITTED FOR ANY OF THE DEVICES PRESCRIBED? [] YES [] NO

DID ANYONE EXPLAIN HOW TO USE THE PRESCRIBED EQUIPMENT? [] YES [] NO

ARE YOU STILL USING THE PRESCRIBED EQUIPMENT? [] YES [] NO

****WERE ANY SURGERIES PERFORMED OR INJECTIONS GIVEN DUE TO THE ABOVE MENTIONED ACCIDENT/ INJURY?**** []YES [X]NO

DATE OF SURGERY WHICH BODY PART?

****WERE ANY INJECTIONS GIVEN DUE TO THE ABOVE MENTIONED ACCIDENT/INJURY?**** [X]YES []NO

DATE OF INJECTION *JUNE 19,2021* WHICH BODY PART? *RIGHT KNEE*

ANY PENDING SURGERY DUE TO THE ABOVE ACCIDENT/INJURY: [X] YES [] NO IF YES- GIVE DETAILS -

DATE:__*WAITING* *FOR*BODYPART:____*RIGHT* *KNEE*_____ *APPROVAL*_____

ANY PENDING INJECTIONS DUE TO THE ABOVE ACCIDENT/INJURY: [] YES [X] NO IF YES-GIVE DETAILS-

DATE: BODY PART:

PAST MEDICAL HISTORY

WERE YOU EVER IN AN ACCIDENT BEFORE? [X]YES []NO IF YES, APPROXIMATELY WHEN? *3/2004*

WERE ANY INJURIES SUSTAINED? [X] YES [] NO IF YES, WHAT WERE THE *LOWER BACK*

WERE YOU EVER IN AN ACCIDENT AFTER THIS ACCIDENT? [] YES [X] NO IF YES, APPROXIMATELY WHEN?

WERE ANY INJURIES SUSTAINED? [] YES [] NO IF YES, WHAT WERE THE

DID YOU EVER UNDERGO ANY SURGERY NOT RELATED TO THE ABOVE MENTIONED ACCIDENT/INCIDENT? [] YES [X] NO

IF YES, PLEASE EXPLAIN : DATE:

PLEASE INDICATE IF YOU HAVE THE FOLLOWING: [] NONE [] DIABETES [X] HIGH BLOOD PRESSURE [X] ASTHMA [] ELEVATED CHOLESTEROL [] ARTHRITIS [] THYROID DISEASE [] HEART DISEASE [] LUNG DISEASE [] KIDNEY DISEASE [] OTHER :

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? [X] YES [] NO IF YES, PLEASE LIST NAME, DOSAGE AND FREQUENCY:

EDARBI PROAIR SINGULAR

DO YOU HAVE ANY ALLERGIES? *YES SEA FOOD ,MOTRIN*

ACTIVITIES OF DAILY LIVING

HOW FAR CAN YOU WALK? [] NO LIMIT []1 MILE [X]1/2 MILE []1/4 MILE []1 BLOCK []OTHER:

HOW LONG CAN YOU STAND BEFORE YOU HAVE TO SIT? []NO LIMIT []2 HOURS []1HOUR []30 MINUTES [X]20 MINUTES []10MINUTES []5 MINUTES []OTHER:

HOW LONG CAN YOU SIT BEFORE YOU HAVE TO CHANGE POSITIONS BECAUSE OF PAIN? []NO LIMIT []2 HOURS [X]1 HOUR []30 MINUTES []20 MINUTES []10 MINUTES []5 MINUTES

WHAT ACTIVITIES ARE YOU UNABLE TO DO BECAUSE OF YOUR INJURY? [X]GARDENING [X]SPORTS []DRIVING [X]WASHINGDISHES [X]WASHING CLOTHES []VACUUMING [X]SWEEPING [X]TYING YOUR SHOES []COOKING [X]PERSONALHYGIENE []CHILDCARE NEEDS [X]SHOPPING/RUNNING ERRANDS *RIGHT KNEE EFFECTS ME DOING EVERYTHING NEED TO SLOW DOWN*

WHAT ARE YOUR TYPICAL ACTIVITIES THROUGHOUT THE DAY AND/OR RECREATIONAL ACTIVITIES SINCE THE ACCIDENT? *SHOWER WALKING UP DOWN STAIRS GETTING OUT OF CAR DRIVING LAYING IN BED I GET RESTLESS LEG AND BENDING HARD TO DO USING TOTAL UPPER BODY TO MOVE THINGS . LEG H AS PAIN INSIDE INNER KNEE*

ARE YOU ABLE TO DRIVE: [X] YES [] NO HOW OFTEN DO YOU DRIVE: *OFTEN*

SOCIAL HISTORY

DO YOU PARTICIPATE IN VOLUNTEER ACTIVITIES: [] YES [X] NO

DO YOU SMOKE? [] YES [X] NO

HOW MANY PACK A DAY DO YOU SMOKE?

HOW MANY YEARS DO YOU SMOKE?

DO YOU CONSUME ALCOHOL? [X] YES [] NO

HOW OFTEN DO YOU CONSUME ALCOHOL? *OCCASIONALLY*

WORK HISTORY / SCHOOL HISTORY

WERE YOU EMPLOYED AT THE TIME OF THE ACCIDENT / INCIDENT? [] FULL TIME [] PART TIME

WHAT WAS YOUR OCCUPATION AT THE TIME OF THE ACCIDENT / INCIDENT (BE SPECIFIC)? *EMERGENCY MEDICAL TECHNICIAN*

WHAT DID YOUR DUTIES ENTAIL? *HEAVY LIFTING , CLIMBING , RUNNING UP DOWN STAIRS , MOVING LIFTING CARRYING WEIGHTS FROM 50-400 LBS , TXP PT AND MOVING FROM STX AND DRIVING LONG HOURS STANDING AND SITTING FOR 1-2 HOURS AND HAVING HEAVY CLOTHING TO WEAR UNIFORM*

WERE YOU A STUDENT? [] YES [X] NO IF YES, WHAT GRADE WERE YOU IN ?

DID YOU MISS ANY TIME FROM WORK/SCHOOL? [X] YES [] NO IF YES, HOW LONG? *THREE MONTHS THREE MONTHS*

ARE YOU CURRENTLY WORKING ? [] YES [X] NO [] FULL TIME [] PART TIME [] SAME JOB [] NEW

WHAT IS YOU CURRENT OCCUPATION?:

JOB IF YOU ARE NOT CURRENTLY WORKING, IS IT BECAUSE OF THE ACCIDENT? [X] YES [] NO

YOU ARE ABLE TO PERFORM YOUR JOB DUTIES: [] WITHOUT LIMITATIONS [] WITH LIMITATIONS (GIVE DETAILS)

HAVE YOU WORKED AT ALL SINCE THIS INJURY? *NO*

APPROXIMATELY WHEN DO YOU ANTICIPATE RETURNING TO WORK? *UNKNOWN AT THIS TIME*

CURRENT COMPLAINTS (BODY PARTS):

FEEL SHARP PAIN IN: *RIGHT KNEE*

FEEL STIFFNESS IN: *RIGHT KNEE*

AGGRAVATING FACTORS/TRIGGERS: *MOVEMENT, INACTIVITY, SLEEPING, OVERWORKING, STRESS, FATIGUE, LIFTING AND CARRYING*

COMPARED TO THE INITIAL INJURY/CONDITION, IN YOUR OPINION, ARE YOU: [] PAIN FREE [] IMPROVED [X] SAME [] WORSE

CLAIMANT'S NAME: BAYANI DILLARD

CLAIMANT'S SIGNATURE:

DATE OF SIGNATURE: *08/26/2021*

1251616533

COVID-19 Questionnaire

Please Review and Complete this Form

Please respond by checking any box applicable to you and sign below, and provide the completed copy to the Clinic Manager.

[X] YES [] No Have you been tested for COVID-19?

1. If you have tested positive for COVID-19 please indicate which of the following statements are true, if any:

[] If you were symptomatic (had symptoms), you have been in isolation for at least 14-days since symptoms first began, and you have not had symptoms in the past 3 days.

[] If you were asymptomatic (did not have symptoms), you have been in isolation for at least 14-days beginning from the date you were tested and you have not experienced any symptoms during this 14-day period.

[] You have NOT completed a 14-day quarantine. If you check this box, please note the date you were diagnosed with COVID-19 and the date you first became symptomatic (if applicable).

Date first symptomatic: __/__/____ Date diagnosed with COVID-19: __/__/____

2. If you have not tested positive for COVID-19, please select any of the following that apply:

[] Have you travelled internationally in the past 14 days? If so, please note the date of your return and the area(s) you visited.

Date of return from international travel: ____/____/____ Areas visited:

[] Have you had close contact (defined as within closer than 6 feet for 10 minutes or more) with someone who was diagnosed with or suspected to have COVID-19 within the past 14 days? (For example, a family member you live with or a co-worker). If so, please note the last date you had contact with this person and whether the person was actually diagnosed.

Date of last contact with person: ____/____/____ Person actually diagnosed: [] Yes [] No

[] Have you been mandated to go into quarantine by your physician or a department of health within the past 14 days? If so, please explain the date the quarantine began and the reason for quarantine.

Date quarantine began: ____/____/____ Reason for quarantine:

[] Have you had fever, chills, cough, shortness of breath, sore throat, or any other flu-like symptoms within the past 14 days? If so, please note the date you first became symptomatic (had symptoms) and the last date you were symptomatic.

Date first became symptomatic: __/____/____ Date last symptomatic: ____/____/____

Name (printed): Bayani Dillard Signature: Date: 08/26/2021

BAYANI DILLARD 1/2

21580911

NEW YORK STATE | Workers' Compensation Board

PO Box 5205
Binghamton, NY 13902-5205

Customer Service Toll-Free Line: 877-632-4996
Statewide Fax Line: 877-533-0337
www.wcb.ny.gov

COVER SHEET FOR REPORT OF INDEPENDENT MEDICAL EXAMINATION

A copy of each report of Independent Medical Examination shall be submitted on the same day and in the same manner to the Workers' Compensation Board, the insurance carrier or self-insured employer, the claimant's attending physician or other attending independent examiner, the claimant's representative, if any, and the claimant.

CHECK ONE: ☑ PHYSICIAN ☐ PODIATRIST ☐ CHIROPRACTOR ☐ PSYCHOLOGIST

THIS EXAMINATION WAS REQUESTED BY: ☑ CARRIER/EMPLOYER ☐ CLAIMANT

WCB Case No.	Carrier Case No. (If Known)	Date of Injury/Illness	Injured Person's Social Security No.	Date of Examination
G3051719	73141129-110	6/11/2021		5/19/2022

	FIRST NAME / MIDDLE INITIAL / LAST NAME	ADDRESS (Include Apt. No.)
Injured Person	Bayani Dillard	52 Charles Street, Malverne, NY, 11565
Insurance Carrier/ Self-Insured Employer	NYSIF	199 Church Street, New York, NY, 10007
Independent Examiner		
	Authorization No.	Date of Report of Independent Medical Examination

Start Time of Patient Examination	End Time of Patient Examination	Total Time Spent Reviewing Records
1:31	1:41	10 Mins

IF EXAMINER CONDUCTED THIS EXAMINATION AS AN EMPLOYEE OF AN IME COMPANY, OR UNDER CONTRACT OR ARRANGEMENT WITH AN IME COMPANY, STATE NAME AND WORKERS' COMPENSATION BOARD REGISTRATION NUMBER OF IME COMPANY.

Attach Report of Independent Medical Examination

Report of Independent Medical Examination must include this cover sheet and a narrative report that includes the components listed below. If the examination concludes Schedule Loss of Use and/or Non-Schedule Permanent Partial Disability please include the IME-4.3A and/or IME-4.3B with the cover sheet and your medical narrative.

- A description of the examination;
- A list of all documents or information reviewed by the IME evaluator;
- The examiner's professional opinion; and
- A signed and dated certification at the end of the report of the independent medical examination as follows:
  - I hereby certify that this report is a full and truthful representation of my professional opinion with respect to the claimant's condition; that no person or entity has caused, directed or encouraged me to submit a report that differs substantially from my professional opinion; and I have reviewed the report and attest to its accuracy.
  - The signature and date must be below the required certification.

Any questionnaire or intake sheets completed by the claimant either before arriving or after arriving for the independent medical examination must be attached to this cover sheet with the report.

In certifying on the cover sheet, you are certifying to the entire contents of the Report of Independent Medical Examination.

I hereby certify that this report is a full and truthful representation of my professional opinion with respect to the claimant's condition; that no person or entity has caused, directed or encouraged me to submit a report that differs substantially from my professional opinion; and I have reviewed the report and attest to its accuracy.

Independent Examiner's Name

5/20/2022
Date

Independent Examiner's Signature

2158091144

Louis Romeo, M.D.
Diplomate American Board of Orthopedic Surgery

2545 Hempstead Tpke Suite 221,
East Meadow, NY 11554

05/19/2022

MEDEX ANALYTIC SERVICES
3200 N University Drive, Suite 210
Coral Springs, FL 33065

Claimant:	Dillard, Bayani
Claim#:	73141129-110
WCB#:	G3051719
Emp. Name:	Flushing Hospital
DOB:	11/05/1976
DOA:	06/11/2021

To Whom It May Concern:

As you requested, I have performed an orthopedic medical re-evaluation regarding the above-named claimant, Mr. Bayani Dillard, on 05/19/2022 in the East Meadow, NY office. He reports that he drove himself to this examination. Mr. Dillard presented a valid photo identification prior to the evaluation.

My findings are as follows:

IDENTIFICATION:

Mr. Dillard is a 46-year-old right-handed male. His self-reported height is 6 feet 0 inches, weight is 324 pounds and he has black hair with brown eyes.

HISTORY OF ACCIDENT:

Mr. Dillard was employed as a Emergency medical technician for Flushing Hospital, he was involved in a work-related accident on 06/11/2021. The claimant slipped on wet floor and sustained an injury to the right knee.

Mr. Dillard went to the emergency room of Flushing Hospital hospital that same day for an evaluation and treatment.

Claimant: Dillard, Bayani
DOB: 11/05/1976
DOA: 06/11/2021

SUBSEQUENT TREATMENT:

Mr. Dillard came under the care of various medical professionals for further assessment. He was referred for physical therapy, massage therapy, heat treatment, ice treatment and TENS unit. The treatment began at a frequency of five times a week. Mr. Dillard reports that the treatment provided only temporary relief of symptoms. Mr. Dillard had X-rays of the right knee, and MRI study of the right knee.

He underwent right knee surgery on 1/10/22.

CURRENT COMPLAINTS:

At the time of this examination, Mr. Dillard states that he has a complaint of pain in the right knee.

SOCIAL STATUS:

Mr. Dillard was employed full time as a Emergency medical technician at the time of the accident.

Mr. Dillard verbally states that he is planning to return to work full duty in 06/22.

The claimant's reported highest education level is: associate degree.

PAST MEDICAL HISTORY:

Mr. Dillard had history of a prior accident in 2004. The claimant sustained lower back, right shoulder and left shoulder injuries at the time of the prior accident. The claimant has history of high blood pressure and asthma.

PAST SURGICAL HISTORY:

Mr. Dillard denies undergoing any prior surgery.

SUBSEQUENT MEDICAL HISTORY:

The claimant reports that since the accident of record, no new injuries have been sustained and no new accidents have occurred.

REVIEW OF RECORDS:

I have reviewed the following medical records:

1. Physical therapy progress notes, dated 06/18/2021 through 07/28/2021.
2. Chiropractic progress notes, dated 06/19/2021 through 07/28/2021.
3. Physical therapy re-evaluation report, dated 07/12/2021.
4. MRI report of the right knee, dated 06/21/2021. Impressions: Osseous structures are intact. Superficial chondral erosions on the medial femoral condyle: Oblique tear on the undersurface of the mid body of the medial lmeniscus and partial anterior subluxation of the anterior horn of the medial meniscus ventral to the margin of the medial tibial plateau. Chondral erosion a discrete subcentimeter degenerative osteochondral lesion on anterior superior margin of the lateral femoral condyle at articulation with the lateral patella facet. Fluid surrounding the popliteus tendon at the posterolateral comer. Lateral patellar tilt. Attenuated diameter oftlle medial patellar retinaculum and medial patellofemoral ligament. Moderate joint effusion with fluid extending into the suprapatellar bursa. Mild edema in subcutaneous tissues ventral to the knee.
5. X-ray report of the right knee, dated 06/22/2021. Impressions: Patellar enthesopathy. Tricompartmental osteoarthritis, most pronounced in the medial tibiofemoral compartment. If clinical symptoms persist consider further imaging with MRI, provided there are no medical contraindications.
6. Ultrasound report of the right knee, dated 06/22/2021. Impressions: Source of pain not elucidated on this exam. If clinical symptoms persist consider further imaging with MRI, provided there are no medical contraindications.
7. Evaluation report, at Island Musculoskeletal Care, M.D., P.C., dated 07/23/2021, 09/13/2021, 11/15/2021, and 01/26/2022.
8. Physical therapy SOAP notes, dated 08/02/2021 through 03/10/2022.
9. My prior IME report, dated 08/26/2021 (through a different IME vendor).
10. Letter of medical necessity, at Island Musculoskeletal Care, M.D., P.C., dated 09/20/2021
11. Operative report, dated 01/10/2022. Procedures: Right knee medial meniscus tear,marked synovitis of right knee, chondromalacia of patella grade 3, femoral trochlea grade 3,

Claimant: Dillard, Bayani
DOB: 11/05/1976
DOA: 06/11/2021

chondromalacia of medial femoral condyle grade 3, medial-tibial plateau grade 3.

FINDINGS ON PHYSICAL EXAMINATION:

The claimant was in no way injured during the examination and left the examination room in no more discomfort than when entering the room.

The claimant ambulated with a normal symmetrical gait.

The claimant uses no assistive devices to ambulate. The claimant was not wearing any orthopedic devices.

The claimant required no help getting on or off the examination table. The claimant was able to rise from the chair without difficulty.

The claimant did not take any medications today prior to the examination.

All motions are measured with a hand held goniometer.

RIGHT KNEE:

Examination reveals well healed anterior scar . There is no heat, effusion, erythema or crepitus noted. There is swelling noted. There is complaint of tenderness noted on palpation over medial joint line. Ranges of motion were performed without complaints of pain.

- Lachman's - Negative.
- Stable on Varus/Valgus Stress - Yes.

Ranges of motion:

	Claimant	Normal
Flexion	140/140/140 degrees	140 degrees
Extension	0 degrees	0 degrees

Claimant: Dillard, Bayani
DOB: 11/05/1976
DOA: 06/11/2021

Left Knee:

Ranges of motion:

	Claimant	Normal
Flexion	140 degrees	140 degrees
Extension	0 degrees	0 degrees

DIAGNOSIS:

1. Right Knee status post surgery

DISABILITY:

There is no evidence of a causally related disability of 0% based on clinical findings of today's examination.

Upon completion of the examination, Mr. Dillard offers no complaints as a result of this examination and left the examining area stable and unchanged.

If you have any further questions regarding Mr. Dillard, please do not hesitate to contact me.

ATTESTATION:

Pursuant to CPLR 2106, I, Louis C. Romeo, MD hereby affirms under the penalties of perjury, that I am duly licensed to practice medicine in the State of New York. I affirm, under the penalties of perjury, that my assertions and conclusions contained in the above report are true.

I, Louis C. Romeo, MD being a doctor duly licensed to practice medicine in the State of New York, am not a party of the above entitled action, and hereby affirm the forgoing statements to be true, under penalty of perjury pursuant to the Civil Practice Law and Rules section 2106.

I, Louis C. Romeo, MD being a doctor duly licensed to practice medicine in the State of New York, pursuant to the applicable provisions of the Civil Practice Law and Rules section 2106, hereby affirms under the penalties of perjury that the statements contained herein are true and accurate.

Claimant: Dillard, Bayani
DOB: 11/05/1976
DOA: 06/11/2021

I affirm to the best of my knowledge that I am unaware of a conflict of interest between me, the examiner, the claimant examinee or the claimant's healthcare provider(s).

Very truly yours,

Louis C. Romeo, FAAOS, FACS
IME Authorization #: 189682-8B

Available for testimony:
I will be available to testify by appointment only with four weeks advanced notice.

New York Medical & Diagnostic Center
80-46 Kew Gardens Road
Kew Gardens, NY 11415
Tel: (718) 261-1000
Fax: (718) 261-0336

DILLERD, BAYANI
MRN: 51372
DOB: 11/05/1976
Referring Doctor: GUILLAUME, PA, LOUIS
DOS:06/22/2021

Exam: X-RAY KNEE RIGHT

CLINICAL HISTORY: Pain.

TECHNIQUE: Radiographs right knee AP, lateral and oblique projections.
COMPARISON: No similar prior studies provided for direct comparison.

FINDINGS:

Patellar enthesopathy. Tricompartmental osteoarthritis, most pronounced in the medial tibiofemoral compartment, including joint space narrowing with osteophytosis.

No specific radiographic evidence of recent fracture, subluxation or destructive process. No obvious soft tissue mass.

IMPRESSION:

Patellar enthesopathy. Tricompartmental osteoarthritis, most pronounced in the medial tibiofemoral compartment. If clinical symptoms persist consider further imaging with MRI, provided there are no medical contraindications.

Report Reviewed on: 6/22/21
☐ Normal Result
☐ Urgent Appt
☐ Routine Appt
Review Dr Name: Louis Guillaume - PA
Review Dr Signature:

Thank you for the courtesy of this referral

Dicated by: MATTHEW DIAMENT, M.D.

Approved by:

New York Medical & Diagnostic Center

80-48 Kew Gardens Road
Kew Gardens, NY 11415
Tel: (718) 261-1000
Fax: (718) 261-0336

DILLERD, BAYANI
MRN: 51372
DOB: 11/05/1976
Referring Doctor: GUILLAUME, PA, LOUIS
DOS:06/22/2021

Exam: ULTRASOUND LIMITED RT KNEE (SOFT TISSUE) NON-VASC

CLINICAL STATEMENT: Pain.

TECHNIQUE: Sonographic evaluation of the right knee was performed. Representative images submitted.

FINDINGS:

No gross soft tissue mass demonstrated.

No obvious, full-thickness and/or retracted tendon tear demonstrated.

No fluid collection demonstrated.

IMPRESSION:

Source of pain not elucidated on this exam. If clinical symptoms persist consider further imaging with MRI, provided there are no medical contraindications.

Thank you for the courtesy of this referral

Dicated by: MATTHEW DIAMENT, M.D.

Approved by:

Patient Name: DILLERD, BAYANI
Patient ID: HEW127576
DOB: 19761105
MRN: 03603623
Study Date: 06/21/2021 09:31:55
Study Description: 73721KRT MRI KNEE RIGHT W/O

Report Time: 06/21/2021 09:59:00
Report Status: Final
Time Received: 06/22/2021 17:06:25
Interpreter: (jmccleavey)
Transcriptionist: (888)

Begin of Report Content

LOUIS P GUILLAUME, PA

80-46 KEW GARDENS RD

KEW GARDENS NY 11415

RE:DILLERD, BAYANI DOS:06/21/2021

MRN:HEW127576

DOB:11/05/1976

MRI KNEE RIGHT W/O

History: Work related injury June 11, 2021. Right knee pain.

Technique:

PD fat suppression axial, coronal and sagittal sequences and T1 coronal sequence were performed of the right knee without gadolinium contrast.

This service was furnished during a public health emergency. Additional time and supplies were utilized to accommodate the recommended safety protocols.

Comparison: None

Findings:

The osseous structures of the right knee are intact with no fracture, medullary bone edema or evidence of marrow replacement process.

Medial compartment evaluation demonstrates superficial chondral erosions on the medial femoral condyle. Medial meniscus demonstrates an oblique undersurface tear through the mid body and partial

anterior subluxation of the anterior horn ventral to the anterior margin of the medial tibial plateau. Medial collateral ligament is intact.

No pes anserinus bursitis. Semimembranosus and medial head of the gastrocnemius are intact.

Lateral compartment evaluation demonstrates chondral erosion and discrete subcentimeter degenerative osteochondral lesion on the anterior superior margin of the lateral femoral condyle and articulation with the lateral patella facet. No chondral defects in the central articular surfaces in the lateral compartment. Lateral meniscus and fibular collateral ligament are intact.

Iliotibial band, biceps femoris and lateral head of the gastrocnemius are intact and appear unremarkable.

Fluid surrounds the popliteus tendon at the posterolateral corner.

Cruciate ligaments are intact without altered signal.

Lateral patellar tilt.

Distal quadriceps tendon, patellar tendon and lateral patellar retinaculum are intact. Attenuated diameter of the medial patellar retinaculum and medial patellofemoral ligament.

Joint effusion with fluid extending into the suprapatellar bursa. Lateral suprapatellar plica.

Mild edema in the subcutaneous tissues ventral to the knee.

Impression:

Osseous structures are intact.

Superficial chondral erosions on the medial femoral condyle.

Oblique tear on the undersurface of the mid body of the medial meniscus and partial anterior subluxation of the anterior horn of the medial meniscus ventral to the margin of the medial tibial plateau.

Chondral erosion a discrete subcentimeter degenerative osteochondral lesion on the anterior superior margin of the lateral femoral condyle at articulation with the lateral patella facet.

Fluid surrounding the popliteus tendon at the posterolateral corner.

Lateral patellar tilt.

Attenuated diameter of the medial patellar retinaculum and medial patellofemoral ligament.

Moderate joint effusion with fluid extending into the suprapatellar bursa.

Mild edema in subcutaneous tissues ventral to the knee.

Thank you for the courtesy of this referral.

Sincerely,

Dictated by: JAMES R. MCCLEAVEY, M.D.

Electronically approved by: JAMES R. MCCLEAVEY, M.D.

JRM:/PI

Transcription Date/Time: 06/22/2021 05:05 PM

CC:

Page PAGE 1 of NUMPAGES 2

End of Report Content

From: NRS Medical To: GUILLAUME LOUIS P Page: 1/2 Date: 6/23/2021 8:13:40 AM

NRS NEIGHBORHOOD RADIOLOGY SERVICES, PC

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1-800-220-2220 - www.neighborhoodrad.com

5/26/5

51372

LOUIS P GUILLAUME, PA
80-46 KEW GARDENS RD
KEW GARDENS NY 11415

RE:DILLERD, BAYANI **DOS:06/21/2021**
MRN:HEW127576
DOB:11/05/1976
MRI KNEE RIGHT W/O

History: Work related injury June 11, 2021. Right knee pain.

Technique:
PD fat suppression axial, coronal and sagittal sequences and T1 coronal sequence were performed of the right knee without gadolinium contrast.

This service was furnished during a public health emergency. Additional time and supplies were utilized to accommodate the recommended safety protocols.

Comparison: None

Findings:
The osseous structures of the right knee are intact with no fracture, medullary bone edema or evidence of marrow replacement process.

Medial compartment evaluation demonstrates superficial chondral erosions on the medial femoral condyle. Medial meniscus demonstrates an oblique undersurface tear through the mid body and partial anterior subluxation of the anterior horn ventral to the anterior margin of the medial tibial plateau. Medial collateral ligament is intact.
No pes anserinus bursitis. Semimembranosus and medial head of the gastrocnemius are intact.

Lateral compartment evaluation demonstrates chondral erosion and discrete subcentimeter degenerative osteochondral lesion on the anterior superior margin of the lateral femoral condyle and articulation with the lateral patella facet. No chondral defects in the central articular surfaces in the lateral compartment. Lateral meniscus and fibular collateral ligament are intact.
Iliotibial band, biceps femoris and lateral head of the gastrocnemius are intact and appear unremarkable.
Fluid surrounds the popliteus tendon at the posterolateral corner.

Cruciate ligaments are intact without altered signal.

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NRS | NEIGHBORHOOD RADIOLOGY SERVICES, PC

Bewley
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Forest Hills - Queens Boulevard • 113-01 Queens Boulevard, Forest Hills, NY 11375
Sunnyside - Queens Boulevard • 47-19 Greenpoint Avenue, Sunnyside, NY 11104
Astoria • 27-37 Crescent Street, Suite 102, Astoria, NY 11102
Elmhurst • 79-01 Broadway, Elmhurst, NY 11373

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LOUIS P GUILLAUME, PA
80-46 KEW GARDENS RD
KEW GARDENS NY 11415

Date received 06-21-2021
☐ Normal Result
☐ Review Appt
☐ Urgent Appt
Review Physician Louis Guillaume PA.
Copy Delegated

RE:DILLERD, BAYANI **DOS:06/21/2021**
MRN:HEW127576
DOB:11/05/1976
MRI KNEE RIGHT W/O

Lateral patellar tilt.
Distal quadriceps tendon, patellar tendon and lateral patellar retinaculum are intact. Attenuated diameter of the medial patellar retinaculum and medial patellofemoral ligament.
Joint effusion with fluid extending into the suprapatellar bursa. Lateral suprapatellar plica.
Mild edema in the subcutaneous tissues ventral to the knee.

Impression:
Osseous structures are intact.
Superficial chondral erosions on the medial femoral condyle.
Oblique tear on the undersurface of the mid body of the medial meniscus and partial anterior subluxation of the anterior horn of the medial meniscus ventral to the margin of the medial tibial plateau.
Chondral erosion a discrete subcentimeter degenerative osteochondral lesion on the anterior superior margin of the lateral femoral condyle at articulation with the lateral patella facet.
Fluid surrounding the popliteus tendon at the posterolateral corner.
Lateral patellar tilt.
Attenuated diameter of the medial patellar retinaculum and medial patellofemoral ligament.
Moderate joint effusion with fluid extending into the suprapatellar bursa.
Mild edema in subcutaneous tissues ventral to the knee.

Thank you for the courtesy of this referral.

Sincerely,

Dictated by: JAMES R. MCCLEAVEY, M.D.
Electronically approved by: JAMES R. MCCLEAVEY, M.D.

JRM:/PI
Transcription Date/Time: 06/22/2021 05:05 PM

CC:

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WORKERS' COMPENSATION BOARD

State of New York - Workers' Compensation Board

Subsequent Report of Injury
Report Type (MTC) IP-Initial Payment

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.
The Claim Administrator has begun payment of indemnity benefits and payments are ongoing.

Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719 **Date of Injury** 06/11/2021

Claim Administrator Claim Number 73141129-110 **Maintenance Type Code Date** 06/24/2021

Claim Type I - Indemnity for Lost Time **WCB Received Date** 06/24/2021

Agreement to Compensate W - Without Liability

INSURER INFORMATION

FEIN xxxxx3200 **Insurer ID** W204002

CLAIM ADMINISTRATOR INFORMATION

Name New York State Insurance Fund **FEIN** xxxxx3200

Claim Representative Name Yogesh Patel **Postal Code** 10007-1100

Business Phone Number 6317564176 **Fax Number**

E-mail Address ypate@nysif.com **Claim Admin ID** W204002

Late Reason

EMPLOYEE INFORMATION

First Name Bayani **Middle Name/Initial**

Last Name Dillard **Suffix**

Date of Birth 11/05/1976

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx9312

CLAIM INFORMATION

Date Employer Had Knowledge of Date of Disability 06/14/2021 **Employment Status** 1 - Regular/Full-time Employee

Pre-existing Disability **Number of Days Worked Per Week** 3

Work Days Scheduled (S-Scheduled N-Non Scheduled) S M T W T F S **Work Week Type**

Calculated Wage $1,362.31 **Wage Period** 01 - Weekly

Calculated Weekly Compensation Amount $908.21 **Denial Rescission Date**

Employer Paid Salary Prior To Acquisition

Date Claim Administrator Notified of Employee Representation

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

Employer Paid Salary in Lieu of Compensation

Type of Loss 01 - Traumatic Injury

Date of Maximum Medical Improvement

PERMANENT IMPAIRMENT

Impairment Percentage

Body Part

Death Result of Injury

Date of Death

Number of Dependents 0

Dependent/Payee Relationship

WORK STATUS

First Day of Disability After The Waiting Period

Current Date Last Day Worked

Initial Date Last Day Worked

Current Date Disability Began

Initial Date Disability Began 06/12/2021

Latest Return to Work Status Date

Initial Return to Work Date

Return To Work Type

Physical Restrictions

Return To Work Same Employer

BENEFITS

Reduced Benefit Amount

Non-Consecutive Period B - Benefit Period

Estimated Gross Weekly Amt.

Benefits

Benefit Types

070 - Temporary Partial

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross Effective Date	Weekly Gross Amount	Weekly Net Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid
070	06/12/2021	06/28/2021	2	1	06/12/2021	$450.00	06/12/2021	$450.00	06/23/2021	$990.00

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount

PAYMENTS

Award/Order Date

Payment Reasons					
070 - Temporary Partial					
Payment Reason Code	Payee	Start Date	Through Date	Issue Date	Amount Paid
070	Bayani Dillard	06/12/2021	06/28/2021	06/23/2021	$990.00

Recoveries

Recovery Type	Amount

Reduced Earnings

Week Number	Actual Reduced Earnings

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx1781

Insured FEIN xxxxx1781

CONCURRENT EMPLOYER INFORMATION

Name

Contact Business Phone

Wage

TO THE CLAIMANT

Your employer or its insurance carrier has started to make payments without prejudice for the accident which occurred on the date shown below. Under this program, an employer or its insurance carrier begins making payments to you in order to provide you with temporary funds, while still investigating the circumstances of the reported accident or injury, including an investigation as to whether it is the correct insurance carrier. You should have received a notice from the employer or carrier indicating that payments have begun. The reason that you are receiving payments should be identified on the notice you received from the employer or insurance carrier. Contact your employer or its insurance carrier, if you have not received this notice. If you have not started to receive payments, contact the nearest office of the Workers' Compensation Board immediately.

If the employer or insurance carrier is still investigating the circumstances of the reported accident or injury, payments are made pursuant to Workers' Compensation Law 21-a. **The payment of temporary compensation is not an admission by the employer that it is liable for your injury or injuries.** Your acceptance of temporary payments will not prejudice your claim for further benefits. Your employer may request that you enter into an agreement in order to ensure the continuation of payments of temporary compensation. Temporary compensation and prescribed medical payments may continue for up to one year from the date of first payment, or until your employer contests your right to compensation, or until the Board's determination of your claim, whichever is first. Your employer may stop temporary payments at any time provided it sends you a notice of termination of temporary payments within five days after the last payment is made. If your employer stops temporary payments, it will notify you in writing whether or not it is contesting your claim. (Contact the Board immediately if your payments stop and you do not receive a written notice from the employer.) The Board will then notify you of any further action taken in your case. If your employer does not send you a notice of termination of temporary benefits within one year after the start of payments, your employer will be considered to have admitted liability for your claim.

WORKERS' COMPENSATION BOARD

State of New York - Workers' Compensation Board

Subsequent Report of Injury
Report Type (MTC) CB-Change in Benefit Type

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

The Claim Administrator has changed the benefit type from what was previously reported.

Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719 **Date of Injury** 06/11/2021

Claim Administrator Claim Number 73141129-110 **Maintenance Type Code Date** 07/22/2021

Claim Type I - Indemnity for Lost Time **WCB Received Date** 07/22/2021

Agreement to Compensate L - With Liability

INSURER INFORMATION

FEIN xxxxx3200 **Insurer ID** W204002

CLAIM ADMINISTRATOR INFORMATION

Name New York State Insurance Fund **FEIN** xxxxx3200

Claim Representative Name Yogesh Patel **Postal Code** 10007-1100

Business Phone Number 6317564176 **Fax Number**

E-mail Address ypate@nysif.com **Claim Admin ID** W204002

Late Reason

EMPLOYEE INFORMATION

First Name Bayani **Middle Name/Initial**

Last Name Dillard **Suffix**

Date of Birth 11/05/1976

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx9312

CLAIM INFORMATION

Date Employer Had Knowledge of Date of Disability 06/14/2021 **Employment Status**

Work Days Scheduled (S-Scheduled N-Non Scheduled) S M T W T F S **Work Week Type**

Calculated Wage $1,362.31 **Wage Period**

Calculated Weekly Compensation Amount $908.21

Employer Paid Salary Prior To Acquisition

Date Claim Administrator Notified of Employee Representation

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

Employer Paid Salary in Lieu of Compensation

Type of Loss 01 - Traumatic Injury

Date of Maximum Medical Improvement

PERMANENT IMPAIRMENT

Impairment Percentage

Body Part

Number of Dependents 0

Dependent/Payee Relationship

WORK STATUS

First Day of Disability After The Waiting Period

Current Date Last Day Worked

Initial Return to Work Date

Current Date Disability Began

Latest Return to Work Status Date

Return To Work Type

Physical Restrictions

Return To Work Same Employer

BENEFITS

Reduced Benefit Amount R - Reclassification of Benefit

Non-Consecutive Period

Estimated Gross Weekly Amt.

Benefits

Benefit Types

050 - Temporary Total

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross Effective Date	Weekly Gross Amount	Weekly Net Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid
050	06/18/2021	07/26/2021	5	2	06/18/2021	$908.21	06/18/2021	$908.21		$4,904.33

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
350 - Total Payments to Physicians	$591.01	460 - Total Physical Therapy Costs	$635.96

PAYMENTS

Award/Order Date

Recoveries

Recovery Type	Amount

Reduced Earnings

Week Number	Actual Reduced Earnings

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx1781 **Insured FEIN** xxxxx1781

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____

WORKERS' COMPENSATION BOARD

State of New York - Workers' Compensation Board

Subsequent Report of Injury
Report Type (MTC) CB-Change in Benefit Type

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.
The Claim Administrator has changed the benefit type from what was previously reported.

Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719 **Date of Injury** 06/11/2021

Claim Administrator Claim Number 73141129-110 **Maintenance Type Code Date** 09/09/2021

Claim Type I - Indemnity for Lost Time **WCB Received Date** 09/09/2021

Agreement to Compensate L - With Liability

INSURER INFORMATION

FEIN xxxxx3200 **Insurer ID** W204002

CLAIM ADMINISTRATOR INFORMATION

Name New York State Insurance Fund **FEIN** xxxxx3200

Claim Representative Name Yogesh Patel **Postal Code** 10007-1100

Business Phone Number 6317564176 **Fax Number**

E-mail Address ypate@nysif.com **Claim Admin ID** W204002

Late Reason

EMPLOYEE INFORMATION

First Name Bayani **Middle Name/Initial**

Last Name Dillard **Suffix**

Date of Birth 11/05/1976

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx9312

CLAIM INFORMATION

Date Employer Had Knowledge of Date of Disability 06/14/2021 **Employment Status**

Work Days Scheduled (S-Scheduled N-Non Scheduled) S M T W T F S **Work Week Type**

Calculated Wage $1,362.31 **Wage Period**

Calculated Weekly Compensation Amount $908.21

Employer Paid Salary Prior To Acquisition

Date Claim Administrator Notified of Employee Representation

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

Employer Paid Salary in Lieu of Compensation

Type of Loss 01 - Traumatic Injury

Date of Maximum Medical Improvement

PERMANENT IMPAIRMENT

Impairment Percentage

Body Part

Number of Dependents 0

Dependent/Payee Relationship

WORK STATUS

First Day of Disability After The Waiting Period

Current Date Last Day Worked

Initial Return to Work Date

Current Date Disability Began

Latest Return to Work Status Date

Return To Work Type

Physical Restrictions

Return To Work Same Employer

BENEFITS

Reduced Benefit Amount

Non-Consecutive Period

Estimated Gross Weekly Amt.

Benefits

Benefit Types
050 - Temporary Total
070 - Temporary Partial

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross Effective Date	Weekly Gross Amount	Weekly Net Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid
050	06/18/2021	08/23/2021	9	2	06/18/2021	$908.21	06/18/2021	$908.21		$8,537.17
070	08/24/2021	09/07/2021	2	1	08/24/2021	$227.00	08/24/2021	$227.00		$499.40

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
350 - Total Payments to Physicians	$1,171.33	370 - Total Other Medical	$91.55
460 - Total Physical Therapy Costs	$2,951.82		

PAYMENTS

Award/Order Date _____

Recoveries

Recovery Type	Amount

Reduced Earnings

Week Number	Actual Reduced Earnings

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx1781 Insured FEIN xxxxx1781

CONCURRENT EMPLOYER INFORMATION

Name _____ Contact Business Phone _____ Wage _____

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.) 1285121388

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 06/18/2021 06/18/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 6/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z1Z1ZD2

B. Doctor's Information

1. Your name: NAIK (Last) APPASAHED 3 (First / MI) 2. WCB Authorization #: S150818

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

6. Billing Group or Practice Name: NEW YORK MEDICAL & DIAGNOSTIC CENTER

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1992822019

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
06	18	21	06	18	21	11		99204		1	324.69	1		

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 324.69	$ 80.63	$ 244.06

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 6/11/21

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: 1285121388

3. List additional body parts affected by this injury, if any:

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:

5. Based on this examination, does the patient need diagnostic tests or referrals? ☒ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☒ MRI (*specify*): rt knee
- ☐ Labs (*specify*):
- ☒ X-rays (*specify*): rt knee
- ☒ Other (*specify*): dx ultrasoubd r knee

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☒ Physical Therapist
- ☐ Specialist in:
- ☐ Other (*specify*):

***Important:** Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.*

6. Describe treatment rendered today: examination

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☒ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ___ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions:

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☒ The patient cannot return to work because (explain): rt knee injury
   - b. ☐ The patient can return to work without limitations on:
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on:
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain):

   Describe/quantify the limitations:

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☐ I provided the services listed above.

☒ I actively supervised the health-care provider named below who provided these services.

Provider's name Specialty

Board Authorized Health Care Provider signature:

Name Signature Specialty Date 06/24/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 06/18/2021 06/18/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 6/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z1Z1ZD2

B. Doctor's Information

1. Your name: NAIK (Last) APPASAHED 3 (First / MI) 2. WCB Authorization #: S150818

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

6. Billing Group or Practice Name: NEW YORK MEDICAL & DIAGNOSTIC CENTER

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1992822019

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
06	18	21	06	18	21	11		99204		1	324.69	1		

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 324.69	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 11/30/1/5365

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☒ MRI (*specify*): rt knee
- ☐ Labs (*specify*): _____
- ☒ X-rays (*specify*): rt knee
- ☒ Other (*specify*): dx ultrasoubd r knee

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☒ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: examination

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☒ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☒ The patient cannot return to work because (explain): rt knee injury
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting ☐ Lifting ☐ Sitting
     - ☐ Climbing stairs/ladders ☐ Operating heavy equipment ☐ Standing
     - ☐ Environmental conditions ☐ Operation of motor vehicles ☐ Use of public transportation
     - ☐ Kneeling ☐ Personal protective equipment ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☐ I provided the services listed above.

☒ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			06/24/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.) 1285121381

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 06/19/2021 06/19/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) L (MI) 2. Date of injury/illness: 6/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z1Z2ZD2

B. Doctor's Information

1. Your name: NAIK (Last) APPASAHED 3 (First) _____ (MI) 2. WCB Authorization #: S150818

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

6. Billing Group or Practice Name: NEW YORK MEDICAL & DIAGNOSTIC CENTER

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1992822019

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
06	19	21	06	19	21	11		76942	RT		500.00	1		11415
06	19	21	06	19	21	11		20610	RT	1	62.98	1		11415
06	19	21	06	19	21	11		99070	RT	1	11.00	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 573.98	$ 50.38	$ 523.60

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: 12651211301

3. List additional body parts affected by this injury, if any:

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan
- ☐ EMG/NCS
- ☐ MRI (*specify*):
- ☐ Labs (*specify*):
- ☐ X-rays (*specify*):
- ☐ Other (*specify*):

Referrals
- ☐ Chiropractor
- ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in:
- ☐ Other (*specify*):

***Important:** Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.*

6. Describe treatment rendered today: RIGHT KNEE STEROID INJECT/ASPIRATION

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ___ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions:

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☒ The patient cannot return to work because (explain): rt knee injury
   - b. ☐ The patient can return to work without limitations on:
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on:
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain):

   Describe/quantify the limitations:

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☐ I provided the services listed above.

☒ I actively supervised the health-care provider named below who provided these services.

Provider's name: Specialty:

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			06/24/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

11830005140

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 06/19/2021 06/19/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 6/11/21 3. Soc. Sec. #: _____
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 51372Z1Z2ZD2

B. Doctor's Information

1. Your name: NAIK (Last) APPASAHED 3 (First / MI) 2. WCB Authorization #: S150818
3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN
5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)
6. Billing Group or Practice Name: NEW YORK MEDICAL & DIAGNOSTIC CENTER
7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)
8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1992822019

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W
3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
06	19	21	06	19	21	11		76942	RT		500.00	1		11415
06	19	21	06	19	21	11		20610	RT	1	62.98	1		11415
06	19	21	06	19	21	11		99070	RT	1	11.00	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 573.98	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: 1103005140

3. List additional body parts affected by this injury, if any:

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*):
- ☐ Labs (*specify*):
- ☐ X-rays (*specify*):
- ☐ Other (*specify*):

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in:
- ☐ Other (*specify*):

***Important:** Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.*

6. Describe treatment rendered today: RIGHT KNEE STEROID INJECT/ASPIRATION

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ___ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions:

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☒ The patient cannot return to work because (explain): rt knee injury
   - b. ☐ The patient can return to work without limitations on:
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on:
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain):

   Describe/quantify the limitations:

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☐ I provided the services listed above.

☒ I actively supervised the health-care provider named below who provided these services.

Provider's name Specialty

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			06/24/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 06/19/2021 06/19/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 06/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z2Z1ZD2

B. Doctor's Information

1. Your name: Rivera (Last) Jerome (First) _____ (MI) 2. WCB Authorization #: PT043531-3

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

6. Billing Group or Practice Name: NY MEDICAL & DIAGNOSTIC CENTER

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1023670361

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, su
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
06	19	21	06	19	21	11		97162	59	1,2	99.25	1		11415
06	19	21	06	19	21	11		97010		1,2	20.03	1		11415
06	19	21	06	19	21	11		97014		1,2	25.40	1		11415
06	19	21	06	19	21	11		97140		1,2	44.33	1		11415
06	19	21	06	19	21	11		97150		1,2	38.04	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 227.05	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

6/11/21

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 11791367 ~~06/24/2021~~

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☐ The patient cannot return to work because (explain): _____
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Other (explain): _____
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			06/24/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

117913675 8 **C-4.2**

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 06/21/2021 06/21/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 06/11/21 3. Soc. Sec. #: _____
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 51372Z2Z2ZD2

B. Doctor's Information

1. Your name: AZARIO (Last) XIMENA (First) _____ (MI) 2. WCB Authorization #: PT046855-3
3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN
5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)
6. Billing Group or Practice Name: ny medical & diagnostic center
7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)
8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1497349880

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W
3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, su
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
06	21	21	06	21	21	11		97150		1,2	38.04	1		11415
06	21	21	06	21	21	11		97140		1,2	44.33	1		11415
06	21	21	06	21	21	11		97014		1,2	25.40	1		11415
06	21	21	06	21	21	11		97010		1,2	20.03	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.80	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

11791 06/11/21

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: ~~06/24/2021~~

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☐ The patient cannot return to work because (explain): _____
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting ☐ Lifting ☐ Sitting
     - ☐ Climbing stairs/ladders ☐ Operating heavy equipment ☐ Standing
     - ☐ Environmental conditions ☐ Operation of motor vehicles ☐ Use of public transportation
     - ☐ Kneeling ☐ Personal protective equipment ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			06/24/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.) 1285124384

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 06/22/2021 06/22/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) L (MI) 2. Date of injury/illness: 6/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z3Z1ZD2

B. Doctor's Information

1. Your name: Gillman (Last) Martin (First) _____ (MI) 2. WCB Authorization #: C007375-1

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 Kew Gardens Road (Number and Street) Kew Gardens (City) NY (State) 114151154 (Zip Code)

6. Billing Group or Practice Name: NEW YORK MEDICAL & DIAGNOSTIC

7. Billing address: 80-46 Kew Gardens Road (Number and Street) Kew Gardens (City) NY (State) 114151154 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1487640546

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
06	22	21	06	22	21	11		99203		1	75.00	1		

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 75.00	$ 0.00	$ 75.00

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 6/11/21

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: 1285124309

3. List additional body parts affected by this injury, if any:

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*):
- ☐ Labs (*specify*):
- ☐ X-rays (*specify*):
- ☐ Other (*specify*):

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in:
- ☐ Other (*specify*):

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: examination

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ___ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions:

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☒ The patient cannot return to work because (explain):
   - b. ☐ The patient can return to work without limitations on:
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on:
     - ☐ Bending/twisting ☐ Lifting ☐ Sitting
     - ☐ Climbing stairs/ladders ☐ Operating heavy equipment ☐ Standing
     - ☐ Environmental conditions ☐ Operation of motor vehicles ☐ Use of public transportation
     - ☐ Kneeling ☐ Personal protective equipment ☐ Use of upper extremities
     - ☐ Other (explain):

   Describe/quantify the limitations:

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name Specialty

Board Authorized Health Care Provider signature: 06/24/2021

Name Signature Specialty Date

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

1179136756 **C-4.2**

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 06/22/2021 06/22/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 6/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z3Z1ZD2

B. Doctor's Information

1. Your name: Gillman (Last) Martin (First) _____ (MI) 2. WCB Authorization #: C007375-1

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 Kew Gardens Road (Number and Street) Kew Gardens (City) NY (State) 114151154 (Zip Code)

6. Billing Group or Practice Name: NEW YORK MEDICAL & DIAGNOSTIC

7. Billing address: 80-46 Kew Gardens Road (Number and Street) Kew Gardens (City) NY (State) 114151154 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1487640546

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
06	22	21	06	22	21	11		99203		1	75.00	1		

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 75.00	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 11/29/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: examination

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0 100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☒ The patient cannot return to work because (explain): _____
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting ☐ Lifting ☐ Sitting
     - ☐ Climbing stairs/ladders ☐ Operating heavy equipment ☐ Standing
     - ☐ Environmental conditions ☐ Operation of motor vehicles ☐ Use of public transportation
     - ☐ Kneeling ☐ Personal protective equipment ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			06/24/2021

1179136757

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 06/23/2021 06/23/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 06/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z2Z3ZD2

B. Doctor's Information

1. Your name: AZARIO (Last) XIMENA (First) MI 2. WCB Authorization #: PT046855-3

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

6. Billing Group or Practice Name: ny medical & diagnostic center

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1497349880

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, su
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
06	23	21	06	23	21	11		97150		1,2	38.04	1		11415
06	23	21	06	23	21	11		97140		1,2	44.33	1		11415
06	23	21	06	23	21	11		97014		1,2	25.40	1		11415
06	23	21	06	23	21	11		97010		1,2	20.03	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.80	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

11791 06/11/21

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: ~~06/24/2021~~

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

***Important:** Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.*

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☐ The patient cannot return to work because (explain): _____
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting ☐ Lifting ☐ Sitting
     - ☐ Climbing stairs/ladders ☐ Operating heavy equipment ☐ Standing
     - ☐ Environmental conditions ☐ Operation of motor vehicles ☐ Use of public transportation
     - ☐ Kneeling ☐ Personal protective equipment ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			06/24/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

1187051228 **C-4.2**

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 06/25/2021 06/25/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 06/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z2Z4ZD2

B. Doctor's Information

1. Your name: Abuseif (Last) maged (First / MI) 2. WCB Authorization #: PT044000-8

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 Kew Gardens Road (Number and Street) Kew Gardens (City) NY (State) 114151154 (Zip Code)

6. Billing Group or Practice Name: NEW YORK MEDICAL & DIAGNOSTIC CENTER

7. Billing address: 80-46 Kew Gardens Road (Number and Street) Kew Gardens (City) NY (State) 114151154 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1487128898

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, su
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
06	25	21	06	25	21	11		97150		1,2	38.04	1		11415
06	25	21	06	25	21	11		97140		1,2	44.33	1		11415
06	25	21	06	25	21	11		97014		1,2	25.40	1		11415
06	25	21	06	25	21	11		97010		1,2	20.03	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.80	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

6/11/21

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 11875122 ~~06/24/2021~~

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☐ The patient cannot return to work because (explain): _____
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			06/29/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 06/28/2021 06/28/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of Injury/illness: 6/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z1Z3ZD2

B. Doctor's Information

1. Your name: NAIK (Last) APPASAHED 3 (First / MI) 2. WCB Authorization #: S150818

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

6. Billing Group or Practice Name: NEW YORK MEDICAL & DIAGNOSTIC CENTER

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1992822019

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
06	28	21	06	28	21	11		99070		1	495.00	1		11415
06	28	21	06	28	21	11		97535		1	35.42	1		11415
06	28	21	06	28	21	11		99070		1	28.50	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 558.92	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: _____

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☒ The patient cannot return to work because (explain): rt knee injury
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting ☐ Lifting ☐ Sitting
     - ☐ Climbing stairs/ladders ☐ Operating heavy equipment ☐ Standing
     - ☐ Environmental conditions ☐ Operation of motor vehicles ☐ Use of public transportation
     - ☐ Kneeling ☐ Personal protective equipment ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☐ I provided the services listed above.

☒ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name _____ Signature _____ Specialty _____ Date 06/29/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

1187851229

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 06/28/2021 06/28/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 6/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z1Z3ZD2

B. Doctor's Information

1. Your name: NAIK (Last) APPASAHED 3 (First / MI) 2. WCB Authorization #: S150818

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

6. Billing Group or Practice Name: NEW YORK MEDICAL & DIAGNOSTIC CENTER

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1992822019

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W _____

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
06	28	21	06	28	21	11		99070		1	495.00	1		11415
06	28	21	06	28	21	11		97535		1	35.42	1		11415
06	28	21	06	28	21	11		99070		1	28.50	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 558.92	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 06/19/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

***Important:** Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.*

6. Describe treatment rendered today: _____

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☒ The patient cannot return to work because (explain): rt knee injury
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☐ I provided the services listed above.

