C2C DIAR [redacted]/872 12333 11-28-2012 2

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE DME

RECONSIDERATION REQUEST FORM Redetermination Number: _____

Contractor #: 18003, CIGNA Government Services, DME MAC - C

DIRECTIONS: If you wish to appeal this decision, at a minimum, complete/include information for items 1, 2a, 6 & 7. To serve you better, mail a copy of the decision letter and this form to:

C2C Solutions, Inc.
Qualified Independent Contractor (QIC)
P.O. Box 44013
Jacksonville, FL 32231-4103

1. NAME OF BENEFICIARY: [redacted]

2a. MEDICARE NUMBER: [redacted]

2b. CLAIM NUMBER (ICN/DCN), IF AVAILABLE: DCN 12255000125

3. PROVIDER NAME: Advanced Respiratory, Inc

4. PERSON APPEALING: _____ Beneficiary X Provider of Service

_____ Representative

5. ADDRESS OF PERSON APPEALING: 1849 Solutions Ctr, Chicago, IL 60677-1008.

6. ITEM OR SERVICE YOU WISH TO APPEAL: E0483

7. DATE OF SERVICE: FROM 09/27/2011 TO 10/27/2011

8. DOES THIS APPEAL INVOLVE AN OVERPAYMENT? _____ YES X NO

9. WHY DO YOU DISAGREE? WHAT ARE YOUR REASONS FOR YOUR APPEAL

We are requesting individual consideration for medical necessity based on the merits of the attached medical records.

10. DO YOU HAVE ANY SUPPORTING MATERIAL TO ASSIST YOUR APPEAL?
EXAMPLE: Medical Records, Office Records/Progress Notes, CMN

11. PRINTED NAME OF PERSON APPEALING: Eileen Brennan

12. SIGNATURE OF PERSON APPEALING: Eileen Brennan

DATE: 11/16/12

CGS
Jurisdiction C
P.O. Box 20010
Nashville, TN 37202

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE DME

November 3, 2012

Advanced Respiratory Inc
1849 Solutions Ctr
Chicago, IL 60677-1008

Beneficiary Name: [redacted] HICN: [redacted]
Appeal Number: 12255000125 Date of Service: September 27, 2011and October 27, 2011
Type of Service: High Frequency Chest Wall Oscillation Devices
Supplier: Advanced Respiratory Inc

Dear Advanced Respiratory Inc:

DECISION
This letter is to inform you of an UNFAVORABLE Medicare Appeal decision on the above referenced claims. Based on a new and independent review of the claims at issue, we find the high frequency chest wall oscillation is not covered by Medicare. The patient is not responsible for payment. If you disagree with this decision, you may appeal to the Qualified Independent Contractor (QIC), C2C Solutions, Inc., as explained in the Future Appeal Rights section of this letter.

SUMMARY OF FACTS
Claims were submitted for a high frequency chest wall oscillation for dates of service September 27, 2011 and October 27, 2011. The claims were initially denied because Medicare guidelines were not met. A redetermination request was received on September 11, 2012. The redetermination case included the following documentation: administrative and the medical records.

APPLICABLE MEDICARE GUIDELINES AND RULES
The Medicare coverage policies are set forth below for the item/service in question. These rules are available at www.cgsmedicare.com.

- CMS Medicare Coverage Database, Local Coverage Determination (LCD) ID (L12934), High Frequency Chest Wall Oscillation Devices
- Social Security Act, Section 1879, Limitation on Liability

EXPLANATION OF DECISION

The CMS Coverage Database LCD ID L12934-High Frequency Chest Wall Oscillation Devices, Indications and Limitations of Coverage and/or Medical Necessity states that high frequency chest wall oscillation devices (HFCWO)(E0483) are covered for patients who have one of the specific diagnoses outlined in the LCD. There must also be a well-documented failure of standard treatments to adequately mobilize retained secretions. If all the specific criteria are not met for the HFCWO, the claim will be denied as not medically necessary.

The Licensed Practical Nurse (LPN) has reviewed the medical documentation submitted and determined the HFCWO cannot be allowed because the documentation submitted failed to document failure of standard treatments to adequately mobilize retained secretions.

