IN THE SUPREME COURT OF THE STATE OF NEVADA

****

SUNRISE VILLAS IX HOMEOWNERS ASSOCIATION,

Appellant,

vs.

SIMONE RUSSO,

Respondent.

Case No. 83115

APPELLANT'S APPENDIX
VOLUME 14

ROBERT L. EISENBERG (SBN 950)
SARAH M. MOLLECK (SBN 13830)
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CHRONOLOGICAL INDEX TO APPELLANT'S APPENDIX

* *Plaintiff's Motion to Compel Settlement on Order Shortening Time* was added to the appendix after the first 17 volumes were complete and already numbered (3,750 pages)

Center for Disease, Surgery of the Spine

600 S Rancho Dr Suite 107 Las Vegas NV 891064806
Tel: (702) 254-7926 Fax: (702) 878-9642 Email:

ACCOUNT INQUIRY **05/24/2018 10:45 AM (PST)**

Account# 11130

Guarantor Information:

Simone Russo
4617 Madre Perla
Las Vegas, NV 89101

Home Tel#: (702) 792-4077
Work Tel#:

Patient Information:
Patient# 11130

Simone Russo
4617 Madre Perla
Las Vegas, NV 89101

Home Tel#: (702) 792-4077
Work Tel#:

Payor	Current	31-60 Days	61-90 Days	Over 90	Balance
Self	$25.00	$25.00	$0.00	$25.00	$75.00
Insur	$0.00	$0.00	$0.00	$80.41	$80.41
Collect	$0.00	$0.00	$0.00	$0.00	$0.00
				Unassigned:	$0.00
				Total Balance:	$155.41

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
09/20/2016	160360	THALGOTT	$465.00	$465.00	$0.00	Self-Pay		01/30/2017	0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party			Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE	THALGOTT	092216VJV1	Updated	09/23/2016	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
160360		THALGOTT		160360		09/23/2016	Electronic

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
09/20/2016	99213	25	Office Outpt Est15 Min	M54.12	Radiculopathy, cervical region	MEDICAL	1.00	$180.00	$180.00	$0.00

Mapped ICD9-1	Description
723.4	Neuritis, Brachial Nos

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
09/20/2016	72040		Radex Spi Crv 2/3 Views	M54.12	Radiculopathy, cervical region	XRAY	1.00	$135.00	$135.00	$0.00

Mapped ICD9-1	Description
723.4	Neuritis, Brachial Nos

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
09/20/2016	72100		Radex Spi Lumbosac 2/3 Views	M54.5	Low back pain	XRAY	1.00	$150.00	$150.00	$0.00

Payment Date	Reference	Coverage Type		Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
10/17/2016	883231449	Medical			$110.24			101716dmg1	Updated	10/20/2016			
10/17/2016	883231449	Medical			$326.63			101716dmg1	Updated	10/20/2016			
10/17/2016	883231449	Medical				Self-Pay	$28.13	101716dmg1	Updated	10/20/2016			

				Transfer							
10/17/2016	883231449		Self-Pay	Rebilled Claim			101716dmg1	Updated	10/20/2016		
10/20/2016	4456794295	Medical	TRANSAME	CHECK	$26.13		102016dmg1	Updated	11/02/2016		

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
09/22/2016	161590	THALGOTT	$270.00	$270.00	$0.00	Self-Pay		01/30/2017	0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party			Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE		092316VJV1	Updated	09/23/2016	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
161590		THALGOTT		161590		09/23/2016	Electronic

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
09/22/2016	99214		Office Outpt Est 25 Min	M54.16	Radiculopathy, lumbar region	MEDICAL	1.00	$270.00	$270.00	$0.00

Mapped ICD9-1	Description
724.4	Neuritis, Lumbosacral Nos

Payment Date	Reference	Coverage Type		Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
10/17/2016	883231449	Medical			$83.53			101716dmg1	Updated	10/20/2016			
10/17/2016	883231449	Medical			$165.16			101716dmg1	Updated	10/20/2016			
10/17/2016	883231449	Medical				Self-Pay	$21.31	101716dmg1	Updated	10/20/2016			
10/17/2016	883231449							101716dmg1	Updated	10/20/2016			
10/20/2016	4456794295	Medical			$21.31			102016dmg1	Updated	11/02/2016			

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
10/20/2016	168140	THALGOTT	$180.00	$180.00	$0.00	TRANSAME	Medical		0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party			Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE		103016VJV1	Updated	10/31/2016	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
168140		THALGOTT		168140		10/31/2016	Electronic

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
10/20/2016	99213		Office Outpt Est15 Min	M54.12	Radiculopathy, cervical region	MEDICAL	1.00	$180.00	$180.00	$0.00

Mapped ICD9-1	Description
723.4	Neuritis, Brachial Nos

Payment Date	Reference	Coverage Type		Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
11/15/2016	883263578	Medical			$56.74			111516dmg1	Updated	11/30/2016			
11/15/2016	883263578	Medical			$108.78			111516dmg1	Updated	11/30/2016			
11/15/2016	883263578	Medical				TRANSAME	$14.48	111516dmg1	Updated	11/30/2016			
11/15/2016	883263578	Medical						111516dmg1	Updated	11/30/2016			
11/28/2016	4456834393	Medical			$14.48			112816dmg1	Updated	11/30/2016			

RUSSO-00250

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
10/27/2016	169290	THALGOTT	$180.00	$180.00	$0.00	TRANSAME	Medical	01/12/2017	0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party			Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE		103116VJV5	Updated	10/31/2016	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
169290	Paper	THALGOTT		169290		10/31/2016	Electronic

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
10/27/2016	99213		Office Outpt Est15 Min	M48.02	Spinal stenosis, cervical region	MEDICAL	1.00	$180.00	$180.00	$0.00

Mapped ICD9-1	Description
723.0	Stenosis, Cervical Spinal

Payment Date	Reference	Coverage Type		Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
11/15/2016	883263578	Medical			$56.74			111516dmg1	Updated	11/30/2016			
11/15/2016	883263578	Medical			$108.78			111516dmg1	Updated	11/30/2016			
11/15/2016	883263576	Medical				TRANSAME	$14.48	111516dmg1	Updated	11/30/2016			
11/15/2016	883263578	Medical						111516dmg1	Updated	11/30/2016			
11/28/2016	4456034393	Medical			$14.48			112816dmg1	Updated	11/30/2016			

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
11/02/2016	175230	THALGOTT	$37,475.00	$37,475.00	$0.00	AMASUP	Medical	12/07/2016	0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
MTNVIEW1	CDSS	IPMTNVIE	THALGOTT	110216VJV5	Updated	12/07/2016	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
175230	Electronic	THALGOTT		175230		12/07/2016	Electronic

Voucher Notes

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
11/02/2016	22551		Arthrd Ant Interbody Decompress Cervical	M54.12	Radiculopathy, cervical region	SURGICAL	1.00	$10,500.00	$10,500.00	$0.00
11/02/2016	63075	XS	Dskc Ant Dcmprn Crv 1 Ntrspc	M54.12	Radiculopathy, cervical region	SURGICAL	1.00	$6,300.00	$6,300.00	$0.00
11/02/2016	63076	XS	Dskc Ant Dcmprn Crv Ea Ntrspc	M54.12	Radiculopathy, cervical region	SURGICAL	1.00	$1,675.00	$1,675.00	$0.00
11/02/2016	63081		Vcrpec Ant Dcmprn Crv 1 Sgm	M54.12	Radiculopathy, cervical region	SURGICAL	1.00	$9,450.00	$9,450.00	$0.00

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due

RUSSO-00251

11/02/2016	69990		Microsurg Tqs Req Use Oprating Mcrscp	M54.12	Radiculopathy, cervical region	SURGICAL	1.00	$2,200.00	$2,200.00	$0.00

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
11/02/2016	22846		Anterior Instrumentation 4-7 Vertebral S	M54.12	Radiculopathy, cervical region	SURGICAL	1.00	$4,050.00	$4,050.00	$0.00

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
11/02/2016	22851		Application Intervert Biomechanical	M54.12	Radiculopathy, cervical region	SURGICAL	1.00	$2,100.00	$2,100.00	$0.00

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
11/02/2016	20936		Autograft Spine Surgery Local From Same	M54.12	Radiculopathy, cervical region	SURGICAL	1.00	$1,000.00	$1,000.00	$0.00

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
11/02/2016	76000	26,XS	Fluor Spx <1 Hr Phys Tm Oth/Thn 71023/71	M54.12	Radiculopathy, cervical region	XRAY	1.00	$200.00	$200.00	$0.00

Payment Date	Reference	Coverage Type	Insurance	Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
12/22/2016	883303359	Medical	MEDICARE	CHECK	$3,088.64			122216dmg1	Updated	12/30/2016			
12/22/2016	883303359	Medical	MEDICARE	Commercial Insurance Adjustment	$19,898.43			122216dmg1	Updated	12/30/2016			
01/18/2017	883328045	Medical	MEDICARE	CHECK	$787.93			011817dmg1	Updated	01/31/2017			
01/12/2017	4456877565	Medical	AMASUP	CHECK	$787.93			011217dmg1	Updated	01/31/2017			
02/01/2017	883341612	Medical	MEDICARE	CHECK	$0.00			020117dmg1	Updated	02/28/2017			
02/01/2017	883341612	Medical	MEDICARE	Commercial Insurance Transfer		MEDICARE	$32,810.50	020117dmg1	Updated	02/28/2017			
04/10/2017	883411856	Medical	MEDICARE	CHECK	$685.23			041017BPR1	Updated	04/16/2017			
04/10/2017	883411856	Medical	MEDICARE	Medicare Adjustment	$9,639.97			041017BPR1	Updated	04/16/2017			
04/10/2017	883411856	Medical	MEDICARE	Commercial Insurance Transfer		AMASUP	$2,586.87	041017BPR1	Updated	04/16/2017			
07/17/2017	contract adj	Medical	AMASUP	Commercial Insurance Adjustment	$2,586.87			071717slb1	Updated	07/18/2017			

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
11/02/2016	175231	THALGOTT	$5,000.00	$5,000.00	$0.00	AMASUP	Medical	05/05/2017	0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
MTNVIEWI	CDSS	IPMTNVIE	THALGOTT	110216VJV5	Updated	12/07/2016	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
175230	Paper	THALGOTT		175230	MEDICARE	12/07/2016	Electronic

Voucher Notes
05052017--- billed 2nd with eobs – janet

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
11/02/2016	22552	XS	Arthrd Ant Interdy Cervcl Belw C2 Ea Add	M54.12	Radiculopathy, cervical region	SURGICAL	2.00	$5,000.00	$5,000.00	$0.00

Payment Date	Reference	Coverage Type	Insurance	Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
12/22/2016	883303359	Medical	MEDICARE	CHECK	$640.18			122216dmg1	Updated	12/30/2016			
12/22/2016	883303359	Medical	MEDICARE	Commercial	$4,196.51			122216dmg1	Updated	12/30/2016			

				Insurance Adjustment						
01/18/2017	883328045	Medical	MEDICARE	CHECK	($640.18)			011817dmg1	Updated	01/31/2017
01/18/2017	883328045	Medical	MEDICARE	Commercial Insurance Adjustment	($4,196.51)			011817dmg1	Updated	01/31/2017
01/12/2017	4456877565	Medical	AMASUP	CHECK	$163.31			011217dmg1	Updated	01/31/2017
02/01/2017	883341612	Medical	MEDICARE	CHECK	($640.18)			020117dmg1	Updated	02/28/2017
04/10/2017	883411856	Medical	MEDICARE	Medicare Adjustment	$476.87			041017BPR1	Updated	04/16/2017
04/10/2017	883411856	Medical	MEDICARE	CHECK	$640.18			041017BPR1	Updated	04/16/2017
04/10/2017	883411856	Medical	MEDICARE	Medicare Adjustment	$4,196.51			041017BPR1	Updated	04/16/2017
04/10/2017	883411856	Medical	MEDICARE	Commercial Insurance Transfer		AMASUP	$163.31	041017BPR1	Updated	04/16/2017
07/17/2017	w/o adj	Medical	AMASUP	Commercial Insurance Adjustment	$163.31			071717slb1	Updated	07/18/2017

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
11/15/2016	171620	THALGOTT	$135.00	$135.00	$0.00	AMASUP	Medical	02/03/2017	0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE	THALGOTT	111816ETT1	Updated	11/28/2016	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
171620	Electronic	THALGOTT		171620	MEDICARE	12/15/2016	Paper

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
11/15/2016	99024		Po F-Up Vst Related To Original Px	M54.12	Radiculopathy, cervical region	MEDICAL	1.00	$0.00	$0.00	$0.00

Mapped ICD9-1	Description
723.4	Neuritis, Brachial Nos

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
11/15/2016	72040		Radex Spl Crv 2/3 Views	M54.12	Radiculopathy, cervical region	XRAY	1.00	$135.00	$135.00	$0.00

Mapped ICD9-1	Description
723.4	Neuritis, Brachial Nos

Payment Date	Reference	Coverage Type	Insurance	Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
02/02/2017	Rebill Transaction	Medical	MEDICARE	Rebilled Claim				Rebill	Updated	02/02/2017			
02/17/2017	883359110	Medical	MEDICARE	CHECK	$26.04			021717BPR1	Updated	02/28/2017			
02/17/2017	883359110	Medical	MEDICARE	Medicare Adjustment	$102.32			021717BPR1	Updated	02/28/2017			
02/17/2017	883359110	Medical	MEDICARE	Medicare Transfer		AMASUP	$6.64	021717BPR1	Updated	02/28/2017			
03/08/2017	4456939173	Medical	AMASUP	CHECK	$6.64			030817BPR1	Updated	03/22/2017			

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
12/08/2016	171840	THALGOTT	$315.00	$315.00	$0.00	AMASUP	Medical	12/16/2016	0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By

OFFICE CDSS OFFICE THALGOTT 120816VOV1 Updated 12/16/2016 Simone Russo $0.00 $0.00

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
171840	Electronic	THALGOTT		171840	MEDICARE	12/16/2016	Electronic

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
12/08/2016	99213	25	Office Outpt Est15 Min	M48.02	Spinal stenosis, cervical region	MEDICAL	1.00	$180.00	$180.00	$0.00

Mapped ICD9-1	Description
723.4	Neuritis, Brachial Nos

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
12/08/2016	72040		Radex Spi Crv 2/3 Views	M48.02	Spinal stenosis, cervical region	XRAY	1.00	$135.00	$135.00	$0.00

Mapped ICD9-1	Description
723.4	Neuritis, Brachial Nos

Payment Date	Reference	Coverage Type	Insurance	Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
12/22/2016	314002366	Medical	MEDICARE	CHECK	$0.00			122216dmg1	Updated	12/30/2016			
01/03/2017	883313409	Medical	MEDICARE	CHECK	$82.78			010317dmg1	Updated	01/16/2017			
01/03/2017	883313409	Medical	MEDICARE	Commercial Insurance Adjustment	$211.10			010317dmg1	Updated	01/16/2017			
01/03/2017	883313409	Medical	MEDICARE	Commercial Insurance Transfer		AMASUP	$21.12	010317dmg1	Updated	01/16/2017			
02/07/2017	4456888576	Medical	AMASUP	CHECK	$21.12			020717dmg1	Updated	02/28/2017			

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
01/19/2017	185160	THALGOTT	$25.00	$25.00	$0.00	Self-Pay		01/30/2017	0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE		012417BPR1	Updated	01/26/2017	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
0		THALGOTT		185160	Self-Pay	01/30/2017	

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
01/19/2017	NOSHOW		No show	M54.5	Low back pain	OTHER	1.00	$25.00	$25.00	$0.00

Payment Date	Reference	Coverage Type	Insurance	Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
04/27/2017	Self pay write-off		Self-Pay	Self Pay Adjustment	$25.00			042617WOA1	Updated	05/01/2017			

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
01/24/2017	185240	THALGOTT	$25.00	$25.00	$0.00	Self-Pay		01/30/2017	0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE		012417BPR1	Updated	01/26/2017	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
0		THALGOTT		185240	Self-Pay	01/30/2017	

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
01/24/2017	NOSHOW		No show	M54.5	Low back pain	OTHER	1.00	$25.00	$25.00	$0.00

RUSSO-00254

Payment Date	Reference	Coverage Type	Insurance	Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
04/27/2017	self pay write-off		Self-Pay	Self Pay Adjustment	$25.00			042617WOA1	Updated	05/01/2017			

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
02/21/2017	189400	THALGOTT	$315.00	$315.00	$0.00	Self-Pay	Medical	04/01/2017	0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE	THALGOTT	022117BPR1	Updated	02/22/2017	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
189400		THALGOTT		189400	MEDICARE	02/22/2017	Electronic

Voucher Notes

per AMA pt was not covrd at the time of service -- transferd bal to pt

resp -- Janet

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
02/21/2017	99213	25	Office Outpt Est15 Min	M54.16	Radiculopathy, lumbar region	MEDICAL	1.00	$180.00	$180.00	$0.00

Mapped ICD9-1	Description
724.4	Neuritis, Lumbosacral Nos

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
02/21/2017	72040	FX	Radex Spl Crv 2/3 Views	M54.16	Radiculopathy, lumbar region	XRAY	1.00	$135.00	$135.00	$0.00

Mapped ICD9-1	Description
724.4	Neuritis, Lumbosacral Nos

Payment Date	Reference	Coverage Type	Insurance	Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
03/08/2017	883377148	Medical	MEDICARE	CHECK	$78.95			030817BPR1	Updated	03/22/2017			
03/08/2017	883377148	Medical	MEDICARE	Medicare Adjustment	$215.49			030817BPR1	Updated	03/22/2017			
03/08/2017	883377148	Medical	MEDICARE	Medicare Transfer		AMASUP	$20.56	030817BPR1	Updated	03/22/2017			
03/23/2017	transfer	Medical	AMASUP	Commercial Insurance Transfer		Self-Pay	$20.56	032317JLG1	Updated	03/23/2017			
03/23/2017	transfer		Self-Pay	Rebilled Claim				032317JLG1	Updated	03/23/2017			
04/17/2017	4456987262	Medical	AMASUP	CHECK	$20.56			041717BPR1	Updated	04/21/2017			

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
04/06/2017	198590	THALGOTT	$435.00	$435.00	$0.00	AMASUP	Medical	05/16/2017	0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE	THALGOTT	040617BPR3	Updated	04/07/2017	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
198590	Paper	THALGOTT		198590	MEDICARE	04/07/2017	Electronic

Voucher Notes

05052017\---- billed 2nd with eobs -- janet

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
04/06/2017	99214	25	Office Outpt Est 25 Min	M54.16	Radiculopathy, lumbar region	MEDICAL	1.00	$300.00	$300.00	$0.00

RUSSO-00255

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
04/06/2017	72040	FX	Radex Spi Crv 2/3 Views	M54.16	Radiculopathy, lumbar region	XRAY	1.00	$135.00	$135.00	$0.00

Payment Date	Reference	Coverage Type	Insurance	Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
05/01/2017	883434425	Medical	MEDICARE	CHECK	$105.56			050117BPR1	Updated	05/05/2017			
05/01/2017	883434425	Medical	MEDICARE	Medicare Adjustment	$297.60			050117BPR1	Updated	05/05/2017			
05/01/2017	883434425	Medical	MEDICARE	Sequestration Reduction	$4.36			050117BPR1	Updated	05/05/2017			
05/01/2017	883434425	Medical	MEDICARE	Commercial Insurance Transfer		AMASUP	$27.48	050117BPR1	Updated	05/05/2017			
05/01/2017	883434425	Medical	AMASUP	Rebilled Claim				050117BPR1	Updated	05/05/2017			
05/11/2017	4457021017	Medical	AMASUP	CHECK	$27.48			051117BPR1	Updated	05/18/2017			

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
08/15/2017	225840	THALGOTT	$25.00	$0.00	$25.00	Self-Pay		09/01/2017	265	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE		081517dmg1	Updated	08/17/2017	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
0		THALGOTT		225840	Self-Pay	09/01/2017	

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
08/15/2017	NOSHOW		No show	M54.5	Low back pain	OTHER	1.00	$25.00	$0.00	$25.00

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
08/22/2017	225190	THALGOTT	$585.00	$585.00	$0.00	AMASUP	Medical	08/22/2017	0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE	THALGOTT	082217dmg1	Updated	08/23/2017	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
225190	Electronic	THALGOTT		225190	MEDICARE	08/22/2017	Electronic

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
08/22/2017	99214	25	Office Outpt Est 25 Min	M48.02	Spinal stenosis, cervical region	MEDICAL	1.00	$300.00	$300.00	$0.00
08/22/2017	72040		Radex Spi Crv 2/3 Views	M48.02	Spinal stenosis, cervical region	XRAY	1.00	$135.00	$135.00	$0.00
08/22/2017	72100		Radex Spi Lumbosac 2/3 Views	M48.02	Spinal stenosis, cervical region	XRAY	1.00	$150.00	$150.00	$0.00

Payment Date	Reference	Coverage Type	Insurance	Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
09/15/2017	883574584	Medical	MEDICARE	EFT Payment	$136.40			091317dmg1	Updated	09/19/2017			
09/15/2017	883574584	Medical	MEDICARE	Commercial Insurance Adjustment	$410.30			091317dmg1	Updated	09/19/2017			
09/15/2017	883574584	Medical	MEDICARE	Sequestration Reduction	$2.79			091317dmg1	Updated	09/19/2017			
09/15/2017	883574584	Medical	MEDICARE	Commercial Insurance Transfer		AMASUP	$35.51	091317dmg1	Updated	09/19/2017			
09/15/2017	4457176126	Medical	AMASUP	CHECK	$35.51			092717dmg1	Updated	09/29/2017			

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient

11/28/2017	248670	THALGOTT	$585.00	$585.00	$0.00	AMASUP	Medical	11/30/2017	0 Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE	THALGOTT	112817slb1	Updated	11/30/2017	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
248670	Electronic	THALGOTT		248670	MEDICARE	11/30/2017	Electronic

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
11/28/2017	99214	25	Office Outpt Est 25 Min	M48.02	Spinal stenosis, cervical region	MEDICAL	1.00	$300.00	$300.00	$0.00
11/28/2017	72040		Radex Spi Crv 2/3 Views	Z98.1	Arthrodesis status	XRAY	1.00	$135.00	$135.00	$0.00
11/28/2017	72100		Radex Spi Lumbosac 2/3 Views	Z98.1	Arthrodesis status	XRAY	1.00	$150.00	$150.00	$0.00

Payment Date	Reference	Coverage Type	Insurance	Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
12/19/2017	883678583	Medical	MEDICARE	EFT Payment	$136.40			121917dmg1	Updated	12/30/2017			
12/19/2017	883678583	Medical	MEDICARE	Commercial Insurance Adjustment	$410.30			121917dmg1	Updated	12/30/2017			
12/19/2017	883678583	Medical	MEDICARE	Sequestration Reduction	$2.79			121917dmg1	Updated	12/30/2017			
12/19/2017	883678583	Medical	MEDICARE	Commercial Insurance Transfer		AMASUP	$35.51	121917dmg1	Updated	12/30/2017			
12/21/2017	4457286164	Medical	AMASUP	CHECK	$35.51			010318dmg1	Updated	01/10/2018			

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
12/28/2017	256140	THALGOTT	$300.00	$300.00	$0.00	AMASUP	Medical	01/03/2018	0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE		122817slb1	Updated	01/03/2018	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
256140	Electronic	THALGOTT		256140	MEDICARE	01/03/2018	Electronic

Voucher Notes
per patricia at 2dary the DOS paid on 01.18.18 CHK#4457314891.

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
12/28/2017	99214		Office Outpt Est 25 Min	M48.02	Spinal stenosis, cervical region	MEDICAL	1.00	$300.00	$300.00	$0.00

Mapped ICD9-1	Description
723.0	Stenosis, Cervical Spinal

Payment Date	Reference	Coverage Type	Insurance	Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
01/17/2018	883707090	Medical	MEDICARE	EFT Payment	$83.21			011718dmg1	Updated	01/19/2018			
01/17/2018	883707090	Medical	MEDICARE	Commercial Insurance Adjustment	$193.43			011718dmg1	Updated	01/19/2018			
01/17/2018	883707090	Medical	MEDICARE	Sequestration Reduction	$1.70			011718dmg1	Updated	01/19/2018			
01/17/2018	883707090	Medical	MEDICARE	Commercial Insurance Transfer		AMASUP	$21.66	011718dmg1	Updated	01/19/2018			
01/18/2018	4457314891	Medical	AMASUP	CHECK	$21.66			020218dmg1	Updated	02/27/2018			

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage	Billed Date	Age	Patient

							Type			
01/02/2018	257080	GODFREY	$435.00	$435.00	$0.00	AMASUP	Medical	01/04/2018	0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE	TMG	010218slb1	Updated	01/03/2018	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
257080	Electronic	GODFREY		257080	MEDICARE	01/04/2018	Electronic

Voucher Notes
02.19.18 slb- per patricia at secodary they pd 120.23 chk#445309630 pd on 01.12.18

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
01/02/2018	99214	25	Office Outpt Est 25 Min	Z98.1	Arthrodesis status	MEDICAL	1.00	$300.00	$300.00	$0.00

Mapped ICD9-1	Description
V45.4	Arthrodesis Status

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
01/02/2018	72040		Radex Spl Crv 2/3 Views	Z98.1	Arthrodesis status	XRAY	1.00	$135.00	$135.00	$0.00

Mapped ICD9-1	Description
V45.4	Arthrodesis Status

Payment Date	Reference	Coverage Type	Insurance	Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
01/10/2018	314319716	Medical	MEDICARE	EFT Payment	$0.00			011018dmg1	Updated	01/14/2018			
01/10/2018	314319716	Medical	MEDICARE	Commercial Insurance Adjustment	$314.77			011018dmg1	Updated	01/14/2018			
01/10/2018	314319716	Medical	MEDICARE	Commercial Insurance Transfer		AMASUP	$120.23	011018dmg1	Updated	01/14/2018			
01/12/2018	4457309630	Medical	AMASUP	CHECK	$120.23			020218dmg1	Updated	02/27/2018			

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
01/12/2018	263650	THALGOTT	$25,925.00	$25,844.59	$80.41	AMASUP	Medical	01/28/2018	116	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
VALLEY	CDSS	VHIP	THALGOTT	011218surl	Updated	01/28/2018	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
263650	Electronic	THALGOTT		263650	MEDICARE	01/28/2018	Electronic

Voucher Notes
02.19.18 slb- did a reopeing had to add a modifier to line 22830.
02.19.18 slb-conformation number 5718050490150

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
01/12/2018	63015		Lam W/O Ffd > 2 Vrt Seg Crv	M48.02	Spinal stenosis, cervical region	SURGICAL	1.00	$9,000.00	$9,000.00	$0.00

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
01/12/2018	22600		Arthrodesis Pst/Pstlat Cervical Belw C2	M48.02	Spinal stenosis, cervical region	SURGICAL	1.00	$5,850.00	$5,850.00	$0.00

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due

01/12/2018	22830		Exploration Spinal Fusion	M48.02	Spinal stenosis, cervical region	SURGICAL	1.00	$4,050.00	$3,969.59	$80.41

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
01/12/2018	22842		Posterior Segmental Instrumentation 3-6	M48.02	Spinal stenosis, cervical region	SURGICAL	1.00	$4,050.00	$4,050.00	$0.00

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
01/12/2018	20930		Allograft For Spine Surgery Only Morsell	M48.02	Spinal stenosis, cervical region	SURGICAL	1.00	$775.00	$775.00	$0.00

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
01/12/2018	20936		Autograft Spine Surgery Local From Same	M48.02	Spinal stenosis, cervical region	SURGICAL	1.00	$1,000.00	$1,000.00	$0.00

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
01/12/2018	20937		Autograft Spine Surgery Morsetized Sep I	M48.02	Spinal stenosis, cervical region	SURGICAL	1.00	$1,000.00	$1,000.00	$0.00

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
01/12/2018	76000	26,XS	Fluor Spx <1 Hr Phys Tm Oth/Thn 71023/71	M48.02	Spinal stenosis, cervical region	XRAY	1.00	$200.00	$200.00	$0.00

Payment Date	Reference	Coverage Type	Insurance	Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
02/12/2018	883432343	Medical	MEDICARE	EFT Payment	$2,352.86			021218dmg1	Updated	02/18/2018			
02/12/2018	883432343	Medical	MEDICARE	Commercial Insurance Adjustment	$18,867.83			021218dmg1	Updated	02/18/2018			
02/12/2018	883432343	Medical	MEDICARE	Sequestration Reduction	$48.02			021218dmg1	Updated	02/18/2018			
02/14/2018	4457344852	Medical	TRANSAME	CHECK	$695.29			022318dmg1	Updated	02/28/2018			
02/26/2018	883746581	Medical	MEDICARE	EFT Payment	$312.05			022618dmg1	Updated	02/28/2018			
02/26/2018	883746581	Medical	MEDICARE	Commercial Insurance Adjustment	$3,651.17			022618dmg1	Updated	02/28/2018			
02/26/2018	883746581	Medical	MEDICARE	Sequestration Reduction	$6.37			022618dmg1	Updated	02/28/2018			
02/26/2018	883746581	Medical	MEDICARE	Commercial Insurance Transfer		AMASUP	$80.41	022618dmg1	Updated	02/28/2018			
05/04/2018	medicare-883821916		Self-Pay	EFT Payment	$82.42			050418DCM1	Updated	05/14/2018			
05/04/2018	medicare-883821916		Self-Pay	Medicare Adjustment	($82.42)			050418DCM1	Updated	05/14/2018			

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
01/30/2018	263330	THALGOTT	$135.00	$135.00	$0.00	AMASUP	Medical	02/01/2018	0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE	THALGOTT	013018slb1	Updated	01/31/2018	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
263330	Electronic	THALGOTT		263330	MEDICARE	02/01/2018	Electronic

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
01/30/2018	99024		Po F-Up Vst Related To Original Px	M48.02	Spinal stenosis, cervical region	MEDICAL	1.00	$0.00	$0.00	$0.00

Mapped ICD9-1	Description
723.4	Neuritis, Brachial Nos

RUSSO-00259

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
01/30/2018	72040		Radex Spi Crv 2/3 Views	M54.12	Radiculopathy, cervical region	XRAY	1.00	$135.00	$135.00	$0.00

Payment Date	Reference	Coverage Type	Insurance	Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
02/16/2018	883738271	Medical	MEDICARE	EFT Payment	$25.24			021618dmg1	Updated	02/18/2018			
02/16/2018	883738271	Medical	MEDICARE	Commercial Insurance Adjustment	$102.73			021618dmg1	Updated	02/18/2018			
02/16/2018	883738271	Medical	MEDICARE	Sequestration Reduction	$0.52			021618dmg1	Updated	02/18/2018			
02/16/2018	883738271	Medical	MEDICARE	Commercial Insurance Transfer		AMASUP	$6.51	021618dmg1	Updated	02/18/2018			
02/20/2018	4457351471	Medical	AMASUP	CHECK	$6.51			030618DCM1	Updated	03/16/2018			
05/04/2018	medicare-883821916		Self-Pay	EFT Payment	$0.79			050418DCM1	Updated	05/14/2018			
05/04/2018	medicare-883821916		Self-Pay	Medicare Adjustment	($0.79)			050418DCM1	Updated	05/14/2018			

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
03/06/2018	272990	THALGOTT	$25.00	$0.00	$25.00	Self-Pay		04/09/2018	45	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE		030618DCM1	Updated	03/08/2018	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
0		THALGOTT		272990	Self-Pay	04/09/2018	

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
03/06/2018	NOSHOW		No show	M54.5	Low back pain	OTHER	1.00	$25.00	$0.00	$25.00

Mapped ICD9-1	Description
721.2	Lumbago

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
03/13/2018	272680	THALGOTT	$0.00	$0.00	$0.00	MEDICARE	Medical	04/05/2018	0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE		VRE031518billing21#	Updated	03/29/2018	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
272680	Electronic	THALGOTT		272680	MEDICARE	04/05/2018	Electronic

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
03/13/2018	99024		Po F-Up Vst Related To Original Px	M48.02	Spinal stenosis, cervical region	MEDICAL	1.00	$0.00	$0.00	$0.00

Mapped ICD9-1	Description
723.0	Stenosis, Cervical Spinal

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
03/13/2018	275250	THALGOTT	$285.00	$285.00	$0.00	AMASUP	Medical	04/20/2018	0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE	THALGOTT	VRE032818billing22#	Updated	04/16/2018	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
275250	Paper	THALGOTT		275250	MEDICARE	04/18/2018	Paper

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
03/13/2018	99024		Po F-Up Vst Related To Original Px	M48.02	Spinal stenosis, cervical region	MEDICAL	1.00	$0.00	$0.00	$0.00

Mapped ICD9-1	Description
723.0	Stenosis, Cervical Spinal

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
03/13/2018	72040		Radex Spi Crv 2/3 Views	M48.02	Spinal stenosis, cervical region	XRAY	1.00	$135.00	$135.00	$0.00

Mapped ICD9-1	Description
723.0	Stenosis, Cervical Spinal

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
03/13/2018	72100		Radex Spi Lumbosac 2/3 Views	M54.5	Low back pain	XRAY	1.00	$150.00	$150.00	$0.00

Mapped ICD9-1	Description
724.2	Lumbago

Payment Date	Reference	Coverage Type	Insurance	Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
04/05/2018	883788075	Medical	MEDICARE	EFT Payment	$51.85			040518DCM2	Updated	04/20/2018			
04/05/2018	883788075	Medical	MEDICARE	Commercial Insurance Adjustment	$218.73			040518DCM2	Updated	04/20/2018			
04/05/2018	883788075	Medical	MEDICARE	Sequestration Reduction	$1.06			040518DCM2	Updated	04/20/2018			
04/05/2018	883788075	Medical	MEDICARE	Commercial Insurance Transfer		AMASUP	$13.36	040518DCM2	Updated	04/20/2018			
04/09/2018	4457404758	Medical	AMASUP	CHECK	$13.36			041718DCM2	Updated	04/20/2018			
05/04/2018	medicare-883821916		Self-Pay	EFT Payment	$1.60			050418DCM1	Updated	05/14/2018			
05/04/2018	medicare-883821916		Self-Pay	Medicare Adjustment	($1.60)			050418DCM1	Updated	05/14/2018			