☒ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			06/29/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

1187051227 **C-4.2**

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 06/28/2021 06/28/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 06/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z2Z5ZD2

B. Doctor's Information

1. Your name: AZARIO (Last) XIMENA (First) _____ (MI) 2. WCB Authorization #: PT046855-3

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

6. Billing Group or Practice Name: ny medical & diagnostic center

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1497349880

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, su
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
06	28	21	06	28	21	11		97150		1,2	38.04	1		11415
06	28	21	06	28	21	11		97140		1,2	44.33	1		11415
06	28	21	06	28	21	11		97124		1,2	25.02	1		11415
06	28	21	06	28	21	11		97010		1,2	20.03	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.42	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

6/11/21

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 06/24/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

***Important:** Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.*

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☐ The patient cannot return to work because (explain): _____
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			06/29/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

118823721

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 06/30/2021 06/30/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 06/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z2Z6ZD2

B. Doctor's Information

1. Your name: AZARIO (Last) XIMENA (First) _____ (MI) 2. WCB Authorization #: PT046855-3

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

6. Billing Group or Practice Name: ny medical & diagnostic center

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1497349880

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W _____

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, su
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
06	30	21	06	30	21	11		97150		1,2	38.04	1		11415
06	30	21	06	30	21	11		97140		1,2	44.33	1		11415
06	30	21	06	30	21	11		97014		1,2	25.40	1		11415
06	30	21	06	30	21	11		97010		1,2	20.03	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.80	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: ~~06/24/2021~~ 6/11/21

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: L18802372 1

3. List additional body parts affected by this injury, if any:

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*):
- ☐ Labs (*specify*):
- ☐ X-rays (*specify*):
- ☐ Other (*specify*):

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in:
- ☐ Other (*specify*):

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions:

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☐ The patient cannot return to work because (explain):
   - b. ☐ The patient can return to work without limitations on:
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on:
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain):

   Describe/quantify the limitations:

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name Specialty

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			07/01/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/02/2021 07/02/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 06/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z2Z7ZD2

B. Doctor's Information

1. Your name: AZARIO (Last) XIMENA (First) _____ (MI) 2. WCB Authorization #: PT046855-3

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

6. Billing Group or Practice Name: ny medical & diagnostic center

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1497349880

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, su
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	02	21	07	02	21	11		97150		1,2	38.04	1		11415
07	02	21	07	02	21	11		97140		1,2	44.33	1		11415
07	02	21	07	02	21	11		97014		1,2	25.40	1		11415
07	02	21	07	02	21	11		97010		1,2	20.03	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.80	$ 41.56	$ 86.24

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

1255603160

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: ~~06/24/2021~~ 6/11/21

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings:

3. List additional body parts affected by this injury, if any:

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*):
- ☐ Labs (*specify*):
- ☐ X-rays (*specify*):
- ☐ Other (*specify*):

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in:
- ☐ Other (*specify*):

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ___ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions:

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☐ The patient cannot return to work because (explain):
   - b. ☐ The patient can return to work without limitations on:
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on:
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain):

   Describe/quantify the limitations:

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name Specialty

Board Authorized Health Care Provider signature: Cenia Osorio 07/06/2021

Name Signature Specialty Date

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

1285121379

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/02/2021 07/02/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 6/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z1Z5ZD2

B. Doctor's Information

1. Your name: NAIK (Last) APPASAHED 3 (First / MI) 2. WCB Authorization #: S150818

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

6. Billing Group or Practice Name: NEW YORK MEDICAL & DIAGNOSTIC CENTER

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1992822019

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	02	21	07	02	21	11		99214		1	127.41	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.41	$ 75.00	$ 52.41

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: 1285171379

3. List additional body parts affected by this injury, if any:

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan
- ☐ EMG/NCS
- ☐ MRI (*specify*):
- ☐ Labs (*specify*):
- ☐ X-rays (*specify*):
- ☐ Other (*specify*):

Referrals
- ☐ Chiropractor
- ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☒ Physical Therapist
- ☐ Specialist in:
- ☐ Other (*specify*):

***Important:** Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.*

6. Describe treatment rendered today: examination

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☒ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ___ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions:

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☒ The patient cannot return to work because (explain): rt knee injury
   - b. ☐ The patient can return to work without limitations on:
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on:
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain):

   Describe/quantify the limitations:

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☐ I provided the services listed above.

☒ I actively supervised the health-care provider named below who provided these services.

Provider's name: Specialty:

Board Authorized Health Care Provider signature: 07/08/2021

Name / Signature / Specialty / Date

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/02/2021 07/02/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) L (MI) 2. Date of injury/illness: 6/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z1Z4ZD2

B. Doctor's Information

1. Your name: NAIK (Last) APPASAHED 3 (First) (MI) 2. WCB Authorization #: S150818

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

6. Billing Group or Practice Name: NEW YORK MEDICAL & DIAGNOSTIC CENTER

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1992822019

C. Billing Information

1. Employer's Insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	02	21	07	02	21	11		99070		1	342.00	12		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 342.00	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: _____

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☒ The patient cannot return to work because (explain): rt knee injury
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Other (explain): _____
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☐ I provided the services listed above.

☒ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			07/08/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

119401966?

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/02/2021 07/02/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 6/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z1Z4ZD2

B. Doctor's Information

1. Your name: NAIK (Last) APPASAHED 3 (First) (MI) 2. WCB Authorization #: S150818

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

6. Billing Group or Practice Name: NEW YORK MEDICAL & DIAGNOSTIC CENTER

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1992822019

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	02	21	07	02	21	11		99070		1	342.00	12		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 342.00	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: 1194019662

3. List additional body parts affected by this injury, if any:

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*):
- ☐ Labs (*specify*):
- ☐ X-rays (*specify*):
- ☐ Other (*specify*):

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in:
- ☐ Other (*specify*):

***Important:** Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.*

6. Describe treatment rendered today:

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ___ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions:

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☒ The patient cannot return to work because (explain): rt knee injury
   - b. ☐ The patient can return to work without limitations on:
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on:
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain):

   Describe/quantify the limitations:

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☐ I provided the services listed above.

☒ I actively supervised the health-care provider named below who provided these services.

Provider's name Specialty

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			07/08/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/02/2021 07/02/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 6/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z1Z5ZD2

B. Doctor's Information

1. Your name: NAIK (Last) APPASAHED 3 (First) (MI) 2. WCB Authorization #: S150818

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

6. Billing Group or Practice Name: NEW YORK MEDICAL & DIAGNOSTIC CENTER

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1992822019

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	02	21	07	02	21	11		99214		1	127.41	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.41	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☒ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: examination

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☒ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☒ The patient cannot return to work because (explain): rt knee injury
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☐ I provided the services listed above.

☒ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			07/08/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/07/2021 07/07/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 06/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z2Z9ZD2

B. Doctor's Information

1. Your name: AZARIO (Last) XIMENA (First) _____ (MI) 2. WCB Authorization #: PT046855-3

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

6. Billing Group or Practice Name: ny medical & diagnostic center

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1497349880

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, su
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	07	21	07	07	21	11		97110		1,2	37.91	1		11415
07	07	21	07	07	21	11		97140		1,2	44.33	1		11415
07	07	21	07	07	21	11		97014		1,2	25.40	1		11415
07	07	21	07	07	21	11		97010		1,2	20.03	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.67	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

6/11/21

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: ~~06/24/2021~~

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

***Important:** Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.*

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☐ The patient cannot return to work because (explain): _____
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			07/08/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

11931101 C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/02/2021 07/02/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 06/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z2Z7ZD2

B. Doctor's Information

1. Your name: AZARIO (Last) XIMENA (First) _____ (MI) 2. WCB Authorization #: PT046855-3

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

6. Billing Group or Practice Name: ny medical & diagnostic center

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1497349880

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12208 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, su
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	02	21	07	02	21	11		97150		1,2	38.04	1		11415
07	02	21	07	02	21	11		97140		1,2	44.33	1		11415
07	02	21	07	02	21	11		97014		1,2	25.40	1		11415
07	02	21	07	02	21	11		97010		1,2	20.03	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.80	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 6/11/21

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

***Important:** Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.*

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ___ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☐ The patient cannot return to work because (explain): _____
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			07/06/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

11931181 C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/05/2021 07/05/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 06/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z2Z8ZD2

B. Doctor's Information

1. Your name: MANOSAN (Last) PRUETTIYAPA (First) (MI) 2. WCB Authorization #: PT044217-8

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

6. Billing Group or Practice Name: NY MEDICAL & DIAGNOSTIC CENTER

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1396309910

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, su
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	05	21	07	05	21	11		97150		1,2	38.04	1		11415
07	05	21	07	05	21	11		97140		1,2	44.33	1		11415
07	05	21	07	05	21	11		97014		1,2	25.40	1		11415
07	05	21	07	05	21	11		97010		1,2	20.03	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.80	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 6/11/21 ~~06/24/2021~~

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☐ The patient cannot return to work because (explain): _____
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			07/06/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/09/2021 07/09/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 06/11/21 3. Soc. Sec. #: _____
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 51372Z2Z10ZD2

B. Doctor's Information

1. Your name: AZARIO (Last) XIMENA (First) _____ (MI) 2. WCB Authorization #: PT046855-3
3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN
5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)
6. Billing Group or Practice Name: ny medical & diagnostic center
7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)
8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1497349880

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W
3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, su
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	09	21	07	09	21	11		97150		1,2	38.04	1		11415
07	09	21	07	09	21	11		97140		1,2	44.33	1		11415
07	09	21	07	09	21	11		97014		1,2	25.40	1		11415
07	09	21	07	09	21	11		97010		1,2	20.03	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.80	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

6/11/21

Patient's Name: Dillard Bayani L (Last, First, MI) Date of injury/onset of illness: ~~06/24/2021~~

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: 1200107540

3. List additional body parts affected by this injury, if any:

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*):
- ☐ Labs (*specify*):
- ☐ X-rays (*specify*):
- ☐ Other (*specify*):

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in:
- ☐ Other (*specify*):

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ___ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions:

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☐ The patient cannot return to work because (explain):
   - b. ☐ The patient can return to work without limitations on:
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on:
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain):

   Describe/quantify the limitations:

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name Specialty

Board Authorized Health Care Provider signature:

07/13/2021

Name Signature Specialty Date

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier, and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/12/2021 07/12/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 06/11/21 3. Soc. Sec. #: _____
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 51372Z2Z11ZD2

B. Doctor's Information

1. Your name: AZARIO (Last) XIMENA (First) _____ (MI) 2. WCB Authorization #: PT046855-3
3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN
5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)
6. Billing Group or Practice Name: ny medical & diagnostic center
7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)
8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1497349880

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W_____
3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, su
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	12	21	07	12	21	11		97150		1,2	38.04	1		11415
07	12	21	07	12	21	11		97140		1,2	44.33	1		11415
07	12	21	07	12	21	11		97014		1,2	25.40	1		11415
07	12	21	07	12	21	11		97010		1,2	20.03	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.80	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: ~~06/24/2021~~ 6/11/21

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: 1200187539

3. List additional body parts affected by this injury, if any:

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*):
- ☐ Labs (*specify*):
- ☐ X-rays (*specify*):
- ☐ Other (*specify*):

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in:
- ☐ Other (*specify*):

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions:

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☐ The patient cannot return to work because (explain):
   - b. ☐ The patient can return to work without limitations on:
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on:
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain):

   Describe/quantify the limitations:

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			07/13/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report 708125515 C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/14/2021 07/14/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 06/11/21 3. Soc. Sec. #: _____
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 51372Z2Z12ZD2

B. Doctor's Information

1. Your name: AZARIO (Last) XIMENA (First) _____ (MI) 2. WCB Authorization #: PT046855-3
3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN
5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)
6. Billing Group or Practice Name: ny medical & diagnostic center
7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)
8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1497349880

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W
3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, su
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	14	21	07	14	21	11		97140		1,2	44.33	1		11415
07	14	21	07	14	21	11		97150		1,2	38.04	1		11415
07	14	21	07	14	21	11		97014		1,2	25.40	1		11415
07	14	21	07	14	21	11		97010		1,2	20.03	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.80	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

6/11/21

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: ~~06/24/2021~~ 1206125319

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☐ The patient cannot return to work because (explain): _____
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting ☐ Lifting ☐ Sitting
     - ☐ Climbing stairs/ladders ☐ Operating heavy equipment ☐ Standing
     - ☐ Environmental conditions ☐ Operation of motor vehicles ☐ Use of public transportation
     - ☐ Kneeling ☐ Personal protective equipment ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

07/20/2021

Name | Signature | Specialty | Date

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/16/2021 07/16/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 06/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z2Z13ZD2

B. Doctor's Information

1. Your name: Rivera (Last) Jerome (First) (MI) 2. WCB Authorization #: PT043531-3

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

6. Billing Group or Practice Name: NY MEDICAL & DIAGNOSTIC CENTER

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1023670361

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, su
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	16	21	07	16	21	11		97110		1,2	37.91	1		11415
07	16	21	07	16	21	11		97140		1,2	44.33	1		11415
07	16	21	07	16	21	11		97014		1,2	25.40	1		11415
07	16	21	07	16	21	11		97010		1,2	20.03	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.67	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: ~~08/24/2021~~ 12/06/25516

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☐ The patient cannot return to work because (explain): _____
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting ☐ Lifting ☐ Sitting
     - ☐ Climbing stairs/ladders ☐ Operating heavy equipment ☐ Standing
     - ☐ Environmental conditions ☐ Operation of motor vehicles ☐ Use of public transportation
     - ☐ Kneeling ☐ Personal protective equipment ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

07/20/2021

Name | Signature | Specialty | Date

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report 20812551 C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/19/2021 07/19/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 06/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z2Z14ZD2

B. Doctor's Information

1. Your name: AZARIO (Last) XIMENA (First) (MI) 2. WCB Authorization #: PT046855-3

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

6. Billing Group or Practice Name: ny medical & diagnostic center

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1497349880

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 88899 (Number and Street) Albany (City) NY (State) 12200 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, su
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	19	21	07	19	21	11		97110		1,2	37.91	1		11415
07	19	21	07	19	21	11		97140		1,2	44.33	1		11415
07	19	21	07	19	21	11		97014		1,2	25.40	1		11415
07	19	21	07	19	21	11		97010		1,2	20.03	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.67	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

6/11/21

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: ~~06/24/2021~~ 12/06/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☐ The patient cannot return to work because (explain): _____
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			07/20/2021

1347001436

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/21/2021 07/21/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of Injury/Illness: 6/11/21 3. Soc. Sec. #: _____
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 51372Z1Z7ZD2

B. Doctor's Information

1. Your name: NAIK (Last) APPASAHED (First) _____ (MI) 2. WCB Authorization #: S150818
3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN
5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)
6. Billing Group or Practice Name: NEW YORK MEDICAL & DIAGNOSTIC CENTER
7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)
8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1992822019

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W_____
3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	21	21	07	21	21	11		99214		1,2	127.41	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.41	$ 0.00	$ 127.41

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

1347061422

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☒ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

***Important:** Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.*

6. Describe treatment rendered today: examination

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☒ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☒ The patient cannot return to work because (explain): rt knee injury
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting ☐ Lifting ☐ Sitting
     - ☐ Climbing stairs/ladders ☐ Operating heavy equipment ☐ Standing
     - ☐ Environmental conditions ☐ Operation of motor vehicles ☐ Use of public transportation
     - ☐ Kneeling ☐ Personal protective equipment ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			08/03/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/21/2021 07/21/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 6/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z1Z7ZD2

B. Doctor's Information

1. Your name: NAIK (Last) APPASAHED (First) _____ (MI) 2. WCB Authorization #: S150818

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

6. Billing Group or Practice Name: NEW YORK MEDICAL & DIAGNOSTIC CENTER

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1992822019

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(3)		
(4)		

* Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	21	21	07	21	21	11		99214		1,2	127.41	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO)

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.41	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☒ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

***Important:** Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.*

6. Describe treatment rendered today: examination

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☒ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☒ The patient cannot return to work because (explain): rt knee injury
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting ☐ Lifting ☐ Sitting
     - ☐ Climbing stairs/ladders ☐ Operating heavy equipment ☐ Standing
     - ☐ Environmental conditions ☐ Operation of motor vehicles ☐ Use of public transportation
     - ☐ Kneeling ☐ Personal protective equipment ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			08/03/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

122105687

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/21/2021 07/21/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 6/11/21 3. Soc. Sec. #: _____
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 51372Z1Z7ZD2

B. Doctor's Information

1. Your name: NAIK (Last) APPASAHED (First) _____ (MI) 2. WCB Authorization #: S150818
3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN
5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)
6. Billing Group or Practice Name: NEW YORK MEDICAL & DIAGNOSTIC CENTER
7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)
8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1992822019

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W
3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	21	21	07	21	21	11		99214		1,2	127.41	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.41	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: 122103 5507

3. List additional body parts affected by this injury, if any:

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*):
- ☐ Labs (*specify*):
- ☐ X-rays (*specify*):
- ☐ Other (*specify*):

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☒ Physical Therapist
- ☐ Specialist in:
- ☐ Other (*specify*):

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: examination

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☒ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ___ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions:

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☒ The patient cannot return to work because (explain): rt knee injury
   - b. ☐ The patient can return to work without limitations on:
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on:
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain):

   Describe/quantify the limitations:

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name / Signature / Specialty / Date: 08/03/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

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Date(s) of Examination: 07/21/2021 07/21/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 06/11/21 3. Soc. Sec. #: _____
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 51372Z2Z15ZD2

B. Doctor's Information

1. Your name: AZARIO (Last) XIMENA (First) _____ (MI) 2. WCB Authorization #: PT046855-3
3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN
5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)
6. Billing Group or Practice Name: ny medical & diagnostic center
7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)
8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1497349880

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W
3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, su
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	21	21	07	21	21	11		97140		1,2	44.33	1		11415
07	21	21	07	21	21	11		97110		1,2	37.91	1		11415
07	21	21	07	21	21	11		97014		1,2	25.40	1		11415
07	21	21	07	21	21	11		97010		1,2	20.03	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.67	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

6/11/21
12185795

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 06/24/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☐ The patient cannot return to work because (explain): _____
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			07/22/2021

NEW YORK STATE | Workers' Compensation Board

ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE AND INSURER'S RESPONSE

MG-2

For additional variance requests in this case, attach Form MG-2.1.
Answer all questions where information is known.

G3051719

Granted In Part

WCB Case #:	Claim Administrator Claim (carrier case) #: 73141129	Date of Injury/Illness: 06/24/2021

A. Patient's Name: Bayani L Dillard (First / MI / Last) Social Security No.:

Patient's Address: 52 Charles Street Malverne, NY 11565

Employer's Name & Address: JAMAICA HOSPITAL MEDICAL 89DR/AN WYCK EXPY JAMAICA NY 11418

Insurer's Name & Address: NYSIF Po Box 66699 Albany NY 12206

B. Attending Doctor's Name & Address: Appasaheb Naik 80-46 KEW GARDENS RD KEW GARDENS, NY 11415

Individual Provider's WCB Authorization No.: 1 5 0 8 1 8 - 3 W NPI No.: 1023670361

Telephone No.: 718-261-1000 Fax No.: 718261-0336

C. *The undersigned requests approval to VARY from the WCB Medical Treatment Guidelines as indicated below:*

Guideline Reference: K - E 7 E [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE)*

Approval Requested for: (one request type per form)

Therapeutic excercise for the right knee 3 times a week for 8 weeks

STATEMENT OF MEDICAL NECESSITY - See item 5 on instruction page.

Your explanation must provide the following information:
- the basis for your opinion that the medical care you propose is appropriate for the patient and is medically necessary at this time; and
- an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:
- a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment; and
- the specific duration or frequency of treatment for which a variance is requested.

Variance requests for treatment or testing that is not recommended or not addressed, must include:
- the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
- medical evidence in support of efficacy of the proposed treatment or testing- may include relevant medical literature published in recognized peer reviewed journals.

Date of service of supporting medical in WCB case file, if not attached: 07/19/2021

Date(s) of previously denied variance request for substantially similar treatment, if applicable:

Provider must enter in A the designated fax or email address this request was sent to. Insurer/self-insurer's designated contact information is available online at: wcb.ny.gov/medical-treatment-guideline-variance-request. Check "Designated contact information not available", if appropriate. If the request was sent to a different (contact information is not available on Board's website) or additional fax or email address provided by the insurer, complete B. If you are unable to send or receive email or fax, complete C.

A. *Insurer's designated fax # or email address as provided on the Board's website:* 212-587-7540 nysif-mg2-c4auth@nysif.com

☐ ***Designated contact information not available.***

B. *If the request was also submitted to another fax # or email address provided by the insurer, provide here:*

C. *I am not equipped to send or receive forms by fax or email. This form was mailed (return receipt requested) on:*

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Guidelines. I certify that the patient understands and agrees to undergo the proposed medical care. I ☐ did / ☒ did not contact the insurer by telephone to discuss this variance request before making the request. I contacted the insurer by telephone on (date) _____ and spoke to (person spoke to or was not able to speak to anyone) _____

I sent or directed my office to send a copy of this request to the insurer, the Chair, the patient and the patient's legal representative, if any, on the same day, and sent or directed my office to send a copy to the Workers' Compensation Board within two (2) business days of the date below. In addition, I certify that I do not have a substantially similar request pending and that this request contains additional supporting medical evidence if it is substantially similar to a prior denied request.

Provider's Signature: [signature] Date: 7/21/2021

MG-2.0 4-18

Patient Name: Bayani L Dillard	WCB Case #:	Date of Injury/Illness: 06/24/2021

D. INSURER'S / EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW

☐ The self-insurer/insurer hereby gives notice that it will have the patient examined by an Independent Medical Examiner or the claimant's medical records reviewed by a Records Reviewer and submit Form IME-4 within 30 calendar days of the variance request.

By: (print name) _____ Title: _____

Signature: _____ Date: _____

E. INSURER'S / EMPLOYER'S RESPONSE TO VARIANCE REQUEST

Insurer's response to the variance request is indicated in the checkboxes on the right. Insurer denial, when appropriate, should be reviewed by a health professional. (Attach written report of medical professional.) If request is approved or denied, sign and date the form in Section E.

Physical Therapy to Right Knee 3 times a week for 6 weeks - Granted

INSURER'S / EMPLOYER'S RESPONSE
If service is denied or granted in part, explain in space provided.

☐ Granted
☒ Granted in Part
☐ Without Prejudice

☐ Denied
☐ Burden of Proof Not Met
☐ Substantially Similar Request Pending or Denied

Name of the Medical Professional who reviewed the denial, if applicable: _____

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal representative, if any, and any other parties of interest, with the written report of the medical professional in the office of the insurer/employer/self-insured employer/Special Fund attached, within two (2) business days of the date below.

(Please complete if request is denied.) If the issue cannot be resolved informally, I opt for the decision to be made by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the patient, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB Hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

By: (print name) Y. Patel Title: CSRI

Signature: ypatel Date: 07/27/21

F. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND INSURER / EMPLOYER

I certify that the provider's variance request initially denied above is now granted or partially granted.

By: (print name) _____ Title: _____

Insurer's Signature: _____ Date: _____

G. CLAIMANT'S / CLAIMANT REPRESENTATIVE'S REQUEST FOR REVIEW OF INSURER'S / EMPLOYER'S DENIAL

NOTE to Claimant's / Claimant Licensed Representative's: The claimant should only sign this section after the request is fully or partially denied. This section should not be completed at the time of initial request.

YOU MUST COMPLETE THIS SECTION IF YOU WANT THE BOARD TO REVIEW THE INSURER'S DENIAL OF THE PROVIDER'S VARIANCE REQUEST.

☐ I request that the Workers' Compensation Board review the insurer's denial of my doctor's request for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

Claimant's / Claimant Representative's Signature: _____ Date: 07/21/2021

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

NYS Workers' Compensation Board
PO Box 5205
Binghamton, NY 13902-5205

Email Filing: wcbclaimsfiling@wcb.ny.gov • Customer Service: (877) 632-4996 • Statewide Fax: (877) 533-0337

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CONTINUATION TO FORM MG-2, ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE MG-2.1

WCB Case #:	Claim Administrator Claim (Carrier Case) #: 73141129	Date of Injury/Illness: 06/24/2021

Patient's Name: Bayani L Dillard Social Security No.:

Doctor's Name: Appasaheb Naik WCB Authorization No.: 150818-3W NPI No.: 1992822019

INSTRUCTIONS TO ATTENDING DOCTOR: **This form must be filed attached to completed Form MG-2** if requesting approval for additional variance(s) in the same case. Supporting medical must be attached or identified for each request.

A. *The undersigned requests additional approval(s) to VARY from the WCB Medical Treatment Guidelines as indicated below:*

2. Guideline Reference: [K] - [E] [8] [L] [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: _____ Date(s) of previously denied variance request: _____

Approval Requested for: Soft tissue mobilization for the right knee 3 times a week for 8 weeks

Medical Necessity:

3. Guideline Reference: [K] - [E] [8] [K] [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: _____ Date(s) of previously denied variance request: _____

Approval Requested for: Joint manipulation for the right knee 3 times a week for 8 weeks

Medical Necessity:

4. Guideline Reference: [K] - [E] [8] [K] [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: _____ Date(s) of previously denied variance request: _____

Approval Requested for: Ultrasound for the right knee 3 times a week for 8 weeks

Medical Necessity:

5. Guideline Reference: [K] - [E] [8] [C] [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: _____ Date(s) of previously denied variance request: _____

Approval Requested for: Electrical stimulation for the right knee 3 times a week for 8 weeks

Medical Necessity:

STATEMENT OF MEDICAL NECESSITY - See requirements on Form MG-2.

Your explanation must provide the following information:
- the basis for your opinion that the medical care you propose is appropriate for the claimant and is medically necessary at this time; and
- an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:
- a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment; and
- the specific duration or frequency of treatment for which a variance is requested.

Variance requests for treatment or testing that is not recommended or not addressed, must include:
- the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
- medical evidence in support of efficacy of the proposed treatment or testing- may include relevant medical literature published in recognized peer reviewed journals.

Patient Name: Bayani L Dillard	WCB Case Number:	Date of Injury: 06/24/2021

HEALTH PROVIDER'S CERTIFICATION

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Medical Treatment Guidelines. I certify that the claimant understands and agrees to undergo the proposed medical care.

A copy was sent (see address on instruction page) to the Workers' Compensation Board, and copies were provided to the claimant's legal representative, if any, to the claimant if not represented, and to any other parties of interest within two (2) business days of the date below.

In addition, I certify that I do not have a substantially similar request pending and that this request contains additional supporting medical evidence if it is substantially similar to a prior denied request.

Provider's Signature: _____ Date: 7/21/21

B. INSURER'S/EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW

☐ The insurer/employer hereby gives notice that it will have the claimant examined by an Independent Medical Examiner and submit Form IME-4 within 30 calendar days of the Variance Request, with respect to: ☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5

By: (print name): _____ Title: _____

Signature: _____ Date: _____

C. INSURER'S/EMPLOYER'S RESPONSE TO ADDITIONAL VARIANCE REQUEST(S)

Insurer's response to the variance request is indicated in the checkboxes below. If any additional request(s) are denied, give reason(s) for denial or partial granted below. Identify reasons by Request No. 2-5. (Attach written report of medical professional for each denial as explained on Form MG-2.)

Request No. 2: ☐ Granted ☒ Granted in Part ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied
☐ Without Prejudice

Request No. 3: ☐ Granted ☒ Granted in Part ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied
☐ Without Prejudice

Request No. 4: ☐ Granted ☒ Granted in Part ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied
☐ Without Prejudice

Request No. 5: ☐ Granted ☒ Granted in Part ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied
☐ Without Prejudice

Physical Therapy to Right Knee 3 times a week for 6 weeks - Granted

Name of the Medical Professional who reviewed the denial, if appropriate: _____

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal representative, if any, and any other parties of interest, with the written report of the medical professional in the office of the insurer/employer/self-insured employer/Special Fund attached, within two (2) business days of the date below.

(Please complete if request is denied.) If the issue cannot be resolved informally, I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

By: (print name): Y. Patel Title: CSRI

Signature: y.patel Date: 07/27/21

D. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND CARRIER

I certify that the provider's variance request initially denied above is now granted or partially granted for the following requests:

☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5

By: (print name): _____ Title: _____

Signature: _____ Date: _____

E. CLAIMANT'S/CLAIMANT'S REPRESENTATIVE REQUEST FOR REVIEW OF SELF-INSURED EMPLOYER'S/INSURER'S DENIAL

NOTE to Claimant/Claimant's Attorney or Licensed Representative: The claimant should only sign this section after the request is denied. This section should not be completed at the time of initial request.

☐ I request that the Workers' Compensation Board review the insurer's denial of my doctor's ☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5 for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

Claimant's / Claimant Representative's Signature: _____ Date: _____

CONTINUATION TO FORM MG-2, ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE

MG-2.1

WCB Case #:	Claim Administrator Claim (Carrier Case) #: 73141129	Date of Injury/Illness: 08/24/2021

Patient's Name: Bayani L Dillard Social Security No.:

Doctor's Name: Appasaheb Naik WCB Authorization No.: 150618-3W NPI No.: 1992822019

INSTRUCTIONS TO ATTENDING DOCTOR: **This form must be filed attached to completed Form MG-2** if requesting approval for additional variance(s) in the same case. Supporting medical must be attached or identified for each request.

A. *The undersigned requests additional approval(s) to VARY from the WCB Medical Treatment Guidelines as indicated below:*

2. Guideline Reference: [K] - [E] [Y] [A] [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: _____ Date(s) of previously denied variance request: _____

Approval Requested for: Activities of the right knee 3 times a week for 8 weeks

Medical Necessity:

3. Guideline Reference: [K] - [E] [Y] [C] [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: _____ Date(s) of previously denied variance request: _____

Approval Requested for: Gait trainning for the right knee 3 times a week for 8 weeks

Medical Necessity:

4. Guideline Reference: [N] - [O] [N] [E] [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: _____ Date(s) of previously denied variance request: _____

Approval Requested for:

Medical Necessity:

5. Guideline Reference: [N] - [O] [N] [E] [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: _____ Date(s) of previously denied variance request: _____

Approval Requested for:

Medical Necessity:

STATEMENT OF MEDICAL NECESSITY - See requirements on Form MG-2.

Your explanation must provide the following information:
- the basis for your opinion that the medical care you propose is appropriate for the claimant and is medically necessary at this time; and
- an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:
- a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment; and
- the specific duration or frequency of treatment for which a variance is requested.

Variance requests for treatment or testing that is not recommended or not addressed, must include:
- the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
- medical evidence in support of efficacy of the proposed treatment or testing- may include relevant medical literature published in recognized peer reviewed journals.

Patient Name: Bayani L Dillard	WCB Case Number:	Date of Injury: 08/24/2021

HEALTH PROVIDER'S CERTIFICATION

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Medical Treatment Guidelines. I certify that the claimant understands and agrees to undergo the proposed medical care.

A copy was sent (see address on instruction page) to the Workers' Compensation Board, and copies were provided to the claimant's legal representative, if any, to the claimant if not represented, and to any other parties of interest within two (2) business days of the date below.

In addition, I certify that I do not have a substantially similar request pending and that this request contains additional supporting medical evidence if it is substantially similar to a prior denied request.

Provider's Signature: _____ Date: 07/21/2021

B. INSURER'S/EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW

☐ The insurer/employer hereby gives notice that it will have the claimant examined by an Independent Medical Examiner and submit Form IME-4 within 30 calendar days of the Variance Request, with respect to: ☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5

By: (print name): _____ Title: _____

Signature: _____ Date: _____

C. INSURER'S/EMPLOYER'S RESPONSE TO ADDITIONAL VARIANCE REQUEST(S)

Insurer's response to the variance request is indicated in the checkboxes below. If any additional request(s) are denied, give reason(s) for denial or partial granted below. Identify reasons by Request No. 2-5. (Attach written report of medical professional for each denial as explained on Form MG-2.)

Request No. 2: ☐ Granted ☒ Granted in Part ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied
☐ Without Prejudice

Request No. 3: ☐ Granted ☒ Granted in Part ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied
☐ Without Prejudice

Request No. 4: ☐ Granted ☐ Granted in Part ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied
☐ Without Prejudice

Request No. 5: ☐ Granted ☐ Granted in Part ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied
☐ Without Prejudice

Physical Therapy to Right Knee 3 times a week for 6 weeks - Granted

Name of the Medical Professional who reviewed the denial, if appropriate: _____

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal representative, if any, and any other parties of interest, with the written report of the medical professional in the office of the insurer/employer/self-insured employer/Special Fund attached, within two (2) business days of the date below.

(Please complete if request is denied.) If the issue cannot be resolved informally, I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

By: (print name): Y. Patel Title: CSRI

Signature: ypatel Date: 07/27/21

D. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND CARRIER

I certify that the provider's variance request initially denied above is now granted or partially granted for the following requests:

☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5

By: (print name): _____ Title: _____

Signature: _____ Date: _____

E. CLAIMANT'S/CLAIMANT'S REPRESENTATIVE REQUEST FOR REVIEW OF SELF-INSURED EMPLOYER'S/INSURER'S DENIAL

NOTE to Claimant/Claimant's Attorney or Licensed Representative: The claimant should only sign this section after the request is denied. This section should not be completed at the time of initial request.

☐ I request that the Workers' Compensation Board review the insurer's denial of my doctor's ☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5 for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

Claimant's / Claimant Representative's Signature: _____ Date: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

NEW YORK STATE | Workers' Compensation Board

ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE AND INSURER'S RESPONSE

MG-2

For additional variance requests in this case, attach Form MG-2.1.
Answer all questions where information is known.

WCB Case #	Claim Administrator Claim (carrier case) #: 73141129	Date of Injury/Illness: 06/24/2021

A. Patient's Name: Bayani L Dillard (First / MI / Last) Social Security No.:

Patient's Address: 52 Charles Street Malverne, NY 11565

Employer's Name & Address: JAMAICA HOSPITAL MEDICA89DUVAN WYCK EXPY JAMAICA NY 11418

Insurer's Name & Address: NYSIF Po Box 66699 Albany NY 12206

B. Attending Doctor's Name & Address: Appasaheb Naik 80-46 KEW GARDENS RD KEW GARDENS, NY 11415

Individual Provider's WCB Authorization No.: 1 5 0 8 1 8 . 3 W NPI No.: 1023670361

Telephone No.: 718-261-1000 Fax No.: 718261-0336

C. *The undersigned requests approval to VARY from the WCB Medical Treatment Guidelines as indicated below:*

Guideline Reference: K - E 7 E *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE)*

Approval Requested for: (one request type per form)

Therapeutic excercise for the right knee 3 times a week for 8 weeks

STATEMENT OF MEDICAL NECESSITY - See item 5 on instruction page.

Your explanation must provide the following information:
- the basis for your opinion that the medical care you propose is appropriate for the patient and is medically necessary at this time; and
- an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:
- a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment; and
- the specific duration or frequency of treatment for which a variance is requested.

Variance requests for treatment or testing that is not recommended or not addressed, must include:
- the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
- medical evidence in support of efficacy of the proposed treatment or testing- may include relevant medical literature published in recognized peer reviewed journals.

Date of service of supporting medical in WCB case file, if not attached: 07/19/2021

Date(s) of previously denied variance request for substantially similar treatment, if applicable:

Provider must enter in A the designated fax or email address this request was sent to. Insurer/self-insurer's designated contact information is available online at: wcb.ny.gov/medical-treatment guideline-variance-request. Check "Designated contact information not available", if appropriate. If the request was sent to a different (contact information is not available on Board's website) or additional fax or email address provided by the insurer, complete B. If you are unable to send or receive email or fax, complete C.

A. *Insurer's designated fax # or email address as provided on the Board's website:* 212-587-7540 nysif-mg2-c4auth@nysif.com

☐ ***Designated contact information not available.***

B. *If the request was also submitted to another fax # or email address provided by the insurer, provide here:*

C. *I am not equipped to send or receive forms by fax or email. This form was mailed (return receipt requested) on:*

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Guidelines. I certify that the patient understands and agrees to undergo the proposed medical care. I ☐ did / ☒ did not contact the insurer by telephone to discuss this variance request before making the request. I contacted the insurer by telephone on (date) _____ and spoke to (person spoke to or was not able to speak to anyone) _____

I sent or directed my office to send a copy of this request to the insurer, the Chair, the patient and the patient's legal representative, if any, on the same day, and sent or directed my office to send a copy to the Workers' Compensation Board within two (2) business days of the date below. In addition, I certify that I do not have a substantially similar request pending and that this request contains additional supporting medical evidence if it is substantially similar to a prior denied request.

Provider's Signature: _____ Date: 7/21/2021

Patient Name: Bayani L Dillard	WCB Case #:	Date of Injury/Illness: 06/24/2021

D. INSURER'S / EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW

☐ The self-insurer/insurer hereby gives notice that it will have the patient examined by an Independent Medical Examiner or the claimant's medical records reviewed by a Records Reviewer and submit Form IME-4 within 30 calendar days of the variance request.

By: (print name) _____ Title: _____

Signature: _____ Date: _____

E. INSURER'S / EMPLOYER'S RESPONSE TO VARIANCE REQUEST

Insurer's response to the variance request is indicated in the checkboxes on the right. Insurer denial, when appropriate, should be reviewed by a health professional. (Attach written report of medical professional.) If request is approved or denied, sign and date the form in Section E.

INSURER'S / EMPLOYER'S RESPONSE
If service is denied or granted in part, explain in space provided.

☐ Granted
☐ Granted in Part ☐ Without Prejudice
☐ Denied
☐ Burden of Proof Not Met
☐ Substantially Similar Request Pending or Denied

Name of the Medical Professional who reviewed the denial, if applicable: _____

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal representative, if any, and any other parties of interest, with the written report of the medical professional in the office of the insurer/employer/self-insured employer/Special Fund attached, within two (2) business days of the date below.

(Please complete if request is denied.) If the issue cannot be resolved informally, I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the patient, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB Hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

By: (print name) _____ Title: _____

Signature: _____ Date: _____

F. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND INSURER / EMPLOYER

I certify that the provider's variance request initially denied above is now granted or partially granted.

By: (print name) _____ Title _____

Insurer's Signature: _____ Date: _____

G. CLAIMANT'S / CLAIMANT REPRESENTATIVE'S REQUEST FOR REVIEW OF INSURER'S / EMPLOYER'S DENIAL

NOTE to Claimant's / Claimant Licensed Representative's: The claimant should only sign this section after the request is fully or partially denied. This section should not be completed at the time of initial request.

YOU MUST COMPLETE THIS SECTION IF YOU WANT THE BOARD TO REVIEW THE INSURER'S DENIAL OF THE PROVIDER'S VARIANCE REQUEST.

☐ I request that the Workers' Compensation Board review the insurer's denial of my doctor's request for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

Claimant's / Claimant Representative's Signature: _____ Date: 07/21/2021

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

NYS Workers' Compensation Board
PO Box 5205
Binghamton, NY 13902-52055

Email Filing: wcbclaimsfiling@wcb.ny.gov • Customer Service: (877) 632-4996 • Statewide Fax: (877) 533-0337

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CONTINUATION TO FORM MG-2, ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE MG-2.1

WCB Case #:	Claim Administrator Claim (Carrier Case) #: 73141129	Date of Injury/Illness: 06/24/2021

Patient's Name: Bayani L Dillard Social Security No.:

Doctor's Name: Appasaheb Naik WCB Authorization No.: 150818-3W NPI No.: 1992822019

INSTRUCTIONS TO ATTENDING DOCTOR: **This form must be filed attached to completed Form MG-2** if requesting approval for additional variance(s) in the same case. Supporting medical must be attached or identified for each request.

A. *The undersigned requests additional approval(s) to VARY from the WCB Medical Treatment Guidelines as indicated below:*

2. Guideline Reference: [K] - [E] [8] [L] [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: Date(s) of previously denied variance request:

Approval Requested for: Soft tissue mobilization for the right knee 3 times a week for 8 weeks

Medical Necessity:

3. Guideline Reference: [K] - [E] [8] [K] [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: Date(s) of previously denied variance request:

Approval Requested for: Joint manipulation for the right knee 3 times a week for 8 weeks

Medical Necessity:

4. Guideline Reference: [K] - [E] [8] [R] [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: Date(s) of previously denied variance request:

Approval Requested for: Ultrasound for the right knee 3 times a week for 8 weeks

Medical Necessity:

5. Guideline Reference: [K] - [E] [8] [C] [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: Date(s) of previously denied variance request:

Approval Requested for: Electrical stimulation for the right knee 3 times a week for 8 weeks

Medical Necessity:

STATEMENT OF MEDICAL NECESSITY - See requirements on Form MG-2.

Your explanation must provide the following information:
- the basis for your opinion that the medical care you propose is appropriate for the claimant and is medically necessary at this time; and
- an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:
- a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment; and
- the specific duration or frequency of treatment for which a variance is requested.

Variance requests for treatment or testing that is not recommended or not addressed, must include:
- the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
- medical evidence in support of efficacy of the proposed treatment or testing- may include relevant medical literature published in recognized peer reviewed journals.

Patient Name: Bayani L Dillard	WCB Case Number:	Date of Injury: 06/24/2021

HEALTH PROVIDER'S CERTIFICATION

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Medical Treatment Guidelines. I certify that the claimant understands and agrees to undergo the proposed medical care.

A copy was sent (see address on instruction page) to the Workers' Compensation Board, and copies were provided to the claimant's legal representative, if any, to the claimant if not represented, and to any other parties of interest within two (2) business days of the date below.

In addition, I certify that I do not have a substantially similar request pending and that this request contains additional supporting medical evidence if it is substantially similar to a prior denied request.

Provider's Signature: _____ Date: 7/21/21

B. INSURER'S/EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW

☐ The insurer/employer hereby gives notice that it will have the claimant examined by an Independent Medical Examiner and submit Form IME-4 within 30 calendar days of the Variance Request, with respect to: ☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5

By: (print name): _____ Title: _____

Signature: _____ Date: _____

C. INSURER'S/EMPLOYER'S RESPONSE TO ADDITIONAL VARIANCE REQUEST(S)

Insurer's response to the variance request is indicated in the checkboxes below. If any additional request(s) are denied, give reason(s) for denial or partial granted below. Identify reasons by Request No. 2-5. (Attach written report of medical professional for each denial as explained on Form MG-2.)

Request No. 2: ☐ Granted ☐ Granted in Part ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied
☐ Without Prejudice

Request No. 3: ☐ Granted ☐ Granted in Part ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied
☐ Without Prejudice

Request No. 4: ☐ Granted ☐ Granted in Part ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied
☐ Without Prejudice

Request No. 5: ☐ Granted ☐ Granted in Part ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied
☐ Without Prejudice

Name of the Medical Professional who reviewed the denial, if appropriate: _____

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal representative, if any, and any other parties of interest, with the written report of the medical professional in the office of the insurer/employer/self-insured employer/ Special Fund attached, within two (2) business days of the date below

(Please complete if request is denied.) If the issue cannot be resolved informally, I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

By: (print name): _____ Title: _____

Signature: _____ Date: _____

D. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND CARRIER

I certify that the provider's variance request initially denied above is now granted or partially granted for the following requests:

☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5

By: (print name): _____ Title: _____

Signature: _____ Date: _____

E. CLAIMANT'S/CLAIMANT'S REPRESENTATIVE REQUEST FOR REVIEW OF SELF-INSURED EMPLOYER'S/INSURER'S DENIAL

NOTE to Claimant/Claimant's Attorney or Licensed Representative: The claimant should only sign this section after the request is denied. This section should not be completed at the time of initial request.

☐ I request that the Workers' Compensation Board review the insurer's denial of my doctor's ☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5 for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

Claimant's / Claimant Representative's Signature: _____ Date: _____

CONTINUATION TO FORM MG-2, ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE — MG-2.1

WCB Case #:	Claim Administrator Claim (Carrier Case) #: 73141129	Date of Injury/Illness: 06/24/2021

Patient's Name: Bayani L Dillard Social Security No.:

Doctor's Name: Appasaheb Naik WCB Authorization No.: 150818-3W NPI No.: 1992822019

INSTRUCTIONS TO ATTENDING DOCTOR: **This form must be filed attached to completed Form MG-2** if requesting approval for additional variance(s) in the same case. Supporting medical must be attached or identified for each request.

A. *The undersigned requests additional approval(s) to VARY from the WCB Medical Treatment Guidelines as indicated below:*

2. Guideline Reference: K - E 7 A ☐ *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: _____ Date(s) of previously denied variance request: _____

Approval Requested for: Activties of the right knee 3 times a week for 8 weeks

Medical Necessity: _____

3. Guideline Reference: K - E 7 C ☐ *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: _____ Date(s) of previously denied variance request: _____

Approval Requested for: Gait trainning for the right knee 3 times a week for 8 weeks

Medical Necessity: _____

4. Guideline Reference: N - O N E ☐ *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: _____ Date(s) of previously denied variance request: _____

Approval Requested for: _____

Medical Necessity: _____

5. Guideline Reference: N - O N E ☐ *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: _____ Date(s) of previously denied variance request: _____

Approval Requested for: _____

Medical Necessity: _____

STATEMENT OF MEDICAL NECESSITY - See requirements on Form MG-2.

Your explanation must provide the following information:
- the basis for your opinion that the medical care you propose is appropriate for the claimant and is medically necessary at this time; and
- an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:
- a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment, and
- the specific duration or frequency of treatment for which a variance is requested.

Variance requests for treatment or testing that is not recommended or not addressed, must include:
- the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
- medical evidence in support of efficacy of the proposed treatment or testing- may include relevant medical literature published in recognized peer reviewed journals.

Patient Name: Bayani L Dillard	WCB Case Number:	Date of Injury: 06/24/2021

HEALTH PROVIDER'S CERTIFICATION

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Medical Treatment Guidelines. I certify that the claimant understands and agrees to undergo the proposed medical care.

A copy was sent (see address on instruction page) to the Workers' Compensation Board, and copies were provided to the claimant's legal representative, if any, to the claimant if not represented, and to any other parties of interest within two (2) business days of the date below.

In addition, I certify that I do not have a substantially similar request pending and that this request contains additional supporting medical evidence if it is substantially similar to a prior denied request.

Provider's Signature: _____ Date: 07/21/2021

B. INSURER'S/EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW

☐ The insurer/employer hereby gives notice that it will have the claimant examined by an Independent Medical Examiner and submit Form IME-4 within 30 calendar days of the Variance Request, with respect to: ☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5

By: (print name): _____ Title: _____

Signature: _____ Date: _____

C. INSURER'S/EMPLOYER'S RESPONSE TO ADDITIONAL VARIANCE REQUEST(S)

Insurer's response to the variance request is indicated in the checkboxes below. If any additional request(s) are denied, give reason(s) for denial or partial granted below. Identify reasons by Request No. 2-5. (Attach written report of medical professional for each denial as explained on Form MG-2.)

Request No. 2: ☐ Granted ☐ Granted in Part ☐ Without Prejudice ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied

Request No. 3: ☐ Granted ☐ Granted in Part ☐ Without Prejudice ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied

Request No. 4: ☐ Granted ☐ Granted in Part ☐ Without Prejudice ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied

Request No. 5: ☐ Granted ☐ Granted in Part ☐ Without Prejudice ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied

_____

_____

_____

Name of the Medical Professional who reviewed the denial, if appropriate: _____

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal representative, if any, and any other parties of interest, with the written report of the medical professional in the office of the insurer/employer/self-insured employer/ Special Fund attached, within two (2) business days of the date below.

(Please complete if request is denied.) If the issue cannot be resolved informally, I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

By: (print name): _____ Title: _____

Signature: _____ Date: _____

D. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND CARRIER

I certify that the provider's variance request initially denied above is now granted or partially granted for the following requests:

☐ Request No. 2 ☐ Request No. 3 ☐ Request No 4 ☐ Request No. 5

By: (print name): _____ Title: _____

Signature: _____ Date: _____

E. CLAIMANT'S/CLAIMANT'S REPRESENTATIVE REQUEST FOR REVIEW OF SELF-INSURED EMPLOYER'S/INSURER'S DENIAL

NOTE to Claimant/Claimant's Attorney or Licensed Representative: The claimant should only sign this section after the request is denied. This section should not be completed at the time of initial request.

☐ I request that the Workers' Compensation Board review the insurer's denial of my doctor's ☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5 for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

Claimant's / Claimant Representative's Signature: _____ Date: _____

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

1213672400

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/23/2021 07/23/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 06/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z2Z16ZD2

B. Doctor's Information

1. Your name: AZARIO (Last) XIMENA (First) (MI) 2. WCB Authorization #: PT046855-3

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

6. Billing Group or Practice Name: ny medical & diagnostic center

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1497349880

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, su
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	23	21	07	23	21	11		97140		1,2	44.33	1		11415
07	23	21	07	23	21	11		97110		1,2	37.91	1		11415
07	23	21	07	23	21	11		97010		1,2	20.03	1		11415
07	23	21	07	23	21	11		97014		1,2	25.40	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.67	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L [redacted] (Last / First / MI) Date of injury/onset of illness: ~~08/24/2021~~ 6/11/21

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: 1215072406

3. List additional body parts affected by this injury, if any:

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*):
- ☐ Labs (*specify*):
- ☐ X-rays (*specify*):
- ☐ Other (*specify*):

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in:
- ☐ Other (*specify*):

***Important:** Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.*

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions:

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☐ The patient cannot return to work because (explain):
   - b. ☐ The patient can return to work without limitations on:
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on:
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain):

   Describe/quantify the limitations:

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			07/27/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/26/2021 07/26/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 06/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z2Z17ZD2

B. Doctor's Information

1. Your name: AZARIO (Last) XIMENA (First) (MI) 2. WCB Authorization #: PT046855-3

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

6. Billing Group or Practice Name: ny medical & diagnostic center

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1497349880

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, su
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	26	21	07	26	21	11		97140		1,2	44.33	1		11415
07	26	21	07	26	21	11		97110		1,2	37.91	1		11415
07	26	21	07	26	21	11		97014		1,2	25.40	1		11415
07	26	21	07	26	21	11		97010		1,2	20.03	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.67	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

6/11/21

Patient's Name: Dillard Bayani L , . . _____ Date of injury/onset of illness: ~~06/24/2021~~
Last First MI

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ___ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☐ The patient cannot return to work because (explain): _____
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			07/27/2021

Employee Claim

C-3

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.state.ny.us.

WCB Case Number (If you know it): G3051719

A. YOUR INFORMATION (Employee)

1. Name: Bayani Dillard (First / MI / Last) 2. Date of Birth: 11 / 5 / 1976
3. Mailing address: 52 Charles Street , Malverne, NY 11565 (Number and Street/PO Box / City / State / Zip Code)
4. Social Security Number: 106 - 70 - 9312 5. Phone Number: (917) 386-5380 6. Gender: ☑ Male ☐ Female
7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☑ No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: Flushing Hospital Medical Center 2. Phone Number: (718) 670-5944
3. Your work address: 4500 Parson Blvd., Flushing, NY 11355 (Number and Street / City / State / Zip Code)
4. Date you were hired: 3 / 3 / 2003 5. Your supervisor's name: Tiffany Santos
6. List names/addresses of any other employer(s) at the time of your injury/illness: _____
7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? EMS
2. What types of activities did you normally perform at work? Heavy lifiting, moving equipment and people
3. Was your job? (check one) ☑ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____
4. What was your gross pay (before taxes) per pay period? 1,900 5. How often were you paid? Bi-weekly (every 2 w
6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☑ No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: 6 / 11 / 2021 2. Time of injury: 1:30 ☐ AM ☑ PM
3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) McDonalds: 160-11 Willets Blvd, 11357
4. Was this your usual work location? ☐ Yes ☑ No If no, why were you at this location? _____
5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) Slipped and fell
6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) Slipped and fell
7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): Right Knee

Received by WCB Fax on 7/27/2021 11:10:14 AM

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

YOUR NAME: Bayani Dillard (First MI Last) DATE OF INJURY/ILLNESS: 6 / 11 / 2021

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☑ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
   If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
   If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☑ Yes ☐ No
    If yes, notice was given to: Tiffany Santos ☑ orally ☑ in writing Date notice given: 6 / 11 / 2021

11. Did anyone see your injury happen? ☑ Yes ☐ No ☐ Unknown If yes, list names: _____
    Tom Reardon

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? 6 / 11 / 2021 ☑ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☑ No If yes, on what date? ___/___/___ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? 6 / 11 / 2021 ☐ None received (skip to question F-5)
2. Were you treated on site? ☑ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☑ Emergency Room
   ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
   Name and address where you were first treated: _____
   Flushing Hospital: 4500 Parson Blvd,, Flushing, NY 11358. Phone Number: (718) 620-5000
4. Are you still being treated for this injury/illness? ☑ Yes ☐ No
   Give the name and address of the doctor(s) treating you for this injury/illness: Dr. Guillaume
   Island Mosclusklelal Care Phone Number: (516) -887-1787
5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
   If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
   _____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
   If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: X Bayani Dillard Print Name: Bayani Dillard Date: 7 / 27 / 2021

On behalf of Employee: _____ Print Name: _____ Date: ___/___/___

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: 7 / 27 / 2021

Print Name: Rex E. Zucchofski Title: Attorney

ID No., if any: R 200270 If Licensed Representative, License No.: _____ Expiration Date: ___/___/___

Received by WCB Fax on 7/27/2021 11:10:14 AM

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/28/2021 07/28/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) L (MI) 2. Date of injury/illness: 6/11/21 3. Soc. Sec. #: _____

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 51372Z1Z8ZD2

B. Doctor's Information

1. Your name: NAIK (Last) APPASAHED 3 (First) (MI) 2. WCB Authorization #: S150818

3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

6. Billing Group or Practice Name: NEW YORK MEDICAL & DIAGNOSTIC CENTER

7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)

8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1992822019

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W

3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	28	21	07	28	21	11		99214		1	127.41	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.41	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☒ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

***Important:** Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.*

6. Describe treatment rendered today: examination

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☒ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☒ The patient cannot return to work because (explain): rt knee injury
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting ☐ Lifting ☐ Sitting
     - ☐ Climbing stairs/ladders ☐ Operating heavy equipment ☐ Standing
     - ☐ Environmental conditions ☐ Operation of motor vehicles ☐ Use of public transportation
     - ☐ Kneeling ☐ Personal protective equipment ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☐ I provided the services listed above.

☒ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			08/03/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/28/2021 07/28/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 6/11/21 3. Soc. Sec. #: _____
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 51372Z1Z8ZD2

B. Doctor's Information

1. Your name: NAIK (Last) APPASAHED 3 (First / MI) 2. WCB Authorization #: S150818
3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN
5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)
6. Billing Group or Practice Name: NEW YORK MEDICAL & DIAGNOSTIC CENTER
7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 114151145 (Zip Code)
8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1992822019

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W
3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	28	21	07	28	21	11		99214		1	127.41	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.41	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: 1221055636

3. List additional body parts affected by this injury, if any:

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*):
- ☐ Labs (*specify*):
- ☐ X-rays (*specify*):
- ☐ Other (*specify*):

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☒ Physical Therapist
- ☐ Specialist in:
- ☐ Other (*specify*):

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: examination

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☒ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions:

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☒ The patient cannot return to work because (explain): rt knee injury
   - b. ☐ The patient can return to work without limitations on:
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on:
     - ☐ Bending/twisting
     - ☐ Climbing stairs/ladders
     - ☐ Environmental conditions
     - ☐ Kneeling
     - ☐ Lifting
     - ☐ Operating heavy equipment
     - ☐ Operation of motor vehicles
     - ☐ Personal protective equipment
     - ☐ Sitting
     - ☐ Standing
     - ☐ Use of public transportation
     - ☐ Use of upper extremities
     - ☐ Other (explain):

   Describe/quantify the limitations:

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☐ I provided the services listed above.

☒ I actively supervised the health-care provider named below who provided these services.