FINANCIAL RESPONSIBILITY

The Social Security Act (Section 1879) allows Medicare payment to be made for certain services for which payment would otherwise not be made. Payment may only be made if neither the supplier nor the beneficiary could reasonably have been expected to know these services were excluded by Medicare. This provision affects services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

After reviewing the claims, we have determined that the services were not reasonable and necessary. We have also determined the beneficiary could not have been expected to know these services were excluded from coverage. Prior to furnishing this service you did not obtain a valid signed Advance Beneficiary Notice of Noncoverage notifying the beneficiary that Medicare would not pay. Based on the information contained in the CMS Medicare Coverage Database, Local Coverage Determination (LCD) for High Frequency Chest Wall Oscillation Devices (L12934), you could have been expected to know these services were excluded. Therefore, you are liable for full charges for the services.

Beneficiaries who have incurred a charge for this service may be due a refund. In order to receive reimbursement, the beneficiary must submit the following to this office: (1) a copy of this notice, (2) the supplier's invoice, and (3) a receipt or other documents indicating the beneficiary has made payment.

FUTURE APPEALS RIGHTS

If you disagree with this decision, you must request a reconsideration, in writing, within 180 days of receiving this letter. Your reconsideration request must include a copy of this letter along with the beneficiary's name, Medicare number, item or service in question, date of service, name of person appealing, signature, and date of signature. You may request an appeal by using the form enclosed with this letter. A copy of the reconsideration request form is also located at www.cgsmedicare.com or at www.C2Cinc.com. Reconsideration requests must be mailed to:

C2C Solutions, Inc.
Attn: DME Qualified Independent Contractor (QIC)
P. O. Box 44013
Jacksonville, FL 32231-4103

All evidence should be submitted with the reconsideration request (including any additional evidence indicated in the Explanation of Decision section above). All evidence must be presented before the

reconsideration decision is issued. You will not be allowed to submit any new evidence to the Administrative Law Judge or further appeals unless you can demonstrate good cause for not submitting the evidence to the QIC during the reconsideration process.

If you need more information or have any questions, please visit our Web site at www.cgsmedicare.com or call 1-866-270-4909.

Sincerely,

CGS, DME MAC Jurisdiction C
Medicare Appeals Department

cc: [redacted]

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MEDICARE DME REDETERMINATION REQUEST FORM

SUPPLIER INFORMATION

Supplier Name:	Advanced Respiratory Inc
PTAN:	0828240001
NPI:	1053357905
Tax ID:	41-1419350
Address:	1849 Solution Center
City:	Chicago
State:	IL
Zip Code:	60677-1108
Phone Number:	800-426-4224

- O Jurisdiction A – NHIC, Corp.
- O Jurisdiction B – National Government Services
- ● Jurisdiction C – CIGNA Government Services
- O Jurisdiction D – Noridian Administrative Services

BENEFICIARY INFORMATION

Patient Name:	[redacted]
Medicare Number:	[redacted]
State:	[redacted]
Phone Number:	[redacted]

Requestor's Name/Supplier Contact Name:	Eileen Brennan
Requestor's Signature:	Eileen Brennan 9/11/12

Overpayment Appeal: ☐ Yes If yes, who requested overpayment: ☐ Medical Review ☐ ZPIC/PSC ☐ CERT ☐ RAC

Date of Service	HCPCS & Modifiers	CCN	Date of Initial Determination
9/27/2011	E0483 RRKJGZ	12243790170000	9/6/2012
10/27/2011	E0483 RRKJGZ	12244791286000	9/7/2012

Suggested Documentation Check List:

- ☒ Medicare Remittance Advice
- ☐ ABN
- ☒ CMN/DIF/Physician's Written Order
- ☒ Medical Documentation

Reasons/Rationale:

Please review the attached documentation for reasonable and necessary. We are requesting individual consideration outside LCD for high frequency chest wall oscillation therapy.

Fax Numbers:

NHIC, Corp	1-781-741-3118
National Government Services Inc.	1-317-595-4737
CIGNA Government Services	1-615-782-4630
Noridian Administrative Services, LLC	1-888-408-7405

3954549

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REMITTANCE ADVICE

PAYEE

ADVANCED RESPIRATORY, INC
1849 SOLUTIONS CTR
CHICAGO, IL 606771008
ID: 1053357905
Federal Tax ID: 411419350

PAYER

CGS - DME MAC JURISDICTION C
P O BOX 20010
NASHVILLE, TN 372020010
ID: 18003

CHECK INFORMATION

Remit Date: 09/06/2012
Wire/Check Amt.: $ 41,057.51
Check #: 042000012486683

Member ID Number: [redacted]
Patient Name: [redacted]
Production Date: 09/04/2012
Claim Status: 4 - Denied