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
04/12/2018	282070	THALGOTT	$25.00	$0.00	$25.00	Self-Pay		05/04/2018	20	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE		041218DCM1	Updated	04/16/2018	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
0		THALGOTT		282070	Self-Pay	05/04/2018	

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
04/12/2018	NOSHOW		No show	M54.5	Low back pain	OTHER	1.00	$25.00	$0.00	$25.00

Mapped ICD9-1	Description
724.2	Lumbago

Center for Disease, Surgery of the Spine

600 S Rancho Dr Suite 107 Las Vegas NV 891064806
Tel: (702) 971-2343 Fax: (702) 878-9642 Email:

ACCOUNT INQUIRY **01/18/2019 10:04 AM (PST)**

Account# 11130

Guarantor Information:

Simone Russo
4617 Madre Perla
Las Vegas, NV 89101

Home Tel#: (702) 792-4077
Work Tel#:

Patient Information:
Patient# 11130

Simone Russo
4617 Madre Perla
Las Vegas, NV 89101

Home Tel#: (702) 792-4077
Work Tel#:

Payor	Current	31-60 Days	61-90 Days	Over 90	Balance
Self	$0.00	$0.00	$0.00	$0.00	$0.00
Insur	$1,380.00	$0.00	$0.00	$0.00	$1,380.00
Collect	$0.00	$0.00	$0.00	$0.00	$0.00
				Unassigned:	$0.00
				Total Balance:	$1,380.00

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
07/03/2018	306890	THALGOTT	$0.00	$0.00	$0.00	MEDICARE	Medical		0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE	THALGOTT	VRE091418MNeste2#	Updated, New Pmts	09/14/2018	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
306890		THALGOTT		306890	MEDICARE		

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
07/03/2018	99024		Po F-Up Vst Related To Original Px	M48.02	Spinal stenosis, cervical region	MEDICAL	1.00	$0.00	$0.00	$0.00

Diag2	Description	Diag3	Description	Diag4	Description
M54.5	Low back pain	M54.16	Radiculopathy, lumbar region		

Mapped ICD9-1	Description	Mapped ICD9-2	Description	Mapped ICD9-3	Description	Mapped ICD9-4	Description
723.0	Stenosis, Cervical Spinal	724.2	Lumbago	724.4	Neuritis, Lumbosacral Nos		

Payment Date	Reference	Coverage Type	Insurance	Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
08/27/2018	314539275	Medical	MEDICARE	EFT Payment	$0.00			VRE091418MNeste2#	Entered				

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
07/26/2018	312380	THALGOTT	$135.00	$0.00	$135.00	MEDICARE	Medical	01/11/2019	7	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE		072618Off1	Updated	08/16/2018	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
312380	Paper	THALGOTT		312380	MEDICARE	08/27/2018	Electronic

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
07/26/2018	99024		Po F-Up Vst Related To Original Px	M48.02	Spinal stenosis, cervical region	MEDICAL	1.00	$0.00	$0.00	$0.00

Diag2	Description	Diag3	Description	Diag4	Description
M54.12	Radiculopathy, cervical region	G82.50	Quadriplegia, unspecified		

Mapped ICD9-1	Description	Mapped ICD9-2	Description	Mapped ICD9-3	Description	Mapped ICD9-4	Description
723.0	Stenosis, Cervical Spinal	723.4	Neuritis, Brachial Nos	344.00	Quadriplegia Nos		

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
07/26/2018	72040		Radex Spi Crv 2/3 Views	M48.02	Spinal stenosis, cervical region	XRAY	1.00	$135.00	$0.00	$135.00

Diag2	Description	Diag3	Description	Diag4	Description
M54.12	Radiculopathy, cervical region				

Mapped ICD9-1	Description	Mapped ICD9-2	Description	Mapped ICD9-3	Description	Mapped ICD9-4	Description
723.0	Stenosis, Cervical Spinal	723.4	Neuritis, Brachial Nos				

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
08/09/2018	316760	THALGOTT	$0.00	$0.00	$0.00	MEDICARE	Medical		0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE	THALGOTT	080918Off1	Updated	08/23/2018	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
0		THALGOTT		316760	MEDICARE		

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
08/09/2018	99024		Po F-Up Vst Related To Original Px	M54.16	Radiculopathy, lumbar region	MEDICAL	1.00	$0.00	$0.00	$0.00

Diag2	Description	Diag3	Description	Diag4	Description
M48.02	Spinal stenosis, cervical region	Z98.1	Arthrodesis status		

Mapped ICD9-1	Description	Mapped ICD9-2	Description	Mapped ICD9-3	Description	Mapped ICD9-4	Description
724.4	Neuritis, Lumbosacral Nos	723.0	Stenosis, Cervical Spinal	V45.4	Arthrodesis Status		

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage	Billed Date	Age	Patient

							Type			
09/11/2018	326040	THALGOTT	$300.00	$300.00	$0.00	MEDICARE	Medical	01/11/2019	0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE	THALGOTT	091118Off1	Updated	09/19/2018	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
326040	Paper	THALGOTT		326040	MEDICARE	09/19/2018	Electronic

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
09/11/2018	99214		Office Outpt Est 25 Min	M54.12	Radiculopathy, cervical region	MEDICAL	1.00	$300.00	$300.00	$0.00

Diag2	Description	Diag3	Description	Diag4	Description
G82.50	Quadriplegia, unspecified	R26.0	Ataxic gait		

Mapped ICD9-1	Description	Mapped ICD9-2	Description	Mapped ICD9-3	Description	Mapped ICD9-4	Description
723.4	Neuritis, Brachial Nos	344.00	Quadriplegia Nos	781.2	Symptom, Abnormality, Gait		

Payment Date	Reference	Coverage Type	Insurance	Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
10/17/2018	16577494-001	Medical	AMASUP	INSURANCE PAYMENT	$21.58			101718MON1	Updated	12/20/2018			
10/04/2018	CHECK 883985558	Medical	MEDICARE	INSURANCE PAYMENT	$83.75			100418COM1	Updated	12/20/2018			
10/04/2018	CHECK 883985558	Medical	MEDICARE	Commercial Insurance Adjustment	$194.67			100418COM1	Updated	12/20/2018			

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
10/18/2018	339560	THALGOTT	$300.00	$300.00	$0.00	AMASUP	Medical	01/11/2019	0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE	THALGOTT	101818Off1	Updated	11/05/2018	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
339560	Paper	THALGOTT		339560	MEDICARE	11/05/2018	Electronic

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
10/18/2018	99214		Office Outpt Est 25 Min	M54.12	Radiculopathy, cervical region	MEDICAL	1.00	$300.00	$300.00	$0.00

Diag2	Description	Diag3	Description	Diag4	Description
M48.02	Spinal stenosis, cervical region				

Mapped ICD9-1	Description	Mapped ICD9-2	Description	Mapped ICD9-3	Description	Mapped ICD9-4	Description
723.4	Neuritis, Brachial Nos	723.0	Stenosis, Cervical Spinal				

Payment Date	Reference	Coverage Type	Insurance	Transaction	Pmt Amt	Transfer To	Trsf Amt	Batch#	Status	Date Updated	Void Batch#	Date Voided	Voided By
11/19/2018	CHECK 884037560	Medical	MEDICARE	INSURANCE PAYMENT	$83.75			111918MDC1	Updated	01/10/2019			

11/19/2018	CHECK 884037560	Medical	MEDICARE	Commercial Insurance Adjustment	$194.67		111918MDC1	Updated	01/10/2019
11/19/2018	CHECK 884037560	Medical	MEDICARE	Commercial Insurance Transfer		AMASUP $21.58	111918MDC1	Updated	01/10/2019
11/19/2018	CHECK 884037560	Medical	AMASUP	Rebilled Claim			111918MDC1	Updated	01/10/2019
12/04/2018	16708156-001	Medical	AMASUP	INSURANCE PAYMENT	$21.58		120418PAY1	Updated	01/15/2019

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
11/06/2018	342390	THALGOTT	$300.00	$0.00	$300.00	MEDICARE	Medical	01/11/2019	7	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE	THALGOTT	110618Off1	Updated	11/16/2018	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
342390	Paper	THALGOTT		342390	MEDICARE	11/16/2018	Electronic

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
11/06/2018	99214		Office Outpt Est 25 Min	M48.02	Spinal stenosis, cervical region	MEDICAL	1.00	$300.00	$0.00	$300.00

Diag2	Description	Diag3	Description	Diag4	Description
M54.16	Radiculopathy, lumbar region	R26.0	Ataxic gait		

Mapped ICD9-1	Description	Mapped ICD9-2	Description	Mapped ICD9-3	Description	Mapped ICD9-4	Description
723.0	Stenosis, Cervical Spinal	724.4	Neuritis, Lumbosacral Nos	781.2	Symptom, Abnormality, Gait		

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
12/11/2018	351440	THALGOTT	$345.00	$0.00	$345.00	MEDICARE	Medical	01/11/2019	7	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE		121118Off1	Updated	12/17/2018	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
351440	Paper	THALGOTT		351440	MEDICARE	12/17/2018	Electronic

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
12/11/2018	99213	25	Office Outpt Est15 Min	M54.16	Radiculopathy, lumbar region	MEDICAL	1.00	$210.00	$0.00	$210.00

Diag2	Description	Diag3	Description	Diag4	Description
M48.02	Spinal stenosis, cervical region	M54.5	Low back pain	R26.0	Ataxic gait

Mapped ICD9-1	Description	Mapped ICD9-2	Description	Mapped ICD9-3	Description	Mapped ICD9-4	Description
724.4	Neuritis, Lumbosacral Nos	723.0	Stenosis, Cervical Spinal	724.2	Lumbago	781.2	Symptom, Abnormality, Gait

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due

RUSSO-00266

12/11/2018	72040	Radex Spi Crv 2/3 Views	M48.02	Spinal stenosis, cervical region	XRAY	1.00	$135.00	$0.00	$135.00

Mapped ICD9-1	Description	Mapped ICD9-2	Description	Mapped ICD9-3	Description	Mapped ICD9-4	Description
723.0	Stenosis, Cervical Spinal						

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
12/13/2018	352960	THALGOTT	$300.00	$0.00	$300.00	MEDICARE	Medical	01/11/2019	7	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE	THALGOTT	121318Off1	Updated	12/18/2018	Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
352960	Paper	THALGOTT		352960	MEDICARE	12/18/2018	Electronic

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
12/13/2018	99214		Office Outpt Est 25 Min	M48.02	Spinal stenosis, cervical region	MEDICAL	1.00	$300.00	$0.00	$300.00

Diag2	Description	Diag3	Description	Diag4	Description
M54.12	Radiculopathy, cervical region	M62.838	Other muscle spasm		

Mapped ICD9-1	Description	Mapped ICD9-2	Description	Mapped ICD9-3	Description	Mapped ICD9-4	Description
723.0	Stenosis, Cervical Spinal	723.4	Neuritis, Brachial Nos	728.85	Spasm, Muscle		

Service Date	Voucher#	Provider	Chg Amt	Pmts/Adjs	Balance	Payor	Coverage Type	Billed Date	Age	Patient
01/15/2019	358450	THALGOTT	$300.00	$0.00	$300.00	MEDICARE	Medical		0	Simone Russo

Location	Department	Place Of Svc	Refer. Dr.	Batch#	Voucher Status	Date Updated	Responsible Party	Co-Ins Amt	Co-Ins Paid	Void Batch#	Date Voided	Voided By
OFFICE	CDSS	OFFICE	THALGOTT	011519Off1	Entered		Simone Russo	$0.00	$0.00			

Claim#	Bill Media	Billing Prov	Local Use Text	Orig Voucher#	Orig Payor	Orig Bill Date	Orig Media
0		THALGOTT		358450	MEDICARE		

Dates of Service	Procedure	Mods	Description	Diag1	Description	TOS	Units	Fee Amt	Pmts/Adjs	Amt Due
01/15/2019	99214		Office Outpt Est 25 Min	M54.12	Radiculopathy, cervical region	MEDICAL	1.00	$300.00	$0.00	$300.00

Diag2	Description	Diag3	Description	Diag4	Description
M48.02	Spinal stenosis, cervical region	M54.16	Radiculopathy, lumbar region		

Mapped ICD9-1	Description	Mapped ICD9-2	Description	Mapped ICD9-3	Description	Mapped ICD9-4	Description
723.4	Neuritis, Brachial Nos	723.0	Stenosis, Cervical Spinal	724.4	Neuritis, Lumbosacral Nos		

Center for Disease and Surgery of the Spine
600 South Rancho Drive Suite 107
Las Vegas, NV 89106
Phone: (702) 878-8370
Fax: (702) 878-9642

Simone Russo **Patient #:** 11130 **DOB:** 09/05/1942 (76 years)

Date of Encounter: 07/03/2018 02:57 PM

History of Present Illness *(John Thalgott, MD 07/03/2018 02:58 PM)*
The patient is a 75 year old male who presents for a follow up visit. The patient feels well with minor complaints. The patient has been compliant with instructions. Note for "Follow up": Patient is here to have his sutures removed.

Allergies *(John Thalgott, MD; 07/03/2018 02:58 PM)*
No Known Drug Allergies 02/02/2016

Past Medical History (John Thalgott, MD; *07/03/2018 02:58 PM)*
Hypertension (401.9 | I10)
Degenerative cervical spinal stenosis (723.0 | M48.02)
Low back pain (724.2 | M54.5)
Cervical radiculopathy at C6 (723.4 | M54.12)
Bilateral lumbar radiculopathy (724.4 | M54.16)
Quadriplegia (344.00 | G82.50)
Ataxic gait (781.2 | R26.0)
S/P cervical spinal fusion (V45.4 | Z98.1)

Social History *(John Thalgott, MD; 07/03/2018 02:58 PM)*
Tobacco use: Former smoker
Non Drinker/No Alcohol Use

Medication History *(John Thalgott, MD; 07/03/2018 02:58 PM)*
Medrol (2MG Tablet 1 (one) Package Oral use as directed, Taken starting 11/28/2017) Active - Hx Entry.
Norvasc (10MG Tablet Oral) Active - Hx Entry.
Losartan Potassium (100MG Tablet Oral) Active - Hx Entry.
Flomax (0.4MG Capsule Oral) Active - Hx Entry.
Hydrochlorothiazide (25MG Tablet Oral) Active - Hx Entry.
Elavil (100MG Tablet Oral) Active - Hx Entry.
Medications Reconciled Specific strength unknown - Active - Hx Entry.

Past Surgical *(John Thalgott, MD; 07/03/2018 02:58 PM)*
Lumbar Spine surgery
Shoulder Surgery

Review of Systems *(John Thalgott, MD; 07/03/2018 02:58 PM)*
General Not Present- Fatigue and Fever.
Skin Not Present- Rash.
HEENT Not Present- Headache, Hearing Loss and Visual Disturbances.
Respiratory Not Present- Cough and Difficulty Breathing.
Cardiovascular Not Present- Chest Pain, Shortness of Breath and Swelling of Extremities.
Gastrointestinal Not Present- Abdominal Pain and Difficulty Swallowing.
Musculoskeletal Present- Back Pain and Leg Pain.
Neurological Not Present- Dizziness, Numbness and Weakness.
Psychiatric Not Present- Anxiety.

Vitals *(John Thalgott, MD; 07/03/2018 02:58 PM)*

07/03/2018 02:58 PM
Weight: 210 lb (Patient reported) **Height:** 69 in (Patient reported)
Body Surface Area: 2.11 m² **Body Mass Index:** 31.01 kg/m²

Physical Exam *(John Thalgott, MD; 07/03/2018 03:28 PM)*
The physical exam findings are as follows:
stable and unchanged neruo unchanged. now with cervical c6 radiculapthy and weakness in to wrist extensors and limited rom of cervical c6.9/22/2016 now has severe radicular pain and is ataxic and this is a changed and now hypereflexic in knees jerk but is nonreflexic at ankle. 10/20/2016 unchanged ataxia with stable motor 10/27/2016 ataxia is worse and radiculapthys is better today 12/8/2016 neuro unchanged and having left c6 pain and gait is improved . 2/21/2017 stable and with antalgic and ataxic with decreased sensation at c6 on the left with decreased grip and pinch on the left 8/22/2017 stable with weak left upper in c6 and c7 12/28/2017 nwo much more ataxic and worsening of lower ext weakness and has had recent left cts release. 1/2/2017- Ataxic and unsteady gait. 1/30/2018 stable but still ataxic wound is healing and no signs of infection. 2/6/2018- Neuro intact, stable. Improved ataxic and antalgic gait. Well-healed surgical incision in posterior cervical incision. Left arm strength is 4/5 vs 5/5 on right. Decreased brachial DTR on the left side. 4/5 BLE leg strength. 3/13/2018 stable and unchanged with atrophy of left hand and discordiantion 6/5/2018 stable with weakness in upper and lower ext diffuse and still having clawing of the right hand 6/19/2019 stable with improving hand and lower motor fuction and better sensation 7/3/2018 stable neuro improved wounds clean and healing sutures out

Neurologic
Sensory - Paresthesia - Right hand, Left hand, Right L5 and Left L5. **Gait** - Broad-based.

Musculoskeletal
Spine/Ribs/Pelvis - Gait and Station - Abnormal Gait Patterns - antalgic gait and ataxic gait. Cervical Spine: Assessment of pain reveals the following findings: - The pain is characterized as - mild. Location - upper trapezius area, (R) and upper trapezius area, (L). Lumbosacral Spine: Inspection and Palpation - Tenderness - moderate, flank, (R) and flank, (L). Surrounding tissue tension/texture is - spasm. Strength and Tone - Functional Assessment - . Lumbosacral Spine - Functional Testing - Straight Leg Raising Test negative, Trendelenburg's Sign negative.

Assessment & Plan *(John Thalgott, MD; 07/03/201803:28 PM)*
Cervical radiculopathy at C6 (Working Diagnosis) (723.4 | M54.12)
Current Plans:

Degenerative cervical spinal stenosis (Established Diagnosis) (723.0 | M48.02)
Current Plans:

Ataxic gait (Principal Diagnosis) (781.2 | R26.0)
Current Plans:

S/P cervical spinal fusion (Principal Diagnosis) (V45.4 | Z98.1)
Current Plans:

John Thalgott MD

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Las Vegas, NV 89106
Phone: (702) 878-8370
Fax: (702) 878-9642

Simone Russo **Patient #:** 11130 **DOB:** 09/05/1942 (76 years)

Date of Encounter: 07/26/2018 04:47 PM

History of Present Illness *(John Thalgott, MD 07/26/2018 05:56 PM)*
The patient is a 75 year old male who presents for a follow up visit. The patient feels well with minor complaints. The patient has been compliant with instructions. Note for "Follow up": Patient has ulcers on his bottom and they hurt him alot. He does have an appointment with wound specialist and is hoping to go into the hypobarric chamber. xray shows stable spin and is improved alot post op c3 decompresion posterior

Allergies *(John Thalgott, MD; 07/26/2018 04:47 PM)*
No Known Drug Allergies 02/02/2016

Past Medical History (John Thalgott, MD; *07/26/2018 04:47 PM)*
Hypertension (401.9 | I10)
Degenerative cervical spinal stenosis (723.0 | M48.02)
Cervical radiculopathy at C6 (723.4 | M54.12)
Low back pain (724.2 | M54.5)
Bilateral lumbar radiculopathy (724.4 | M54.16)
Quadriplegia (344.00 | G82.50)
Ataxic gait (781.2 | R26.0)
S/P cervical spinal fusion (V45.4 | Z98.1)

Social History *(John Thalgott, MD; 07/26/2018 04:47 PM)*
Tobacco use: Former smoker
Non Drinker/No Alcohol Use

Medication History *(John Thalgott, MD; 07/26/2018 04:47 PM)*
Medrol (2MG Tablet 1 (one) Package Oral use as directed, Taken starting 11/28/2017) Active - Hx Entry.
Norvasc (10MG Tablet Oral) Active - Hx Entry.
Losartan Potassium (100MG Tablet Oral) Active - Hx Entry.
Flomax (0.4MG Capsule Oral) Active - Hx Entry.
Hydrochlorothiazide (25MG Tablet Oral) Active - Hx Entry.
Elavil (100MG Tablet Oral) Active - Hx Entry.
Medications Reconciled Specific strength unknown - Active - Hx Entry.

Past Surgical *(John Thalgott, MD; 07/26/2018 04:47 PM)*
Lumbar Spine surgery
Shoulder Surgery

Review of Systems *(John Thalgott, MD; 07/26/2018 04:47 PM)*
General Not Present- Fatigue and Fever.
Skin Not Present- Rash.
HEENT Not Present- Headache, Hearing Loss and Visual Disturbances.
Respiratory Not Present- Cough and Difficulty Breathing.
Cardiovascular Not Present- Chest Pain, Shortness of Breath and Swelling of Extremities.
Gastrointestinal Not Present- Abdominal Pain and Difficulty Swallowing.
Musculoskeletal Present- Back Pain and Leg Pain.
Neurological Not Present- Dizziness, Numbness and Weakness.
Psychiatric Not Present- Anxiety.

Vitals *(John Thalgott, MD; 07/26/2018 04:47 PM)*
07/26/2018 04:47 PM
Weight: 210 lb (Patient reported) **Height:** 69 in (Patient reported)
Body Surface Area: 2.11 m² **Body Mass Index:** 31.01 kg/m²

Physical Exam *(John Thalgott, MD; 07/26/2018 04:47 PM)*
The physical exam findings are as follows:
stable and unchanged neruo unchanged. now with cervical c6 radiculapthy and weakness in to wrist extensors and limited rom of cervical c6.9/22/2016 now has severe radicular pain and is ataxic and this is a changed and now hypereflexic in knees jerk but is nonreflexic at ankle. 10/20/2016 unchanged ataxia with stable motor 10/27/2016 ataxia is worse and radiculapthys is better today 12/8/2016 neuro unchanged and having left c6 pain and gait is improved . 2/21/2017 stable and with antalgic and ataxic with decreased sensation at c6 on the left with decreased grip and pinch on the left 8/22/2017 stable with weak left upper in c6 and c7 12/28/2017 nwo much more ataxic and worsening of lower ext weakness and has had recent left cts release. 1/2/2017- Ataxic and unsteady gait. 1/30/2018 stable but still ataxic wound is healing and no signs of infection. 2/6/2018- Neuro intact, stable. Improved ataxic and antalgic gait. Well-healed surgical incision in posterior cervical incision. Left arm strength is 4/5 vs 5/5 on right. Decreased brachial DTR on the left side. 4/5 BLE leg strength. 3/13/2018 stable and unchanged with atrophy of left hand and discordiantion 6/5/2018 stable with weakness in upper and lower ext diffuse and still having clawling of the right hand 6/19/2019 stable with improving hand and lower motor fuction and better sensation 7/3/2018 stable neuro improved wounds clean and healing sutures out

Neurologic
Sensory - Paresthesia - Right hand, Left hand, Right L5 and Left L5. **Gait** - Broad-based.

Musculoskeletal
Spine/Ribs/Pelvis - Gait and Station - Abnormal Gait Patterns - antalgic gait and ataxic gait. Cervical Spine: Assessment of pain reveals the following findings: - The pain is characterized as - mild. Location - upper trapezius area, (R) and upper trapezius area, (L). Lumbosacral Spine: Inspection and Palpation - Tenderness - moderate, flank, (R) and flank, (L). Surrounding tissue tension/texture is - spasm. Strength and Tone - Functional Assessment - . Lumbosacral Spine - Functional Testing - Straight Leg Raising Test negative, Trendelenburg's Sign negative.

Assessment & Plan *(John Thalgott, MD; 07/26/201805:57 PM)*

Degenerative cervical spinal stenosis (Established Diagnosis) (723.0 | M48.02)
Current Plans:

Cervical radiculopathy at C6 (Working Diagnosis) (723.4 | M54.12)
Current Plans:

Quadriplegia (Established Diagnosis) (344.00 | G82.50)
Current Plans:
- X-ray of cervical spine, 2 or 3 views (72040) Routine (stable post op)
- Follow up in 2 months or as needed

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Simone Russo **Patient #:** 11130 **DOB:** 09/05/1942 (76 years)

Date of Encounter: 08/09/2018 03:46 PM

History of Present Illness *(John Thalgott, MD 08/09/2018 03:49 PM)*
The patient is a 75 year old male who presents for a follow up visit. The patient is gradually improving. The patient has been compliant with instructions. Current medication use: no side effects. The patient sleeps an average of 7 hours per night. Note for "Follow up": pt in today follow up 8 weeks surgery PCF , and doing great. pt is improving, pt had home physical therapy and now has completed, needs new referral for out pt P.T.

Allergies *(John Thalgott, MD; 08/09/2018 03:49 PM)*
No Known Drug Allergies 02/02/2016

Past Medical History (John Thalgott, MD; *08/09/2018 03:49 PM)*
Hypertension (401.9 | I10)
Degenerative cervical spinal stenosis (723.0 | M48.02)
Bilateral lumbar radiculopathy (724.4 | M54.16)
Low back pain (724.2 | M54.5)
Cervical radiculopathy at C6 (723.4 | M54.12)
Ataxic gait (781.2 | R26.0)
Quadriplegia (344.00 | G82.50)
S/P cervical spinal fusion (V45.4 | Z98.1)

Social History *(John Thalgott, MD; 08/09/2018 03:49 PM)*
Tobacco use: Former smoker
Non Drinker/No Alcohol Use

Past Surgical *(John Thalgott, MD; 08/09/2018 03:49 PM)*
Lumbar Spine surgery
Shoulder Surgery

Review of Systems *(John Thalgott, MD; 08/09/2018 03:49 PM)*
General Not Present- Fatigue and Fever.
Skin Not Present- Rash.
HEENT Not Present- Headache, Hearing Loss and Visual Disturbances.
Respiratory Not Present- Cough and Difficulty Breathing.
Cardiovascular Not Present- Chest Pain, Shortness of Breath and Swelling of Extremities.
Gastrointestinal Not Present- Abdominal Pain and Difficulty Swallowing.
Musculoskeletal Present- Back Pain and Leg Pain.
Neurological Not Present- Dizziness, Numbness and Weakness.
Psychiatric Not Present- Anxiety.

Vitals *(John Thalgott, MD; 08/09/2018 03:49 PM)*
08/09/2018 03:49 PM
Weight: 210 lb (Patient reported) **Height:** 69 in (Patient reported)
Body Surface Area: 2.11 m² **Body Mass Index:** 31.01 kg/m²

Physical Exam *(John Thalgott, MD; 08/09/2018 03:53 PM)*
The physical exam findings are as follows:
stable and unchanged neruo unchanged. now with cervical c6 radiculapthy and weakness in to wrist extensors and limited rom of cervical c6.9/22/2016 now has severe radicular pain and is ataxic and this is a changed and now hypereflexic in knees jerk but is nonreflexic at ankle. 10/20/2016 unchanged ataxia with stable motor 10/27/2016 ataxia is worse and radiculapthys is better today 12/8/2016 neuro unchanged and having left c6 pain and gait is improved . 2/21/2017 stable and with antalgic and ataxic with decreased sensation at c6 on the left with decreased grip and pinch on the left 8/22/2017 stable with weak left upper in c6 and c7 12/28/2017 nwo much more ataxic and worsening of lower ext weakness and has had recent left cts release. 1/2/2017- Ataxic and unsteady gait. 1/30/2018 stable but still ataxic wound is healing and no signs of infection. 2/6/2018- Neuro intact, stable. Improved ataxic and antalgic gait. Well-healed surgical incision in posterior cervical incision. Left arm strength is 4/5 vs 5/5 on right. Decreased brachial DTR on the left side. 4/5 BLE leg strength. 3/13/2018 stable and unchanged with atrophy of left hand and discordiantion 6/5/2018 stable with weakness in upper and lower ext diffuse and still having clawing of the right hand 6/19/2019 stable with improving hand and lower motor fuction and better sensation 7/3/2018 stable neuro improved wounds clean and healing sutures out 8/9/2018 stable and unchanged wound clean and healing neuro much improved with ataxic gait

Neurologic
Sensory - Paresthesia - Right hand, Left hand, Right L5 and Left L5. **Gait** - Broad-based.

Musculoskeletal
Spine/Ribs/Pelvis - Gait and Station - Abnormal Gait Patterns - antalgic gait and ataxic gait. Cervical Spine: Assessment of pain reveals the following findings: - The pain is characterized as - mild. Location - upper trapezius area, (R) and upper trapezius area, (L). Lumbosacral Spine: Inspection and Palpation - Tenderness - moderate, flank, (R) and flank, (L). Surrounding tissue tension/texture is - spasm. Strength and Tone - Functional Assessment - . Lumbosacral Spine - Functional Testing - Straight Leg Raising Test negative, Trendelenburg's Sign negative.

Assessment & Plan *(John Thalgott, MD; 08/09/201803:54 PM)*

Low back pain (Principal Diagnosis) (724.2 | M54.5)
Current Plans:
- Follow up in 1 month or as needed

Bilateral lumbar radiculopathy (Principal Diagnosis) (724.4 | M54.16)
Current Plans:

Degenerative cervical spinal stenosis (Established Diagnosis) (723.0 | M48.02)
Current Plans:

Cervical radiculopathy at C6 (Working Diagnosis) (723.4 | M54.12)
Current Plans:

Quadriplegia (Established Diagnosis) (344.00 | G82.50)
Current Plans:

Ataxic gait (Principal Diagnosis) (781.2 | R26.0)
Current Plans:

S/P cervical spinal fusion (Principal Diagnosis) (V45.4 | Z98.1)
Current Plans:

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Simone Russo **Patient #:** 11130 **DOB:** 09/05/1942 (76 years)

Date of Encounter: 09/11/2018 04:12 PM

History of Present Illness *(John Thalgott, MD 09/11/2018 04:51 PM)*
The patient is a 76 year old male who presents for a follow up visit. The patient feels well with minor complaints. The patient has been compliant with instructions. Note for "Follow up": Patient is going to PT for 3 times a week for the past couple of weeks. pt is now partially wheelchair depended and has been progressive witgh upper and lower ext. weakness which has waxed and wanned and no w is somewhat stabale but the prognosis is porr and will need constant care in future with possible assisited living situation because of weakness and progressive inablilty for self care and is highly possible will need home care in near future will skilled nursing and PT/OT. Also is now not a comunity ambulator and requires assistance when outside the home in terms of driving and access to buildings store doctors office and obtaining supplies.

Allergies *(John Thalgott, MD; 09/11/2018 04:14 PM)*
No Known Drug Allergies 02/02/2016

Past Medical History (John Thalgott, MD; *09/11/2018 04:14 PM)*
Hypertension (401.9 | I10)
Degenerative cervical spinal stenosis (723.0 | M48.02)
Cervical radiculopathy at C6 (723.4 | M54.12)
Low back pain (724.2 | M54.5)
Bilateral lumbar radiculopathy (724.4 | M54.16)
Ataxic gait (781.2 | R26.0)
Quadriplegia (344.00 | G82.50)
S/P cervical spinal fusion (V45.4 | Z98.1)

Social History *(John Thalgott, MD; 09/11/2018 04:14 PM)*
Tobacco use: Former smoker
Non Drinker/No Alcohol Use

Medication History *(John Thalgott, MD; 09/11/2018 04:14 PM)*
Medrol (2MG Tablet 1 (one) Package Oral use as directed, Taken starting 11/28/2017) Active - Hx Entry.
Norvasc (10MG Tablet Oral) Active - Hx Entry.
Losartan Potassium (100MG Tablet Oral) Active - Hx Entry.
Flomax (0.4MG Capsule Oral) Active - Hx Entry.
Hydrochlorothiazide (25MG Tablet Oral) Active - Hx Entry.
Elavil (100MG Tablet Oral) Active - Hx Entry.
Medications Reconciled Specific strength unknown - Active - Hx Entry.

Past Surgical *(John Thalgott, MD; 09/11/2018 04:14 PM)*
Lumbar Spine surgery
Shoulder Surgery

Review of Systems *(John Thalgott, MD; 09/11/2018 04:13 PM)*
General Not Present- Fatigue and Fever.
Skin Not Present- Rash.
HEENT Not Present- Headache, Hearing Loss and Visual Disturbances.
Respiratory Not Present- Cough and Difficulty Breathing.
Cardiovascular Not Present- Chest Pain, Shortness of Breath and Swelling of Extremities.
Gastrointestinal Not Present- Abdominal Pain and Difficulty Swallowing.
Musculoskeletal Present- Back Pain and Leg Pain.
Neurological Not Present- Dizziness, Numbness and Weakness.
Psychiatric Not Present- Anxiety.

Vitals *(John Thalgott, MD; 09/11/2018 04:14 PM)*
09/11/2018 04:14 PM
Weight: 210 lb (Patient reported) **Height:** 69 in (Patient reported)
Body Surface Area: 2.11 m² **Body Mass Index:** 31.01 kg/m²

Physical Exam *(John Thalgott, MD; 09/11/2018 04:52 PM)*
The physical exam findings are as follows:
stable and unchanged neruo unchanged. now with cervical c6 radiculapthy and weakness in to wrist extensors and limited rom of cervical c6.9/22/2016 now has severe radicular pain and is ataxic and this is a changed and now hypereflexic in knees jerk but is nonreflexic at ankle. 10/20/2016 unchanged ataxia with stable motor 10/27/2016 ataxia is worse and radiculapthys is better today 12/8/2016 neuro unchanged and having left c6 pain and gait is improved . 2/21/2017 stable and with antalgic and ataxic with decreased sensation at c6 on the left with decreased grip and pinch on the left 8/22/2017 stable with weak left upper in c6 and c7 12/28/2017 nwo much more ataxic and worsening of lower ext weakness and has had recent left cts release. 1/2/2017- Ataxic and unsteady gait. 1/30/2018 stable but still ataxic wound is healing and no signs of infection. 2/6/2018- Neuro intact, stable. Improved ataxic and antalgic gait. Well-healed surgical incision in posterior cervical incision. Left arm strength is 4/5 vs 5/5 on right. Decreased brachial DTR on the left side. 4/5 BLE leg strength. 3/13/2018 stable and unchanged with atrophy of left hand and discordiantion 6/5/2018 stable with weakness in upper and lower ext diffuse and still having clawling of the right hand 6/19/2019 stable with improving hand and lower motor fuction and better sensation 7/3/2018 stable neuro improved wounds clean and healing sutures out 8/9/2018 stable and unchanged wound clean and healing neuro much improved with ataxic gait 9/11/2018 stable with very severe ataxic gait with wheelchair today and diffuse weakness in both lower ext.