Provider's name Specialty

Board Authorized Health Care Provider signature:

08/03/2021

Name Signature Specialty Date

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

1215131667 **C-4.2**

Use this form to report *continuing* services. (To report the first time you treated the patient, use Form C-4. To report permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 07/28/2021 07/28/2021

WCB Case Number (if known): _____ Carrier Case Number (if known): 73141129

A. Patient's Information

1. Name: Dillard Bayani L (Last / First / MI) 2. Date of injury/illness: 06/11/21 3. Soc. Sec. #: _____
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 51372Z2Z18ZD2

B. Doctor's Information

1. Your name: AZARIO (Last) XIMENA (First) (MI) 2. WCB Authorization #: PT046855-3
3. WCB Rating Code: _____ 4. Federal Tax ID #: 113405167 The Tax ID # is the (*check one*): ☐ SSN ☐ EIN
5. Office address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)
6. Billing Group or Practice Name: ny medical & diagnostic center
7. Billing address: 80-46 KEW GARDENS RD (Number and Street) KEW GARDENS (City) NY (State) 11415 (Zip Code)
8. Office phone #: 718-261-1000 9. Billing phone #: 718-261-1000 10. Treating Provider's NPI #: 1497349880

C. Billing Information

1. Employer's insurance carrier: NYSIF 2. Carrier Code #: W
3. Insurance carrier's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	M23.91	Unspecified internal derangement of right knee
(2)	S83.241D	Oth tear of medial meniscus, current injury, r knee, su
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
07	28	21	07	28	21	11		97140		1,2	44.33	1		11415
07	28	21	07	28	21	11		97110		1,2	37.91	1		11415
07	28	21	07	28	21	11		97014		1,2	25.40	1		11415
07	28	21	07	28	21	11		97010		1,2	20.03	1		11415

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 127.67	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: _____

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard Bayani L (Last / First / MI) Date of injury/onset of illness: ~~06/24/2021~~ 6/11/21

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: _____

3. List additional body parts affected by this injury, if any: _____

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: _____

5. Based on this examination, does the patient need diagnostic tests or referrals? ☐ Yes ☐ No If yes, check all that apply:

Tests:
- ☐ CT Scan ☐ EMG/NCS
- ☐ MRI (*specify*): _____
- ☐ Labs (*specify*): _____
- ☐ X-rays (*specify*): _____
- ☐ Other (*specify*): _____

Referrals
- ☐ Chiropractor ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in: _____
- ☐ Other (*specify*): _____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidelines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? ☐ Within a week ☐ 1-2 wks ☐ 3-4 wks ☐ 5-6 wks ☐ 7-8 wks ☐ ____ months ☐ as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? ☒ Yes ☐ No
2. Are the patient's complaints consistent with his/her history of the injury/illness? ☒ Yes ☐ No
3. Is the patient's history of the injury/illness consistent with your objective findings? ☒ Yes ☐ No ☐ N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100 %
5. Describe findings and relevant diagnostic test results: _____

F. Return to Work

1. Is patient working now? ☐ Yes ☒ No If yes, are there work restrictions? ☐ Yes ☐ No If yes, describe the work restrictions: _____

   How long will the work restrictions apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time

2. Can patient return to work? (*check only one*):
   - a. ☐ The patient cannot return to work because (explain): _____
   - b. ☐ The patient can return to work without limitations on: _____
   - c. ☐ The patient can return to work with the following limitations (check all that apply) on: _____
     - ☐ Bending/twisting ☐ Lifting ☐ Sitting
     - ☐ Climbing stairs/ladders ☐ Operating heavy equipment ☐ Standing
     - ☐ Environmental conditions ☐ Operation of motor vehicles ☐ Use of public transportation
     - ☐ Kneeling ☐ Personal protective equipment ☐ Use of upper extremities
     - ☐ Other (explain): _____

   Describe/quantify the limitations: _____

   How long will these limitations apply? ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Unknown at this time ☐ N/A

3. With whom will you discuss the patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A
4. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one:

☒ I provided the services listed above.

☐ I actively supervised the health-care provider named below who provided these services.

Provider's name _____ Specialty _____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
			07/29/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 08/02/2021 - 08/06/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI)
2. Date of injury/illness: 06/11/2021
3. Soc.Sec. #: 000-00-9312
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Acosta (Last) Mary Jane (First) (MI)
2. WCB Authorization #: PT037451-2W
3. WCB Rating Code PT
4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN
5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)
6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE
7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)
8. Office phone #: 516-887-1787
9. Billing phone # 516-374-6838
10. Treating Provider's NPI # 1124433792

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND
2. Carrier Code #: W
3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

Enter ICD10 Code:	ICD10 Descriptor:
(1) S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)	
(3)	
(4)	

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
08	02	21	08	02	21	11		97140		1	40 40	1		11580-2108
08	02	21	08	02	21	11		97110		1	37 91	1		11580-2108
08	02	21	08	02	21	11		97035		1	23 02	1		11580-2108
08	02	21	08	02	21	11		97010		1	5 25	1		11580-2108
08	02	21	08	02	21	11		97161		1	90 44	1		11580-2108
08	06	21	08	06	21	11		97140		1	40 40	1		11580-2108

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 303 60	$	$

☐ Check here if services were provided by a WCB preferred provider organization (PPO

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of Injury/onset of illness: 06/11/2021

1229868888

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:

none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify): ____
- [ ] Labs (Specify): ____
- [ ] X-rays (Specify): ____
- [ ] Other (Specify): ____

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in ____
- [ ] Other (Specify): ____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results: ____

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions:

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on ____
   c. [ ] The patient can return to work with the following limitations (check all that apply) on ____
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify): ____

   Describe/quantify the limitations: ____

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name ____ Specialty ____

Board Authorized Health Care Provider signature:

Mary Jane Acosta PT		PHYSICAL THERAPIST	08/11/2021
Name	Signature	Specialty	Date

CONTINUATION TO CARRIER EMPLOYER BILLING PORTION OF FORM C-4

Doctor's Name: Mary Jane Acosta

WCB Case Number: G3051719

Carrier Case Number: 73141129-110

Date of Accident/Inju: 06/11/2021 1229060088

Patient: Dillard, Bayani

Patient's Social Security Number: 000-00-9312

A Dates of Service From MM	DD	YY	To MM	DD	YY	B Place of Service	C Leave Blank	D (USE WCB CODES) Procedures, Services or Supplies (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E Diagnosis Code	F $ Charges	G Days or Units	H COB	I Zip Code Where Service was Rendered
08	06	21	08	06	21	11		97110		1	37 91	1		11580-2108
08	06	21	08	06	21	11		97035		1	23 02	1		11580-2108
08	06	21	08	06	21	11		97010		1	5 25	1		11580-2108

C-4 (8-08)

THE INJURED WORKER SHOULD NOT PAY THIS BILL

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 08/04/2021 - 08/04/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI)
2. Date of injury/illness: 06/11/2021
3. Soc.Sec. #: 000-00-9312
4. Address (if changed from previous report): 32 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Tanlioco (Last) Joseph (First) (MI)
2. WCB Authorization #: PT019886-7W
3. WCB Rating Code PT
4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN
5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)
6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE
7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)
8. Office phone #: 516-887-1787
9. Billing phone # 516-374-6838
10. Treating Provider's NPI # 1851372908

C. Billing Information

1. Employer's Insurance company: STATE INSURANCE FUND
2. Carrier Code #: W
3. Insurance company's address: Po Box 66899 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
08	04	21	08	04	21	11		97140		1	40 40	1		11580-2108
08	04	21	08	04	21	11		97110		1	37 91	1		11580-2108
08	04	21	08	04	21	11		97035		1	23 02	1		11580-2108
08	04	21	08	04	21	11		97010		1	5 25	1		11580-2108

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

☐ Check here if services were provided by a WCB preferred provider organization (PPO

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 06/11/2021

1231115516

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify): ____
- [ ] Labs (Specify): ____
- [ ] X-rays (Specify): ____
- [ ] Other (Specify): ____

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in ____
- [ ] Other (Specify): ____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____ months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results: ____

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions: ____

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):

a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion

b. [ ] The patient can return to work without limitations on ____

c. [ ] The patient can return to work with the following limitations (check all that apply) on ____
- [ ] Bending/twisting
- [ ] Climbing stairs/ladders
- [ ] Environmental conditions
- [ ] Kneeling
- [ ] Lifting
- [ ] Operating heavy equipment
- [ ] Operation of motor vehicles
- [ ] Personal protective equipment
- [ ] Sitting
- [ ] Standing
- [ ] Use of public transportation
- [ ] Use of upper extremities
- [ ] Other (Specify): ____

Describe/quantify the limitations: ____

How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name ____ Specialty ____

Board Authorized Health Care Provider signature:

Joseph Tanlioco PT		PHYSICAL THERAPIST	08/12/2021
Name	Signature	Specialty	Date

Workers' Compensation Board

ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE AND INSURER'S RESPONSE

MG-2

For additional variance requests in this case, attach Form MG-2.1.
Answer all questions where information is known.

WCB Case #: G3061719	Claim Administrator Claim (Carrier Case) 73141129-110	Date of Injury/Illness: 6/11/2021

A. Patient's Name: Bayani (First) Dillard (MI) (Last) Social Security Number: 000-00-9312

Patient's Address: 52 Charles Street, Malverne, NY 11565

Employer's Name & Address: Flushing Hospital Medical Center, 4500 Parsons Blvd, Flushing, , NY 11355

Insurer's Name & Address: STATE INSURANCE FUND, Po Box 66699 Albany, NY 12206

B. Attending Doctor's Name & Address: Gus Katsigiorgis DO, 1512 Broadway, Hewlett, NY 11557-1429

Individual Provider's WCB Authorization No.: 2 3 4 2 4 4 2 W NPI No.: 1033105564

Telephone No.: 516-374-6838 Fax No.: ~~516-374-2362~~ 516 374-1039

C. *The undersigned requests approval to VARY from the WCB Medical Treatment Guidelines as indicated below:*

Guideline Reference: K - D 6 F [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE)*

Approval Requested for: (one request type per form) PLEASE REVIEW MEDICALREPORTS FOR SURGERY RIGHT KNEE ARTHROSCOPY WITH POSSIBLE MENISCECTOMY

STATEMENT OF MEDICAL NECESSITY -- See item 5 on instruction page.

Your explanation must provide the following information:
- the basis for your opinion that the medical care you propose is appropriate for the patient and is medically necessary at this time; and
- an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:
- a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment; and
- the specific duration or frequency of treatment for which a variance is requested.

Variance requests for treatment or testing that is not recommended or not addressed, must include:
- the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
- medical evidence in support of efficacy of the proposed treatment or testing- may include relevant medical literature published in recognized peer reviewed journals.

Date of Service of Supporting Medical in WCB Case File, if not attached: 7/23/2021

Date(s) of previously denied variance request for substantially similar treatment, if applicable:

Provider must enter in A the designated fax or email address this request was sent to. Insurer/self-insurer's designated contact information is available online at: wcb.ny.gov/medical-treatment-guideline-variance-request. Check "Designated contact information not available", if appropriate. If the request was sent to a different (contact information is not available on Board's website) or additional fax or email address provided by the insurer, complete B. If you are unable to send or receive email or fax, complete C.

A. *Insurer's designated fax # or email address as provided on the Board's website:* NYSIFMRC.CASeMgt@NYSIF.com

[ ] ***Designated contact information not available.***

B. *If the request was also submitted to another fax # or email address provided by the insurer, provide here:* _____

C. *I am not equipped to send or receive forms by fax or email. This form was mailed (return receipt requested) on:* _____

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Guidelines. I certify that the patient understands and agrees to undergo the proposed medical care. I [ ] did / [x] did not contact the insurer by telephone to discuss this variance request before making the request. I contacted the Insurer by telephone on (date) 8/5/2021 and spoke to (person spoke to or was not able to speak to anyone)

I sent or directed my office to send a copy of this request to the Insurer, the Chair, the patient and the patient's legal representative, if any, on the same day, and sent or directed my office to send a copy to the Workers' Compensation Board within two (2) business days of the date below. In addition, I certify that I do not have a substantially similar request pending and that this request contains additional supporting medical evidence if it is substantially similar to a prior denied request.

Provider's Signature: _____ Date: 8/5/2021

MG-2.0 4-18

Patient Name: Bayani Dillard	WCB Case #: G3051719	Date of Injury/Illness: 6/11/2021

D. INSURER'S / EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW

☐ The self-insurer/carrier hereby gives notice that it will have the claimant examined by an Independent Medical Examiner or the claimant's medical records reviewed by a Records Reviewer and submit Form IME-4 within 30 calendar days of the Variance Request.

By: (print name)..... Title:.....

Signature:..... Date:.....

E. INSURER'S / EMPLOYER'S RESPONSE TO VARIANCE REQUEST

Insurer's response to the variance request is indicated in the checkboxes on the right. Insurer denial, when appropriate, should be reviewed by a health professional. (Attach written report of medical professional.) If request is approved or denied, sign and date the form in Section E.

Follow Knee - MTG

INSURER'S/EMPLOYER'S RESPONSE
If service is denied or granted in part, explain in space

- ☒ Granted
- ☐ Granted In Part
- ☐ Without Prejudice
- ☐ Denied
- ☐ Burden of Proof Not Met
- ☐ Substantially Similar Request Pending or Denied

Name of the Medical Professional who reviewed the denial, if applicable:.....

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal counsel, if any, and any other parties of interest, with the written report of the medical professional in the office of the carrier/employer/selfinsured employer/Special Fund attached, within two (2) business days of the date below.

(Please complete if request is denied.) If the issue cannot be resolved informally, I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair ☐ or at a WCB adjunction. I understand that if either party, the insurer or the patient, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB Hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

By: (print name) Y. Patel Title: CSRI

Signature: ypatel Date: 08/13/21

F. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND INSURER / EMPLOYER

I certify that the provider's variance request initially denied above is now granted or partially granted.

By: (print name)..... Title.....

Insurer's Signature:..... Date:.....

G. CLAIMANT'S / CLAIMANT REPRESENTATIVE'S REQUEST FOR REVIEW OF SELF-INSURED INSURER'S / EMPLOYER'S DENIAL

NOTE to Claimant's / Claimant Licensed Representative's: The claimant should only sign this section after the request is fully or partially denied. This section should not be completed at the time of initial request.

YOU MUST COMPLETE THIS SECTION IF YOU WANT THE BOARD TO REVIEW THE INSURER'S DENIAL OF THE PROVIDER'S VARIANC

☐ I request that the Workers' Compensation Board review the insurer's denial of my doctor's request for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made ☐by the Medical Arbitrator designated by the Chair or ☐through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

Claimant's / Claimant Representative's Signature: ..... Date: .....

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

NYS Workers' Compensation Board
PO Box 5205
Binghamton, NY 13902-5205

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Workers' Compensation Board

ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE AND INSURER'S RESPONSE

MG-2

For additional variance requests in this case, attach Form MG-2.1.
Answer all questions where information is known.

WCB Case #: G3051719	Claim Administrator Claim (Carrier Case) 73141129-110	Date of Injury/Illness: 6/11/2021

A. Patient's Name: Bayani (First) Dillard (MI) (Last) Social Security Number: 000-00-9312

Patient's Address: 52 Charles Street, Malvarne, NY 11565

Employer's Name & Address: Flushing Hospital Medical Center, 4500 Parsons Blvd, Flushing, , NY 11355

Insurer's Name & Address: STATE INSURANCE FUND, Po Box 66699 Albany, NY 12206

B. Attending Doctor's Name & Address: Gus Katsigiorgis DO, 1512 Broadway, Hewlett, NY 11557-1429

Individual Provider's WCB Authorization No.: 2 3 4 2 4 4 2 W NPI No.: 1033105564

Telephone No.: 516-374-6838 Fax No.: ~~516-374-2362~~ 516 374-1039

C. *The undersigned requests approval to VARY from the WCB Medical Treatment Guidelines as indicated below:*

Guideline Reference: K - D 6 F [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE)*

Approval Requested for: (one request type per form) PLEASE REVIEW MEDICALREPORTS FOR SURGERY RIGHT KNEE ARTHROSCOPY WITH POSSIBLE MENISCECTOMY

STATEMENT OF MEDICAL NECESSITY – See item 5 on instruction page.

Your explanation must provide the following information:
- the basis for your opinion that the medical care you propose is appropriate for the patient and is medically necessary at this time; and
- an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:
- a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment; and
- the specific duration or frequency of treatment for which a variance is requested.

Variance requests for treatment or testing that is not recommended or not addressed, must include:
- the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
- medical evidence in support of efficacy of the proposed treatment or testing- may include relevant medical literature published in recognized peer reviewed journals.

Date of Service of Supporting Medical in WCB Case File, if not attached: 7/23/2021

Date(s) of previously denied variance request for substantially similar treatment, if applicable:

Provider **must** enter in **A** the designated fax or email address this request was sent to. Insurer/self-insurer's designated contact information is available online at: wcb.ny.gov/medical-treatment-guideline-variance-request. Check "Designated contact information not available", if appropriate. If the request was sent to a different (contact information is not available on Board's website) or additional fax or email address provided by the insurer, complete **B**. If you are unable to send or receive email or fax, complete **C**.

A. *Insurer's designated fax # or email address as provided on the Board's website:* NYSIF MG2 CLAIMS@NYSIF.COM

[ ] ***Designated contact information not available.***

B. *If the request was also submitted to another fax # or email address provided by the insurer, provide here:* _____

C. *I am not equipped to send or receive forms by fax or email. This form was mailed (return receipt requested) on:* _____

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Guidelines. I certify that the patient understands and agrees to undergo the proposed medical care. I [ ] did / [x] did not contact the insurer by telephone to discuss this variance request before making the request. I contacted the insurer by telephone on (date) 8/5/2021 and spoke to (person spoke to or was not able to speak to anyone)

I sent or directed my office to send a copy of this request to the insurer, the Chair, the patient and the patient's legal representative, if any, on the same day, and sent or directed my office to send a copy to the Workers' Compensation Board within two (2) business days of the date below. In addition, I certify that I do not have a substantially similar request pending and that this request contains additional supporting medical evidence if it is substantially similar to a prior denied request.

Provider's Signature: [signature] Date: 8/5/2021

Patient Name: Bayani Dillard	WCB Case # G3051719	Date of Injury/Illness 6/11/2021

D. INSURER'S / EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW

☐ The self-insurer/carrier hereby gives notice that it will have the claimant examined by an Independent Medical Examiner or the claimant's medical records reviewed by a Records Reviewer and submit Form IME-4 within 30 calendar days of the Variance Request.

By: (print name)..... Title:.....

Signature:..... Date:.....

E. INSURER'S / EMPLOYER'S RESPONSE TO VARIANCE REQUEST

Insurer's response to the variance request is indicated in the checkboxes on the right. Insurer denial, when appropriate, should be reviewed by a health professional. (Attach written report of medical professional.) If request is approved or denied, sign and date the form in Section E.

.....

.....

.....

.....

INSURER'S/EMPLOYER'S RESPONSE
If service is denied or granted in part, explain in space

☐ Granted
☐ Granted in Part
☐ Without Preiudice

☐ Denied
☐ Burden of Proof Not Met
☐ Substantially Similar Request Pending or Denied

Name of the Medical Professional who reviewed the denial, if applicable:.....

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal counsel, if any, and any other parties of interest, with the written report of the medical professional in the office of the carrier/employer/selfinsured employer/Special Fund attached, within two (2) business days of the date below.

(Please complete if request is denied.) If the issue cannot be resolved informally, I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair ☐ or at a WCB adjunction. I understand that if either party, the insurer or the patient, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB Hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

By: (print name)..... Title: .....

Signature: ..... Date: .....

F. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND INSURER / EMPLOYER

I certify that the provider's variance request initially denied above is now granted or partially granted.

By: (print name)..... Title:.....

Insurer's Signature:..... Date:.....

G. CLAIMANT'S / CLAIMANT REPRESENTATIVE'S REQUEST FOR REVIEW OF SELF-INSURED INSURER'S / EMPLOYER'S DENIAL

NOTE to Claimant's / Claimant Licensed Representative's: The claimant should only sign this section after the request is fully or partially denied. This section should not be completed at the time of initial request.

YOU MUST COMPLETE THIS SECTION IF YOU WANT THE BOARD TO REVIEW THE INSURER'S DENIAL OF THE PROVIDER'S VARIANC

☐ I request that the Workers' Compensation Board review the insurer's denial of my doctor's request for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made ☐by the Medical Arbitrator designated by the Chair or ☐through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

Claimant's / Claimant Representative's Signature: ..... Date: .....

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

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Doctor's Progress Report

C-4.2

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 08/12/2021 - 08/12/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI) 2. Date of injury/illness: 06/11/2021 3. Soc.Sec. #: 000-00-9312

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Acosta (Last) Mary Jane (First) (MI) 2. WCB Authorization #: PT037451-2W

3. WCB Rating Code: PT 4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN

5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)

6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE

7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)

8. Office phone #: 516-887-1787 9. Billing phone # 516-374-6838 10. Treating Provider's NPI # 1124433792

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND 2. Carrier Code #: W

3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

Enter ICD10 Code:	ICD10 Descriptor:
(1) S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)	
(3)	
(4)	

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
08	12	21	08	12	21	11		97140		1	40 40	1		11580-2108
08	12	21	08	12	21	11		97110		1	37 91	1		11580-2108
08	12	21	08	12	21	11		97035		1	23 02	1		11580-2108
08	12	21	08	12	21	11		97010		1	5 25	1		11580-2108

☐ Check here if services were provided by a WCB preferred provider organization (PPO

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

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Patient's Name: Dillard (Last) Bayani (First) ___ (MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:

none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify): ___
- [ ] Labs (Specify): ___
- [ ] X-rays (Specify): ___
- [ ] Other (Specify): ___

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in ___
- [ ] Other (Specify): ___

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ___ months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results: ___

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions:

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on ___
   c. [ ] The patient can return to work with the following limitations (check all that apply) on ___
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify): ___

   Describe/quantify the limitations: ___

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name ___ Specialty ___

Board Authorized Health Care Provider signature:

Mary Jane Acosta PT		PHYSICAL THERAPIST	08/13/2021
Name	Signature	Specialty	Date

123208066

C-4.2

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Doctor's Progress Report

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 08/13/2021 - 08/13/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI)
2. Date of injury/illness: 06/11/2021
3. Soc.Sec. #: 000-00-9312
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Lusan-urena (Last) Marygrace (First) (MI)
2. WCB Authorization #: PT023781-8
3. WCB Rating Code: PT
4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN
5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)
6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE
7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)
8. Office phone #: 516-887-1787
9. Billing phone #: 516-374-6838
10. Treating Provider's NPI #: 1609042985

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND
2. Carrier Code #: W
3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
08	13	21	08	13	21	11		97140		1	40 40	1		11580-2108
08	13	21	08	13	21	11		97110		1	37 91	1		11580-2108
08	13	21	08	13	21	11		97035		1	23 02	1		11580-2108
08	13	21	08	13	21	11		97010		1	5 25	1		11580-2108

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

☐ Check here if services were provided by a WCB preferred provider organization (PPO

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

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1232080064

Patient's Name: Dillard (Last) Bayani (First) ____ (MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:
none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify): ____
- [ ] Labs (Specify): ____
- [ ] X-rays (Specify): ____
- [ ] Other (Specify): ____

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in ____
- [ ] Other (Specify): ____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results: ____

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions:

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on ____
   c. [ ] The patient can return to work with the following limitations (check all that apply) on ____
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify): ____

Describe/quantify the limitations: ____

How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name ____ Specialty ____

Board Authorized Health Care Provider signature

Name	Signature	Specialty	Date
Marygrace Lusan-urena PT		PHYSICAL THERAPIST	08/16/2021

123208062

C-4.2

Doctor's Progress Report

NEW YORK STATE | Workers' Compensation Board

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Date(s) of Examination: 08/14/2021 - 08/14/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI)
2. Date of injury/illness: 06/11/2021
3. Soc.Sec. #: 000-00-9312
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Acosta (Last) Mary Jane (First) (MI)
2. WCB Authorization #: PT037451-2W
3. WCB Rating Code: PT
4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN
5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)
6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE
7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)
8. Office phone #: 516-887-1787
9. Billing phone #: 516-374-6838
10. Treating Provider's NPI #: 1124433792

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND
2. Carrier Code #: W
3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

Enter ICD10 Code:	ICD10 Descriptor:
(1) S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)	
(3)	
(4)	

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
08	14	21	08	14	21	11		97140		1	40 40	1		11580-2108
08	14	21	08	14	21	11		97110		1	37 91	1		11580-2108
08	14	21	08	14	21	11		97035		1	23 02	1		11580-2108
08	14	21	08	14	21	11		97010		1	5 25	1		11580-2108

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

☐ Check here if services were provided by a WCB preferred provider organization (PPO

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

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1232888863

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:

none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify):
- [ ] Labs (Specify):
- [ ] X-rays (Specify):
- [ ] Other (Specify):

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in
- [ ] Other (Specify):

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ___months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions:

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on
   c. [ ] The patient can return to work with the following limitations (check all that apply) on
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify):

Describe/quantify the limitations:

How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name Specialty

Board Authorized Health Care Provider signature:

Mary Jane Acosta PT (Name) | Signature | PHYSICAL THERAPIST (Specialty) | 08/16/2021 (Date)

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 08/17/2021 - 08/17/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI) 2. Date of injury/illness: 06/11/2021 3. Soc.Sec. #: 000-00-9312

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Acosta (Last) Mary Jane (First) (MI) 2. WCB Authorization #: PT037451-2W

3. WCB Rating Code PT 4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN

5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)

6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE

7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)

8. Office phone #: 516-887-1787 9. Billing phone # 516-374-6838 10. Treating Provider's NPI # 1124433792

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND 2. Carrier Code #: W

3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

Enter ICD10 Code:	ICD10 Descriptor:
(1) S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)	
(3)	
(4)	

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
08	17	21	08	17	21	11		97140		1	40 40	1		11580-2108
08	17	21	08	17	21	11		97110		1	37 91	1		11580-2108
08	17	21	08	17	21	11		97035		1	23 02	1		11580-2108
08	17	21	08	17	21	11		97010		1	5 25	1		11580-2108

☐ Check here if services were provided by a WCB preferred provider organization (PPO

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard (Last) Bayani (First) ____ (MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify): ____
- [ ] Labs (Specify): ____
- [ ] X-rays (Specify): ____
- [ ] Other (Specify): ____

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in ____
- [ ] Other (Specify): ____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results: ____

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions: ____

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on ____
   c. [ ] The patient can return to work with the following limitations (check all that apply) on ____
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify): ____

   Describe/quantify the limitations: ____

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name ____ Specialty ____

Board Authorized Health Care Provider signature:

Mary Jane Acosta PT		PHYSICAL THERAPIST	08/18/2021
Name	Signature	Specialty	Date

1237161446

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 08/18/2021 - 08/18/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI)
2. Date of injury/illness: 06/11/2021
3. Soc.Sec. #: 000-00-9312
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Acosta (Last) Mary Jane (First) (MI)
2. WCB Authorization #: PT037451-2W
3. WCB Rating Code: PT
4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN
5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)
6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE
7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)
8. Office phone #: 516-887-1787
9. Billing phone #: 516-374-6838
10. Treating Provider's NPI #: 1124433792

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND
2. Carrier Code #: W
3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/Units	COB	Zip code where service was rendered
08	18	21	08	18	21	11		97140		1	40 40	1		11580-2108
08	18	21	08	18	21	11		97110		1	37 01	1		11580-2108
08	18	21	08	18	21	11		97035		1	23 02	1		11580-2108
08	18	21	08	18	21	11		97010		1	5 25	1		11580-2108

☐ Check here if services were provided by a WCB preferred provider organization (PPO

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

1237161446

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 08/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:
none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify):
- [ ] Labs (Specify):
- [ ] X-rays (Specify):
- [ ] Other (Specify):

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in
- [ ] Other (Specify):

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ___ months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions:

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on
   c. [ ] The patient can return to work with the following limitations (check all that apply) on
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify):

   Describe/quantify the limitations:

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name Specialty

Board Authorized Health Care Provider signature:

Mary Jane Acosta PT		PHYSICAL THERAPIST	08/19/2021
Name	Signature	Specialty	Date

12391 C-4.2

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 08/20/2021 - 08/20/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI) 2. Date of injury/illness: 06/11/2021 3. Soc.Sec. #: 000-00-9312

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Tanlioco (Last) Joseph (First) (MI) 2. WCB Authorization #: PT019586-7W

3. WCB Rating Code: PT 4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN

5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)

6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE

7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)

8. Office phone #: 516-887-1787 9. Billing phone #: 516-374-6838 10. Treating Provider's NPI #: 1851372908

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND 2. Carrier Code #: W

3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

Enter ICD10 Code:	ICD10 Descriptor:
(1) S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)	
(3)	
(4)	

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
08	20	21	08	20	21	11		97140		1	40 40	1		11580-2108
08	20	21	08	20	21	11		97110		1	37 91	1		11580-2108
08	20	21	08	20	21	11		97035		1	23 02	1		11580-2108
08	20	21	08	20	21	11		97010		1	5 25	1		11580-2108

Total Charges	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

☐ Check here if services were provided by a WCB preferred provider organization (PPO

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

1239132859

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:
none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify):
- [ ] Labs (Specify):
- [ ] X-rays (Specify):
- [ ] Other (Specify):

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in
- [ ] Other (Specify):

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ___months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions:

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on
   c. [ ] The patient can return to work with the following limitations (check all that apply) on
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify):

   Describe/quantify the limitations:

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name Specialty

Board Authorized Health Care Provider signature

Joseph Tanlioco PT		PHYSICAL THERAPIST	08/23/2021
Name	Signature	Specialty	Date

1243119114

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

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Date(s) of Examination: 08/24/2021 - 08/24/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI)
2. Date of injury/illness: 06/11/2021
3. Soc.Sec. #: 000-00-9312
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Lusan-urena (Last) Marygrace (First) (MI)
2. WCB Authorization #: PT023781-8
3. WCB Rating Code: PT
4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN
5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)
6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE
7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)
8. Office phone #: 516-887-1787
9. Billing phone # 516-374-6838
10. Treating Provider's NPI # 1609042985

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND
2. Carrier Code #: W
3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
08	24	21	08	24	21	11		97140		1	40 40	1		11580-2108
08	24	21	08	24	21	11		97110		1	37 91	1		11580-2108
08	24	21	08	24	21	11		97035		1	23 02	1		11580-2108
08	24	21	08	24	21	11		97010		1	5 25	1		11580-2108

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

☐ Check here if services were provided by a WCB preferred provider organization (PPO

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

1243119114

Patient's Name: Dillard (Last) Bayani (First) ____ (MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify): ____
- [ ] Labs (Specify): ____
- [ ] X-rays (Specify): ____
- [ ] Other (Specify): ____

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in ____
- [ ] Other (Specify): ____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____ months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results: ____

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions: ____

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on ____
   c. [ ] The patient can return to work with the following limitations (check all that apply) on ____
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify): ____

   Describe/quantify the limitations: ____

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name ____ Specialty ____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
Marygrace Lusan-urena PT		PHYSICAL THERAPIST	08/25/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

124513335 C-4.2

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 08/25/2021 - 08/25/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI)
2. Date of injury/illness: 06/11/2021
3. Soc.Sec. #: 000-00-9312
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Tanlloco (Last) Joseph (First) (MI)
2. WCB Authorization #: PT019586-7W
3. WCB Rating Code: PT
4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN
5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)
6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE
7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)
8. Office phone #: 516-887-1787
9. Billing phone #: 516-374-6838
10. Treating Provider's NPI #: 1851372908

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND
2. Carrier Code #: W
3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
08	25	21	08	25	21	11		97140		1	40 40	1		11580-2108
08	25	21	08	25	21	11		97110		1	37 91	1		11580-2108
08	25	21	08	25	21	11		97035		1	23 02	1		11580-2108
08	25	21	08	25	21	11		97010		1	5 25	1		11580-2108

☐ Check here if services were provided by a WCB preferred provider organization (PPO

Total Charges	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify): ____
- [ ] Labs (Specify): ____
- [ ] X-rays (Specify): ____
- [ ] Other (Specify): ____

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in ____
- [ ] Other (Specify): ____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results: ____

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions: ____

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on ____
   c. [ ] The patient can return to work with the following limitations (check all that apply) on ____
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify): ____

   Describe/quantify the limitations: ____

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health care provider named below who provided those services.

Provider's name ____ Specialty ____

Board Authorized Health Care Provider signature:

Joseph Tanlioco PT		PHYSICAL THERAPIST	08/26/2021
Name	Signature	Specialty	Date

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 08/27/2021 - 08/27/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI)
2. Date of injury/illness: 06/11/2021
3. Soc.Sec. #: 000-00-9312
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Acosta (Last) Mary Jane (First) (MI)
2. WCB Authorization #: PT037451-2W
3. WCB Rating Code: PT
4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN
5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)
6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE
7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)
8. Office phone #: 516-887-1787
9. Billing phone #: 516-374-6838
10. Treating Provider's NPI #: 1124433792

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND
2. Carrier Code #: W
3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
08	27	21	08	27	21	11		97140		1	40 40	1		11580-2108
08	27	21	08	27	21	11		97110		1	37 91	1		11580-2108
08	27	21	08	27	21	11		97035		1	23 02	1		11580-2108
08	27	21	08	27	21	11		97010		1	5 25	1		11580-2108

☐ Check here if services were provided by a WCB preferred provider organization (PPO

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

124607588

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify): ____
- [ ] Labs (Specify): ____
- [ ] X-rays (Specify): ____
- [ ] Other (Specify): ____

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in ____
- [ ] Other (Specify): ____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results: ____

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions: ____

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on ____
   c. [ ] The patient can return to work with the following limitations (check all that apply) on ____
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify): ____

   Describe/quantify the limitations: ____

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name ____ Specialty ____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
Mary Jane Acosta PT		PHYSICAL THERAPIST	08/30/2021

CONTINUATION TO CARRIER EMPLOYER BILLING PORTION OF FORM C-4

1259633163

Doctor's Name: Joseph Tanlioco

WCB Case Number: G3051719

Carrier Case Number: 73141129-110

Date of Accident/Inju: 06/11/2021

Patient: Dillard, Bayani

Patient's Social Security Number: 000-00-9312

A Dates of Service From MM	DD	YY	To MM	DD	YY	B Place of Service	C Leave Blank	D (USE WCB CODES) Procedures, Services or Supplies (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E Diagnosis Code	F $ Charges	G Days or Units	H COB	I Zip Code Where Service was Rendered
09	04	21	09	04	21	11		97035		1	23 02	1		11580-2108
09	04	21	09	04	21	11		97010		1	5 25	1		11580-2108

THE INJURED WORKER SHOULD NOT PAY THIS BILL

C-4 (8-09)

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

1256062999

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 09/02/2021 - 09/02/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI)
2. Date of injury/illness: 06/11/2021
3. Soc.Sec. #: 000-00-9312
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Tanlioco (Last) Joseph (First) (MI)
2. WCB Authorization #: PT019586-7W
3. WCB Rating Code: PT
4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN
5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)
6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE
7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)
8. Office phone #: 516-887-1787
9. Billing phone #: 516-374-6838
10. Treating Provider's NPI #: 1851372908

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND
2. Carrier Code #: W
3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
09	02	21	09	02	21	11		97140		1	40 40	1		11580-2108
09	02	21	09	02	21	11		97110		1	37 91	1		11580-2108
09	02	21	09	02	21	11		97035		1	23 02	1		11580-2108
09	02	21	09	02	21	11		97010		1	5 25	1		11580-2108

☐ Check here if services were provided by a WCB preferred provider organization (PPO

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none 1256062999

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify):
- [ ] Labs (Specify):
- [ ] X-rays (Specify):
- [ ] Other (Specify):

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in
- [ ] Other (Specify):

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____ months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions:

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on
   c. [ ] The patient can return to work with the following limitations (check all that apply) on
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify):

   Describe/quantify the limitations:

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name Specialty

Board Authorized Health Care Provider signature:

Joseph Tanlioco PT		PHYSICAL THERAPIST	09/03/2021
Name	Signature	Specialty	Date

125903163

Doctor's Progress Report

C-4.2

NEW YORK STATE | Workers' Compensation Board

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 09/03/2021 - 09/04/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI)
2. Date of injury/illness: 06/11/2021
3. Soc.Sec. #: 000-00-9312
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Tanlioco (Last) Joseph (First) (MI)
2. WCB Authorization #: PT019586-7W
3. WCB Rating Code: PT
4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN
5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)
6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE
7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)
8. Office phone #: 516-887-1787
9. Billing phone #: 516-374-6838
10. Treating Provider's NPI #: 1851372908

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND
2. Carrier Code #: W
3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

Enter ICD10 Code:	ICD10 Descriptor:
(1) S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)	
(3)	
(4)	

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Procedures, Services or Supplies (Use WCB Codes) CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COD	Zip code where service was rendered
09	03	21	09	03	21	11		97140		1	40 40	1		11580-2108
09	03	21	09	03	21	11		97110		1	37 91	1		11580-2108
09	03	21	09	03	21	11		97035		1	23 02	1		11580-2108
09	03	21	09	03	21	11		97010		1	5 25	1		11580-2108
09	04	21	09	04	21	11		97140		1	40 40	1		11580-2108
09	04	21	09	04	21	11		97110		1	37 91	1		11580-2108

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 213 16	$	$

☐ Check here if services were provided by a WCB preferred provider organization (PPO

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

www.wcb.ny.gov

1Z5563316 3

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify): ____
- [ ] Labs (Specify): ____
- [ ] X-rays (Specify): ____
- [ ] Other (Specify): ____

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in ____
- [ ] Other (Specify): ____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results: ____

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions: ____

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on ____
   c. [ ] The patient can return to work with the following limitations (check all that apply) on ____
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify): ____

   Describe/quantify the limitations: ____

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name ____ Specialty ____

Board Authorized Health Care Provider signature:

Joseph Tanlioco PT		PHYSICAL THERAPIST	09/08/2021
Name	Signature	Specialty	Date

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

1259128320 C-4.2

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 09/08/2021 - 09/08/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI)
2. Date of injury/illness: 06/11/2021
3. Soc.Sec. #: 000-00-9312
4. Address (if changed from previous report): 52 Charles Street (Number and Street), Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Lusan-urena (Last) Marygrace (First) (MI)
2. WCB Authorization #: PT023781-8
3. WCB Rating Code: PT
4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN
5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)
6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE
7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)
8. Office phone #: 516-887-1787
9. Billing phone #: 516-374-6838
10. Treating Provider's NPI #: 1609042985

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND
2. Carrier Code #: W
3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

Enter ICD10 Code:	ICD10 Descriptor:
(1) S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)	
(3)	
(4)	

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
09	08	21	09	08	21	11		97140		1	40 40	1		11580-2108
09	08	21	09	08	21	11		97110		1	37 91	1		11580-2108
09	08	21	09	08	21	11		97035		1	23 02	1		11580-2108
09	08	21	09	08	21	11		97010		1	5 25	1		11580-2108

☐ Check here if services were provided by a WCB preferred provider organization (PPO

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 08/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify): ____
- [ ] Labs (Specify): ____
- [ ] X-rays (Specify): ____
- [ ] Other (Specify): ____

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in ____
- [ ] Other (Specify): ____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____ months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results: ____

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions: ____

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on ____
   c. [ ] The patient can return to work with the following limitations (check all that apply) on ____
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify): ____

   Describe/quantify the limitations: ____

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name ____ Specialty ____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
Marygrace Lusan-urena PT		PHYSICAL THERAPIST	09/09/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

159134333 **C-4.2**

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 09/09/2021 - 09/09/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI)
2. Date of injury/illness: 06/11/2021
3. Soc.Sec. #: 000-00-9312
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Lusan-urena (Last) Marygrace (First) (MI)
2. WCB Authorization #: PT023781-8
3. WCB Rating Code: PT
4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN
5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)
6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE
7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)
8. Office phone #: 516-887-1787
9. Billing phone #: 516-374-6838
10. Treating Provider's NPI #: 1609042985

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND
2. Carrier Code #: W
3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
09	09	21	09	09	21	11		97140		1	40 40	1		11580-2108
09	09	21	09	09	21	11		97110		1	37 91	1		11580-2108
09	09	21	09	09	21	11		97035		1	23 02	1		11580-2108
09	09	21	09	09	21	11		97010		1	5 25	1		11580-2108

☐ Check here if services were provided by a WCB preferred provider organization (PPO

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify): ____
- [ ] Labs (Specify): ____
- [ ] X-rays (Specify): ____
- [ ] Other (Specify): ____

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in ____
- [ ] Other (Specify): ____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results: ____

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions: ____

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):

a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion

b. [ ] The patient can return to work without limitations on ____

c. [ ] The patient can return to work with the following limitations (check all that apply) on ____
- [ ] Bending/twisting
- [ ] Climbing stairs/ladders
- [ ] Environmental conditions
- [ ] Kneeling
- [ ] Lifting
- [ ] Operating heavy equipment
- [ ] Operation of motor vehicles
- [ ] Personal protective equipment
- [ ] Sitting
- [ ] Standing
- [ ] Use of public transportation
- [ ] Use of upper extremities
- [ ] Other (Specify): ____

Describe/quantify the limitations: ____

How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name ____ Specialty ____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
Marygrace Lusan-urena PT		PHYSICAL THERAPIST	09/10/2021

1260052240

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report C-4.2

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 09/10/2021 - 09/10/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI) 2. Date of injury/illness: 06/11/2021 3. Soc.Sec. #: 000-00-9312

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Tanlioco (Last) Joseph (First) (MI) 2. WCB Authorization #: PT019586-7W

3. WCB Rating Code: PT 4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN

5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)

6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE

7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)

8. Office phone #: 516-887-1787 9. Billing phone #: 516-374-6838 10. Treating Provider's NPI #: 1851372908

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND 2. Carrier Code #: W

3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
09	10	21	09	10	21	11		97140		1	40 40	1		11580-2108
09	10	21	09	10	21	11		97110		1	37 91	1		11580-2108
09	10	21	09	10	21	11		97035		1	23 02	1		11580-2108
09	10	21	09	10	21	11		97010		1	5 25	1		11580-2108

☐ Check here if services were provided by a WCB preferred provider organization (PPO

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 06/11/2021 1266857740

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify):
- [ ] Labs (Specify):
- [ ] X-rays (Specify):
- [ ] Other (Specify):

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in
- [ ] Other (Specify):

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ___months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions:

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):

a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion

b. [ ] The patient can return to work without limitations on

c. [ ] The patient can return to work with the following limitations (check all that apply) on

- [ ] Bending/twisting
- [ ] Climbing stairs/ladders
- [ ] Environmental conditions
- [ ] Kneeling
- [ ] Lifting
- [ ] Operating heavy equipment
- [ ] Operation of motor vehicles
- [ ] Personal protective equipment
- [ ] Sitting
- [ ] Standing
- [ ] Use of public transportation
- [ ] Use of upper extremities
- [ ] Other (Specify):

Describe/quantify the limitations:

How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A

4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name Specialty

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
Joseph Tanlioco PT		PHYSICAL THERAPIST	09/13/2021

1272005634 **C-4.2**

Workers' Compensation Board

Doctor's Progress Report

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 09/13/2021 - 09/13/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI) 2. Date of injury/illness: 06/11/2021 3. Soc.Sec. #: 000-00-9312

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Katsigiorgis (Last) Gus (First) (MI) 2. WCB Authorization #: 234244-2W

3. WCB Rating Code: OPCOS 4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN

5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)

6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE

7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)

8. Office phone #: 516-887-1787 9. Billing phone # 516-374-6838 10. Treating Provider's NPI # 1033105564

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND 2. Carrier Code #: W

3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

Enter ICD10 Code:	ICD10 Descriptor:
(1) S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)	
(3)	
(4)	

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
09	13	21	09	13	21	11		99213		1	87 80	1		11580-2108

Total Charges	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 87 80	$	$

☐ Check here if services were provided by a WCB preferred provider organization (PPO

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: Physical Exam

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

www.wcb.ny.gov

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify):
- [ ] Labs (Specify):
- [ ] X-rays (Specify):
- [ ] Other (Specify):

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [x] Physical Therapist
- [ ] Specialist in
- [x] Other (Specify): Rt Knee Arthroscopy

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today:

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ___months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions:

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on
   c. [ ] The patient can return to work with the following limitations (check all that apply) on
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify):

   Describe/quantify the limitations:

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [x] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name Specialty

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
Gus Katsigiorgis DO		PHYSICIAN	09/22/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report 126005974 C-4.2

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 09/13/2021 - 09/13/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI) 2. Date of injury/illness: 06/11/2021 3. Soc.Sec. #: 000-00-9312

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Lusan-urena (Last) Marygrace (First) (MI) 2. WCB Authorization #: PT023781-8

3. WCB Rating Code: PT 4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN

5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)

6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE

7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)

8. Office phone #: 516-887-1787 9. Billing phone # 516-374-6838 10. Treating Provider's NPI # 1609042985

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND 2. Carrier Code #: W

3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
09	13	21	09	13	21	11		97140		1	40 40	1		11580-2108
09	13	21	09	13	21	11		97110		1	37 91	1		11580-2108
09	13	21	09	13	21	11		97035		1	23 02	1		11580-2108
09	13	21	09	13	21	11		97010		1	5 25	1		11580-2108

☐ Check here if services were provided by a WCB preferred provider organization (PPO

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 06/11/2021 4 8

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify): ____
- [ ] Labs (Specify): ____
- [ ] X-rays (Specify): ____
- [ ] Other (Specify): ____

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in ____
- [ ] Other (Specify): ____

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results: ____

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions: ____

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on ____
   c. [ ] The patient can return to work with the following limitations (check all that apply) on ____
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify): ____

   Describe/quantify the limitations: ____

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name ____ Specialty ____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
Marygrace Lusan-urena PT		PHYSICAL THERAPIST	09/14/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 09/15/2021 - 09/15/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI)
2. Date of injury/illness: 06/11/2021
3. Soc.Sec. #: 000-00-9312
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Acosta (Last) Mary Jane (First) (MI)
2. WCB Authorization #: PT037451-2W
3. WCB Rating Code: PT
4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN
5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)
6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE
7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)
8. Office phone #: 516-887-1787
9. Billing phone # 516-374-6838
10. Treating Provider's NPI # 1124433792

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND
2. Carrier Code #: W
3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

Enter ICD10 Code:	ICD10 Descriptor:
(1) S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)	
(3)	
(4)	

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
09	15	21	09	15	21	11		97140		1	40 40	1		11580-2108
09	15	21	09	15	21	11		97110		1	37 91	1		11580-2108
09	15	21	09	15	21	11		97035		1	23 02	1		11580-2108
09	15	21	09	15	21	11		97010		1	5 25	1		11580-2108

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

☐ Check here if services were provided by a WCB preferred provider organization (PPO

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of Injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none 1266012143

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify):
- [ ] Labs (Specify):
- [ ] X-rays (Specify):
- [ ] Other (Specify):

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in
- [ ] Other (Specify):

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ___months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions:

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):

a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion

b. [ ] The patient can return to work without limitations on

c. [ ] The patient can return to work with the following limitations (check all that apply) on

- [ ] Bending/twisting
- [ ] Climbing stairs/ladders
- [ ] Environmental conditions
- [ ] Kneeling
- [ ] Lifting
- [ ] Operating heavy equipment
- [ ] Operation of motor vehicles
- [ ] Personal protective equipment
- [ ] Sitting
- [ ] Standing
- [ ] Use of public transportation
- [ ] Use of upper extremities
- [ ] Other (Specify):

Describe/quantify the limitations:

How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name Specialty

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
Mary Jane Acosta PT		PHYSICAL THERAPIST	09/17/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report 126786245 C-4.2

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 09/17/2021 - 09/17/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI)
2. Date of injury/illness: 06/11/2021
3. Soc.Sec. #: 000-00-9312
4. Address (if changed from previous report): 52 Charlos Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Lusan-urena (Last) Marygrace (First) (MI)
2. WCB Authorization #: PT023781-8
3. WCB Rating Code: PT
4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN
5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)
6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE
7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)
8. Office phone #: 516-887-1787
9. Billing phone #: 516-374-6838
10. Treating Provider's NPI #: 1609042985

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND
2. Carrier Code #: W
3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

Enter ICD10 Code:	ICD10 Descriptor:
(1) S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)	
(3)	
(4)	

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
09	17	21	09	17	21	11		97140		1	40 40	1		11580-2108
09	17	21	09	17	21	11		97110		1	37 91	1		11580-2108
09	17	21	09	17	21	11		97035		1	23 02	1		11580-2108
09	17	21	09	17	21	11		97010		1	5 25	1		11580-2108

☐ Check here if services were provided by a WCB preferred provider organization (PPO

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard (Last) Bayani (First) ___ (MI) Date of Injury/onset of illness? 06/11/2021 5 7

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any:

none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify): ___
- [ ] Labs (Specify): ___
- [ ] X-rays (Specify): ___
- [ ] Other (Specify): ___

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in ___
- [ ] Other (Specify): ___

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ___ months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results: ___

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions:

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on ___
   c. [ ] The patient can return to work with the following limitations (check all that apply) on ___
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify): ___

   Describe/quantify the limitations: ___

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name ___ Specialty ___

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
Marygrace Lusan-urena PT		PHYSICAL THERAPIST	09/20/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 09/20/2021 - 09/20/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI)
2. Date of injury/illness: 06/11/2021
3. Soc.Sec. #: 000-00-9312
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Tanlioco (Last) Joseph (First) (MI)
2. WCB Authorization #: PT019586-7W
3. WCB Rating Code: PT
4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN
5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)
6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE
7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)
8. Office phone #: 516-887-1787
9. Billing phone #: 516-374-6838
10. Treating Provider's NPI #: 1851372908

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND
2. Carrier Code #: W
3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
09	20	21	09	20	21	11		97140		1	40 40	1		11580-2108
09	20	21	09	20	21	11		97110		1	37 91	1		11580-2108
09	20	21	09	20	21	11		97035		1	23 02	1		11580-2108
09	20	21	09	20	21	11		97010		1	5 25	1		11580-2108

☐ Check here if services were provided by a WCB preferred provider organization (PPO

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of Injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify):
- [ ] Labs (Specify):
- [ ] X-rays (Specify):
- [ ] Other (Specify):

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [ ] Physical Therapist
- [ ] Specialist in
- [ ] Other (Specify):

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions:

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on
   c. [ ] The patient can return to work with the following limitations (check all that apply) on
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify):

Describe/quantify the limitations:

How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [ ] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name Specialty

Board Authorized Health Care Provider signature:

Joseph Tanlioco PT		PHYSICAL THERAPIST	09/21/2021
Name	Signature	Specialty	Date

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report 1272021130 C-4.2

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 09/22/2021 - 09/22/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI) 2. Date of injury/illness: 06/11/2021 3. Soc.Sec. #: 000-00-9312

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Tanlioco (Last) Joseph (First) (MI) 2. WCB Authorization #: PT019586-7W

3. WCB Rating Code: PT 4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN

5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)

6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE

7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)

8. Office phone #: 516-887-1787 9. Billing phone # 516-374-6838 10. Treating Provider's NPI # 1851372908

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND 2. Carrier Code #: W

3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

Enter ICD10 Code:	ICD10 Descriptor:
(1) S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)	
(3)	
(4)	

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
09	22	21	09	22	21	11		97140		1	40 40	1		11580-2108
09	22	21	09	22	21	11		97110		1	37 91	1		11580-2108
09	22	21	09	22	21	11		97035		1	23 02	1		11580-2108
09	22	21	09	22	21	11		97010		1	5 25	1		11580-2108

☐ Check here if services were provided by a WCB preferred provider organization (PPO

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify): ____
- [ ] Labs (Specify): ____
- [ ] X-rays (Specify): ____
- [ ] Other (Specify): ____

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [x] Physical Therapist
- [ ] Specialist in ____
- [x] Other (Specify): Rt Knee Arthroscopy

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____ months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results: ____

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions: ____

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   - a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   - b. [ ] The patient can return to work without limitations on ____
   - c. [ ] The patient can return to work with the following limitations (check all that apply) on ____
     - [ ] Bending/twisting
     - [ ] Climbing stairs/ladders
     - [ ] Environmental conditions
     - [ ] Kneeling
     - [ ] Lifting
     - [ ] Operating heavy equipment
     - [ ] Operation of motor vehicles
     - [ ] Personal protective equipment
     - [ ] Sitting
     - [ ] Standing
     - [ ] Use of public transportation
     - [ ] Use of upper extremities
     - [ ] Other (Specify): ____

   Describe/quantify the limitations: ____

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [x] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name ____ Specialty ____

Board Authorized Health Care Provider signature:

Joseph Tanlioco PT		PHYSICAL THERAPIST	09/23/2021
Name	Signature	Specialty	Date

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report 4119342

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 09/25/2021 - 09/25/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI)
2. Date of injury/illness: 06/11/2021
3. Soc.Sec. #: 000-00-9312
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Tanlioco (Last) Joseph (First) (MI)
2. WCB Authorization #: PT019586-7W
3. WCB Rating Code: PT
4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN
5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)
6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE
7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)
8. Office phone #: 516-887-1787
9. Billing phone #: 516-374-6838
10. Treating Provider's NPI #: 1851372908

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND
2. Carrier Code #: W
3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
09	25	21	09	25	21	11		97140		1	40 40	1		11580-2108
09	25	21	09	25	21	11		97110		1	37 91	1		11580-2108
09	25	21	09	25	21	11		97035		1	23 02	1		11580-2108
09	25	21	09	25	21	11		97010		1	5 25	1		11580-2108

☐ Check here if services were provided by a WCB preferred provider organization (PPO

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 06/11/2021 12 7 6 1 1 0 2 1 4 2

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify):
- [ ] Labs (Specify):
- [ ] X-rays (Specify):
- [ ] Other (Specify):

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [x] Physical Therapist
- [ ] Specialist in
- [x] Other (Specify): Rt Knee Arthroscopy

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____ months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions:

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on
   c. [ ] The patient can return to work with the following limitations (check all that apply) on
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify):

   Describe/quantify the limitations:

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [x] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name Specialty

Board Authorized Health Care Provider signature:

Joseph Tanlioco PT		PHYSICAL THERAPIST	09/27/2021
Name	Signature	Specialty	Date

NEW YORK STATE | Workers' Compensation Board

ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE AND INSURER'S RESPONSE

MG-2

For additional variance requests in this case, attach Form MG-2.1.
Answer all questions where information is known.

WCB Case #:	Claim Administrator Claim (carrier case) #: 73141129-110	Date of Injury/Illness: 6/11/2021

A. Patient's Name: DILLARD, BAYANI (First, MI, Last) Social Security No.:

Patient's Address: 52 CHARLES STREET MALVERNE, NY 11565

Employer's Name & Address: FLUSHING HOSPITAL MEDICAL CENTER

Insurer's Name & Address: NYSIF PO BOX 66596 ALBANY NY

B. Attending Doctor's Name & Address: GUS KATSIGIORGIS, D.O., 125 FRANKLIN AVENUE VALLEY STREAM, NY 11580

Individual Provider's WCB Authorization No.: 2 3 4 2 4 4 - 2 0 NPI No.: 1033105564

Telephone No.: 516-887-1787 Fax No.: 516-900-9508

C. *The undersigned requests approval to VARY from the WCB Medical Treatment Guidelines as indicated below:*

Guideline Reference: K - D 6 u

(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE)

Approval Requested for: (one request type per form)

REQUEST FOR POST OPERATIVE COLD THERAPY UNIT WITH COMPRESSION AND DVT, FOR HOME USE; 1 HOUR, 3x/DAY, FOR A RENTAL OF 21 DAYS RIGHT KNEE.