Group: CGS - DME MAC JURISDICTION C
ICN/Claim Number: 12243790170000
Diagnosis Related Group: N/A
Patient Number: [redacted]
Type of Bill: 121 (Inpatient)

CLAIM DETAIL:

Procedure Code	Dates of Service	Submitted Charges	Adjustment Amount	Allowed Amount	Paid Charges
HC:E0483:RR:KJ:GZ	09/27/2011	$ 1,263.46	$ 0.00	$ 0.00	$ 0.00

Reported Charges:	$ 1,263.46	**Patient Resp:**	$ 0.00	**Total Paid Charges:**	$ 0.00
Denied Charges:	$ 1,263.46	**Copay/Coins:**	$ 0.00	**Total Allowed Charges:**	$ 0.00
		Deductible:	$ 0.00	**Total Adjustments:**	$ 0.00

ERA CODES:

MOA Remark Code	Description (Outpatient Adjudication Information)
MA13	Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
MA01	Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.

CAS Reason Code	Description	Amount
CO 50	NOT MEDICAL NECESSITY BY PAYOR	$ 1,263.46

CAS Group Code	Description
CO	Contractual Obligations

LQ Message Code	Description
HE M25	The information furnished does not substantiate the need for this level of service

C2C DIAR_00000011872 12333 11-28-2012 2

REMITTANCE ADVICE

PAYEE

ADVANCED RESPIRATORY, INC
1849 SOLUTIONS CTR
CHICAGO, IL 606771008
ID: 1053357905
Federal Tax ID: 411419350

PAYER

CGS - DME MAC JURISDICTION C
P O BOX 20010
NASHVILLE, TN 372020010
ID: 18003

CHECK INFORMATION

Remit Date: 09/07/2012
Wire/Check Amt.: $ 13,894.10
Check #: 042000012493492

Member ID Number: [redacted]
Patient Name: [redacted]
Production Date: 09/05/2012
Claim Status: 4 - Denied

Group: CGS - DME MAC JURISDICTION C
ICN/Claim Number: 12244791286000
Diagnosis Related Group: N/A
Patient Number: [redacted]
Type of Bill: 121 (Inpatient)

CLAIM DETAIL:

Procedure Code	Dates of Service	Submitted Charges	Adjustment Amount	Allowed Amount	Paid Charges
HC:E0483:RR:KJ:GZ	10/27/2011	$ 1,263.46	$ 0.00	$ 0.00	$ 0.00

Reported Charges:	$ 1,263.46	**Patient Resp:**	$ 0.00	**Total Paid Charges:**	$ 0.00
Denied Charges:	$ 1,263.46	**Copay/Coins:**	$ 0.00	**Total Allowed Charges:**	$ 0.00
		Deductible:	$ 0.00	**Total Adjustments:**	$ 0.00

ERA CODES:

MOA Remark Code	Description (Outpatient Adjudication Information)
MA13	Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
MA01	Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.

CAS Reason Code	Description	Amount
CO 50	NOT MEDICAL NECESSITY BY PAYOR	$ 1,263.46

CAS Group Code	Description
CO	Contractual Obligations

LQ Message Code	Description
HE M25	The information furnished does not substantiate the need for this level of service

C2C DIAR_0000001187 2 12333 11-28-201 2

ORDER FORM / PRESCRIPTION

The Vest. Airway Clearance System

INSTRUCTIONS:

1. Complete Order Form
2. Sign and date Prescription (No signature stamps accepted.)
3. Fax this form with copy of signed Patient Consent Form, if patient available.

1 ORDER INFORMATION (Please print)

Patient Name: [redacted] (First / Last) Birth date: 10 / 25 / 1930

Patient Address: [redacted] (Street / City / State / Zip) Gender: ☑ Male ☐ Female

Contact Name: _____ (If other than patient) ( ) relationship

Primary language: _____ (If other than English)

Day phone: [redacted] ☐ Home ☐ Work ☐ Cell

Evening phone: _____ ☐ Home ☐ Work ☐ Cell

Primary Pulmonary diagnosis: 494.0 Bronchiectasis

Secondary diagnosis: 516.3

Primary Care Physician (PCP): Allen Castello

PCP Phone #: 407-877-4458

Patient Insurance Information

	Insurance Company Name	Policy / ID #	Customer Service Phone Number
Primary	Medicare	[redacted]	877-847-4992
Secondary	Tricare		866-773-0404