Neurologic
Sensory - Paresthesia - Right hand, Left hand, Right L5 and Left L5. **Gait** - Broad-based.

Musculoskeletal
Spine/Ribs/Pelvis - Gait and Station - Abnormal Gait Patterns - antalgic gait and ataxic gait. Cervical Spine: Assessment of pain reveals the following findings: - The pain is characterized as - mild. Location - upper trapezius area, (R) and upper trapezius area, (L). Lumbosacral Spine: Inspection and Palpation - Tenderness - moderate, flank, (R) and flank, (L). Surrounding tissue tension/texture is - spasm. Strength and Tone - Functional Assessment - . Lumbosacral Spine - Functional Testing - Straight Leg Raising Test negative, Trendelenburg's Sign negative.

Assessment & Plan *(John Thalgott, MD; 09/11/201804:53 PM)*
Quadriplegia (Established Diagnosis) (344.00 | G82.50)
Current Plans:

Cervical radiculopathy at C6 (Working Diagnosis) (723.4 | M54.12)
Current Plans:

Ataxic gait (Principal Diagnosis) (781.2 | R26.0)
Current Plans:
- Follow up in 1 month or as needed

John Thalgott MD

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Simone Russo **Patient #:** 11130 **DOB:** 09/05/1942 (76 years)

Date of Encounter: 10/18/2018 01:59 PM

History of Present Illness *(John Thalgott, MD 10/18/2018 02:01 PM)*
The patient is a 76 year old male who presents for a follow up visit. The patient feels well with minor complaints. The patient has been compliant with instructions. Current medication use: no side effects. Note for "Follow up": Patient is having some problems with shortness of breathe. He belives that it is a trachea problem. He is also still having the neuropathic pain. He is not taking any neuontain or pain medicaitons.

Allergies *(John Thalgott, MD; 10/18/2018 02:01 PM)*
No Known Drug Allergies 02/02/2016

Past Medical History (John Thalgott, MD; *10/18/2018 02:01 PM)*
Hypertension (401.9 | I10)
Low back pain (724.2 | M54.5)
Bilateral lumbar radiculopathy (724.4 | M54.16)
Degenerative cervical spinal stenosis (723.0 | M48.02)
Cervical radiculopathy at C6 (723.4 | M54.12)
Ataxic gait (781.2 | R26.0)
Quadriplegia (344.00 | G82.50)
S/P cervical spinal fusion (V45.4 | Z98.1)

Social History *(John Thalgott, MD; 10/18/2018 02:01 PM)*
Tobacco use: Former smoker
Non Drinker/No Alcohol Use

Medication History *(John Thalgott, MD; 10/18/2018 02:01 PM)*
Medrol (2MG Tablet 1 (one) Package Oral use as directed, Taken starting 11/28/2017) Active - Hx Entry.
Norvasc (10MG Tablet Oral) Active - Hx Entry.
Losartan Potassium (100MG Tablet Oral) Active - Hx Entry.
Flomax (0.4MG Capsule Oral) Active - Hx Entry.
Hydrochlorothiazide (25MG Tablet Oral) Active - Hx Entry.
Elavil (100MG Tablet Oral) Active - Hx Entry.
Medications Reconciled Specific strength unknown - Active - Hx Entry.

Past Surgical *(John Thalgott, MD; 10/18/2018 02:01 PM)*
Lumbar Spine surgery
Shoulder Surgery

Review of Systems *(John Thalgott, MD; 10/18/2018 02:01 PM)*
General Not Present- Fatigue and Fever.
Skin Not Present- Rash.
HEENT Not Present- Headache, Hearing Loss and Visual Disturbances.
Respiratory Not Present- Cough and Difficulty Breathing.
Cardiovascular Not Present- Chest Pain, Shortness of Breath and Swelling of Extremities.
Gastrointestinal Not Present- Abdominal Pain and Difficulty Swallowing.
Musculoskeletal Present- Back Pain and Leg Pain.
Neurological Not Present- Dizziness, Numbness and Weakness.
Psychiatric Not Present- Anxiety.

Vitals *(John Thalgott, MD; 10/18/2018 02:01 PM)*
10/18/2018 02:01 PM
Weight: 210 lb (Patient reported) **Height:** 69 in (Patient reported)
Body Surface Area: 2.11 m² **Body Mass Index:** 31.01 kg/m²

Physical Exam *(John Thalgott, MD; 10/18/2018 02:33 PM)*
The physical exam findings are as follows:
stable and unchanged neruo unchanged. now with cervical c6 radiculapthy and weakness in to wrist extensors and limited rom of cervical c6.9/22/2016 now has severe radicular pain and is ataxic and this is a changed and now hypereflexic in knees jerk but is nonreflexic at ankle. 10/20/2016 unchanged ataxia with stable motor 10/27/2016 ataxia is worse and radiculapthys is better today 12/8/2016 neuro unchanged and having left c6 pain and gait is improved . 2/21/2017 stable and with antalgic and ataxic with decreased sensation at c6 on the left with decreased grip and pinch on the left 8/22/2017 stable with weak left upper in c6 and c7 12/28/2017 nwo much more ataxic and worsening of lower ext weakness and has had recent left cts release. 1/2/2017- Ataxic and unsteady gait. 1/30/2018 stable but still ataxic wound is healing and no signs of infection. 2/6/2018- Neuro intact, stable. Improved ataxic and antalgic gait. Well-healed surgical incision in posterior cervical incision. Left arm strength is 4/5 vs 5/5 on right. Decreased brachial DTR on the left side. 4/5 BLE leg strength. 3/13/2018 stable and unchanged with atrophy of left hand and discordiantion 6/5/2018 stable with weakness in upper and lower ext diffuse and still having clawing of the right hand 6/19/2019 stable with improving hand and lower motor fuction and better sensation 7/3/2018 stable neuro improved wounds clean and healing sutures out 8/9/2018 stable and unchanged wound clean and healing neuro much improved with ataxic gait 9/11/2018 stable with very severe ataxic gait with wheelchair today and diffuse weakness in both lower ext. 10/18/2018 stable and quadrapalegia and ataxic gait and has sob with neck flexion

Neurologic
Sensory - Paresthesia - Right hand, Left hand, Right L5 and Left L5. **Gait** - Broad-based.

Musculoskeletal
Spine/Ribs/Pelvis - Gait and Station - Abnormal Gait Patterns - antalgic gait and ataxic gait. Cervical Spine: Assessment of pain reveals the following findings: - The pain is characterized as - mild. Location - upper trapezius area, (R) and upper trapezius area, (L). Lumbosacral Spine: Inspection and Palpation - Tenderness - moderate, flank, (R) and flank, (L). Surrounding tissue tension/texture is - spasm. Strength and Tone - Functional Assessment - . Lumbosacral Spine - Functional Testing - Straight Leg Raising Test negative, Trendelenburg's Sign negative.

Assessment & Plan *(John Thalgott, MD; 10/18/201802:41 PM)*

Cervical radiculopathy at C6 (Working Diagnosis) (723.4 | M54.12)
Current Plans:
- Referred to Pulmonology, for evaluation and follow up, (Pulmonary Diseases)
- Follow up in 1 month or as needed
- Follow up in 1 month or as needed

Degenerative cervical spinal stenosis (Established Diagnosis) (723.0 | M48.02)
Current Plans:

Ataxic gait (Principal Diagnosis) (781.2 | R26.0)
Current Plans:

S/P cervical spinal fusion (Principal Diagnosis) (V45.4 | Z98.1)
Current Plans:

Quadriplegia (Established Diagnosis) (344.00 | G82.50)
Current Plans:

John Thalgott MD

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Simone Russo **Patient #:** 11130 **DOB:** 09/05/1942 (76 years)

Date of Encounter: 11/06/2018 12:59 PM

History of Present Illness *(John Thalgott, MD 11/06/2018 01:20 PM)*
The patient is a 76 year old male who presents for a follow up visit. The patient does not feel well. The patient has been compliant with instructions. Note for "Follow up": Patient is having severe pain in the buttocks, and rectum. Neuropathic pain. will get to geppy and valaquez for general medicine.Aslo get in to stewart asap

Allergies *(John Thalgott, MD; 11/06/2018 01:00 PM)*
No Known Drug Allergies 02/02/2016

Past Medical History (John Thalgott, MD; *11/06/2018 01:00 PM)*
Hypertension (401.9 | I10)
Cervical radiculopathy at C6 (723.4 | M54.12)
Degenerative cervical spinal stenosis (723.0 | M48.02)
Low back pain (724.2 | M54.5)
Bilateral lumbar radiculopathy (724.4 | M54.16)
Quadriplegia (344.00 | G82.50)
Ataxic gait (781.2 | R26.0)
S/P cervical spinal fusion (V45.4 | Z98.1)

Social History *(John Thalgott, MD; 11/06/2018 01:00 PM)*
Tobacco use: Former smoker
Non Drinker/No Alcohol Use

Medication History *(John Thalgott, MD; 11/06/2018 01:01 PM)*
Medrol (2MG Tablet 1 (one) Package Oral use as directed, Taken starting 11/28/2017) Active - Hx Entry.
Norvasc (10MG Tablet Oral) Active - Hx Entry.
Losartan Potassium (100MG Tablet Oral) Active - Hx Entry.
Flomax (0.4MG Capsule Oral) Active - Hx Entry.
Hydrochlorothiazide (25MG Tablet Oral) Active - Hx Entry.
Elavil (100MG Tablet Oral) Active - Hx Entry.
Medications Reconciled Specific strength unknown - Active - Hx Entry.

Past Surgical *(John Thalgott, MD; 11/06/2018 01:00 PM)*
Lumbar Spine surgery
Shoulder Surgery

Review of Systems *(John Thalgott, MD; 11/06/2018 01:00 PM)*
General Not Present- Fatigue and Fever.
Skin Not Present- Rash.
HEENT Not Present- Headache, Hearing Loss and Visual Disturbances.
Respiratory Not Present- Cough and Difficulty Breathing.
Cardiovascular Not Present- Chest Pain, Shortness of Breath and Swelling of Extremities.
Gastrointestinal Not Present- Abdominal Pain and Difficulty Swallowing.
Musculoskeletal Present- Back Pain and Leg Pain.
Neurological Not Present- Dizziness, Numbness and Weakness.
Psychiatric Not Present- Anxiety.

Vitals *(John Thalgott, MD; 11/06/2018 01:01 PM)*

11/06/2018 01:01 PM
Weight: 210 lb (Patient reported) **Height:** 69 in (Patient reported)
Body Surface Area: 2.11 m² **Body Mass Index:** 31.01 kg/m²

Physical Exam *(John Thalgott, MD; 11/06/2018 01:21 PM)*
The physical exam findings are as follows:
stable and unchanged neruo unchanged. now with cervical c6 radiculapthy and weakness in to wrist extensors and limited rom of cervical c6.9/22/2016 now has severe radicular pain and is ataxic and this is a changed and now hypereflexic in knees jerk but is nonreflexic at ankle. 10/20/2016 unchanged ataxia with stable motor 10/27/2016 ataxia is worse and radiculapthys is better today 12/8/2016 neuro unchanged and having left c6 pain and gait is improved . 2/21/2017 stable and with antalgic and ataxic with decreased sensation at c6 on the left with decreased grip and pinch on the left 8/22/2017 stable with weak left upper in c6 and c7 12/28/2017 nwo much more ataxic and worsening of lower ext weakness and has had recent left cts release. 1/2/2017- Ataxic and unsteady gait. 1/30/2018 stable but still ataxic wound is healing and no signs of infection. 2/6/2018- Neuro intact, stable. Improved ataxic and antalgic gait. Well-healed surgical incision in posterior cervical incision. Left arm strength is 4/5 vs 5/5 on right. Decreased brachial DTR on the left side. 4/5 BLE leg strength. 3/13/2018 stable and unchanged with atrophy of left hand and discordiantion 6/5/2018 stable with weakness in upper and lower ext diffuse and still having clawling of the right hand 6/19/2019 stable with improving hand and lower motor fuction and better sensation 7/3/2018 stable neuro improved wounds clean and healing sutures out 8/9/2018 stable and unchanged wound clean and healing neuro much improved with ataxic gait 9/11/2018 stable with very severe ataxic gait with wheelchair today and diffuse weakness in both lower ext. 10/18/2018 stable and quadrapalegia and ataxic gait and has sob with neck flexion 11/6/2018 stable and unchanged

Neurologic
Sensory - Paresthesia - Right hand, Left hand, Right L5 and Left L5. **Gait** - Broad-based.

Musculoskeletal
Spine/Ribs/Pelvis - Gait and Station - Abnormal Gait Patterns - antalgic gait and ataxic gait. Cervical Spine: Assessment of pain reveals the following findings: - The pain is characterized as - mild. Location - upper trapezius area, (R) and upper trapezius area, (L). Lumbosacral Spine: Inspection and Palpation - Tenderness - moderate, flank, (R) and flank, (L). Surrounding tissue tension/texture is - spasm. Strength and Tone - Functional Assessment - . Lumbosacral Spine - Functional Testing - Straight Leg Raising Test negative, Trendelenburg's Sign negative.

Assessment & Plan *(John Thalgott, MD; 11/06/201801:23 PM)*

Degenerative cervical spinal stenosis (Established Diagnosis) (723.0 | M48.02)
Current Plans:

Bilateral lumbar radiculopathy (Principal Diagnosis) (724.4 | M54.16)
Current Plans:

Ataxic gait (Principal Diagnosis) (781.2 | R26.0)
Current Plans:

Quadriplegia (Established Diagnosis) (344.00 | G82.50)
Current Plans:
- Referred to Pain Management, for evaluation and follow up, (Pain Management)
- Referred to Pulmonology, for evaluation and follow up, (Pulmonary Diseases)
- Follow up as needed

John Thalgott MD

Center for Disease and Surgery of the Spine
600 South Rancho Drive Suite 107
Las Vegas, NV 89106
Phone: (702) 878-8370
Fax: (702) 878-9642

Simone Russo **Patient #:** 11130 **DOB:** 09/05/1942 (76 years)

Date of Encounter: 12/11/2018 04:11 PM

History of Present Illness *(John Thalgott, MD 12/11/2018 04:23 PM)*
The patient is a 76 year old male who presents for a follow up visit. The patient does not feel well. The patient has been compliant with instructions. Note for "Follow up": Patient is having some spams/right side in the cervical spine.pt has severe right trap spasm and neuro is unchanged and xray show good hardware position and stable upper cervical spine

Allergies *(John Thalgott, MD; 12/11/2018 04:12 PM)*
No Known Drug Allergies 02/02/2016

Past Medical History (John Thalgott, MD; *12/11/2018 04:12 PM)*
Hypertension (401.9 | I10)
Bilateral lumbar radiculopathy (724.4 | M54.16)
Degenerative cervical spinal stenosis (723.0 | M48.02)
Cervical radiculopathy at C6 (723.4 | M54.12)
Low back pain (724.2 | M54.5)
Quadriplegia (344.00 | G82.50)
Ataxic gait (781.2 | R26.0)
S/P cervical spinal fusion (V45.4 | Z98.1)

Social History *(John Thalgott, MD; 12/11/2018 04:12 PM)*
Tobacco use: Former smoker
Non Drinker/No Alcohol Use

Medication History *(John Thalgott, MD; 12/11/2018 04:12 PM)*
Medrol (2MG Tablet 1 (one) Package Oral use as directed, Taken starting 11/28/2017) Active - Hx Entry.
Norvasc (10MG Tablet Oral) Active - Hx Entry.
Losartan Potassium (100MG Tablet Oral) Active - Hx Entry.
Flomax (0.4MG Capsule Oral) Active - Hx Entry.
Hydrochlorothiazide (25MG Tablet Oral) Active - Hx Entry.
Elavil (100MG Tablet Oral) Active - Hx Entry.
Medications Reconciled Specific strength unknown - Active - Hx Entry.

Past Surgical *(John Thalgott, MD; 12/11/2018 04:12 PM)*
Lumbar Spine surgery
Shoulder Surgery

Review of Systems *(John Thalgott, MD; 12/11/2018 04:12 PM)*
General Not Present- Fatigue and Fever.
Skin Not Present- Rash.
HEENT Not Present- Headache, Hearing Loss and Visual Disturbances.
Respiratory Not Present- Cough and Difficulty Breathing.
Cardiovascular Not Present- Chest Pain, Shortness of Breath and Swelling of Extremities.
Gastrointestinal Not Present- Abdominal Pain and Difficulty Swallowing.
Musculoskeletal Present- Back Pain and Leg Pain.
Neurological Not Present- Dizziness, Numbness and Weakness.
Psychiatric Not Present- Anxiety.

Vitals *(John Thalgott, MD; 12/11/2018 04:12 PM)*

12/11/2018 04:12 PM
Weight: 210 lb (Patient reported) **Height:** 69 in (Patient reported)
Body Surface Area: 2.11 m² **Body Mass Index:** 31.01 kg/m²

Physical Exam *(John Thalgott, MD; 12/11/2018 04:23 PM)*
The physical exam findings are as follows:
stable and unchanged neruo unchanged. now with cervical c6 radiculapthy and weakness in to wrist extensors and limited rom of cervical c6.9/22/2016 now has severe radicular pain and is ataxic and this is a changed and now hypereflexic in knees jerk but is nonreflexic at ankle. 10/20/2016 unchanged ataxia with stable motor 10/27/2016 ataxia is worse and radiculapthys is better today 12/8/2016 neuro unchanged and having left c6 pain and gait is improved . 2/21/2017 stable and with antalgic and ataxic with decreased sensation at c6 on the left with decreased grip and pinch on the left 8/22/2017 stable with weak left upper in c6 and c7 12/28/2017 nwo much more ataxic and worsening of lower ext weakness and has had recent left cts release. 1/2/2017- Ataxic and unsteady gait. 1/30/2018 stable but still ataxic wound is healing and no signs of infection. 2/6/2018- Neuro intact, stable. Improved ataxic and antalgic gait. Well-healed surgical incision in posterior cervical incision. Left arm strength is 4/5 vs 5/5 on right. Decreased brachial DTR on the left side. 4/5 BLE leg strength. 3/13/2018 stable and unchanged with atrophy of left hand and discordiantion 6/5/2018 stable with weakness in upper and lower ext diffuse and still having clawling of the right hand 6/19/2019 stable with improving hand and lower motor fuction and better sensation 7/3/2018 stable neuro improved wounds clean and healing sutures out 8/9/2018 stable and unchanged wound clean and healing neuro much improved with ataxic gait 9/11/2018 stable with very severe ataxic gait with wheelchair today and diffuse weakness in both lower ext. 10/18/2018 stable and quadrapalegia and ataxic gait and has sob with neck flexion 11/6/2018 stable and unchanged 12/11/2018 stable and neuro unchanged with severe right trap spasm

Neurologic
Sensory - Paresthesia - Right hand, Left hand, Right L5 and Left L5. **Gait** - Broad-based.

Musculoskeletal
Spine/Ribs/Pelvis - Gait and Station - Abnormal Gait Patterns - antalgic gait and ataxic gait. Cervical Spine: Assessment of pain reveals the following findings: - The pain is characterized as - mild. Location - upper trapezius area, (R) and upper trapezius area, (L). Lumbosacral Spine: Inspection and Palpation - Tenderness - moderate, flank, (R) and flank, (L). Surrounding tissue tension/texture is - spasm. Strength and Tone - Functional Assessment - . Lumbosacral Spine - Functional Testing - Straight Leg Raising Test negative, Trendelenburg's Sign negative.

Assessment & Plan *(John Thalgott, MD; 12/11/201804:26 PM)*

Bilateral lumbar radiculopathy (Principal Diagnosis) (724.4 | M54.16)
Current Plans:

Degenerative cervical spinal stenosis (Established Diagnosis) (723.0 | M48.02)
Current Plans:

Low back pain (Principal Diagnosis) (724.2 | M54.5)
Current Plans:

Ataxic gait (Principal Diagnosis) (781.2 | R26.0)
Current Plans:

Trapezius muscle spasm (Established Diagnosis) (728.85 | M62.838)
Current Plans:
- MRI CERVICAL SPINE W/O CONTRAST (72141) Routine ()
- Instructed to make follow-up appointment for office visit following completion of diagnostic tests

John Thalgott MD

Center for Disease and Surgery of the Spine
600 South Rancho Drive Suite 107
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Phone: (702) 878-8370
Fax: (702) 878-9642

Simone Russo **Patient #:** 11130 **DOB:** 09/05/1942 (76 years)

Date of Encounter: 12/13/2018 11:52 AM

History of Present Illness *(John Thalgott, MD 12/13/2018 12:13 PM)*
The patient is a 76 year old male presenting to discuss diagnostic procedure results. The patient had a CT scan. Note for "Follow up diagnostic procedure": now with stenosis at ant cc3/c4 above level of old fusion with cord changes This shoul be fixed as now having severe c4 symptoms on the right

Allergies *(John Thalgott, MD; 12/13/2018 11:52 AM)*
No Known Drug Allergies 02/02/2016

Past Medical History (John Thalgott, MD; *12/13/2018 11:52 AM)*
Hypertension (401.9 | I10)
Degenerative cervical spinal stenosis (723.0 | M48.02)
Bilateral lumbar radiculopathy (724.4 | M54.16)
Low back pain (724.2 | M54.5)
Cervical radiculopathy at C6 (723.4 | M54.12)
Quadriplegia (344.00 | G82.50)
Trapezius muscle spasm (728.85 | M62.838)
Ataxic gait (781.2 | R26.0)
S/P cervical spinal fusion (V45.4 | Z98.1)

Social History *(John Thalgott, MD; 12/13/2018 11:52 AM)*
Tobacco use: Former smoker
Non Drinker/No Alcohol Use

Medication History *(John Thalgott, MD; 12/13/2018 11:52 AM)*
Medrol (2MG Tablet 1 (one) Package Oral use as directed, Taken starting 11/28/2017) Active - Hx Entry.
Norvasc (10MG Tablet Oral) Active - Hx Entry.
Losartan Potassium (100MG Tablet, Oral) Active.
Flomax (0.4MG Capsule Oral) Active - Hx Entry.
Hydrochlorothiazide (25MG Tablet, Oral) Active.
Elavil (100MG Tablet Oral) Active - Hx Entry.
Medications Reconciled Specific strength unknown - Active - Hx Entry.

Past Surgical *(John Thalgott, MD; 12/13/2018 11:52 AM)*
Lumbar Spine surgery
Shoulder Surgery

Review of Systems *(John Thalgott, MD; 12/13/2018 11:52 AM)*
General Not Present- Fatigue and Fever.
Skin Not Present- Rash.
HEENT Not Present- Headache, Hearing Loss and Visual Disturbances.
Respiratory Not Present- Cough and Difficulty Breathing.
Cardiovascular Not Present- Chest Pain, Shortness of Breath and Swelling of Extremities.
Gastrointestinal Not Present- Abdominal Pain and Difficulty Swallowing.
Musculoskeletal Present- Back Pain and Leg Pain.
Neurological Not Present- Dizziness, Numbness and Weakness.
Psychiatric Not Present- Anxiety.

Vitals *(John Thalgott, MD; 12/13/2018 11:53 AM)*
12/13/2018 11:53 AM
Weight: 210 lb (Patient reported) **Height:** 69 in (Patient reported)
Body Surface Area: 2.11 m² **Body Mass Index:** 31.01 kg/m²

Physical Exam *(John Thalgott, MD; 12/13/2018 12:13 PM)*
The physical exam findings are as follows:
stable and unchanged neruo unchanged. now with cervical c6 radiculapthy and weakness in to wrist extensors and limited rom of cervical c6.9/22/2016 now has severe radicular pain and is ataxic and this is a changed and now hypereflexic in knees jerk but is nonreflexic at ankle. 10/20/2016 unchanged ataxia with stable motor 10/27/2016 ataxia is worse and radiculapthys is better today 12/8/2016 neuro unchanged and having left c6 pain and gait is improved . 2/21/2017 stable and with antalgic and ataxic with decreased sensation at c6 on the left with decreased grip and pinch on the left 8/22/2017 stable with weak left upper in c6 and c7 12/28/2017 nwo much more ataxic and worsening of lower ext weakness and has had recent left cts release. 1/2/2017- Ataxic and unsteady gait. 1/30/2018 stable but still ataxic wound is healing and no signs of infection. 2/6/2018- Neuro intact, stable. Improved ataxic and antalgic gait. Well-healed surgical incision in posterior cervical incision. Left arm strength is 4/5 vs 5/5 on right. Decreased brachial DTR on the left side. 4/5 BLE leg strength. 3/13/2018 stable and unchanged with atrophy of left hand and discordiantion 6/5/2018 stable with weakness in upper and lower ext diffuse and still having clawiing of the right hand 6/19/2019 stable with improving hand and lower motor fuction and better sensation 7/3/2018 stable neuro improved wounds clean and healing sutures out 8/9/2018 stable and unchanged wound clean and healing neuro much improved with ataxic gait 9/11/2018 stable with very severe ataxic gait with wheelchair today and diffuse weakness in both lower ext. 10/18/2018 stable and quadrapalegia and ataxic gait and has sob with neck flexion 11/6/2018 stable and unchanged 12/11/2018 stable and neuro unchanged with severe right trap spasm 12/13/2018 stable and now with c4 symtpoms as before

Neurologic
Sensory - Paresthesia - Right hand, Left hand, Right L5 and Left L5. **Gait** - Broad-based.

Musculoskeletal
Spine/Ribs/Pelvis - Gait and Station - Abnormal Gait Patterns - antalgic gait and ataxic gait. Cervical Spine: Assessment of pain reveals the following findings: - The pain is characterized as - mild. Location - upper trapezius area, (R) and upper trapezius area, (L). Lumbosacral Spine: Inspection and Palpation - Tenderness - moderate, flank, (R) and flank, (L). Surrounding tissue tension/texture is - spasm. Strength and Tone - Functional Assessment - . Lumbosacral Spine - Functional Testing - Straight Leg Raising Test negative, Trendelenburg's Sign negative.

Assessment & Plan *(John Thalgott, MD; 12/13/201812:14 PM)*
Degenerative cervical spinal stenosis (Established Diagnosis) (723.0 | M48.02)
Current Plans:

Cervical radiculopathy at C6 (Working Diagnosis) (723.4 | M54.12)
Current Plans:

Trapezius muscle spasm (Established Diagnosis) (728.85 | M62.838)
Current Plans:

Quadriplegia (Established Diagnosis) (344.00 | G82.50)
Current Plans:

- ANTERIOR CERVICAL DISCECTOMY (63075) Routine ()
- SPINE INSTRUMENTATION, ANTERIOR, 2-3 SEGMENTS (22845) Routine ()
- I went over the risks of anterior cervical fusion which include the possibility of esophageal injury, death, carotid artery injury, vocal cord paralysis, graft migration, hematoma, arytenoid dislocation, hoarseness, infection, and CSF leak. I have also discussed the possibility of nonunion, screw/plate breakage, and/or removal of hardware; degeneration above or below the operative level; smokers have a significant higher rate of infection, nonunion, wound healing problems, perineural fibrosis, and poorer outcomes; and additional surgeries. Surgery includes incision of the neck, moving of the esophagus and trachea to one side and the jugular vein and carotid artery to the other, identification of the levels radiographically, either removing the disc or replacing it with a piece of bone or removing the disc and vertebral body and replacing it with a cage. That would be a vertebrectomy and afterwards a plate is placed with two screws in each vertebral body. There is the risk of adjacent segment breakdown, death from mediastinitis, and all patients have swallowing problems that may be permanent. This was all discussed with the patient who fully understands and accepts these risks.

- Follow up in 3 weeks or as needed

John Thalgott MD

Center for Disease and Surgery of the Spine
600 South Rancho Drive Suite 107
Las Vegas, NV 89106
Phone: (702) 878-8370
Fax: (702) 878-9642

Simone Russo **Patient #:** 11130 **DOB:** 09/05/1942 (76 years)

Date of Encounter: 01/15/2019 04:34 PM

History of Present Illness *(John Thalgott, MD 01/15/2019 04:44 PM)*
The patient is a 76 year old male who presents for a follow up visit. The patient feels well with minor complaints (neck pain having no complications

bowel issues since the surgery
very difficult to have a bowel movement
needs the records/ and needs some type of diagnosis). Note for "Follow up": pt is seeing dr. stone who is GI md who deals with spinal related problems with colon which Sam has related to his spinal and neurologic problems. Pt will need c3/c4 ant cervical fusion as it relates to the prior anterior fusion which was directly related to aug 27 2016 fall.

Allergies *(John Thalgott, MD; 01/15/2019 04:37 PM)*
No Known Drug Allergies 02/02/2016

Past Medical History (John Thalgott, MD; *01/15/2019 04:37 PM)*
Hypertension (401.9 | I10)
Constipation (564.00 | K59.00)
Cervical radiculopathy at C6 (723.4 | M54.12)
Degenerative cervical spinal stenosis (723.0 | M48.02)
Bilateral lumbar radiculopathy (724.4 | M54.16)
Low back pain (724.2 | M54.5)
Ataxic gait (781.2 | R26.0)
Quadriplegia (344.00 | G82.50)
Trapezius muscle spasm (728.85 | M62.838)
S/P cervical spinal fusion (V45.4 | Z98.1)

Social History *(John Thalgott, MD; 01/15/2019 04:37 PM)*
Tobacco use: Former smoker
Non Drinker/No Alcohol Use

Medication History *(John Thalgott, MD; 01/15/2019 04:38 PM)*
Medrol (2MG Tablet, 1 (one) Package Oral use as directed, Taken starting 11/28/2017) Active.
Norvasc (10MG Tablet, Oral) Active.
Flomax (0.4MG Capsule, Oral) Active.
Elavil (100MG Tablet, Oral) Active.
Medications Reconciled.

Past Surgical *(John Thalgott, MD; 01/15/2019 04:37 PM)*
Lumbar Spine surgery
Shoulder Surgery

Review of Systems *(John Thalgott, MD; 01/15/2019 04:37 PM)*
General Not Present- Fatigue and Fever.
Skin Not Present- Rash.
HEENT Not Present- Headache, Hearing Loss and Visual Disturbances.
Respiratory Not Present- Cough and Difficulty Breathing.
Cardiovascular Not Present- Chest Pain, Shortness of Breath and Swelling of Extremities.
Gastrointestinal Not Present- Abdominal Pain and Difficulty Swallowing.
Musculoskeletal Present- Back Pain and Leg Pain.
Neurological Not Present- Dizziness, Numbness and Weakness.
Psychiatric Not Present- Anxiety.

Vitals *(John Thalgott, MD; 01/15/2019 04:38 PM)*
01/15/2019 04:38 PM
Weight: 210 lb (Patient reported) **Height:** 69 in (Patient reported)
Body Surface Area: 2.11 m² **Body Mass Index:** 31.01 kg/m²

Physical Exam *(John Thalgott, MD; 01/15/2019 04:46 PM)*
The physical exam findings are as follows:
stable and unchanged neruo unchanged. now with cervical c6 radiculapthy and weakness in to wrist extensors and limited rom of cervical c6.9/22/2016 now has severe radicular pain and is ataxic and this is a changed and now hypereflexic in knees jerk but is nonreflexic at ankle. 10/20/2016 unchanged ataxia with stable motor 10/27/2016 ataxia is worse and radiculapthys is better today 12/8/2016 neuro unchanged and having left c6 pain and gait is improved . 2/21/2017 stable and with antalgic and ataxic with decreased sensation at c6 on the left with decreased grip and pinch on the left 8/22/2017 stable with weak left upper in c6 and c7 12/28/2017 nwo much more ataxic and worsening of lower ext weakness and has had recent left cts release. 1/2/2017- Ataxic and unsteady gait. 1/30/2018 stable but still ataxic wound is healing and no signs of infection. 2/6/2018- Neuro intact, stable, Improved ataxic and antalgic gait. Well-healed surgical incision in posterior cervical incision. Left arm strength is 4/5 vs 5/5 on right. Decreased brachial DTR on the left side. 4/5 BLE leg strength. 3/13/2018 stable and unchanged with atrophy of left hand and discordiantion 6/5/2018 stable with weakness in upper and lower ext diffuse and still having clawing of the right hand 6/19/2019 stable with improving hand and lower motor fuction and better sensation 7/3/2018 stable neuro improved wounds clean and healing sutures out 8/9/2018 stable and unchanged wound clean and healing neuro much improved with ataxic gait 9/11/2018 stable with very severe ataxic gait with wheelchair today and diffuse weakness in both lower ext. 10/18/2018 stable and quadrapalegia and ataxic gait and has sob with neck flexion 11/6/2018 stable and unchanged 12/11/2018 stable and neuro unchanged with severe right trap spasm 12/13/2018 stable and now with c4 symtpoms as before 1/15/2019 stable and unchanged with ataxia and c4 radiculapathy

Neurologic
Sensory - Paresthesia - Right hand, Left hand, Right L5 and Left L5. **Gait** - Broad-based.

Musculoskeletal
Spine/Ribs/Pelvis - Gait and Station - Abnormal Gait Patterns - antalgic gait and ataxic gait. Cervical Spine: Assessment of pain reveals the following findings: - The pain is characterized as - mild. Location - upper trapezius area, (R) and upper trapezius area, (L). Lumbosacral Spine: Inspection and Palpation - Tenderness - moderate, flank, (R) and flank, (L). Surrounding tissue tension/texture is - spasm. Strength and Tone - Functional Assessment - . Lumbosacral Spine - Functional Testing - Straight Leg Raising Test negative, Trendelenburg's Sign negative.