STATEMENT OF MEDICAL NECESSITY - See item 5 on instruction page.

Your explanation must provide the following information:
- the basis for your opinion that the medical care you propose is appropriate for the patient and is medically necessary at this time; and
- an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:
- a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment; and
- the specific duration or frequency of treatment for which a variance is requested.

Variance requests for treatment or testing that is not recommended or not addressed, must include:
- the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
- medical evidence in support of efficacy of the proposed treatment or testing- may include relevant medical literature published in recognized peer reviewed journals.

Date of service of supporting medical in WCB case file, if not attached: 09/20/2021

Date(s) of previously denied variance request for substantially similar treatment, if applicable:

Provider must enter in A the designated fax or email address this request was sent to. Insurer/self-insurer's designated contact information is available online at: wcb.ny.gov/medical-treatment-guideline-variance-request. Check "Designated contact information not available", if appropriate. If the request was sent to a different (contact information is not available on Board's website) or additional fax or email address provided by the insurer, complete B. If you are unable to send or receive email or fax, complete C.

A. *Insurer's designated fax # or email address as provided on the Board's website:* NYSIF-MG2-C4Auth@nysif.com

☐ ***Designated contact information not available.***

B. *If the request was also submitted to another fax # or email address provided by the insurer, provide here:* wcbclaimsfiling@wcb.ny.gov;

C. *I am not equipped to send or receive forms by fax or email. This form was mailed (return receipt requested) on* _____

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Guidelines. I certify that the patient understands and agrees to undergo the proposed medical care. I ☑ did / ☐ did not contact the insurer by telephone to discuss this variance request before making the request. I contacted the insurer by telephone on (date) _____ and spoke to (person spoke to or was not able to speak to anyone) _____

I sent or directed my office to send a copy of this request to the insurer, the Chair, the patient and the patient's legal representative, if any, on the same day, and sent or directed my office to send a copy to the Workers' Compensation Board within two (2) business days of the date below. In addition, I certify that I do not have a substantially similar request pending and that this request contains additional supporting medical evidence if it is substantially similar to a prior denied request.

Provider's Signature: _____ Date: 9/28/2021

MG-2.0 4-18

Patient Name: DILLARD, BAYANI	WCB Case #:	Date of Injury/Illness: 06/11/2021

D. INSURER'S / EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW

☐ The self-insurer/insurer hereby gives notice that it will have the patient examined by an Independent Medical Examiner or the claimant's medical records reviewed by a Records Reviewer and submit Form IME-4 within 30 calendar days of the variance request.

By: (print name) _____ Title: _____

Signature: _____ Date: _____

E. INSURER'S / EMPLOYER'S RESPONSE TO VARIANCE REQUEST

Insurer's response to the variance request is indicated in the checkboxes on the right. Insurer denial, when appropriate, should be reviewed by a health professional. (Attach written report of medical professional.) If request is approved or denied, sign and date the form in Section E.

INSURER'S / EMPLOYER'S RESPONSE
If service is denied or granted in part, explain in space provided.

☐ Granted
☐ Granted in Part
☐ Without Prejudice

☐ Denied
☐ Burden of Proof Not Met
☐ Substantially Similar Request Pending or Denied

Name of the Medical Professional who reviewed the denial, if applicable: _____

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal representative, if any, and any other parties of interest, with the written report of the medical professional in the office of the insurer/employer/ self-insured employer/Special Fund attached, within two (2) business days of the date below.

(Please complete if request is denied.) If the issue cannot be resolved informally, I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the patient, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB Hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

By: (print name) _____ Title: _____

Signature: _____ Date: _____

F. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND INSURER / EMPLOYER

I certify that the provider's variance request initially denied above is now granted or partially granted.

By: (print name) _____ Title: _____

Insurer's Signature: _____ Date: _____

G. CLAIMANT'S / CLAIMANT REPRESENTATIVE'S REQUEST FOR REVIEW OF INSURER'S / EMPLOYER'S DENIAL

NOTE to Claimant's / Claimant Licensed Representative's: The claimant should only sign this section after the request is fully or partially denied. This section should not be completed at the time of initial request.

YOU MUST COMPLETE THIS SECTION IF YOU WANT THE BOARD TO REVIEW THE INSURER'S DENIAL OF THE PROVIDER'S VARIANCE REQUEST.

☐ I request that the Workers' Compensation Board review the insurer's denial of my doctor's request for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

Claimant's / Claimant Representative's Signature: _____ Date: _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

NYS Workers' Compensation Board
PO Box 5206
Binghamton, NY 13902-52055

Email Filing: wcbclaimsfiling@wcb.ny.gov • Customer Service: (877) 632-4996 • Statewide Fax: (877) 533-0337

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NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 09/28/2021 - 09/28/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI) 2. Date of injury/illness: 06/11/2021 3. Soc.Sec. #: 000-00-9312

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Acosta (Last) Mary Jane (First) (MI) 2. WCB Authorization #: PT037451-2W

3. WCB Rating Code: PT 4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN

5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)

6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE

7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)

8. Office phone #: 516-887-1787 9. Billing phone # 516-374-6838 10. Treating Provider's NPI # 1124433792

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND 2. Carrier Code #: W

3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

Enter ICD10 Code:	ICD10 Descriptor:
(1) S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)	
(3)	
(4)	

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Procedures, Services or Supplies (Use WCB Codes) CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
09	28	21	09	28	21	11		97140		1	40 40	1		11580-2108
09	28	21	09	28	21	11		97110		1	37 91	1		11580-2108
09	28	21	09	28	21	11		97035		1	23 02	1		11580-2108
09	28	21	09	28	21	11		97010		1	5 25	1		11580-2108

☐ Check here if services were provided by a WCB preferred provider organization (PPO

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none 1277102550

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify):
- [ ] Labs (Specify):
- [ ] X-rays (Specify):
- [ ] Other (Specify):

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [x] Physical Therapist
- [ ] Specialist in
- [x] Other (Specify): Rt Knee Arthroscopy

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions:

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on
   c. [ ] The patient can return to work with the following limitations (check all that apply) on
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify):

   Describe/quantify the limitations:

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [x] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name Specialty

Board Authorized Health Care Provider signature:

Mary Jane Acosta PT		PHYSICAL THERAPIST	09/29/2021
Name	Signature	Specialty	Date

Workers' Compensation Board

G3051719

ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE AND INSURER'S RESPONSE

MG-2

For additional variance requests in this case, attach Form MG-2.1.
Answer all questions where information is known.

WCB Case #:	Claim Administrator Claim (carrier case) #: 73141129-110	Date of Injury/Illness: 6/11/2021

A. Patient's Name: DILLARD, BAYANI (First / MI / Last) Social Security No.:

Patient's Address: 52 CHARLES STREET MALVERNE, NY 11565

Employer's Name & Address: FLUSHING HOSPITAL MEDICAL CENTER

Insurer's Name & Address: NYSIF PO BOX 66996 ALBANY NY

B. Attending Doctor's Name & Address: GUS KATSIGIORGIS, D.O., 125 FRANKLIN AVENUE VALLEY STREAM, NY 11580

Individual Provider's WCB Authorization No.: 2 3 4 2 4 4 - 2 0 NPI No.: 1033106564

Telephone No.: 516-887-1787 Fax No.: 516-900-9508

C. *The undersigned requests approval to VARY from the WCB Medical Treatment Guidelines as indicated below:*

Guideline Reference: K - D 6 u

(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE)

Approval Requested for: (one request type per form)

REQUEST FOR POST OPERATIVE COLD THERAPY UNIT WITH COMPRESSION AND DVT, FOR HOME USE; 1 HOUR, 3x/DAY, FOR A RENTAL OF 21 DAYS RIGHT KNEE.

FOR 21 DAYS RENTAL OF ALL EQUIPMENTS WILL PAY $255.00 - ALL INCLUDED.

STATEMENT OF MEDICAL NECESSITY - See item 6 on instruction page.
Your explanation must provide the following information:
- the basis for your opinion that the medical care you propose is appropriate for the patient and is medically necessary at this time; and
- an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:
- a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment; and
- the specific duration or frequency of treatment for which a variance is requested.

Variance requests for treatment or testing that is not recommended or not addressed, must include:
- the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
- medical evidence in support of efficacy of the proposed treatment or testing- may include relevant medical literature published in recognized peer reviewed journals.

Date of service of supporting medical in WCB case file, if not attached: 09/20/2021

Date(s) of previously denied variance request for substantially similar treatment, if applicable:

Provider must enter in A the designated fax or email address this request was sent to. Insurer/self-insurer's designated contact information is available online at: wcb.ny.gov/medical-treatment-guideline-variance-request. Check "Designated contact information not available", if appropriate. If the request was sent to a different (contact information is not available on Board's website) or additional fax or email address provided by the insurer, complete B. If you are unable to send or receive email or fax, complete C.

A. *Insurer's designated fax # or email address as provided on the Board's website:* NYSIF-MG2-C4Auth@nysif.com

☐ ***Designated contact information not available.***

B. *If the request was also submitted to another fax # or email address provided by the insurer, provide here:* wcbclaimsfiling@wcb.ny.gov;

C. *I am not equipped to send or receive forms by fax or email. This form was mailed (return receipt requested) on:*

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Guidelines. I certify that the patient understands and agrees to undergo the proposed medical care. I ☑ did / ☐ did not contact the insurer by telephone to discuss this variance request before making the request. I contacted the insurer by telephone on (date) _____ and spoke to (person spoke to or was not able to speak to anyone) _____

I sent or directed my office to send a copy of this request to the insurer, the Chair, the patient and the patient's legal representative, if any, on the same day, and sent or directed my office to send a copy to the Workers' Compensation Board within two (2) business days of the date below. In addition, I certify that I do not have a substantially similar request pending and that this request contains additional supporting medical evidence if it is substantially similar to a prior denied request.

Provider's Signature: _____ Date: 9/28/2021

Patient Name: DILLARD, BAYANI	WCB Case #:	Date of Injury/Illness: 06/11/2021

D. INSURER'S / EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW

☐ The self-insurer/insurer hereby gives notice that it will have the patient examined by an Independent Medical Examiner or the claimant's medical records reviewed by a Records Reviewer and submit Form IME-4 within 30 calendar days of the variance request.

By: (print name) _____ Title: _____

Signature: _____ Date: _____

E. INSURER'S / EMPLOYER'S RESPONSE TO VARIANCE REQUEST

Insurer's response to the variance request is indicated in the checkboxes on the right. Insurer denial, when appropriate, should be reviewed by a health professional. (Attach written report of medical professional.) If request is approved or denied, sign and date the form in Section E.

FOR 21 DAYS RENTAL OF ALL EQUIPMENTS
WILL PAY $255.00 - ALL INCLUDED.

INSURER'S / EMPLOYER'S RESPONSE
If service is denied or granted in part, explain in space provided.

☐ Granted
☒ Granted in Part
☐ Without Prejudice

☐ Denied
☐ Burden of Proof Not Met
☐ Substantially Similar Request Pending or Denied

Name of the Medical Professional who reviewed the denial, if applicable: _____

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal representative, if any, and any other parties of interest, with the written report of the medical professional in the office of the insurer/employer/self-insured employer/Special Fund attached, within two (2) business days of the date below.

(Please complete if request is denied.) If the issue cannot be resolved informally, I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the patient, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB Hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

By: (print name) Y. Patel Title: CSRI

Signature: ypatel Date: 09/30/21

F. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND INSURER / EMPLOYER

I certify that the provider's variance request initially denied above is now granted or partially granted.

By: (print name) _____ Title: _____

Insurer's Signature: _____ Date: _____

G. CLAIMANT'S / CLAIMANT REPRESENTATIVE'S REQUEST FOR REVIEW OF INSURER'S / EMPLOYER'S DENIAL

NOTE to Claimant's / Claimant Licensed Representative's: The claimant should only sign this section after the request is fully or partially denied. This section should not be completed at the time of initial request.

YOU MUST COMPLETE THIS SECTION IF YOU WANT THE BOARD TO REVIEW THE INSURER'S DENIAL OF THE PROVIDER'S VARIANCE REQUEST.

☐ I request that the Workers' Compensation Board review the insurer's denial of my doctor's request for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

Claimant's / Claimant Representative's Signature: _____ Date: _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

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PAGE 11 * RCVD AT 9/28/2021 12:08:22 PM [Eastern Daylight Time] * SVR:ALB-RFAX1-12/14 * DNIS:3120023 * CSID: * ANI:1049 * DURATION (mm-ss):16-34

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 09/29/2021 - 09/29/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI) 2. Date of injury/illness: 06/11/2021 3. Soc.Sec. #: 000-00-9312

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Tanlioco (Last) Joseph (First) (MI) 2. WCB Authorization #: PT019586-7W

3. WCB Rating Code PT 4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN

5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)

6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE

7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)

8. Office phone #: 516-887-1787 9. Billing phone # 516-374-6838 10. Treating Provider's NPI # 1851372908

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND 2. Carrier Code #: W

3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

Enter ICD10 Code:	ICD10 Descriptor:
(1) S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)	
(3)	
(4)	

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Carrier Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
09	29	21	09	29	21	11		97140		1	40 40	1		11580-2108
09	29	21	09	29	21	11		97110		1	37 91	1		11580-2108
09	29	21	09	29	21	11		97035		1	23 02	1		11580-2108
09	29	21	09	29	21	11		97010		1	5 25	1		11580-2108

☐ Check here if services were provided by a WCB preferred provider organization (PPO

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify): ____
- [ ] Labs (Specify): ____
- [ ] X-rays (Specify): ____
- [ ] Other (Specify): ____

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [x] Physical Therapist
- [ ] Specialist in ____
- [x] Other (Specify): Rt Knee Arthroscopy

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____ months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results: ____

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions: ____

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on ____
   c. [ ] The patient can return to work with the following limitations (check all that apply) on ____
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify): ____

   Describe/quantify the limitations: ____

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [x] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name ____ Specialty ____

Board Authorized Health Care Provider signature:

Joseph Tanlioco PT (Name) — Signature — PHYSICAL THERAPIST (Specialty) — 09/30/2021 (Date)

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

1279044810

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 09/30/2021 - 09/30/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI)
2. Date of injury/illness: 06/11/2021
3. Soc.Sec. #: 000-00-9312
4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)
5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Tanlioco (Last) Joseph (First) (MI)
2. WCB Authorization #: PT019586-7W
3. WCB Rating Code: PT
4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN
5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)
6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE
7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)
8. Office phone #: 516-887-1787
9. Billing phone #: 516-374-6838
10. Treating Provider's NPI #: 1851372908

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND
2. Carrier Code #: W
3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)
4. Diagnosis or nature of disease or injury:

Enter ICD10 Code:	ICD10 Descriptor:
(1) S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)	
(3)	
(4)	

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
09	30	21	09	30	21	11		97140		1	40 40	1		11580-2108
09	30	21	09	30	21	11		97110		1	37 91	1		11580-2108
09	30	21	09	30	21	11		97035		1	23 02	1		11580-2108
09	30	21	09	30	21	11		97010		1	5 25	1		11580-2108

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

☐ Check here if services were provided by a WCB preferred provider organization (PPO

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 06/11/2021

127984821B

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury; patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify):
- [ ] Labs (Specify):
- [ ] X-rays (Specify):
- [ ] Other (Specify):

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [x] Physical Therapist
- [ ] Specialist in
- [x] Other (Specify): Rt Knee Arthroscopy

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____ months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results:

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions:

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on
   c. [ ] The patient can return to work with the following limitations (check all that apply) on
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities
      - [ ] Other (Specify):

   Describe/quantify the limitations:

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [x] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name Specialty

Board Authorized Health Care Provider signature:

Joseph Tanlioco PT		PHYSICAL THERAPIST	10/01/2021
Name	Signature	Specialty	Date

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report C-4.2

1281029684

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 10/04/2021 - 10/04/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI) 2. Date of injury/illness: 06/11/2021 3. Soc.Sec. #: 000-00-9312

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Acosta (Last) Mary Jane (First) (MI) 2. WCB Authorization #: PT037451-2W

3. WCB Rating Code PT 4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN

5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)

6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE

7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)

8. Office phone #: 516-887-1787 9. Billing phone # 516-374-6838 10. Treating Provider's NPI # 1124433792

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND 2. Carrier Code #: W

3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

	Enter ICD10 Code:	ICD10 Descriptor:
(1)	S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)		
(3)		
(4)		

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
10	04	21	10	04	21	11		97140		1	40 40	1		11580-2108
10	04	21	10	04	21	11		97110		1	37 91	1		11580-2108
10	04	21	10	04	21	11		97035		1	23 02	1		11580-2108
10	04	21	10	04	21	11		97010		1	5 25	1		11580-2108

☐ Check here if services were provided by a WCB preferred provider organization (PPO

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 58	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

www.wcb.ny.gov

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify): ____
- [ ] Labs (Specify): ____
- [ ] X-rays (Specify): ____
- [ ] Other (Specify): ____

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [x] Physical Therapist
- [ ] Specialist in ____
- [x] Other (Specify): Rt Knee Arthroscopy

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____ months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results: ____

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions: ____

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
   a. [x] The patient cannot return to work because (explain) Pain & restricted range of motion
   b. [ ] The patient can return to work without limitations on ____
   c. [ ] The patient can return to work with the following limitations (check all that apply) on ____
      - [ ] Bending/twisting
      - [ ] Climbing stairs/ladders
      - [ ] Environmental conditions
      - [ ] Kneeling
      - [ ] Other (Specify): ____
      - [ ] Lifting
      - [ ] Operating heavy equipment
      - [ ] Operation of motor vehicles
      - [ ] Personal protective equipment
      - [ ] Sitting
      - [ ] Standing
      - [ ] Use of public transportation
      - [ ] Use of upper extremities

   Describe/quantify the limitations: ____

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [x] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name ____ Specialty ____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
Mary Jane Acosta PT		PHYSICAL THERAPIST	10/05/2021

NEW YORK STATE | Workers' Compensation Board

Doctor's Progress Report

C-4.2

Use this form to report continuing services. (To report the first time you treated the patient, use Form C-4. To reports permanent impairment, use Form C-4.3.)

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination: 10/11/2021 - 10/11/2021

WCB Case # (if known): G3051719 Carrier Case #: 73141129-110

A. Patient's Information

1. Name: Dillard (Last) Bayani (First) (MI) 2. Date of injury/illness: 06/11/2021 3. Soc.Sec. #: 000-00-9312

4. Address (if changed from previous report): 52 Charles Street (Number and Street) Malverne (City) NY (State) 11565 (Zip Code)

5. Patient's Account #: 264184

B. Doctor's Information

1. Your name: Acosta (Last) Mary Jane (First) (MI) 2. WCB Authorization #: PT037451-2W

3. WCB Rating Code: PT 4. Federal Tax ID #: 113292487 The Tax ID # is the (check one): ☐ SSN ☒ EIN

5. Office address: 125 FRANKLIN AVENUE (Number and Street) VALLEY STREAM (City) NY (State) 11580-2108 (Zip Code)

6. Billing group or practice name: ISLAND MUSCULOSKELETAL CARE

7. Billing address: PO Box 360 (Number and Street) Hewlett (City) NY (State) 11557-9998 (Zip Code)

8. Office phone #: 516-887-1787 9. Billing phone # 516-374-6838 10. Treating Provider's NPI # 1124433792

C. Billing Information

1. Employer's insurance company: STATE INSURANCE FUND 2. Carrier Code #: W

3. Insurance company's address: Po Box 66699 (Number and Street) Albany (City) NY (State) 12206 (Zip Code)

4. Diagnosis or nature of disease or injury:

Enter ICD10 Code:	ICD10 Descriptor:
(1) S83.241D	Oth tear of medial meniscus, current injury, r knee, subs
(2)	
(3)	
(4)	

Relate ICD10 codes in (1), (2), (3), or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPC	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered
10	11	21	10	11	21	11		97140		1	40 40	1		11580-2108
10	11	21	10	11	21	11		97110		1	37 91	1		11580-2108
10	11	21	10	11	21	11		97035		1	23 02	1		11580-2108
10	11	21	10	11	21	11		97010		1	5 25	1		11580-2108

☐ Check here if services were provided by a WCB preferred provider organization (PPO

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$ 106 56	$	$

D. Examination and Treatment

1. Describe any diagnostic test(s) rendered at this visit: none

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Patient's Name: Dillard (Last) Bayani (First) (MI) Date of injury/onset of illness: 06/11/2021

2. List any changes revealed by your most recent examination in the following: area of injury, type/nature of injury, patient's subjective complaints or your objective findings: none

3. List additional body parts affected by this injury, if any: none

4. Based on your most recent examination, list changes to the original treatment plan, prescription medications or assistive devices, if any: none

5. Based on this examination, does the patient need diagnostic tests or referrals? [x] Yes [ ] No If yes, check all that apply:

Tests:
- [ ] CT Scans
- [ ] EMG/NCS
- [ ] MRI (Specify): ____
- [ ] Labs (Specify): ____
- [ ] X-rays (Specify): ____
- [ ] Other (Specify): ____

Referrals:
- [ ] Chiropractor
- [ ] Internist/Family Physician
- [ ] Occupational Therapis
- [x] Physical Therapist
- [ ] Specialist in ____
- [x] Other (Specify): Rt Knee Arthroscopy

Important: Form C-4 AUTH should be used to request any special medical service over $1000 or for those services requiring pre-authorization pursuant to the Medical Treatment Guidlines for the back, neck, knee and shoulder.

6. Describe treatment rendered today: physical therapy

7. When is patient's next follow-up visit? [ ] Within a week [x] 1-2 wks [ ] 3-4 wks [ ] 5-6 wks [ ] 7-8 wks [ ] ____ months [ ] as needed

E. Doctor's Opinion (based on this examination)

1. In your opinion, was the incident that the patient described the competent medical cause of this injury/illness? [x] Yes [ ] No
2. Are the patient's complaints consistent with his/her history of the injury/illness? [x] Yes [ ] No
3. Is the patient's history of the injury/illness consistent with your objective findings? [x] Yes [ ] No [ ] N/A (no findings at this time)
4. What is the percentage (0-100%) of temporary impairment? 100.00 %
5. Describe findings and relevant diagnostic test results: ____

F. Return to Work

1. Is patient working now? [ ] Yes [x] No If yes, are there work restrictions? [ ] Yes [ ] No If yes, describe the work restrictions: ____

How long will the work restrictions apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time

2. Can the patient return to work? (*check only one*):
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   - c. [ ] The patient can return to work with the following limitations (check all that apply) on ____
     - [ ] Bending/twisting
     - [ ] Climbing stairs/ladders
     - [ ] Environmental conditions
     - [ ] Kneeling
     - [ ] Lifting
     - [ ] Operating heavy equipment
     - [ ] Operation of motor vehicles
     - [ ] Personal protective equipment
     - [ ] Sitting
     - [ ] Standing
     - [ ] Use of public transportation
     - [ ] Use of upper extremities
     - [ ] Other (Specify): ____

   Describe/quantify the limitations: ____

   How long will the work limitations apply? [ ] 1-2 days [ ] 3-7 days [ ] 8-14 days [ ] 15+ days [ ] Unknown at this time [ ] N/A

3. With whom will you discuss the patient's return to work and/or limitations? [x] with patient [ ] with patient's employer [ ] N/A
4. Would the patient benefit from vocational rehabilitation? [ ] Yes [x] No

This form is signed under penalty of perjury.

Board Authorized Health Care Provider - Check one

[x] I provided the services listed above.

[ ] I actively supervised the health-care provider named below who provided these service

Provider's name ____ Specialty ____

Board Authorized Health Care Provider signature:

Name	Signature	Specialty	Date
Mary Jane Acosta PT		PHYSICAL THERAPIST	10/12/2021

WORKERS' COMPENSATION BOARD

State of New York - Workers' Compensation Board

Subsequent Report of Injury
Report Type (MTC) PY-Payment Report

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.
The Claim Administrator has made payment(s) as reflected in Benefits and/or Payments Section of this document.

Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719 **Date of Injury** 06/11/2021

Claim Administrator Claim Number 73141129-110 **Maintenance Type Code Date** 11/12/2021

Claim Type I - Indemnity for Lost Time **WCB Received Date** 11/12/2021

Agreement to Compensate L - With Liability

INSURER INFORMATION

FEIN xxxxx3200 **Insurer ID** W204002

CLAIM ADMINISTRATOR INFORMATION

Name New York State Insurance Fund **FEIN** xxxxx3200

Claim Representative Name Yogesh Patel **Postal Code** 10007-1100

Business Phone Number 6317564176 **Fax Number**

E-mail Address ypate@nysif.com **Claim Admin ID** W204002

Late Reason

EMPLOYEE INFORMATION

First Name Bayani **Middle Name/Initial**

Last Name Dillard **Suffix**

Date of Birth 11/05/1976

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx9312

CLAIM INFORMATION

Date Employer Had Knowledge of Date of Disability 06/14/2021 **Employment Status** 1 - Regular/Full-time Employee

Pre-existing Disability **Number of Days Worked Per Week** 5

Work Days Scheduled (S-Scheduled N-Non Scheduled) S M T W T F S **Work Week Type**

Calculated Wage $1,362.31 **Wage Period** 01 - Weekly

Calculated Weekly Compensation Amount $908.21 **Denial Rescission Date**

Employer Paid Salary Prior To Acquisition

Date Claim Administrator Notified of Employee Representation

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

Employer Paid Salary in Lieu of Compensation

Type of Loss 01 - Traumatic Injury

Date of Maximum Medical Improvement

PERMANENT IMPAIRMENT

Impairment Percentage

Body Part

Death Result of Injury

Date of Death

Number of Dependents 0

Dependent/Payee Relationship

WORK STATUS

First Day of Disability After The Waiting Period

Latest Return to Work Status Date

Initial Date Disability Began 06/12/2021

Initial Return to Work Date

Return To Work Type

Physical Restrictions

Return To Work Same Employer

BENEFITS

Reduced Benefit Amount

Estimated Gross Weekly Amt.

Benefits

Benefit Types
050 - Temporary Total
070 - Temporary Partial

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross		Weekly Net		Benefit Payment Issue Date	Amount Paid
					Effective Date	Amount	Effective Date	Amount		

Benefits - Cumulative

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
050 - Temporary Total	06/18/2021	08/25/2021	9	4	$8,900.46
070 - Temporary Partial	08/26/2021	11/19/2021	12	2	$7,440.00

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	$900.00	350 - Total Payments to Physicians	$1,259.13
370 - Total Other Medical	$570.85	460 - Total Physical Therapy Costs	$5,448.94

PAYMENTS

Award/Order Date _____ Lump Sum Payment/Settlement _____

Payment Reasons

340 - Total Claimant's Legal Expenses

Payment Reason Code	Payee	Start Date	Through Date	Issue Date	Amount Paid
340	REX E. ZACHOFSKY, PLLC	11/10/2021	11/10/2021	11/10/2021	$900.00

Recoveries

Recovery Type	Amount

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx1781 Insured FEIN xxxxx1781

CONCURRENT EMPLOYER INFORMATION

Name _____ Contact Business Phone _____ Wage _____

WORKERS' COMPENSATION BOARD

State of New York - Workers' Compensation Board

Subsequent Report of Injury
Report Type (MTC) CB-Change in Benefit Type

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.
The Claim Administrator has changed the benefit type from what was previously reported.

Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719 **Date of Injury** 06/11/2021

Claim Administrator Claim Number 73141129-110 **Maintenance Type Code Date** 11/12/2021

Claim Type I - Indemnity for Lost Time **WCB Received Date** 11/12/2021

Agreement to Compensate L - With Liability

INSURER INFORMATION

FEIN xxxxx3200 **Insurer ID** W204002

CLAIM ADMINISTRATOR INFORMATION

Name New York State Insurance Fund **FEIN** xxxxx3200

Claim Representative Name Yogesh Patel **Postal Code** 10007-1100

Business Phone Number 6317564176 **Fax Number**

E-mail Address ypate@nysif.com **Claim Admin ID** W204002

Late Reason

EMPLOYEE INFORMATION

First Name Bayani **Middle Name/Initial**

Last Name Dillard **Suffix**

Date of Birth 11/05/1976

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx9312

CLAIM INFORMATION

Date Employer Had Knowledge of Date of Disability 06/14/2021 **Employment Status**

Work Days Scheduled (S-Scheduled N-Non Scheduled) S M T W T F S **Work Week Type**

Calculated Wage $1,362.31 **Wage Period**

Calculated Weekly Compensation Amount $908.21

Employer Paid Salary Prior To Acquisition

Date Claim Administrator Notified of Employee Representation

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

Employer Paid Salary in Lieu of Compensation

Type of Loss 01 - Traumatic Injury

Date of Maximum Medical Improvement

PERMANENT IMPAIRMENT

Impairment Percentage

Body Part

Number of Dependents 0

Dependent/Payee Relationship

WORK STATUS

First Day of Disability After The Waiting Period

Current Date Last Day Worked

Initial Return to Work Date

Current Date Disability Began

Latest Return to Work Status Date

Return To Work Type

Physical Restrictions

Return To Work Same Employer

BENEFITS

Reduced Benefit Amount R - Reclassification of Benefit

Non-Consecutive Period

Estimated Gross Weekly Amt.

Benefits

Benefit Types

050 - Temporary Total

070 - Temporary Partial

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross Effective Date	Weekly Gross Amount	Weekly Net Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid
050	06/18/2021	08/25/2021	9	4	06/18/2021	$908.21	06/18/2021	$908.21		$8,900.46
070	08/26/2021	11/19/2021	12	2	08/26/2021	$600.00	08/26/2021	$600.00		$7,440.00

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	$900.00	350 - Total Payments to Physicians	$1,259.13
370 - Total Other Medical	$570.85	460 - Total Physical Therapy Costs	$5,448.94

PAYMENTS

Award/Order Date

Recoveries

Recovery Type	Amount

Reduced Earnings

Week Number	Actual Reduced Earnings

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx1781

Insured FEIN xxxxx1781

CONCURRENT EMPLOYER INFORMATION

Name

Contact Business Phone

Wage

Workers' Compensation Board

ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE AND INSURER'S RESPONSE

MG-2

For additional variance requests in this case, attach Form MG-2.1.
Answer all questions where information is known.

WCB Case #:G3051719	Claim Administrator Claim (Carrier Case) 73141129-110	Date of Injury/Illness: 6/11/2021

A. Patient's Name: Bayani (First) Dillard (MI) (Last) Social Security Number: 000-00-0312

Patient's Address: 52 Charles Street, Malverne, NY 11565

Employer's Name & Address: Flushing Hospital Medical Center, 4500 Parsons Blvd, Flushing, NY 11355

Insurer's Name & Address: STATE INSURANCE FUND, Po Box 66699 Albany, NY 12206

B. Attending Doctor's Name & Address: Gus Katsigiorgis DO, 126 Franklin Ave, Valley Stream, NY 11580-2108

Individual Provider's WCB Authorization No.: 2 3 4 2 4 4 2 W NPI No.: 1033105564

Telephone No.: 516-887-1787 Fax No.: 516-887-2059

C. *The undersigned requests approval to VARY from the WCB Medical Treatment Guidelines as indicated below:*

Guideline Reference: K - E 7 E [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE)*

Approval Requested for: (one request type per form) 97110- THERAPEUTIC EXERCISE- 3 TIMES PER WEEK FOR 6 WEEKS- RIGHT KNEE- PLEASE SEE THE ATTACHED RE-EVALUATION NOTE.

STATEMENT OF MEDICAL NECESSITY -- See item 5 on instruction page.

Your explanation must provide the following information:
- the basis for your opinion that the medical care you propose is appropriate for the patient and is medically necessary at this time; and
- an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:
- a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment; and
- the specific duration or frequency of treatment for which a variance is requested.

Variance requests for treatment or testing that is not recommended or not addressed, must include:
- the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
- medical evidence in support of efficacy of the proposed treatment or testing- may include relevant medical literature published in recognized peer reviewed journals.

Date of Service of Supporting Medical in WCB Case File, if not attached: 11/23/2021

Date(s) of previously denied variance request for substantially similar treatment, if applicable:

Provider must enter in **A** the designated fax or email address this request was sent to. Insurer/self-insurer's designated contact information is available online at: wcb.ny.gov/medical-treatment-guideline-variance-request. Check "Designated contact information not available", if appropriate. If the request was sent to a different (contact information is not available on Board's website) or additional fax or email address provided by the insurer, complete **B**. If you are unable to send or receive email or fax, complete **C**.

A. *Insurer's designated fax # or email address as provided on the Board's website:* NYSIF-MG2-C4AUTH@NYSIF.COM

☐ ***Designated contact information not available.***

B. *If the request was also submitted to another fax # or email address provided by the insurer, provide here:* _____

C. *I am not equipped to send or receive forms by fax or email. This form was mailed (return receipt requested) on:* _____

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Guidelines. I certify that the patient understands and agrees to undergo the proposed medical care. I ☐ did / ☒ did not contact the insurer by telephone to discuss this variance request before making the request. I contacted the insurer by telephone on (date) 11/24/2021 and spoke to (person spoke to or was not able to speak to anyone)

I sent or directed my office to send a copy of this request to the insurer, the Chair, the patient and the patient's legal representative, if any, on the same day, and sent or directed my office to send a copy to the Workers' Compensation Board within two (2) business days of the date below. In addition, I certify that I do not have a substantially similar request pending and that this request contains additional supporting medical evidence if it is substantially similar to a prior denied request.

Provider's Signature: _____ Date: 11/24/2021

Patient Name: Bayani Dillard	WCB Case #: G3051719	Date of Injury/Illness: 6/11/2021

D. INSURER'S / EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW

☐ The self-insurer/carrier hereby gives notice that it will have the claimant examined by an Independent Medical Examiner or the claimant's medical records reviewed by a Records Reviewer and submit Form IME-4 within 30 calendar days of the Variance Request.

By: (print name) ..... Title: .....

Signature: ..... Date: .....

E. INSURER'S / EMPLOYER'S RESPONSE TO VARIANCE REQUEST

Insurer's response to the variance request is indicated in the checkboxes on the right. Insurer denial, when appropriate, should be reviewed by a health professional. (Attach written report of medical professional.) If request is approved or denied, sign and date the form in Section E.

Granted only post-op Physical Therapy.

INSURER'S/EMPLOYER'S RESPONSE
If service is denied or granted in part, explain in space

- ☒ Granted
- ☐ Granted in Part
- ☐ Without Prejudice
- ☐ Denied
- ☐ Burden of Proof Not Met
- ☐ Substantially Similar Request Pending or Denied

Name of the Medical Professional who reviewed the denial, if applicable .....

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal counsel, if any, and any other parties of interest, with the written report of the medical professional in the office of the carrier/employer/self-insured employer/Special Fund attached, within two (2) business days of the date below.

(Please complete if request is denied.) If the issue cannot be resolved informally, I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair ☐ or at a WCB adjunction. I understand that if either party, the insurer or the patient, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB Hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

By: (print name) Y. Patel Title: CSRI

Signature: ypatel Date: 12/01/21

F. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND INSURER / EMPLOYER

I certify that the provider's variance request initially denied above is now granted or partially granted.

By: (print name) ..... Title: .....

Insurer's Signature: ..... Date: .....

G. CLAIMANT'S / CLAIMANT REPRESENTATIVE'S REQUEST FOR REVIEW OF SELF-INSURED INSURER'S / EMPLOYER'S DENIAL

NOTE to Claimant's / Claimant Licensed Representative's: The claimant should only sign this section after the request is fully or partially denied. This section should not be completed at the time of initial request.

YOU MUST COMPLETE THIS SECTION IF YOU WANT THE BOARD TO REVIEW THE INSURER'S DENIAL OF THE PROVIDER'S VARIANC

☐ I request that the Workers' Compensation Board review the insurer's denial of my doctor's request for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made ☐by the Medical Arbitrator designated by the Chair or ☐through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

Claimant's / Claimant Representative's Signature: ..... Date: .....

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

NYS Workers' Compensation Board
PO Box 5205
Binghamton, NY 13902-5205

Email Filing: wcbclaimsfiling@wcb.ny.gov • Customer Service: (877) 632-4996 • Statewide Fax: (877) 533-0337

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CONTINUATION TO FORM MG-2, ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE **MG-2.1**

WCB Case #: G3051719	Claim Administrator Claim (Carrier Case) 73141129-110	Date of Injury/Illness: 6/11/2021

Patient's Name: Bayani Dillard Social Security Number: 000-00-9312

Doctor's Name: Gus Katsiglorgis DO WCB Authorization No.: 23424428W NPI No. 1033105564

INSTRUCTIONS TO ATTENDING DOCTOR: **This form must be filed attached to completed Form MG-2** if requesting approval for additional variance(s) in the same case. Supporting medical must be attached or identified for each request.

A. *The undersigned requests additional approval(s) to VARY from the WCB Medical Treatment Guidelines as indicated below:*

2. Guideline Reference: K - E 8 K [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: 11/23/2021 Date(s) of previously denied variance request ____

Approval Requested for: 97140- MOBILIZATION- 3 TIMES PER WEEK FOR 8 WEEKS- RIGHT KNEE

Medical Necessity PLEASE SEE THE ATTACHED RE-EVALUATION NOTE.

3. Guideline Reference: K - E 8 N [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: 11/23/2021 Date(s) of previously denied variance request ____

Approval Requested for: 97010- SUPERFICIAL HEAT AND COLD- 3 TIMES PER WEEK FOR 8 WEEKS- RIGHT KNEE

Medical Necessity PLEASE SEE THE ATTACHED RE-EVALUATION NOTE.

4. Guideline Reference: K - E 8 R [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: 11/23/2021 Date(s) of previously denied variance request ____

Approval Requested for: 97035- ULTRASOUND- 3 TIMES PER WEEK FOR 8 WEEKS- RIGHT KNEE

Medical Necessity PLEASE SEE THE ATTACHED RE-EVALUATION NOTE.

5. Guideline Reference: [ ] - [ ] [ ] [ ] [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB Case File, if not attached: 11/23/2021 Date(s) of previously denied variance request ____

Approval Requested for: ____

Medical Necessity ____

STATEMENT OF MEDICAL NECESSITY -- See requirements on Form MG-2.

Your explanation must provide the following information:

- the basis for your opinion that the medical care you propose is appropriate for the claimant and is medically necessary at this time; and
- an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:

- a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment; and
- the specific duration or frequency of treatment for which a variance is requested.

Variance requests for treatment or testing that is not recommended or not addressed, must include:

- the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
- medical evidence in support of efficacy of the proposed treatment or testing- may include relevant medical literature published in recognized peer reviewed journals.

Patient Name: Bayani Dillard	WCB Case #93051719	Date of Injury/Illne 5/11/2021

HEALTH PROVIDER'S CERTIFICATION

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Medical Treatment Guidelines. I certify that the claimant understands and agrees to undergo the proposed medical care.

A copy was sent (see address on instruction page) to the Workers' Compensation Board, and copies were provided to the claimant's legal representative, if any, to the claimant if not represented, and to any other parties of interest within two (2) business days of the date below.

In addition, I certify that I do not have a substantially similar request pending and that this request contains additional supporting medical evidence if it is

Provider's Signature: [signature] Date: 11/24/2021

B. INSURER'S/EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW

☐ The insurer/employer hereby gives notice that it will have the claimant examined by an Independent Medical Examiner and submit Form IME-4 within 30 calendar days of the Variance Request, with respect to: ☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5

By: (print name) ..... Title: .....

Signature: ..... Date: .....

C. INSURER'S/EMPLOYER'S RESPONSE TO ADDITIONAL VARIANCE REQUEST(S)

Insurer's response to the variance request is indicated in the checkboxes below. If any additional request(s) are denied, give reason(s) for denial or partial granted below. Identify reasons by Request No. 2-5. (Attach written report of medical professional for each denial as explained on Form MG-2.)

Request No. 2: ☒ Granted ☐ Granted in Part ☐ Without Prejudice ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied

Request No. 3: ☒ Granted ☐ Granted in Part ☐ Without Prejudice ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied

Request No. 4: ☒ Granted ☐ Granted in Part ☐ Without Prejudice ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied

Request No. 5: ☐ Granted ☐ Granted in Part ☐ Without Prejudice ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied

Granted only post-op Physical Therapy.

Name of the Medical Professional who reviewed the denial, if appropriate: .....

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal representative if any, and any other parties of interest, with the written report of the medical professional in the office of the insurer/employer/self-insured employer/Special Fund attached, within two (2) business days of the date below.

(Please complete if request is denied.) If the issue cannot be resolved informally, I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

By: (print name) Y. Patel Title: CSRI

Signature: ypatel Date: 12/01/21

D. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND CARRIER

I certify that the provider's variance request initially denied above is now granted or partially granted for the following requests:

☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 Request No. 5

By: (print name) ..... Title: .....

Signature: ..... Date: .....

E. CLAIMANT'S/CLAIMANT'S REPRESENTATIVE REQUEST FOR REVIEW OF SELF-INSURED EMPLOYER'S/INSURER'S DENIAL

NOTE to Claimant/Claimant's Attorney or Licensed Representative: The claimant should only sign this section after the request is denied. This section should not be completed at the time of initial request.

☐ I request that the Workers' Compensation Board review the insurer's denial of my doctor's ☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5 for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

Claimant's / Claimant Representative's Signature: ..... Date: .....

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Workers' Compensation Board

ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE AND INSURER'S RESPONSE

MG-2

For additional variance requests in this case, attach Form MG-2.1.
Answer all questions where information is known.

WCB Case #G3051719	Claim Administrator Claim (Carrier Case) 73141129-110	Date of Injury/Illness: 6/11/2021

A. Patient's Name: Bayani (First) Dillard (Last) Social Security Number: 000-00-9312

Patient's Address: 52 Charles Street, Malverne, NY 11565

Employer's Name & Address: Flushing Hospital Medical Center, 4500 Parsons Blvd, Flushing, , NY 11355

Insurer's Name & Address: STATE INSURANCE FUND, Po Box 66699 Albany, NY 12206

B. Attending Doctor's Name & Address: Gus Katsigiorgis DO, 125 Franklin Ave, Valley Stream, NY 11580-2108

Individual Provider's WCB Authorization No.: 2 3 4 2 4 4 - 2 W NPI No. 1033105564

Telephone No. 516-887-1787 Fax No. 516-887-2059

C. *The undersigned requests approval to VARY from the WCB Medical Treatment Guidelines as indicated below:*

Guideline Reference: K - E 7 E [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE)*

Approval Requested for: (one request type per form) 97110- THERAPEUTIC EXERCISE- 3 TIMES PER WEEK FOR 8 WEEKS- RIGHT KNEE- PLEASE SEE THE ATTACHED RE-EVALUATION NOTE.

STATEMENT OF MEDICAL NECESSITY -- See item 5 on instruction page.

Your explanation must provide the following information:
- the basis for your opinion that the medical care you propose is appropriate for the patient and is medically necessary at this time; and
- an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:
- a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment; and
- the specific duration or frequency of treatment for which a variance is requested.

Variance requests for treatment or testing that is not recommended or not addressed, must include:
- the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
- medical evidence in support of efficacy of the proposed treatment or testing- may include relevant medical literature published in recognized peer reviewed journals.

Date of Service of Supporting Medical in WCB Case File, if not attached: 11/23/2021

Date(s) of previously denied variance request for substantially similar treatment, if applicable:

Provider **must** enter in **A** the designated fax or email address this request was sent to. Insurer/self-insurer's designated contact information is available online at: wcb.ny.gov/medical-treatment-guideline-variance-request. Check "Designated contact information not available", if appropriate. If the request was sent to a different (contact information is not available on Board's website) or additional fax or email address provided by the insurer, complete **B**. If you are unable to send or receive email or fax, complete **C**.

A. *Insurer's designated fax # or email address as provided on the Board's website:* NYSIF-MG2-C4AUTH@NYSIF.COM

[ ] ***Designated contact information not available.***

B. *If the request was also submitted to another fax # or email address provided by the insurer, provide here:* _____

C. *I am not equipped to send or receive forms by fax or email. This form was mailed (return receipt requested) on:* _____

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Guidelines. I certify that the patient understands and agrees to undergo the proposed medical care. I [ ] did / [x] did not contact the insurer by telephone to discuss this variance request before making the request. I contacted the insurer by telephone on (date) 11/24/2021 and spoke to (person spoke to or was not able to speak to anyone)

_____

I sent or directed my office to send a copy of this request to the insurer, the Chair, the patient and the patient's legal representative, if any, on the same day, and sent or directed my office to send a copy to the Workers' Compensation Board within two (2) business days of the date below. In addition, I certify that I do not have a substantially similar request pending and that this request contains additional supporting medical evidence if it is substantially similar to a prior denied request.

Provider's Signature: _____ Date: 11/24/2021

MG-2.0 4-18

Patient Name: Bayani Dillard	WCB Case #: G3051719	Date of Injury/Illness: 6/11/2021

D. INSURER'S / EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW

☐ The self-insurer/carrier hereby gives notice that it will have the claimant examined by an Independent Medical Examiner or the claimant's medical records reviewed by a Records Reviewer and submit Form IME-4 within 30 calendar days of the Variance Request.

By: (print name)..... Title:.....

Signature:..... Date:.....

E. INSURER'S / EMPLOYER'S RESPONSE TO VARIANCE REQUEST

Insurer's response to the variance request is indicated in the checkboxes on the right. Insurer denial, when appropriate, should be reviewed by a health professional. (Attach written report of medical professional.) If request is approved or denied, sign and date the form in Section E.

.....

.....

.....

.....

INSURER'S/EMPLOYER'S RESPONSE
If service is denied or granted in part, explain in space

☐ Granted
☐ Granted in Part
☐ Without Prejudice

☐ Denied
☐ Burden of Proof Not Met
☐ Substantially Similar Request Pending or Denied

Name of the Medical Professional who reviewed the denial, if applicable:.....

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal counsel, if any, and any other parties of interest, with the written report of the medical professional in the office of the carrier/employer/selfinsured employer/Special Fund attached, within two (2) business days of the date below.

(Please complete if request is denied.) If the issue cannot be resolved informally, I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair ☐ or at a WCB adjunction. I understand that if either party, the insurer or the patient, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB Hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

By: (print name)..... Title:.....

Signature:..... Date:.....

F. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND INSURER / EMPLOYER

I certify that the provider's variance request initially denied above is now granted or partially granted.

By: (print name)..... Title:.....

Insurer's Signature:..... Date:.....

G. CLAIMANT'S / CLAIMANT REPRESENTATIVE'S REQUEST FOR REVIEW OF SELF-INSURED INSURER'S / EMPLOYER'S DENIAL

NOTE to Claimant's / Claimant Licensed Representative's: The claimant should only sign this section after the request is fully or partially denied. This section should not be completed at the time of initial request.

YOU MUST COMPLETE THIS SECTION IF YOU WANT THE BOARD TO REVIEW THE INSURER'S DENIAL OF THE PROVIDER'S VARIANC

☐ I request that the Workers' Compensation Board review the insurer's denial of my doctor's request for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made ☐by the Medical Arbitrator designated by the Chair or ☐through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

Claimant's / Claimant Representative's Signature: ..... Date: .....

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT

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CONTINUATION TO FORM MG-2, ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE **MG-2.1**

WCB Case #: G3081719	Claim Administrator Claim (Carrier Case) 73141129-110	Date of Injury/Illness: 6/11/2021

Patient's Name: Bayani Dillard Social Security Number: 000-00-9312

Doctor's Name: Gus Katsigiorgis DO WCB Authorization No.: 2342442W NPI No. 1033105564

INSTRUCTIONS TO ATTENDING DOCTOR: **This form must be filed attached to completed Form MG-2** if requesting approval for additional variance(s) in the same case. Supporting medical must be attached or identified for each request.

A. *The undersigned requests additional approval(s) to VARY from the WCB Medical Treatment Guidelines as indicated below:*

2. Guideline Reference: K - E 8 K [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: 11/23/2021 Date(s) of previously denied variance request_____

Approval Requested for: 97140- MOBILIZATION- 3 TIMES PER WEEK FOR 8 WEEKS- RIGHT KNEE

Medical Necessity PLEASE SEE THE ATTACHED RE-EVALUATION NOTE.

3. Guideline Reference: K - E 8 N [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: 11/23/2021 Date(s) of previously denied variance request_____

Approval Requested for: 97010- SUPERFICIAL HEAT AND COLD- 3 TIMES PER WEEK FOR 8 WEEKS- RIGHT KNEE

Medical Necessity PLEASE SEE THE ATTACHED RE-EVALUATION NOTE.

4. Guideline Reference: K - E 8 R [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached 11/23/2021 Date(s) of previously denied variance request_____

Approval Requested for: 97035- ULTRASOUND- 3 TIMES PER WEEK FOR 8 WEEKS- RIGHT KNEE

Medical Necessity PLEASE SEE THE ATTACHED RE-EVALUATION NOTE.

5. Guideline Reference: [ ] - [ ] [ ] [ ] [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB Case File, if not attached 11/23/2021 Date(s) of previously denied variance request_____

Approval Requested for:

Medical Necessity

STATEMENT OF MEDICAL NECESSITY -- See requirements on Form MG-2.

Your explanation must provide the following information:

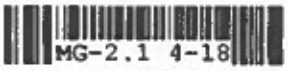
- the basis for your opinion that the medical care you propose is appropriate for the claimant and is medically necessary at this time; and
- an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:

- a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment; and
- the specific duration or frequency of treatment for which a variance is requested.

Variance requests for treatment or testing that is not recommended or not addressed, must include:

- the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
- medical evidence in support of efficacy of the proposed treatment or testing- may include relevant medical literature published in recognized peer reviewed journals.



Patient Name: ..Bayani..Dillard.....	WCB Case #G3051719.....	Date of Injury/Illne .....6/11/2021.....

HEALTH PROVIDER'S CERTIFICATION

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Medical Treatment Guidelines. I certify that the claimant understands and agrees to undergo the proposed medical care.

A copy was sent (see address on instruction page) to the Workers' Compensation Board, and copies were provided to the claimant's legal representative, if any, to the claimant if not represented, and to any other parties of interest within two (2) business days of the date below.

In addition, I certify that I do not have a substantially similar request pending and that this request contains additional supporting medical evidence if it is

Provider's Signature: ..... Date: ....11/24/2021.....

B. INSURER'S/EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW

☐ The insurer/employer hereby gives notice that it will have the claimant examined by an Independent Medical Examiner and submit Form IME-4 within 30 calendar days of the Variance Request, with respect to: ☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5

By: (print name)..... Title: .....

Signature: ..... Date: .....

C. INSURER'S/EMPLOYER'S RESPONSE TO ADDITIONAL VARIANCE REQUEST(S)

Insurer's response to the variance request is indicated in the checkboxes below. If any additional request(s) are denied, give reason(s) for denial or partial granted below. Identify reasons by Request No. 2-5. (Attach written report of medical professional for each denial as explained on Form MG-2.)

Request No. 2: ☐ Granted ☐ Granted in Part ☐ Without Prejudice ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied

Request No. 3: ☐ Granted ☐ Granted in Part ☐ Without Prejudice ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied

Request No. 4: ☐ Granted ☐ Granted in Part ☐ Without Prejudice ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied

Request No. 5: ☐ Granted ☐ Granted in Part ☐ Without Prejudice ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied

.....

.....

Name of the Medical Professional who reviewed the denial, if appropriate:.....

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal representative if any, and any other parties of interest, with the written report of the medical professional in the office of the insurer/employer/self-insured employer/Special Fund attached, within two (2) business days of the date below.

(Please complete if request is denied.) If the issue cannot be resolved informally, I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

By: (print name)..... Title: .....

Signature: ..... Date: .....

D. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND CARRIER

I certify that the provider's variance request initially denied above is now granted or partially granted for the following requests:

☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 Request No. 5

By: (print name)..... Title: .....

Signature: ..... Date: .....

E. CLAIMANT'S/CLAIMANT'S REPRESENTATIVE REQUEST FOR REVIEW OF SELF-INSURED EMPLOYER'S/INSURER'S DENIAL

NOTE to Claimant/Claimant's Attorney or Licensed Representative: The claimant should only sign this section after the request is denied. This section should not be completed at the time of initial request.

☐ I request that the Workers' Compensation Board review the insurer's denial of my doctor's ☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5 for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

Claimant's / Claimant Representative's Signature: ..... Date: .....

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

WORKERS' COMPENSATION BOARD

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) SA-Sub-Annual

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719

Date of Injury 06/11/2021

Claim Administrator Claim Number 73141129-110

Maintenance Type Code Date 01/06/2022

WCB Received Date 01/06/2022

Agreement to Compensate

INSURER INFORMATION

FEIN xxxxx3200

Insurer ID W204002

CLAIM ADMINISTRATOR INFORMATION

Name New York State Insurance Fund

FEIN xxxxx3200

Claim Representative Name

Postal Code 10007-1100

Business Phone Number

Fax Number

E-mail Address ypate@nysif.com

Claim Admin ID W204002

EMPLOYEE INFORMATION

First Name Bayani

Middle Name/Initial

Last Name Dillard

Suffix

Date of Birth 11/05/1976

Employee ID Type S - Employee Social Security Number

Employee ID xxxxx9312

BENEFITS

Benefits

Benefit Types
050 - Temporary Total
070 - Temporary Partial

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross		Weekly Net		Benefit Payment Issue Date	Amount Paid
					Effective Date	Amount	Effective Date	Amount		

Benefits - Cumulative

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
050 - Temporary Total	06/18/2021	08/25/2021	9	4	$8,900.46
070 - Temporary Partial	08/26/2021	12/31/2021	18	2	$11,040.00

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	$900.00	350 - Total Payments to Physicians	$1,558.46
360 - Total Hospital Costs	$95.39	370 - Total Other Medical	$570.85
460 - Total Physical Therapy Costs	$5,723.02		

Recoveries

Recovery Type	Amount

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____

Workers' Compensation Board

State of New York - Workers' Compensation Board

Subsequent Report of Injury
Report Type (MTC) CB-Change in Benefit Type

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.
The Claim Administrator has changed the benefit type from what was previously reported.

Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719 **Date of Injury** 06/11/2021

Claim Administrator Claim Number 73141129-110 **Maintenance Type Code Date** 01/26/2022

Claim Type I - Indemnity for Lost Time **WCB Received Date** 01/27/2022

Agreement to Compensate L - With Liability

INSURER INFORMATION

FEIN xxxxx3200 **Insurer ID** W204002

CLAIM ADMINISTRATOR INFORMATION

Name New York State Insurance Fund **FEIN** xxxxx3200

Claim Representative Name Yogesh Patel **Postal Code** 10007-1100

Claim Representative Business Phone Number 6317564176

E-mail Address ypate@nysif.com **Claim Admin ID** W204002

Late Reason

EMPLOYEE INFORMATION

First Name Bayani **Middle Name/Initial**

Last Name Dillard **Suffix**

Date of Birth 11/05/1976

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx9312

CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability 06/14/2021 **Employment Status**

Current Date Employer Had Knowledge of Current Date of Disability **Work Week Type**

Work Days Scheduled (S-Scheduled N-Non Scheduled) S M T W T F S **Wage Period**

Calculated Wage $1,362.31

Calculated Weekly Compensation Amount $908.21

Employer Paid Salary Prior To Acquisition

Date Claim Administrator Notified of Employee Representation

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

Employer Paid Salary in Lieu of Compensation

Type of Loss 01 - Traumatic Injury

Date of Maximum Medical Improvement

PERMANENT IMPAIRMENT

Impairment Percentage	Body Part Location	Body Part

Number of Dependents

DEPENDENT/PAYEE

Dependent/Payee Relationship	First Name	Last Name	Date of Birth

WORK STATUS

First Day of Disability After The Waiting Period

Current Date Last Day Worked

Current Date Disability Began

Initial RTW Date

Latest RTW/Status Date

Initial RTW Type Code

Latest RTW Type Code

Initial RTW Physical Restrictions

Latest RTW Physical Restrictions

Initial RTW With Same Employer

Latest RTW With Same Employer

BENEFITS

Reduced Benefit Amount

Non-Consecutive Period

Estimated Gross Weekly Amt.