2 PRESCRIPTION Prescriber must sign (no signature stamps accepted) and date prescription, and select the protocol.

Office of Dr. Jorge L. Hernandez

308 E. Hazel St. Orlando, FL 32804 (~~100 W Gore St Orlando, Fla 32806~~)

Phone: 407-895-4060 (~~407-835-0360~~)

Fax: (~~407-835-4070~~)

Rx The Vest™ airway clearance system

(select one - see reverse side for description)

☑ STANDARD ORDER (Lifetime Rx = 99 months) ☐ 30-DAY EVALUATION

Prescriber Signature: _____ Date: 10-19-10

Prescriber Name: (Please print) Jorge L. Hernandez (First / Last)

Prescriber's UPIN: F47939

PROTOCOL

	Standard	Custom
Treatments per day:	2	
Minutes per treatment:	20	
Frequencies:	10 - 14	
Minimum minutes of use per day:	10	

3 FAX THIS FORM AND ALL DOCUMENTS TO 1-800-870-8452

Completed by: Zulmary Phone: _____ Total # of pages: _____

Account # INST12257

Advanced Respiratory
now part of Hill-Rom

1020 West County Road F
St. Paul, Minnesota 55126
P: 800-426-4224 or 651-490-1468
F: 877-368-5081 or 651-234-1209
www.thevest.com

Medical Record Signature Attestation Statement

Note: This form provides a suggested format for a signature attestation statement. Submission of a signature attestation statement and use of this form is optional.

Name of Patient:	[redacted]
Medicare Number:	[redacted]

I, Jorge Hernandez (Print full name of physician/practitioner), hereby attest that the medical record entry for 10/19/10 (Date of service) accurately reflects signatures/notations that I made in my capacity as a(n) MD (Insert credentials, e.g. MD) when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

Signature of Author of the Medical Record

12-9-10

Date

In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry. Reviewers will not consider attestation statements where there is no associated medical record entry or someone other than the author (even a partner in the same group practice) of the medical record entry in question signs this statement.

C2C DIAR_00000011872 [illegible] 2012 2

HEALTH CENTRAL
10000 WEST COLONIAL DR.
OCOEE, FL. 34761
(407)296-1000

PT NAME: [redacted]
MRH: [redacted]
ACCT#: [redacted]
CK-IN#: 1110459

DOB: 10/25/30 78Y
LOC: O/P
ADM PHY: HERNANDEZ,JORGE L
EXAM DATE: 04/08/09 0741

Dr. JORGE L HERNANDEZ
308 EAST HAZEL STREET

ORLANDO FL 32804

Chk-in #	Order	Exam
1110459	0002	7126 CT THORAX WITH CONTRAST

Ord Diag: 518.3-PULMONARY EOSINOPHILIA

CT THORAX WITH CONTRAST

DATE: 4/8/09

INDICATION: Pulmonary eosinophilia. History of bilateral infiltrates.

COMPARISON: CT chest dated 7/17/06 and 11/6/06.

FINDINGS: The appearance of the chest is essentially unchanged when compared to the study from 11/6/06. There is some scarring posterior right apex and some linear interstitial changes predominantly in the lower lobes that I favor represents scarring and fibrosis. There is no frank pulmonary consolidation noted. There are no effusions. There is no mediastinal or hilar adenopathy. There are some small subcentimeter nodes in the aortopulmonary window.

CONCLUSION: Interstitial changes most consistent with interstitial fibrosis at the lung bases that shows little change when compared to the previous study. There is some slight bronchiectasis at the bases as well.

Job #594553
Health Central
RADIOLOGY CONSULTATION

[redacted]

FINAL

C2C DIAR_000000118721 HEALTH CENTRAL 8-2012 2

10000 WEST COLONIAL DR.
OCOEE, FL. 34761
(407)296-1000

PT NAME: [redacted]
MR#: [redacted]
ACCT#: [redacted]
CK-IN#: 1110459

DOB: 10/25/30 78Y
LOC: O/P
ADM PHY: HERNANDEZ,JORGE L
EXAM DATE: 04/08/09 0741

Dr. JORGE L HERNANDEZ
308 EAST HAZEL STREET

ORLANDO FL 32804

Checkin-Exam Code Summary
1110459-7126

Transcriptionist- ELLEN M BREMNER
Reading Radiologist- JOE F FRANKLIN
Releasing Radiologist- JOE F FRANKLIN
Released Date Time- 04/08/09 1703