Assessment & Plan *(John Thalgott, MD; 01/15/2019 04:49 PM)*
Cervical radiculopathy at C6 (Working Diagnosis) (723.4 | M54.12)
Current Plans:

Degenerative cervical spinal stenosis (Established Diagnosis) (723.0 | M48.02)
Current Plans:

Bilateral lumbar radiculopathy (Principal Diagnosis) (724.4 | M54.16)
Current Plans:

Quadriplegia (Established Diagnosis) (344.00 | G82.50)
Current Plans:

Ataxic gait (Principal Diagnosis) (781.2 | R26.0)
Current Plans:

- Referred to Gastroenterology, for evaluation and follow up, (Gastroenterologist)
- Follow up as needed

John Thalgott MD

VHM- Valley Hospital Medical Center
620 Shadow Lane
Las Vegas, NV 89106-4194

Patient: RUSSO, SIMONE F
MRN: VHM63485207; SVH35440123
FIN: VHM0000115712267
DOB/Sex: 9/5/1942 / Male
Patient Room: VHM N2; 0217; 01

Admit: 1/12/2018
Disch: Disch Time:
Attending: Thalgott MD,John
Copy To: n/a

Operative Record

DOCUMENT NAME:	Operative Reports
SERVICE DATE/TIME:	1/12/2018 12:07 PST
RESULT STATUS:	Auth (Verified)
PERFORM INFORMATION:	Thalgott MD,John (1/12/2018 12:18 PST)
SIGN INFORMATION:	Thalgott MD,John (1/12/2018 12:18 PST)

Indication for Surgery
Progressive quadriparesis with ataxia

Preoperative Diagnosis
Spinal stenosis status post C4-C6 anterior fusion with subsidence restenosis weakness of left upper extremity C6 with discoordination progressive ataxia and spastic weakness in both lower extremities

Postoperative Diagnosis
Spinal stenosis C4-5 C5-6 C6-7

Operation
1) microscopic complete laminectomy C4-C5-C6 and C7 2) Exploration spinal fusion C4-5 C5-6 C6-7 3) lateral mass instrumentation C4 C5-C6-C7 4) harvest right iliac crest use of local bone graft use of allograft 5) arthrodesis C4-5 C5-6 C6-7 posterior 6) use of fluoroscopy

Surgeon(s)
Thalgott MD, John (Surgeon)

Assistant
P. Davis PAC

Anesthesia Type and Anesthesiologist
General
Klein MD, Ira A (Attending Anesthesiologist)

Estimated Blood Loss
100cc

Urine Output
See anesthesia note

Findings
High grade stenosis C5-6 C6-7

Specimen(s)
None

Complications
None

Technique
Risk procedure gone over in detail the patient is a physician and is with his wife by myself and my staff is a large chance without the surgery that he he will be wheelchair bound he is basically limited household ambulator which is progressive over the last month or 2

Transcription

VHM- Valley Hospital Medical Center

Patient: RUSSO, SIMONE F
MRN: VHM63495207; SVH35440123
FIN: VHM0000115712267

Admit: 1/12/2018
Disch:
Attending: Thalgott MD,John

Operative Record

the patient was worked up and had a paralyzed diaphragm on the right cleared by the pulmonary status he is at high risk for interoperative complications she had E. coli infection in the past he is more likely for E. coli or M MRSA infection at this point he was placed on a Hibiclens regimen 2 days before the day of surgery which he reports being compliant with further risks are decompression operative swelling with vascular suit with a vascular injury to his cord upon 3 mansion postoperative bleeding with epidural hematoma total partial paralysis death patient has a paralyzed diaphragm he if he has phrenic nerve involvement contralateral side he may need a diaphragmatic pacer this may or may not make any difference in his neural status indeed he could be worse to complete completely paralyzed regardless of the technical outcome of the surgery the possibility of CSF leak Mr. malposition of screws positioning neuropathy not limited to but including ulnar neuropathy brachioplexopathy peroneal neuropathy blindness and not make any difference in his symptoms or his ataxia indeed he can be worse as of his progressive neurologic deterioration over the last weeks I felt that decompression posteriorly was indicated. Have a nonunion and had subsidence of his anterior construct and he is implied or given he understood the inherent risks benefits and wished to proceed

Description of procedure after suitable level general anesthesia was obtained neuro monitoring was instituted timeout was done neuro monitoring showed some motor deficit in the left side SSEPs were fairly normal prophylaxis thermoregulation padding bony prominence position on the Jackson table with a horseshoe was done by myself the nursing staff and anesthesia great care was taken to make sure his eyes were protected bony prominences were padded. He was taped in position was checked and image intensification after the timeout was done draping and prepping vancomycin and Ancef were given midline approach was made carried fascia subperiosteal dissection exposed the lamina and spinous process on lateral mass at C4-C5-C6 and C7 self-care retractors placed was checked and image intensification once that was completed the unilateral lateral mass instrumentation was begun by drilling lateral mass up and out 20° after description Magro at C4 C6 and C7 the rod was instituted unilateral fixation each be used because of the anterior fixation and a case of decompression post anteriorly lumber aspects of microscope was then brought into the field and spinous processes and the lamina were debulk with a rondure using a Midas Rex under microscopic control the complete lamina was removed to the lateral masses at C4 and C5-C6 and C7 this technique used the Midas Rex to thin the lamina and then a neural hook lifted the lamina off this dura there were no intrusions into the spinal canal the lateral recesses were taken down with a very small Kerrison once he is completely decompressed motors appeared to disappear this SSEPs remained there were no interoperative occasions the spinal cord was completely decompressed appear to be pulsatile the SSEPs did not change preoperatively than the neurologist was consulted through the monitoring technician who felt that the motors were not reliable once that was completed the decompression was completed the wound was pulse lavaged with protecting spinal cord and a sheet of DuraGen and then DuraSeal was placed over that then a sheet of fibular and FloSeal a small incision was made over the right iliac crest across his open rondure and carina removed bone from iliac crest during the the decompression phase of bone trap was harvested twice and then the local bone graft harvested bone graft and allograft made and also biologic slurry. Prior to starting the decompression instrumentation the push pull test showed that there was motion at every segment C4-5 C5-6 and C6-7. Once that was completed the lateral mass after the interpretation decompression decorticated and the bone graft placed around the lateral masses lateral to the instrumentation vancomycin powder was placed throughout the wound the fascia closed with strata fix subcu drains placed subcu with 2-0 Vicryl skin with running Prolene Bioclusive dressing was placed the harvested bone graft was closed with subcu with 2-0 Vicryl skin with staples Bioclusive dressings placed no interoperative complications noted the this is dictated prior to the patient awakening at 1220

Electronically Signed By: Thalgott, John MD
On: 01.12.2018 12:18 PST

Center for Disease and Surgery of the Spine
500 South Rancho Drive Suite 107
Las Vegas, NV 89106
Phone: (702) 878-8370
Fax: (702) 878-9642

Simone Russo **Patient #:** 11130 **DOB:** 09/05/1942 (75 years)

Date of Encounter: 01/29/2018 12:36 PM

History of Present Illness *(John Thalgott, MD 01/30/2018 03:20 PM)*
The patient is a 75 year old male who presents for a follow up visit. The patient has been compliant with instructions. Note for "Follow up": pt has improved and ataxia is improved and now having still 4/ 5 weakness in left upper ext. wounds clean and healing d/c sutures

Past Medical History (John Thalgott, MD; *01/30/2018 03:15 PM)*
Hypertension (401.9 | I10)
Low back pain (724.2 | M54.5)
Cervical radiculopathy at C6 (723.4 | M54.12)
Degenerative cervical spinal stenosis (723.0 | M48.02)
Bilateral lumbar radiculopathy (724.4 | M54.16)
Quadriplegia (344.00 | G82.50)
Ataxic gait (781.2 | R26.0)
S/P cervical spinal fusion (V45.4 | Z98.1)

Medication History *(John Thalgott, MD; 01/30/2018 03:15 PM)*
Medrol (2MG Tablet 1 (one) Package Oral use as directed, Taken starting 11/28/2017) Active - Hx Entry.
Norvasc (10MG Tablet Oral) Active - Hx Entry.
Losartan Potassium (100MG Tablet Oral) Active - Hx Entry.
Flomax (0.4MG Capsule Oral) Active - Hx Entry.
Hydrochlorothiazide (25MG Tablet Oral) Active - Hx Entry.
Elavil (100MG Tablet Oral) Active - Hx Entry.
Medications Reconciled Specific strength unknown - Active - Hx Entry.

Review of Systems *(John Thalgott, MD; 01/30/2018 03:15 PM)*
General Not Present- Fatigue and Fever.
Skin Not Present- Rash.
HEENT Not Present- Headache, Hearing Loss and Visual Disturbances.
Respiratory Not Present- Cough and Difficulty Breathing.
Cardiovascular Not Present- Chest Pain, Shortness of Breath and Swelling of Extremities.
Gastrointestinal Not Present- Abdominal Pain and Difficulty Swallowing.
Musculoskeletal Present- Back Pain and Leg Pain.
Neurological Not Present- Dizziness, Numbness and Weakness.
Psychiatric Not Present- Anxiety.

Vitals *(John Thalgott, MD; 01/30/2018 03:16 PM)*
01/30/2018 03:16 PM
Weight: 210 lb (Patient reported) **Height:** 69 in (Patient reported)
Body Surface Area: 2.11 m² **Body Mass Index:** 31.01 kg/m²

14A.App.3016

Physical Exam *(John Thalgott, MD; 01/30/2018 03:28 PM)*
The physical exam findings are as follows:
stable and unchanged neruo unchanged now with cervical c6 radiculapthy and weakness in te wrist extensors and limited rom of cervical c6.9/22/2016 now has severe radicular pain and is ataxic and this is a changed and now hypereflexic in knees jerk but is nonreflexic at ankle. 10/20/2016 unchanged ataxia with stable motor 10/27/2016 ataxia is worse and radiculapthys is better today 12/8/2016 neuro unchanged and having left c6 pain and gait is improved . 2/21/2017 stable and with antalgic and ataxic with decreased sensation at c6 on the left with decreased grip and pinch on the left 8/22/2017 stable with weak left upper in c6 and c7 12/28/2017 nwo much more ataxic and worsening of lower ext weakness and has had recent left cts release. 1/2/2017- Ataxic and unsteady gait. 1/30/2018 stable but still ataxic wound is healing and no signs of infection

Neurologic
Sensory - Paresthesia - Right hand, Left hand, Right L5 and Left L5. **Gait** - Broad-based.

Musculoskeletal
Spine/Ribs/Pelvis - Gait and Station - Abnormal Gait Patterns - antalgic gait and ataxic gait. Cervical Spine: Assessment of pain reveals the following findings: - The pain is characterized as - mild. Location - upper trapezius area, (R) and upper trapezius area, (L). Lumbosacral Spine: Inspection and Palpation - Tenderness - moderate, flank, (R) and flank, (L). Surrounding tissue tension/texture is - spasm. Strength and Tone - Functional Assessment - , Lumbosacral Spine - Functional Testing - Straight Leg Raising Test negative, Trendelenburg's Sign negative.

Assessment & Plan *(John Thalgott, MD; 01/30/201803:31 PM)*

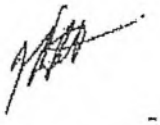
Degenerative cervical spinal stenosis (Established Diagnosis) (723.0 | M48.02)
Current Plans:

Bilateral lumbar radiculopathy (Principal Diagnosis) (724.4 | M54.16)
Current Plans:

Cervical radiculopathy at C6 (Working Diagnosis) (723.4 | M54.12)
Current Plans:

Ataxic gait (Principal Diagnosis) (781.2 | R26.0)
Current Plans:

S/P cervical spinal fusion (Principal Diagnosis) (V45.4 | Z98.1)
Current Plans:
- X-ray of cervical spine, 2 or 3 views (72040) Routine (stable and unchanged hardware intact)
- Follow up in 1 week or as needed



John Thalgott MD

Center for Disease and Surgery of the Spine

600 South Rancho Drive Suite 107
Las Vegas, NV 89106
Phone: (702) 878-8370
Fax: (702) 878-9642

Simone Russo **Patient #:** 11130 **DOB:** 09/05/1942 (75 years)

Date of Encounter: 02/06/2018 04:04 PM

History of Present Illness *(Timian Godfrey 02/06/2018 04:24 PM)*
The patient is a 75 year old male who presents for a follow up visit. The patient has been compliant with instructions. Note for "Follow up": Almost 4 weeks s/p PCF C4-C7. The patient has one more day of Levaquin. He states incisional pain is almost gone. He has persistent C4-C5 radiculopathy on the left side. He has noticed that his left leg function has improved by about 50%. The patient is getting physical therapy at home now and is doing well.

Allergies *(Timian Godfrey; 02/06/2018 04:07 PM)*
No Known Drug Allergies 02/02/2016

Past Medical History (Timian Godfrey; *02/06/2018 04:07 PM)*
Hypertension (401.9 | I10)
Bilateral lumbar radiculopathy (724.4 | M54.16)
Cervical radiculopathy at C6 (723.4 | M54.12)
Low back pain (724.2 | M54.5)
Degenerative cervical spinal stenosis (723.0 | M48.02)
Quadriplegia (344.00 | G82.50)
Ataxic gait (781.2 | R26.0)
S/P cervical spinal fusion (V45.4 | Z98.1)

Social History *(Timian Godfrey; 02/06/2018 04:07 PM)*
Tobacco use: Former smoker
Non Drinker/No Alcohol Use

Medication History *(Timian Godfrey; 02/06/2018 04:07 PM)*
Medrol (2MG Tablet 1 (one) Package Oral use as directed, Taken starting 11/28/2017) Active - Hx Entry.
Norvasc (10MG Tablet Oral) Active - Hx Entry.
Losartan Potassium (100MG Tablet Oral) Active - Hx Entry.
Flomax (0.4MG Capsule Oral) Active - Hx Entry.
Hydrochlorothiazide (25MG Tablet Oral) Active - Hx Entry.
Elavil (100MG Tablet Oral) Active - Hx Entry.
Medications Reconciled Specific strength unknown - Active - Hx Entry.

Past Surgical *(Timian Godfrey; 02/06/2018 04:07 PM)*
Lumbar Spine surgery
Shoulder Surgery

Review of Systems *(Timian Godfrey; 02/06/2018 04:07 PM)*
General Not Present- Fatigue and Fever.
Skin Not Present- Rash.
HEENT Not Present- Headache, Hearing Loss and Visual Disturbances.
Respiratory Not Present- Cough and Difficulty Breathing.
Cardiovascular Not Present- Chest Pain, Shortness of Breath and Swelling of Extremities.
Gastrointestinal Not Present- Abdominal Pain and Difficulty Swallowing.
Musculoskeletal Present- Back Pain and Leg Pain.
Neurological Not Present- Dizziness, Numbness and Weakness.
Psychiatric Not Present- Anxiety.

Vitals *(Timian Godfrey; 02/06/2018 04:07 PM)*
~~02/06/2018 04:07 PM~~
Weight: 210 lb (Patient reported) **Height:** 69 in (Patient reported)
Body Surface Area: 2.11 m² **Body Mass Index:** 31.01 kg/m²

Physical Exam *(Timian Godfrey; 02/06/2018 04:26 PM)*
The physical exam findings are as follows:
stable and unchanged neruo unchanged. now with cervical c6 radiculapthy and weakness in to wrist extensors and limited rom of cervical c6.9/22/2016 now has severe radicular pain and is ataxic and this is a changed and now hypereflexic in knees jerk but is nonreflexic at ankle. 10/20/2016 unchanged ataxia with stable motor 10/27/2016 ataxia is worse and radiculapthys is better today 12/8/2016 neuro unchanged and having left c6 paln and gait is improved . 2/21/2017 stable and with antalgic and ataxic with decreased sensation at c6 on the left with decreased grip and pinch on the left 8/22/2017 stable with weak left upper in c6 and c7 12/28/2017 nwo much more ataxic and worsening of lower ext weakness and has had recent left cts release. 1/2/2017- Ataxic and unsteady gait. 1/30/2018 stable but still ataxic wound is healing and no signs of infection. 2/6/2018- Neuro intact, stable, Improved ataxic and antalgic gait. Well-healed surgical incision in posterior cervical incision. Left arm strength is 4/5 vs 5/5 on right. Decreased brachial DTR on the left side. 4/5 BLE leg strength.

Neurologic
Sensory - Paresthesia - Right hand, Left hand, Right L5 and Left L5. **Gait** - Broad-based.

Musculoskeletal
Spine/Ribs/Pelvis - Gait and Station - Abnormal Gait Patterns - antalgic gait and ataxic gait. Cervical Spine: Assessment of pain reveals the following findings: - The pain is characterized as - mild. Location - upper trapezius area, (R) and upper trapezius area, (L). Lumbosacral Spine: Inspection and Palpation - Tenderness - moderate, flank, (R) and flank, (L). Surrounding tissue tension/texture is - spasm. Strength and Tone - Functional Assessment - . Lumbosacral Spine - Functional Testing - Straight Leg Raising Test negative, Trendelenburg's Sign negative.

Assessment & Plan *(Timian Godfrey; 02/06/2018 04:35 PM)*

S/P cervical spinal fusion (Principal Diagnosis) (V45.4 | Z98.1)
Current Plans:
- X-ray of cervical spine, 2 or 3 views (72040) Routine (Hardware in good position)
- Follow up in 1 month or as needed

Degenerative cervical spinal stenosis (Established Diagnosis) (723.0 | M48.02)
Current Plans:

Ataxic gait (Principal Diagnosis) (781.2 | R26.0)
Current Plans:

Timian Godfrey

Center for Disease and Surgery of the Spine
600 South Rancho Drive Suite 107
Las Vegas, NV 89106
Phone: (702) 878-8370
Fax: (702) 878-9642

Simone Russo **Patient #:** 11130 **DOB:** 09/05/1942 (75 years)

Date of Encounter: 03/13/2018 04:29 PM

History of Present Illness *(John Thalgott, MD 03/13/2018 05:01 PM)*
The patient is a 75 year old male who presents for a follow up visit. The patient does not feel well. The patient has been compliant with instructions. Note for "Follow up": Pt is having the same problems he was the last time he was here with no changes. now stable and not making progress pt want to get injection and get pain under controopll and may need water therapy

Past Medical History (John Thalgott, MD; *03/13/2018 04:38 PM*)
Hypertension (401.9 | I10)
Bilateral lumbar radiculopathy (724.4 | M54.16)
Cervical radiculopathy at C6 (723.4 | M54.12)
Degenerative cervical spinal stenosis (723.0 | M48.02)
Low back pain (724.2 | M54.5)
Quadriplegia (344.00 | G82.50)
Ataxic gait (781.2 | R26.0)
S/P cervical spinal fusion (V45.4 | Z98.1)

Medication History *(John Thalgott, MD; 03/13/2018 04:38 PM)*
Medrol (2MG Tablet, 1 (one) Package Oral use as directed, Taken starting 11/28/2017) Active.
Norvasc (10MG Tablet, Oral) Active.
Losartan Potassium (100MG Tablet, Oral) Active.
Flomax (0.4MG Capsule, Oral) Active.
Hydrochlorothiazide (25MG Tablet, Oral) Active.
Elavil (100MG Tablet, Oral) Active.
Medications Reconciled.

Review of Systems *(John Thalgott, MD; 03/13/2018 04:38 PM)*
General Not Present- Fatigue and Fever.
Skin Not Present- Rash.
HEENT Not Present- Headache, Hearing Loss and Visual Disturbances.
Respiratory Not Present- Cough and Difficulty Breathing.
Cardiovascular Not Present- Chest Pain, Shortness of Breath and Swelling of Extremities.
Gastrointestinal Not Present- Abdominal Pain and Difficulty Swallowing.
Musculoskeletal Present- Back Pain and Leg Pain.
Neurological Not Present- Dizziness, Numbness and Weakness.
Psychiatric Not Present- Anxiety.

Vitals *(John Thalgott, MD; 03/13/2018 04:38 PM)*
03/13/2018 04:38 PM
Weight: 210 lb (Patient reported) **Height:** 69 in (Patient reported)
Body Surface Area: 2.11 m² **Body Mass Index:** 31.01 kg/m²

Physical Exam *(John Thalgott, MD; 03/13/2018 05:04 PM)*
The physical exam findings are as follows:
stable and unchanged neuro unchanged. now with cervical c6 radiculapthy and weakness in to wrist extensors and limited rom of cervical c6.9/22/2016 now has severe radicular pain and is ataxic and this is a changed and now hypereflexic in knees jerk but is nonreflexic at ankle. 10/20/2016 unchanged ataxia with stable motor 10/27/2016 ataxia is worse and radiculapthys is better today 12/8/2016 neuro unchanged and having left c6 pain and gait is improved . 2/21/2017 stable and with antalgic and ataxic with decreased sensation at c6 on the left with decreased grip and pinch on the left 8/22/2017 stable with weak left upper in c6 and c7 12/28/2017 nwo much more ataxic and worsening of lower ext weakness and has had recent left cts release. 1/2/2017- Ataxic and unsteady gait. 1/30/2018 stable but still ataxic wound is healing and no signs of infection. 2/6/2018- Neuro intact, stable. Improved ataxic and antalgic gait. Well-healed surgical incision in posterior cervical incision. Left arm strength is 4/5 vs 5/5 on right. Decreased brachial DTR on the left side. 4/5 BLE leg strength. 3/13/2018 stable and unchanged with atrophy of left hand and discordiantion

Neurologic
Sensory - Paresthesia - Right hand, Left hand, Right L5 and Left L5. **Gait** - Broad-based.

Musculoskeletal
Spine/Ribs/Pelvis - Gait and Station - Abnormal Gait Patterns - antalgic gait and ataxic gait. Cervical Spine: Assessment of pain reveals the following findings: - The pain is characterized as - mild. Location - upper trapezius area, (R) and upper trapezius area, (L). Lumbosacral Spine: Inspection and Palpation - Tenderness - moderate, flank, (R) and flank, (L). Surrounding tissue tension/texture is - spasm. Strength and Tone - Functional Assessment - . Lumbosacral Spine - Functional Testing - Straight Leg Raising Test negative, Trendelenburg's Sign negative.

Assessment & Plan *(John Thalgott, MD; 03/13/2018 05:24 PM)*

Degenerative cervical spinal stenosis (Established Diagnosis) (723.0 | M48.02)
Current Plans:

Low back pain (Principal Diagnosis) (724.2 | M54.5)
Current Plans:

Cervical radiculopathy at C6 (Working Diagnosis) (723.4 | M54.12)
Current Plans:

Ataxic gait (Principal Diagnosis) (781.2 | R26.0)
Current Plans:

S/P cervical spinal fusion (Principal Diagnosis) (V45.4 | Z98.1)
Current Plans:

- X-ray of cervical spine, 2 or 3 views (72040) Routine (hardware intact)
- X-ray of lumbar spine, 2 or 3 bending views (72120) Routine (hardare intact)
- Referred to Pain Management, for evaluation and follow up, (Pain Management)
- Follow up in 6 weeks or as needed

John Thalgott MD

Oasis Home Health, Inc

PHYSICAL THERAPY EVALUATION

Patient: Russo, Simone F. - 000107195 Home Health Provider: Patel, Ashish (PT) Date of Assessment: 02/28/2018

Mileage: Time In: **11:30 AM** Time Out: **12:15 PM**

Duration: **45** Minutes

Physician Name: Thulgotyoim (MD) DOB: 07/07/1942

Physician Fax: **702-878-9642**

Date Physician Contacted: **02/28/2018** Time Physician Contacted: **1:30 PM** Treating Dx: **generalized weakness, difficulty ambulating**

Hx of falls: **No** If Accident: type Where:

At risk for falls due to: **NA** Pending litigation: ○ yes ⊖ no

History of current condition/Reason for referral: C4-C7 fusion

Eligibility

HOMEBOUND STATUS:
Requires use of a device and /or the assistance of an other person to leave home. Patient has functional deficits making the ability to leave home difficult. Start Effective Date: 01/26/2018

Prior Level of Function before this episode of illness/injury:

Self care: ☑ Independent ☐ Assistance
Mobility: ☑ Independent ☐ Assistance
Transfers: ☑ Independent ☐ Assistance
Ambulation: ☑ Independent ☐ Assistance
Device(s) used: **4WW**
Comments:

Pain Assessment: Intensity Scale = 4/10(pre) 5/10(post)

Location: **neck and left arm** Frequency: **constant**
Pain Characteristics: ☐ sharp ☑ dull/aching ☐ burning ☐ radiating ☐ other
Medications: **See med profile**
Does pain interfere with activity/movement? ⊖ YES ○ NO describe:

Cognition: ☑ WFL ☐ Impaired **Oriented to:** ☑ Person ☑ Place ☑ Time ☑ Events
Sensation: ☑ Intact ☐ Impaired **Tone:** ☑ Intact ☐ Impaired **Posture: Forward flexed**
Vitals: (Assess if indicated by patient dx/status) **BP:** Before exercise **124/82** After exercise ☐ R ☑ L **HR: 81 RESP Rate: 18**
Shortness of breath: ☑ Never ☐ At rest ☐ Walking more than 20 feet ☐ With mod exertion ☐ With min exertion

Functional Assessment Describe level of physical assistance needed, device (s) needed with each item

I = Independent *MI* = Modified Independence *S* = Supervision *MinA* = Minimal Assistance *ModA* = Moderate Assistance *MaxA* = Maximum Assistance *TotalA* = Total Assistance

Wheelchair Mobility		Bed Mobility		Transfers	
W/C management	NA	Rolls/scoots in bed	SBA	Sit-to-stand	SBA
		Supine-to-sit	SBA	Sit/Stand/Pivot	SBA
W/C propulsion	NA	Sit-to-supine	SBA	Toilet Transfers	NT
		Sit to EOB	SBA	Shower/Tub Transfers	NT

Equipment needs:

Strength: 5 = Normal 4 = Good 3 = Fair 2 = Poor 1 = Trace 0 = Absent
RUE: 4 LUE: + 3 Comments:
RLE: 4 LLE: + 3

ROM: (Specify movement/degree of range/PROM/AROM)
UE: **AROM WFL for both upper limbs, limited to 90 degrees at this time due to cervical surgery**
LE: **AROM WFL for both lower limbs**

Balance Assessment:
Standing: Static ⊖ Normal ○ Good ○ Fair ○ Poor Dynamic ⊖ Normal ○ Good ○ Fair ○ Poor
Sitting: Static ⊖ Normal ○ Good ○ Fair ○ Poor Dynamic ⊖ Normal ○ Good ○ Fair ○ Poor
Comments:

Oasis Home Health, Inc

PHYSICAL THERAPY EVALUATION

Patient: Russo, Simone F. - 000107195 Home Health Provider: Patel, Ashish (PT) Date of Assessment: 02/28/2018

Gait Assessment: Weight bearing status: ☑ R ☑ L LE Assistive Device(s): **4WW**
Distance walked: **110 ft** Surface type: **Level**
Assistance required: Indoors: **SBA Exiting home/outdoors: NT**
steps in/out of home: **1 step entry** ☐ w/rail or ☑ w/o rail
Additional gait assessment findings:

Gait Deviations: ☑ Ataxic gait pattern ☐ Antalgic gait pattern ☐ Festinating ☐ Shuffling ☑ Decreased gait speed ☑ Widened base of support
☐ Other:
OTHER TESTING PERFORMED (SPECIFY):

This form has been electronically signed by:
Patel, Ashish (PT) PT 02/28/2018 10:13:35 PM CST

Page < 1 >

VARIABLE FACTORS/ CONDITIONS AFFECTING PATIENT'S RESPONSE

Anticipated Outcomes / Treatment Goals

Frequency/Duration of Treatment: PT/PTA: 2 x week for 3 weeks starting 02/25/2018 (week 6)

Interventions/Education Provided

Interventions

PT TREATMENT PLAN:
Instruct Pt/Cg: Posture Training/Exercises Start Effective Date: 02/03/2018
Instruct Pt/Pcg: Balance exercises; sitting and standing. Start Effective Date: 02/03/2018
Instruct Pt/Pcg: Gait Training Start Effective Date: 02/03/2018
Instruct Pt/Pcg: Home Exercise Program Start Effective Date: 02/03/2018
Instruct Pt/Pcg: Lower Body Muscle Strengthening Exercises Start Effective Date: 02/03/2018
Instruct Pt/Pcg: Transfer Training Start Effective Date: 02/03/2018

Intervention specifics:

Continued seated exercises for both lower limbs x 30 reps, all planes of motion.
Lumbar stretches x 20 second hold x 10 reps for both lower limbs
Seated upper limb exercises x 20 reps for left hand/arm numbness
Gait training with 4WW with emphasis on increased step length and stance time.

Response to interventions/education:

Continues to tolerate all therapy interventions well, need to work more balance related exercises to help improve functional ambulation and decreased risk for falls.
Patient educated to work more on balance exercises and transitional movements for sit to stand as he has most difficulty with this activity.

Supplies Used/Issued:

Goal Status

Goals

PT SHORT TERM AND LONG TERM GOALS:
Ambulation endurance will be 3 mins or 300 feet within 4 wks Start Effective Date: 02/03/2018 Progress Toward Goal: 30%
Demonstrate proper use of 4WW within 4 wks Start Effective Date: 02/03/2018 Progress Toward Goal: 40%
Demonstrates ability to follow home exercise program by requiring no verbal cues. Start Effective Date: 02/03/2018 Progress Toward Goal:

Oasis Home Health, Inc

PHYSICAL THERAPY EVALUATION

Patient: Russo, Simone F. - 000107185 Home Health Provider: Patel, Ashish (PT) Date of Assessment: 02/26/2018

60%
Improve strength of both lower limbs to 4-/5 within 4 wks Start Effective Date: 02/03/2018 Progress Toward Goal: 60%
Improve transfers to Mod I assist using 4WW within 4 wks Start Effective Date: 02/03/2018 Progress Toward Goal: 60%
Independent with transfer skills within 4 wks Start Effective Date: 02/03/2018 Progress Toward Goal: 60%
Patient will meet max. rehab potential within 4 wks Start Effective Date: 02/03/2018 Progress Toward Goal: 60%
Return to optimal and safe functionality within 4 wks Start Effective Date: 02/03/2018 Progress Toward Goal: 60%

Ongoing skilled need *(select all that apply and describe)*: ☑ Impaired ROM ☐ Impaired ADL/IADL ☐ Impaired sensory function ☐ Impaired cognitive
☐ Pain ☑ Fall risk ☐ Other

Care Planning/Coordination

☐ Changes made to Plan of Care *(Specify)*:
☐ Patient, Patient's Representative and Caregiver (if any and as appropriate) agreed to and participated in Plan of Care changes
Care Coordination with: ☐ Physician ☐ Case Manager ☐ Clinical Manager ☐ SN ☐ PT ☐ PTA ☐ OT ☐ COTA ☐ ST ☐ Aide ☐ MSW ☑ Other: **HH agency**
Coordination details: **continued PT needs**
Discharge Plan activities: **contiue till all goals are met regarding home PT**
☐ Changes made to Discharge Plan (indicate changes below) ☐ Patient, Patient's Representative (if any) and Caregiver were involved in and agreed with changes

Discharge Planning

PT DISCHARGE PLAN:
Discharge to care of: Self/Caregiver/Physician Start Effective Date: 02/03/2018
Discharge when patient/team goals met Start Effective Date: 02/03/2018

Plans for next visit:

continue with newly established POC for therapy services for additional 3 weeks thus to improve functional independence

Date of next physician visit:

New or changed Meds/ Treatments since last visit? ○ Yes ◉ No

Physician order completed for above changes? ◉ Yes ○ No

What does pt/cg want to accomplish during this course of treatment? get stronger and walk longer distances, return to PLOF

Rehab Potential

PT REHAB POTENTIAL:
PT Rehab Potential: Good Start Effective Date: 02/03/2018

Safety Measures

SAFETY MEASURES:
Clear Pathways Start Effective Date: 01/26/2018
Fall Precautions Start Effective Date: 02/03/2018
Keep Pathways Clear Start Effective Date: 02/03/2018
Use of Assistive Devices Start Effective Date: 02/03/2018

Conferenced with: Home health agency

Comments

1. No changes in medications since last visit
2. No open skin sores note for both feet

Patient's Signature

Oasis Home Health, Inc

PHYSICAL THERAPY EVALUATION

Patient: Russo, Simone F. - 000107185 Home Health Provider: Patel, Ashish (PT) Date of Assessment: 02/28/2018

See paper

Signed on 03/07/2018 10:57:05 PM CST

Physician Signature: Date: 4/04/18

This form has been electronically signed by:
Patel, Ashish (PT) PT 02/28/2018 10:13:35 PM CST

Oasis Home Health, Inc
5010 S Decatur Blvd
Las Vegas, NV 89118
702-382-3030 - phone
702-382-9394 - fax

Fax

To: Thalgott, John (MD) From: Oasis Home Health, Inc
Fax: 17028789642 Pages: 3
Date: 03/14/2018

Please return fax to 702-382-9394.

Oasis Home Health, Inc
5010 S Decatur Blvd
Las Vegas, NV 89118
702-382-3030 - phone
702-382-9394 - fax

Fax

To: Thalgott, John (MD) **From:** Oasis Home Health, Inc
Fax: 17028789642 **Pages:** 6
Date: 04/19/2018

Please return fax to 702-382-9394.

COMMENTS: We have all order back signed except for these. Please sign and fax back ASAP.Thanks.