Overpayment Amount - Current

Benefit Change Reason Code B - Employee Treating Physician medical report

Benefits

Benefit Types

070 - Temporary Partial

050 - Temporary Total

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross Effective Date	Weekly Gross Amount	Weekly Net Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid
070	08/26/2021	01/09/2022	19	3	08/26/2021	$600.00	08/26/2021	$600.00	01/25/2022	$11,760.00
050	01/10/2022	01/28/2022	12	3	06/18/2021	$908.21	06/18/2021	$908.21	01/25/2022	$11,443.45

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	$900.00	350 - Total Payments to Physicians	$1,558.46
360 - Total Hospital Costs	$95.39	370 - Total Other Medical	$570.85
460 - Total Physical Therapy Costs	$5,723.02		

PAYMENTS

Award/Order Date _____

Recoveries

Recovery Type	Amount

Reduced Earnings

Actual Reduced Earnings	Reduced Earnings Week Start Date	Reduced Earnings Week End Date	Reduced Earnings Net Weekly Amount Due By Claim Administrator

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx1781

Insured FEIN xxxxx1781

CONCURRENT EMPLOYER INFORMATION

Name _____ Contact Business Phone _____ Wage _____

Workers' Compensation Board

ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE AND INSURER'S RESPONSE

MG-2

For additional variance requests in this case, attach Form MG-2.1.
Answer all questions where information is known.

WCB Case #G3061719	Claim Administrator Claim (Carrier Case) 73141129-110	Date of Injury/Illness: 6/11/2021

A. Patient's Name: Bayani (First) Dillard (Last) Social Security Number: 000-00-9312

Patient's Address: 52 Charles Street, Malverne, NY 11565

Employer's Name & Address: Flushing Hospital Medical Center, 4500 Parsons Blvd, Flushing, , NY 11355

Insurer's Name & Address: STATE INSURANCE FUND, Po Box 66699 Albany, NY 12206

B. Attending Doctor's Name & Address: Gus Katsigiorgis DO, 125 Franklin Ave, Valley Stream, NY 11580-2108

Individual Provider's WCB Authorization No.: 2 3 4 2 4 4 - 2 W NPI No.: 1033105564

Telephone No.: 516-887-1787 Fax No.: 516-887-2069

C. *The undersigned requests approval to VARY from the WCB Medical Treatment Guidelines as indicated below:*

Guideline Reference: K - E 7 E [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE)*

Approval Requested for: (one request type per form) 97110- THERAPEUTIC EXERCISE- 3 TIMES PER WEEK FOR 8 WEEKS- RIGHT KNEE- PLEASE SEE THE ATTACHED RE-EVALUATION NOTE.

STATEMENT OF MEDICAL NECESSITY -- See item 5 on instruction page.

Your explanation must provide the following information:
- the basis for your opinion that the medical care you propose is appropriate for the patient and is medically necessary at this time; and
- an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:
- a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment; and
- the specific duration or frequency of treatment for which a variance is requested.

Variance requests for treatment or testing that is not recommended or not addressed, must include:
- the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
- medical evidence in support of efficacy of the proposed treatment or testing- may include relevant medical literature published in recognized peer reviewed journals.

Date of Service of Supporting Medical in WCB Case File, if not attached: 3/28/2022

Date(s) of previously denied variance request for substantially similar treatment, if applicable:

Provider **must** enter in **A** the designated fax or email address this request was sent to. Insurer/self-insurer's designated contact information is available online at: wcb.ny.gov/medical-treatment-guideline-variance-request. Check "Designated contact information not available", if appropriate. If the request was sent to a different (contact information is not available on Board's website) or additional fax or email address provided by the insurer, complete **B**. If you are unable to send or receive email or fax, complete **C**.

A. *Insurer's designated fax # or email address as provided on the Board's website:* NYSIF-MG2-C4AUTH@NYSIF.COM

[ ] ***Designated contact information not available.***

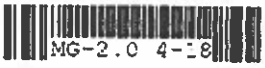
B. *If the request was also submitted to another fax # or email address provided by the insurer, provide here:* _____

C. *I am not equipped to send or receive forms by fax or email. This form was mailed (return receipt requested) on:* _____

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Guidelines. I certify that the patient understands and agrees to undergo the proposed medical care. I [ ] did / [x] did not contact the insurer by telephone to discuss this variance request before making the request. I contacted the insurer by telephone on (date) 4/11/2022 and spoke to (person spoke to or was not able to speak to anyone)

I sent or directed my office to send a copy of this request to the insurer, the Chair, the patient and the patient's legal representative, if any, on the same day, and sent or directed my office to send a copy to the Workers' Compensation Board within two (2) business days of the date below. In addition, I certify that I do not have a substantially similar request pending and that this request contains additional supporting medical evidence if it is substantially similar to a prior denied request.

Provider's Signature: _____ Date: 4/11/2022



Patient Name: ..Bayani..Dillard.....	WCB Case #.....G3051719.....	Date of Injury/Illness .....6/11/2021.....

D. INSURER'S / EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW

☐ The self-insurer/carrier hereby gives notice that it will have the claimant examined by an Independent Medical Examiner or the claimant's medical records reviewed by a Records Reviewer and submit Form IME-4 within 30 calendar days of the Variance Request.

By: (print name)..... Title:.....

Signature:..... Date:.....

E. INSURER'S / EMPLOYER'S RESPONSE TO VARIANCE REQUEST

Insurer's response to the variance request is indicated in the checkboxes on the right. Insurer denial, when appropriate, should be reviewed by a health professional. (Attach written report of medical professional.) If request is approved or denied, sign and date the form in Section E.

.....

.....

.....

.....

INSURER'S/EMPLOYER'S RESPONSE
If service is denied or granted in part, explain in space

- ☐ Granted
- ☐ Granted in Part
- ☐ Without Prejudice
- ☐ Denied
- ☐ Burden of Proof Not Met
- ☐ Substantially Similar Request Pending or Denied

Name of the Medical Professional who reviewed the denial, if applicable:.....

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal counsel, if any, and any other parties of interest, with the written report of the medical professional in the office of the carrier/employer/selfinsured employer/Special Fund attached, within two (2) business days of the date below.

(Please complete if request is denied.) If the issue cannot be resolved informally, I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair ☐ or at a WCB adjunction. I understand that if either party, the insurer or the patient, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB Hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

By: (print name)..... Title: .....

Signature: ..... Date: .....

F. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND INSURER / EMPLOYER

I certify that the provider's variance request initially denied above is now granted or partially granted.

By: (print name)..... Title:.....

Insurer's Signature:..... Date:.....

G. CLAIMANT'S / CLAIMANT REPRESENTATIVE'S REQUEST FOR REVIEW OF SELF-INSURED INSURER'S / EMPLOYER'S DENIAL

NOTE to Claimant's / Claimant Licensed Representative's: The claimant should only sign this section after the request is fully or partially denied. This section should not be completed at the time of initial request.

YOU MUST COMPLETE THIS SECTION IF YOU WANT THE BOARD TO REVIEW THE INSURER'S DENIAL OF THE PROVIDER'S VARIANC

☐ I request that the Workers' Compensation Board review the insurer's denial of my doctor's request for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made ☐by the Medical Arbitrator designated by the Chair or ☐through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

Claimant's / Claimant Representative's Signature: ..... Date: .....

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT

NYS Workers' Compensation Board
PO Box 5205
Binghamton, NY 13902-5205

Email Filing: wcbclaimsfiling@wcb.ny.gov • Customer Service: (877) 632-4996 • Statewide Fax: (877) 533-0337

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CONTINUATION TO FORM MG-2, ATTENDING DOCTOR'S REQUEST FOR APPROVAL OF VARIANCE MG-2.1

WCB Case #: G3061719	Claim Administrator Claim (Carrier Case) 73141129-110	Date of Injury/Illness: 6/11/2021

Patient's Name: Bayani Dillard Social Security Number: 000-00-9312

Doctor's Name: Gus Katsigiorgis DO WCB Authorization No.: 2342442W NPI No. 1033105664

INSTRUCTIONS TO ATTENDING DOCTOR: This form must be filed attached to completed Form MG-2 if requesting approval for additional variance(s) in the same case. Supporting medical must be attached or identified for each request.

A. *The undersigned requests additional approval(s) to VARY from the WCB Medical Treatment Guidelines as indicated below:*

2. Guideline Reference: K - E 8 K [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: 3/28/2022 Date(s) of previously denied variance request _____

Approval Requested for: 97140- MOBILIZATION- 3 TIMES PER WEEK FOR 8 WEEKS- RIGHT KNEE

Medical Necessity: PLEASE SEE THE ATTACHED RE-EVALUATION NOTE.

3. Guideline Reference: K - E 8 N [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: 3/28/2022 Date(s) of previously denied variance request _____

Approval Requested for: 97010- SUPERFICIAL HEAT AND COLD- 3 TIMES PER WEEK FOR 8 WEEKS- RIGHT KNEE

Medical Necessity: PLEASE SEE THE ATTACHED RE-EVALUATION NOTE.

4. Guideline Reference: K - E 8 R [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB case file, if not attached: 3/28/2022 Date(s) of previously denied variance request _____

Approval Requested for: 97035- ULTRASOUND- 3 TIMES PER WEEK FOR 8 WEEKS- RIGHT KNEE

Medical Necessity: PLEASE SEE THE ATTACHED RE-EVALUATION NOTE.

5. Guideline Reference: [ ] - [ ] [ ] [ ] [ ] *(In first box, indicate injury and/or condition: K = Knee, S = Shoulder, B = Mid and Low Back, N = Neck, C = Carpal Tunnel, P = Non-Acute Pain. In remaining boxes, indicate corresponding section of WCB Medical Treatment Guidelines. If the treatment requested is not addressed by the Guidelines, in the remaining boxes use NONE.)*

Date of service of supporting medical in WCB Case File, if not attached: 3/28/2022 Date(s) of previously denied variance request _____

Approval Requested for:

Medical Necessity

STATEMENT OF MEDICAL NECESSITY -- See requirements on Form MG-2.

Your explanation must provide the following information:

- the basis for your opinion that the medical care you propose is appropriate for the claimant and is medically necessary at this time; and
- an explanation why alternatives set forth in the Medical Treatment Guidelines are not appropriate or sufficient.

Additionally, variance requests to extend treatment beyond recommended maximum duration/frequency must include:

- a description of the functional outcomes that, as of the date of the variance request, have continued to demonstrate objective improvement from that treatment and are reasonably expected to further improve with additional treatment; and
- the specific duration or frequency of treatment for which a variance is requested.

Variance requests for treatment or testing that is not recommended or not addressed, must include:

- the signs and symptoms that have failed to improve with previous treatments provided according to the Medical Treatment Guidelines; and
- medical evidence in support of efficacy of the proposed treatment or testing- may include relevant medical literature published in recognized peer reviewed journals.

MG-2.1 (4-18) Continued on Reverse

Patient Name: ..Bayani. Dillard.....	WCB Case #G3061719.....	Date of Injury/Illne .....6/11/2021.....

HEALTH PROVIDER'S CERTIFICATION

I certify that I am making the above request for approval of a variance and my affirmative statements are true and correct. I certify that I have read and applied the Medical Treatment Guidelines to the treatment and care in this case and that I am requesting this variance before rendering any medical care that varies from the Medical Treatment Guidelines. I certify that the claimant understands and agrees to undergo the proposed medical care.

A copy was sent (see address on instruction page) to the Workers' Compensation Board, and copies were provided to the claimant's legal representative, if any, to the claimant if not represented, and to any other parties of interest within two (2) business days of the date below.

In addition, I certify that I do not have a substantially similar request pending and that this request contains additional supporting medical evidence if it is

Provider's Signature: ..... Date: ....4/11/2022.....

B. INSURER'S/EMPLOYER'S NOTICE OF INDEPENDENT MEDICAL EXAMINATION (IME) OR MEDICAL RECORDS REVIEW

☐ The insurer/employer hereby gives notice that it will have the claimant examined by an Independent Medical Examiner and submit Form IME-4 within 30 calendar days of the Variance Request, with respect to: ☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5

By: (print name)..... Title: .....

Signature: ..... Date: .....

C. INSURER'S/EMPLOYER'S RESPONSE TO ADDITIONAL VARIANCE REQUEST(S)

Insurer's response to the variance request is indicated in the checkboxes below. If any additional request(s) are denied, give reason(s) for denial or partial granted below. Identify reasons by Request No. 2-5. (Attach written report of medical professional for each denial as explained on Form MG-2.)

Request No. 2: ☐ Granted ☐ Granted in Part ☐ Without Prejudice ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied

Request No. 3: ☐ Granted ☐ Granted in Part ☐ Without Prejudice ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied

Request No. 4: ☐ Granted ☐ Granted in Part ☐ Without Prejudice ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied

Request No. 5: ☐ Granted ☐ Granted in Part ☐ Without Prejudice ☐ Denied ☐ Burden of Proof Not Met ☐ Substantially Similar Request Pending or Denied

.....

.....

Name of the Medical Professional who reviewed the denial, if appropriate:.....

I certify that copies of this form were sent to the Treating Medical Provider requesting the variance, the Workers' Compensation Board, the claimant's legal representative if any, and any other parties of interest, with the written report of the medical professional in the office of the insurer/employer/self-insured employer/Special Fund attached, within two (2) business days of the date below.

(Please complete if request is denied.) If the issue cannot be resolved informally, I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

By: (print name)..... Title: .....

Signature: ..... Date: .....

D. DENIAL INFORMALLY DISCUSSED AND RESOLVED BETWEEN PROVIDER AND CARRIER

I certify that the provider's variance request initially denied above is now granted or partially granted for the following requests:

☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5

By: (print name)..... Title: .....

Signature: ..... Date: .....

E. CLAIMANT'S/CLAIMANT'S REPRESENTATIVE REQUEST FOR REVIEW OF SELF-INSURED EMPLOYER'S/INSURER'S DENIAL

NOTE to Claimant/Claimant's Attorney or Licensed Representative: The claimant should only sign this section after the request is denied. This section should not be completed at the time of initial request.

☐ I request that the Workers' Compensation Board review the insurer's denial of my doctor's ☐ Request No. 2 ☐ Request No. 3 ☐ Request No. 4 ☐ Request No. 5 for approval to vary from the Medical Treatment Guidelines. I opt for the decision to be made ☐ by the Medical Arbitrator designated by the Chair or ☐ through WCB adjudication. I understand that if either party, the insurer or the claimant, opts in writing for resolution through adjudication, the case shall proceed for proposed decision and, if not therein resolved, to a WCB hearing. I understand that if neither party opts for resolution by adjudication, the variance issue will be decided by a medical arbitrator and the resolution is binding and not appealable under WCL § 23.

Claimant's / Claimant Representative's Signature: ..... Date: .....

Workers' Compensation Board

State of New York - Workers' Compensation Board

Subsequent Report of Injury
Report Type (MTC) CB-Change in Benefit Type

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.
The Claim Administrator has changed the benefit type from what was previously reported.

Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719 **Date of Injury** 06/11/2021

Claim Administrator Claim Number 73141129-110 **Maintenance Type Code Date** 04/19/2022

Claim Type I - Indemnity for Lost Time **WCB Received Date** 04/19/2022

Agreement to Compensate L - With Liability

INSURER INFORMATION

FEIN xxxxx3200 **Insurer ID** W204002

CLAIM ADMINISTRATOR INFORMATION

Name New York State Insurance Fund **FEIN** xxxxx3200

Claim Representative Name Yogesh Patel **Postal Code** 10007-1100

Claim Representative Business Phone Number 6317564176

E-mail Address ypate@nysif.com **Claim Admin ID** W204002

Late Reason

EMPLOYEE INFORMATION

First Name Bayani **Middle Name/Initial**

Last Name Dillard **Suffix**

Date of Birth 11/05/1976

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx9312

CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability 06/14/2021 **Employment Status**

Current Date Employer Had Knowledge of Current Date of Disability **Work Week Type**

Work Days Scheduled (S-Scheduled N-Non Scheduled) S M T W T F S **Wage Period** 01 - Weekly

Calculated Wage $1,362.31

Calculated Weekly Compensation Amount $908.21

Employer Paid Salary Prior To Acquisition

Date Claim Administrator Notified of Employee Representation

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

Employer Paid Salary in Lieu of Compensation

Type of Loss 01 - Traumatic Injury

Date of Maximum Medical Improvement

PERMANENT IMPAIRMENT

Impairment Percentage	Body Part Location	Body Part

Number of Dependents

DEPENDENT/PAYEE

Dependent/Payee Relationship	First Name	Last Name	Date of Birth

WORK STATUS

First Day of Disability After The Waiting Period

Current Date Last Day Worked

Current Date Disability Began

Initial RTW Date

Latest RTW/Status Date

Initial RTW Type Code

Latest RTW Type Code

Initial RTW Physical Restrictions

Latest RTW Physical Restrictions

Initial RTW With Same Employer

Latest RTW With Same Employer

BENEFITS

Reduced Benefit Amount

Non-Consecutive Period

Estimated Gross Weekly Amt.

Overpayment Amount - Current $0.00

Benefit Change Reason Code B - Employee Treating Physician medical report

Benefits

Benefit Types

050 - Temporary Total

070 - Temporary Partial

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross Effective Date	Weekly Gross Amount	Weekly Net Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid
050	01/10/2022	04/06/2022	22	1	06/18/2021	$908.21	06/18/2021	$908.21	04/18/2022	$20,162.26
070	04/07/2022	04/22/2022	22	0	08/26/2021	$600.00	08/26/2021	$600.00	04/18/2022	$13,200.00

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	$900.00	350 - Total Payments to Physicians	$5,109.89
360 - Total Hospital Costs	$3,252.16	370 - Total Other Medical	$589.30
460 - Total Physical Therapy Costs	$7,699.87	470 - Total Durable Medical Costs	$255.00

PAYMENTS

Award/Order Date _____

Recoveries

Recovery Type	Amount

Reduced Earnings

Actual Reduced Earnings	Reduced Earnings Week Start Date	Reduced Earnings Week End Date	Reduced Earnings Net Weekly Amount Due By Claim Administrator

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx1781 **Insured FEIN** xxxxx1781

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____

Workers' Compensation Board

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) SA-Sub-Annual

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719

Date of Injury 06/11/2021

Claim Administrator Claim Number 73141129-110

Maintenance Type Code Date 06/03/2022

WCB Received Date 06/03/2022

INSURER INFORMATION

FEIN xxxxx3200

Insurer ID W204002

CLAIM ADMINISTRATOR INFORMATION

Name New York State Insurance Fund

FEIN xxxxx3200

Claim Representative Name

Postal Code 10007-1100

Claim Representative Business Phone Number

E-mail Address ypate@nysif.com

Claim Admin ID W204002

EMPLOYEE INFORMATION

First Name Bayani

Middle Name/Initial

Last Name Dillard

Suffix

Date of Birth 11/05/1976

Employee ID Type S - Employee Social Security Number

Employee ID xxxxx9312

BENEFITS

Overpayment Amount - Current $0.00

Benefits

Benefit Types
050 - Temporary Total
070 - Temporary Partial

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross		Weekly Net		Benefit Payment Issue Date	Amount Paid
					Effective Date	Amount	Effective Date	Amount		

Benefits - Cumulative

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
050 - Temporary Total	06/18/2021	04/06/2022	22	1	$20,162.26
070 - Temporary Partial	08/26/2021	06/03/2022	28	0	$16,800.00

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	$900.00	350 - Total Payments to Physicians	$5,197.69
360 - Total Hospital Costs	$3,252.16	370 - Total Other Medical	$884.03
460 - Total Physical Therapy Costs	$8,530.72	470 - Total Durable Medical Costs	$255.00

Recoveries

Recovery Type	Amount

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____

UPMARCH

21070

EMPLOYER'S REPORT OF INJURED EMPLOYEE'S CHANGE IN EMPLOYMENT STATUS RESULTING FROM INJURY

C-11

PO Box 5205, Binghamton, NY 13902-5205
Fax #: (877)-533-0337 • Web Upload Link: https://webdoc.xrxfs.com/login.aspx • Email Filing: webclaimsfiling@wcb.ny.gov

This report is to be filed directly with the Chair, Workers' Compensation Board as soon as the employment status of an injured employee, as reported on First Report of Injury, or on a previous Form C-11 or EC-11, is changed. Change in employment status includes return to work, discontinuance of work, increase or decrease of regular hours of work and increase or reduction of wages. **A copy should also be sent to your Insurer.**

Claim Information - ALL COMMUNICATION SHOULD INCLUDE THESE NUMBERS

Date of Injury/Illness: 6/11/21 WCB Case #: G3051719

Claim Administrator Claim (Carrier Case) #: 73141129-110

Employee Information

Last Name: Villaro First Name: Bayanc MI:

Mailing Address: 52 Charles St Line 2:

City: Mineola State: NY Zip Code: 11501 Country:

Daytime phone #: Email Address:

Social Security #: 9312 Date of Birth: 11/5/76 Gender: ☒ Male ○ Female

Employer Information

Employer Name: Flushing Hospital Medical Center

Mailing Address: 4500 Parsons Blvd Line 2:

City: Flushing State: NY Zip Code: 11355 Country:

Employer Phone #: 718-206-8423 Federal Tax ID #: The Tax ID # is the (check one): ○ SSN ○ EIN

Insurer Information

Insurer Name: NY State Insurance Fund

Mailing Address: 199 Church Street Line 2: Insurer ID (W#): 204002

City: New York State: NY Zip Code: 10007 Country:

Insurer Phone #:

Date of first full day employee lost from work: 6/14/21 Date employee first returned to work: 6/07/22

Loss of time resulting from the above injury since initial date of lost time or last C-11 filed with the Board:

Loss of Time Start Date	Return To Work Date	Reason

As a result of the above injury, was there an increase or decrease in hours worked or wages paid? ○ Yes ☒ No

If yes, enter status of change below:

Employment Status	Effective Date	Hours per Day	Days per Week	Earnings	Remarks
Prior to Injury		8	5	812.90	5mo
Changed To					

An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Prepared By:

Last Name: Baaske First Name: Adriana MI:

Employer Name: Jamaica Hospital Medical Center

Official Title: Leave Administrator Phone #: 718-206-8423

Email Address: Abaaske@jhmc.org Date of this report: 6/13/22

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Workers' Compensation Board

State of New York - Workers' Compensation Board

Subsequent Report of Injury
Report Type (MTC) SX-Full Suspension

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.
The Claim Administrator has suspended indemnity benefits for the reasons reflected in the Suspension Section of this document.

Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719 **Date of Injury** 06/11/2021

Claim Administrator Claim Number 73141129-110 **Maintenance Type Code Date** 06/16/2022

Claim Type I - Indemnity for Lost Time **WCB Received Date** 06/16/2022

INSURER INFORMATION

FEIN xxxxx3200 **Insurer ID** W204002

CLAIM ADMINISTRATOR INFORMATION

Name New York State Insurance Fund **FEIN** xxxxx3200

Claim Representative Name Yogesh Patel **Postal Code** 10007-1100

Claim Representative Business Phone Number 6317564176

E-mail Address ypate@nysif.com **Claim Admin ID** W204002

Late Reason

EMPLOYEE INFORMATION

First Name Bayani **Middle Name/Initial**

Last Name Dillard **Suffix**

Date of Birth 11/05/1976

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx9312

CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability 06/14/2021 **Employment Status** 1 - Regular/Full-time Employee

Current Date Employer Had Knowledge of Current Date of Disability **Work Week Type**

Work Days Scheduled (S-Scheduled N-Non Scheduled) S M T W T F S **Wage Period** 01 - Weekly

Calculated Wage $1,362.31 **Anticipated Wage Loss**

Calculated Weekly Compensation Amount $908.21

Employer Paid Salary Prior To Acquisition

Date Claim Administrator Notified of Employee Representation

EMPLOYEE INJURY

Full Wages Paid for Date of Injury Yes

Type of Loss 01 - Traumatic Injury

Date of Maximum Medical Improvement

PERMANENT IMPAIRMENT

Impairment Percentage	Body Part Location	Body Part

Death Result of Injury

Date of Death

Number of Dependents

DEPENDENT/PAYEE

Dependent/Payee Relationship	First Name	Last Name	Date of Birth

WORK STATUS

Initial Date Disability Began 06/12/2021

Initial RTW Date 06/06/2022

Latest RTW/Status Date

Initial RTW Type Code A - Actual

Latest RTW Type Code

Initial RTW Physical Restrictions No

Latest RTW Physical Restrictions

Initial RTW With Same Employer Yes

Latest RTW With Same Employer

SUSPENSION

Suspension Effective Date 06/05/2022 Suspension Reason Code - Full S1 - Suspension, RTW or Medically Determined/Qualified to RTW

Suspension Reason

CLAIMANT RETURNED TO WORK AT FULL PAY.

BENEFITS

Reduced Benefit Amount

Estimated Gross Weekly Amt.

Overpayment Amount - Current $0.00

Net to Zero Code

Benefits

Benefit Types
050 - Temporary Total
070 - Temporary Partial

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross Effective Date	Weekly Gross Amount	Weekly Net Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid
070	08/26/2021	06/05/2022	28	1	08/26/2021	$600.00	08/26/2021	$600.00	06/15/2022	$16,920.00

Benefits - Cumulative

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
050 - Temporary Total	06/18/2021	04/06/2022	22	1	$20,162.26

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	$900.00	350 - Total Payments to Physicians	$5,197.69
360 - Total Hospital Costs	$3,252.16	370 - Total Other Medical	$1,334.03
460 - Total Physical Therapy Costs	$8,530.72	470 - Total Durable Medical Costs	$255.00

PAYMENTS

Award/Order Date _____

Recoveries

Recovery Type	Amount

Reduced Earnings

Actual Reduced Earnings	Reduced Earnings Week Start Date	Reduced Earnings Week End Date	Reduced Earnings Net Weekly Amount Due By Claim Administrator

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx1781 **Insured FEIN** xxxxx1781

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____

Workers' Compensation Board

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) SA-Sub-Annual

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719

Date of Injury 06/11/2021

Claim Administrator Claim Number 73141129-110

Maintenance Type Code Date 12/12/2022

WCB Received Date 12/12/2022

INSURER INFORMATION

FEIN xxxxx3200

Insurer ID W204002

CLAIM ADMINISTRATOR INFORMATION

Name New York State Insurance Fund

FEIN xxxxx3200

Claim Representative Name

Postal Code 10007-1100

Claim Representative Business Phone Number

E-mail Address ypate@nysif.com

Claim Admin ID W204002

EMPLOYEE INFORMATION

First Name Bayani

Middle Name/Initial

Last Name Dillard

Suffix

Date of Birth 11/05/1976

Employee ID Type S - Employee Social Security Number

Employee ID xxxxx9312

BENEFITS

Overpayment Amount - Current $0.00

Benefits

Benefit Types
050 - Temporary Total
070 - Temporary Partial

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross Effective Date	Weekly Gross Amount	Weekly Net Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid

Benefits - Cumulative

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
050 - Temporary Total	06/18/2021	04/06/2022	22	1	$20,162.26
070 - Temporary Partial	08/26/2021	06/05/2022	28	1	$16,920.00

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	$900.00	350 - Total Payments to Physicians	$5,373.29
360 - Total Hospital Costs	$3,252.16	370 - Total Other Medical	$1,604.03
460 - Total Physical Therapy Costs	$10,851.37	470 - Total Durable Medical Costs	$255.00

Recoveries

Recovery Type	Amount

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____

Workers' Compensation Board

State of New York - Workers' Compensation Board

Subsequent Report of Injury
Report Type (MTC) PY-Payment Report

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.
The Claim Administrator has made payment(s) as reflected in Benefits and/or Payments Section of this document.

Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719 **Date of Injury** 06/11/2021

Claim Administrator Claim Number 73141129-163 **Maintenance Type Code Date** 05/15/2023

Claim Type I - Indemnity for Lost Time **WCB Received Date** 05/15/2023

Agreement to Compensate L - With Liability

INSURER INFORMATION

FEIN xxxxx3200 **Insurer ID** W204002

CLAIM ADMINISTRATOR INFORMATION

Name New York State Insurance Fund **FEIN** xxxxx3200

Claim Representative Name Charles Termini **Postal Code** 10007-1100

Claim Representative Business Phone Number 9147016268

E-mail Address ctermini@nysif.com **Claim Admin ID** W204002

Late Reason

EMPLOYEE INFORMATION

First Name Bayani **Middle Name/Initial**

Last Name Dillard **Suffix**

Date of Birth 11/05/1976

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx9312

CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability: 06/14/2021

Employment Status: 2 - Part-time Employee

Current Date Employer Had Knowledge of Current Date of Disability:

Number of Days Worked Per Week: 3

Pre-existing Disability:

Work Week Type: F - Fixed Work Week

Work Days Scheduled (S-Scheduled N-Non Scheduled): S M T W T F S — N N S N S S N

Wage Period: 01 - Weekly

Calculated Wage: $1,362.31

Denial Rescission Date:

Calculated Weekly Compensation Amount: $908.21

Employer Paid Salary Prior To Acquisition:

Date Claim Administrator Notified of Employee Representation:

EMPLOYEE INJURY

Full Wages Paid for Date of Injury: Yes

Employer Paid Salary In Lieu of Compensation:

Type of Loss: 01 - Traumatic Injury

Date of Maximum Medical Improvement:

PERMANENT IMPAIRMENT

Impairment Percentage	Body Part Location	Body Part
26.75%	R - Right	52 - Upper Leg

Death Result of Injury: Date of Death: Number of Dependents: 0

DEPENDENT/PAYEE

Dependent/Payee Relationship	First Name	Last Name	Date of Birth

WORK STATUS

First Day of Disability After The Waiting Period:

Initial Date Disability Began: 06/12/2021

Initial RTW Date: 06/06/2022

Latest RTW/Status Date:

Initial RTW Type Code: A - Actual

Latest RTW Type Code:

Initial RTW Physical Restrictions: No

Latest RTW Physical Restrictions:

Initial RTW With Same Employer: Yes

Latest RTW With Same Employer:

BENEFITS

Reduced Benefit Amount _____

Estimated Gross Weekly Amt. _____

Overpayment Amount - Current $0.00

Jurisdiction Claim Number - Related _____

Net to Zero Code _____

Benefits

Benefit Types
050 - Temporary Total
070 - Temporary Partial
530 - Perm Partial Sch Lump Sum Pmt/Settlement

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross Effective Date	Weekly Gross Amount	Weekly Net Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid
070	08/26/2021	06/05/2022	27	4	08/26/2021	$908.21	08/26/2021	$908.21	05/15/2023	$25,248.23
530	06/12/2021	12/04/2022								$24,376.36

Benefits - Cumulative

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
050 - Temporary Total	06/18/2021	04/06/2022	22	2	$20,343.91

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	$5,825.00	350 - Total Payments to Physicians	$5,709.43
360 - Total Hospital Costs	$3,252.16	370 - Total Other Medical	$2,404.03
460 - Total Physical Therapy Costs	$11,567.62	470 - Total Durable Medical Costs	$255.00

PAYMENTS

Award/Order Date _____ **Lump Sum Payment/Settlement** AW - Award

Payment Reasons

340 - Total Claimant's Legal Expenses

530 - Perm Partial Sch Lump Sum Pmt/Settlement

530 - Perm Partial Sch Lump Sum Pmt/Settlement

070 - Temporary Partial

Payment Reason Code	Payee	Start Date	Through Date	Issue Date	Amount Paid
340	REX E. ZACHOFSKY, PLLC	05/15/2023	05/15/2023	05/15/2023	$4,925.00
530	Bayani Dillard	05/15/2023	05/15/2023	05/15/2023	$726.57
530	Bayani Dillard	05/15/2023	05/15/2023	05/15/2023	$23,649.79
070	Bayani Dillard	04/07/2022	06/05/2022	05/15/2023	$3,584.87

Recoveries

Recovery Type	Amount

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx1781 **Insured FEIN** xxxxx1781

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____

Workers' Compensation Board

State of New York - Workers' Compensation Board

Subsequent Report of Injury
Report Type (MTC) CA-Change in Benefit Amount

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.
The Claim Administrator has changed the net weekly amount from what was previously reported, but the benefit type has not changed.

Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719 **Date of Injury** 06/11/2021

Claim Administrator Claim Number 73141129-163 **Maintenance Type Code Date** 05/15/2023

Claim Type I - Indemnity for Lost Time **WCB Received Date** 05/15/2023

Agreement to Compensate L - With Liability

INSURER INFORMATION

FEIN xxxxx3200 **Insurer ID** W204002

CLAIM ADMINISTRATOR INFORMATION

Name New York State Insurance Fund **FEIN** xxxxx3200

Claim Representative Name Charles Termini **Postal Code** 10007-1100

Claim Representative Business Phone Number 9147016268

E-mail Address ctermini@nysif.com **Claim Admin ID** W204002

Late Reason

EMPLOYEE INFORMATION

First Name Bayani **Middle Name/Initial**

Last Name Dillard **Suffix**

Date of Birth 11/05/1976

Employee ID Type S - Employee Social Security Number **Employee ID** xxxxx9312

CLAIM INFORMATION

Initial Date Employer Had Knowledge of Date of Disability: 06/14/2021

Employment Status: 2 - Part-time Employee

Current Date Employer Had Knowledge of Current Date of Disability:

Work Week Type:

Work Days Scheduled (S-Scheduled N-Non Scheduled): S M T W T F S

Wage Period: 01 - Weekly

Calculated Wage: $1,362.31

Calculated Weekly Compensation Amount: $908.21

Employer Paid Salary Prior To Acquisition:

Date Claim Administrator Notified of Employee Representation:

EMPLOYEE INJURY

Full Wages Paid for Date of Injury: Yes

Employer Paid Salary in Lieu of Compensation:

Type of Loss: 01 - Traumatic Injury

Date of Maximum Medical Improvement:

PERMANENT IMPAIRMENT

Impairment Percentage	Body Part Location	Body Part
26.75%	R - Right	52 - Upper Leg

Death Result of Injury: Number of Dependents:

DEPENDENT/PAYEE

Dependent/Payee Relationship	First Name	Last Name	Date of Birth

BENEFITS

Reduced Benefit Amount:

Non-Consecutive Period:

Overpayment Amount - Current: $0.00

Benefit Change Reason Code: D - Jurisdiction Directed

Net to Zero Code:

Benefits

Benefit Types
050 - Temporary Total
070 - Temporary Partial
530 - Perm Partial Sch Lump Sum Pmt/Settlement

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross Effective Date	Weekly Gross Amount	Weekly Net Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid
050	06/18/2021	04/06/2022	22	2	06/18/2021	$908.21	06/18/2021	$908.21	05/15/2023	$20,343.91
070	08/26/2021	06/05/2022	27	4	08/26/2021	$908.21	08/26/2021	$908.21	05/15/2023	$25,248.23

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross Effective Date	Weekly Gross Amount	Weekly Net Effective Date	Weekly Net Amount	Benefit Payment Issue Date	Amount Paid
530	06/12/2021	12/04/2022								$24,376.36

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	$5,825.00	350 - Total Payments to Physicians	$5,709.43
360 - Total Hospital Costs	$3,252.16	370 - Total Other Medical	$2,404.03
460 - Total Physical Therapy Costs	$11,567.62	470 - Total Durable Medical Costs	$255.00

PAYMENTS

Award/Order Date _____

Recoveries

Recovery Type	Amount

Reduced Earnings

Actual Reduced Earnings	Reduced Earnings Week Start Date	Reduced Earnings Week End Date	Reduced Earnings Net Weekly Amount Due By Claim Administrator

EMPLOYER / INSURED INFORMATION

Employer FEIN xxxxx1781 **Insured FEIN** xxxxx1781

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____

Workers' Compensation Board

State of New York - Workers' Compensation Board

Subsequent Report of Injury

Report Type (MTC) SA-Sub-Annual

This paper contains information that has been provided electronically to the Board. Do not serve a copy of this on the Board.

Employee Name Bayani Dillard

WCB Case Number (JCN) G3051719

Date of Injury 06/11/2021

Claim Administrator Claim Number 73141129-163

Maintenance Type Code Date 06/01/2023

WCB Received Date 06/01/2023

INSURER INFORMATION

FEIN xxxxx3200

Insurer ID W204002

CLAIM ADMINISTRATOR INFORMATION

Name New York State Insurance Fund

FEIN xxxxx3200

Claim Representative Name

Postal Code 10007-1100

Claim Representative Business Phone Number

E-mail Address ctermini@nysif.com

Claim Admin ID W204002

EMPLOYEE INFORMATION

First Name Bayani

Middle Name/Initial

Last Name Dillard

Suffix

Date of Birth 11/05/1976

Employee ID Type S - Employee Social Security Number

Employee ID xxxxx9312

BENEFITS

Overpayment Amount - Current $0.00

Benefits

Benefit Types
050 - Temporary Total
070 - Temporary Partial
530 - Perm Partial Sch Lump Sum Pmt/Settlement

Benefit Type Code	Start Date	Through Date	Claim Weeks	Claim Days	Weekly Gross		Weekly Net		Benefit Payment Issue Date	Amount Paid
					Effective Date	Amount	Effective Date	Amount		

Benefits - Cumulative

Benefit Type	Start Date	Through Date	Claim Weeks	Claim Days	Amount Paid
050 - Temporary Total	06/18/2021	04/06/2022	22	2	$20,343.91
070 - Temporary Partial	08/26/2021	06/05/2022	27	4	$25,248.23
530 - Perm Partial Sch Lump Sum Pmt/Settlement	06/12/2021	12/04/2022	26	4	$24,376.36

Benefits - A - Adjustments / C - Credits / R - Redistributions

Benefit Type	Type	Adjustment/Credit/Redistribution	Start Date	End Date	Weekly Amount

Other Benefits

Other Benefit Type	Amount	Other Benefit Type	Amount
340 - Total Claimant's Legal Expenses	$5,825.00	350 - Total Payments to Physicians	$5,709.43
360 - Total Hospital Costs	$3,252.16	370 - Total Other Medical	$2,404.03
460 - Total Physical Therapy Costs	$11,567.62	470 - Total Durable Medical Costs	$255.00

Recoveries

Recovery Type	Amount

CONCURRENT EMPLOYER INFORMATION

Name _____ **Contact Business Phone** _____ **Wage** _____

1229060088

(Valley) Island Musculoskeletal Care MD, PC
128 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: Dillard, Bayani
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check In Date/Time: 8/2/2021 9:58:52 AM
Location: (Valley) Island Musculoskeletal Care MD, PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Mary Jane Acosta, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

SUBJECTIVE:

Patient was seen for initial evaluation and treatment for pain on the right knee due to work related injury. Patient c/o constant sharp pain on the right knee with stiffness and swelling. He also c/o clicking on the knee when he is walking. He reports that he has difficulty in getting up from prolonged sitting and weight bearing activities such as prolonged standing, walking and negotiating the stairs. He is taking Tylenol as needed and he using knee brace.

The patient presents with Pain, Weakness, Clicking, Crepitus, Swelling, Tightness and Stiffness in the right knee. Patient reports the following functional complaints/deficits include Activities of daily living, Ambulation, Ambulation on uneven surfaces, Sit to Stand/Stand to Sit transfers, Ascending stairs, Descending stairs, Entering or exiting a motor vehicle, Bending, Bathing, Household chores, Leisure activities, Lifting heavy objects, Driving and Unable to sleep.

PS: 7/10

HISTORY:

Past Medical History
Hypertension, Asthma
HPI: Patient works as a EMT. On 06/11/2021, patient reports that he felt pain on the right knee when he stepped out from the ambulance and it aggravated when he slipped and fell on the bathroom of Mc Donald which caused an injury on the right knee. He reports that he went to Flushing Hospital and CAT scan was done and received PT somewhere else with mild improvement. He came in our office and referred for x-ray and continue PT. He also mentioned that he will undergo surgery on the right knee.

OBJECTIVE: Knee Evaluation:

	Strength		Active ROM		Passive ROM	
	Right	Left	Right	Left	Right	Left
Flexion (0-135)	3- /5		0-80			
Extension (0-135)	3- /5		80-0			

RIGHT KNEE: Palpation Tests gr. 2-3 tenderness on right medial aspect of the knee and infrapatellar area; moderate swelling on right knee; moderate tightness on right hamstring, TFL and gastroc- soleus complex; moderate crepitus on right knee flexion- extension; moderate muscle guarding on right knee flexion

Special Tests
McMurray's: Positive

Therex Hamstring stretch x 10shx 10 reps x 2 sets

1229060088

(Valley) Island Musculoskeletal Care MD. PC
128 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 8/2/2021 9:58:52 AM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Mary Jane Acosta, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Quads sets x6shx 10 reps x 2 sets
SLR x 10 reps x 2 sets
Hip abduction in sidelying position x10 reps x 2sets
Hamstring curls x 10 reps x 2 sets
Adductor squeeze x 6shx 10 reps x2 sets
Clam shell using red TB x 10 reps x2 sets
Calf raises x 10 reps x 2 sets

Manual Therapy:

Soft Tissue Mobilization		Comments: right knee
Myofascial Release		Comments: right knee

Therapeutic Modalities:

Electric Stimulation, Premod	Min: 15	Comments: right knee
Therapeutic Ultrasound	Min: 8	Comments: right knee
Hot Pack	Min: 15	Comments: right knee

ASSESSMENT:

Pt. presents with decreased strength, decreased AROM, increased pain impacting function Patient would benefit from a course of skilled PT in conjunction with a home exercise program to work on current functional deficits with weight bearing activities such as ambulation, stairs negotiation, squatting, getting up from sitting and tolerance to prolonged standing by promoting gains from the limiting factors to achieve goals for him to be able to perform his job as an EMT.

Short Term Goals:

1229060088

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: Dillard, Bayani
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check In Date/Time: 8/2/2021 9:59:52 AM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Mary Jane Acosta, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Time Frame: 2-4 weeks

Decrease Knee Pain to 4/10		
Increase Right Knee Flexion ROM	50% of normal limits	and Strength 4-/5
Increase Right Knee Extension ROM	50% of normal limits	and Strength 4-/5

Increase Activity Tolerance to ADL/IDLs
Patient will be able to amb 1-2 blocks feet with minimal discomfort without AD
Patient will be able to negotiate 1-2 flight(s) of stairs with minimal discomfort
Patient will be able to sit to stand with minimal assistance from his/her upper extremities
Patient is aware of heel/toe gait with minimal cueing
Lift an object like a bag of groceries from the floor
Do usual house work/ school work
Getting in and out of the car
Getting in and out of the bath

Long Term Goals:
Time Frame: 6-8 weeks

Decrease Knee Pain to 0/10		
Increase Right Knee Flexion ROM	100% of normal limits	and Strength 5/5
Increase Right Knee Extension ROM	100% of normal limits	and Strength 5/5

Increase Activity Tolerance to ADL/IDLs to WNL
Independent in HEP
Patient will be able to amb >10 blocks feet with no discomfort without AD
Patient will be able to sit to stand with no assistance from his/her upper extremities
Patient will be able to negotiate uneven terrain for 1 block feet
Patient will be able to return to running pain free
Patient is aware of heel/toe gait with no cueing
Squatting
Hopping
Trying to pivot on same LE without being off balance

PLAN:

1229060088

(Valley) Island Musculoskeletal Care MD. PC
128 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 8/2/2021 9:58:52 AM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Mary Jane Acosta, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)388-5380

Plan of Care/Treatment Plan: Patient Education, Progressive Resistive Therapeutic Exercise, Manual Therapy Techniques, Home Exercise Program, Modality to Decrease Pain - Electrical Stimulation, Hot and/or Cold Packs	
Rehab Potential: Rehab potential good to meet treatment goals.	
Frequency and Duration of Treatment: 3 times a week	for 8 weeks

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		right knee
Electric Stim (97014)	15		right knee
Ultrasound (97035)		8	right knee
Exercises (97110)		15	right knee
Eval - WC/COM - 20 min (97161)		20	right knee
Manual Therapy (97140)		10	right knee
	Total 15	Total 53	Total Min. TX Time 68

Diagnosis codes
Other tear of medial meniscus, current injury, right knee, initial encounter (S83.241A)

Electronically signed by Mary Jane Acosta, PT at 01:41 PM, AUGUST 02, 2021

1231115516

(Valley) Island Musculoskeletal Care MD. PC
128 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2069

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 44 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check In Date/Time: 8/4/2021 10:51:20 AM Physician: Joseph Tanlioco, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Note

Subjective:

REPORTS OF PAIN IN THE MEDIAL ASPECT OF THE R KNEE.
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. LOM IN THE R KNEE, TENDERNESS IN THE R KNEE.

Therex:

THERAPEUTIC EXERCISES			
Ball Squeezes	6 SH	10 REPS	2 SET(S)
SLR	2 LB(S)	10 REPS	2 SET(S)

Therapeutic Modalities:

Electric Stimulation	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack			
	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 25	Total Min. TX Time 40

1231115516

(Valley) Island Musculoskeletal Care MD. PC
126 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: Dillard, Bayani
Acc No: 264184
Gender: MALE
Age: 44 Year(s)
DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565.
Phone: (917)386-5380
Check in Date/Time: 8/4/2021 10:51:20 AM
Physician: Joseph Tanlioco, PT
Location: (Valley) Island Musculoskeletal Care MD. PC
Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Diagnosis codes

Encounter for examination and observation following work accident (Z04.2)

Electronically signed by Joseph Tanlioco, PT at 11:41 AM, AUGUST 04, 2021

1229868888

(Valley) Island Musculoskeletal Care MD. PC
126 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1767 Fax: 516-887-2059

Patient Name: Dillard, Bayani
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check In Date/Time: 8/6/2021 10:56:38 AM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Mary Jane Acosta, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5360

Note

Subjective:

PATIENT COMPLAINS OF PAIN ON MEDIAL ASPECT OF R KNEE WITH DIFFICULTY IN BENDING,PROLONGED STANDING,WALKING AND CLIMBING STAIRS
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. AMBULATORY WITH R KNEE BRACE MOD TENDERNESS ON MEDIAL AND LATERAL ASPECT OF R KNEE; WEAKNESS OF R KNEE FLEXORS AND EXTENSORS MS; MOD SPASM ON R VMO MS; LOM OF R KNEE WITH PAIN AT END RANGE; MOD TIGHTNESS ON HAMSTRINGS MS

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

1229860888

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: Dillard, Bayani
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check In Date/Time: 8/8/2021 10:66:36 AM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Mary Jane Acosta, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 25	Total Min. TX Time 40

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 11:00 AM, AUGUST 06, 2021

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 44 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 8/12/2021 11:49:27 AM Physician: Mary Jane Acosta, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Note

Subjective:

PATIENT CONTINUES TO HAVE PAIN AGGRAVATED WITH PROLONGED WALKING AND STAIRCLIMBING
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. AMBULATORY WITH R KNEE BRACE LOM OF THE R KNEE JT; TIGHTNESS OF THE GASTROC SOLEUS; WEAKNESS OF THE QUADS; MOD TENDERNESS ON THE MED AND LAT ASPECT OF THE R KNEE

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 44 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 8/12/2021 11:49:27 AM Physician: Mary Jane Acosta, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 11:51 AM, AUGUST 12, 2021

1232080064

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check In Date/Time: 8/13/2021 11:32:00 AM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Marygrace Lusen-urena, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

PT C/O DIFFICULTIES WITH STAIR NEGOTIATIONS AND PROLONGED WEIGHT BEARING ACTIVITIES.
Patient reports pain of the R KNEE.

Objective: AMBULATORY WITH R KNEE BRACE; MS WEAKNESS AND LOM ON R KNEE, AP; TIGHTNESS OF HAMSTRING AND ITB; TENDERNESS ON MEDIOLATERAL ASPECT OF THE R KNEE; DECREASE CADENCE SECONDARY TO PAIN.

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation ar still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

1232080064

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: Dillard, Bayani
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check In Date/Time: 8/13/2021 11:32:00 AM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Marygrace Lusan-urena, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Marygrace Lusan-urena, PT at 03:11 PM, AUGUST 13, 2021

1232080063

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 8/14/2021 9:53:22 AM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Mary Jane Acosta, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

PATIENT COMPLAINS OF HAVING DIFFICULTY IN SQUATTING,PROLONGED STANDING AND WALKING
Patient reports pain of the R KNEE.

Objective: AMBULATORY WITH R KNEE BRACE; LOM OF R KNEE WITH PAIN AT END RANGE; MOD TENDERNESS ON PERIPATELLAR AREA OF R KNEE; WEAKNESS OF R QUADS MS; MOD TIGHTNESS ON HAMSTRINGS MS

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

1232080063

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 8/14/2021 9:53:22 AM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Mary Jane Acosta, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 10:00 AM, AUGUST 14, 2021

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 8/17/2021 10:47:08 AM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Mary Jane Acosta, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

PATIENT CONTINUES TO HAVE PAIN AGGRAVATED WITH PROLONGED WALKING
Patient reports pain of the R KNEE.

Objective: AMBULATORY WITH R KNEE BRACE; MOD TENDERNESS ON PERIPATELLAR AREA OF R KNEE; WEAKNESS OF I QUADS MS; LOM OF THE R KNEE JTS; TIGHTNESS OF THE GASTROC SOLEUS

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: Dillard, Bayani
Acc No: 264184
Gender: MALE
Age: 44 Year(s)
DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565,
Phone: (917)386-5380
Check in Date/Time: 8/17/2021 10:47:08 AM
Physician: Mary Jane Acosta, PT
Location: (Valley) Island Musculoskeletal Care MD. PC
Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 10:48 AM, AUGUST 17, 2021

1237161446

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: Dillard, Bayani
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check In Date/Time: 8/18/2021 11:49:10 AM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Mary Jane Acosta, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

PATIENT STILL C/O PAIN WITH SQUATTING ACTIVITIES
Patient reports pain of the R KNEE.

Objective: AMBULATORY WITH R KNEE BRACE; DECREASED MS STRENGTH OF THE QUADS; TIGHTNESS OF THE CALF MS; LOM OF THE R KNEE JTS

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

1237161446

(Valley) Island Musculoskeletal Care MD. PC
128 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: Dillard, Bayani
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check In Date/Time: 8/18/2021 11:49:10 AM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Mary Jane Acosta, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 11:50 AM, AUGUST 18, 2021

1239132059

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 8/20/2021 2:32:56 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Joseph Tanfiocco, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

PATIENT CONTINUES TO HAVE PAIN WITH SQUATTING ACTIVITIES
Patient reports pain of the R KNEE.

Objective: AMBULATORY WITH R KNEE BRACE; DECREASED ROM OF THE R KNEE JTS; WEAKNESS OF THE R KNEE MS; TIGHTNESS OF THE CALF MS

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

1239132059

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 44 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 8/20/2021 2:32:56 PM Physician: Joseph Tanlioco, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 02:58 PM, AUGUST 20, 2021

1243119114

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 8/24/2021 1:06:13 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Marygrace Lusan-urena, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

PATIENT CONTINUES TO C/O PAIN AND DISCOMFORT ON R KNEE AGGRAVTDWITH PROLONGED STANDING AND WITH DIFFICULTY FROM SIT TO STAND
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. AMBULATORY WITH R KNEE BRACE; MODERATE TENDERNESS ON R KNEE;WEAKNESS OF THE R KNEE MS; TIGHTNESS OF THE CALF MS;LOM ON R KNEE FLEXION/EXTENSION

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness.. PT TOLERATED ALL TX GIVEN WELL

Plan:

Plan: Continue with current plan of care progressing as tolerated.

1243119114

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 8/24/2021 1:06:13 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976

Physician: Marygrace Lusan-urena, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE

Phone: (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Marygrace Lusan-urena, PT at 01:09 PM, AUGUST 24, 2021

1245133399

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 8/25/2021 2:48:40 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Joseph Tanlioco, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

Patient reports of pain and discomfort on R knee aggravated with prolonged standing, walking and ascending/descending stairs.
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. AMBULATORY WITH R KNEE BRACE; MODERATE TENDERNESS ON R KNEE;WEAKNESS OF THE R KNEE MS; TIGHTNESS OF THE CALF MS;LOM ON R KNEE FLEXION/EXTENSION

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities.. Patient tolerated all treatment well.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

1245133399

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 8/25/2021 2:48:40 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Joseph Tanlioco, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 02:54 PM, AUGUST 25, 2021

1246007588

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 8/27/2021 3:54:54 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Mary Jane Acosta, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

PATIENT CONTINUES TO HAVE PAIN WHEN DOING HOUSEHOLD CHORES
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. AMBULATORY WITH R KNEE BRACE; WEAKNESS OF THE KN EXTENSORS; MODERATE TENDERNESS ON R KNEE;WEAKNESS OF THE R KNEE MS; TIGHTNESS OF THE CALF MS

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength a improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

1246007588

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 8/27/2021 3:54:54 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Mary Jane Acosta, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 03:56 PM, AUGUST 27, 2021

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

1256862999

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 9/2/2021 3:44:15 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Joseph Tanlioco, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

PATIENT CONTINUES TO HAVE PAIN WITH STAIRCLIMBING
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. AMBULATORY WITH R KNEE BRACE; MODERATE TENDERNESS ON R KNEE;WEAKNESS OF THE R KNEE MS;LOM OF THE R KNEE JTS

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

1256062999

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 9/2/2021 3:44:15 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Joseph Tanlioco, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 03:47 PM, SEPTEMBER 02, 2021

1259633163

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malveme, NY, 11565,
Check in Date/Time: 9/3/2021 5:45:15 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Joseph Tanlioco, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

Patient still continue to have pain aggravated by prolonged walking, standing and ascending/descending stairs.
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. AMBULATORY WITH R KNEE BRACE; MODERATE TENDERNESS ON R KNEE;WEAKNESS OF THE R KNEE MS;LOM OF THE R KNEE JTS

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities.. Patient tolerated all given treatment well.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

1259633163

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Acc No: 264184
Gender: MALE
Age: 44 Year(s)
DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565,
Phone: (917)386-5380
Check in Date/Time: 9/3/2021 5:45:15 PM
Physician: Joseph Tanlioco, PT
Location: (Valley) Island Musculoskeletal Care MD. PC
Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 05:48 PM, SEPTEMBER 03, 2021

1259833163

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Acc No: 264184
Gender: MALE
Age: 44 Year(s)
DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565,
Phone: (917)386-5380
Check in Date/Time: 9/4/2021 11:30:26 AM
Physician: Joseph Tanlioco, PT
Location: (Valley) Island Musculoskeletal Care MD. PC
Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Note

Subjective:

Patient reports he continue to have pain and still not able to stand as long as he wants, difficulty with high impact activities such as stairs, squatting.

Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. AMBULATORY WITH R KNEE BRACE; Decrease cadence wh walking, no limp noted. There is not swelling on the right knee. grade 2 tenderness on the medial and lateral aspect the left knee

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength a improve functional activities.. Patient tolerated all given treatment well.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

1259633163

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 44 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 9/4/2021 11:30:26 AM Physician: Joseph Tanlioco, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Refering Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 11:32 AM, SEPTEMBER 04, 2021

1259128320

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 44 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check In Date/Time: 9/8/2021 2:32:04 PM Physician: Marygrace Lusan-urena, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Note

Subjective:

PATIENT CONTINUES TO HAVE PAIN WITH PROLONGED WALKING
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. AMBULATORY WITH R KNEE BRACE; WEAKNESS OF THE R MSL; TIGHTNESS OF THE GASTROC SOLEUS; LOM OF THE R KNEE JTS '

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength a improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

1259128320

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 44 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 9/8/2021 2:32:04 PM Physician: Marygrace Lusan-urena, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Marygrace Lusan-urena, PT at 02:42 PM, SEPTEMBER 08, 2021

1259134333

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 44 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check In Date/Time: 9/9/2021 4:30:27 PM Physician: Marygrace Lusan-urena, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Note

Subjective:

PATIENT CONTINUES TO HAVE TIGHTNESS WITH STAIR NEGOTIATION
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. AMBULATORY WITH R KNEE BRACE; DECREASED ROM OF T KNEE JTS; WEAKNESS OF THE R KNEE EXTENSORS; TIGHTNESS OF THE GASTROC SOLEUS

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength ar improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

1259134333

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 44 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 9/9/2021 4:30:27 PM Physician: Marygrace Lusan-urena, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Marygrace Lusan-urena, PT at 04:33 PM, SEPTEMBER 09, 2021

1268052240

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 9/10/2021 4:14:27 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Joseph Tanlioco, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

PATIENT STILL REPORTS PAIN WITH SQUATTING ACTIVITIES
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. AMBULATORY WITH R KNEE BRACE; MOD TENDERNESS ON TH MED AND LAT ASPECT OF THE R KNEE; LOM OF THE R KNEE FLEXION

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

1260052240

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Acc No: 264184
Gender: MALE
Age: 44 Year(s)
DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565,
Phone: (917)386-5380
Check in Date/Time: 9/10/2021 4:14:27 PM
Physician: Joseph Tanlioco, PT
Location: (Valley) Island Musculoskeletal Care MD. PC
Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 04:19 PM, SEPTEMBER 10, 2021

Joseph Tanlioco, PT

1260859740

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 9/13/2021 5:00:08 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Marygrace Lusan-urena, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

PATIENT COMPLAINS OF HAVING DIFFICULTY IN BENDING AND SQUATTING ACTIVITIES
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MOD TENDERNESS ON THE PERIPATELLAR AREA OF THE R KNEE; LOM OF THE R KNEE WITH PAIN AT END RANGE; WEAKNESS OF R QUADS MS; MOD TIGHTNESS ON HAMSTRINGS MS

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

1268059740

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malveme, NY, 11565,
Check in Date/Time: 9/13/2021 5:00:08 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Marygrace Lusan-urena, PT
Refering Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Marygrace Lusan-urena, PT at 05:02 PM, SEPTEMBER 13, 2021

Marygrace Lusan-urena, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

1266012143

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 9/15/2021 4:33:27 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Mary Jane Acosta, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

PATIENT STILL REPORTS PAIN WHEN DOING HOUSEHOLD CHORES
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. TIGHTNESS OF THE CALF MS; DECREASED ROM OF THE R KNEE FLEXION; MOD TENDERNESS ON THE MED AND LAT ASPECT OF THE R KNEE

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2103
Phone: 516-887-1787 Fax: 516-887-2059

1266812143

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 9/15/2021 4:33:27 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Mary Jane Acosta, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 04:37 PM, SEPTEMBER 15, 2021

Mary Jane Acosta, PT

1267062457

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 9/17/2021 2:17:49 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Marygrace Lusan-urena, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

PATIENT CONTINEUS TO HAVE PAIN WITH SIT TO STAND TRANSFERS
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MOD TENDERNESS ON THE MED AND LAT ASPECT OF THE R KNEE; LOM OF THE R KNEE JTS; TIGHTNESS OF THE CALF MS

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

1267062457

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malveme, NY, 11565,
Check in Date/Time: 9/17/2021 2:17:49 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Marygrace Lusan-urena, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Marygrace Lusan-urena, PT at 02:24 PM, SEPTEMBER 17, 2021

Marygrace Lusan-urena, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 9/20/2021 1:25:34 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Joseph Tanlioco, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

PATIENT COMPLAINS OF HAVING DIFFICULTY IN SQUATTING AND CLIMBING STAIRS
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. WEAKNESS OF R QUADS MS; MOD TENDERNESS ON THE PERIPATELLAR AREA OF THE R KNEE; LOM OF THE R KNEE JTS; MOD TIGHTNESS OF THE HAMSTRINGS MS

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 9/20/2021 1:25:34 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Joseph Tanlioco, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 01:31 PM, SEPTEMBER 20, 2021

Joseph Tanlioco, PT

1272021130

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 9/22/2021 6:09:23 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Joseph Tanlioco, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

PATIENT CONTINUES TO HAVE PAIN WITH SQUATTING ACTIVITIES
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MOD TENDERNESS ON THE PERIPATELLAR AREA OF THE R KNEE; DECREASED MS STRENGTH OF THE KNEE EXTENSORS

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

1272821130

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Acc No: 264184
Gender: MALE
Age: 44 Year(s)
DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565,
Phone: (917)386-5380
Check In Date/Time: 9/22/2021 6:09:23 PM
Physician: Joseph Tanlioco, PT
Location: (Valley) Island Musculoskeletal Care MD. PC
Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 06:10 PM, SEPTEMBER 22, 2021

Joseph Tanlioco, PT

1274119342

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 9/25/2021 12:04:30 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Joseph Tanlioco, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

PATIENT STILL C/O HAVING DIFFICULTY IN CLIMBING STAIRS
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. LOM OF R KNEE WITH PAIN AT EDN RANGE; MOD TENDERN ON THE MEDIAL AND LATERAL ASPECT OF THE R KNEE; WEAKNESS OF R QUADS MS; MOD TIGHTNESS ON HAMSTRII MS

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength an improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

1274119342

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 9/25/2021 12:04:30 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Joseph Tanlioco, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 12:06 PM, SEPTEMBER 25, 2021

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

1277102558

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 9/28/2021 4:03:53 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Mary Jane Acosta, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

PATIENT CONTINUES TO HAVE PAIN WHEN DOING HOUSEHOLD CHORES
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. WEAKNESS OF THE R KNEE MS; TIGHTNESS OF THE CALF MS; DECREASED ROM OF THE R KNEE JTS

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

1277102558

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 44 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 9/28/2021 4:03:53 PM Physician: Mary Jane Acosta, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 04:05 PM, SEPTEMBER 28, 2021

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malveme, NY, 11565,
Check in Date/Time: 9/29/2021 5:17:27 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Joseph Tanlioco, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

PATIENT STILL REPORTS PAIN AND TIGHTNESS WITH SQUATTING AND STAIRCLIMBING
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MOD TENDERNESS ON THE MED AND LAT ASPECT OF THE R KNEE; WEAKNESS OF THE R KNEE MS; TIGHTNESS OF THE CALF MS

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 9/29/2021 5:17:27 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Joseph Tanlioco, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 05:22 PM, SEPTEMBER 29, 2021

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

1279044810

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 44 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 9/30/2021 4:12:12 PM Physician: Joseph Tanlioco, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Note

Subjective:

PATIENT STILL REPORTS PAIN AND TIGHTNESS WHEN PERFORMING ADLS
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. LOM OF THE R KNEE JTS; MOD TENDERNESS ON THE MED LAT ASPECT OF THE R KNEE; WEAKNESS OF THE R QUADS

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength a improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

1279044810

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 9/30/2021 4:12:12 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Joseph Tanlioco, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 04:39 PM, SEPTEMBER 30, 2021

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

1281029604

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malveme, NY, 11565,
Check in Date/Time: 10/4/2021 12:44:09 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Mary Jane Acosta, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

PATIENT STILL REPORTS PAIN ON THE R KNEE JOINT DURING PROLONGED WALKING.
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. WEAKNESS OF R KNEE EXTENSORS; LOM OF THE R KNEE JT; MOD TENDERNESS ON THE MED AND LAT ASPECT OF THE R KNEE.

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

1281029604

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 44 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 10/4/2021 12:44:09 PM Physician: Mary Jane Acosta, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 04:59 PM, OCTOBER 04, 2021

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

1288181498

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 10/11/2021 12:53:49 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Mary Jane Acosta, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Note

Subjective:

PATIENT C/O HVING DIFFICULTY IN SQUATTING AND CLIMBING STAIRS
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. LOM OF THE R KNEE WITH PAIN AT END RANGE; MOD TENDERNESS ON THE MED AND LAT ASPECT OF THE R KNEE; WEAKNESS OF QUADS MS; MOD TIGHTNESS ON HAMSTRINGS MS

Therex:

THERAPEUTIC EXERCISES						
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS	
Self Stretching	Hams			10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

1288101490

Patient Name: **Dillard, Bayani**
Age: 44 Year(s)
Address: 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time: 10/11/2021 12:53:49 PM
Location: (Valley) Island Musculoskeletal Care MD. PC
Insurance: WCOFFICE

Acc No: 264184
DOB: 11/05/1976
Physician: Mary Jane Acosta, PT
Referring Physician: GUS KATSIGIORGIS, DO

Gender: MALE
Phone: (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 12:55 PM, OCTOBER 11, 2021

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 44 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/14/2021 6:19:25 PM Physician. Joseph Tanlioco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT C/O HAVING DIFFICULTY IN PROLONGED STANDING AND WALKING
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MOD TENDERNESS ON THE PERIPATELLAR AREA OF THE R KNEE; WEAKNESS OF R KNEE FLEXORS AND EXTENSORS MS; MOD TIGHTNESS ON HAMSTRINGS MS; MILD SWELLING ON R KNEE

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS	
Self Stretching	Hams		10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 44 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/14/2021 6:19:25 PM Physician. Joseph Tanlioco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 06:27 PM, OCTOBER 14, 2021

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 44 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check In Date/Time. 10/15/2021 10:12:21 AM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT C/O HAVING DISCOMFORT AND DIFFICULTY IN SQUATTING AND CLIMBING STAIRS
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MILD TO MOD TENDERNESS ON THE MEDIAL ASPECT OF THE R KNEE; WEAKNESS OF R QUADS MS; MOD TIGHTNESS ON HAMSTRINGS MS; MILD SPASM ON R VMO MS

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS	
Self Stretching	Hams		10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH 10 REPS 2 SET(S)				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 44 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/15/2021 10 12 21 AM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 10:13 AM, OCTOBER 15, 2021

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 44 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/16/2021 12:02:13 PM Physician. Joseph Tanlioco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT C/O ACHING PAIN AND STIFFNESS ON R KNEE WITH DIFFICULTY IN WALKING AND NEGOTIATING THE STAIRS.

Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MOD TENDERNESS ON THE MEDIAL ASPECT OF THE R KNEE; WEAKNESS OF R QUADS MS; MOD TIGHTNESS ON HAMSTRINGS MS; MILD SWELLING ON R ANTERIOR KNEE

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS	
Self Stretching	Hams		10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH 10 REPS 2 SET(S)				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 44 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/16/2021 12:02:13 PM Physician. Joseph Tanlioco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 12:05 PM, OCTOBER 16, 2021

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender: MALE
Age. 44 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/18/2021 12.15.53 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT COMPLAINS OF PAIN ON R KNEE AGGRAVATED ON SQUATTING ACTIVITIES
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. LOM OF R KNEE DUE TO PAIN AND STIFFNESS; MOD TENDERNESS ON THE INFRAPATELLAR AREA OF THE R KNEE; WEAKNESS OF R KNEE FLEXORS AND EXTENSORS MS; MILD SPASM ON R VMO MS

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS	
Self Stretching	Hams		10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 44 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/18/2021 12:15:53 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Marygrace Lusan-urena, PT at 12:21 PM, OCTOBER 18, 2021

Marygrace Lusan-urena, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 44 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/20/2021 3:00:35 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT COMPLAINS OF HAVING DIFFICULTY IN TRANSFERS AND CLIMBING STAIRS
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MOD TENDERNESS ON THE MEDIAL AND LATERAL ASPECT OF THE R KNEE; WEAKNESS OF R QUADS MS; MILD ANTALGIC GAIT PATTERN; MILD TIGHTNESS ON HAMSTRINGS MS

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS	
Self Stretching	Hams		10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 44 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/20/2021 3:00:35 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 03:01 PM, OCTOBER 20, 2021

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 44 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/22/2021 3:47:23 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT COMPLAINS OF HAVING DIFFICULTY IN GETTING UP AFTER PROLONGED SITTING POSITION
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. DECREASED ROM OF R KNEE DUE TO PAIN AND STIFFNESS; MOD TENDERNESS ON THE PSOTERIOR ASPECT OF THE R KNEE; MILD SPASM ON R VMO MS; DIFFICULTY IN SIT TO STAND TRANSFERS

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS	
Self Stretching	Hams		10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 44 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time 10/22/2021 3:47:23 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Marygrace Lusan-urena, PT at 04:02 PM, OCTOBER 22, 2021

Marygrace Lusan-urena, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender: MALE
Age. 44 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/27/2021 3:38:28 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT COMPLAINS OF HAVING DIFFICULTY IN DRIVING FOR TOO LONG
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MOD TENDERNESS ON THE PERIPATELLAR AREA OF THE R KNEE; WEAKNESS OF RT QUADS MS; MOD TIGHTNESS ON HAMSTRINGS AND CALF MS

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS	
Self Stretching	Hams		10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 44 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/27/2021 3:38:28 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 03:45 PM, OCTOBER 27, 2021

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender MALE
Age. 44 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/1/2021 1:55:04 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O PAIN WHEN ASCENDING AND DESCENDING STAIRS.
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MOD TIGHTNESS ON HAMSTRINGS AND CALF MS; MOD TENDERNESS ON THE PERIPATELLAR AREA OF THE R KNEE; WEAKNESS OF RT QUADS MS.

Therex:

THERAPEUTIC EXERCISES				
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS 2 SETS	
Self Stretching	Hams		10 SH 10 REPS	2 SET(S)
Ball Squeezes	6 SH 10 REPS 2 SET(S)			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities.. PT TOLERATED ALL GIVEN TREATMENTS WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 44 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check In Date/Time. 11/1/2021 1:55:04 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 01:59 PM, NOVEMBER 01, 2021

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 44 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/2/2021 6:16:13 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O HAVING DIFFICULTY IN BENDING AND SQUATTING ACTIVITIES
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. LOM OF R KNEE WITH PAIN AT END RANGE; MOD TIGHTNESS ON HAMSTRINGS MS; MOD TENDERNESS ON THE MEDIAL ASPECT OF THE R KNEE; MILD ANTALGIC GAIT PATTERN

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS	
Self Stretching	Hams		10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 44 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/2/2021 6:16:13 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Marygrace Lusan-urena, PT at 06:19 PM, NOVEMBER 02, 2021

Marygrace Lusan-urena, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender MALE
Age. 44 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time 11/3/2021 4:26:37 PM Physician. Joseph Tanloco, PT
Location (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O HAVING DIFFICULTY IN TRANSFERS,PROLONGED STANDING,WALKING AND CLIMBING STAIRS
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. DECREASED ROM OF R KNEE SECONDARY TO PAIN AND STIFFNESS; MOD TIGHTNESS ON HAMSTRINGS MS; MOD TENDERNESS ON THE POSTERIOR ASPECT OF THE R KNEE; MILD SPASM ON R VMO MS

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS	
Self Stretching	Hams		10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH 10 REPS 2 SET(S)				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 44 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/3/2021 4:26:37 PM Physician. Joseph Tanlioco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 04:59 PM, NOVEMBER 03, 2021

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time. 11/8/2021 12:22:27 PM
Location. (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB. 11/05/1976
Physician. Marygrace Lusan-urena, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Note

Subjective:

PATIENT COMPLAINS OF HAVING DIFFICULTY IN GETTING UP AFTER PROLONGED SITTING > 20-30 MINS
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MOD TIGHTNESS ON HAMSTRINGS MS; MOD TENDERNESS ON THE PERIPATELLAR AREA OF THE R KNEE; MILD ANTALGIC GAIT PATTERN; LOM OF R KNEE WITH PAIN AT END RANGE; DIFFICULTY IN SIT TO STAND TRANSFERS

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS	
Self Stretching	Hams		10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time 11/8/2021 12:22:27 PM
Location (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB 11/05/1976
Physician Marygrace Lusan-urena, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Marygrace Lusan-urena, PT at 12:25 PM, NOVEMBER 08, 2021

Marygrace Lusan-urena, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/11/2021 5:29:36 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT COMPLAINS OF PAIN ON R KNEE GETS AGGRAVATED ON CLIMBING STAIRS
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MILD SPASM ON R VMO MS; MOD TIGHTNESS ON HAMSTRINGS MS; MOD TENDERNESS ON THE MEDIAL AND POSTERIOR ASPECT OF THE R KNEE; DECREASED ROM OF R KNEE SECONDARY TO PAIN AND STIFFNESS

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS	
Self Stretching	Hams		10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/11/2021 5:29:36 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Marygrace Lusan-urena, PT at 05:32 PM, NOVEMBER 11, 2021

Marygrace Lusan-urena, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/15/2021 11 24 40 AM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT STILL COMPLAINS OF HAVING DIFFICULTY IN BENDING AND SQUATTING ACTIVITIES
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MOD TENDERNESS ON THE PERIPATELLAR AREA OF THE R KNEE; DECREASED FLEXIBILITY OF HAMSTRINGS AND GASTROCSOLEUS COMPLEX MS; WEAKNESS OF R KNEE FLEXORS AND EXTENSORS MS

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS	
Self Stretching	Hams		10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender: MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/15/2021 11 24 40 AM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 11:26 AM, NOVEMBER 15, 2021

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/18/2021 5:34:15 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT COMPLAINS OF HAVING DIFFICULTY AND DISCOMFORT IN DRIVING FOR TOO LONG
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. LOM OF R KNEE DUE TO PAIN AND STIFFNESS; MOD TENDERNESS ON THE MEDIAL AND INFERIOR ASPECT OF THE R KNEE; WEAKNESS OF R QUADS MS; MOD TIGHTNESS ON HAMSTRINGS MS

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS	
Self Stretching	Hams		10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH 10 REPS 2 SET(S)				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/18/2021 5:34:15 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Marygrace Lusan-urena, PT at 05:41 PM, NOVEMBER 18, 2021

Marygrace Lusan-urena, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/23/2021 4.52.53 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

SUBJECTIVE:

Patient was seen for re- evaluation and treatment for pain on the right knee due to work related injury. Patient reports of less frequent c/o on the right knee with increased ROM and muscle strength. Patient mentioned that he's supposed to do surgery on the right knee in October but the Anesthesiologist wants him to get test for sleep apnea and his A1C was high. So, the doctor didn't continue the surgery that day and still waiting for the bloodwork to be low especially on the A1C. Patient c/o intermittent sharp pain on the right knee with stiffness and swelling. He also c/o clicking on the knee when he is walking. He reports that he has difficulty in getting up from prolonged sitting and weight bearing activities such as prolonged standing, walking and negotiating the stairs. He states that he goes up and down the stairs sideways due to pain on the right knee. He is taking Tylenol as needed and he using knee brace.

The patient presents with Pain, Weakness, Clicking, Crepitus, Swelling, Tightness and Stiffness in the left knee. Patient reports the following functional complaints/deficits include Activities of daily living, Ambulation, Ambulation on uneven surfaces, Sit to Stand/Stand to Sit transfers, Ascending stairs, Descending stairs, Entering or exiting a motor vehicle, Bending, Bathing, Household chores, Leisure activities, Lifting heavy objects, Driving and Unable to sleep. Independent in ambulation with hinged knee brace; moderate antalgic gait on the right knee, listing to the left; decreased knee flexion- extension

PS: 7/10

HISTORY:

Past Medical History
Hypertension, Asthma
HPI: Patient works as a EMT. On 06/11/2021, patient reports that he felt pain on the right knee when he stepped out from the ambulance and it aggravated when he slipped and fell on the bathroom of Mc Donald which caused an injury on the right knee. He reports that he went to Flushing Hospital and CAT scan was done and received PT somewhere else with mild improvement. He came in our office and referred for x-ray and continue PT. He also mentioned that he will undergo surgery on the right knee.

OBJECTIVE: Knee Evaluation:

	Strength		Active ROM		Passive ROM	
	Right	Left	Right	Left	Right	Left
Flexion (0-135)	3 /5		0-90			
Extension (0-135)	3 /5		90-0			

PREVIOUS ROM AND MMT ON RIGHT KNEE:

Flexion (0-135): 3- /5; 0-80
Extension (0-135): 3- /5; 80-0

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/23/2021 4:52:53 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

RIGHT KNEE: Palpation Tests gr. 2 tenderness on right medial aspect of the knee and infrapatellar area; moderate swelling on right knee; moderate tightness on right hamstring, TFL and gastroc- soleus complex; moderate crepitus on right knee flexion- extension; moderate muscle guarding on right knee flexion

Special Tests

McMurray's: Positive

Therex Hamstring stretch x 10shx 10 reps x 2 sets
Quads sets x6shx 10 reps x 2 sets
SLR x 10 reps x 2 sets
Hip abduction in sidelying position x10 reps x 2sets
Hamstring curls x 10 reps x 2 sets
Adductor squeeze x 6shx 10 reps x2 sets
Clam shell using red TB x 10 reps x2 sets
Calf raises x 10 reps x 2 sets

Manual Therapy:

Soft Tissue Mobilization	Comments: right knee
Myofascial Release	Comments: right knee

Therapeutic Modalities:

Electric Stimulation, Premod	Min: 15	Comments: right knee
Therapeutic Ultrasound	Min: 8	Comments: right knee
Hot Pack	Min: 15	Comments: right knee

ASSESSMENT:

Patient reports of less frequent c/o on the right knee with increased ROM and muscle strength as shown to the objective assessment. Patient would benefit from a course of skilled PT in conjunction with a home exercise program to work on current functional deficits with weight bearing activities such as ambulation, stairs negotiation, squatting, getting up from sitting and tolerance to prolonged standing by promoting gains from the limiting factors to achieve goals for him to be able to perform his job as an EMT in responding emergencies.

Short Term Goals:

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/23/2021 4:52:53 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Time Frame: 2-4 weeks

Decrease Knee Pain to 4/10

Increase Right Knee Flexion ROM	50% of normal limits	and Strength 4-/5
Increase Right Knee Extension ROM	50% of normal limits	and Strength 4-/5

Increase Activity Tolerance to ADL/IDLs
Patient will be able to amb 1-2 blocks feet with minimal discomfort without AD
Patient will be able to negotiate 1-2 flight(s) of stairs with minimal discomfort
Patient will be able to sit to stand with minimal assistance from his/her upper extremities
Patient is aware of heel/toe gait with minimal cueing
Lift an object like a bag of groceries from the floor
Do usual house work/ school work
Getting in and out of the car
Getting in and out of the bath

Long Term Goals:

Time Frame: 6-8 weeks

Decrease Knee Pain to 0/10

Increase Right Knee Flexion ROM	100% of normal limits	and Strength 5/5
Increase Right Knee Extension ROM	100% of normal limits	and Strength 5/5

Increase Activity Tolerance to ADL/IDLs to WNL
Independent in HEP
Patient will be able to amb >10 blocks feet with no discomfort without AD
Patient will be able to sit to stand with no assistance from his/her upper extremities
Patient will be able to negotiate uneven terrain for 1 block feet
Patient will be able to return to running pain free
Patient is aware of heel/toe gait with no cueing
Squatting
Hopping
Trying to pivot on same LE without being off balance

PLAN:

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/23/2021 4:52:53 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Plan of Care/Treatment Plan: Patient Education, Progressive Resistive Therapeutic Exercise, Manual Therapy Techniques, Home Exercise Program, Modality to Decrease Pain - Electrical Stimulation, Hot and/or Cold Packs

Rehab Potential: Rehab potential good to meet treatment goals.

Frequency and Duration of Treatment: 3 times a week for 8 weeks

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		right knee
Electric Stim (97014)	15		right knee
Ultrasound (97035)		8	right knee
Exercises (97110)		15	right knee
Re-eval- WC/COM- 20 min (97164)		20	right knee
Manual Therapy (97140)		10	right knee
	Total 15	Total 53	Total Min. TX Time 68

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 06:29 PM, NOVEMBER 23, 2021

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time. 11/29/2021 10:28:55 AM
Location. (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB. 11/05/1976
Physician. Mary Jane Acosta, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Note

Subjective:

PATIENT COMPLAINS OF INTERMITTENT SHARP PAIN ON R KNEE WITH STIFFNESS AND SWELLING
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MOD TENDERNESS ON THE PERIPATELLAR AREA OF THE R KNEE; WEAKNESS OF R KNEE FLEXORS AND EXTENSORS MS; MOD TIGHTNESS ON HAMSTRINGS MS; MILD SWELLING ON R KNEE ; MILD ANTALGIC GAIT PATTERN

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS	
Self Stretching	Hams		10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH 10 REPS 2 SET(S)				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/29/2021 10:28:55 AM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 10:31 AM, NOVEMBER 29, 2021

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time 1/26/2022 11:06.22 AM Physician. Mary Jane Acosta, PT
Location (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

SUBJECTIVE:

Patient was seen for re- evaluation and treatment for s/p right knee arthroscopy on 01/10/2022 due to work related injury. Patient states that he's been using the ice machine at home after the surgery, 3x/ day for 1 hour. Patient reports that he got weak after the surgery and states that he cannot get up after the surgery on the right knee. He came today and the doctor removed the stiches and referred to start PT. Patient c/o intermittent sharp pain on the right knee with stiffness and swelling. He states that he as difficulty in getting up from sitting > 1 hour, Standing > 30 minutes and walking for short distance from room to bathroom and kitchen, house to car and car to doctor's building. He also reports that he's been going up and down the stairs in sideways. He is taking Tylenol, Advil or Aleve as needed

The patient presents with Pain, Weakness, Swelling, Soreness, Tightness and Stiffness in the right knee. Patient reports the following functional complaints/deficits include Activities of daily living, Ambulation, Ambulation on uneven surfaces, Sit to Stand/Stand to Sit transfers, Ascending stairs, Descending stairs, Entering or exiting a motor vehicle, Bending, Bathing, Household chores, Leisure activities, Lifting heavy objects, Driving and Unable to sleep. Independent in ambulation without assistive device; moderate antalgic gait on the right knee, listing to the left; decreased knee flexion- extension

PS: 6/10

HISTORY:

Past Medical History
Hypertension, Asthma
Surgeries: s/p right knee arthroscopy on 01/10/2022
HPI: Patient works as a EMT. On 06/11/2021, patient reports that he felt pain on the right knee when he stepped out from the ambulance and it aggravated when he slipped and fell on the bathroom of Mc Donald which caused an injury on the right knee. He reports that he went to Flushing Hospital and CAT scan was done and received PT somewhere else with mild improvement. He came in our office and referred for x-ray and continue PT. He also mentioned that he will undergo surgery on the right knee.

Social History

OBJECTIVE: Knee Evaluation:

	Strength		Active ROM		Passive ROM	
	Right	Left	Right	Left	Right	Left
Flexion (0-135)	3- /5		0-70			
Extension (0-135)	3- /5		70-0			

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 1/26/2022 11:06:22 AM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

RIGHT KNEE: Palpation Tests gr. 2-3 tenderness on right medial aspect of the knee and infrapatellar area; moderate swelling on right knee; moderate tightness on right hamstring, TFL and gastroc- soleus complex; moderate muscle guarding on right knee flexion; + healing wound, no drainage noted; + sterile strip on the surgical site area

Therex Hamstring stretch x 10shx 10 reps x 2 sets
Quads sets x6shx 10 reps x 2 sets
SLR x 10 reps x 2 sets
Hip abduction in sidelying position x10 reps x 2sets
Hamstring curls x 10 reps x 2 sets
Adductor squeeze x 6shx 10 reps x2 sets
Clam shell using red TB x 10 reps x2 sets
Calf raises x 10 reps x 2 sets
Bike ergo x 10 minutes

Manual Therapy:

Soft Tissue Mobilization	Comments: right knee
Myofascial Release	Comments: right knee

Therapeutic Modalities:

Electric Stimulation, Premod	Min: 15	Comments: right knee
Therapeutic Ultrasound	Min: 8	Comments: right knee
Hot Pack	Min: 15	Comments: right knee

ASSESSMENT:

Patient reports of less frequent c/o on the right knee with increased ROM and muscle strength as shown to the objective assessment. Patient would benefit from a course of skilled PT in conjunction with a home exercise program to work on current functional deficits with weight bearing activities such as ambulation, stairs negotiation, squatting, getting up from sitting and tolerance to prolonged standing by promoting gains from the limiting factors to achieve goals for him to be able to perform his job as an EMT in responding emergencies.

Short Term Goals:

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 45 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check In Date/Time: 1/26/2022 11:06:22 AM Physician: Mary Jane Acosta, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Time Frame: 2-4 weeks

Decrease Knee Pain to 4/10

Increase Right Knee Flexion ROM	50% of normal limits	and Strength 4-/5
Increase Right Knee Extension ROM	50% of normal limits	and Strength 4-/5

Increase Activity Tolerance to ADL/IDLs

Patient will be able to amb 1-2 blocks feet with minimal discomfort without AD

Patient will be able to negotiate 1-2 flight(s) of stairs with minimal discomfort

Patient will be able to sit to stand with minimal assistance from his/her upper extremities

Patient is aware of heel/toe gait with minimal cueing

Lift an object like a bag of groceries from the floor

Do usual house work/ school work

Getting in and out of the car

Getting in and out of the bath

Long Term Goals:

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 1/26/2022 11:06:22 AM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Time Frame: 6-8 weeks

Decrease Knee Pain to 0/10

Increase Right Knee Flexion ROM — 100% of normal limits — and Strength 5/5

Increase Right Knee Extension ROM — 100% of normal limits — and Strength 5/5

Increase Activity Tolerance to ADL/IDLs to WNL

Independent in HEP

Patient will be able to amb >10 blocks feet with no discomfort without AD

Patient will be able to negotiate 8-9 flight(s) of stairs with no discomfort

Patient will be able to sit to stand with no assistance from his/her upper extremities

Patient will be able to negotiate uneven terrain for 2-3 block feet

Patient will be able to return to running pain free

Patient is aware of heel/toe gait with no cueing

Squatting

Kneeling

Making sharp turns while running

Hopping

Trying to pivot on same LE without being off balance

PLAN:

Plan: Continue with skilled PT services per plan of care.

Plan of Care/Treatment Plan: Patient Education, Progressive Resistive Therapeutic Exercise, Manual Therapy Techniques, Home Exercise Program, Modality to Decrease Pain - Electrical Stimulation, Hot and/or Cold Packs

Rehab Potential: Rehab potential good to meet treatment goals.

Frequency and Duration of Treatment: 3 times a week — for 8 weeks

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 1/26/2022 11:06:22 AM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		right knee
Electric Stim (97014)	15		right knee
Ultrasound (97035)		8	right knee
Exercises (97110)		15	right knee
Re-eval- WC/COM- 20 min (97164)		20	right knee
Manual Therapy (97140)		10	right knee
	Total 15	Total 53	Total Min. TX Time 68

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)
H/O arthroscopy of right knee (Z98.890)

Electronically signed by Mary Jane Acosta, PT at 01:16 PM, JANUARY 26, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time 2/3/2022 5.14.22 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT COMPLAINS OF PAIN ON R KNEE WITH DIFFICULTY IN GETTING IN AND OUT OF THE BED
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. LOM OF R KNEE WITH PAIN AT END RANGE; STILL NOTED MILD SWELLING ON R KNEE; MOD TENDERNESS ON THE MEDIAL AND INFERIOR ASPECT OF THE R KNEE; WEAKNESS OF R QUADS MS; MOD TIGHTNESS ON HAMSTRINGS AND CALF MS

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS	
Self Stretching	Hams		10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH 10 REPS 2 SET(S)				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB 11/05/1976
Address 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time 2/3/2022 5:14:22 PM Physician. Marygrace Lusan-urena, PT
Location (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Marygrace Lusan-urena, PT at 05:20 PM, FEBRUARY 03, 2022

Marygrace Lusan-urena, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time. 2/14/2022 2:48:03 PM
Location. (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB. 11/05/1976
Physician. Marygrace Lusan-urena, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Note

Subjective:

PATIENT COMPLAINS OF STIFFNESS AND PAIN ON R KNEE THAT IS AGGRAVATED WITH CLIMBING STAIRS
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MOD TENDERNESS ON THE PERIPATELLAR AREA OF THE R KNEE; WEAKNESS OF R KNEE FLEXORS AND EXTENSORS MS; MOD TIGHTNESS ON HAMSTRINGS MS; MILD SPASM ON R VMO MS

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS	
Self Stretching	Hams		10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH 10 REPS 2 SET(S)				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time 2/14/2022 2.48.03 PM
Location. (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB. 11/05/1976
Physician. Marygrace Lusan-urena, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Marygrace Lusan-urena, PT at 02:49 PM, FEBRUARY 14, 2022

Marygrace Lusan-urena, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 2/15/2022 11.02 22 AM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT COMPLAINS OF WEAKNESS ON R KNEE WITH DIFFICULTY IN STANDING AND WALKING FOR TOO LONG
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. LOM OF R KNEE WITH PAIN AT END RANGE; MOD TENDERNESS ON THE MEDIAL ASPECT OF THE R KNEE; WEAKNESS OF R QUADS MS; MOD TIGHTNESS ON HAMSTRINGS MS

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS	
Self Stretching	Hams		10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 2/15/2022 11 02 22 AM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 11:03 AM, FEBRUARY 15, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Acc No. 264184
Gender. MALE
Age. 45 Year(s)
DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565,
Phone. (917)386-5380
Check in Date/Time. 2/22/2022 3:45:00 PM
Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC
Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT REPORTS PAIN IN THE R KNEE WHILE WALKING TODAY.
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. TENDERNESS ON THE MEDIAL ASPECT OF THE R KNEE; WEAKNESS OF R QUADS MS; MOD TIGHTNESS ON HAMSTRINGS MS

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS	
Self Stretching	Hams		10 SH	10 REPS	2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check In Date/Time. 2/22/2022 3:45:00 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 03:52 PM, FEBRUARY 22, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time 2/23/2022 4:26:46 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT COMPLAINS OF PAIN ON R KNEE WITH DIFFICULTY IN CLIMBING STAIRS
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. LOM OF R KNEE WITH PAIN AT END RANGE; MOD TENDERNESS ON THE INFRAPATELLAR AREA OF THE R KNEE; WEAKNESS OF R QUADS MS; MOD SPASM ON R VMO MS

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time. 2/23/2022 4 26.46 PM
Location. (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB. 11/05/1976
Physician. Mary Jane Acosta, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 05:07 PM, FEBRUARY 24, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Acc No. 264184
Gender. MALE
Age. 45 Year(s)
DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565,
Phone. (917)386-5380
Check in Date/Time. 2/24/2022 4:58:34 PM
Physician. Joseph Tanloco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC
Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT COMPLAINS OF PAIN ON R KNEE WITH DIFFICULTY IN GETTING UP AFTER PROLONGED SITTING > 20 - 30 MINS
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MOD TENDERNESS ON THE MEDIAL AND LATERAL ASPECT OF THE R KNEE; WEAKNESS OF R KNEE FLEXORS AND EXTENSORS MS; MOD TIGHTNESS ON HAMSTRINGS AND CALF MS; MILD ANTALGIC GAIT PATTERN

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 2/24/2022 4 58 34 PM Physician. Joseph Tanlioco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS. DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 05:04 PM, FEBRUARY 24, 2022

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time. 3/1/2022 6:20:43 PM
Location. (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB. 11/05/1976
Physician. Joseph Tanlioco, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Note

Subjective:

PATIENT COMPLAINS OF HAVING DIFFICULTY IN BENDIGN,SQUATTING,KNEELING AND CLIMBING STAIRS
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. LOM OF R KNEE WITH PAIN AT END RANGE; MOD TENDERNESS ON THE PERIPATELLAR AREA OF THE R KNEE; WEAKNESS OF R QUADS MS; MOD TIGHTNESS ON HAMSTRINGS MS; MILD SPASM ON R VMO MS

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 3/1/2022 6.20.43 PM Physician. Joseph Tanlioco, PT
Location (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)
H/O arthroscopy of right knee (Z98.890)

Electronically signed by Joseph Tanlioco, PT at 06:23 PM. MARCH 01, 2022

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Acc No. 264184
Gender. MALE
Age. 45 Year(s)
DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565,
Phone. (917)386-5380
Check in Date/Time. 3/2/2022 4:38:21 PM
Physician. Joseph Tanloco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC
Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT COMPLAINS OF HAVING DIFFICULTY IN PROLONGED STANDING AND WALKING
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MOD TENDERNESS ON THE MEDIAL AND INFERIOR ASPECT OF THE R KNEE; WEAKNESS OF R QUADS MS; MOD TIGHTNESS ON HAMSTRINGS MS; DECREASED ROM OF R KNEE SECONDARY TO PAIN AND STIFFNESS

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time. 3/2/2022 4.38.21 PM
Location. (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB. 11/05/1976
Physician. Joseph Tanlioco, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 04:39 PM, MARCH 02, 2022

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 3/4/2022 3.58.41 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT COMPLAINS OF PAIN ON R KNEE WITH DIFFICULTY IN BENDING,SQUATTING AND CLIMBING STAIRS
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. LOM OF R KNEE WITH PAIN AT END RANGE; MOD TENDERNESS ON THE INFRAPATELLAR AREA OF THE R KNEE; WEAKNESS OF R QUADS MS; MOD SPASM ON R VMO MS

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 3/4/2022 3:58:41 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 04:00 PM, MARCH 04, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time. 3/9/2022 4.44.41 PM
Location. (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB. 11/05/1976
Physician. Joseph Tanlioco, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Note

Subjective:

PATIENT COMPLAINS OF PAIN ON R KNEE WITH AGGRAVATED WITH STANDING AFTER PROLONGED SITTING
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MOD TENDERNESS ON THE MEDIAL AND INFERIOR ASPECT OF THE R KNEE; WEAKNESS OF R KNEE FLEXORS AND EXTENSORS MS; MOD TIGHTNESS ON HAMSTRINGS AND CALF MS; MILD SPASM ON R VMO MS

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 3/9/2022 4.44.41 PM Physician. Joseph Tanlioco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 04:48 PM, MARCH 09, 2022

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Acc No. 264184
Gender. MALE
Age. 45 Year(s)
DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565,
Phone. (917)386-5380
Check in Date/Time. 3/10/2022 4.57.46 PM
Physician. Joseph Tanlioco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC
Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT COMPLAINS OF PAIN AND STIFFNESS ON R KNEE AGGRAVATED ON CLIMBING STAIRS
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. LOM OF R KNEE WITH PAIN AT END RANGE; MOD TENDERNESS ON THE INFRAPATELLAR AREA OF THE R KNEE; WEAKNESS OF R QUADS MS; MILD ANTALGIC GAIT PATTERN

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check In Date/Time. 3/10/2022 4:57:46 PM Physician. Joseph Tanlioco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 05:00 PM, MARCH 10, 2022

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 3/11/2022 2.43.54 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O PAIN WHEN ASCENDING AND DESCENDING STAIRS.
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MILD ANTALGIC GAIT PATTERN; LOM OF R KNEE WITH PAIN AT END RANGE; MOD TENDERNESS ON THE INFRAPATELLAR AREA OF THE R KNEE; WEAKNESS OF R QUADS MS.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness.. PT TOLERATED ALL GIVENT REATMENTS WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check In Date/Time. 3/11/2022 2:43:54 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 02:45 PM, MARCH 11, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time. 3/14/2022 11:38:31 AM
Location. (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB. 11/05/1976
Physician. Mary Jane Acosta, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Note

Subjective:

PT C/O PAIN WHEN ASCENDING AND DESCENDING STAIRS.
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. WEAKNESS OF R QUADS MS; MILD ANTALGIC GAIT PATTERN; LOM OF R KNEE WITH PAIN AT END RANGE; MOD TENDERNESS ON THE INFRAPATELLAR AREA OF THE R KNEE.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness.. PT PERFORMED ALL GIVEN EXERCISES WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 3/14/2022 11:38:31 AM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 11:39 AM, MARCH 14, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 3/16/2022 3.06.56 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O PAIN WHEN STANDING AND WALKING FOR PROLONGED PERIODS OF TIME.
Patient reports pain of the R KNEE.

Objective: Patient arrived to PT in no apparent distress. MOD TENDERNESS ON THE INFRAPATELLAR AREA OF THE R KNEE; WEAKNESS OF R QUADS MS; MILD ANTALGIC GAIT PATTERN; LOM OF R KNEE WITH PAIN AT END RANGE.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness.. PT TOLERATED ALL GIVEN TREATMENTS WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender MALE
Age. 45 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 3/16/2022 3:06:56 PM Physician Mary Jane Acosta, PT
Location (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)
H/O arthroscopy of right knee (Z98.890)

Electronically signed by Mary Jane Acosta, PT at 03:08 PM, MARCH 16, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 45 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 3/18/2022 11:51:31 AM Physician: Joseph Tanlioco, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Note

Subjective:

PT C/O DIFFICULTIES WITH PROLONGED WEIGHT BEARING ACTIVITIES AND WALKING ON UNEVEN TERRAIN.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: Patient arrived to PT in no apparent distress. MOD TENDERNESS ON THE INFRAPATELLAR AREA OF THE R KNEE; WEAKNESS OF R QUADS MS; MILD ANTALGIC GAIT PATTERN; LOM OF R KNEE WITH PAIN AT END RANGE.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time 3/18/2022 11:51 31 AM Physician. Joseph Tanlioco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 12:46 PM, MARCH 18, 2022

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time. 3/22/2022 1 55 00 PM
Location. (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB 11/05/1976
Physician. Joseph Tanloco, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Note

Subjective:

PT C/O PAIN WHEN ASCENDING AND DESCENDING STAIRS.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: Patient arrived to PT in no apparent distress. LOM OF R KNEE WITH PAIN AT END RANGE; MOD TENDERNESS ON THE INFRAPATELLAR AREA OF THE R KNEE; WEAKNESS OF R QUADS MS; MILD ANTALGIC GAIT PATTERN.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities., Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness.. PT TOLERATED ALL GIVEN TREATMENTS WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time. 3/22/2022 1:55:00 PM
Location. (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB. 11/05/1976
Physician. Joseph Tanlioco, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 02:57 PM, MARCH 25, 2022

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time. 3/23/2022 10:37:42 AM
Location. (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB. 11/05/1976
Physician. Marygrace Lusan-urena, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Note

Subjective:

PT C/O DIFFICULTIES WITH STAIR NEGOTIATIONS AND WALKING ON UNEVEN TERRAIN.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: MOD TENDERNESS ON THE INFRAPATELLAR AREA OF THE R KNEE; WEAKNESS OF R QUADS MS; MILD ANTALGIC GAIT PATTERN; LOM OF R KNEE WITH PAIN AT END RANGE.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 3/23/2022 10:37:42 AM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Marygrace Lusan-urena, PT at 10:59 AM, MARCH 23, 2022

Marygrace Lusan-urena, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender MALE
Age. 45 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time 3/25/2022 4:28:09 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT STILL REPORTS OF DIFFICULTY PERFOMING STAIR CLIMING ACTIVITIESS AND WALKING ON UNEVEN TERRAIN.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: MOD TENDERNESS ON THE INFRAPATELLAR AREA OF THE R KNEE; WEAKNESS OF R QUADS MS; MILD ANTALGIC GAIT PATTERN; LOM OF R KNEE WITH PAIN AT END RANGE.WEAKNESS OF THE QUADS.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities.. PATIENT TOLERATED THE THERAPY WELL WITHOUT INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time. 3/25/2022 4 28 09 PM
Location. (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB. 11/05/1976
Physician. Marygrace Lusan-urena, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Marygrace Lusan-urena, PT at 04:36 PM, MARCH 25, 2022

Marygrace Lusan-urena, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 3/28/2022 3.18.36 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

SUBJECTIVE:

Patient was seen for re- evaluation and treatment for pain on the right knee. Patient underwent s/p right knee arthroscopy on 01/10/2022 due to work related injury. Patient reports of significant improvement with decreased in pain from 6/10 to 4/10 and with increased in ROM by 30 degrees and muscle strength from 3-/5 to 3+/5. Patient significant improvement in getting in and out of the bathroom, donning/ doffing undergarment and putting his shoes from moderate to severe difficulty before. Patient is able to ambulate 8 blocks without difficulty from before that he needs to use single tip cane and he can only walk around the house. Patient is able to tolerate standing for 1 hour from moderate difficulty in tolerating 30 minutes of standing before. Patient is able to tolerate sitting for 2 hours from moderate difficulty in tolerating sitting for 1 hour before. Patient is able to tolerate in negotiating 2 flights of stairs alternately from before the he could negotiate the stairs sideways, 1 flight of stairs. However, patient still c/o intermittent aching pain on the right knee with stiffness. He still has mild difficulty in getting up from prolonged sitting, squatting and doing household chores that requires kneeling and squatting. He is taking Tylenol as need and use knee brace as needed.

The patient presents with Pain, Weakness, Clicking, Crepitus, Swelling, Soreness, Tightness and Stiffness in the right knee. Patient reports the following functional complaints/deficits include Activities of daily living, Ambulation, Ambulation on uneven surfaces, Sit to Stand/Stand to Sit transfers, Ascending stairs, Descending stairs, Entering or exiting a motor vehicle, Household chores and Leisure activities. Patient reports the following improvements Bending, Bathing, Household chores, Lifting heavy objects, Driving and Unable to sleep. Independent in ambulation without assistive device; mild antalgic gait on the right knee, listing to the left; decreased knee flexion- extension

PS: 6/10 previous to 4/10

HISTORY:

Past Medical History
Hypertension, Asthma
Surgeries: s/p right knee arthroscopy on 01/10/2022
HPI: Patient works as a EMT. On 06/11/2021, patient reports that he felt pain on the right knee when he stepped out from the ambulance and it aggravated when he slipped and fell on the bathroom of Mc Donald which caused an injury on the right knee. He reports that he went to Flushing Hospital and CAT scan was done and received PT somewhere else with mild improvement. He came in our office and referred for x-ray and continue PT. He also mentioned that he will undergo surgery on the right knee.

Social History

OBJECTIVE: Knee Evaluation:

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 3/28/2022 3:18:36 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

	Strength		Active ROM		Passive ROM	
	Right	Left	Right	Left	Right	Left
Flexion (0-135)	3+ /5		0-100			
Extension (0-135)	3+ /5		100-0			

RIGHT KNEE: Palpation Tests gr. 1-2 tenderness on right medial aspect of the knee and infrapatellar area; mild swelling on right knee; moderate tightness on right hamstring, TFL and gastroc- soleus complex; no muscle guarding noted on right knee flexion

Therex Hamstring stretch x 10shx 10 reps x 2 sets
Quads sets x6shx 10 reps x 2 sets
SLR x 10 reps x 2 sets using 4 lbs ankle weight
Hip abduction in sidelying position x10 reps x 2sets using 3 lbs ankle weight
Adductor squeeze x 6shx 10 reps x2 sets
Clam shell using red TB x 10 reps x2 sets
Bike ergo x 10 minutes
Leg press x 10 reps x 2 sets using 30 lbs

Manual Therapy:

Soft Tissue Mobilization	Comments: right knee
Myofascial Release	Comments: right knee

Therapeutic Modalities:

Electric Stimulation, Premod	Min: 15	Comments: right knee
Therapeutic Ultrasound	Min: 8	Comments: right knee
Hot Pack	Min: 15	Comments: right knee

ASSESSMENT:

Patient reports of decreased in pain from 6/10 to 4/10, decreased in tenderness from gr. 2-3 tenderness to gr. 1-2 tenderness, decreased moderate swelling to mild swelling and increased in muscle strength from 3-/5 to 3+/5 and increased in ROM by 30 degrees. Patient also improved from moderate antalgic gait to mild antalgic gait without any assistive device. Patient would benefit from a course of skilled PT in conjunction with a home exercise program to work on current functional deficits with weight bearing activities such as ambulation, stairs negotiation, squatting, getting up from sitting and tolerance to prolonged standing by promoting gains from the limiting factors to achieve goals for him to be able to perform his job as an EMT in responding emergencies.

FUNCTIONAL IMPROVEMENT/ GAINS AFTER THE SURGERY WITH CONJUNCTION OF PT:
- Patient significant improvement in getting in and out of the bathroom, donning/ doffing undergarment and putting his shoes from moderate to severe difficulty before.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Acc No. 264184
Gender. MALE
Age. 45 Year(s)
DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565,
Phone. (917)386-5380
Check in Date/Time. 3/28/2022 3.18.36 PM
Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC
Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

- Patient is able to ambulate 8 blocks without difficulty from before that he needs to use single tip cane and he can only walk around the house.
- Patient is able to tolerate standing for 1 hour from moderate difficulty in tolerating 30 minutes of standing before.
- Patient is able to tolerate sitting for 2 hours from moderate difficulty in tolerating sitting for 1 hour before.
- Patient is able to tolerate in negotiating 2 flights of stairs alternately from before the he could negotiate the stairs sideways, 1 flight of stairs

Short Term Goals:

Time Frame: 2-4 weeks

Decrease Knee Pain to 4/10

Increase Right Knee Flexion ROM	50% of normal limits	and Strength 4-/5
Increase Right Knee Extension ROM	50% of normal limits	and Strength 4-/5

Increase Activity Tolerance to ADL/IDLs

Patient will be able to amb 1-2 blocks feet with minimal discomfort without AD

Patient will be able to negotiate 1-2 flight(s) of stairs with minimal discomfort

Patient will be able to sit to stand with minimal assistance from his/her upper extremities

Patient is aware of heel/toe gait with minimal cueing

Lift an object like a bag of groceries from the floor

Do usual house work/ school work

Getting in and out of the car

Getting in and out of the bath

Long Term Goals:

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time. 3/28/2022 3:18:36 PM
Location. (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB. 11/05/1976
Physician. Mary Jane Acosta, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Time Frame: 6-8 weeks

Decrease Knee Pain to 0/10

Increase Right Knee Flexion ROM	100% of normal limits	and Strength 5/5
Increase Right Knee Extension ROM	100% of normal limits	and Strength 5/5

Increase Activity Tolerance to ADL/IDLs to WNL
Independent in HEP
Patient will be able to amb >10 blocks feet with no discomfort without AD
Patient will be able to negotiate 8-9 flight(s) of stairs with no discomfort
Patient will be able to sit to stand with no assistance from his/her upper extremities
Patient will be able to negotiate uneven terrain for 2-3 block feet
Patient will be able to return to running pain free
Patient is aware of heel/toe gait with no cueing
Squatting
Kneeling
Making sharp turns while running
Hopping
Trying to pivot on same LE without being off balance

PLAN:

Plan: Continue with skilled PT services per plan of care.

Plan of Care/Treatment Plan: Patient Education, Progressive Resistive Therapeutic Exercise, Manual Therapy Techniques, Home Exercise Program, Modality to Decrease Pain - Electrical Stimulation, Hot and/or Cold Packs

Rehab Potential: Rehab potential good to meet treatment goals.

Frequency and Duration of Treatment: 3 times a week for 8 weeks

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check In Date/Time 3/28/2022 3.18.36 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		right knee
Electric Stim (97014)	15		right knee
Ultrasound (97035)		8	right knee
Exercises (97110)		15	right knee
Re-eval- WC/COM- 20 min (97164)		20	right knee
Manual Therapy (97140)		10	right knee
	Total 15	Total 53	Total Min. TX Time 68

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 11:57 AM, MARCH 29, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 3/30/2022 5:02:24 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O PAIN WHEN STANDING AND WALKING FOR PROLONGED PERIODS OF TIME.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: LOM OF R KNEE WITH PAIN AT END RANGE.WEAKNESS OF THE QUADS; MOD TENDERNESS ON THE INFRAPATELLAR AREA OF THE R KNEE; WEAKNESS OF R QUADS MS; MILD ANTALGIC GAIT PATTERN.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities.. PT PERFORMED ALL GIVEN EXERCISES WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time. 3/30/2022 5:02:24 PM
Location. (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB. 11/05/1976
Physician. Mary Jane Acosta, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)
H/O arthroscopy of right knee (Z98.890)

Electronically signed by Mary Jane Acosta, PT at 05:08 PM, MARCH 30, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 4/1/2022 3.25.57 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O PAIN WHEN STANDING AND WALKING FOR PROLONGED PERIODS OF TIME.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: MILD ANTALGIC GAIT PATTERN; LOM OF R KNEE WITH PAIN AT END RANGE.WEAKNESS OF THE QUADS; MOD TENDERNESS ON THE INFRAPATELLAR AREA OF THE R KNEE; WEAKNESS OF R QUADS MS.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities.. PT TOLERATED ALL GIVEN TREATMENTS WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time. 4/1/2022 3:25:57 PM
Location. (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB. 11/05/1976
Physician. Mary Jane Acosta, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)
H/O arthroscopy of right knee (Z98.890)

Electronically signed by Mary Jane Acosta, PT at 04:18 PM, APRIL 01, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 4/4/2022 2:23:35 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O PAIN WHEN ASCENDING AND DESCENDING STAIRS.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: WEAKNESS OF R QUADS MS; MILD ANTALGIC GAIT PATTERN; LOM OF R KNEE WITH PAIN AT END RANGE.WEAKNESS OF THE QUADS; MOD TENDERNESS ON THE INFRAPATELLAR AREA OF THE R KNEE.

Therex:

THERAPEUTIC EXERCISES				
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS
Self Stretching	Hams		10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH 10 REPS	2 SET(S)		
Bike	10 MINS			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities.. PT PERFORMED ALL GIVEN EXERCISES WITHOUT AN INCREASE IN PAIN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time 4/4/2022 2.23.35 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)
H/O arthroscopy of right knee (Z98.890)

Electronically signed by Mary Jane Acosta, PT at 02:25 PM, APRIL 04, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check In Date/Time. 4/6/2022 4.16.09 PM
Location. (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB. 11/05/1976
Physician. Joseph Tanlioco, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Note

Subjective:

PT C/O DIFFICULTIES WITH STAIR NEGOTIATIONS SECONDARY TO R KNEE PAIN.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: WEAKNESS OF R QUADS MS; LOM OF R KNEE WITH PAIN AT END RANGE; MOD TENDERNESS ON THE INFRAPATELLAR AREA OF THE R KNEE; MODERATE DIFFICULTIES WITH SIT TO STAND TRANSITIONING.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check In Date/Time. 4/6/2022 4.16.09 PM Physician. Joseph Tanlioco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 04:23 PM, APRIL 06, 2022

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time. 5/20/2022 9.44.52 AM
Location. (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB. 11/05/1976
Physician. Mary Jane Acosta, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Note

Subjective:

PATIENT C/O ACHING PAIN AND STIFFNESS WITH DIFFICULTY IN WALKING AND NEGOTIATING THE STAIRS.

Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: WEAKNESS OF R QUADS MS; MOD TENDERNESS ON THE INFRAPATELLAR AREA OF THE R KNEE; MODERATE TIGHTNESS ON HAMSTRING AND TFL

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 5/20/2022 9 44.52 AM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 09:46 AM, MAY 20, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 5/31/2022 12:39:18 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O PAIN WHEN ASCENDING AND DESCENDING STAIRS.

Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: MODERATE TIGHTNESS ON HAMSTRING AND TFL; WEAKNESS OF R QUADS MS; MOD TENDERNESS ON THE INFRAPATELLAR AREA OF THE R KNEE.

Therex:

THERAPEUTIC EXERCISES				
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS
Self Stretching	Hams		10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH 10 REPS	2 SET(S)		
Bike	10 MINS			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities, and Educated to start moving to at least within pain-free range to prevent stiffness.. PT PERFORMED ALL GIVEN EXERCISES WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 5/31/2022 12.39.18 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)
H/O arthroscopy of right knee (Z98.890)

Electronically signed by Mary Jane Acosta, PT at 12:46 PM. MAY 31, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 6/3/2022 5.26.58 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT STILL REPORTS OF KNEE BUCKLING WHEN WALKING.

Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: WEAKNESS OF R QUADS MS; MOD TENDERNESS ON THE INFRAPATELLAR AREA OF THE R KNEE.MODERATE TIGHTNESS ON HAMSTRING AND TFL;

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time 6/3/2022 5.26.58 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Marygrace Lusan-urena, PT at 05:28 PM, JUNE 03, 2022

Marygrace Lusan-urena, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone 516-887-1787 Fax 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender: MALE
Age 45 Year(s) DOB 11/05/1976
Address 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check In Date/Time 6/8/2022 4:29:14 PM Physician. Joseph Tanlioco, PT
Location (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

Patient reports of still feeling weak on his right knee and having difficulty to perform activities requiring force such as stairs negotiation and squatting

Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: There is equal weight bearing on both LE when standing. Grade 1 tenderness on the medial and lateral side of the right knee joint. Mild swelling today on inspect of the right knee compared to the contralateral left side.

Therex:

THERAPEUTIC EXERCISES				
Isometric/ROM EXs	QUAD SETS	6 SH	10 REPS	2 SETS
Self Stretching	Hams		10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH 10 REPS	2 SET(S)		
Bike	10 MINS			

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 6/8/2022 4:29:14 PM Physician. Joseph Tanlioco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
Chondromalacia, right knee (M94.261)
H/O arthroscopy of right knee (Z98.890)

Electronically signed by Joseph Tanlioco, PT at 05:29 PM, JUNE 08, 2022

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 6/11/2022 12:15:21 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT REPORTS PAIN AND TIGHTNESS IN THE R KNEE.

Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: TIGHTNESS IN THE R KNEE, ;LOM IN THE R KNEE,TENDERNESS IN THE R KNEE.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 6/11/2022 12.15.21 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Marygrace Lusan-urena, PT at 12:19 PM, JUNE 11, 2022

Marygrace Lusan-urena, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 6/13/2022 2:57:58 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O PAIN WHEN STANDING AND WALKING FOR PROLONGED PERIODS OF TIME.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: TENDERNESS IN THE R KNEE; TIGHTNESS IN THE R KNEE, ;LOM IN THE R KNEE;

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities.. PT TOLERATED ALL GIVEN TREATMENTS WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender: MALE
Age 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time 6/13/2022 2 57.58 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Marygrace Lusan-urena, PT at 05:30 PM, JUNE 13, 2022

Marygrace Lusan-urena, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender: MALE
Age 45 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 6/15/2022 1:26:51 PM Physician. Joseph Tanlioco, PT
Location (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O STIFFNESS IN THE R KNEE WALKING THIS MORNING.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: TIGHTNESS IN THE R KNEE, ;LOM IN THE R KNEE; TENDERNESS IN THE R KNEE;

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 6/15/2022 1 26.51 PM Physician. Joseph Tanlioco, PT
Location (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 01:28 PM, JUNE 15, 2022

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 6/16/2022 5:21:49 PM Physician. Joseph Tanlioco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O PAIN WHEN STANDING AND WALKING FOR PROLONGED PERIODS OF TIME.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: TENDERNESS IN THE R KNEE; TIGHTNESS IN THE R KNEE, ;LOM IN THE R KNEE.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness.. PT TOLERATED ALL GIVEN TREATMENTS WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 6/16/2022 5:21:49 PM Physician. Joseph Tanlioco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 05:26 PM, JUNE 16, 2022

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age 45 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time 6/22/2022 6 19 10 PM Physician. Joseph Tanlioco, PT
Location (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O PAIN WHEN ASCENDING AND DESCENDING STAIRS.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: LOM IN THE R KNEE; TENDERNESS IN THE R KNEE; TIGHTNESS IN THE R KNEE.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness.. PT PERFORMED ALL GIVEN EXERCISES WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 6/22/2022 6:19:10 PM Physician. Joseph Tanlioco, PT
Location (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 06:23 PM, JUNE 22, 2022

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender: MALE
Age: 45 Year(s) DOB: 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time: 6/29/2022 6:05:02 PM Physician: Mary Jane Acosta, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O PAIN WHEN STANDING AND WALKING FOR PROLONGED PERIODS OF TIME.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: LOM IN THE R KNEE; TENDERNESS IN THE R KNEE; TIGHTNESS IN THE R KNEE.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness.. PT PERFORMED ALL GIVEN EXERCISES WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 6/29/2022 6:05:02 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 06:11 PM, JUNE 29, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 7/2/2022 11:54:21 AM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O PAIN WHEN STANDING AND WALKING FOR PROLONGED PERIODS OF TIME.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: TIGHTNESS IN THE R KNEE; LOM IN THE R KNEE; TENDERNESS IN THE R KNEE.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness.. PT TOLERATED ALL GIVEN TREATMENTS WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 7/2/2022 11:54:21 AM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 12:41 PM, JULY 02, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani**
Age. 45 Year(s)
Address. 52 Charles Street, Malverne, NY, 11565,
Check in Date/Time. 7/6/2022 11:56:25 AM
Location. (Valley) Island Musculoskeletal Care MD. PC
Insurance. WCOFFICE

Acc No. 264184
DOB. 11/05/1976
Physician. Mary Jane Acosta, PT
Referring Physician. GUS KATSIGIORGIS, DO

Gender. MALE
Phone. (917)386-5380

Note

Subjective:

PT C/O PAIN WHEN STANDING AND WALKING FOR PROLONGED PERIODS OF TIME.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: TENDERNESS IN THE R KNEE; TIGHTNESS IN THE R KNEE; LOM IN THE R KNEE.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness.. PT PERFORMED ALL GIVEN EXERCISES WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check In Date/Time 7/6/2022 11:56:25 AM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 12:23 PM, JULY 06, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 45 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 7/13/2022 4:42:41 PM Physician: Mary Jane Acosta, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Note

SUBJECTIVE:

Patient was seen for re- evaluation and treatment for pain on the right knee. Patient underwent s/p right knee arthroscopy on 01/10/2022 due to work related injury. Patient received 12 visits of skilled PT dated 03/30/2022 to 07/13/2022. Patient continues to show significant improvement with decreased in pain from 4/10 to 2/10 and with increased in ROM by 10 degrees and muscle strength from 3+/5 to 4-/5. Patient reports of improvement in function in ADLs as shown in ASSESSMENT. Patient reports that he went back to work as an EMT and been working 12-16 hours/day for 3-4 days/ week. He states that at the end of the day he feels the pain on the right knee and needs to take Tylenol. He also reports that he needs to slow down and he go up and down 1 step at a time when he responds to emergency and his team needs to take the stairs. He states that he needs to use the knee brace when he is working. However, patient still c/o intermittent aching pain on the right knee with stiffness. He still has mild difficulty in getting up from prolonged sitting, squatting and doing household chores that requires kneeling. He is taking Tylenol as need and use knee brace as needed.

The patient presents with Pain, Weakness, Clicking, Swelling, Soreness, Tightness and Stiffness in the right knee. Patient reports the following functional complaints/deficits include Activities of daily living, Ambulation, Ambulation on uneven surfaces, Sit to Stand/Stand to Sit transfers, Ascending stairs, Descending stairs, Entering or exiting a motor vehicle, Household chores and Leisure activities. Patient reports the following improvements Bending, Bathing, Household chores, Lifting heavy objects, Driving and Unable to sleep. Independent in ambulation without assistive device; mild antalgic gait on the right knee, listing to the left; decreased knee flexion- extension

PS: 4/10 previous to 2/10 at present

HISTORY:

Past Medical History
Hypertension, Asthma
Surgeries: s/p right knee arthroscopy on 01/10/2022
HPI: Patient works as a EMT. On 06/11/2021, patient reports that he felt pain on the right knee when he stepped out from the ambulance and it aggravated when he slipped and fell on the bathroom of Mc Donald which caused an injury on the right knee. He reports that he went to Flushing Hospital and CAT scan was done and received PT somewhere else with mild improvement. He came in our office and referred for x-ray and continue PT. He also mentioned that he will undergo surgery on the right knee.

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Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 45 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 7/13/2022 4:42:41 PM Physician: Mary Jane Acosta, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Social History

OBJECTIVE: Knee Evaluation:

	Strength		Active ROM		Passive ROM	
	Right	Left	Right	Left	Right	Left
Flexion (0-135)	4- /5		0-110			
Extension (0-135)	4- /5		110-0			

RIGHT KNEE: Palpation Tests gr. 1 tenderness on right medial aspect of the knee and infrapatellar area; mild swelling on right knee; mild tightness on right hamstring, TFL and gastroc- soleus complex; no muscle guarding noted on right knee flexion

Therex Hamstring stretch x 10shx 10 reps x 2 sets
Quads sets x6shx 10 reps x 2 sets
SLR x 10 reps x 2 sets using 4 lbs ankle weight
Hip abduction in sidelying position x10 reps x 2sets using 3 lbs ankle weight
Adductor squeeze x 6shx 10 reps x2 sets
Clam shell using red TB x 10 reps x2 sets
Bike ergo x 10 minutes
Leg press x 10 reps x 2 sets using 30 lbs

Manual Therapy:

Soft Tissue Mobilization	Comments: right knee
Myofascial Release	Comments: right knee

Therapeutic Modalities:

Electric Stimulation, Premod	Min: 15	Comments: right knee
Therapeutic Ultrasound	Min: 8	Comments: right knee
Hot Pack	Min: 15	Comments: right knee

ASSESSMENT:

Patient reports of decreased in pain from 6/10 to 4/10, decreased in tenderness from gr. 2-3 tenderness to gr. 1-2 tenderness, decreased moderate swelling to mild swelling and increased in muscle strength from 3-/5 to 3+/5 and increased in ROM by 30 degrees. Patient also improved from moderate antalgic gait to mild antalgic gait without any assistive device. Patient would benefit from a course of skilled PT in conjunction with a home exercise program to work on current functional deficits with weight bearing activities such as ambulation, stairs negotiation, squatting, getting up from sitting and tolerance to prolonged standing by promoting gains from the limiting factors to achieve goals for him to

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Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 45 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 7/13/2022 4:42:41 PM Physician: Mary Jane Acosta, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

be able to perform his job as an EMT in responding emergencies.

FUNCTIONAL IMPROVEMENT/ GAINS AFTER THE SURGERY WITH CONJUNCTION OF PT:
- Patient is able to ambulate 8-9 blocks without difficulty
- Patient is able to tolerate standing for 1 hour.
- Patient is able to tolerate sitting for 2 hours.
- Patient is able to tolerate in negotiating 2 flights of stairs alternately.

Short Term Goals:

Time Frame: 2-4 weeks

Decrease Knee Pain to 4/10

Increase Right Knee Flexion ROM	50% of normal limits	and Strength 4-/5
Increase Right Knee Extension ROM	50% of normal limits	and Strength 4-/5

Increase Activity Tolerance to ADL/IDLs

Patient will be able to amb 3-4 blocks feet with minimal discomfort without AD

Patient will be able to negotiate 2-3 flight(s) of stairs with minimal discomfort

Patient will be able to sit to stand with minimal assistance from his/her upper extremities

Patient is aware of heel/toe gait with minimal cueing

Lift an object like a bag of groceries from the floor

Do usual house work/ school work

Getting in and out of the car

Getting in and out of the bath

Long Term Goals:

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
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Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 45 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY. 11565, Phone: (917)386-5380
Check in Date/Time: 7/13/2022 4:42:41 PM Physician: Mary Jane Acosta, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Time Frame: 6-8 weeks

Decrease Knee Pain to 0/10

Increase Right Knee Flexion ROM	100% of normal limits	and Strength 5/5
Increase Right Knee Extension ROM	100% of normal limits	and Strength 5/5

Increase Activity Tolerance to ADL/IDLs to WNL

Independent in HEP

Patient will be able to amb >10 blocks feet with no discomfort without AD

Patient will be able to negotiate 8-9 flight(s) of stairs with no discomfort

Patient will be able to sit to stand with no assistance from his/her upper extremities

Patient will be able to negotiate uneven terrain for 2-3 block feet

Patient will be able to return to running pain free

Patient is aware of heel/toe gait with no cueing

Squatting

Kneeling

Making sharp turns while running

Hopping

Trying to pivot on same LE without being off balance

PLAN:

Plan: Continue with skilled PT services per plan of care.	
Plan of Care/Treatment Plan: Patient Education, Progressive Resistive Therapeutic Exercise, Manual Therapy Techniques, Home Exercise Program, Modality to Decrease Pain - Electrical Stimulation, Hot and/or Cold Packs	
Rehab Potential: Rehab potential good to meet treatment goals.	
Frequency and Duration of Treatment: 3 times a week	for 8 weeks

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Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 45 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 7/13/2022 4:42:41 PM Physician: Mary Jane Acosta, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		right knee
Electric Stim (97014)	15		right knee
Ultrasound (97035)		8	right knee
Exercises (97110)		15	right knee
Re-eval- WC/COM- 20 min (97164)		20	right knee
Manual Therapy (97140)		10	right knee
	Total 15	Total 53	Total Min. TX Time 68

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 08:56 AM, JULY 14, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Inj. Date 06/11/2021

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender MALE
Age. 45 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/3/2022 3 33.17 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WC - State Insurance Fund [73141129-110]

Note

Subjective:

PT REPORTS ON AND OFF PAIN IN THE R KNEE.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: TIGHTNESS IN THE R KNEE; LOM IN THE R KNEE,TENDERNESS IN THE R KNEE.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Inj. Date 06/11/2021

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/3/2022 3:33:17 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WC - State Insurance Fund [73141129-110]

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)

Electronically signed by Marygrace Lusan-urena, PT at 03:35 PM, OCTOBER 03, 2022

Marygrace Lusan-urena, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/19/2022 3:13:04 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O PAIN WHEN STANDING AND WALKING FOR PROLONGED PERIODS OF TIME.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: WEAKNESS NOTED ON R KNEE DURING EXTENSION; TIGHTNESS IN THE R KNEE; LOM IN THE R KNEE,TENDERNESS IN THE R KNEE.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities.. PT TOLERATED ALL GIVEN TREAWTMENTS WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/19/2022 3:13:04 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 03:16 PM, OCTOBER 19, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender MALE
Age. 45 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/24/2022 2.41.53 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O PAIN WHEN ASCENDING AND DESCENDING STAIRS.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: TENDERNESS NOTED ON ANTERIOR ASPECT OF R KNEEWEAKNESS NOTED ON R KNEE DURING EXTENSION; TIGHTNESS IN THE R KNEE.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities.. PT TOLERATED ALL GIVEN TREAWTMENTS WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/24/2022 2:41:53 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 03:02 PM, OCTOBER 24, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender: MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/29/2022 10:32:54 AM Physician. Joseph Tanlioco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

Patient rewports of momentary increase in pain and tightness on the right knee when standing up from prolonged sitting.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: Mild swelling on the right knee joint compared to the contralateral left knee. Moderate difficulty with sit to stand transfers

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	10 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities.. PT TOLERATED ALL GIVEN TREAWTMENTS WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 10/29/2022 10.32.54 AM Physician. Joseph Tanlioco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Chondromalacia, right knee (M94.261)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 11:54 AM, OCTOBER 29, 2022

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/4/2022 12:34:23 PM Physician. Joseph Tanloco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PATIENT REPORTS PAIN AND TIGHTNESS ON THE R KNEE WITRH TENDERNESS.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: TENDERNESS IN THE R KNEE, LOM IN THE R KNEE.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	15 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 45 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/4/2022 12:34:23 PM Physician. Joseph Tanlioco, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Chondromalacia, right knee (M94.261)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Joseph Tanlioco, PT at 12:50 PM, NOVEMBER 04, 2022

Joseph Tanlioco, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Inj. Date. 06/11/2021

Patient Name. **Dillard, Bayani**
Acc No. 264184
Gender. MALE
Age. 46 Year(s)
DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565,
Phone. (917)386-5380
Check in Date/Time. 11/8/2022 5:15:27 PM
Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC
Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WC - State Insurance Fund [73141129-110]

Note

Subjective:

PT C/O PAIN WHEN PERFORMING HOUSEHOLD CHORES.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: TENDERNESS IN THE R KNEE, LOM IN THE R KNEE;

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
Bike	15 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Inj. Date. 06/11/2021

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 46 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/8/2022 5:15:27 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WC - State Insurance Fund [73141129-110]

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		25	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Chondromalacia, right knee (M94.261)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 05:32 PM, NOVEMBER 08, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 46 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/10/2022 2:39:04 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT REPORTS AFTER STANDING FOR A LONG PERIOD FELT INCREASE IN PAIN AND SWELLING ON R KNEE
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: +SWELLING ON R KNEE;GR 2 TENDERNESS IN THE R KNEE, LOM IN THE R KNEE;

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
	15 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Instructed to ice affected body part 20 minutes at home when signs of inflammation are still present. and Educated to start moving to at least within pain-free range to prevent stiffness.. PT REFUSED BIKE EXERCISE TODAY DUE TO INCREASE IN PAIN OF R KNEE

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender: MALE
Age. 46 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/10/2022 2:39:04 PM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		15	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 33	Total Min. TX Time 48

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Chronic pain of right knee (M25.561)

Electronically signed by Marygrace Lusan-urena, PT at 02:46 PM, NOVEMBER 10, 2022

Marygrace Lusan-urena, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender: MALE
Age. 46 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/12/2022 11.26.17 AM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O PAIN AND TIGHTNESS IN THE R KNEE.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: TENDERNESS IN THE R KNEE, LOM IN THE R KNEE;

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
	15 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities..

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 46 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/12/2022 11:26:17 AM Physician. Marygrace Lusan-urena, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		25	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 43	Total Min. TX Time 58

Diagnosis codes
Chondromalacia, right knee (M94.261)
H/O arthroscopy of right knee (Z98.890)
Chronic pain of right knee (M25.561)

Electronically signed by Marygrace Lusan-urena, PT at 11:33 AM, NOVEMBER 12, 2022

Marygrace Lusan-urena, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Inj. Date 06/11/2021

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender: MALE
Age. 46 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/14/2022 5:22:22 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WC - State Insurance Fund [73141129-110]

Note

Subjective:

PT C/O PAIN WHEN ASCENDING AND DESCENDING STAIRS.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: TENDERNESS IN THE R KNEE, LOM IN THE R KNEE; LOM ON R KNEE ON ALL PLANES SECONDARY TO PAIN.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
	15 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities.. PT TOLERATED ALL GIVEN TREATMENTS WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Inj. Date 06/11/2021

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 46 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/14/2022 5:22:22 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WC - State Insurance Fund [73141129-110]

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		25	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 43	Total Min. TX Time 58

Diagnosis codes
Chondromalacia, right knee (M94.261)
H/O arthroscopy of right knee (Z98.890)

Electronically signed by Mary Jane Acosta, PT at 05:30 PM, NOVEMBER 14, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 46 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/16/2022 5:28:33 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O PAIN WHEN STANDING AND WALKING FOR PROLONGED PERIODS OF TIME.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: TENDERNESS IN THE R KNEE, LOM IN THE R KNEE; LOM ON R KNEE ON ALL PLANES SECONDARY TO PAIN.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
	15 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Therapeutic Ultrasound	Right	Min: 8	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities.. PT TOLERATED ALL GIVEN TREATMENTS WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 46 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/16/2022 5:28:33 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Ultrasound (97035)		8	R KNEE
Exercises (97110)		25	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 43	Total Min. TX Time 58

Diagnosis codes
Chondromalacia, right knee (M94.261)
H/O arthroscopy of right knee (Z98.890)

Electronically signed by Mary Jane Acosta, PT at 05:29 PM, NOVEMBER 16, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 46 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/21/2022 5.43.45 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Note

Subjective:

PT C/O PAIN WHEN STANDING AND WALKING FOR PROLONGED PERIODS OF TIME.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: LOM IN THE R KNEE; LOM ON R KNEE ON ALL PLANES SECONDARY TO PAIN; TENDERNESS IN THE R KNEE.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
	15 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities.. PT PERFORMED ALL GIVEN EXERCISES WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age. 46 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/21/2022 5:43:45 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Exercises (97110)		25	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 43	Total Min. TX Time 58

Diagnosis codes
H/O arthroscopy of right knee (Z98.890)
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)

Electronically signed by Mary Jane Acosta, PT at 05:59 PM, NOVEMBER 21, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 46 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 11/23/2022 5:14:01 PM Physician: Mary Jane Acosta, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WCOFFICE

Note

Subjective:

PT C/O PAIN WHEN ASCENDING AND DESCENDING STAIRS.
Patient reports pain of the R KNEE.
The current numeric pain rating scale is 7/10.

Objective: TENDERNESS IN THE R KNEE; LOM IN THE R KNEE; LOM ON R KNEE ON ALL PLANES SECONDARY TO PAIN.

Therex:

THERAPEUTIC EXERCISES					
Isometric/ROM EXs	QUAD SETS		6 SH	10 REPS	2 SETS
Self Stretching	Hams			10 SH	10 REPS 2 SET(S)
Ball Squeezes	6 SH	10 REPS	2 SET(S)		
	15 MINS				

Therapeutic Modalities:

Time: 23 minutes			
Electric Stimulation, Premod	Right	Min: 15	Comments: R KNEE
Hot Pack	Right	Min: 15	Comments: R KNEE

Manual Therapy:

Time: 10 minutes	
Technique	Location, Grade, Reps
Soft Tissue Mobilization	R KNEE

Assessment:

Assessment: Patient will benefit from skilled physical therapy treatment to reduce pain, increase muscle strength and improve functional activities.. PT TOLERATED ALL GIVEN TREATMENTS WITHOUT AN INCREASE IN PAIN.

Plan:

Plan: Continue with current plan of care progressing as tolerated.

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 46 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/23/2022 5:14:01 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WCOFFICE

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		R KNEE
Electric Stim (97014)	15		R KNEE
Exercises (97110)		25	R KNEE
Manual Therapy (97140)		10	R KNEE
	Total 15	Total 43	Total Min. TX Time 58

Diagnosis codes
Chondromalacia, right knee (M94.261)
H/O arthroscopy of right knee (Z98.890)

Electronically signed by Mary Jane Acosta, PT at 05:15 PM, NOVEMBER 23, 2022

Mary Jane Acosta, PT

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Inj. Date 06/11/2021

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 46 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/28/2022 4 52 17 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WC - State Insurance Fund [73141129-110]

Note

SUBJECTIVE:

Patient was seen for re- evaluation and treatment for pain on the right knee. Patient underwent s/p right knee arthroscopy on 01/10/2022 due to work related injury. Patient received 12 visits of skilled PT out of 24 approved/ authorized visits dated 10/03/2022 to 11/23/2022. Patient reports of significant improvement on the right knee and was able to go back to work as an EMT. Patient also met some of the goals in short term goal. Patient reports that the therapy has been helping him a lot especially in strengthening his knee and able to perform weight bearing activities such as prolonged standing, walking and negotiating the stairs. Patient reports that he could perform his job and able lift a patient less than 150 lbs as long as he has assistant when he is working. He reports that he sometimes needs to take Tylenol, apply HMP and do some stretching when he works >16 hours due to pain and swelling on the right knee. He reports that the pain is tolerable now and states that it's almost normal. However, there are days that he feels a sharp pain on the right knee in certain movement especially when lifting >150 lbs weight of the patient and needs to do pivoting/ turning.

Patient still would like to continue physical therapy since it's been helping him a lot. Patient also reports that he wanted to strengthen his right knee since he doesn't have any exercise equipment at home.

The patient presents with Pain, Weakness, Tightness and Stiffness Patient reports the following functional complaints/deficits include Activities of daily living, Ambulation, Ambulation on uneven surfaces, Ascending stairs, Descending stairs and Leisure activities. Patient reports the following improvements Sit to Stand/Stand to Sit transfers, Entering or exiting a motor vehicle, Bending, Bathing, Household chores, Lifting heavy objects, Driving and Unable to sleep.

PS: 1-2/10

HISTORY:

Past Medical History
Hypertension, Asthma
Surgeries: s/p right knee arthroscopy on 01/10/2022
HPI: Patient works as a EMT. On 06/11/2021, patient reports that he felt pain on the right knee when he stepped out from the ambulance and it aggravated when he slipped and fell on the bathroom of Mc Donald which caused an injury on the right knee. He reports that he went to Flushing Hospital and CAT scan was done and received PT somewhere else with mild improvement. He came in our office and referred for x-ray and continue PT. He also mentioned that he will undergo surgery on the right knee.

Social History

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Inj. Date 06/11/2021

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 46 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time 11/28/2022 4 52 17 PM Physician. Mary Jane Acosta, PT
Location (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WC - State Insurance Fund [73141129-110]

OBJECTIVE: Knee Evaluation:

	Strength		Active ROM		Passive ROM	
	Right	Left	Right	Left	Right	Left
Flexion (0-135)	4 /5		0-120			
Extension (0-135)	4 /5		WNL			

RIGHT KNEE: Palpation Tests gr. 1 tenderness on right medial aspect of the knee and infrapatellar area; No swelling on right knee; mild tightness on right hamstring, TFL and gastroc- soleus complex

Therex Hamstring stretch x 10shx 10 reps x 2 sets
Quads sets x6shx 10 reps x 2 sets
SLR x 10 reps x 2 sets using 4 lbs ankle weight
Hip abduction in sidelying position x10 reps x 2sets using 3 lbs ankle weight
Adductor squeeze x 6shx 10 reps x2 sets
Clam shell using red TB x 10 reps x2 sets
Bike ergo x 10 minutes
Leg press x 10 reps x 2 sets using 30 lbs

Manual Therapy:

Soft Tissue Mobilization	Comments: right knee
Myofascial Release	Comments: right knee

Therapeutic Modalities:

Electric Stimulation, Premod	Min: 15	Comments: right knee
Therapeutic Ultrasound	Min: 8	Comments: right knee
Hot Pack	Min: 15	Comments: right knee

ASSESSMENT:

Patient reports of significant improvement on the right knee and was able to go back to work as an EMT. Patient also met some of the goals in short term goal. Patient reports that the therapy has been helping him a lot especially in strengthening his knee and able to perform weight bearing activities such as prolonged standing, walking and negotiating the stairs. Patient would benefit from a course of skilled PT in conjunction with a home exercise program to work on current functional deficits with weight bearing activities such as ambulation, stairs negotiation, squatting, getting up from sitting and tolerance to prolonged standing by promoting gains from the limiting factors to achieve goals for him to be able to perform his job as an EMT in responding emergencies.

FUNCTIONAL IMPROVEMENT/ GAINS AFTER THE SURGERY WITH CONJUNCTION OF PT:
- Patient is able to ambulate 1/2 a mile or almost a mile

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Phone. 516-887-1787 Fax. 516-887-2059

Inj. Date 06/11/2021

Patient Name **Dillard, Bayani** Acc No. 264184 Gender MALE
Age. 46 Year(s) DOB 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time 11/28/2022 4:52:17 PM Physician Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WC - State Insurance Fund [73141129-110]

- Patient is able to tolerate standing for 1 hour.
- Patient is able to tolerate sitting for 2 hours.
- Patient is able to tolerate in negotiating 2 flights of stairs alternately.

Short Term Goals:

Time Frame: 2-4 weeks

Decrease Knee Pain to 4/10		
Increase Right Knee Flexion ROM	50% of normal limits	and Strength 4-/5
Increase Right Knee Extension ROM	50% of normal limits	and Strength 4-/5
Increase Activity Tolerance to ADL/IDLs		
Patient will be able to amb 3-4 blocks feet with minimal discomfort without AD	-MET	
Patient will be able to negotiate 2-3 flight(s) of stairs with minimal discomfort		
Patient will be able to sit to stand with minimal assistance from his/her upper extremities	- MET	
Patient is aware of heel/toe gait with minimal cueing	-MET	
Lift an object like a bag of groceries from the floor	-MET	
Do usual house work/ school work	-MET	
Getting in and out of the car	-MET	
Getting in and out of the bath	-MET	

New Goal:

Patient is able to ambulate for 5-6 blocks without pain and difficulty.

Long Term Goals:

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone: 516-887-1787 Fax: 516-887-2059

Inj. Date: 06/11/2021

Patient Name: **Dillard, Bayani** Acc No: 264184 Gender: MALE
Age: 46 Year(s) DOB: 11/05/1976
Address: 52 Charles Street, Malverne, NY, 11565, Phone: (917)386-5380
Check in Date/Time: 11/28/2022 4:52:17 PM Physician: Mary Jane Acosta, PT
Location: (Valley) Island Musculoskeletal Care MD. PC Referring Physician: GUS KATSIGIORGIS, DO
Insurance: WC - State Insurance Fund [73141129-110]

Time Frame: 6-8 weeks

Decrease Knee Pain to 0/10		
Increase Right Knee Flexion ROM	100% of normal limits	and Strength 5/5
Increase Right Knee Extension ROM	100% of normal limits	and Strength 5/5
Increase Activity Tolerance to ADL/IDLs to WNL		
Independent in HEP		
Patient will be able to amb >10 blocks feet with no discomfort without AD		
Patient will be able to negotiate 8-9 flight(s) of stairs with no discomfort		
Patient will be able to sit to stand with no assistance from his/her upper extremities		
Patient will be able to negotiate uneven terrain for 2-3 block feet		
Patient will be able to return to running pain free		
Patient is aware of heel/toe gait with no cueing	-MET	
Squatting		
Kneeling		
Making sharp turns while running		
Hopping		
Trying to pivot on same LE without being off balance		

PLAN:

Plan: Continue with skilled PT services per plan of care.

Plan of Care/Treatment Plan: Patient Education, Progressive Resistive Therapeutic Exercise, Manual Therapy Techniques, Home Exercise Program, Modality to Decrease Pain - Electrical Stimulation, Hot and/or Cold Packs

Rehab Potential: Rehab potential good to meet treatment goals.

Frequency and Duration of Treatment: 3 times a week for 8 weeks

(Valley) Island Musculoskeletal Care MD. PC
125 Franklin Ave
Valley Stream, NY 11580-2108
Phone. 516-887-1787 Fax. 516-887-2059

Inj. Date 06/11/2021

Patient Name. **Dillard, Bayani** Acc No. 264184 Gender. MALE
Age. 46 Year(s) DOB. 11/05/1976
Address. 52 Charles Street, Malverne, NY, 11565, Phone. (917)386-5380
Check in Date/Time. 11/28/2022 4:52:17 PM Physician. Mary Jane Acosta, PT
Location. (Valley) Island Musculoskeletal Care MD. PC Referring Physician. GUS KATSIGIORGIS, DO
Insurance. WC - State Insurance Fund [73141129-110]

Procedure	un Timed Tx	Timed Tx	
Hot/Cold(97010)	15		right knee
Electric Stim (97014)	15		right knee
Ultrasound (97035)		8	right knee
Exercises (97110)		30	right knee
Re-eval- WC/COM- 20 min (97164)		20	right knee
Manual Therapy (97140)		10	right knee
	Total 15	Total 68	Total Min. TX Time 83

Diagnosis codes
Other tear of medial meniscus of right knee as current injury, subsequent encounter (S83.241D)
H/O arthroscopy of right knee (Z98.890)

Electronically signed by Mary Jane Acosta, PT at 10:32 AM, NOVEMBER 29, 2022

Mary Jane Acosta, PT

NY MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167)
80-46 KEW GARDENS RD
KEW GARDENS, NY 11415
718-261-1000
Today's date: July 21, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Saturday June 19, 2021 Provider: Jerome Rivera PT

NPI#: 1023670361
Electronically signed by Jerome Rivera PT on 06/19/2021 at 10:04am

Patient is a right handed 44 year old obese male patient who complains of severe pain on his right knee graded 10/10 on PS and difficulty with ADLs including Lifting, pushing, pulling, self-care, bed mobility, transfers, bending, sitting, standing, stair management, recreational activities and cleaning. Condition started on 6/11/21 when patient had a work related injury. Patient jumped off the vehicle as he was responding to an emergency. After seeing the patient, he started to feel the pain on his right knee and he was limping.Pt then fell on his right knee and suffered from bruising.Pt then went to the ER to have his knee check. However, patient has been having pain that has been getting worse so he sought medical consultation and was referred for PT

PMHx:Asthma, Htn
Surgical Hx: Denies
.

Subjective

Lower Extremity: *Location:* knee: right. *Pain quality:* achy, dull, stiff. *Range:* 9->10/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS 18/80
1 Any of your usual work, housework, or school activities. 1
2 Your usual hobbies, re creational or sporting activities. 1
3 Getting into or out of the bath. 1
4 Walking between rooms. 1
5 Putting on your shoes or socks. 1
6 Squatting. 1
7 Lifting an object, like a bag of groceries from the floor. 1
8 Performing light activities around your home.
9 Performing heavy activities around your home. 1
10 Getting into or out of a car. 1
11 Walking 2 blocks. 1
12 Walking a mile. 1
13 Going up or down 10 stairs (about 1 flight of stairs).1
14 Standing for 1 hour. 1
15 Sitting for 1 hour. 1
16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0
19 Hopping. 1
20 Rolling over in bed. 1

(1) Antalgic gait
(1) Bruising on the right knee and thigh
. *Left hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5;

NY MEDICAL & DIAGNOSTIC CENTER 80-46 KEW GARDENS RD KEW GARDENS, NY 11415
Encounter dated 06/19/2021 for Bayani L Dillard #51372
DOB:11/05/1976 Today's date: 07/21/2021

external rotation: 3-/5. *Right Knee ROM (active):* flexion: 75/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3-/5; knee adductors: 3-/5; knee abductors: 3-/5; hamstring: 3-/5.

Assessment

LowerExtremity assessment: This patient is a 44 years old female who was referred for outpatient physical therapy services. Pt presents with difficulty with ADLs, decreased joint flexibility, and muscle strength. Pt will benefit from a therapy program. Patient requires skilled therapy to restore prior level of function utlizing the treatment and modalities in this POC.
Patient was seen and treated today through telehealth and completed all therapeutic exercises without any adverse effects.
. *Diagnosis:* M23.91 (Unspecified internal derangement of right knee), M25.561 (Pain in right knee), S83.241A (Oth tear of medial meniscus, current injury, r knee, init), S83.411A (Sprain of medial collateral ligament of right knee, init), S83.421A (Sprain of lateral collateral ligament of right knee, init). *CPT code(s):* 97162.

Treatment & Plan

Short term Goals:
1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

Long term Goals:
1. To eliminate pain and tenderness.
2. To improve on M strength to WNL.
3. To improve on Flexibility to WNL.
4. To improve function and endurance in doing ADL's to WNL.
   - 4.a Patient will be able to walk >1 hour without pain and difficulty
   - 4.b Patient will be able to sit >1 hour without pain, difficulty and the need to change position.
   - 4.c Patient will be able to stand >1 hour without pain and difficulty
   - 4.d Patient will be able to travel >2 hours without pain and difficulty
   - 4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes). ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)
. *Informed consent:* Patient agreed to begin care.

End of note. Electronically signed by Jerome Rivera PT on 06/19/2021 at 10:04am

Abbreviations:
ADL: activities of daily living
ROM: range of motion
WNL: within normal limits

NY MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167) 1170136755
80-46 KEW GARDENS RD
KEW GARDENS, NY 11415
718-261-1000
Today's date: June 24, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Saturday June 19, 2021 Provider: Jerome Rivera PT

NPI#: 1023670361
Electronically signed by Jerome Rivera PT on 06/19/2021 at 10:04am

Patient is a right handed 44 year old obese male patient who complains of severe pain on his right knee graded 10/10 on PS and difficulty with ADLs including Lifting, pushing, pulling, self-care, bed mobility, transfers, bending, sitting, standing, stair management, recreational activities and cleaning. Condition started on 6/11/21 when patient had a work related injury. Patient jumped off the vehicle as he was responding to an emergency. After seeing the patient, he started to feel the pain on his right knee and he was limping.Pt then fell on his right knee and suffered from bruising.Pt then went to the ER to have his knee check. However, patient has been having pain that has been getting worse so he sought medical consultation and was referred for PT

PMHx:Asthma, Htn
Surgical Hx: Denies
.

Subjective

Lower Extremity: *Location:* knee: right. *Pain quality:* achy, dull, stiff. *Range:* 9->10/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS= 18/80
1 Any of your usual work, housework, or school activities. 1
2 Your usual hobbies, re creational or sporting activities. 1
3 Getting into or out of the bath. 1
4 Walking between rooms. 1
5 Putting on your shoes or socks. 1
6 Squatting. 1
7 Lifting an object, like a bag of groceries from the floor. 1
8 Performing light activities around your home.
9 Performing heavy activities around your home. 1
10 Getting into or out of a car. 1
11 Walking 2 blocks. 1
12 Walking a mile. 1
13 Going up or down 10 stairs (about 1 flight of stairs).1
14 Standing for 1 hour. 1

15 Sitting for 1 hour. 1
16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0
19 Hopping. 1
20 Rolling over in bed. 1

(+) Antalgic gait
(+) Bruising on the right knee and thigh
. *Left hip manual muscle testing:* flexion: 3-/5; extension: 3 /5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right Knee ROM (active):* flexion: 75/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3-/5; knee adductors: 3-/5; knee abductors: 3-/5; hamstring: 3-/5.

Assessment

LowerExtremity assessment: This patient is a 44 years old female who was referred for outpatient physical therapy services. Pt presents with difficulty with ADLs, decreased joint flexibility, and muscle strength. Pt will benefit from a therapy program. Patient requires skilled therapy to restore prior level of function utlizing the treatment and modalities in this POC.
Patient was seen and treated today through telehealth and completed all therapeutic exercises without any adverse effects.
. *Diagnosis:* M23.91 (Unspecified internal derangement of right knee), M25.561 (Pain in right knee), S83.241A (Oth tear of medial meniscus, current injury, r knee, init), S83.411A (Sprain of medial collateral ligament of right knee, init), S83.421A (Sprain of lateral collateral ligament of right knee, init). *CPT code(s):* 97162.

Treatment & Plan

Short term Goals:
1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

Long term Goals:
1. To eliminate pain and tenderness.
2. To improve on M strength to WNL.
3. To improve on Flexibility to WNL.
4. To improve function and endurance in doing ADL's to WNL.
   4.a Patient will be able to walk >1 hour without pain and difficulty
   4.b Patient will be able to sit >1 hour without pain, difficulty and the need to change position.
   4.c Patient will be able to stand >1 hour without pain and difficulty
   4.d Patient will be able to travel >2 hours without pain and difficulty
   4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes). ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)
. *Informed consent:* Patient agreed to begin care.

End of note. Electronically signed by Jerome Rivera PT on 06/19/2021 at 10:04am

Saturday June 19, 2021 Provider: Jerome Rivera PT

NPI#: 1023670361
Electronically signed by Jerome Rivera PT on 06/19/2021 at 11:40am

Patient is a right handed 44 year old obese male patient who complains of severe pain on his right knee graded 10/10 on PS and difficulty with ADLs including Lifting, pushing, pulling, self-care, bed mobility, transfers, bending, sitting, standing, stair management, recreational activities and cleaning. Condition started on 6/11/21 when patient had a work related injury. Patient jumped off the vehicle as he was responding to an emergency. After seeing the patient, he started to feel the pain on his right knee and he was limping.Pt then fell on his right knee and suffered from bruising.Pt then went to the ER to have his knee check. However, patient has been having pain that has been getting worse so he sought medical consultation and was referred for PT

PMHx:Asthma, Htn
Surgical Hx: Denies
.

Subjective

Lower Extremity: *Location:* knee: right. *Pain quality:* achy, dull, stiff. *Range:* 9->10/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS= 18/80
1 Any of your usual work, housework, or school activities. 1
2 Your usual hobbies, re creational or sporting activities. 1
3 Getting into or out of the bath. 1
4 Walking between rooms. 1
5 Putting on your shoes or socks. 1
6 Squatting. 1
7 Lifting an object, like a bag of groceries from the floor. 1
8 Performing light activities around your home.
9 Performing heavy activities around your home. 1

10 Getting into or out of a car. 1
11 Walking 2 blocks. 1
12 Walking a mile. 1
13 Going up or down 10 stairs (about 1 flight of stairs).1
14 Standing for 1 hour. 1
15 Sitting for 1 hour. 1
16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0
19 Hopping. 1
20 Rolling over in bed. 1

(+) Antalgic gait
(+) Bruising on the right knee and thigh
. *Left hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right Knee ROM (active):* flexion: 75/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3-/5; knee adductors: 3-/5; knee abductors: 3-/5; hamstring: 3-/5.

Assessment

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Treatment & Plan

Short term Goals:
1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

Long term Goals:
1. To eliminate pain and tenderness.
2. To improve on M strength to WNL.
3. To improve on Flexibility to WNL.
4. To improve function and endurance in doing ADL's to WNL.
   4.a Patient will be able to walk >1 hour without pain and difficulty

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4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes). ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)
. *Informed consent:* Patient agreed to begin care.

End of note. Electronically signed by Jerome Rivera PT on 06/19/2021 at 11:40am

Abbreviations:
ADL: activities of daily living
ROM: range of motion
WNL: within normal limits

NY MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167)
80-46 KEW GARDENS RD
KEW GARDENS, NY 11415
718-261-1000
Today's date: June 24, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Monday June 21, 2021 Provider: XIMENA AZARIO PT

NPI#: 1497349880
Electronically signed by XIMENA AZARIO PT on 06/21/2021 at 8:42pm

Subjective

Lower Extremity: Patient followed his exercise program and responded well to his treatment today. *Location:* knee: right. *Pain quality:* achy, dull, stiff. *Range:* 9->10/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS= 18/80
1 Any of your usual work, housework, or school activities. 1
2 Your usual hobbies, re creational or sporting activities. 1
3 Getting into or out of the bath. 1
4 Walking between rooms. 1
5 Putting on your shoes or socks. 1
6 Squatting. 1
7 Lifting an object, like a bag of groceries from the floor. 1
8 Performing light activities around your home.
9 Performing heavy activities around your home. 1
10 Getting into or out of a car. 1
11 Walking 2 blocks. 1
12 Walking a mile. 1
13 Going up or down 10 stairs (about 1 flight of stairs).1
14 Standing for 1 hour. 1
15 Sitting for 1 hour. 1
16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0
19 Hopping. 1
20 Rolling over in bed. 1

(+) Antalgic gait
(+) Bruising on the right knee and thigh
. *Left hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction:

3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right Knee ROM (active):* flexion: 75/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3-/5; knee adductors: 3-/5; knee abductors: 3-/5; hamstring: 3-/5.

Assessment

LowerExtremity assessment: This patient is a 44 years old female who was referred for outpatient physical therapy services. Pt presents with difficulty with ADLs, decreased joint flexibility, and muscle strength. Pt will benefit from a therapy program. Patient requires skilled therapy to restore prior level of function utlizing the treatment and modalities in this POC.
Patient was seen and treated today through telehealth and completed all therapeutic exercises without any adverse effects.
. *Diagnosis:* M23.91 (Unspecified internal derangement of right knee), M25.561 (Pain in right knee), S83.241A (Oth tear of medial meniscus, current injury, r knee, init), S83.411A (Sprain of medial collateral ligament of right knee, init), S83.421A (Sprain of lateral collateral ligament of right knee, init). *CPT code(s):* 97150, 97140, 97014, 97010.

Treatment & Plan

Short term Goals:
1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

Long term Goals:
1. To eliminate pain and tenderness.
2. To improve on M strength to WNL.
3. To improve on Flexibility to WNL.
4. To improve function and endurance in doing ADL's to WNL.
   4.a Patient will be able to walk >1 hour without pain and difficulty
   4.b Patient will be able to sit >1 hour without pain, difficulty and the need to change position.
   4.c Patient will be able to stand >1 hour without pain and difficulty
   4.d Patient will be able to travel >2 hours without pain and difficulty
   4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes). ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)
. *Informed consent:* Patient agreed to begin care.

End of note. Electronically signed by XIMENA AZARIO PT on 06/21/2021 at 8:42pm

NY MEDICAL & DIAGNOSTIC CENTER 80-46 KEW GARDENS RD KEW GARDENS, NY 11415
Encounter dated 06/21/2021 for Bayani L Dillard #51372
DOB:11/05/1976 Today's date: 06/24/2021

Abbreviations:
ADL: activities of daily living
ROM: range of motion
WNL: within normal limits

NY MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167)
80-46 KEW GARDENS RD
KEW GARDENS, NY 11415
718-261-1000
Today's date: June 24, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Wednesday June 23, 2021 Provider: XIMENA AZARIO PT

NPI#: 1497349880
Electronically signed by XIMENA AZARIO PT on 06/23/2021 at 8:23pm

Subjective

Lower Extremity: Patient followed his exercise program and responded well to his treatment today. Patient reported walking with less difficulty and stiffness. The patient had a positive response to his treatment today. *Location:* knee: right. *Pain quality:* achy, dull, stiff. *Range:* 9->10/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS= 18/80
1 Any of your usual work, housework, or school activities. 1
2 Your usual hobbies, re creational or sporting activities. 1
3 Getting into or out of the bath. 1
4 Walking between rooms. 1
5 Putting on your shoes or socks. 1
6 Squatting. 1
7 Lifting an object, like a bag of groceries from the floor. 1
8 Performing light activities around your home.
9 Performing heavy activities around your home. 1
10 Getting into or out of a car. 1
11 Walking 2 blocks. 1
12 Walking a mile. 1
13 Going up or down 10 stairs (about 1 flight of stairs).1
14 Standing for 1 hour. 1
15 Sitting for 1 hour. 1
16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0
19 Hopping. 1
20 Rolling over in bed. 1

(+) Antalgic gait
(+) Bruising on the right knee and thigh
. *Left hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal

rotation: 3-/5; external rotation: 3-/5. *Right hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right Knee ROM (active):* flexion: 75/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3-/5; knee adductors: 3-/5; knee abductors: 3-/5; hamstring: 3-/5.

Assessment

LowerExtremity assessment: This patient is a 44 years old female who was referred for outpatient physical therapy services. Pt presents with difficulty with ADLs, decreased joint flexibility, and muscle strength. Pt will benefit from a therapy program. Patient requires skilled therapy to restore prior level of function utlizing the treatment and modalities in this POC.
Patient was seen and treated today through telehealth and completed all therapeutic exercises without any adverse effects.
. *Diagnosis:* M23.91 (Unspecified internal derangement of right knee), M25.561 (Pain in right knee), S83.241A (Oth tear of medial meniscus, current injury, r knee, init), S83.411A (Sprain of medial collateral ligament of right knee, init), S83.421A (Sprain of lateral collateral ligament of right knee, init). *CPT code(s):* 97150, 97140, 97014, 97010.

Treatment & Plan

Short term Goals:
1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

Long term Goals:
1. To eliminate pain and tenderness.
2. To improve on M strength to WNL.
3. To improve on Flexibility to WNL.
4. To improve function and endurance in doing ADL's to WNL.
   4.a Patient will be able to walk >1 hour without pain and difficulty
   4.b Patient will be able to sit >1 hour without pain, difficulty and the need to change position.
   4.c Patient will be able to stand >1 hour without pain and difficulty
   4.d Patient will be able to travel >2 hours without pain and difficulty
   4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes). ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)
. *Informed consent:* Patient agreed to begin care.

NY MEDICAL & DIAGNOSTIC CENTER 80-46 KEW GARDENS RD KEW GARDENS, NY 11415
Encounter dated 06/23/2021 for Bayani L Dillard #51372
DOB:11/05/1976 Today's date: 06/24/2021

End of note. Electronically signed by XIMENA AZARIO PT on 06/23/2021 at 8:23pm

Abbreviations:
ADL: activities of daily living
ROM: range of motion
WNL: within normal limits

1187051228

NY MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167)
80-46 KEW GARDENS RD
KEW GARDENS, NY 11415
718-261-1000
Today's date: June 29, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Friday June 25, 2021 Provider: maged Abuseif PT

NPI#: 1487128898
Electronically signed by maged Abuseif PT on 06/25/2021 at 11:22am

Subjective

Lower Extremity: less soreness and pain , adl's better but patient is able to do more

Patient reports of the following:
1. Patient can tolerate >30 minutes of sitting
2. Patient can tolerate >30 minutes of standing
3. Patient can tolerate >30 minutes of walking
4. Patient can tolerate >30 minutes of watching television
5 Patient can tolerate 7 lbs of weight during pushing activities
6. Patient can tolerate 7 lbs of weight during pulling activities
7. Patient can tolerate 7 lbs of weight during lifting activities
8. Patient reports that social activities are affected due to pain
9. Patient reports of some difficulty with self care.
10. Patient reports of mod difficulty with housework and cleaning. *Location:* knee: right. *Pain quality:* achy, dull, stiff. *Range:* 9->10/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS= 18/80
1 Any of your usual work, housework, or school activities. 1
2 Your usual hobbies, re creational or sporting activities. 1
3 Getting into or out of the bath. 1
4 Walking between rooms. 1
5 Putting on your shoes or socks. 1
6 Squatting. 1
7 Lifting an object, like a bag of groceries from the floor. 1
8 Performing light activities around your home.
9 Performing heavy activities around your home. 1
10 Getting into or out of a car. 1
11 Walking 2 blocks. 1
12 Walking a mile. 1
13 Going up or down 10 stairs (about 1 flight of stairs).1
14 Standing for 1 hour. 1

15 Sitting for 1 hour. 1
16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0
19 Hopping. 1
20 Rolling over in bed. 1

(+) Antalgic gait
(+) Bruising on the right knee and thigh
. *Left hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right Knee ROM (active):* flexion: 75/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3-/5; knee adductors: 3-/5; knee abductors: 3-/5; hamstring: 3-/5.

Assessment

LowerExtremity assessment: This patient is a 44 years old female who was referred for outpatient physical therapy services. Pt presents with difficulty with ADLs, decreased joint flexibility, and muscle strength. Pt will benefit from a therapy program. Patient requires skilled therapy to restore prior level of function utlizing the treatment and modalities in this POC.
Patient was seen and treated today through telehealth and completed all therapeutic exercises without any adverse effects.
. *Diagnosis:* M23.91 (Unspecified internal derangement of right knee), M25.561 (Pain in right knee), S83.241A (Oth tear of medial meniscus, current injury, r knee, init), S83.411A (Sprain of medial collateral ligament of right knee, init), S83.421A (Sprain of lateral collateral ligament of right knee, init). *CPT code(s):* 97150, 97140, 97014, 97010.

Treatment & Plan

Short term Goals:
1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

Long term Goals:
1. To eliminate pain and tenderness.
2. To improve on M strength to WNL.
3. To improve on Flexibility to WNL.
4. To improve function and endurance in doing ADL's to WNL.
   4.a Patient will be able to walk >1 hour without pain and difficulty
   4.b Patient will be able to sit >1 hour without pain, difficulty and the need to change position.
   4.c Patient will be able to stand >1 hour without pain and difficulty
   4.d Patient will be able to travel >2 hours without pain and difficulty
   4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes). ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)
. *Informed consent:* Patient agreed to begin care.

End of note. Electronically signed by maged Abuseif PT on 06/25/2021 at 11:22am

Abbreviations:
ADL: activities of daily living
ROM: range of motion
WNL: within normal limits

1187051227

NY MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167)
80-46 KEW GARDENS RD
KEW GARDENS, NY 11415
718-261-1000
Today's date: June 29, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Monday June 28, 2021 Provider: XIMENA AZARIO PT

NPI#: 1497349880
Electronically signed by XIMENA AZARIO PT on 06/28/2021 at 8:11pm

Subjective

Lower Extremity: less soreness and pain , adl's better but patient is able to do more

Patient reports of the following:
1. Patient can tolerate >30 minutes of sitting
2. Patient can tolerate >30 minutes of standing
3. Patient can tolerate >30 minutes of walking
4. Patient can tolerate >30 minutes of watching television
5 Patient can tolerate 7 lbs of weight during pushing activities
6. Patient can tolerate 7 lbs of weight during pulling activities
7. Patient can tolerate 7 lbs of weight during lifting activities
8. Patient reports that social activities are affected due to pain
9. Patient reports of some difficulty with self care.
10. Patient reports of mod difficulty with housework and cleaning

The patient reported less pain and stiffness in his right lower extremity. He tolerated his treatment well today. *Location:* knee: right. *Pain quality:* achy, dull, stiff. *Range:* 9->10/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS= 18/80
1 Any of your usual work, housework, or school activities. 1
2 Your usual hobbies, re creational or sporting activities. 1
3 Getting into or out of the bath. 1
4 Walking between rooms. 1
5 Putting on your shoes or socks. 1
6 Squatting. 1
7 Lifting an object, like a bag of groceries from the floor. 1
8 Performing light activities around your home.
9 Performing heavy activities around your home. 1
10 Getting into or out of a car. 1
11 Walking 2 blocks. 1

12 Walking a mile. 1
13 Going up or down 10 stairs (about 1 flight of stairs).1
14 Standing for 1 hour. 1
15 Sitting for 1 hour. 1
16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0
19 Hopping. 1
20 Rolling over in bed. 1

(+) Antalgic gait
(+) Bruising on the right knee and thigh
. *Left hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right Knee ROM (active):* flexion: 75/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3-/5; knee adductors: 3-/5; knee abductors: 3-/5; hamstring: 3-/5.

Assessment

LowerExtremity assessment: This patient is a 44 years old female who was referred for outpatient physical therapy services. Pt presents with difficulty with ADLs, decreased joint flexibility, and muscle strength. Pt will benefit from a therapy program. Patient requires skilled therapy to restore prior level of function utlizing the treatment and modalities in this POC.
Patient was seen and treated today through telehealth and completed all therapeutic exercises without any adverse effects.
. *Diagnosis:* M23.91 (Unspecified internal derangement of right knee), M25.561 (Pain in right knee), S83.241A (Oth tear of medial meniscus, current injury, r knee, init), S83.411A (Sprain of medial collateral ligament of right knee, init), S83.421A (Sprain of lateral collateral ligament of right knee, init). *CPT code(s):* 97150, 97140, 97124, 97010.