DD : 4/8/09 0939
Report : 04/08 1256

Pulmonary Medicine Associates, P.A.
Jorge L. Hernandez, M.D., F.C.C.P.
Pulmonary Disease/ Critical Care/ Internal Medicine
308 E Hazel St. Orlando, Fl. 32804
Phone: (407) 895-9060 Fax: (407) 895-6010

Date: 7/7/09 **Referring Physician: Allen Castillo**

Patient's Name: [redacted] **Age:** 78

Chief Complaint: This is a patient with recurrent bronchitis with no recent respiratory complaints. He denies fever, chills or shortness of breath.

Physical Examination:

HR: 56 **T:** 97.7 **BP:** 139/69 **O2 sat:** 97 on room air **WT:** 177

Chest: Negative Lungs: Clear bilateral BS Cardiac: Normal sinus rhythm Extremities: No edema

CT thorax: 4/8/09 interstitial changes, no change compared with 7/17/06

Impressions:

1. **Lung scarring**
2. **Recurrent bronchitis**

Recommendations:

1. **Continue current therapy**

The patient was advised to contact our office in the interim should they develop any new onset or significant changes in symptoms to be evaluated sooner.

SCHEDULE A FOLLOW UP APPOINTMENT IN 4 motnhs JLH/rb

Jorge Hernandez, M.D. F.C.C.P.

FAXED 7.16.09

Pulm nary Medicine Associates, P.A.
Jorge L. Hernandez, M.D., F.C.C.P.
Pulmonary Disease/ Critical Care/ Internal Medicine
308 E Hazel St. Orlando, Fl. 32804
Phone: (407) 895-9060 Fax: (407) 895-6010

Date: 11/3/09 **Referring Physician: Allen Castello**

Patient's Name: [redacted] **Age:** 79

Chief Complaint: This is a patient with recurrent bronchitis. He has no complaints at this visit.

The 14 point review of systems is unremarkable except as noted above.

Physical Examination:

HR: 51 **T:** 97.7 **BP:** 138/66 **O2 sat:** 96 on room air **WT:** 177 **BMI:** 26

Chest: Negative **Lungs: Clear bilateral BS** **Cardiac: Normal sinus rhythm**
Extremities: No edema

Impressions:

1. **Bronchitis, resolved**
2. **Lung scarring**
3. **Ex-smoker**

Recommendations:

1. **Yearly CXR**
2. **Return in 6 months/PRN**

The patient was advised to contact our office in the interim should they develop any new onset or significant changes in symptoms to be evaluated sooner.

SCHEDULE A FOLLOW UP APPOINTMENT IN 6 months/PRN JLH/rb

Jorge Hernandez, M.D. F.C.C.P.

PULMONARY MEDICINE ASSOCIATES, P.A.
JORGE L. HERNANDEZ, M.D., F.C.C.P.
VERA ANDERSON, A.R.N.P.
Pulmonary Diseases / Critical Care / Internal Medicine
308 E. Hazel St., Orlando, FL 32804
Phone: (407) 895-9060 Fax: (407) 895-9010

RE: [redacted] 04/06/10

REFERRING PHYSICIAN: Allen R. Castello, M.D.

HISTORY OF PRESENT ILLNESS: This is a 79-year-old gentleman who is here for a 6-month followup with a history of interstitial lung disease. He is currently stable.

REVIEW OF SYSTEMS: At this time, review of systems is pertinent only for postnasal drainage; otherwise, negative.

PHYSICAL EXAMINATION: Afebrile at 97.6. Blood pressure is 106/68. Heart rate is 52. SPO2 is 95% on room air. He is 5 feet 9 inches, weighs 170 pounds. His BMI is 25. Alert, oriented, in no acute distress. HEENT: Unremarkable. Neck is supple. No JVD, bruit or lymphadenopathy. Chest is clear. Heart is with regular rate and rhythm. No S3. Abdomen is soft, nontender. Audible bowel sounds. Extremities: No clubbing, cyanosis or edema. Integument: Intact. Musculoskeletal: Without deficits noted.

LABORATORY DATA: PFT in 04/2009 shows normal spirometry and normal diffusion capacity.

IMPRESSION:
1. Interstitial lung disease.
2. Bronchiectasis, currently stable.

RECOMMENDATIONS:
1. CT thorax.
2. Annual followup.