Oasis Home Health, Inc

PHYSICAL THERAPY EVALUATION

Patient: Russo, Simone F. - 000107195 Home Health Provider: Patel, Ashish (PT) Date of Assessment: 02/03/2018

Mileage: Time In: **1:00 PM** Time Out: **1:45 PM**

Duration: **45** Minutes

Physician Name: Tringali, John (MD) DOB: 9/5/1942

Physician Fax: **702-878-9642**

Date Physician Contacted: **02/03/2018** Time Physician Contacted: **2:00 PM** Treating Dx: **generalized weakness, difficulty ambulating**

Hx of falls: **No** If Accident: type Where:

At risk for falls due to: **NA** Pending litigation: ○ yes ⊖ no

History of current condition/Reason for referral: C4-C7 fusion

Eligibility

HOMEBOUND STATUS:
Requires use of a device and /or the assistance of an other person to leave home. Patient has functional deficits making the ability to leave home difficult. Start Effective Date: 01/26/2018

Prior Level of Function before this episode of illness/injury:

Self care: ☑ Independent ☐ Assistance
Mobility: ☑ Independent ☐ Assistance
Transfers: ☑ Independent ☐ Assistance
Ambulation: ☑ Independent ☐ Assistance
Device(s) used: **4WW**
Comments:

Pain Assessment: Intensity Scale = **7**/10(pre) **8**/10(post)
Location: **neck and left arm** Frequency: **constant**
Pain Characteristics: ☑ sharp ☐ dull/aching ☑ burning ☑ radiating ☐ other
Medications: **See med profile**
Does pain interfere with activity/movement? ○ YES ⊖ NO describe:

Cognition: ☑ WFL ☐ Impaired **Oriented to:** ☑ Person ☑ Place ☑ Time ☑ Events
Sensation: ☑ Intact ☐ Impaired **Tone:** ☑ Intact ☐ Impaired **Posture: Forward flexed**
Vitals: (Assess if indicated by patient dx/status) **BP:** Before exercise **118/77** After exercise ☐ R ☑ L **HR: 62 RESP Rate: 18**
Shortness of breath: ☑ Never ☐ At rest ☐ Walking more than 20 feet ☐ With mod exertion ☐ With min exertion

Functional Assessment Describe level of physical assistance needed, device (s) needed with each item

I = Independent *MI* = Modified Independence *S* = Supervision *MinA* = Minimal Assistance *ModA* = Moderate Assistance *MaxA* = Maximum Assistance *TotalA* = Total Assistance

Wheelchair Mobility		Bed Mobility		Transfers	
W/C management	NA	Rolls/scoots in bed	SBA	Sit-to-stand	SBA
		Supine-to-sit	SBA	Sit/Stand/Pivot	SBA
W/C propulsion	NA	Sit-to-supine	SBA	Toilet Transfers	NT
		Sit to EOB	SBA	Shower/Tub Transfers	NT

Equipment needs: has 4WW

Strength: 5 = Normal 4 = Good 3 = Fair 2 = Poor 1 = Trace 0 = Absent

RUE: **3** LUE: **3** Comments:
RLE: **3** LLE: **3**
left sided weakness greater than right sided weakness

ROM: (Specify movement/degree of range/PROM/AROM)
UE: **AROM WFL for both upper limbs, limited to 90 degrees at this time due to cervical surgery**
LE: **AROM WFL for both lower limbs**

Balance Assessment:
Standing: Static ⊖ Normal ○ Good ○ Fair ○ Poor Dynamic ○ Normal ○ Good ⊖ Fair ○ Poor
Sitting: Static ⊖ Normal ○ Good ○ Fair ○ Poor Dynamic ○ Normal ○ Good ⊖ Fair ○ Poor
Comments:

Oasis Home Health, Inc

PHYSICAL THERAPY EVALUATION

Patient: Russo, Simone F. - 000107195 Home Health Provider: Patel, Ashish (PT) Date of Assessment: 02/03/2018

Gait Assessment: Weight bearing status: **Full** ☒R ☒L LE Assistive Device(s): **4WW**
Distance walked: **35 ft** Surface type: **Level**
Assistance required: Indoors: **SBA** Exiting home/outdoors: **NT**
steps in/out of home: **1 step entry** ☐ w/rail or ☐ w/o rail
Additional gait assessment findings:

Gait Deviations: ☒Ataxic gait pattern ☐ Antalgic gait pattern ☐ Festinating ☒ Shuffling ☒ Decreased gait speed ☒ Widened base of support
☐ Other:
OTHER TESTING PERFORMED (SPECIFY):

This form has been electronically signed by:
Patel, Ashish (PT) PT 02/03/2018 10:04:10 PM CST

Page < 1 2 >

VARIABLE FACTORS/ CONDITIONS AFFECTING PATIENT'S RESPONSE

Anticipated Outcomes / Treatment Goals

Frequency/Duration of Treatment: PT/PTA: 1 x week for 1 week starting 02/03/2018 (week 2), PT/PTA: 2 x week for 3 weeks starting 02/04/2018 (week 3)

Interventions/Education Provided

Interventions

PT TREATMENT PLAN:
Assess: Evaluation of patient's functional status and home environment. Start Effective Date: 02/03/2018
Instruct Pt/Cg: Posture Training/Exercises Start Effective Date: 02/03/2018
Instruct Pt/Pcg: Balance exercises; sitting and standing. Start Effective Date: 02/03/2018
Instruct Pt/Pcg: Gait Training Start Effective Date: 02/03/2018
Instruct Pt/Pcg: Home Exercise Program Start Effective Date: 02/03/2018
Instruct Pt/Pcg: Lower Body Muscle Strengthening Exercises Start Effective Date: 02/03/2018
Instruct PT/Pcg: Safety precautions Start Effective Date: 02/03/2018
Instruct Pt/Pcg: Transfer Training Start Effective Date: 02/03/2018

Intervention specifics:

bilateral lower leg strengthening, dynamic standing balance, balance exercises, transfer training, functional mobility, fall recovery, energy conservation

Response to interventions/education:

tolerated well for first visit/evaluation, PT spoke with patient regarding course of action to help improve functional independence and increased strength for all limbs

Supplies Used/Issued:

Goal Status

Goals

Oasis Home Health, Inc

PHYSICAL THERAPY EVALUATION

Patient: Russo, Simone F. - 000107195 Home Health Provider: Patel, Ashish (PT) Date of Assessment: 02/03/2018

PT SHORT TERM AND LONG TERM GOALS:
Ambulation endurance will be 3 mins or 300 feet within 4 wks Start Effective Date: 02/03/2018
Demonstrate proper use of 4WW within 4 wks Start Effective Date: 02/03/2018
Demonstrates ability to follow home exercise program by requiring no verbal cues. Start Effective Date: 02/03/2018
Improve strength of both lower limbs to 4-/5 within 4 wks Start Effective Date: 02/03/2018
Improve transfers to Mod I assist using 4WW within 4 wks Start Effective Date: 02/03/2018
Independent with ambulation using 4WW within 4 wks Start Effective Date: 02/03/2018
Independent with transfer skills within 4 wks Start Effective Date: 02/03/2018
Patient will meet max. rehab potential within 4 wks Start Effective Date: 02/03/2018
Return to optimal and safe functionality within 4 wks Start Effective Date: 02/03/2018

Ongoing skilled need *(select all that apply and describe):* ☑ Impaired ROM ☑ Impaired ADL/IADL ☐ Impaired sensory function ☐ Impaired cognitive ☑ Pain ☑ Fall risk ☐ Other

Goals discussed as this is first visit since coming home with home health PT.

Care Planning/Coordination

☐ Changes made to Plan of Care *(Specify):*
☐ Patient, Patient's Representative and Caregiver (if any and as appropriate) agreed to and participated in Plan of Care changes
Care Coordination with: ☐ Physician ☐ Case Manager ☐ Clinical Manager ☑ SN ☐ PT ☐ PTA ☑ OT ☐ COTA ☐ ST ☐ Aide ☐ MSW ☐ Other:
Coordination details: **continued PT needs**
Discharge Plan activities: **contiue till all goals are met regarding home PT**
☐ Changes made to Discharge Plan (indicate changes below) ☐ Patient, Patient's Representative (if any) and Caregiver were involved in and agreed with changes

Discharge Planning

PT DISCHARGE PLAN:
Discharge to care of: Self/Caregiver/Physician Start Effective Date: 02/03/2018
Discharge when patient/team goals met Start Effective Date: 02/03/2018

Plans for next visit:

continue with POC as established by PT

Date of next physician visit:

New or changed Meds/ Treatments since last visit? ○ Yes ◉ No

Physician order completed for above changes? ◉ Yes ○ No

What does pt/cg want to accomplish during this course of treatment?

Rehab Potential

PT REHAB POTENTIAL:
PT Rehab Potential: Good Start Effective Date: 02/03/2018

Safety Measures

SAFETY MEASURES:
Fall Precautions Start Effective Date: 02/03/2018
Keep Pathways Clear Start Effective Date: 02/03/2018
Use of Assistive Devices Start Effective Date: 02/03/2018

Conferenced with: Home health agency, RN

Comments

Oasis Home Health, Inc

PHYSICAL THERAPY EVALUATION

Patient: Russo, Simone F. - 000107185 Home Health Provider: Patel, Ashish (PT) Date of Assessment: 02/03/2018

Patient's Signature

See paper

Signed on 02/03/2018 10:01:20 PM CST

Physician Signature: **Date:** 4/20/18

This form has been electronically signed by:
Patel, Ashish (PT) PT,02/03/2018 10:04:10 PM CST

Oasis Home Health, Inc

PHYSICAL THERAPY EVALUATION

Patient: Russo, Simone F. - 000107195 Home Health Provider: Patel, Ashish (PT) Date of Assessment: 02/28/2018

Page < 1 2 >

Mileage: Time In: **11:30 AM** Time Out: **12:15 PM**

Duration: **45 Minutes**

Physician Name: Thalgott, John (MD) DOB: 9/9/1942

Physician Fax: **702-878-9642**

Date Physician Contacted: **02/28/2018** Time Physician Contacted: **1:30 PM** Treating Dx: **generalized weakness, difficulty ambulating**

Hx of falls: **No** If Accident: type Where:

At risk for falls due to: **NA** Pending litigation: ○ yes ◉ no

History of current condition/Reason for referral: C4-C7 fusion

Eligibility

HOMEBOUND STATUS:

Requires use of a device and /or the assistance of an other person to leave home. Patient has functional deficits making the ability to leave home difficult. Start Effective Date: 01/28/2018

Prior Level of Function before this episode of illness/injury:

Self care: ☑ Independent ☐ Assistance

Mobility: ☑ Independent ☐ Assistance

Transfers: ☑ Independent ☐ Assistance

Ambulation: ☑ Independent ☐ Assistance

Device(s) used: **4WW**

Comments:

Pain Assessment: Intensity Scale = 4/10(pre) 5/10(post)

Location: **neck and left arm** Frequency: **constant**

Pain Characteristics: ☐ sharp ☑ dull/aching ☐ burning ☐ radiating ☐ other

Medications: **See med profile**

Does pain interfere with activity/movement? ◉ YES ○ NO describe:

Cognition: ☑ WFL ☐ Impaired **Oriented to:** ☑ Person ☑ Place ☑ Time ☑ Events

Sensation: ☑ Intact ☐ Impaired **Tone:** ☑ Intact ☐ Impaired **Posture: Forward flexed**

Vitals: (Assess if indicated by patient dx/status) **BP:** Before exercise **124/82** After exercise ☐ R ☑ L **HR: 81 RESP Rate: 18**

Shortness of breath: ☑ Never ☐ At rest ☐ Walking more than 20 feet ☐ With mod exertion ☐ With min exertion

Functional Assessment. Describe level of physical assistance needed, device (s) needed with each item

I = Independent *MI* = Modified Independence *S* = Supervision *MinA* = Minimal Assistance *ModA* = Moderate Assistance *MaxA* = Maximum Assistance *TotalA* = Total Assistance

Wheelchair Mobility		Bed Mobility		Transfers	
W/C management	NA	Rolls/scoots in bed	SBA	Sit-to-stand	SBA
		Supine-to-sit	SBA	Sit/Stand/Pivot	SBA
W/C propulsion	NA	Sit-to-supine	SBA	Toilet Transfers	NT
		Sit to EOB	SBA	Shower/Tub Transfers	NT

Equipment needs:

Strength: 5 = Normal 4 = Good 3 = Fair 2 = Poor 1 = Trace 0 = Absent

RUE: 4 LUE: + 3 Comments:

RLE: 4 LLE: + 3

ROM: (Specify movement/degree of range/PROM/AROM)

UE: **AROM WFL for both upper limbs, limited to 90 degrees at this time due to cervical surgery**

LE: **AROM WFL for both lower limbs**

Balance Assessment:

Standing: **Static** ◉ Normal ○ Good ○ Fair ○ Poor **Dynamic** ◉ Normal ○ Good ○ Fair ○ Poor

Sitting: **Static** ◉ Normal ○ Good ○ Fair ○ Poor **Dynamic** ◉ Normal ○ Good ○ Fair ○ Poor

Comments:

Oasis Home Health, Inc

PHYSICAL THERAPY EVALUATION

Patient: Russo, Simona F. - 000107195 Home Health Provider: Patel, Ashish (PT) Date of Assessment: 02/26/2018

Gait Assessment: Weight bearing status: ☒ R ☒ L LE Assistive Device(s): **4WW**
Distance walked: 110 ft Surface type: **Level**
Assistance required: Indoors: **SBA** Exiting home/outdoors: **NT**
 # steps in/out of home: 1 step entry ☐ w/rail or ☒ w/o rail
Additional gait assessment findings:

Gait Deviations: ☒ Ataxic gait pattern ☐ Antalgic gait pattern ☐ Festinating ☐ Shuffling ☒ Decreased gait speed ☒ Widened base of support
☐ Other:
OTHER TESTING PERFORMED (SPECIFY):

This form has been electronically signed by:
Patel, Ashish (PT) PT 02/26/2018 10:13:35 PM CST

Page < 1 >

VARIABLE FACTORS/ CONDITIONS AFFECTING PATIENT'S RESPONSE

Anticipated Outcomes / Treatment Goals

Frequency/Duration of Treatment: PT/PTA: 2 x week for 3 weeks starting 02/25/2018 (week 6)

Interventions/Education Provided

Interventions

PT TREATMENT PLAN:
Instruct Pt/Cg: Posture Training/Exercises Start Effective Date: 02/03/2018
Instruct Pt/Pcg: Balance exercises; sitting and standing. Start Effective Date: 02/03/2018
Instruct Pt/Pcg: Gait Training Start Effective Date: 02/03/2018
Instruct Pt/Pcg: Home Exercise Program Start Effective Date: 02/03/2018
Instruct Pt/Pcg: Lower Body Muscle Strengthening Exercises Start Effective Date: 02/03/2018
Instruct Pt/Pcg: Transfer Training Start Effective Date: 02/03/2018

Intervention specifics:

Continued seated exercises for both lower limbs x 30 reps, all planes of motion.
Lumbar stretches x 20 second hold x 10 reps for both lower limbs
Seated upper limb exercises x 20 reps for left hand/arm numbness
Gait training with 4WW with emphasis on increased step length and stance time.

Response to interventions/education:

Continues to tolerate all therapy interventions well, need to work more balance related exercises to help improve functional ambulation and decreased risk for falls.
Patient educated to work more on balance exercises and transitional movements for sit to stand as he has most difficulty with this activity.

Supplies Used/Issued:

Goal Status

Goals

PT SHORT TERM AND LONG TERM GOALS:
Ambulation endurance will be 3 mins or 300 feet within 4 wks Start Effective Date: 02/03/2018 Progress Toward Goal: 30%
Demonstrate proper use of 4WW within 4 wks Start Effective Date: 02/03/2018 Progress Toward Goal: 40%
Demonstrates ability to follow home exercise program by requiring no verbal cues. Start Effective Date: 02/03/2018 Progress Toward Goal:

Oasis Home Health, Inc

PHYSICAL THERAPY EVALUATION

Patient: Russo, Simona F. - 000107195 Home Health Provider: Patel, Ashish (PT) Date of Assessment: 02/28/2018

50%
Improve strength of both lower limbs to 4-/5 within 4 wks Start Effective Date: 02/03/2018 Progress Toward Goal: 50%
Improve transfers to Mod I assist using 4WW within 4 wks Start Effective Date: 02/03/2018 Progress Toward Goal: 50%
Independent with transfer skills within 4 wks Start Effective Date: 02/03/2018 Progress Toward Goal: 50%
Patient will meet max. rehab potential within 4 wks Start Effective Date: 02/03/2018 Progress Toward Goal: 50%
Return to optimal and safe functionality within 4 wks Start Effective Date: 02/03/2018 Progress Toward Goal: 50% ☐

Ongoing skilled need *(select all that apply and describe)*: ☐ Impaired ROM ☒ Impaired ADL/IADL ☐ Impaired sensory function ☐ Impaired cognitive

☐ Pain ☒ Fall risk ☐ Other

Care Planning/Coordination

☐ Changes made to Plan of Care *(Specify)*:

☐ Patient, Patient's Representative and Caregiver (if any and as appropriate) agreed to and participated in Plan of Care changes

Care Coordination with: ☐ Physician ☐ Case Manager ☐ Clinical Manager ☐ SN ☐ PT ☐ PTA ☐ OT ☐ COTA ☐ ST ☐ Aide ☐ MSW ☒ Other: **HH agency**

Coordination details: **continued PT needs**

Discharge Plan activities: **contiue till all goals are met regarding home PT**

☐ Changes made to Discharge Plan (Indicate changes below) ☐ Patient, Patient's Representative (if any) and Caregiver were involved in and agreed with changes

Discharge Planning

PT DISCHARGE PLAN:
Discharge to care of: Self/Caregiver/Physician Start Effective Date: 02/03/2018
Discharge when patient/team goals met Start Effective Date: 02/03/2018

Plans for next visit:

continue with newly established POC for therapy services for additional 3 weeks thus to improve functional independence

Date of next physician visit:

New or changed Meds/ Treatments since last visit? ○ Yes ⊖ No

Physician order completed for above changes? ⊖ Yes ○ No

What does pt/cg want to accomplish during this course of treatment? get stronger and walk longer distances, return to PLOF

Rehab Potential

PT REHAB POTENTIAL:
PT Rehab Potential: Good Start Effective Date: 02/03/2018

Safety Measures

SAFETY MEASURES:
Clear Pathways Start Effective Date: 01/26/2018
Fall Precautions Start Effective Date: 02/03/2018
Keep Pathways Clear Start Effective Date: 02/03/2018
Use of Assistive Devices Start Effective Date: 02/03/2018

Conferenced with: Home health agency

Comments

1. No changes in medications since last visit
2. No open skin sores note for both feet

Patient's Signature

Oasis Home Health, Inc

OCCUPATIONAL THERAPY EVALUATION

Patient: Russo, Simone F. - 000107195 Home Health Provider: Ndoko, Becky (OT) Date of Assessment: 02/01/2018

Mileage: Time In: 1:25 PM Time Out: 2:10 PM

Duration: 45 Minutes

Treating Dx: Muscle weakness

Physician Name: Thalgott, John (MD) Physician Fax: 702-878-9642 DOB 9/5/1942

Date Physician Contacted: 02/01/2018 Time Physician Contacted: Hx of Falls: Yes

Physical Environment: Patient lives with spouse (available 24/7) in a SSH.

Past Medical/Social Hx: C4-C7 Laminectomy, C4-C7 Exploration of fusion, C4-C7 Posterior fusion secondary to progressive quadriparesis ataxia and restenosis.

Eligibility

HOMEBOUND STATUS:
Requires use of a device and /or the assistance of an other person to leave home. Patient has functional deficits making the ability to leave home difficult.
Start Effective Date: 02/01/2018

Prior Level of Function before this episode of illness/injury:
Toileting: ○ Independent ⊖ Assistance
Mobility: ○ Independent ⊖ Assistance
Transfers: ○ Independent ⊖ Assistance
Bath/Shower: ○ Independent ⊖ Assistance
Homemaking: ○ Independent ⊖ Assistance
Dressing: ○ Independent ⊖ Assistance

Pain Assessment: Intensity scale = 7/10
Location: L UE
Pain Characteristics: ☐ sharp ☒ dull/ aching ☐ burning ☐ radiating ☐ other
Medications: Patient takes Pain medications.
Does pain interfere with activity/ movement? ⊖ YES ○ NO If Yes, describe:
Pain affects ability to complete ADLs.

Comments:

Current Level of Functioning: I=INDEPENDENT S=SUPERVISION A=ASSISTANCE D=DEPENDENT E=EQUIPMENT

	I	S	A	D	E			I	S	A	D	E	
FEEDING/ MEAL SET UP	⊖	○	○	○	☐		TOILETING	○	○	⊖	○	☐	4WW
GROOMING	○	○	⊖	○	☒	4WW	TRANSFERS:						
BATH/ SHOWER	○	○	⊖	○	☒		Sit-to-stand	○	○	⊖	○	☐	Min A
DRESS UPPER BODY	⊖	○	○	○	☐		Sit/ Stand/ Pivot	○	○	○	○	☐	CGA
DRESS LOWER BODY	○	○	⊖	○	☒	Max A from spouse	Toilet Transfers	○	○	⊖	○	☒	Min A with 4WW
HOMEMAKING	○	○	○	⊖	☐	Dependent on Spouse	Shower/ Tub Transfers	○	○	⊖	○	☒	Shower Chair.

OCCUPATIONAL/ LEISURE INTERESTS:

Comments:

Equipment in home: 4WW, Shower chair, grab bars.

Equipment needed: None

Shortness of breath: ☒ Never ☐ At rest ☐ Walking more than 20 feet ☐ With mod exertion ☐ With min exertion

Cognition: ☒ WFL ☐ Impaired: Oriented to: ☒ Person ☒ Place ☒ Time ☒ Events

Sensation: ☐ Intact ☒ Impaired: Sensation impaired in LE's, and minimally in L UE. Tone: ☒ Intact ☐ Impaired

Fine Motor Coordination: ☐ WFL ☒ Impaired: FM coordination impaired in Moderately in L UE/ Mildly in R UE. Patient demonstrates Fair (-) fine motor coordination.

Gross Motor Coordination: ☒ WFL ☐ Impaired:

Upper Extremity Function: WFL

ROM: (Specify movement/ degree of range/ PROM/ AROM) WFL

STRENGTH: 5=Normal 4=Good 3=Fair 2=Poor 1=Trace 0=Absent

Additional testing/ comments: RUE/LUE strength not tested secondary to cervical spinal precautions. Barthel Index of Activities of Daily Living: Patient scored 12/20 indicating disability with functional performance.

Oasis Home Health, Inc

OCCUPATIONAL THERAPY EVALUATION

Patient: Russo, Simone F. - 000107195 Home Health Provider: Ndoko, Becky (OT) Date of Assessment: 02/01/2018

RUE: LUE: Right Hand: + 3 Left Hand: 3 Balance/ Mobility: **Patient requires Min A with functional mobility within home environment.**

Frequency/ Duration of Treatment: OT/COTA: 2 x week for 4 weeks starting 02/04/2018 (week 3)

Interventions/Education Provided

Interventions

OT TREATMENT PLAN:
Assess: Evaluation of patient's functional status and home environment. Start Effective Date: 02/01/2018
Instruct Pt/Pcg: ADL training Start Effective Date: 02/01/2018
Instruct Pt/Pcg: Home safety precautions Start Effective Date: 02/01/2018
Instruct Pt/Pcg: Tub/shower safety Start Effective Date: 02/01/2018

Intervention specifics:
OT Evaluation. Education provided on cervical spine precautions. Patient stated he is not aware of any precautions. Patient requires continued education/training with cervical spine precautions to increase safety with ADLs. Functional mobility training completed within home environment. Patient required Min A using 4WW. Bed mobility training completed with Min A. Patient required verbal cues for log rolling techniques to maintain spinal precautions.
Patient/spouse educated on increasing shower chair height to facilitate patient's ability to complete sit>stands in walk in shower. Education provided on use of grab bars to facilitate safety with bathing tasks.

Patient/spouse educated on OT POC/Frequency.
Response to interventions/education:
Patient tolerated treatment session well.

Supplies Used/Issued: 4WW

Goal Status

Goals

OT SHORT TERM AND LONG TERM GOALS:
Start Effective Date: 02/02/2018
Patient will increase fine motor coordination in B UE's to Fair (+) in order to manipulate small objects. Start Effective Date: 02/02/2018
Patient will safely complete all functional transfers with Supervision. Start Effective Date: 02/02/2018
Patient will safely complete all Lower body dressing tasks with Supervision. Start Effective Date: 02/02/2018
Patient will safely transition from supine<>sitting position with Modified Independence. Start Effective Date: 02/02/2018
Patient will verbalize and demonstrate 100% return with cervical spine precautions in order to increase safety with ADL performance. Start Effective Date: 02/02/2018

Ongoing skilled need *(select all that apply and describe)*: ☐ Impaired ROM ☑ Impaired ADL/IADL ☑ Impaired sensory function ☐ Impaired cognitive ☑ Pain ☑ Fall risk ☐ Other

Care Planning/Coordination

☐ Changes made to Plan of Care *(Specify)*: N/A
☐ Patient, Patient's Representative and Caregiver (if any and as appropriate) agreed to and participated in Plan of Care changes
Care Coordination with: ☐ Physician ☐ Case Manager ☐ Clinical Manager ☐ SN ☐ PT ☐ PTA ☐ OT ☐ COTA ☐ ST ☐ Aide ☐ MSW ☐ Other:
Coordination details: N/A
Discharge Plan activities: N/A
☐ Changes made to Discharge Plan (indicate changes below) ☐ Patient, Patient's Representative (if any) and Caregiver were involved in and agreed with changes

Discharge Planning

OT DISCHARGE PLAN:
Discharge when patient has reached maximum rehab potential. Start Effective Date: 02/02/2018

Plans for next visit:
ADL Training, Bed mobility training, Therapeutic activities.

Oasis Home Health, Inc

OCCUPATIONAL THERAPY EVALUATION

Patient: Russo, Simone F. - 000107195 Home Health Provider: Ndoko, Becky (OT) Date of Assessment: 02/01/2018

Date of next physician visit:

New or changed Meds/ Treatments since last visit? ○ Yes ◉ No

Physician order completed for above changes? ◉ Yes ○ No

What does pt/cg want to accomplish during this course of treatment?

Rehab Potential

OT REHAB POTENTIAL:
OT Rehab Potential: Good Start Effective Date: 02/02/2018

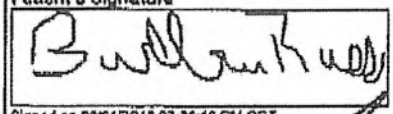
Safety Measures

SAFETY MEASURES:
Safety in ADLs Start Effective Date: 02/02/2018

Conferenced with:

Comments

Patient's Signature



Signed on 02/01/2018 03:36:16 PM CST

Physician Signature: Date: 02/02/2018 4/27/18

This form has been electronically signed by:
Ndoko, Becky (OT) OT 02/02/2018 01:34:33 PM CST

Oasis Home Health, Inc

PHYSICAL THERAPY EVALUATION

Patient: Russo, Simone F. - 000107195 Home Health Provider: Patel, Ashish (PT) Date of Assessment: 02/28/2018

See Paper

Signed on 03/07/2018 10:57:05 PM CST

Physician Signature: Date: 4/20/18

This form has been electronically signed by:
Patel, Ashish (PT) PT 02/28/2018 10:13:35 PM CST

SimonMed
See Tomorrow Today

FINAL

SimonMed-Las Vegas
DIAGNOSTIC IMAGING REPORT

Patient: Russo, Simone Sex: M DOB: Sep 05, 1942 Age: 76 Diag. Imaging # 3598769
Status: Outpatient Stat
Referring Physician: JOHN THALGOTT M.D.

Exam # 25286129 - Dec 13, 2018 - MRI 3T - CERVICAL SPINE W/O CONTRAST

Exam Performed at SimonMed-Las Vegas

INDICATION: M54.12 - Radiculopathy, cervical region. M48.02 - Spinal stenosis, cervical region.

COMPARISON: Outside cervical spine MRI from September 21, 2016. Outside cervical spine CT study (report only, no images available for review) from 11/15/2017.

TECHNIQUE: Multiplanar, multisequential MR images of the cervical spine were obtained without contrast.

FINDINGS:

Postoperative changes of anterior cervical fusion from C4 through C6 with a ventral plate and anterior fixation screws, new in comparison to the prior MRI study. Findings consistent with the previously reported partial corpectomy of C5 with intervertebral prosthesis. Apparent postoperative changes of unilateral right posterior fusion with suspected right hemilaminectomy defects, which appears to be from the C3 through C7 levels. Associated magnetic susceptibility artifact limits regional evaluation.

Reversal of the normal cervical lordosis from C4 through C7, new in comparison to the prior MRI study from 2016. Vertebral body heights at the nonoperative levels are maintained. Apparent grade 1 anterolisthesis of C4 on C5, similar in appearance to the prior MRI study from 2016. Multilevel disc dessication. Intervertebral disc heights at the nonoperative levels are preserved. No discrete aggressive bone marrow lesions.

Cerebellar tonsils are not low lying. Visualized pons and medulla are unremarkable. Cervicomedullary junction is unremarkable.

Evaluation of the spinal cord signal is slightly limited by motion artifact. Subtle T2/STIR signal hyperintensity within the cord at C3-C4 likely relates to myelomalacia/edema. Apparent signal hyperintensity within the right hemicord at the C5 level also likely relates to myelomalacia/edema, likely with some associated atrophy of the right hemicord.

C2-C3: Circumferential disc osteophyte complex, right greater than left uncovertebral joint hypertrophy and minimal bilateral facet arthrosis. Moderate to severe right and moderate left neuroforaminal narrowing. Effacement of the ventral CSF space with mild to moderate spinal canal stenosis. Findings appear slightly progressed over the interval.

C3-C4: Circumferential disc osteophyte complex, asymmetric to the right. Right greater than left uncovertebral joint hypertrophy and bilateral facet arthrosis. Bilateral ligamentum flavum redundancy. Severe bilateral neuroforaminal narrowing. Severe spinal canal stenosis with flattening of the ventral and likely dorsal lateral aspects of the cord. Findings appear progressed over the interval.

C4-C5: Evidence of interval postoperative changes in comparison to the prior MRI study. Apparent posterior osteophytic ridging. Bilateral uncovertebral joint hypertrophy and apparent bilateral facet arthrosis. Severe bilateral neuroforaminal narrowing. Near complete effacement of the ventral CSF space with moderate to severe spinal canal stenosis. Apparent flattening of the ventral cord.

C5-C6: Evidence of interval postoperative changes in comparison to the prior MRI study. Posterior osteophytic ridging and bilateral uncovertebral joint hypertrophy. Right greater than left facet arthrosis. Moderate to severe right and severe left neuroforaminal narrowing. Apparent right ligamentum flavum redundancy, resulting in effacement of the right dorsolateral aspect of the thecal sac. Effacement of the ventral thecal sac with borderline spinal canal stenosis.

C6-C7: Evidence of interval postoperative changes in comparison to the prior MRI study. Posterior osteophytic ridging, bilateral uncovertebral joint hypertrophy and bilateral facet arthrosis. Moderate right and severe left neuroforaminal narrowing. No significant spinal canal stenosis.

C7-T1: No significant disc abnormality, spinal canal stenosis, or neural foraminal narrowing. Bilateral uncovertebral joint hypertrophy and bilateral facet arthrosis. Motion artifact limits evaluation for the degree of neuroforaminal narrowing with suspected moderate to severe bilateral neuroforaminal narrowing. No significant spinal canal stenosis. No significant interval change.

Prevertebral, paraspinal and posterior soft tissues are unremarkable.

Visualized thyroid gland is unremarkable. Visualized lung apices are grossly unremarkable. Visualized carotid and vertebral arteries are patent with expected flow-void signal. Suspected polyp or mucosal retention cyst within the inferior right maxillary sinus.

IMPRESSION:

1. Postoperative changes of anterior cervical fusion from C4 through C6 and suspected unilateral right posterior fusion with suspected right hemilaminectomy defects from the C3 through C7 levels, new in comparison to the prior MRI study. Associated magnetic susceptibility artifact limits regional evaluation.

2. Multilevel degenerative changes, worst at C3-C4, where there is resultant severe bilateral neuroforaminal narrowing and severe spinal canal stenosis with flattening of the spinal cord. Please see above for additional details/findings at the individual levels.

3. Signal hyperintensity within the cord at C3-C4 and within the right hemicord at the C5 level likely relates to myelomalacia/edema, likely with some associated atrophy of the right hemicord at the C5 level.

4. Reversal of the normal cervical lordosis from C4 through C7, new in comparison to the prior MRI study from 2016.

5. Apparent grade 1 anterolisthesis of C4 on C5, similar in appearance.

6. Suspected polyp or mucosal retention cyst within the inferior right maxillary sinus.

The critical findings above have been communicated directly by myself via telephone to Dr. Thalgott on 12/13/2018 at 12:28 PM MST.

ELECTRONICALLY SIGNED BY: Russell D.O., Hannah on Dec 13, 2018

dd: December 13, 2018

Reported by: Hannah Russell D.O.
Electronically signed by: Hannah Russell D.O.

Thank you for your kind referral. If you would like to speak with a Radiologist regarding this exam please call 1-855-RAD-TALK.

DESERT RADIOLOGY
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702-759-8600
WWW.DESERTRAD.COM

MEDICAL IMAGING REPORT
REPORT STATUS: FINAL

Name:	SIMONE RUSSO	**DOB:**	9/5/1942
Patient ID:	000265079	**Gender:**	Male
Exam Date:	5/31/2018 01:59 PM	**Site:**	CENTRA POINT
Age:	75Y 9M	**Acc #:**	510402337
Exam Name:	MR CERVICAL WO CONTRAST | 72141	**Secondary Acc #:**	510402337
Pt Status:			
Referrer:	JONATHAN MCKINNON		
Ref1 Address:	351 N. BUFFALO DR STE B LAS VEGAS, NV 89145		

ADDENDUM

Addendum 1

Addendum created by Christina Geatrakas MD on 6/5/2018 9:43:49 AM PDT

6/5/2018 9:36:32 AM PDT - vRad OC Support:
The physician's office confirmed they did receive the report and Dr. McKinnon scanned it into the patient's chart.
Initial report created on 6/4/2018 11:42:38 AM PDT

EXAM:
MR Cervical Spine Without Intravenous Contrast

EXAM DATE/TIME:
5/31/2018 12:30 PM.The examination was performed on 5/31/2018 but only made available to the interpreting radiologist for review on 6/4/2018.

CLINICAL HISTORY:
75 years old, male; Spinal stenosis, cervical region; Other abnormalities of gait and mobility; Spinal stenosis, lumbar region without neurogenic claudication Sched w pt spouse, ref pt hc, lbs 200, c and l fusions, prep given, demos/ins ver pain cervical and lumbar spine stenosis. Gait disorder peripheral nerve weakness/ hands. Bilat weakness/numbness to legs. Previous surg. L-sp 2012, c-sp. 2017,1-2018. Rrj

TECHNIQUE:
Magnetic resonance images of the cervical spine without intravenous contrast in multiple planes.

COMPARISON:
XA - XR SPINE CERVICAL 2 OR 3 VIEWS 2018-01-12 09:42, CT CERVICAL SP WO CONTRAST 11/15/2017 2:14:04 PM

Continued...