Treatment & Plan

Short term Goals:
1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

Long term Goals:
1. To eliminate pain and tenderness.
2. To improve on M strength to WNL.
3. To improve on Flexibility to WNL.
4. To improve function and endurance in doing ADL's to WNL.
   4.a Patient will be able to walk >1 hour without pain and difficulty
   4.b Patient will be able to sit >1 hour without pain, difficulty and the need to change position.
   4.c Patient will be able to stand >1 hour without pain and difficulty

4.d Patient will be able to travel >2 hours without pain and difficulty

4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes). ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)
. *Informed consent:* Patient agreed to begin care.

End of note. Electronically signed by XIMENA AZARIO PT on 06/28/2021 at 8:11pm

Abbreviations:
ADL: activities of daily living
ROM: range of motion
WNL: within normal limits

NY MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167)
80-46 KEW GARDENS RD
KEW GARDENS, NY 11415
718-261-1000
Today's date: July 1, 2021

1188023721

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Wednesday June 30, 2021 Provider: XIMENA AZARIO PT

NPI#: 1497349880
Electronically signed by XIMENA AZARIO PT on 06/30/2021 at 4:39pm

Subjective

Lower Extremity: less soreness and pain , adl's better but patient is able to do more

Patient reports of the following:
1. Patient can tolerate >30 minutes of sitting
2. Patient can tolerate >30 minutes of standing
3. Patient can tolerate >30 minutes of walking
4. Patient can tolerate >30 minutes of watching television
5 Patient can tolerate 7 lbs of weight during pushing activities
6. Patient can tolerate 7 lbs of weight during pulling activities
7. Patient can tolerate 7 lbs of weight during lifting activities
8. Patient reports that social activities are affected due to pain
9. Patient reports of some difficulty with self care.
10. Patient reports of mod difficulty with housework and cleaning

The patient reported less pain and stiffness in his right lower extremity. He tolerated his treatment well today. Patient reported feeling comfortable with his exercise program and had a positive response to his treatment today. *Location:* knee: right. *Pain quality:* achy, dull, stiff. *Range:* 9->10/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS= 18/80
1 Any of your usual work, housework, or school activities. 1
2 Your usual hobbies, re creational or sporting activities. 1
3 Getting into or out of the bath. 1
4 Walking between rooms. 1
5 Putting on your shoes or socks. 1
6 Squatting. 1
7 Lifting an object, like a bag of groceries from the floor. 1
8 Performing light activities around your home.
9 Performing heavy activities around your home. 1
10 Getting into or out of a car. 1

11 Walking 2 blocks. 1
12 Walking a mile. 1
13 Going up or down 10 stairs (about 1 flight of stairs).1
14 Standing for 1 hour. 1
15 Sitting for 1 hour. 1
16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0
19 Hopping. 1
20 Rolling over in bed. 1

(+) Antalgic gait
(+) Bruising on the right knee and thigh
. *Left hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right Knee ROM (active):* flexion: 75/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3-/5; knee adductors: 3-/5; knee abductors: 3-/5; hamstring: 3-/5.

Assessment

LowerExtremity assessment: This patient is a 44 years old female who was referred for outpatient physical therapy services. Pt presents with difficulty with ADLs, decreased joint flexibility, and muscle strength. Pt will benefit from a therapy program. Patient requires skilled therapy to restore prior level of function utlizing the treatment and modalities in this POC.
Patient was seen and treated today through telehealth and completed all therapeutic exercises without any adverse effects.
. *Diagnosis:* M23.91 (Unspecified internal derangement of right knee), M25.561 (Pain in right knee), S83.241A (Oth tear of medial meniscus, current injury, r knee, init), S83.411A (Sprain of medial collateral ligament of right knee, init), S83.421A (Sprain of lateral collateral ligament of right knee, init). *CPT code(s):* 97150, 97140, 97014, 97010.

Treatment & Plan

Short term Goals:
1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

Long term Goals:
1. To eliminate pain and tenderness.
2. To improve on M strength to WNL.
3. To improve on Flexibility to WNL.
4. To improve function and endurance in doing ADL's to WNL.
   4.a Patient will be able to walk >1 hour without pain and difficulty
   4.b Patient will be able to sit >1 hour without pain, difficulty and the need to change position.

4.c Patient will be able to stand >1 hour without pain and difficulty
4.d Patient will be able to travel >2 hours without pain and difficulty
4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes). ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)
. *Informed consent:* Patient agreed to begin care.

End of note. Electronically signed by XIMENA AZARIO PT on 06/30/2021 at 4:39pm

Abbreviations:
ADL: activities of daily living
ROM: range of motion
WNL: within normal limits

NY MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167) 93118139
80-46 KEW GARDENS RD
KEW GARDENS, NY 11415
718-261-1000
Today's date: July 6, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Friday July 2, 2021 Provider: XIMENA AZARIO PT

NPI#: 1497349880
Electronically signed by XIMENA AZARIO PT on 07/02/2021 at 10:48am

Subjective

Lower Extremity: less soreness and pain , adl's better but patient is able to do more

Patient reports of the following:
1. Patient can tolerate >30 minutes of sitting
2. Patient can tolerate >30 minutes of standing
3. Patient can tolerate >30 minutes of walking
4. Patient can tolerate >30 minutes of watching television
5 Patient can tolerate 7 lbs of weight during pushing activities
6. Patient can tolerate 7 lbs of weight during pulling activities
7. Patient can tolerate 7 lbs of weight during lifting activities
8. Patient reports that social activities are affected due to pain
9. Patient reports of some difficulty with self care.
10. Patient reports of mod difficulty with housework and cleaning

The patient reported less pain and stiffness in his right lower extremity. He tolerated his treatment well today.
Patient reported feeling comfortable with his exercise program and had a positive response to his treatment today.
Patient reported less difficulty when doing his ADL's. He had a positive response to his treatment today. *Location:* knee: right. *Pain quality:* achy, dull, stiff. *Range:* 9->10/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS= 18/80
1 Any of your usual work, housework, or school activities. 1
2 Your usual hobbies, re creational or sporting activities. 1
3 Getting into or out of the bath. 1
4 Walking between rooms. 1
5 Putting on your shoes or socks. 1
6 Squatting. 1
7 Lifting an object, like a bag of groceries from the floor. 1
8 Performing light activities around your home.
9 Performing heavy activities around your home. 1
10 Getting into or out of a car. 1
11 Walking 2 blocks. 1
12 Walking a mile. 1
13 Going up or down 10 stairs (about 1 flight of stairs).1
14 Standing for 1 hour. 1
15 Sitting for 1 hour. 1
16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0

19 Hopping. 1
20 Rolling over in bed. 1

(+) Antalgic gait
(+) Bruising on the right knee and thigh
. *Left hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right Knee ROM (active):* flexion: 75/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3-/5; knee adductors: 3-/5; knee abductors: 3-/5; hamstring: 3-/5.

Assessment

LowerExtremity assessment: This patient is a 44 years old female who was referred for outpatient physical therapy services. Pt presents with difficulty with ADLs, decreased joint flexibility, and muscle strength. Pt will benefit from a therapy program. Patient requires skilled therapy to restore prior level of function utlizing the treatment and modalities in this POC.
Patient was seen and treated today through telehealth and completed all therapeutic exercises without any adverse effects.
. *Diagnosis:* M23.91 (Unspecified internal derangement of right knee), M25.561 (Pain in right knee), S83.241A (Oth tear of medial meniscus, current injury, r knee, init), S83.411A (Sprain of medial collateral ligament of right knee, init), S83.421A (Sprain of lateral collateral ligament of right knee, init). *CPT code(s):* 97150, 97140, 97014, 97010.

Treatment & Plan

Short term Goals:
1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

Long term Goals:
1. To eliminate pain and tenderness.
2. To improve on M strength to WNL.
3. To improve on Flexibility to WNL.
4. To improve function and endurance in doing ADL's to WNL.
   - 4.a Patient will be able to walk >1 hour without pain and difficulty
   - 4.b Patient will be able to sit >1 hour without pain, difficulty and the need to change position.
   - 4.c Patient will be able to stand >1 hour without pain and difficulty
   - 4.d Patient will be able to travel >2 hours without pain and difficulty
   - 4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes). ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)
. *Informed consent:* Patient agreed to begin care.

End of note. Electronically signed by XIMENA AZARIO PT on 07/02/2021 at 10:48am

Abbreviations:
ADL: activities of daily living
ROM: range of motion
WNL: within normal limits

NY MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167) 1193118138
80-46 KEW GARDENS RD
KEW GARDENS, NY 11415
718-261-1000
Today's date: July 6, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Monday July 5, 2021 Provider: PRUETTIYAPA MANOSAN PT

NPI#: 1396309910
Electronically signed by PRUETTIYAPA MANOSAN PT on 07/05/2021 at 2:52pm

Subjective

Lower Extremity: Patient reports some stiffness and tightness on Hamstring and calf ms, limited prolonged walking and standing. . *Location:* knee: right. *Pain quality:* achy, dull, stiff; level: 4/10. *Range:* 9->10/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS= 18/80
1 Any of your usual work, housework, or school activities. 1
2 Your usual hobbies, re creational or sporting activities. 1
3 Getting into or out of the bath. 1
4 Walking between rooms. 1
5 Putting on your shoes or socks. 1
6 Squatting. 1
7 Lifting an object, like a bag of groceries from the floor. 1
8 Performing light activities around your home.
9 Performing heavy activities around your home. 1
10 Getting into or out of a car. 1
11 Walking 2 blocks. 1
12 Walking a mile. 1
13 Going up or down 10 stairs (about 1 flight of stairs).1
14 Standing for 1 hour. 1
15 Sitting for 1 hour. 1
16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0
19 Hopping. 1
20 Rolling over in bed. 1

(+) Antalgic gait
(+) Bruising on the right knee and thigh
. *Left hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right Knee ROM (active):* flexion: 75/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3-/5; knee adductors: 3-/5; knee abductors: 3-/5; hamstring: 3-/5.

Assessment

LowerExtremity assessment: This patient is a 44 years old female who was referred for outpatient physical therapy services. Pt presents with difficulty with ADLs, decreased joint flexibility, and muscle strength. Pt will benefit from a therapy program. Patient requires skilled therapy to restore prior level of function utlizing the treatment and modalities in this POC.
Patient was seen and treated today through telehealth and completed all therapeutic exercises without any adverse effects.
. *Diagnosis:* M23.91 (Unspecified internal derangement of right knee), M25.561 (Pain in right knee), S83.241A (Oth tear of medial

meniscus, current injury, r knee, init), S83.411A (Sprain of medial collateral ligament of right knee, init), S83.421A (Sprain of lateral collateral ligament of right knee, init). *CPT code(s):* 97150, 97140, 97014, 97010.

Treatment & Plan

Short term Goals:

1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

Long term Goals:

1. To eliminate pain and tenderness.
2. To improve on M strength to WNL.
3. To improve on Flexibility to WNL.
4. To improve function and endurance in doing ADL's to WNL.
   - 4.a Patient will be able to walk >1 hour without pain and difficulty
   - 4.b Patient will be able to sit >1 hour without pain, difficulty and the need to change position.
   - 4.c Patient will be able to stand >1 hour without pain and difficulty
   - 4.d Patient will be able to travel >2 hours without pain and difficulty
   - 4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes). ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)
. *Informed consent:* Patient agreed to begin care.

End of note. Electronically signed by PRUETTIYAPA MANOSAN PT on 07/05/2021 at 2:52pm

Abbreviations:
ADL: activities of daily living
ROM: range of motion
WNL: within normal limits

NY MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167)
80-46 KEW GARDENS RD 1194819657
KEW GARDENS, NY 11415
718-261-1000
Today's date: July 8, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Wednesday July 7, 2021 Provider: XIMENA AZARIO PT

NPI#: 1497349880
Electronically signed by XIMENA AZARIO PT on 07/07/2021 at 1:05pm

Subjective

Lower Extremity: Patient reports some stiffness and tightness on Hamstring and calf ms, limited prolonged walking and standing.
Patient is able to sit forone hour without pain.The patient responde well to jhis treatment today. *Location:* knee: right. *Pain quality:* achy, dull, stiff; level: 4/10. *Range:* 9->10/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS= 18/80
1 Any of your usual work, housework, or school activities. 1
2 Your usual hobbies, re creational or sporting activities. 1
3 Getting into or out of the bath. 1
4 Walking between rooms. 1
5 Putting on your shoes or socks. 1
6 Squatting. 1
7 Lifting an object, like a bag of groceries from the floor. 1
8 Performing light activities around your home.
9 Performing heavy activities around your home. 1
10 Getting into or out of a car. 1
11 Walking 2 blocks. 1
12 Walking a mile. 1
13 Going up or down 10 stairs (about 1 flight of stairs).1
14 Standing for 1 hour. 1
15 Sitting for 1 hour. 1
16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0
19 Hopping. 1
20 Rolling over in bed. 1

(+) Antalgic gait
(+) Bruising on the right knee and thigh

. *Left hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right Knee ROM (active):* flexion: 75/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3-/5; knee adductors: 3-/5; knee abductors: 3-/5; hamstring: 3-/5.

Assessment

LowerExtremity assessment: This patient is a 44 years old female who was referred for outpatient physical therapy services. Pt presents with difficulty with ADLs, decreased joint flexibility, and muscle strength. Pt will benefit from a therapy program. Patient requires skilled therapy to restore prior level of function utlizing the treatment and modalities in this POC.
Patient was seen and treated today through telehealth and completed all therapeutic exercises without any adverse effects.
. *Diagnosis:* M23.91 (Unspecified internal derangement of right knee), M25.561 (Pain in right knee), S83.241A (Oth tear of medial meniscus, current injury, r knee, init), S83.411A (Sprain of medial collateral ligament of right knee, init), S83.421A (Sprain of lateral collateral ligament of right knee, init). *CPT code(s):* 97110, 97140, 97014, 97010.

Treatment & Plan

Short term Goals:
1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

Long term Goals:
1. To eliminate pain and tenderness.
2. To improve on M strength to WNL.
3. To improve on Flexibility to WNL.
4. To improve function and endurance in doing ADL's to WNL.
   4.a Patient will be able to walk >1 hour without pain and difficulty
   4.b Patient will be able to sit >1 hour without pain, difficulty and the need to change position.
   4.c Patient will be able to stand >1 hour without pain and difficulty
   4.d Patient will be able to travel >2 hours without pain and difficulty
   4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes). ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)
. *Informed consent:* Patient agreed to begin care.

End of note. Electronically signed by XIMENA AZARIO PT on 07/07/2021 at 1:05pm

Abbreviations:
ADL: activities of daily living
ROM: range of motion
WNL: within normal limits

NY MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167)
80-46 KEW GARDENS RD
KEW GARDENS, NY 11415
718-261-1000 1200107540
Today's date: July 13, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Friday July 9, 2021 Provider: XIMENA AZARIO PT

NPI#: 1497349880
Electronically signed by XIMENA AZARIO PT on 07/09/2021 at 2:39pm

Subjective

Lower Extremity: Patient reports some stiffness and tightness on Hamstring and calf ms, limited prolonged walking and standing.
Patient is able to sit for one hour without pain.The patient responde well to jhis treatment today.
Patient tolerated his treatment well today without any side effects. *Location:* knee: right. *Pain quality:* achy, dull, stiff; level: 4/10. *Range:* 9->10/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS= 18/80
1 Any of your usual work, housework, or school activities. 1
2 Your usual hobbies, re creational or sporting activities. 1
3 Getting into or out of the bath. 1
4 Walking between rooms. 1
5 Putting on your shoes or socks. 1
6 Squatting. 1
7 Lifting an object, like a bag of groceries from the floor. 1
8 Performing light activities around your home.
9 Performing heavy activities around your home. 1
10 Getting into or out of a car. 1
11 Walking 2 blocks. 1
12 Walking a mile. 1
13 Going up or down 10 stairs (about 1 flight of stairs).1
14 Standing for 1 hour. 1
15 Sitting for 1 hour. 1
16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0
19 Hopping. 1
20 Rolling over in bed. 1

(+) Antalgic gait

(+) Bruising on the right knee and thigh
. *Left hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right hip manual muscle testing:* flexion: 3-/5; extension: 3-/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3-/5. *Right Knee ROM (active):* flexion: 75/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3-/5; knee adductors: 3-/5; knee abductors: 3-/5; hamstring: 3-/5.

Assessment

LowerExtremity assessment: This patient is a 44 years old female who was referred for outpatient physical therapy services. Pt presents with difficulty with ADLs, decreased joint flexibility, and muscle strength. Pt will benefit from a therapy program. Patient requires skilled therapy to restore prior level of function utlizing the treatment and modalities in this POC.
Patient was seen and treated today through telehealth and completed all therapeutic exercises without any adverse effects.
. *Diagnosis:* M23.91 (Unspecified internal derangement of right knee), M25.561 (Pain in right knee), S83.241A (Oth tear of medial meniscus, current injury, r knee, init), S83.411A (Sprain of medial collateral ligament of right knee, init), S83.421A (Sprain of lateral collateral ligament of right knee, init). *CPT code(s):* 97150, 97140, 97014, 97010.

Treatment & Plan

Short term Goals:
1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

Long term Goals:
1. To eliminate pain and tenderness.
2. To improve on M strength to WNL.
3. To improve on Flexibility to WNL.
4. To improve function and endurance in doing ADL's to WNL.
   4.a Patient will be able to walk >1 hour without pain and difficulty
   4.b Patient will be able to sit >1 hour without pain, difficulty and the need to change position.
   4.c Patient will be able to stand >1 hour without pain and difficulty
   4.d Patient will be able to travel >2 hours without pain and difficulty
   4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes). ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)

. *Informed consent:* Patient agreed to begin care.

End of note. Electronically signed by XIMENA AZARIO PT on 07/09/2021 at 2:39pm

Abbreviations:
ADL: activities of daily living
ROM: range of motion
WNL: within normal limits

NY MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167)
80-46 KEW GARDENS RD
KEW GARDENS, NY 11415
718-261-1000
Today's date: July 21, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Monday July 12, 2021 Provider: Jerome Rivera PT RE-EVALUATION

NPI#: 1023670361
Electronically signed by Jerome Rivera PT on 07/12/2021 at 4:07pm

Subjective

Lower Extremity:

RE-EVALUATION :

Patient is re evaluated today.

Patient reports of significant improvement of pain and stiffness

Patient reports of the following improvements:

1. Patient can now tolerate 40mintues of standing
2. Patient can now tolerate 45 mintues of walking
3. Patient can now tolerate 45 mintues of sitting
4. Patient can now tolerate squatting with less difficulty
5. Patient can now tolerate knee flexion exercise with 20 lbs of weight
6. Patient can now tolerate knee extension exercise with 20 lbs of weight
7. Patient can do repetitive bending movement with less difficulty.
8. Patient can do housework with minimum to moderate difficulty

Patient reports some stiffness and tightness on Hamstring and calf ms, limited prolonged walking and standing.
Patient followed his exercise program and responded well to his treatment today. *Location:* knee: right. *Pain quality:* achy, dull, stiff; level: 3/10. *Range:* 8->9/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS= 22/80
1 Any of your usual work, housework, or school activities. 2
2 Your usual hobbies, recreational or sporting activities. 2
3 Getting into or out of the bath. 2
4 Walking between rooms. 2
5 Putting on your shoes or socks. 2
6 Squatting. 1
7 Lifting an object, like a bag of groceries from the floor. 1
8 Performing light activities around your home.2
9 Performing heavy activities around your home. 1
10 Getting into or out of a car. 2
11 Walking 2 blocks. 1
12 Walking a mile. 2
13 Going up or down 10 stairs (about 1 flight of stairs).1
14 Standing for 1 hour. 1
15 Sitting for 1 hour. 1

NY MEDICAL & DIAGNOSTIC CENTER 80-46 KEW GARDENS RD KEW GARDENS, NY 11415
Encounter dated 07/12/2021 for Bayani L Dillard #51372
DOB:11/05/1976 Today's date: 07/21/2021

16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0
19 Hopping. 1
20 Rolling over in bed. 1

(+) Antalgic gait
(+) Bruising on the right knee and thigh
. *Left hip manual muscle testing:* flexion: 3/5; extension: 3/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3/5; external rotation: 3-/5. *Right hip manual muscle testing:* flexion: 3/5; extension: 3/5; adduction: 3/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3/5. *Right Knee ROM (active):* flexion: 80/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3/5; knee adductors: 3/5; knee abductors: 3/5; hamstring: 3/5.

Assessment

LowerExtremity assessment: This patient is a 44 years old female who was referred for outpatient physical therapy services. Pt presents with difficulty with ADLs, decreased joint flexibility, and muscle strength. Pt will benefit from a therapy program. Patient requires skilled therapy to restore prior level of function utlizing the treatment and modalities in this POC.
Patient was seen and treated today through telehealth and completed all therapeutic exercises without any adverse effects.
. *Diagnosis:* M23.91 (Unspecified internal derangement of right knee), M25.561 (Pain in right knee), S83.241A (Oth tear of medial meniscus, current injury, r knee, init), S83.411A (Sprain of medial collateral ligament of right knee, init), S83.421A (Sprain of lateral collateral ligament of right knee, init). *CPT code(s):* 97150, 97140, 97014, 97010.

Treatment & Plan

Short term Goals:
1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

Long term Goals:
1. To eliminate pain and tenderness.
2. To improve on M strength to WNL.
3. To improve on Flexibility to WNL.
4. To improve function and endurance in doing ADL's to WNL.
   - 4.a Patient will be able to walk >1 hour without pain and difficulty
   - 4.b Patient will be able to sit >1 hour without pain, difficulty and the need to change position.
   - 4.c Patient will be able to stand >1 hour without pain and difficulty
   - 4.d Patient will be able to travel >2 hours without pain and difficulty
   - 4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes), ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)
. *Informed consent:* Patient agreed to begin care.

End of note. Electronically signed by Jerome Rivera PT on 07/12/2021 at 4:07pm

Abbreviations:
ADL: activities of daily living
ROM: range of motion

NY MEDICAL & DIAGNOSTIC CENTER 80-46 KEW GARDENS RD KEW GARDENS, NY 11415
Encounter dated 07/12/2021 for Bayani L Dillard #51372
DOB:11/05/1976 Today's date: 07/21/2021

WNL: within normal limits

NY MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167) 08125519
80-46 KEW GARDENS RD
KEW GARDENS, NY 11415
718-261-1000
Today's date: July 20, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Wednesday July 14, 2021 Provider: XIMENA AZARIO PT

NPI#: 1497349880
Electronically signed by XIMENA AZARIO PT on 07/14/2021 at 12:03pm

Subjective

Lower Extremity:

Patient reports of significant improvement of pain and stiffness

Patient reports of the following improvements:

1. Patient can now tolerate 40mintues of standing
2. Patient can now tolerate 45 mintues of walking
3. Patient can now tolerate 45 mintues of sitting
4. Patient can now tolerate squatting with less difficulty
5. Patient can now tolerate knee flexion exercise with 20 lbs of weight
6. Patient can now tolerate knee extension exercise with 20 lbs of weight
7. Patient can do repetitive bending movement with less difficulty.
8. Patient can do housework with minimum to moderate difficulty

Patient reports some stiffness and tightness on Hamstring and calf ms, limited prolonged walking and standing. Patient followed his exercise program and responded well to his treatment today.
Patient continues with his exercise plan and had a positive response to his treatment today. *Location:* knee: right. *Pain quality:* achy, dull, stiff; level: 3/10. *Range:* 8->9/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS= 22/80
1 Any of your usual work, housework, or school activities. 2
2 Your usual hobbies, re creational or sporting activities. 2
3 Getting into or out of the bath. 2
4 Walking between rooms. 2
5 Putting on your shoes or socks. 2
6 Squatting. 1
7 Lifting an object, like a bag of groceries from the floor. 1

8 Performing light activities around your home.2
9 Performing heavy activities around your home. 1
10 Getting into or out of a car. 2
11 Walking 2 blocks. 1
12 Walking a mile. 2
13 Going up or down 10 stairs (about 1 flight of stairs).1
14 Standing for 1 hour. 1
15 Sitting for 1 hour. 1
16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0
19 Hopping. 1
20 Rolling over in bed. 1

(+) Antalgic gait
(+) Bruising on the right knee and thigh
. *Left hip manual muscle testing:* flexion: 3/5; extension: 3/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3/5; external rotation: 3-/5. *Right hip manual muscle testing:* flexion: 3/5; extension: 3/5; adduction: 3/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3/5. *Right Knee ROM (active):* flexion: 80/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3/5; knee adductors: 3/5; knee abductors: 3/5; hamstring: 3/5.

Assessment

LowerExtremity assessment: This patient is a 44 years old female who was referred for outpatient physical therapy services. Pt presents with difficulty with ADLs, decreased joint flexibility, and muscle strength. Pt will benefit from a therapy program. Patient requires skilled therapy to restore prior level of function utlizing the treatment and modalities in this POC.
Patient was seen and treated today through telehealth and completed all therapeutic exercises without any adverse effects.
. *Diagnosis:* M23.91 (Unspecified internal derangement of right knee), M25.561 (Pain in right knee), S83.241A (Oth tear of medial meniscus, current injury, r knee, init), S83.411A (Sprain of medial collateral ligament of right knee, init), S83.421A (Sprain of lateral collateral ligament of right knee, init). *CPT code(s):* 97140, 97150, 97014, 97010.

Treatment & Plan

Short term Goals:
1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

Long term Goals:
1. To eliminate pain and tenderness.
2. To improve on M strength to WNL.
3. To improve on Flexibility to WNL.

4. To improve function and endurance in doing ADL's to WNL.
   4.a Patient will be able to walk >1 hour without pain and difficulty
   4.b Patient will be able to sit >1 hour without pain, difficulty and the need to change position.
   4.c Patient will be able to stand >1 hour without pain and difficulty
   4.d Patient will be able to travel >2 hours without pain and difficulty
   4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes). ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)
. *Informed consent:* Patient agreed to begin care.

End of note. Electronically signed by XIMENA AZARIO PT on 07/14/2021 at 12:03pm

Abbreviations:
ADL: activities of daily living
ROM: range of motion
WNL: within normal limits

NY MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167) 1208125518
80-46 KEW GARDENS RD
KEW GARDENS, NY 11415
718-261-1000
Today's date: July 20, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Friday July 16, 2021 Provider: Jerome Rivera PT

NPI#: 1023670361
Electronically signed by Jerome Rivera PT on 07/16/2021 at 2:40pm

Subjective

Lower Extremity:

Patient reports of significant improvement of pain and stiffness

Patient reports of the following improvements:

1. Patient can now tolerate 40mintues of standing
2. Patient can now tolerate 45 mintues of walking
3. Patient can now tolerate 45 mintues of sitting
4. Patient can now tolerate squatting with less difficulty
5. Patient can now tolerate knee flexion exercise with 20 lbs of weight
6. Patient can now tolerate knee extension exercise with 20 lbs of weight
7. Patient can do repetitive bending movement with less difficulty.
8. Patient can do housework with minimum to moderate difficulty

Patient reports some stiffness and tightness on Hamstring and calf ms, limited prolonged walking and standing.
Patient followed his exercise program and responded well to his treatment today.
Patient continues with his exercise plan and had a positive response to his treatment today.
Patient continues with his exercise program and responded well to his treatment today. *Location:* knee: right. *Pain quality:* achy, dull, stiff; level: 3/10. *Range:* 8->9/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS= 22/80
1 Any of your usual work, housework, or school activities. 2
2 Your usual hobbies, re creational or sporting activities. 2
3 Getting into or out of the bath. 2
4 Walking between rooms. 2
5 Putting on your shoes or socks. 2
6 Squatting. 1

7 Lifting an object, like a bag of groceries from the floor. 1
8 Performing light activities around your home.2
9 Performing heavy activities around your home. 1
10 Getting into or out of a car. 2
11 Walking 2 blocks. 1
12 Walking a mile. 2
13 Going up or down 10 stairs (about 1 flight of stairs).1
14 Standing for 1 hour. 1
15 Sitting for 1 hour. 1
16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0
19 Hopping. 1
20 Rolling over in bed. 1

(+) Antalgic gait
(+) Bruising on the right knee and thigh
. *Left hip manual muscle testing:* flexion: 3/5; extension: 3/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3/5; external rotation: 3-/5. *Right hip manual muscle testing:* flexion: 3/5; extension: 3/5; adduction: 3/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3/5. *Right Knee ROM (active):* flexion: 80/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3/5; knee adductors: 3/5; knee abductors: 3/5; hamstring: 3/5.

Assessment

LowerExtremity assessment: This patient is a 44 years old female who was referred for outpatient physical therapy services. Pt presents with difficulty with ADLs, decreased joint flexibility, and muscle strength. Pt will benefit from a therapy program. Patient requires skilled therapy to restore prior level of function utlizing the treatment and modalities in this POC.
Patient was seen and treated today through telehealth and completed all therapeutic exercises without any adverse effects.
. *Diagnosis:* M23.91 (Unspecified internal derangement of right knee), M25.561 (Pain in right knee), S83.241A (Oth tear of medial meniscus, current injury, r knee, init), S83.411A (Sprain of medial collateral ligament of right knee, init), S83.421A (Sprain of lateral collateral ligament of right knee, init). *CPT code(s):* 97110, 97140, 97014, 97010.

Treatment & Plan

Short term Goals:
1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

Long term Goals:
1. To eliminate pain and tenderness.
2. To improve on M strength to WNL.

3. To improve on Flexibility to WNL.
4. To improve function and endurance in doing ADL's to WNL.
   4.a Patient will be able to walk >1 hour without pain and difficulty
   4.b Patient will be able to sit >1 hour without pain, difficulty and the need to change position.
   4.c Patient will be able to stand >1 hour without pain and difficulty
   4.d Patient will be able to travel >2 hours without pain and difficulty
   4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes). ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)
. *Informed consent:* Patient agreed to begin care.

End of note. Electronically signed by Jerome Rivera PT on 07/16/2021 at 2:40pm

Abbreviations:
ADL: activities of daily living
ROM: range of motion
WNL: within normal limits

NY MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167) 208125517
80-46 KEW GARDENS RD
KEW GARDENS, NY 11415
718-261-1000
Today's date: July 20, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Monday July 19, 2021 Provider: XIMENA AZARIO PT

NPI#: 1497349880
Electronically signed by XIMENA AZARIO PT on 07/19/2021 at 10:56am

Subjective

Lower Extremity:

Patient reports of significant improvement of pain and stiffness

Patient reports of the following improvements:

1. Patient can now tolerate 40mintues of standing
2. Patient can now tolerate 45 mintues of walking
3. Patient can now tolcratc 45 mintues of sitting
4. Patient can now tolerate squatting with less difficulty
5. Patient can now tolerate knee flexion exercise with 20 lbs of weight
6. Patient can now tolerate knee extension exercise with 20 lbs of weight
7. Patient can do repetitive bending movement with less difficulty.
8. Patient can do housework with minimum to moderate difficulty

Patient reports some stiffness and tightness on Hamstring and calf ms, limited prolonged walking and standing.
Patient followed his exercise program and responded well to his treatment today.
Patient continues with his exercise plan and had a positive response to his treatment today.
Patient continues with his exercise program and responded well to his treatment today.
Patient reported less pain and less difficulty when he is walkin longer periods of time.He tolerated his treatment well today. *Location:* knee: right. *Pain quality:* achy, dull, stiff; level: 3/10. *Range:* 8->9/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS= 22/80
1 Any of your usual work, housework, or school activities. 2
2 Your usual hobbies, re creational or sporting activities. 2
3 Getting into or out of the bath. 2
4 Walking between rooms. 2
5 Putting on your shoes or socks. 2

6 Squatting. 1
7 Lifting an object, like a bag of groceries from the floor. 1
8 Performing light activities around your home.2
9 Performing heavy activities around your home. 1
10 Getting into or out of a car. 2
11 Walking 2 blocks. 1
12 Walking a mile. 2
13 Going up or down 10 stairs (about 1 flight of stairs).1
14 Standing for 1 hour. 1
15 Sitting for 1 hour. 1
16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0
19 Hopping. 1
20 Rolling over in bed. 1

(+) Antalgic gait
(+) Bruising on the right knee and thigh
. *Left hip manual muscle testing:* flexion: 3/5; extension: 3/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3/5; external rotation: 3-/5. *Right hip manual muscle testing:* flexion: 3/5; extension: 3/5; adduction: 3/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3/5. *Right Knee ROM (active):* flexion: 80/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3/5; knee adductors: 3/5; knee abductors: 3/5; hamstring: 3/5.

Assessment

LowerExtremity assessment: This patient is a 44 years old female who was referred for outpatient physical therapy services. Pt presents with difficulty with ADLs, decreased joint flexibility, and muscle strength. Pt will benefit from a therapy program. Patient requires skilled therapy to restore prior level of function utlizing the treatment and modalities in this POC.
Patient was seen and treated today through telehealth and completed all therapeutic exercises without any adverse effects.
. *Diagnosis:* M23.91 (Unspecified internal derangement of right knee), M25.561 (Pain in right knee), S83.241A (Oth tear of medial meniscus, current injury, r knee, init), S83.411A (Sprain of medial collateral ligament of right knee, init), S83.421A (Sprain of lateral collateral ligament of right knee, init). *CPT code(s):* 97110, 97140, 97014, 97010.

Treatment & Plan

Short term Goals:
1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

Long term Goals:
1. To eliminate pain and tenderness.

2. To improve on M strength to WNL.
3. To improve on Flexibility to WNL.
4. To improve function and endurance in doing ADL's to WNL.
   4.a Patient will be able to walk >1 hour without pain and difficulty
   4.b Patient will be able to sit >1 hour without pain, difficulty and the need to change position.
   4.c Patient will be able to stand >1 hour without pain and difficulty
   4.d Patient will be able to travel >2 hours without pain and difficulty
   4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes). ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)
. *Informed consent:* Patient agreed to begin care.

End of note. Electronically signed by XIMENA AZARIO PT on 07/19/2021 at 10:56am

Abbreviations:
ADL: activities of daily living
ROM: range of motion
WNL: within normal limits

NY MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167)
80-46 KEW GARDENS RD
KEW GARDENS, NY 11415
718-261-1000
Today's date: July 22, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Wednesday July 21, 2021 Provider: XIMENA AZARIO PT

NPI#: 1497349880
Electronically signed by XIMENA AZARIO PT on 07/21/2021 at 4:53pm

Subjective

Lower Extremity:

Patient reports of significant improvement of pain and stiffness

Patient reports of the following improvements:

1. Patient can now tolerate 40mintues of standing
2. Patient can now tolerate 45 mintues of walking
3. Patient can now tolerate 45 mintues of sitting
4. Patient can now tolerate squatting with less difficulty
5. Patient can now tolerate knee flexion exercise with 20 lbs of weight
6. Patient can now tolerate knee extension exercise with 20 lbs of weight
7. Patient can do repetitive bending movement with less difficulty.
8. Patient can do housework with minimum to moderate difficulty

Patient reports some stiffness and tightness on Hamstring and calf ms, limited prolonged walking and standing.
Patient followed his exercise program and responded well to his treatment today.
Patient continues with his exercise plan and had a positive response to his treatment today.
Patient continues with his exercise program and responded well to his treatment today.
Patient reported less pain and less difficulty when he is walking longer periods of time.He tolerated his treatment well today.
Patient reported sitting for longer periods of time with less pain and discomfort. He tolerated his treatment well today.
. *Location:* knee: right. *Pain quality:* achy, dull, stiff; level: 3/10. *Range:* 8->9/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS= 22/80
1 Any of your usual work, housework, or school activities. 2
2 Your usual hobbies, re creational or sporting activities. 2

3 Getting into or out of the bath. 2
4 Walking between rooms. 2
5 Putting on your shoes or socks. 2
6 Squatting. 1
7 Lifting an object, like a bag of groceries from the floor. 1
8 Performing light activities around your home.2
9 Performing heavy activities around your home. 1
10 Getting into or out of a car. 2
11 Walking 2 blocks. 1
12 Walking a mile. 2
13 Going up or down 10 stairs (about 1 flight of stairs).1
14 Standing for 1 hour. 1
15 Sitting for 1 hour. 1
16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0
19 Hopping. 1
20 Rolling over in bed. 1

(+) Antalgic gait
(+) Bruising on the right knee and thigh
. *Left hip manual muscle testing:* flexion: 3/5; extension: 3/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3/5; external rotation: 3-/5. *Right hip manual muscle testing:* flexion: 3/5; extension: 3/5; adduction: 3/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3/5. *Right Knee ROM (active):* flexion: 80/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3/5; knee adductors: 3/5; knee abductors: 3/5; hamstring: 3/5.

Assessment

LowerExtremity assessment: This patient is a 44 years old female who was referred for outpatient physical therapy services. Pt presents with difficulty with ADLs, decreased joint flexibility, and muscle strength. Pt will benefit from a therapy program. Patient requires skilled therapy to restore prior level of function utlizing the treatment and modalities in this POC.
Patient was seen and treated today through telehealth and completed all therapeutic exercises without any adverse effects.
. *Diagnosis:* M23.91 (Unspecified internal derangement of right knee), M25.561 (Pain in right knee), S83.241A (Oth tear of medial meniscus, current injury, r knee, init), S83.411A (Sprain of medial collateral ligament of right knee, init), S83.421A (Sprain of lateral collateral ligament of right knee, init). *CPT code(s):* 97140, 97110, 97014, 97010.

Treatment & Plan

Short term Goals:
1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

NY MEDICAL & DIAGNOSTIC CENTER 80-46 KEW GARDENS RD KEW GARDENS, NY 11415
Encounter dated 07/21/2021 for Bayani L Dillard #51372
DOB:11/05/1976 Today's date: 07/22/2021

Long term Goals:

1. To eliminate pain and tenderness.
2. To improve on M strength to WNL.
3. To improve on Flexibility to WNL.
4. To improve function and endurance in doing ADL's to WNL.
   - 4.a Patient will be able to walk >1 hour without pain and difficulty
   - 4.b Patient will be able to sit >1 hour without pain, difficulty and the need to change position.
   - 4.c Patient will be able to stand >1 hour without pain and difficulty
   - 4.d Patient will be able to travel >2 hours without pain and difficulty
   - 4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes). ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)
. *Informed consent:* Patient agreed to begin care.

End of note. Electronically signed by XIMENA AZARIO PT on 07/21/2021 at 4:53pm

Abbreviations:
ADL: activities of daily living
ROM: range of motion
WNL: within normal limits

NY MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167)
80-46 KEW GARDENS RD
KEW GARDENS, NY 11415
718-261-1000
Today's date: July 27, 2021

1215072406

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Friday July 23, 2021 Provider: XIMENA AZARIO PT

NPI#: 1497349880
Electronically signed by XIMENA AZARIO PT on 07/23/2021 at 2:55pm

Subjective

Lower Extremity:

Patient reports of significant improvement of pain and stiffness

Patient reports of the following improvements:

1. Patient can now tolerate 40mintues of standing
2. Patient can now tolerate 45 mintues of walking
3. Patient can now tolerate 45 mintues of sitting
4. Patient can now tolerate squatting with less difficulty
5. Patient can now tolerate knee flexion exercise with 20 lbs of weight
6. Patient can now tolerate knee extension exercise with 20 lbs of weight
7. Patient can do repetitive bending movement with less difficulty.
8. Patient can do housework with minimum to moderate difficulty

Patient reports some stiffness and tightness on Hamstring and calf ms, limited prolonged walking and standing.
Patient followed his exercise program and responded well to his treatment today.
Patient continues with his exercise plan and had a positive response to his treatment today.
Patient continues with his exercise program and responded well to his treatment today.
Patient reported less pain and less difficulty when he is walking longer periods of time.He tolerated his treatment well today.
Patient reported sitting for longer periods of time with less pain and discomfort. He tolerated his treatment well today.
Patient was seen and treated today and had a positive response to the treatment today. *Location:* knee: right. *Pain quality:* achy, dull, stiff; level: 3/10. *Range:* 8->9/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS= 22/80
1 Any of your usual work, housework, or school activities. 2
2 Your usual hobbies, re creational or sporting activities. 2
3 Getting into or out of the bath. 2
4 Walking between rooms. 2
5 Putting on your shoes or socks. 2
6 Squatting. 1
7 Lifting an object, like a bag of groceries from the floor. 1
8 Performing light activities around your home.2
9 Performing heavy activities around your home. 1
10 Getting into or out of a car. 2
11 Walking 2 blocks. 1
12 Walking a mile. 2

13 Going up or down 10 stairs (about 1 flight of stairs).1
14 Standing for 1 hour. 1
15 Sitting for 1 hour. 1
16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0
19 Hopping. 1
20 Rolling over in bed. 1

(+) Antalgic gait
(+) Bruising on the right knee and thigh
. *Left hip manual muscle testing:* flexion: 3/5; extension: 3/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3/5; external rotation: 3-/5. *Right hip manual muscle testing:* flexion: 3/5; extension: 3/5; adduction: 3/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3/5. *Right Knee ROM (active):* flexion: 80/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3/5; knee adductors: 3/5; knee abductors: 3/5; hamstring: 3/5.

Assessment

LowerExtremity assessment: This patient is a 44 years old female who was referred for outpatient physical therapy services. Pt presents with difficulty with ADLs, decreased joint flexibility, and muscle strength. Pt will benefit from a therapy program. Patient requires skilled therapy to restore prior level of function utlizing the treatment and modalities in this POC.
Patient was seen and treated today through telehealth and completed all therapeutic exercises without any adverse effects.
. *Diagnosis:* M23.91 (Unspecified internal derangement of right knee), M25.561 (Pain in right knee), S83.241A (Oth tear of medial meniscus, current injury, r knee, init), S83.411A (Sprain of medial collateral ligament of right knee, init), S83.421A (Sprain of lateral collateral ligament of right knee, init). *CPT code(s):* 97140, 97110, 97010, 97014.

Treatment & Plan

Short term Goals:
1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

Long term Goals:
1. To eliminate pain and tenderness.
2. To improve on M strength to WNL.
3. To improve on Flexibility to WNL.
4. To improve function and endurance in doing ADL's to WNL.
   - 4.a Patient will be able to walk >1 hour without pain and difficulty
   - 4.b Patient will be able to sit >1 hour without pain, difficulty and the need to change position.
   - 4.c Patient will be able to stand >1 hour without pain and difficulty
   - 4.d Patient will be able to travel >2 hours without pain and difficulty
   - 4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes). ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)
. *Informed consent:* Patient agreed to begin care.

End of note. Electronically signed by XIMENA AZARIO PT on 07/23/2021 at 2:55pm

Abbreviations:
ADL: activities of daily living
ROM: range of motion
WNL: within normal limits

NY MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167)
80-46 KEW GARDENS RD 1215872405
KEW GARDENS, NY 11415
718-261-1000
Today's date: July 27, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Monday July 26, 2021 Provider: XIMENA AZARIO PT

NPI#: 1497349880
Electronically signed by XIMENA AZARIO PT on 07/26/2021 at 1:22pm

Subjective

Lower Extremity:

Patient reports of significant improvement of pain and stiffness

Patient reports of the following improvements:

1. Patient can now tolerate 40mintues of standing
2. Patient can now tolerate 45 mintues of walking
3. Patient can now tolerate 45 mintues of sitting
4. Patient can now tolerate squatting with less difficulty
5. Patient can now tolerate knee flexion exercise with 20 lbs of weight
6. Patient can now tolerate knee extension exercise with 20 lbs of weight
7. Patient can do repetitive bending movement with less difficulty.
8. Patient can do housework with minimum to moderate difficulty

Patient reports some stiffness and tightness on Hamstring and calf ms, limited prolonged walking and standing.
Patient followed his exercise program and responded well to his treatment today.
Patient continues with his exercise plan and had a positive response to his treatment today.
Patient continues with his exercise program and responded well to his treatment today.
Patient reported less pain and less difficulty when he is walking longer periods of time.He tolerated his treatment well today.
Patient reported sitting for longer periods of time with less pain and discomfort. He tolerated his treatment well today.
Patient was seen and treated today and had a positive response to the treatment today.
Patient reported an increase in his pain level today. Patient has been scheduled for meniscus surgery for next week.He tolerated well his treatment today. *Location:* knee: right. *Pain quality:* achy, dull, stiff; level: 3/10. *Range:* 8->9/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS= 22/80
1 Any of your usual work, housework, or school activities. 2
2 Your usual hobbies, re creational or sporting activities. 2
3 Getting into or out of the bath. 2
4 Walking between rooms. 2
5 Putting on your shoes or socks. 2
6 Squatting. 1
7 Lifting an object, like a bag of groceries from the floor. 1
8 Performing light activities around your home.2
9 Performing heavy activities around your home. 1
10 Getting into or out of a car. 2

11 Walking 2 blocks. 1
12 Walking a mile. 2
13 Going up or down 10 stairs (about 1 flight of stairs).1
14 Standing for 1 hour. 1
15 Sitting for 1 hour. 1
16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0
19 Hopping. 1
20 Rolling over in bed. 1

(+) Antalgic gait
(+) Bruising on the right knee and thigh
. *Left hip manual muscle testing:* flexion: 3/5; extension: 3/5; adduction: 3-/5; abduction: 3-/5; internal rotation: 3/5; external rotation: 3-/5. *Right hip manual muscle testing:* flexion: 3/5; extension: 3/5; adduction: 3/5; abduction: 3-/5; internal rotation: 3-/5; external rotation: 3/5. *Right Knee ROM (active):* flexion: 80/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3/5; knee adductors: 3/5; knee abductors: 3/5; hamstring: 3/5.

Assessment

LowerExtremity assessment: This patient is a 44 years old female who was referred for outpatient physical therapy services. Pt presents with difficulty with ADLs, decreased joint flexibility, and muscle strength. Pt will benefit from a therapy program. Patient requires skilled therapy to restore prior level of function utlizing the treatment and modalities in this POC.
Patient was seen and treated today through telehealth and completed all therapeutic exercises without any adverse effects.
. *Diagnosis:* M23.91 (Unspecified internal derangement of right knee), M25.561 (Pain in right knee), S83.241A (Oth tear of medial meniscus, current injury, r knee, init), S83.411A (Sprain of medial collateral ligament of right knee, init), S83.421A (Sprain of lateral collateral ligament of right knee, init). *CPT code(s):* 97140, 97110, 97014, 97010.

Treatment & Plan

Short term Goals:
1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

Long term Goals:
1. To eliminate pain and tenderness.
2. To improve on M strength to WNL.
3. To improve on Flexibility to WNL.
4. To improve function and endurance in doing ADL's to WNL.
   - 4.a Patient will be able to walk >1 hour without pain and difficulty
   - 4.b Patient will be able to sit >1 hour without pain, difficulty and the need to change position.
   - 4.c Patient will be able to stand >1 hour without pain and difficulty
   - 4.d Patient will be able to travel >2 hours without pain and difficulty
   - 4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes). ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)
. *Informed consent:* Patient agreed to begin care.

End of note. Electronically signed by XIMENA AZARIO PT on 07/26/2021 at 1:22pm

Abbreviations:
ADL: activities of daily living
ROM: range of motion
WNL: within normal limits

1215131663

NY MEDICAL & DIAGNOSTIC CENTER (TIN#: xx-xx05167)
80-46 KEW GARDENS RD
KEW GARDENS, NY 11415
718-261-1000
Today's date: July 29, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Wednesday July 28, 2021 Provider: XIMENA AZARIO PT

NPI#: 1497349880
Electronically signed by XIMENA AZARIO PT on 07/28/2021 at 1:47pm

Subjective

Lower Extremity:

Patient reports of significant improvement of pain and stiffness

Patient reports of the following improvements:

1. Patient can now tolerate 40mintues of standing
2. Patient can now tolerate 45 mintues of walking
3. Patient can now tolerate 45 mintues of sitting
4. Patient can now tolerate squatting with less difficulty
5. Patient can now tolerate knee flexion exercise with 20 lbs of weight
6. Patient can now tolerate knee extension exercise with 20 lbs of weight
7. Patient can do repetitive bending movement with less difficulty.
8. Patient can do housework with minimum to moderate difficulty

Patient reports some stiffness and tightness on Hamstring and calf ms, limited prolonged walking and standing.
Patient followed his exercise program and responded well to his treatment today.
Patient continues with his exercise plan and had a positive response to his treatment today.
Patient continues with his exercise program and responded well to his treatment today.
Patient reported less pain and less difficulty when he is walking longer periods of time.He tolerated his treatment well today.
Patient reported sitting for longer periods of time with less pain and discomfort. He tolerated his treatment well today.
Patient was seen and treated today and had a positive response to the treatment today.
Patient reported an increase in his pain level today. Patient has been scheduled for meniscus surgery for next week.He tolerated well his treatment today.
Patient came to treatment today. He will be up for surgery next week. The patient tolerated his treatment well today. *Location:* knee: right. *Pain quality:* achy, dull, stiff; level: 3/10. *Range:* 8->9/10. *Exacerbates symptoms:* sleeping; walking; working; movement; running.

Objective

Lower Extremity: Lower Extremity: LEFS= 22/80
1 Any of your usual work, housework, or school activities. 2
2 Your usual hobbies, re creational or sporting activities. 2
3 Getting into or out of the bath. 2
4 Walking between rooms. 2
5 Putting on your shoes or socks. 2
6 Squatting. 1
7 Lifting an object, like a bag of groceries from the floor. 1
8 Performing light activities around your home.2

9 Performing heavy activities around your home. 1
10 Getting into or out of a car. 2
11 Walking 2 blocks. 1
12 Walking a mile. 2
13 Going up or down 10 stairs (about 1 flight of stairs). 1
14 Standing for 1 hour. 1
15 Sitting for 1 hour. 1
16 Running on even ground. 1
17 Running on uneven ground. 0
18 Making sharp turns while running fast. 0
19 Hopping. 1
20 Rolling over in bed. 1

(+) Antalgic gait
(+) Bruising on the right knee and thigh
. *Left hip manual muscle testing:* flexion: 3/5; extension: 3/5; adduction: 3 /5; abduction: 3 /5; internal rotation: 3/5; external rotation: 3 /5. *Right hip manual muscle testing:* flexion: 3/5; extension: 3/5; adduction: 3/5; abduction: 3 /5; internal rotation: 3 /5; external rotation: 3/5. *Right Knee ROM (active):* flexion: 80/150 pain; extension: pain. *Right knee manual muscle testing:* quadriceps: 3/5; knee adductors: 3/5; knee abductors: 3/5; hamstring: 3/5.

Assessment

LowerExtremity assessment: This patient is a 44 years old female who was referred for outpatient physical therapy services. Pt presents with difficulty with ADLs, decreased joint flexibility, and muscle strength. Pt will benefit from a therapy program. Patient requires skilled therapy to restore prior level of function utlizing the treatment and modalities in this POC.
Patient was seen and treated today through telehealth and completed all therapeutic exercises without any adverse effects.
. *Diagnosis:* M23.91 (Unspecified internal derangement of right knee), M25.561 (Pain in right knee), S83.241A (Oth tear of medial meniscus, current injury, r knee, init), S83.411A (Sprain of medial collateral ligament of right knee, init), S83.421A (Sprain of lateral collateral ligament of right knee, init). *CPT code(s):* 97140, 97110, 97014, 97010.

Treatment & Plan

Short term Goals:
1. To decrease pain, m spasm and tenderness by atleast 2-3 levels
2. To increase flexibility and range of motion by atleast 5 degrees
3. To increase m strength by atleast 1 level
4. To increase functionality by doing ADL's with less difficulty.

Long term Goals:
1. To eliminate pain and tenderness.
2. To improve on M strength to WNL.
3. To improve on Flexibility to WNL.
4. To improve function and endurance in doing ADL's to WNL.
   - 4.a Patient will be able to walk >1 hour without pain and difficulty
   - 4.b Patient will be able to sit >1 hour without pain, difficulty and the need to change position.
   - 4.c Patient will be able to stand >1 hour without pain and difficulty
   - 4.d Patient will be able to travel >2 hours without pain and difficulty
   - 4.e Patient will be able to do activities of daily living such as bed mobility, transfers, stair management with ease.

Treatment & Plan
Patient treated to: relieve pain, improve ADL, improve strength.
Treatment schedule: 3x/week for 12 week.
Physical Modalities: muscle stimulation (15 minutes); therapeutic exercises (15 minutes); heat therapy (15 minutes) manual therapy (15 minutes). ultrasound therapy (15 minutes) Neuromuscular re education (15 minutes) Therapeutic activities (15 minutes) Gait training (15 minutes)

. *Informed consent:* Patient agreed to begin care.

End of note. Electronically signed by XIMENA AZARIO PT on 07/28/2021 at 1:47pm

Abbreviations:
ADL: activities of daily living
ROM: range of motion
WNL: within normal limits

NEW YORK MEDICAL & DIAGNOSTIC (TIN#: xx-xx05167)
80-46 Kew Gardens Road
Kew Gardens, NY 114151154
718-261-1000
Today's date: June 24, 2021

Patient: Bayani L Dillard #51372 DOB: 11/05/1976
Policy ID: 73141129

Tuesday June 22, 2021 Provider: Martin Gillman D.C.

NPI#: 1487640546
Electronically signed by Martin Gillman D.C. on 06/24/2021 at 7:53am

Patient name: Bayani Dillard
File number: 51372
Date of exam: June 22, 2021
Date of accident: June 11, 2021

History:

The patient reports that while working as an EMS work on June 11, 2021, he sustained injury to his right knee. The patient states that while jumping off the EMS vehicle, he landed awkwardly, and felt pain in his right knee. However, he was able to continue working. His knee continued to worsen over the next 1-2 hours. Later that day, while walking, his knee gave out on him and he fell to the ground, landing on his right knee. At that point he felt severe right knee pain. He went to the emergency room of a local hospital where he was examined, had a CT scan performed of the right knee and was then released.
He presents to our office for evaluation and treatment of his right knee work-related injury.

Review of systems:
General:
The patient denies any weakness, fatigue, weight loss or poor appetite.
Cardiac: Denies any kind of palpitations or heart murmur.
GI: Denies any nausea, vomiting, constipation or heartburn.
Psych: Denies any nervousness, insomnia, depression or anxiety.

Physical examination:
Psych: Patient appears to be alert, oriented x3 with good memory.
Skin: No lesions noted, normal color and texture.
Neck: Thyroid appears to be normal in size and non-tender to palpation.

Presenting chief complaints:

Patient reports significant pain and dysfunction of his right knee. He has difficulty arising from a seated position, walking, climbing up or down stairs or kneeling.
The patient has seen a medical doctor at our facility and will be receiving physical therapy treatment at our office for his injury.

NEW YORK MEDICAL & DIAGNOSTIC 80-46 Kew Gardens Road Kew Gardens, NY 114151154
Encounter dated 06/22/2021 for Bayani L Dillard #51372
DOB:11/05/1976 Today's date: 06/24/2021

Chiropractic care is not indicated for this injury.

Diagnosis:

Right knee internal derangement.

Dr. Martin Gillman

End of note. Electronically signed by Martin Gillman D.C. on 06/24/2021 at 7:53am