Vera Anderson, A.R.N.P.

Jorge L. Hernandez, M.D.

VA/TC/2519224-000

FAXED 4-27-10

C2C DIAR_00000011872 12333 11-28-2012 2

Progress Notes

Patient: [redacted]
DOB: 10/25/1930 **Age:** 79 Y **Sex:** Male

Provider: Allen R. Castello, MD
Date: 06/16/2010

Reason for Appointment
1. Worsening arthralgias and back pain.

History of Present Illness
Obtained From The Patient:
79 year old male presents with c/o worsening arthritis and lower back pain. He would like a stronger hydrocodone tablet.

Current Medications
GlipiZIDE XL 2.5 MG 1 tablet Once a day
Micardis 40 MG 1 tablet Once a day
Hydrochlorothiazide 25 MG 1 tablet Once a day
Simvastatin 40 mg 1 tablet every evening Once a day
Fluticasone Propionate 50 MCG/ACT 1 puff in each nostril Once a day
Meclizine HCl 25 MG 1 tablet as needed for dizziness Three times a day
Nexium 40 mg 1 tablet as needed Once daily
Sertraline HCl 25 MG 1 tablet Once a day
Xalatan 0.005 % 1 drop into affected eye every evening Once a day
Cetirizine HCl 10 MG 1 tablet Once a day
Ambien CR 12.5 MG 1 tablet at bedtime as needed Once a day
Hydrocodone-Acetaminophen 10-500 MG 1 tablet as needed for pain every 6 hrs

Past Medical History
DM II
Hypertension
Hypercholesterolemia
CKD III
Osteoarthrosis
DDD
Glaucoma
Allergic rhinitis
Prostatism
Diverticulosis
Hemorrhoids
GERD

Surgical History
Appendectomy

Laminectomy
TUR

Family History
First Degree Relatives: Cancer

Social History
Tobacco: Yes.
Alcohol: Yes.
No Street drugs
No Previous blood transfusions.

Allergies
Penicillin
Ace Cough

Review of Systems

Non-Contributory

Vital Signs
HR 45, RR 12, BP 148/52, Wt 175, Ht 69, BMI 25.84.

Physical Examination
GENERAL:
Appears pleasant in no acute distress.
HEENT:
Eyes, ears, nose and throat are unremarkable.
NECK:
Neck is supple without lymphadenopathy.
CARDIAC:
Regular rate and rhythm without murmur, rub or gallop.
LUNGS:
Lungs are clear to auscultation bilaterally.
ABDOMEN:
Abdomen is soft, nontender, with normal bowel sounds.
EXTREMITIES:
No clubbing, cyanosis or edema.
NEUROLOGICAL:
Neurological exam is nonfocal.

Assessments
1. Diabetes Mellitus type II - 250.00 (Primary)
2. Hypertension - 401.9
3. Hypercholesterolemia - 272.0
4. Chronic kidney disease, Stage III - 585.3
5. Gastroesophageal reflux disease - 530.81
6. Hemorrhoids - 455.6
7. Diverticular disease of colon - 562.10
8. Prostatism - 600.00
9. Allergic rhinitis - 477.9
10. Glaucoma - 365.9
11. Osteoarthrosis - 715.90
12. Long term use of medications - V58.69

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13. Degeneration of lumbar or lumbosacral intervertebral disc - 722.52

Treatment

1. Diabetes Mellitus type II
Continue GlipiZIDE XL Tablet Extended Release 24 Hour, 2.5 MG, Orally, 90, 1 tablet, Once a day, 90 days, Refills 3
LAB: *Hemoglobin A1c (Ordered for 06/16/2010)

2. Hypertension
Continue Hydrochlorothiazide Tablet, 25 MG, Orally, 90, 1 tablet, Once a day, 90 days, Refills 3

3. Chronic kidney disease, Stage III
LAB: *BMP/eGFR (Ordered for 06/16/2010)
LAB: *Urinalysis, complete (Ordered for 06/16/2010)

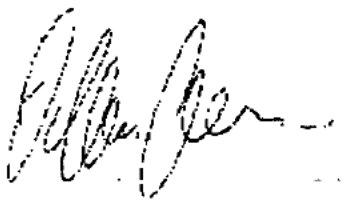
4. Gastroesophageal reflux disease
Continue Nexium Capsule Delayed Release, 40 mg, Orally, 90, 1 tablet as needed, Once daily, 90 days, Refills 3