Name: SIMONE RUSSO
Patient ID: 000255079

Date of Birth: 9/5/1942
Gender: Male
Location: CP

FINDINGS:
Vertebrae: Status post ACDF of C4-C6 with C5 corpectomy. Status post interval posterior decompression of C5-C7. A multiloculated fluid collection is present in the operative bed of C5-C7 measuring 6.5 x 1.9 x 3.2 cm. This is confined to the decompression bed and dorsal epidural space. The dura is intact and there is no evidence of direct communication between the thecal sac/CSF space and the collection. Low grade residual postoperative edema of the C3 and C4 spinous processes is demonstrated and there is mild facet periarticular edema on the left at C3-C4.
Vertebral body height is maintained at each level. There is no acute cervical spondylolisthesis.
Spinal cord: See below.
Soft tissues: Prevertebral soft tissues are normal.

DISCS/SPINAL CANAL/NEURAL FORAMINA:
C2-C3: 3 mm disc bulge. Moderate central canal stenosis. Severe left and moderate right neural foraminal stenosis.
C3-C4: Signal hyperintensity is seen within the spinal cord at C3-C4. There is severe central canal stenosis with 3 mm disc bulge and ligamentum flavum hypertrophy causing direct mass effect on the spinal cord. The thecal sac is effaced. Severe bilateral neural foraminal stenosis secondary to uncovertebral and facet arthropathy.
C4-C5: Moderate central canal stenosis. No disc herniation. Severe left and moderate right neural foraminal stenosis.
C5-C6: No disc herniation. The residual vertebral body of C5 demonstrates slight posterior inferior endplate ridging. There is mild bilateral neural foraminal stenosis. No central canal stenosis.
C6-C7: Less than 2 mm disc bulge or focal scar. No central canal stenosis. Moderate left and mild right neural foraminal stenosis.
C7-T1: No disc herniation or central canal stenosis. Severe bilateral neuroforaminal stenosis secondary to uncovertebral and facet arthropathy.

IMPRESSION:
1. Severe central canal stenosis at C3-C4 with direct mass effect on the spinal cord demonstrating signal hyperintensity indicative of edema or developing myelomalacia. This is secondary to 3 mm disc bulge and ligamentum flavum hypertrophy. Severe bilateral neural foraminal stenosis is present.
2. Moderate central canal stenosis at C4-C5. No disc herniation. Severe left and moderate right neural foraminal stenosis.
3. Severe left and moderate right neural foraminal stenosis at C2-C3. Moderate central canal stenosis with 3 mm disc bulge.
4. Severe bilateral neural foraminal stenosis at C7-T1 secondary to uncovertebral and facet arthropathy.
5. No acute complication of C4-C6 ACDF and C5 corpectomy.
6. Interval posterior decompression of C5-C7 with fluid collection in the operative bed abutting the dorsal thecal sac but without communication to the CSF space.

Addendum Radiologist: CHRISTINA GEATRAKAS
Transcribed By: CHRISTINA GEATRAKAS
Transcribed Date: 6/5/2018 09:43 AM
Electronically Signed by: CHRISTINA GEATRAKAS
Signed Date: 6/5/2018 09:43 AM

EXAM:
MR Cervical Spine Without Intravenous Contrast

EXAM DATE/TIME:
5/31/2018 12:30 PM.The examination was performed on 5/31/2018 but only made available to the interpreting radiologist for review on 6/4/2018.

CLINICAL HISTORY:
75 years old, male; Spinal stenosis, cervical region; Other abnormalities of gait and mobility; Spinal stenosis, lumbar region without neurogenic claudication Sched w pt spouse, ref pt hc, lbs 200, c and l fusions, prep given, demos/ins ver pain cervical and lumbar spine stenosis. Gait disorder peripheral nerve weakness/ hands. Bilat weakness/numbness to legs. Previous surg. L-sp 2012, c-sp. 2017,1-2018. Rrj

TECHNIQUE:
Magnetic resonance images of the cervical spine without intravenous contrast in multiple planes.

COMPARISON:
XA - XR SPINE CERVICAL 2 OR 3 VIEWS 2018-01-12 09:42, CT CERVICAL SP WO CONTRAST 11/15/2017 2:14:04 PM

FINDINGS:
Vertebrae: Status post ACDF of C4-C6 with C5 corpectomy. Status post interval posterior decompression of C5-C7. A multiloculated fluid collection is present in the operative bed of C5-C7 measuring 6.6 x 1.9 x 3.2 cm. This is confined to the decompression bed and dorsal epidural space. The dura is intact and there is no evidence of direct communication between the thecal sac/CSF space and the collection. Low grade residual postoperative edema of the C3 and C4 spinous processes is demonstrated and there is mild facet periarticular

Continued...

Name: SIMONE RUSSO
Patient ID: 000255079
Date of Birth: 9/5/1942
Gender: Male
Location: CP

edema on the left at C3-C4.
Vertebral body height is maintained at each level. There is no acute cervical spondylolisthesis.
Spinal cord: See below.
Soft tissues: Prevertebral soft tissues are normal.

DISCS/SPINAL CANAL/NEURAL FORAMINA:
C2-C3: 3 mm disc bulge. Moderate central canal stenosis. Severe left and moderate right neural foraminal stenosis.
C3-C4: Signal hyperintensity is seen within the spinal cord at C3-C4. There is severe central canal stenosis with 3 mm disc bulge and ligamentum flavum hypertrophy causing direct mass effect on the spinal cord. The thecal sac is effaced. Severe bilateral neural foraminal stenosis secondary to uncovertebral and facet arthropathy.
C4-C5: Moderate central canal stenosis. No disc herniation. Severe left and moderate right neural foraminal stenosis.
C5-C6: No disc herniation. The residual vertebral body of C5 demonstrates slight posterior inferior endplate ridging. There is mild bilateral neural foraminal stenosis. No central canal stenosis.
C6-C7: Less than 2 mm disc bulge or focal scar. No central canal stenosis. Moderate left and mild right neural foraminal stenosis.
C7-T1: No disc herniation or central canal stenosis. Severe bilateral neuroforaminal stenosis secondary to uncovertebral and facet arthropathy.

IMPRESSION:
1. Severe central canal stenosis at C3-C4 with direct mass effect on the spinal cord demonstrating signal hyperintensity indicative of edema or developing myelomalacia. This is secondary to 3 mm disc bulge and ligamentum flavum hypertrophy. Severe bilateral neural foraminal stenosis is present.
2. Moderate central canal stenosis at C4-C5. No disc herniation. Severe left and moderate right neural foraminal stenosis.
3. Severe left and moderate right neural foraminal stenosis at C2-C3. Moderate central canal stenosis with 3 mm disc bulge.
4. Severe bilateral neural foraminal stenosis at C7-T1 secondary to uncovertebral and facet arthropathy.
5. No acute complication of C4-C6 ACDF and C5 corpectomy.
6. Interval posterior decompression of C6-C7 with fluid collection in the operative bed abutting the dorsal thecal sac but without communication to the CSF space.

Report Electronically Signed by: CHRISTINA GEATRAKAS
Report Electronically Signed on: 6/4/2018 11:42 AM

Transcribed By:

Signed by: CHRISTINA GEATRAKAS
Finalized Date: 6/4/2018 11:42 AM

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MEDICAL IMAGING REPORT
REPORT STATUS: FINAL

Name:	SIMONE RUSSO	**DOB:**	9/5/1942
Patient ID:	000255079	**Gender:**	Male
Exam Date:	5/31/2018 02:04 PM	**Site:**	CENTRA POINT
Age:	75Y 9M	**Acc #:**	510402474
Exam Name:	MR LUMBAR WO CONTRAST | 72148	**Secondary Acc #:**	510402474
Pt Status:			
Referrer:	JONATHAN MCKINNON		
Ref'l Address:	351 N. BUFFALO DR STE B LAS VEGAS, NV 89145		

EXAM:
MR Lumbar Spine Without Intravenous Contrast

EXAM DATE/TIME:
5/31/2018 1:00 PM

CLINICAL HISTORY:
75 years old, male; Condition or disease; Stenosis, spinal and other: Gait disorder; Lumbar sacral region

TECHNIQUE:
Magnetic resonance images of the lumbar spine without intravenous contrast in multiple planes.

COMPARISON:
CT LS SP WO CONTRAST 2017-11-15 14:14

FINDINGS:
Vertebrae: Status post anterior and posterior L2-S1 lumbosacral fusion. There is straightening of the normal lumbar lordosis. Interspinous spacers at L2-L3, L3-L4 and L4-L5. There's been a posterior decompression at L5-S1. The vertebral body heights are maintained. No compression fracture.
Marrow: There is T1 hypointensity within the marrow at the L4 and L5 bodies. Signal abnormality not evident on STIR/T2 images. There is a small amount of fluid within the intervertebral discs. The findings may represent postsurgical changes. The possibility of a discitis/vertebral body osteomyelitis not excluded. Please correlate with patient's clinical/laboratory findings.
Spinal cord: The demonstrated cord is normal in signal intensity. The conus medullaris terminates at the L1-L2 level.
Soft tissues: No paraspinal soft tissue mass.

Continued...

Name: SIMONE RUSSO
Patient ID: 000255079

Date of Birth: 9/5/1942
Gender: Male
Location: CP

DISCS/SPINAL CANAL/NEURAL FORAMINA:
T12-L1: No disc herniation identified. No stenosis.
L1-L2: Disc desiccation. Broad-based disc herniation impressing on the ventral aspect of the sac. Facet degenerative change with moderate ligamentous infolding and moderate to severe central canal stenosis. The exiting roots are demonstrated.
L2-L3: Postsurgical changes. No disc herniation identified. No stenosis.
L3-L4: Postsurgical changes. Posterior disc osteophyte complex impresses on the ventral aspect of the sac. Facet degenerative change with ligamentous infolding. Moderate central canal narrowing.
L4-L5: Postsurgical changes. There is a central disc herniation migrating superiorly impressing on the ventral aspect of the sac. There is some flattening the ventral aspect of the sac. There is moderate central canal stenosis.
L5-S1: Postsurgical changes. Disc osteophyte complex impresses on the ventral epidural fat. Mild central canal stenosis. Bilateral foraminal encroachment.

IMPRESSION:
Status post anterior and posterior L2-S1 lumbosacral fusion. There is straightening of the normal lumbar lordosis. Interspinous spacers at L2-L3, L3-L4 and L4-L5. There's been a posterior decompression at L5-S1.
There is T1 hypointensity within the marrow at the L4 and L5 bodies. Signal abnormality not evident on STIR/T2 images. There is a small amount of fluid within the intervertebral discs. The findings may represent postsurgical changes. The possibility of a discitis/vertebral body osteomyelitis not excluded. Please correlate with patient's clinical/laboratory findings.
At L1-L2, there is a broad-based disc herniation impressing on the ventral aspect of the sac. Facet degenerative change with moderate ligamentous infolding and moderate to severe central canal stenosis. The exiting roots are demonstrated.
At L3-L4: Postsurgical changes. There is moderate central canal narrowing.
At L4-L5: Postsurgical changes. There is a central disc herniation migrating superiorly impressing on the ventral aspect of the sac. There is some flattening the ventral aspect of the sac. There is moderate central canal stenosis.
At L5-S1: Postsurgical changes. Disc osteophyte complex impresses on the ventral epidural fat. Mild central canal stenosis. Bilateral foraminal encroachment.

Report Electronically Signed by: Mark Giovannetti
Report Electronically Signed on: 6/4/2018 04:23 AM

Transcribed By:

Signed by: Mark Giovannetti
Finalized Date: 6/4/2018 04:23 AM

vRad

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Final Radiology Report

24/7/365 assistance Call: 866.841.5896 Online chat: https://access.vrad.com

Patient Name:	RUSSO, SIMONE	MRN:	000255079
DOB (Age):	9/5/1942 75	Gender:	M
Date of Exam:	05/31/2018	Accession:	510402337
Referring Physician:	MCKINNON, JONATHAN	# of Images:	118
Ordered As:	MR CERVICAL WO CONTRAST		

EXAM:
MR Cervical Spine Without Intravenous Contrast

EXAM DATE/TIME:
5/31/2018 12:30 PM.The examination was performed on 5/31/2018 but only made available to the interpreting radiologist for review on 6/4/2018.

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FINDINGS:
Vertebrae: Status post ACDF of C4-C6 with C5 corpectomy. Status post interval posterior decompression of C5-C7. A multiloculated fluid collection is present in the operative bed of C5-C7 measuring 6.5 x 1.9 x 3.2 cm. This is confined to the decompression bed and dorsal epidural space. The dura is intact and there is no evidence of direct communication between the thecal sac/CSF space and the collection. Low grade residual postoperative edema of the C3 and C4 spinous processes is demonstrated and there is mild facet periarticular edema on the left at C3-C4. Vertebral body height is maintained at each level. There is no acute cervical spondylolisthesis.
Spinal cord: See below.
Soft tissues: Prevertebral soft tissues are normal.

DISCS/SPINAL CANAL/NEURAL FORAMINA:
C2-C3: 3 mm disc bulge. Moderate central canal stenosis. Severe left and moderate right neural foraminal stenosis.
C3-C4: Signal hyperintensity is seen within the spinal cord at C3-C4. There is severe central canal stenosis with 3 mm disc bulge and ligamentum flavum hypertrophy causing direct mass effect on the spinal cord. The thecal sac is effaced. Severe bilateral neural foraminal stenosis secondary to uncovertebral and facet arthropathy.

C4-C5: Moderate central canal stenosis. No disc herniation. Severe left and moderate right neural foraminal stenosis.
C5-C6: No disc herniation. The residual vertebral body of C5 demonstrates slight posterior inferior endplate ridging. There is mild bilateral neural foraminal stenosis. No central canal stenosis.
C6-C7: Less than 2 mm disc bulge or focal scar. No central canal stenosis. Moderate left and mild right neural foraminal stenosis.
C7-T1: No disc herniation or central canal stenosis. Severe bilateral neuroforaminal stenosis secondary to uncovertebral and facet arthropathy.

IMPRESSION:
1. Severe central canal stenosis at C3-C4 with direct mass effect on the spinal cord demonstrating signal hyperintensity indicative of edema or developing myelomalacia. This is secondary to 3 mm disc bulge and ligamentum flavum hypertrophy. Severe bilateral neural foraminal stenosis is present.
2. Moderate central canal stenosis at C4-C5. No disc herniation. Severe left and moderate right neural foraminal stenosis.
3. Severe left and moderate right neural foraminal stenosis at C2-C3. Moderate central canal stenosis with 3 mm disc bulge.
4. Severe bilateral neural foraminal stenosis at C7-T1 secondary to uncovertebral and facet arthropathy.
5. No acute complication of C4-C6 ACDF and C5 corpectomy.
6. Interval posterior decompression of C5-C7 with fluid collection in the operative bed abutting the dorsal thecal sac but without communication to the CSF space.

Thank you for allowing us to participate in the care of your patient.

Dictated and Authenticated by: Geatrakas, Christina, MD
06/04/2018 11:42 AM Pacific Time (US & Canada)

VHM- Valley Hospital Medical Center
620 Shadow Lane
Las Vegas, NV 89106-4194

Patient: RUSSO, SIMONE F
MRN: VHM63495207; SVH35440123
FIN: VHM0000115712267
DOB/Sex: 9/5/1942 / Male
Patient Room: VHM N2; 0217; 01

Admit: 1/12/2018
Disch: Disch Time:
Attending: Thalgott MD,John
Copy To: n/a

Operative Record

DOCUMENT NAME: Operative Reports
SERVICE DATE/TIME: 1/12/2018 12:07 PST
RESULT STATUS: Auth (Verified)
PERFORM INFORMATION: Thalgott MD,John (1/12/2018 12:18 PST)
SIGN INFORMATION: Thalgott MD,John (1/12/2018 12:18 PST)

Indication for Surgery
Progressive quadriparesis with ataxia

Preoperative Diagnosis
Spinal stenosis status post C4-C6 anterior fusion with subsidence restenosis weakness of left upper extremity C5 with discoordination progressive ataxia and spastic weakness in both lower extremities

Postoperative Diagnosis
Spinal stenosis C4-5 C5-6 C6-7

Operation
1) microscopic complete laminectomy C4-C5-C6 and C7 2) Exploration spinal fusion C4-5 C5-6 C6-7 3) lateral mass instrumentation C4 C5-C6-C7 4) harvest right iliac crest use of local bone graft use of allograft 5) arthrodesis C4-5 C5-6 C6-7 posterior 6) use of fluoroscopy

Surgeon(s)
Thalgott MD, John (Surgeon)

Assistant
P. Davis PAC

Anesthesia Type and Anesthesiologist
General
Klein MD, Ira A (Attending Anesthesiologist)

Estimated Blood Loss
100cc

Urine Output
See anesthesia note

Findings
High grade stenosis C5-6 C6-7

Specimen(s)
None

Complications
None

Technique
Risk procedure gone over in detail the patient is a physician and is with his wife by myself and my staff is a large chance without the surgery that he he will be wheelchair bound he is basically limited household ambulator which is progressive over the last month or 2

Transcription

VHM- Valley Hospital Medical Center

Patient: RUSSO, SIMONE F
MRN: VHM63495207; SVH35440123
FIN: VHM00001157122267

Admit: 1/12/2018
Disch:
Attending: Thalgott MD,John

Operative Record

the patient was worked up and had a paralyzed diaphragm on the right cleared by the pulmonary status he is at high risk for interoperative complications she had E. coli infection in the past he is more likely for E. coli or M MRSA infection at this point he was placed on a Hibiclens regimen 2 days before the day of surgery which he reports being compliant with further risks are decompression operative swelling with vascular salt with a vascular injury to his cord upon 3 mansion postoperative bleeding with epidural hematoma total partial paralysis death patient has a paralyzed diaphragm he if he has phrenic nerve involvement contralateral side he may need a diaphragmatic pacer this may or may not make any difference in his neural status indeed he could be worse to complete completely paralyzed regardless of the technical outcome of the surgery the possibility of CSF leak Mr. malposition of screws positioning neuropathy not limited to but including ulnar neuropathy brachioplexopathy peroneal neuropathy blindness and not make any difference in his symptoms or his ataxia indeed he can be worse as of his progressive neurologic deterioration over the last weeks I felt that decompression posteriorly was indicated. Have a nonunion and had subsidence of his anterior construct and he is implied or given he understood the inherent risks benefits and wished to proceed

Description of procedure after suitable level general anesthesia was obtained neuro monitoring was instituted timeout was done neuro monitoring showed some motor deficit in the left side SSEPs were fairly normal prophylaxis thermoregulation padding bony prominence position on the Jackson table with a horseshoe was done by myself the nursing staff and anesthesia great care was taken to make sure his eyes were protected bony prominences were padded. He was taped in position was checked and image intensification after the timeout was done draping and prepping vancomycin and Ancef were given midline approach was made carried fascia subpericostal dissection exposed the lamina and spinous process on lateral mass at C4-C5-C6 and C7 self-care retractors places was checked and image intensification once that was completed the unilateral lateral mass instrumentation was begun by drilling lateral mass up and out 20° after description Magro at C4 C6 and C7 the rod was instituted unilateral fixation of each be used because of the anterior fixation and a ease of decompression post anteriorly lumber aspects of microscope was then brought into the field and spinous processes and the lamina were debulk with a rondure using a Midas Rex under microscopic control the complete lamina was removed to the lateral masses at C4 and C5-C6 and C7 this technique used the Midas Rex to thin the lamina and then a neural hook lifted the lamina off this dura there were no intrusions into the spinal canal the lateral recesses were taken down with a very small Kerrison once he is completely decompressed motors appeared to disappear this SSEPs remained there were no interoperative occasions the spinal cord was completely decompressed appear to be pulsatile the SSEPs did not change preoperatively than the neurologist was consulted through the monitoring technician who felt that the motors were not reliable once that was completed the decompression was completed the wound was pulse lavaged with protecting spinal cord and a sheet of DuraGen and then DuraSeal was placed over that then a sheet of fibular and FloSeal a small incision was made over the right iliac crest across his open rondure and carina removed bone from iliac crest during the the decompression phase of bone trap was harvested twice and then the local bone graft harvested bone graft and allograft made and also biologic slurry. Prior to starting the decompression instrumentation the push pull test showed that there was motion at every segment C4-5 C5-6 and C6-7. Once that was completed the lateral mass after the interpretation decompression decorticated and the bone graft placed around the lateral masses lateral to the instrumentation vancomycin powder was placed throughout the wound the fascia closed with strata fix subcu drains placed subcu with 2-0 Vicryl skin with running Prolene Bioclusive dressing was placed the harvested bone graft was closed with subcu with 2-0 Vicryl skin with staples Bioclusive dressings placed no interoperative complications noted the this is dictated prior to the patient awakening at 1220

Electronically Signed By: Thalgott, John MD
On: 01.12.2018 12:18 PST

MOUNTAIN VIEW HOSPITAL
A Tenet Health System Hospital

MountainView Hospital
3150 N. Tenaya Way
Las Vegas, NV 89129
Phone: 702.962.7620 | Fax: 702.962.5601
https://mountainview-hospital.com

Physical Therapy

Plan of Care (Re-Evaluation)

Patient Name:	RUSSO, SIMONE F	**Date:**	10/15/2018 03:31 PM
Medical Record #:	G000518062	**DOB:**	9/5/1942
Account #:	G000180011419	**SOC Date:**	8/27/2018
Provider:	Mountain View		
Provider #:			
Treating Clinician:	Denise Randonce, PT		
Referring Physician:	John S Thalgott		
Medicare #:	9500892319	**Visits From SOC:**	11
Certification From:	10/15/2018	**Certification To:**	1/15/2019
Service From:	8/27/2018	**Service To:**	10/15/2018

	Onset Date	Code	Description
Primary Diagnosis:	8/22/2018	M48.02	Spinal stenosis, cervical region

Subjective Comments: Patient reports that if he does not move his bowels, he does not feel able to participate in PT as he has a neurogenic bowel.

Retaining fluid

Patient reports that he is retaining fluid. He has an appt with an internist to attend to his overall health condition.

Prior Functional Status: Independent with no pain or limitation in ambulation, IADL's, work or recreation

Rehabilitative Prognosis: Excellent rehab potential to reach and maintain prior level of function

Systems Review, History: Patient was receiving PT Rx here during one of the episodes when he suffered from overall body weakness. He saw a new neurologist who diagnosed him w/cervical spinal stenosis. Laminectomies were performed on June 11, 2018 and ax gradually reduced. Patient is hopeful tha the can now rehabilitated from all of his spinal issues.

Current Level

Pain: Back Pain - Low Back; At Rest 0/10; With Activity 5/10; Dull; Radiating

Epidurals

Epidurals have been of assistance with pain.

Goals

Impairment Goals; Short Term:
Patient will be independent in HEP in 2 wks - Met
Patient will tolerate 15 min of activity w/o rest in 4 wks - Met
Patient will perform REO WNL in 4 wks - Partially Met
Patient will walk 50 ft w/SPC and supervision in 4 wks - Partially Met

Functional Goals; Long Term:
Patient will have 5/5 strength throughout in 8 wks
Patient will perform TUG timing in <14 sec in 8 wks w/SPC
Patient will be mod I in amb w/SPC >200 ft in 8 wks
Patient will negotiate 4 steps w/rail mod I in 8 wks

Transfer To/From Bed Comments: Mod I

Transfer To/From Chair Comments: Mod I

Ambulation Even Terrain Comments: Patient is able to walk w/FWW mod I. He knows his limitations has has to sit after walking greater than 200 ft.

Ambulation Uneven Terrain Comments: NA

Stair Climbing Comments: NA

Patient Goal(s) and/or Goal Comments: Patient wants to walk better and regain balance. - Partially Met

Physical Therapy

Plan of Care (Re-Evaluation)

Patient Name: RUSSO, SIMONE F
Medical Record #: G000518062
Account #: G00018011419
Provider: Mountain View
Provider #:
Treating Clinician: Denise Readence, PT
Referring Physician: John S Thalgott

Date: 10/15/2018 03:31 PM
DOB: 9/5/1942
SOC Date: 8/27/2018

Patient / Caregiver concurs with established treatment plan and goals: Yes

Range of Motion

AROM is WNL throughout all 4 extremities.

Coordination, Balance, Gait

Romberg
Eyes Open: 14 seconds
Eyes Closed: 0 seconds

Sharpened Romberg
Left: Eyes Open: 0 seconds Eyes Closed: 0 seconds
Right: Eyes Open: 0 seconds Eyes Closed: 0 seconds

Timed Up and Go: 21.2 seconds

Assistive device used during test: FWW

Impairment Observations

Patient continues to be very stressed. He is exercising regularly at home. He has had difficulty donning his ankle supports but definitely walks steadier with them in place. He has had difficulty w/attendance secondary to multiple medical issues but puts forth his best effort in PT. Continued skilled PT Rx is needed to attain goals set upon initial evaluation.

Muscle Tone Comments: Muscle tone appears WNL.

Dominance

Upper Extremity: Left

Strength

Strength is 4+/5 throughout the extremities. Trunk weakness is noted but is improving.

Functional Limitation Reporting

Mobility: Walking and Moving Around

G8978 - Mobility: walking and moving around functional limitation, current status, at therapy episode outset and at reporting intervals

Current Status: CL - At least 60 percent but less than 80 percent impaired, limited or restricted

G8979 - Mobility: walking and moving around functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting

Goal Status: CI - At least 1 percent but less than 20 percent impaired, limited or restricted

Interventions/Plan

EVAL PT HIGH COMPLEX 97163
GAIT TRAINING 15 MIN PT 97116
MANUAL THER TECH 15M PT 97140
NEUROMUSC REEDUCT 15M PT 97112
GAIT TRAINING 15 MIN PT 97116
THER EXERCISES 15 MIN PT 97110
EL ST UN IND NOT WC PT G0283

Frequency of PT: Three times weekly

Duration of PT: 8 weeks

Intervention Comments: Initiated PT Rx on the mat for stretching this date. Assist provided and shoe horn dispensed to don ankle supports. NuStep used at level 6 resistance x 15 min. Treatment ended w/hip abduction on hip machine. PT reassessment completed this date.

Physical Therapy **Plan of Care** (Re-Evaluation)

Patient Name: RUSSO, SIMONE F
Medical Record #: G000518062
Account #: G00018011419
Provider: Mountain View
Provider #:
Treating Clinician: Denise Readence, PT
Referring Physician: John S Thalgott

Date: 10/15/2018 03:31 PM
DOB: 9/5/1942
SOC Date: 8/27/2018

Patient / Caregiver concurs with established treatment plan and goals: Yes

Range of Motion

AROM is WNL throughout all 4 extremities.

Coordination, Balance, Gait

Romberg
Eyes Open: 14 seconds
Eyes Closed: 0 seconds

Sharpened Romberg
Left: Eyes Open: 0 seconds Eyes Closed: 0 seconds
Right: Eyes Open: 0 seconds Eyes Closed: 0 seconds

Timed Up and Go: 21.2 seconds

Assistive device used during test: FWW

Impairment Observations

Patient continues to be very stressed. He is exercising regularly at home. He has had difficulty donning his ankle supports but definitely walks steadier with them in place. He has had difficulty w/attendance secondary to multiple medical issues but puts forth his best effort in PT. Continued skilled PT Rx is needed to attain goals set upon initial evaluation.

Muscle Tone Comments: Muscle tone appears WNL.

Dominance

Upper Extremity: Left

Strength

Strength is 4+/5 throughout the extremities. Trunk weakness is noted but is improving.

Functional Limitation Reporting

Mobility: Walking and Moving Around

GG978 - Mobility: walking and moving around functional limitation, current status, at therapy episode outset and at reporting intervals

Current Status: CL - At least 60 percent but less than 80 percent impaired, limited or restricted

GG979 - Mobility: walking and moving around functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting

Goal Status: CI - At least 1 percent but less than 20 percent impaired, limited or restricted

Interventions/Plan

EVAL PT HIGH COMPLEX 97163
GAIT TRAINING 15 MIN PT 97116
MANUAL THER TECH 15M PT 97140
NEUROMUSC REEDUCT 15M PT 97112
GAIT TRAINING 15 MIN PT 97116
THER EXERCISES 15 MIN PT 97110
EL ST LN IND NOT WC PT G0283

Frequency of PT: Three times weekly
Duration of PT: 8 weeks

Intervention Comments: Initiated PT Rx on the mat for stretching this date. Assist provided and shoe horn dispensed to don ankle supports. NuStep used at level 6 resistance x 15 min. Treatment ended w/hip abduction on hip machine. PT reassessment completed this date.

Physical Therapy

Plan of Care (Re-Evaluation)

Patient Name: RUSSO, SIMONE F
Medical Record #: G000518062
Account #: G00018011419
Provider: Mountain View
Provider #:
Treating Clinician: Denise Readence, PT
Referring Physician: John S Thalgott

Date: 10/15/2018 03:31 PM
DOB: 9/5/1942
SOC Date: 8/27/2018

Discharge Planning: D/C to HEP when LTG's are achieved.

9:48 AM 10/23/18
John S Thalgott Date/Time
I certify the need for these services furnished under this plan of treatment while under my care.

Electronically signed by: 10/16/2018 11:55:06 AM
Denise Readence, PT Date
State License #: 0947

MOUNTAIN VIEW HOSPITAL
A Signature Healthcare System Hospital

MountainView Hospital
3150 N. Tenaya Way
Las Vegas, NV 89129
Phone: 702.962.7620 | Fax: 702.962.5601
https://mountainview-hospital.com

Physical Therapy

Plan of Care (Initial Evaluation)

Patient Name:	RUSSO, SIMONE F	Date:	8/27/2018 03:32 PM
Medical Record #:	G000518062	DOB:	9/5/1942
Account #:	G00017878561	SOC Date:	8/27/2018
Provider:	Mountain View		
Provider #:			
Treating Clinician:	Denise Readence		
Referring Physician:	John S Thalgott		
Medicare #:	9500892319	Visits From SOC:	1
Certification From:	8/27/2018	Certification To:	11/27/2018

	Onset Date	Code	Description
Primary Diagnosis:	8/22/2018	M48.02	Spinal stenosis, cervical region

Subjective Comments: Patient reports that the Myasthenia Gravis diagnosis was not the issue, he had cervical spinal stenosis.

Surgery

Patient underwent C3-4 laminectomies, which reduced cervical spinal stenosis on June 11, 2018.

Prior Functional Status: Independent with no pain or limitation in ambulation, IADL's, work or recreation

Rehabilitative Prognosis: Excellent rehab potential to reach and maintain prior level of function

Decubiti

Patient has decubiti on bilateral buttocks, 2 on R, 1 on L.

Systems Review, History: Patient was receiving PT Rx here during one of the episodes when he suffered from overall body weakness. He saw a new neurologist who diagnosed him w/cervical spinal stenosis. Laminectomies were performed on June 11, 2018 and sx gradually reduced. Patient is hopeful tha the can now rehabilitated from all of his spinal issues.

Falls

Patient is very protective during mobility to prevent falls as a fall could cause irreversible damage.

Initial Level — Goals

Pain: Back Pain - Low Back; At Rest 0/10; With Activity 5/10; Dull; Radiating

Goals

Impairment Goals; Short Term:
Patient will be independent in HEP in 2 wks
Patient will tolerate 15 min of activity w/o rest in 4 wks
Patient will perform ROM WNL in 4 wks
Patient will walk 50 ft w/SPC and supervision in 4 wks

Functional Goals; Long Term:
Patient will have 5/5 strength throughout in 12 wks
Patient will perform TUG timing in <14 sec in 12 wks w/SPC
Patient will be mod I in amb w/SPC >200 ft in 12 wks
Patient will negotiate 4 steps w/rail mod I in 12 wks

Transfer To/From Bed Comments: Mod I

Transfer To/From Chair Comments: Mod I

Ambulation Even Terrain Comments: Patient can walk w/FWW and close supervision. He walks w/as erect a posture as possible. He walks w/adequate BOS but cannot achieve heel strike. He does walk w/step through gait.

Ambulation Uneven Terrain Comments: NA

Stair Climbing Comments: NA

Functional Characteristics and Analysis: Patient has quadriparesis and without sensation in his hands and feet, coordination is reduced. He is motivated to be as independent as possible but is a high fall risk and a fall could paralyze him for good.

Plan of Care (Initial Evaluation)

Patient Name: RUSSO, SIMONE F
Medical Record #: G000518062
Account #: G00017878561
Provider: Mountain View
Provider #:
Treating Clinician: Denise Readence
Referring Physician: John S Thalgott

Date: 8/27/2018 03:32 PM
DOB: 9/5/1942
SOC Date: 8/27/2018

Patient Goal(s) and/or Goal Comments: Patient wants to walk better and regain balance.

Patient / Caregiver concurs with established treatment plan and goals: Yes

Range of Motion

AROM is WNL throughout all 4 extremities.

Coordination, Balance, Gait

Romberg
Eyes Open: 0 seconds
Eyes Closed: 0 seconds

Sharpened Romberg
Left: Eyes Open: 0 seconds Eyes Closed: 0 seconds
Right: Eyes Open: 0 seconds Eyes Closed: 0 seconds

Timed Up and Go Comments: Patient was not up to TUG testing this date.

Impairment Observations

Patient presents w/impaired mobility r/t a long period of immobility r/t surgeries and recoveries. He has strength throughout. He has minimal to no motion in the trunk. He moves en bloc. Falls are not an option as a fall could cause irreversible damage. Patient will benefit from skilled PT Rx to build trunk strength, improve balance and gait and attain patient's highest and safest level of functional mobility.

Muscle Tone Comments: Muscle tone appears WNL.

Dominance

Upper Extremity: Left

Strength

Strength is 4+/5 throughout the extremities. Trunk weakness is noted.

Functional Limitation Reporting

Mobility: Walking and Moving Around

G8978 - Mobility: walking and moving around functional limitation, current status, at therapy episode outset and at reporting intervals
Current Status: CM - At least 80 percent but less than 100 percent impaired, limited or restricted

G8979 - Mobility: walking and moving around functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
Goal Status: CI - At least 1 percent but less than 20 percent impaired, limited or restricted

Interventions/Plan

EVAL PT HIGH COMPLEX 97163
GAIT TRAINING 15 MIN PT 97116
MANUAL THER TECH 15M PT 97140
NEUROMUSC REEDUCT 15M PT 97112
THER ACTIV DIR 15 MIN PT 97530
THER EXERCISES 15 MIN PT 97110

Frequency of PT: Three times weekly
Duration of PT: 12 weeks
Intervention Comments: PT initial evaluation completed this date. Initiated mat activities. Gait training w/FWW.
Discharge Planning: D/C to HEP when LTG's are achieved.