5. Degeneration of lumbar or lumbosacral intervertebral disc
Continue Hydrocodone-Acetaminophen Tablet, 10-500 MG, Orally, 360, 1 tablet as needed for pain, every 8 hrs, 90, Refills 1

6. Others
Continue Sertraline HCl Tablet, 25 MG, Orally, 90, 1 tablet, Once a day, 90 days, Refills 3
Continue Ambien CR Tablet Extended Release, 12.5 MG, Orally, 90, 1 tablet at bedtime as needed, Once a day, 90 days, Refills 1

Procedure Codes
G8447 PT VISIT DOC USING CCHIT CER

Follow Up
3 Months



Electronically signed by Dr. Allen Castello on 09/15/2010 at 01:32 PM EDT

Sign off status: Completed

Pulmonary Medicine Associates, PA

Jorge L. Hernandez, M.D., F.C.C.P.
Pulmonary Medicine/Critical Care/Internal Medicine
308 E Hazel St. Orlando, Fl. 32804
Phone: 407-895-9060 Fax: 407-895-9010

Date: 10-19-10 **Referring Physician:** Allen Castello

Patient's Name: [redacted] **DOB:** _____

HPI: This 79 year old ___male/female (Non Ex Smoker) with TCD, bronchiectasis - c/o occ. cough [illegible]

Review of systems:

Constitutional	Negative	Fever/chills	Night sweats	Daytime hypersomnolence	
Neurologic	Negative	Vertigo	Neck stiffness	Headache	
HEENT	Negative	Ear pain	Post nasal drip	Head/Nasal congestion	
Respiratory	Negative	Dyspnea	rest / exertion	increased	no change improved
Cough	productive _____ dry	Hemoptysis	Wheezes	Nocturnal awakenings	
Cardiovascular	Negative	Chest pain	Chest congestion	Orthopnea	
Gastrointestinal	Negative	Nausea/emesis	Constipation	Diarrhea	Pain
Genitourinary	Negative	Urgency	Frequency	Dysuria	
Integumentary	Negative	Rash	Pruritis	Erythema	
Extremities	Negative	Edema	Ecchymosis	Calf pain	
Musculoskeletal	Negative	Myalgias	Arthalgias	Fatigue	Weakness

Nebulizer: _____ Rescue MDI: _____ Oxygen: _____nocturnal / _____continuous
Vest: _____ CPAP: _____ BiPAP: _____

Physical Exam:
T 97.5 BP: 134/62 HR: 50 RR: ____ SPO2: 96 on room air / oxygen ___lpm at rest
SPO2: _____ on room air with exertion
HT: 5'9" WT: 175 SPO2: _____ on oxygen ___lpm at rest

General:	No acute distress	Tachypneic			
HEENT:	Negative	Pharynx: erythema / exudate	Nose: Mucosa pink / erythematous		
Neck:	Negative	Adenopathy	Deviated trachea	JVD	Thyromegaly
Chest:	Negative	Pectus excavatum	Increase A-P diameter		
Lungs:	Clear	Wheezing	Rales	Rhonchi	Diminished/bases
	Bilat / R / L	Bilat / R / L	Bilat / R / L	Bilat / R / L	Bilat / R / L
Cardiac:	Regular sinus rhythm S1S2	Irregular	Murmur ____grade		Gallop
Abdomen:	Negative	Bowel sounds + / hypo / hyper	Organomegaly		Tenderness____
Extremities:	No edema	Edema _____ trace / 1+ / 2+ / 3+ / 4+	Clubbing		Cyanosis
		Homan's sign neg / pos	Calf tenderness		
Back:	Negative	Scoliosis	Lordosis	Kyphoscoliosis	

Diagnostic Studies:

3VTE
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PFT's: _____ Normal Other: _____
Chest x-ray _____ Normal Other: _____
CT Thorax: _____
CT Sinus: _____
PET scan: _____ Labs: _____
Fiber optic bronchoscopy: BAL _____ malignancy / _____ cultures

Impression: [illegible]

[illegible]

Recommendations: Continue current therapy / Bronchodilators
Chest x-ray CT thorax CT sinus HR CT thorax CTA r/o PE V/Q scan
Thoracentesis right / left _____ hospital PET scan . . .
Fiber optic bronchoscopy fluoro / without fluoro _____ hospital
CT FNA biopsy _____ hospital
Pulmonary function study Rehab swallow Esophagram Venous dopplers ____ Echo_____
Sleep study Overnight oximetry room air / oxygen __lpm / Cpap / Bipap
Oxygen ___lpm continuous / nocturnal ____lpm bled into Bipap / Cpap
Cpap ____cmH2O Bipap _____cmH2O

Labs: CBC BNP CMP LFT's ANA Ace level SCL-70 DS-DNA ESR RF
TSH IgG subclasses total IgE level Rast panel AAT Sputum culture

Medications: Prescription refills provided
Advair _____ Spiriva Symbicort _____ Qvar_____ Asmanex Singulair Zyflo
Nasonex Flonase Veramyst Saline spray Loratadine Clarinex Allegra
Protonix Nexium Omeprazole Aciphex Xolair Tussionex Tessalon Perles
Combivent Proventil Ventolin Proair Xopenex HFA Albuterol solution Atrovent solution
Duoneb solution Xopenx solution Perforomist Brovana Pulmicort
Medrol dose pack Prednisone _____
Zpak Cipro Levaquin Avelox Augmentin Omnicef _____

Referrals: _____
Education: Smoking cessation GERD precautions Weight loss / nutrition Flu / Pneumovax

Follow-up: _____ weeks 6 months ARNP MD Ocoee Orlando

C2C DIAR 00001187212333 11-28-2012

The Vest® Airway Clearance System

Advanced Respiratory, Inc.,
A Hill-Rom Company
1020 West County Road F
St. Paul, MN 55126

The Vest® System Training Checklist

Patient name: [redacted]

Place of Service (circle): Home Group Home Assisted Living Facility Other: _____

Others instructed: [redacted]

Trainer's name: [redacted]

Goal: *At the end of this session, the patient and/or caregiver will be able to perform The Vest® System therapy as prescribed by their physician.*

Training Objectives:

- [x] Review rationale for airway clearance therapy with patient/caregiver
- [x] Review safety instructions for The Vest® System with patient/caregiver
- [x] Patient/caregiver able to demonstrate proper vest fitting
- [x] Patient/caregiver able to demonstrate proper equipment set-up
- [x] Instruct patient/caregiver regarding the prescribed directions for use of The Vest® System
- [x] Patient/caregiver demonstrates ability to perform treatment as directed
- [x] Review location and purpose of hour meter
- [x] Verify patient/caregiver is aware of the need to properly ground The Vest® System during use. If an outlet adapter is required, it should be installed according to the manufacturer's instructions.
- [x] Explain Outcomes Monitoring Program and Reimbursement and Clinical Follow-up Calls
  - Patient/caregiver may be contacted at this number: [redacted]
  - This number is a (HOME) WORK MOBILE OTHER: _____
  - The best time of the day to call at this number is: _____
- [x] Verify Patient/caregiver receipt and awareness of The Vest® System User Manual and contents of the Welcome Folder including Patient Bill of Rights and Responsibilities, Community Resource Listing (including information on state specific agencies), Medicare Supplier Standards, Limited Lifetime Warranty, and Notice of Privacy Practices.
- [x] Provide the Advanced Respiratory, Inc., a Hill-Rom Company, toll free number for any questions regarding The Vest® System and/or the related materials provided.
- [x] Complete all training paperwork

ACKNOWLEDGMENT

The undersigned trainer and the undersigned patient/caregiver each acknowledge that all of the Training Objectives, as marked above, have been satisfactorily completed. The undersigned patient/caregiver further acknowledges receiving delivery of The Vest® System Model 105, serial number 62-01403

The undersigned patient/caregiver acknowledges receiving the Notice of Privacy Practices.

[redacted] _____ 10/27/2010

(Relationship if other than Patient) (Signature Date)

Bruce Brown RRT 10/27/2010

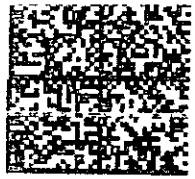
(Trainer's Signature) (Signature Date)

This form must be faxed to Advanced Respiratory, Inc., within 24 hours of training: 3954549

1-866-643-5787

Hill-Rom

Offered by Advanced Respiratory Inc., a Hill-Rom Company



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Hill-Rom Respiratory Care
1020 West County Road F
St Paul, MN 55126

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ADDRESS SERVICE REQUESTED

To:
C2C Solutions, Inc.
DME Quilified Indepandent Contractor
PO Box 44013
Jacksonville, FL 32231-4103

651-490-1468 **800-426-4224** 651-234-1209 Fax