Physical Therapy **Plan of Care** (Initial Evaluation)

Patient Name: RUSSO, SIMONE F
Medical Record #: G000518062
Account #: G00017878561
Provider: Mountain View
Provider #:
Treating Clinician: Denise Rendence
Referring Physician: John S Thalgott

Date: 8/27/2018 03:32 PM
DOB: 9/5/1942
SOC Date: 8/27/2018

8/29/18
John S Thalgott Date/Time
I certify the need for these services furnished under this plan of treatment while under my care.

Electronically signed by: 8/27/2018 4:04:45 PM
Denise Rendence Date
State License #:


PLAINTIFF'S
EXHIBIT
3
A753606
12-17-19
PENGAD 800-631-6989

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	05/24/2017

Subjective:

Chief Complaint: The patient complains of cervical, lumbar, glute and leg pain remains the same.

Reason for Visit: Simone Russo returns for a follow up evaluation and medication refills.

Interim History: The patient returns for a follow up office visit. He complains of upper extremity numbness and tingling. He is dropping things like pills. He has been referred by Dr. Thalgott to Dr. Bess Chang for EMG/ NCS of the upper extremities. His sedation has improved with minimizing the gabapentin. He takes the Xanax only as needed for anxiety. He has continued neck, and low back pain. He is taking suboxone 30 mg, max four tablets per day. He is experiencing no constipation. The pain is worse than at the last visit. He denies any fevers or chills. The patient denies any other significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today.
Location: Pain is located in the neck and low back.
Quality: Patient describes pain as moves around and is sharp, electric shock, throbbing and pins/needles.
Severity: Patient describes current pain level as a 6 on a visual analog scale from 1-10
Duration: Pain since 1/2012.
Timing: Pain is unpredictable during day and night.
Context: Sitting to long
Modifying Factors: None noted.
Adverse Events: None noted by patient
Aberrant Drug Related Behavior: None.
ADL: Uses walker at home.
UDT was reviewed.
NV PMP was reviewed.

The patient denies the following since the last appointment: Seeing another pain management physician, loss of bladder or bowel control, entry into a drug rehab program or facility, familial/friends concerned about amount of medications taking, use of illegal drugs, obtained pain medications from other physicians, suicidal ideation/attempts, seeing a psychiatrist/psychologist. The patient has attested to the following: They are responsible for all medications, they are abiding by the terms of the narcotic agreement, he has not obtained narcotic, sedative or sleep medications from other sources, awareness of pharmacy profile, understanding of 14 day term of controlled substance prescription, informed consent for pan management therapy.

NV PMP 03/28/2017 was reviewed.
UDT 01/2017 was reviewed.

Reviewed Data: KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.

Oswestry Disability Index (ODI):	ODI Score **18.** The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.
Past Medical History:	Hypertension Back Disease
Social History:	Marital Status: Married Children Employment: Retired: Physician for 40 years. Education: Graduate Degree: 4 years. Other: Back. Healthy Decrease in strength and/or endurance Hobbies/Recreational Activities: Before pain: Tennis. Goals: Not noted.
Past Treatments:	Physical Therapy: Last was on 12/13. Surgery
Family History:	Diabetes Hypertension Kidney Disease
Allergies:	.No Known Drug Allergies
Review of Systems:	The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart. The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain, pins/needles and problems with balance.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	140 / 82	BMI: 32.5	
	Weight. 220		Pulse:	64	O2 Sat:	95

Physical Examination

The patient is a pleasant and cooperative 74-year-old male in no apparent distress.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic and slow. He uses a wheeled walker for ambulation.
There is no evidence of symptom magnification.
HEENT: Normocephalic, and atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:

M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
F32.9 Major depressive disorder, single episode, unspecified
M54.12 Radiculopathy, cervical region
M48.02 Spinal stenosis, cervical region
F41.9 Anxiety disorder, unspecified
F43.21 Adjustment disorder with depressed mood

Discussion:

1. Continue suboxone
2. Balance testing
3. Requested records from Spring Mountain Hospital, obtained and reviewed today.
4. No medication side effects
5. Constipation is not an issue currently
6. Continue gabapentin as needed
7. Continue Xanax as needed for anxiety disorder, panic attacks
8. The patient is indicated for ongoing Urine drug testing (UDT) because of chronic pain requiring controlled substances for the control of pain. It was inconsistent for oxycodone and oxymorphone. He was prescribed oxycodone and Oxycontin in the past. The lab testing was marked inconsistent. He is at high risk for opiate adverse effects. The UDT are on a random basis. The most recent UDT results were reviewed. The testing was done with immunoassay on a V-Twin Analyzer which included several drug classes: Amphetamine, barbiturates, benzodiazepines, opiates and specific agents: Propoxyphene, methadone, methaqualone, ethanol glucuronidate, as well as illicit drugs: Cocaine, and PCP. Pertinent positives and negatives were tested with liquid chromatography/mass spectrometry ensuring accuracy and minimizing the likelihood of false positives/false negatives inherent in immunoassay testing. The UDT results were consistent with the prescribed medication(s). There was no evidence of illicit drug use, drug diversion, additional opiate or other drugs ingested (other than the prescribed medications). In summary there was no evidence of aberrant drug behavior that fell outside the narcotic agreement.
9. The Nevada Prescription Monitoring Program (NV PMP) database was queried regarding this patient's prescription history. I reviewed the providers. He has not seen any other providers other than myself. There is no evidence that the patient is engaging in doctor shopping at this time. The PMP Awar$_{(x)}$e program has related, interconnected searches in multiple adjacent and noncontiguous states including but not limited to Arizona, Utah, Idaho, Colorado. The search is unable to query California, or local federal pharmacies including the VA hospital, Nellis Air Force base. Queries detail patient information, location, prescriptions filled, pharmacies and providers writing prescriptions. The patient's NV PMP was queried and reviewed prior to prescribing any controlled substances. The role of the NV PMP is to detect patients obtaining simultaneous prescriptions for controlled substances.

Opiate risk stratification:

The patient is at **high risk** for adverse opiate events. Risk stratification is unchanged since the last visit. The patient is indicated for random UDT 1-3 times every 3 months for prescription medications, non-prescribed medication that may pose a safety risk if taken with prescribed medications and illicit substances, based on patient history, clinical presentation and/or community usage. Community drug usage in Nevada and specifically Las Vegas ranks among the worst in the nation. Nevada had the second highest rate of illegal drug use, excluding marijuana, with 4.83 percent of those surveyed saying they'd used an illegal drug in the past month. Arizona topped the list, with 4.86 percent.[1] Nevada youths had a statistically significantly higher past-year of nonmedical use of pain relievers rate than U.S. youths (8.34% versus 6.51%, p= 0.033) and were ranked 5th tier (along with Oregon, Washington, Idaho, New Mexico, Oklahoma, Arkansas, Mississippi, Indiana, and Kentucky).[2] Given these statistics it is not

[1] https://lasvegassun.com/news/2004/aug/10/study-nevada-ranks-high-in-illegal-drug-use/
[2] http://cdclv.unlv.edu/healthnv_2012/substanceabuse.pdf

surprising that Nevada has the fourth highest rate of drug overdose deaths in the country.[3]Community drug usage in Nevada and specifically ranks among the worst in the nation. Nevada had the second highest rate of illegal drug use, excluding marijuana, with 4.83 percent of those surveyed saying they'd used an illegal drug in the past month. Arizona topped the list, with 4.86 percent.[4] Nevada youths had a statistically significantly higher past-year nonmedical use of pain relievers rate than U.S. youths (8.34% versus 6.51%, p= 0.033) and were ranked 5th tier (along with Oregon, Washington, Idaho, New Mexico, Oklahoma, Arkansas, Mississippi, Indiana, and Kentucky).[5] Given these statistics it is not surprising that Nevada has the fourth highest rate of drug overdose deaths in the country[6] and is a community at high risk for opiate adverse events.

Follow up: Return to clinic in four weeks.

Prescriptions:

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

'Steven Kozmary MD'. 05/27/2017 02:54:27 PM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding: 99214 OFFICE OUTPT DETAILED

[3] http://www.lasvegasnow.com/news/report-nevada-fourth-highest-for-drug-overdose-deaths/185717145
[4] https://lasvegassun.com/news/2004/aug/10/study-nevada-ranks-high-in-illegal-drug-use/
[5] http://cdclv.unlv.edu/healthnv_2012/substanceabuse.pdf
[6] http://www.lasvegasnow.com/news/report-nevada-fourth-highest-for-drug-overdose-deaths/185717145

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	05/03/2017

Subjective:

Chief Complaint: The patient complains of back and leg pain that has increased.

Reason for Visit: Simone Russo returns for a follow up evaluation and medication refills.

Interim History: The patient returns for a follow up office visit. He complains of upper extremity numbness and tingling. He is dropping things like pills. He has been referred by Dr. Thalgott to Dr. Bess Chang for EMG/ NCS of the upper extremities. His sedation has improved with minimizing the gabapentin. He takes the Xanax only as needed for anxiety. He has continued neck, and low back pain. He is taking suboxone 30 mg, max four tablets per day. He is experiencing no constipation. The pain is worse than at the last visit. He denies any fevers or chills. The patient denies any other significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today.
Location: Pain is located in the neck and low back.
Quality: Patient describes pain as moves around and is sharp, electric shock, throbbing and pins/needles.
Severity: Patient describes current pain level as a 6 on a visual analog scale from 1-10
Duration: Pain since 1/2012.
Timing: Pain is unpredictable during day and night.
Context: Sitting to long
Modifying Factors: None noted.
Adverse Events: None noted by patient
Aberrant Drug Related Behavior: None.
ADL: Uses walker at home.
UDT was reviewed.
NV PMP was reviewed.

The patient denies the following since the last appointment: Seeing another pain management physician, loss of bladder or bowel control, entry into a drug rehab program or facility, familial/friends concerned about amount of medications taking, use of illegal drugs, obtained pain medications from other physicians, suicidal ideation/attempts, seeing a psychiatrist/psychologist. The patient has attested to the following: They are responsible for all medications, they are abiding by the terms of the narcotic agreement, he has not obtained narcotic, sedative or sleep medications from other sources, awareness of pharmacy profile, understanding of 14 day term of controlled substance prescription, informed consent for pan management therapy.

NV PMP 03/28/2017 was reviewed.
UDT 01/2017 was reviewed.

Reviewed Data: KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.

14A.App.3064

Oswestry Disability Index (ODI):	ODI Score **14**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.
Past Medical History:	Hypertension Back Disease
Social History:	Marital Status: Married Children Employment: Retired: Physician for 40 years. Education: Graduate Degree: 4 years. Other: Back. Healthy Decrease in strength and/or endurance Hobbies/Recreational Activities: Before pain: Tennis. Goals: Not noted.
Past Treatments:	Physical Therapy: Last was on 12/13. Surgery
Family History:	Diabetes Hypertension Kidney Disease
Allergies:	.No Known Drug Allergies
Review of Systems:	The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart. The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain, pins/needles and problems with balance.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	178 / 80	BMI: 32.5	
	Weight. 220		Pulse:	65	O2 Sat:	96

Physical Examination

The patient is a pleasant and cooperative 74-year-old male in no apparent distress.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic and slow. He uses a wheeled walker for ambulation.
There is no evidence of symptom magnification.
HEENT: Normocephalic, and atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:

M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
F32.9 Major depressive disorder, single episode, unspecified
M54.12 Radiculopathy, cervical region
M48.02 Spinal stenosis, cervical region
F41.9 Anxiety disorder, unspecified
F43.21 Adjustment disorder with depressed mood

Discussion:

1. Continue suboxone
2. Requested records from Spring Mountain Hospital, obtained and reviewed today.
3. No medication side effects
4. Constipation is not an issue currently
5. Continue gabapentin as needed
6. Continue Xanax as needed for anxiety disorder, panic attacks
7. The patient is indicated for ongoing Urine drug testing (UDT) because of chronic pain requiring controlled substances for the control of pain. It was inconsistent for oxycodone and oxymorphone. He was prescribed oxycodone and oxycontin in the past. The lab testing was marked inconsistent. He is at high risk for opiate adverse effects. The UDT are on a random basis. The most recent UDT results were reviewed. The testing was done with immunoassay on a V-Twin Analyzer which included several drug classes: Amphetamine, barbiturates, benzodiazepines, opiates and specific agents: Propoxyphene, methadone, methaqualone, ethanol glucuronidate, as well as illicit drugs: Cocaine, and PCP. Pertinent positives and negatives were tested with liquid chromatography/mass spectrometry ensuring accuracy and minimizing the likelihood of false positives/false negatives inherent in immunoassay testing. The UDT results were consistent with the prescribed medication(s). There was no evidence of illicit drug use, drug diversion, additional opiate or other drugs ingested (other than the prescribed medications). In summary there was no evidence of aberrant drug behavior that fell outside the narcotic agreement.
8. The Nevada Prescription Monitoring Program (NV PMP) database was queried regarding this patient's prescription history. I reviewed the providers. He has not seen any other providers other than myself. There is no evidence that the patient is engaging in doctor shopping at this time. The PMP Awar(x)e program has related, interconnected searches in multiple adjacent and noncontiguous states including but not limited to Arizona, Utah, Idaho, Colorado. The search is unable to query California, or local federal pharmacies including the VA hospital, Nellis Air Force base. Queries detail patient information, location, prescriptions filled, pharmacies and providers writing prescriptions. The patient's NV PMP was queried and reviewed prior to prescribing any controlled substances. The role of the NV PMP is to detect patients obtaining simultaneous prescriptions for controlled substances.

Opiate risk stratification:

The patient is at **high risk** for adverse opiate events. Risk stratification is unchanged since the last visit. The patient is indicated for random UDT 1-3 times every 3 months for prescription medications, non-prescribed medication that may pose a safety risk if taken with prescribed medications and illicit substances, based on patient history, clinical presentation and/or community usage. Community drug usage in Nevada and specifically Las Vegas ranks among the worst in the nation. Nevada had the second highest rate of illegal drug use, excluding marijuana, with 4.83 percent of those surveyed saying they'd used an illegal drug in the past month. Arizona topped the list, with 4.86 percent.[1] Nevada youths had a statistically significantly higher past-year of nonmedical use of pain relievers rate than U.S. youths (8.34% versus 6.51%, p= 0.033) and were ranked 5th tier (along with Oregon, Washington, Idaho, New Mexico, Oklahoma, Arkansas, Mississippi, Indiana, and Kentucky).[2] Given these statistics it is not

[1] https://lasvegassun.com/news/2004/aug/10/study-nevada-ranks-high-in-illegal-drug-use/
[2] http://cdclv.unlv.edu/healthnv_2012/substanceabuse.pdf

surprising that Nevada has the fourth highest rate of drug overdose deaths in the country.[3]Community drug usage in Nevada and specifically ranks among the worst in the nation. Nevada had the second highest rate of illegal drug use, excluding marijuana, with 4.83 percent of those surveyed saying they'd used an illegal drug in the past month. Arizona topped the list, with 4.86 percent.[4] Nevada youths had a statistically significantly higher past-year nonmedical use of pain relievers rate than U.S. youths (8.34% versus 6.51%, p= 0.033) and were ranked 5th tier (along with Oregon, Washington, Idaho, New Mexico, Oklahoma, Arkansas, Mississippi, Indiana, and Kentucky).[5] Given these statistics it is not surprising that Nevada has the fourth highest rate of drug overdose deaths in the country[6] and is a community at high risk for opiate adverse events.

Follow up: Return to clinic in four weeks.

Prescriptions: Suboxone 8mg-2mg sublingual film, Sig: 1-2 SL qd, discontine oxycodone and oxycontin, 30 Days, Qty: 45 Film, Ref: 0
Trazodone hydrochloride 100mg tablet, Sig: 1 po qhs, 30 Days, Qty: 30 Tablet, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

'Steven Kozmary MD'. 05/03/2017 11:47:41 AM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding: 99214 OFFICE OUTPT DETAILED

[3] http://www.lasvegasnow.com/news/report-nevada-fourth-highest-for-drug-overdose-deaths/185717145
[4] https://lasvegassun.com/news/2004/aug/10/study-nevada-ranks-high-in-illegal-drug-use/
[5] http://cdclv.unlv.edu/healthnv_2012/substanceabuse.pdf
[6] http://www.lasvegasnow.com/news/report-nevada-fourth-highest-for-drug-overdose-deaths/185717145

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	03/29/2017

Subjective:

Chief Complaint: The patient complains of neck and low back pain that has remained the same.

Reason for Visit: Simone Russo returns for a follow up evaluation and medication refills.

Interim History: The patient returns for a follow up office visit. His sedation has improved. He attributes the sedation to lack of sleep prior to the las visit. He is concerned with gabapentin. He takes the Xanax on an inconsistent basis only as needed for anxiety. He has continued neck, and low back pain. There is left arm and bilateral lower extremity pain. He is taking suboxone 30 mg, max four tablets per day. He is experiencing no constipation. The pain is worse than at the last visit. He denies any fevers or chills. The patient denies any other significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today.
Location: Pain is located in the neck and low back.
Quality: Patient describes pain as moves around and is sharp, electric shock, throbbing and pins/needles.
Severity: Patient describes current pain level as a 6 on a visual analog scale from 1-10
Duration: Pain since 1/2012.
Timing: Pain is unpredictable during day and night.
Context: Sitting to long
Modifying Factors: None noted.
Adverse Events: None noted by patient
Aberrant Drug Related Behavior: None.
ADL: Uses walker at home.
UDT was reviewed.
NV PMP was reviewed.

The patient denies the following since the last appointment: Seeing another pain management physician, loss of bladder or bowel control, entry into a drug rehab program or facility, familial/friends concerned about amount of medications taking, use of illegal drugs, obtained pain medications from other physicians, suicidal ideation/attempts, seeing a psychiatrist/psychologist. The patient has attested to the following: They are responsible for all medications, they are abiding by the terms of the narcotic agreement, he has not obtained narcotic, sedative or sleep medications from other sources, awareness of pharmacy profile, understanding of 14 day term of controlled substance prescription, informed consent for pan management therapy.

NV PMP 03/28/2017 was reviewed.
UDT 01/2017 was reviewed and is inconsistent from oxycodone.

Reviewed Data: KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.

Oswestry Disability ODI Score **12**. The Oswestry Disability Index (ODI) has become one of the principal condition specific

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Index (ODI): outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.

Past Medical History:
Hypertension
Back Disease

Social History:
Marital Status: Married
Children
Employment: Retired: Physician for 40 years.
Education: Graduate Degree: 4 years.
Other: Back.
Healthy
Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments:
Physical Therapy: Last was on 12/13.
Surgery

Family History:
Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain, pins/needles and problems with balance.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	138 / 90	BMI: 30.3	
	Weight. 205		Pulse:	96	O2 Sat:	98

Physical Examination
The patient is a pleasant and cooperative 74-year-old male in no apparent distress.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic and slow. He uses a wheeled walker for ambulation.
There is no evidence of symptom magnification.
HEENT: Normocephalic, and atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
F32.9 Major depressive disorder, single episode, unspecified
M54.12 Radiculopathy, cervical region
M48.02 Spinal stenosis, cervical region
F41.9 Anxiety disorder, unspecified
F43.21 Adjustment disorder with depressed mood

Discussion:
1. Continue suboxone
2. SP prostatectomy for BPH with no further obstruction after surgery, he still self caths as needed
3. Requested records from Spring Mountain Hospital, obtained and reviewed today.

4. No medication side effects
5. Constipation is not an issue currently although he has history of OIC.
6. Continue gabapentin at the current dosage regimen.
7. Continue Xanax as needed for anxiety disorder, panic attacks
8. The patient is indicated for ongoing Urine drug testing (UDT) because of chronic pain requiring controlled substances for the control of pain. It was inconsistent for oxycodone and oxymorphone. He was prescribed oxycodone and oxycontin in the past. The lab testing was marked inconsistent. He is at high risk for opiate adverse effects. The UDT are on a random basis. The most recent UDT results were reviewed. The testing was done with immunoassay on a V-Twin Analyzer which included several drug classes: Amphetamine, barbiturates, benzodiazepines, opiates and specific agents: Propoxyphene, methadone, methaqualone, ethanol glucuronidate, as well as illicit drugs: Cocaine, and PCP. Pertinent positives and negatives were tested with liquid chromatography/mass spectrometry ensuring accuracy and minimizing the likelihood of false positives/false negatives inherent in immunoassay testing. The UDT results were consistent with the prescribed medication(s). There was no evidence of illicit drug use, drug diversion, additional opiate or other drugs ingested (other than the prescribed medications). In summary there was no evidence of aberrant drug behavior that fell outside the narcotic agreement.
9. The Nevada Prescription Monitoring Program (NV PMP) database was queried regarding this patient's prescription history. I reviewed the providers. He has not seen any other providers other than myself. There is no evidence that the patient is engaging in doctor shopping at this time. The PMP Awar$_{(x)}$e program has related, interconnected searches in multiple adjacent and noncontiguous states including but not limited to Arizona, Utah, Idaho, Colorado. The search is unable to query California, or local federal pharmacies including the VA hospital, Nellis Air Force base. Queries detail patient information, location, prescriptions filled, pharmacies and providers writing prescriptions. The patient's NV PMP was queried and reviewed prior to prescribing any controlled substances. The role of the NV PMP is to detect patients obtaining simultaneous prescriptions for controlled substances.

Opiate risk stratification: The patient is at **high risk** for adverse opiate events. Risk stratification is unchanged since the last visit. The patient is indicated for random UDT 1-3 times every 3 months for prescription medications, non-prescribed medication that may pose a safety risk if taken with prescribed medications and illicit substances, based on patient history, clinical presentation and/or community usage. Community drug usage in Nevada and specifically Las Vegas ranks among the worst in the nation. Nevada had the second highest rate of illegal drug use, excluding marijuana, with 4.83 percent of those surveyed saying they'd used an illegal drug in the past month. Arizona topped the list, with 4.86 percent.[1] Nevada youths had a statistically significantly higher past-year of nonmedical use of pain relievers rate than U.S. youths (8.34% versus 6.51%, p= 0.033) and were ranked 5th tier (along with Oregon, Washington, Idaho, New Mexico, Oklahoma, Arkansas, Mississippi, Indiana, and Kentucky).[2] Given these statistics it is not surprising that Nevada has the fourth highest rate of drug overdose deaths in the country.[3]Community drug usage in Nevada and specifically ranks among the worst in the nation. Nevada had the second highest rate of illegal drug use, excluding marijuana, with 4.83 percent of those surveyed saying they'd used an illegal drug in the past month. Arizona topped the list, with 4.86 percent.[4] Nevada youths had a statistically significantly higher past-year nonmedical use of pain relievers rate than U.S. youths (8.34% versus 6.51%, p= 0.033) and were ranked 5th tier (along with Oregon, Washington, Idaho, New Mexico, Oklahoma, Arkansas, Mississippi, Indiana, and Kentucky).[5] Given these statistics it is not surprising that Nevada has the fourth highest rate of drug overdose deaths in the country[6] and is a community at high risk for opiate adverse events.

Follow up: Return to clinic in four weeks.

Prescriptions: Suboxone 8mg-2mg sublingual film, Sig: 1-2 SL qd, discontine oxycodone and oxycontin, 30 Days, Qty: 60 Film, Ref: 0

[1] https://lasvegassun.com/news/2004/aug/10/study-nevada-ranks-high-in-illegal-drug-use/
[2] http://cdclv.unlv.edu/healthnv_2012/substanceabuse.pdf
[3] http://www.lasvegasnow.com/news/report-nevada-fourth-highest-for-drug-overdose-deaths/185717145
[4] https://lasvegassun.com/news/2004/aug/10/study-nevada-ranks-high-in-illegal-drug-use/
[5] http://cdclv.unlv.edu/healthnv_2012/substanceabuse.pdf
[6] http://www.lasvegasnow.com/news/report-nevada-fourth-highest-for-drug-overdose-deaths/185717145

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

'Steven Kozmary MD'. 03/29/2017 02:25:24 PM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding: 99214 OFFICE OUTPT DETAILED
More than 25 minutes face to face time

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	03/02/2017

Subjective:

Chief Complaint: The patient complains of neck and low back pain remains the same.

Reason for Visit: Simone Russo returns for a follow up evaluation and medication refills.

Interim History: The patient returns for a follow up office visit. He has continued neck, and low back pain. There is left arm and bilateral lower extremity pain. He is taking oxycodone 30 mg, max four tablets per day. He is experiencing constipation. He has had two panic attacks and restarted the Prozac. The pain is worse than at the last visit. He has restarted the gabapentin and Xanax. He denies any fevers or chills. The patient denies any other significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today.
Location: Pain is located in the neck and low back.
Quality: Patient describes pain as moves around and is sharp, electric shock, throbbing and pins/needles.
Severity: Patient describes current pain level as a 6 on a visual analog scale from 1-10
Duration: Pain since 1/2012.
Timing: Pain is unpredictable during day and night.
Context: Sitting to long
Modifying Factors: None noted.
Adverse Events: None noted by patient
Aberrant Drug Related Behavior: None.
ADL: Uses walker at home.
UDT was reviewed.
NV PMP was reviewed.

The patient denies the following since the last appointment: Seeing another pain management physician, loss of bladder or bowel control, entry into a drug rehab program or facility, familial/friends concerned about amount of medications taking, use of illegal drugs, obtained pain medications from other physicians, suicidal ideation/attempts, seeing a psychiatrist/psychologist. The patient has attested to the following: They are responsible for all medications, they are abiding by the terms of the narcotic agreement, he has not obtained narcotic, sedative or sleep medications from other sources, awareness of pharmacy profile, understanding of 14 day term of controlled substance prescription, informed consent for pan management therapy.

NV PMP 03/02/2017 was reviewed.
UDT 01/2017 was reviewed and is inconsistent from oxycodone.

Reviewed Data: KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.

Oswestry Disability Index (ODI): ODI Score **15**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful

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measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.

Past Medical History: Hypertension
Back Disease

Social History: Marital Status: Married
Children
Employment: Retired: Physician for 40 years.
Education: Graduate Degree: 4 years.
Other: Back.
Healthy
Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain, pins/needles and problems with balance.

Objective:

Vitals:

Height:	5'9"	Blood Pressure:	130 / 80	BMI: 30.3	
Weight. 205		Pulse:	77	O2 Sat:	97

Physical Examination The patient is a pleasant and cooperative 74-year-old male in no apparent distress.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic and slow. He uses a wheeled walker for ambulation.
There is no evidence of symptom magnification.
HEENT: Normocephalic, atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
F32.9 Major depressive disorder, single episode, unspecified
M54.12 Radiculopathy, cervical region
M48.02 Spinal stenosis, cervical region
F41.9 Anxiety disorder, unspecified
F43.21 Adjustment disorder with depressed mood

Discussion:
1. No evidence of infection or postoperative complications sp C4-7 anterior cervical fusion, Follow up with Dr. Thalgott sp surgery
2. SP prostatectomy for BPH with obstruction
3. Requested records from Spring Mountain Hospital, not yet obtained.
4. No medication side effects

5. Constipation is not an issue currently although he has history of OIC.
6. Continue gabapentin, Xanax at the current dosage regimen.
7. Discontinue oxycodone 30 mg four per day and oxycontin
8. Start suboxone at 2 8 mg per day. He has taken these in the past and can wean down to one film per day as tolerated.
9. The patient is indicated for ongoing Urine drug testing (UDT) because of chronic pain requiring controlled substances for the control of pain. It was inconsistent for oxycodone and oxymorphone. He is prescribed oxycodone and oxycontin. The lab testing was marked inconsistent. He is at high risk for opiate adverse effects. The UDT are on a random basis. The most recent UDT results were reviewed. The testing was done with immunoassay on a V-Twin Analyzer which included several drug classes: Amphetamine, barbiturates, benzodiazepines, opiates and specific agents: Propoxyphene, methadone, methaqualone, ethanol glucuronidate, as well as illicit drugs: Cocaine, and PCP. Pertinent positives and negatives were tested with liquid chromatography/mass spectrometry ensuring accuracy and minimizing the likelihood of false positives/false negatives inherent in immunoassay testing. The UDT results were consistent with the prescribed medication(s). There was no evidence of illicit drug use, drug diversion, additional opiate or other drugs ingested (other than the prescribed medications). In summary there was no evidence of aberrant drug behavior that fell outside the narcotic agreement.
10. The Nevada Prescription Monitoring Program (NV PMP) database was queried regarding this patient's prescription history. I reviewed the providers. He has not seen any other providers other than myself. There is no evidence that the patient is engaging in doctor shopping at this time. The PMP Awar(x)e program has related, interconnected searches in multiple adjacent and noncontiguous states including but not limited to Arizona, Utah, Idaho, Colorado. The search is unable to query California, or local federal pharmacies including the VA hospital, Nellis Air Force base. Queries detail patient information, location, prescriptions filled, pharmacies and providers writing prescriptions. The patient's NV PMP was queried and reviewed prior to prescribing any controlled substances. The role of the NV PMP is to detect patients obtaining simultaneous prescriptions for controlled substances.

Opiate risk stratification: The patient is at **high risk** for adverse opiate events. Risk stratification is unchanged since the last visit (The current morphine equivalent dosage is 180 mg per day with Neurontin, Xanax also prescribed) The patient is indicated for random UDT 1-3 times every 3 months for prescription medications, non-prescribed medication that may pose a safety risk if taken with prescribed medications and illicit substances, based on patient history, clinical presentation and/or community usage. Community drug usage in Nevada and specifically Las Vegas ranks among the worst in the nation. Nevada had the second highest rate of illegal drug use, excluding marijuana, with 4.83 percent of those surveyed saying they'd used an illegal drug in the past month. Arizona topped the list, with 4.86 percent.[1] Nevada youths had a statistically significantly higher past-year of nonmedical use of pain relievers rate than U.S. youths (8.34% versus 6.51%, p= 0.033) and were ranked 5th tier (along with Oregon, Washington, Idaho, New Mexico, Oklahoma, Arkansas, Mississippi, Indiana, and Kentucky).[2] Given these statistics it is not surprising that Nevada has the fourth highest rate of drug overdose deaths in the country.[3]Community drug usage in Nevada and specifically ranks among the worst in the nation. Nevada had the second highest rate of illegal drug use, excluding marijuana, with 4.83 percent of those surveyed saying they'd used an illegal drug in the past month. Arizona topped the list, with 4.86 percent.[4] Nevada youths had a statistically significantly higher past-year nonmedical use of pain relievers rate than U.S. youths (8.34% versus 6.51%, p= 0.033) and were ranked 5th tier (along with Oregon, Washington, Idaho, New Mexico, Oklahoma, Arkansas, Mississippi, Indiana, and Kentucky).[5] Given these statistics it is not surprising that Nevada has the fourth highest rate of drug overdose deaths in the country[6] and is a community at high risk for opiate adverse events.

Follow up: Return to clinic in four weeks.

[1] https://lasvegassun.com/news/2004/aug/10/study-nevada-ranks-high-in-illegal-drug-use/
[2] http://cdclv.unlv.edu/healthnv_2012/substanceabuse.pdf
[3] http://www.lasvegasnow.com/news/report-nevada-fourth-highest-for-drug-overdose-deaths/185717145
[4] https://lasvegassun.com/news/2004/aug/10/study-nevada-ranks-high-in-illegal-drug-use/
[5] http://cdclv.unlv.edu/healthnv_2012/substanceabuse.pdf
[6] http://www.lasvegasnow.com/news/report-nevada-fourth-highest-for-drug-overdose-deaths/185717145

Prescriptions: Gabapentin 100mg capsule, Sig: 1 po qd, 30 Days, Qty: 30 Capsule, Ref: 0
Suboxone 8mg-2mg sublingual film, Sig: 1-2 SL qd, discontine oxycodone and oxycontin, 30 Days, Qty: 60 Film, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

KWillett, PA-C

'Katherine Willett '. 03/02/2017 03:24:02 PM (kwillett)

S. Kozmary MD

'Steven Kozmary MD'. 03/02/2017 04:21:44 PM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding: 99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	02/07/2017

Subjective:

Chief Complaint: The patient complains of same lumbar and cervical spine pain.

Reason for Visit: Simone Russo returns for a follow up evaluation and medication refills.

Interim History: The patient returns for a follow up office visit. He has difficulty with urinary obstruction and is scheduled for prostatectomy today. He was self cathing for the past two months. He has hematuria. He is taking oxycodone 30 mg and oxycodone 40 ER bid tablets for pain. He is experiencing constipation. He was in bed for five days secondary to pain. He has had two panic attacks and restarted the Prozac. The pain is worse than at the last visit. He has restarted the gabapentin and Xanax. He denies any fevers or chills. The patient denies any other significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today.
Location: Pain is located in the neck and low back.
Quality: Patient describes pain as moves around and is sharp, electric shock, throbbing and pins/needles.
Severity: Patient describes current pain level as a 5-10 on a visual analog scale from 1-10
Duration: Pain since 1/2012.
Timing: Pain is unpredicatable during day and night.
Adverse Events: None noted by patient
Aberrant Drug Related Behavior: None.
ADL: Uses walker at home.
UDT was reviewed.
NV PMP was reviewed.
The patient denies the following since the last appointment: Seeing another pain management physician, loss of bladder or bowel control, entry into a drug rehab program or facility, familial/friends concerned about amount of medications taking, use of illegal drugs, obtained pain medications from other physicians, suicidal ideation/attempts, seeing a psychiatrist/psychologist.
The patient has attested to the following: They are responsible for all medications, they are abiding by the terms of the narcotic agreement, he has not obtained narcotic, sedative or sleep medications from other sources, awareness of pharmacy profile, understanding of 14 day term of controlled substance prescription, informed consent for pan management therapy.

NV PMP 2/7/17 was reviewed.
UDT 1/17 was reviewed and is inconsistent from oxycodone.

Reviewed Data: KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.

Oswestry Disability Index (ODI): ODI Score **14.** The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete

disability.

Past Medical History: Hypertension
Back Disease

Social History: Marital Status: Married
Children
Employment: Retired: Physician for 40 years.
Education: Graduate Degree: 4 years.
Other: Back.
Healthy
Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain, pins/needles and problems with balance.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	110 / 62	BMI: 30.3	
	Weight. 205		Pulse:	77	O2 Sat:	94

Physical Examination The patient is a pleasant and cooperative 74-year-old male.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic and slow. He uses a wheeled walker for ambulation.
There is no evidence of symptom magnification.
HEENT: Normocephalic, atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
F32.9 Major depressive disorder, single episode, unspecified
M54.12 Radiculopathy, cervical region
M48.02 Spinal stenosis, cervical region
F41.9 Anxiety disorder, unspecified
F43.21 Adjustment disorder with depressed mood

Discussion:
1. SP C4-7 anterior cervical fusion
2. Prostatectomy scheduled for this afternoon
3. Continue gabapentin, Xanax
4. Continue oxycodone 30 mg four per day
5. Follow up with Dr. Thalgott
6. The patient is indicated for ongoing Urine drug testing (UDT) because of chronic pain requiring controlled substances for the control of pain. It was inconsistent for oxycodone. I will obtain a

sample to test today. The UDT are on a random basis. The most recent UDT results were reviewed. The testing was done with immunoassay on a V-Twin Analyzer which included several drug classes: Amphetamine, barbiturates, benzodiazepines, opiates and specific agents: Propoxyphene, methadone, methaqualone, ethanol glucuronidate, as well as illicit drugs: Cocaine, and PCP. Pertinent positives and negatives were tested with liquid chromatography/mass spectrometry ensuring accuracy and minimizing the likelihood of false positives/false negatives inherent in immunoassay testing. The UDT results were consistent with the prescribed medication(s). There was no evidence of illicit drug use, drug diversion, additional opiate or other drugs ingested (other than the prescribed medications). In summary there was no evidence of aberrant drug behavior that fell outside the narcotic agreement.

7. The Nevada Prescription Monitoring Program (NV PMP) database was queried regarding this patient's prescription history. There is no evidence that the patient is engaging in doctor shopping at this time. The PMP Awar(x)e program has related, interconnected searches in multiple adjacent and noncontiguous states including but not limited to Arizona, Utah, Idaho, Colorado. The search is unable to query California, or local federal pharmacies including the VA hospital, Nellis Air Force base. Queries detail patient information, location, prescriptions filled, pharmacies and providers writing prescriptions. The patient's NV PMP was queried and reviewed prior to prescribing any controlled substances. The role of the NV PMP is to detect patients obtaining simultaneous prescriptions for controlled substances.

Opiate risk stratification: The patient is at **high risk** for adverse opiate events. (The current morphine equivalent dosage is 180 mg per day with Neurontin, Xanax also prescribed) The patient is indicated for random UDT 1-3 times every 3 months for prescription medications, non-prescribed medication that may pose a safety risk if taken with prescribed medications and illicit substances, based on patient history, clinical presentation and/or community usage. Community drug usage in Nevada and specifically Las Vegas ranks among the worst in the nation. Nevada had the second highest rate of illegal drug use, excluding marijuana, with 4.83 percent of those surveyed saying they'd used an illegal drug in the past month. Arizona topped the list, with 4.86 percent.[1] Nevada youths had a statistically significantly higher past-year of nonmedical use of pain relievers rate than U.S. youths (8.34% versus 6.51%, p= 0.033) and were ranked 5th tier (along with Oregon, Washington, Idaho, New Mexico, Oklahoma, Arkansas, Mississippi, Indiana, and Kentucky).[2] Given these statistics it is not surprising that Nevada has the fourth highest rate of drug overdose deaths in the country.[3]Community drug usage in Nevada and specifically ranks among the worst in the nation. Nevada had the second highest rate of illegal drug use, excluding marijuana, with 4.83 percent of those surveyed saying they'd used an illegal drug in the past month. Arizona topped the list, with 4.86 percent.[4] Nevada youths had a statistically significantly higher past-year nonmedical use of pain relievers rate than U.S. youths (8.34% versus 6.51%, p= 0.033) and were ranked 5th tier (along with Oregon, Washington, Idaho, New Mexico, Oklahoma, Arkansas, Mississippi, Indiana, and Kentucky).[5] Given these statistics it is not surprising that Nevada has the fourth highest rate of drug overdose deaths in the country[6] and is a community at high risk for opiate adverse events.

Follow up: Return to clinic in four weeks.

Prescriptions: Oxycodone hydrochloride 30mg tablet, Sig: 1 o q4 prn pain, maximum four tablets per day, discontinue oxycodone 15 mg, 30 Days, Qty: 120 Tablet, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

'Steven Kozmary MD'. 02/07/2017 10:57:27 AM (SKozmary)
Steven Kozmary

[1] https://lasvegassun.com/news/2004/aug/10/study-nevada-ranks-high-in-illegal-drug-use/
[2] http://cdclv.unlv.edu/healthnv_2012/substanceabuse.pdf
[3] http://www.lasvegasnow.com/news/report-nevada-fourth-highest-for-drug-overdose-deaths/185717145
[4] https://lasvegassun.com/news/2004/aug/10/study-nevada-ranks-high-in-illegal-drug-use/
[5] http://cdclv.unlv.edu/healthnv_2012/substanceabuse.pdf
[6] http://www.lasvegasnow.com/news/report-nevada-fourth-highest-for-drug-overdose-deaths/185717145

NPI: 1659337459
License: 5695

CPT Coding: 99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Celebrating 25 Years of Saving the Southwest

Board Certified Anesthesiology Pain Management

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	01/13/2017

Subjective:

Chief Complaint: The patient complains of pain in the upper and low back remain unchanged.

Reason for Visit: Simone Russo returns for a follow up evaluation and medication refills.

Interim History: The patient returns for a follow up office visit. He travelled to New York last month and suffered worsening low back, leg and interscapular pain. He has undergone cervical spine surgery for disc herniation with Dr. Thalgott. He is taking oxycodone 30 mg and oxycodone 40 ER bid tablets for pain. He is experiencing constipation. He was in bed for five days secondary to pain. He has difficulty with urinary retention. He has had two panic attacks and restarted the Xanax. He had a Medrol dosepak with good relief of his pain and improvement in his walking. The pain is worse than at the last visit. He has restarted the gabapentin and Xanax. He denies any fevers or chills. The patient denies any other significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today.
Location: Pain is located in the neck and low back.
Quality: Patient describes pain as moves around and is sharp, electric shock, throbbing and pins/needles.
Severity: Patient describes current pain level as a 10 on a visual analog scale from 1-10
Duration: Pain since 1/2012.
Timing: Pain is unpredicatable during day and night.
Adverse Events: Constipation.
Aberrant Drug Related Behavior: None.
ADL: Uses walker at home.
UDT was reviewed.
NV PMP was reviewed.
The patient denies the following since the last appointment: Seeing another pain management physician, loss of bladder or bowel control, entry into a drug rehab program or facility, familial/friends concerned about amount of medications taking, use of illegal drugs, obtained pain medications from other physicians, suicidal ideation/attempts, seeing a psychiatrist/psychologist.
The patient has attested to the following: They are responsible for all medications, they are abiding by the terms of the narcotic agreement, he has not obtained narcotic, sedative or sleep medications from other sources, awareness of pharmacy profile, understanding of 14 day term of controlled substance prescription, informed consent for pan management therapy.

NV PMP 1/12/17 was reviewed.
UDT 9/23/16 was reviewed.

Reviewed Data: KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.

Oswestry Disability ODI Score **14**. The Oswestry Disability Index (ODI) has become one of the principal condition specific

14A.App.3080

Index (ODI): outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.

Past Medical History:
Hypertension
Back Disease

Social History:
Marital Status: Married
Children
Employment: Retired: Physician for 40 years.
Education: Graduate Degree: 4 years.
Other: Back.
Healthy
Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments:
Physical Therapy: Last was on 12/13.
Surgery

Family History:
Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain, pins/needles and problems with balance.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	158 / 88	BMI: 31	
	Weight. 210		Pulse:	76	O2 Sat:	94

Physical Examination
The patient is a pleasant and cooperative 74-year-old male.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic and slow. He uses a wheeled walker for ambulation.
There is no evidence of symptom magnification.
HEENT: Normocephalic, atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
F32.9 Major depressive disorder, single episode, unspecified
M54.12 Radiculopathy, cervical region
M48.02 Spinal stenosis, cervical region
F41.9 Anxiety disorder, unspecified
F43.21 Adjustment disorder with depressed mood

Discussion:
1. SP C4-7 anterior cervical fusion
2. Refer to neurology at Cleveland Clinic for evalaution
3. Worsening pain in the low back, legs and interscapular region
4. Continue gabapentin, Xanax

5. Discontinue OxyContin
6. Discontinue steroids
7. Continue oxycodone 30 mg four per day
8. Follow up with urologist for urinary retention
9. The patient is indicated for ongoing Urine drug testing (UDT) because of chronic pain requiring controlled substances for the control of pain. I will obtain a sample to test today. The UDT are on a random basis. The most recent UDT results were reviewed. The testing was done with immunoassay on a V-Twin Analyzer which included several drug classes: Amphetamine, barbiturates, benzodiazepines, opiates and specific agents: Propoxyphene, methadone, methaqualone, ethanol glucuronidate, as well as illicit drugs: Cocaine, and PCP. Pertinent positives and negatives were tested with liquid chromatography/mass spectrometry ensuring accuracy and minimizing the likelihood of false positives/false negatives inherent in immunoassay testing. The UDT results were consistent with the prescribed medication(s). There was no evidence of illicit drug use, drug diversion, additional opiate or other drugs ingested (other than the prescribed medications). In summary there was no evidence of aberrant drug behavior that fell outside the narcotic agreement.
10. The Nevada Prescription Monitoring Program (NV PMP) database was queried regarding this patient's prescription history. There is no evidence that the patient is engaging in doctor shopping at this time. The PMP Awar(x)e program has related, interconnected searches in multiple adjacent and noncontiguous states including but not limited to Arizona, Utah, Idaho, Colorado. The search is unable to query California, or local federal pharmacies including the VA hospital, Nellis Air Force base. Queries detail patient information, location, prescriptions filled, pharmacies and providers writing prescriptions. The patient's NV PMP was queried and reviewed prior to prescribing any controlled substances. The role of the NV PMP is to detect patients obtaining simultaneous prescriptions for controlled substances.

Follow up: Return to clinic in four weeks.

Prescriptions: Oxycodone hydrochloride 30mg tablet, Sig: 1 po q4 prn pain, maximum four per day, discontinue oxycodoen 15 mg tablets, 30 Days, Qty: 120 Tablet, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

'Steven Kozmary MD'. 01/13/2017 02:01:50 PM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding: 99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Celebrating 25 Years of Saving the Northern

Board Certified, American Board of Anesthesiology
Subspecialty Certification in Pain Medicine
Member American Society of Pain Management

Patient: Simone Russo
DOB: 09/05/1942
Gender: Male

PCP:
Referring Physician: John S Thalgott MD
Steven Kozmary
Primary Insurance: Medicare

Exam Date: 11/29/2016

Subjective:

Chief Complaint: The patient complains of the same pain in the neck and low back.

Reason for Visit: Simone Russo returns for a follow up evaluation.

Interim History: The patient returns for a follow up office visit. He has undergone cervical spine surgery for disc herniation with Dr. Thalgott. He is recovering and continues the oxycodone 30 mg tablets for pain. He had an MRI of the cervical spine which shows multilevel posterior disc osteophytes resulting in mild to severe central canal stenosis. He has some low back and bilateral sciatica pain. He is experiencing constipation which seems to be well controlled with Linzess. The pain is the same as the last visit. He taking Prozac, and oxycodone 15 mg. He has discontinued the gabapentin and Xanax. He denies any fevers or chills. The patient denies any other significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today.
Location: Pain is located in the neck and low back.
Quality: Patient describes pain as throbbing, gnawing and pins/needles.
Severity: Patient describes current pain level as a 10 on a visual analog scale from 1-10
Duration: Pain since 1/2012.
Timing: Pain is intermittent, during day and night.
Adverse Events: None.
Aberrant Drug Related Behavior: None.
ADL: Uses walker at home.
UDT was reviewed.
NV PMP was reviewed.
The patient denies the following since the last appointment: Seeing another pain management physician, loss of bladder or bowel control, entry into a drug rehab program or facility, familial/friends concerned about amount of medications taking, use of illegal drugs, obtained pain medications from other physicians, suicidal ideation/attempts, seeing a psychiatrist/psychologist.
The patient has attested to the following: They are responsible for all medications, they are abiding by the terms of the narcotic agreement, they have not obtained narcotic, sedative or sleep medications from other sources, awareness of pharmacy profile, understanding of 14 day term of controlled substance prescription, informed consent for pan management therapy.
NV PMP 11/8/16 was reviewed.
UDT 9/23/16 was reviewed.

Reviewed Data: KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.

Oswestry Disability Index (ODI): ODI Score **11.** The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete

14A.App.3083

disability.

Past Medical History: Hypertension
Back Disease

Social History: Marital Status: Married
Children
Employment: Retired: Physician for 40 years.
Education: Graduate Degree: 4 years.
Other: Back.
Healthy
Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain, pins/needles and problems with balance.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	122 / 84	BMI: 28.8	
	Weight. 195		Pulse:	70	O2 Sat:	96

Physical Examination The patient is a pleasant and cooperative 74-year-old male.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic and slow. He uses a wheeled walker.
There is no evidence of symptom magnification.
HEENT: Normocephalic, atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.
Cervical spine right dressing in place.

Assessment:

Diagnoses:
M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M70.60 Trochanteric bursitis, unspecified hip
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
M54.5 Low back pain
F32.9 Major depressive disorder, single episode, unspecified
K59.00 Constipation, unspecified
M54.12 Radiculopathy, cervical region
M54.2 Cervicalgia
M48.02 Spinal stenosis, cervical region

Discussion:
1. SP C4-7 anterior cervical fusion
2. Worsening pain after surgery
3. Continue oxycodone 30 mg four per day
4. The patient is indicated for ongoing Urine drug testing (UDT) because of chronic pain requiring controlled substances for the control of pain. The UDT are on a random basis. The most recent

UDT results were reviewed. The testing was done with immunoassay on a V-Twin Analyzer which included several drug classes: Amphetamine, barbiturates, benzodiazepines, opiates and specific agents: Propoxyphene, methadone, methaqualone, ethanol glucuronidate, as well as illicit drugs: Cocaine, and PCP. Pertinent positives and negatives were tested with liquid chromatography/mass spectrometry ensuring accuracy and minimizing the likelihood of false positives/false negatives inherent in immunoassay testing. The UDT results were consistent with the prescribed medication(s). There was no evidence of illicit drug use, drug diversion, additional opiate or other drugs ingested (other than the prescribed medications). In summary there was no evidence of aberrant drug behavior that fell outside the narcotic agreement.

5. The Nevada Prescription Monitoring Program (NV PMP) database was queried regarding this patient's prescription history. The PMP Awar(x)e program has related, interconnected searches in multiple adjacent and noncontiguous states including but not limited to Arizona, Utah, Idaho, Colorado. The search is unable to query California, or local federal pharmacies including the VA hospital, Nellis Air Force base. Queries detail patient information, location, prescriptions filled, pharmacies and providers writing prescriptions. The patient's NV PMP was queried and reviewed prior to prescribing any controlled substances. The role of the NV PMP is to detect patients obtaining simultaneous prescriptions for controlled substances. There is no evidence that the patient is engaging in doctor shopping at this time.

Follow up: Return to clinic in four weeks.

Prescriptions: Oxycodone hydrochloride 30mg tablet, Sig: 1 po q4 prn pain, maximum four per day, discontinue oxycodone 15 mg tablets, 45 Days, Qty: 180 Tablet, Ref: 0
Oxycontin 40mg extended-release tablet, Sig: 1 po qhs, 45 Days, Qty: 45 Tablet, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

'Steven Kozmary MD'. 12/28/2016 09:38:39 AM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding: 99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	11/08/2016

Subjective:

Chief Complaint: The patient complains of same lumbar, cervical and bilateral leg pain.

Reason for Visit: Simone Russo returns for a follow up evaluation and medication refills.

Interim History: The patient returns for a follow up office visit. He has undergone cervical spine surgery for disc herniation with Dr. Thalgott. He had an MRI of the cervical spine which shows multilevel posterior disc osteophytes resulting in mild to severe central canal stenosis. He has some low back and bilateral sciatica pain. He is having some urinary retention secondary to neuropathy and now has to self-cath on occasion. He is experiencing constipation which has improved with Linzess. The pain is the same as the last visit. He taking Prozac, and oxycodone 15 mg. He has discontinued the gabapentin and Xanax. He denies any fevers or chills. The patient denies any other significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today.
Location: Pain is located in the neck and low back.
Quality: Patient describes pain as sharp, electric shock and pins/needles.
Severity: Patient describes current pain level as a 8-10 on a visual analog scale from 1-10
Duration: Pain since 1/2012.
Timing: Pain is unpredictable during midday and in the evening.
Adverse Events: Constipation.
Aberrant Drug Related Behavior: None.
ADL: Uses walker at home.
UDT was reviewed.
NV PMP was reviewed.
The patient denies the following since the last appointment: Seeing another pain management physician, loss of bladder or bowel control, entry into a drug rehab program or facility, familial/friends concerned about amount of medications taking, use of illegal drugs, obtained pain medications from other physicians, suicidal ideation/attempts, seeing a psychiatrist/psychologist.
The patient has attested to the following: They are responsible for all medications, they are abiding by the terms of the narcotic agreement, they have not obtained narcotic, sedative or sleep medications from other sources, awareness of pharmacy profile, understanding of 14 day term of controlled substance prescription, informed consent for pan management therapy.
NV PMP 11/8/16 was reviewed.
UDT 9/23/16 was reviewed.

Reviewed Data: KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.

Oswestry Disability Index (ODI): ODI Score **10**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete

disability.

Past Medical History: Hypertension
Back Disease

Social History: Marital Status: Married
Children
Employment: Retired: Physician for 40 years.
Education: Graduate Degree: 4 years.
Other: Back.
Healthy
Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain, pins/needles and problems with balance.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	120 / 76	BMI: 28.8	
	Weight. 195		Pulse:	75	O2 Sat:	92

Physical Examination The patient is a pleasant and cooperative 74-year-old male.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic and slow. He uses a wheeled walker.
There is no evidence of symptom magnification.
HEENT: Normocephalic, atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.
Cervical spine right dressing in place.

Assessment:

Diagnoses:
M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M70.60 Trochanteric bursitis, unspecified hip
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
M54.5 Low back pain
F32.9 Major depressive disorder, single episode, unspecified
K59.00 Constipation, unspecified
M54.12 Radiculopathy, cervical region
M54.2 Cervicalgia
M48.02 Spinal stenosis, cervical region

Discussion:
1. SP C4-7 anterior cervical fusion
2. Worsening pain after surgery
3. Increase oxycodone from 15 to 30 mg four per day
4. The patient is indicated for ongoing Urine drug testing (UDT) because of chronic pain requiring controlled substances for the control of pain. The UDT are on a random basis. The most recent

UDT results were reviewed. The testing was done with immunoassay on a V-Twin Analyzer which included several drug classes: Amphetamine, barbiturates, benzodiazepines, opiates and specific agents: Propoxyphene, methadone, methaqualone, ethanol glucuronidate, as well as illicit drugs: Cocaine, and PCP. Pertinent positives and negatives were tested with liquid chromatography/mass spectrometry ensuring accuracy and minimizing the likelihood of false positives/false negatives inherent in immunoassay testing. The UDT results were consistent with the prescribed medication(s). There was no evidence of illicit drug use, drug diversion, additional opiate or other drugs ingested (other than the prescribed medications). In summary there was no evidence of aberrant drug behavior that fell outside the narcotic agreement.

5. The Nevada Prescription Monitoring Program (NV PMP) database was queried regarding this patient's prescription history. The PMP Awar(x)e program has related, interconnected searches in multiple adjacent and noncontiguous states including but not limited to Arizona, Utah, Idaho, Colorado. The search is unable to query California, or local federal pharmacies including the VA hospital, Nellis Air Force base. Queries detail patient information, location, prescriptions filled, pharmacies and providers writing prescriptions. The patient's NV PMP was queried and reviewed prior to prescribing any controlled substances. The role of the NV PMP is to detect patients obtaining simultaneous prescriptions for controlled substances. There is no evidence that the patient is engaging in doctor shopping at this time.

Follow up: Return to clinic in four weeks.

Prescriptions:

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

'Steven Kozmary MD'. 11/09/2016 06:31:03 AM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695
CPT Coding: 99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	10/18/2016

Subjective:

Chief Complaint: The patient complains of worsening pain in the neck and low back.

Reason for Visit: Simone Russo returns for a follow up evaluation and medication refills.

Interim History: The patient returns for a follow up office visit with continued right neck, interscpualr pain. He has had an MRI of the cervical spine which shows multilevel posterior disc osteophytes resulting in mild to severe central canal stenosis. He has some low back and bilateral sciatica pain. He is having difficulty with urinary retention secondary to neuropathy and now has to self-cath. He is experiencing severe constipation. The pain is worse since the last visit. He taking Prozac and suboxone. He is now using gabapentin on a regular basis rather than an occasional basis for the neuropathic pain. He denies any fevers or chills. The patient denies any other significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today.
Location: Pain is located in the neck and low back.
Quality: Patient describes pain as sharp, electric shock and pins/needles.
Severity: Patient describes current pain level as a 8 on a visual analog scale from 1-10
Duration: Pain since 1/2012.
Timing: Pain is unpredictable during midday and in the evening.
Adverse Events: Constipation.
Aberrant Drug Related Behavior: None.
ADL: Uses walker at home.
UDT was reviewed.
NV PMP was reviewed.
The patient denies the following since the last appointment: Seeing another pain management physician, loss of bladder or bowel control, entry into a drug rehab program or facility, familial/friends concerned about amount of medications taking, hospitalizations, use of illegal drugs, obtained pain medications from other physicians, suicidal ideation/attempts, seeing a psychiatrist/psychologist.
The patient has attested to the following: They are responsible for all medications, they are abiding by the terms of the narcotic agreement, they have not obtained narcotic, sedative or sleep medications from other sources, awareness of pharmacy profile, understanding of 14 day term of controlled substance prescription, informed consent for pan management therapy.

Reviewed Data: KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.

Oswestry Disability Index (ODI): ODI Score **16.** The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.

Past Medical History: Hypertension
Back Disease

Social History: Marital Status: Married
Children
Employment: Retired: Physician for 40 years.
Education: Graduate Degree: 4 years.
Other: Back.
Healthy
Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain, pins/needles and problems with balance.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	148 / 78	BMI: 29.5	
	Weight. 200		Pulse:	81	O2 Sat:	97

Physical Examination The patient is a pleasant and cooperative 74-year-old male.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic and slow. He uses a wheeled walker.
There is no evidence of symptom magnification.
HEENT: Normocephalic, atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M70.60 Trochanteric bursitis, unspecified hip
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
M54.5 Low back pain
F32.9 Major depressive disorder, single episode, unspecified
K59.00 Constipation, unspecified

Discussion:
M54.12 Radiculopathy, cervical region
M54.2 Cervicalgia
M48.02 Spinal stenosis, cervical region

He has new onset interscapular pain and has had an MRI of the cervical spine. The results are not yet available. He has seen Dr. Thalgott for severe central canal cervical stenosis. His symtpoms have markedly worsened. I discussed his medical condition with the patient in detail.

Plan:

Follow up: Return to clinic in four weeks.

Prescriptions: Oxycodone hydrochloride 15mg tablet, Sig: 1 po q4 prn pain, maximum four tablets per day, 30 Days,

Qty: 120 Tablet, Ref: 0
Relistor 12mg/0.6ml solution for injection, Sig: 1 SQ qd prn severe constipation, 30 Days, Qty: 30 Milliliter, Ref: 0
Xanax 0.5mg tablet, Sig: 1 po qhs, maximum one tablet per day, 30 Days, Qty: 10 Tablet, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

'Steven Kozmary MD'. 10/29/2016 08:51:35 AM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695
Face to face time greater than 25 minutes
CPT Coding: 99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	09/20/2016

Subjective:

Chief Complaint:	The patient complains of the same pain in the upper back and low back.
Reason for Visit:	Simone Russo returns for a follow up evaluation and medication refills.
Interim History:	The patient returns for a follow up office visit with continued right neck, interscpualr pain. He has had an MRI of the cervical spine. The results are not yet available. He has some low back and bilateral sciatica pain. He is having difficulty with urinary retention secondary to neuropathy and now has to self-cath. He is experiencing severe constipation. The pain is worse since the last visit. He taking Prozac and suboxone. He is now using gabapentin on a regular basis rather than an occasional basis for the neuropathic pain. He denies any fevers or chills. The patient denies any other significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today. He denies any fevers or chills. Location: Pain is located in the lower back and bilateral legs. Quality: Patient describes pain as tingling, electric shock and pins/needles. Severity: Patient describes current pain level as a 8 on a visual analog scale from 1-10 Duration: Pain since 1/2012. Timing: Pain is intermittent and unpredictable in the evening. Adverse Events: not noted. Aberrant Drug Related Behavior: None. ADL: Uses walker at home. UDT was reviewed. NV PMP was reviewed. The patient denies the following since the last appointment: Seeing another pain management physician, loss of bladder or bowel control, entry into a drug rehab program or facility, familial/friends concerned about amount of medications taking, hospitalizations, use of illegal drugs, obtained pain medications from other physicians, suicidal ideation/attempts, seeing a psychiatrist/psychologist. The patient has attested to the following: They are responsible for all medications, they are abiding by the terms of the narcotic agreement, they have not obtained narcotic, sedative or sleep medications from other sources, awareness of pharmacy profile, understanding of 14 day term of controlled substance prescription, informed consent for pan management therapy.
Reviewed Data:	KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.
Oswestry Disability Index (ODI):	ODI Score **15**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.

Past Medical History: Hypertension
Back Disease

Social History: Marital Status: Married
Children
Employment: Retired: Physician for 40 years.
Education: Graduate Degree: 4 years.
Other: Back.
Healthy
Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain, pins/needles and problems with balance.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	114 / 62	BMI: 29.5	
	Weight. 200		Pulse:	85	O2 Sat:	93

Physical Examination The patient is a pleasant and cooperative 74-year-old male.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic and slow. He uses a wheeled walker.
There is no evidence of symptom magnification.
HEENT: Normocephalic, atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M70.60 Trochanteric bursitis, unspecified hip
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
M54.5 Low back pain
F32.9 Major depressive disorder, single episode, unspecified
K59.00 Constipation, unspecified

Discussion:
M54.12 Radiculopathy, cervical region
M54.2 Cervicalgia

He has new onset interscapular pain and has had an MRI of the cervical spine. The results are not yet available. He has seen Dr. Thalgott today. I will start him on oxycodone 30 mg.

Plan:
1. Increase oxycodone from 15 to 30
2. MRI results pending
3. UDT at next visit
4. He is taking metafolbic plus RF

Follow up: Return to clinic in four weeks.

Prescriptions: Oxycodone hydrochloride 30mg tablet, Sig: 1 o q4 prn pain, maximum four tablets per day, discotinue oxycodoen 15 mg, 30 Days, Qty: 120 Tablet, Ref: 0
NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

' Steven Kozmary MD'. 09/20/2016 03:46:45 PM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding: 99214 OFFICE OUTPT DETAILED

Addended by - 'Steven Kozmary' 9/20/2016 3:51:09 PM
The patient is indicated for ongoing Urine drug testing (UDT) because of chronic pain requiring controlled substances for the control of pain. The UDT are on a random basis. The most recent UDT results were reviewed. The testing was done with immunoassay on a V-Twin Analyzer which included several drug classes: Amphetamine, barbiturates, benzodiazepines, opiates and specific agents: Propoxyphene, methadone, methaqualone, ethanol glucuronidate, as well as illicit drugs: Cocaine, and PCP. Pertinent positives and negatives were tested with liquid chromatography/mass spectrometry ensuring accuracy and minimizing the likelihood of false positives/false negatives inherent in immunoassay testing. The UDT results were consistent with the prescribed medication(s). There was no evidence of illicit drug use, drug diversion, additional opiate or other drugs ingested (other than the prescribed medications). In summary there was no evidence of aberrant drug behavior that fell outside the narcotic agreement.

The Nevada Prescription Monitoring Program (NV PMP) database was queried regarding this patient's prescription history. The PMP Awar(x)e program has related, interconnected searches in multiple adjacent and noncontiguous states including but not limited to Arizona, Utah, Idaho, Colorado. The search is unable to query California, or local federal pharmacies including the VA hospital, Nellis Air Force base. Queries detail patient information, location, prescriptions filled, pharmacies and providers writing prescriptions. The patient's NV PMP was queried and reviewed prior to prescribing any controlled substances. The role of the NV PMP is to detect patients obtaining simultaneous prescriptions for controlled substances. There is no evidence that the patient is engaging in doctor shopping at this time.

S. Kozmary MD

' Steven Kozmary MD'. 09/20/2016 03:51:07 PM (SKozmary)

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	09/13/2016

Subjective:

Chief Complaint: The patient complains of the same pain in the low back and legs.

Reason for Visit: Simone Russo returns for a follow up evaluation and medication refills.

Interim History: The patient returns for a follow up office visit with continued low back and bilateral sciatica pain. His neuropathy pain in the lower extremities has worsened. He has travelled to New York and recently returned. He also reports cervical pain and right interscapular pain. He has not had an MRI of the cervical spine to date. I reviewed his chart back to 2014. He is having difficulty with urinary retention secondary to neuropathy and now has to self-cath. He is experiencing severe constipation. The pain is worse since the last visit. He taking Prozac and suboxone. He is now using gabapentin on a regular basis rather than an occasional basis for the neuropathic pain. He denies any fevers or chills. The patient denies any other significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today. He denies any fevers or chills.
Location: Pain is located in the lower back and bilateral legs.
Quality: Patient describes pain as tingling, electric shock and pins/needles.
Severity: Patient describes current pain level as a 8 on a visual analog scale from 1-10
Duration: Pain since 1/2012.
Timing: Pain is intermittent and unpredictable in the evening.
Adverse Events: not noted.
Aberrant Drug Related Behavior: None.
ADL: Uses walker at home.

UDT was reviewed.
NV PMP was reviewed.

Reviewed Data: KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.

Oswestry Disability Index (ODI): ODI Score **15**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.

Past Medical History: Hypertension
Back Disease

Social History: Marital Status: Married
Children
Employment: Retired: Physician for 40 years.

Education: Graduate Degree: 4 years.
Other: Back.
Healthy
Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain, pins/needles and problems with balance.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	124 / 76	BMI: 29.5	
	Weight. 200		Pulse:	83	O2 Sat:	94

Physical Examination The patient is a pleasant and cooperative 74-year-old male.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic and slow. He uses a wheeled walker.
There is no evidence of symptom magnification.
HEENT: Normocephalic, atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M70.60 Trochanteric bursitis, unspecified hip
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
M54.5 Low back pain
F32.9 Major depressive disorder, single episode, unspecified
K59.00 Constipation, unspecified

Discussion:

He has new onset interscapular pain. I will discontinued suboxone and start him on oxycodone. I will start him on relistor for OIC. The patient understood and has agreed to our plan. The patient does not show signs of clinical depression and denies any suicidal ideation. I discussed the risks, benefits and options of the therapy with the patient.

The Nevada Prescription Monitoring Program (NV PMP) database was queried regarding this patient's prescription history. The PMP Awar(x)e program has related, interconnected searches in multiple adjacent and noncontiguous states including but not limited to Arizona, Utah, Idaho, Colorado. The search is unable to query California, or local federal pharmacies including the VA hospital, Nellis Air Force base. Queries detail patient information, location, prescriptions filled, pharmacies and providers writing prescriptions. The patient's NV PMP was queried and reviewed prior to prescribing any controlled substances. The role of the NV PMP is to detect patients obtaining simultaneous prescriptions for controlled substances. There is no evidence that the patient is engaging in doctor shopping at this time.

14A.App.3096

Plan:

1. Discontinue suboxone
2. Start oxycodone 15 mg up to four tablets per day
3. UDT at next visit
4. Relistor for opiate induced constipation

Follow up: Return to clinic in four weeks.

Prescriptions: Medrol 4mg tablet, Sig: take as directed, 1 medrol dosepak, 6 Days, Qty: 1 Tablet, Ref: 0
Oxycodone hydrochloride 15mg tablet, Sig: 1 po q4 prn pain, maximum four tablets per day, 30 Days, Qty: 120 Tablet, Ref: 0
Relistor 12mg/0.6ml solution for injection, Sig: 1 SQ qd prn severe constipation, 30 Days, Qty: 30 Syringe, Ref: 0
Xanax 0.5mg tablet, Sig: 1 po qhs, maximum one tablet per day, 30 Days, Qty: 10 Tablet, Ref: 0
NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

'Steven Kozmary MD'. 09/13/2016 02:05:28 PM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding: 99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	08/09/2016

Subjective:

Chief Complaint:	The patient complains of the same pain in the lower back and legs.
Reason for Visit:	Simone Russo returns for a follow up evaluation and medication refills.
Interim History:	The patient returns for a follow up office visit with continued low back and bilateral sciatica pain. He is having difficulty with urinary retention secondary to neuropathy. The pain is essentially unchanged since the last visit. He denies any medication side effects. He taking Prozac and suboxone. He does testosterone self-injection on a weekly basis. He has discontinued the Elavil. He is using gabapentin on an occasional basis for neuropathic pain. He had difficulty with the sustained release gabapentin. He denies any fevers or chills. The patient denies any other significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today. He denies any fevers or chills. Location: Pain is located in the lower back and bilateral legs. Quality: Patient describes pain as tingling, electric shock and pins/needles. Severity: Patient describes current pain level as a 5 on a visual analog scale from 1-10 Duration: Pain since 1/2012. Timing: Pain is intermittent and unpredictable in the evening. Adverse Events: not noted. Aberrant Drug Related Behavior: None. ADL: Uses walker at home. NV PMP was reviewed UDT was reviewed.
Reviewed Data:	KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.
Oswestry Disability Index (ODI):	ODI Score **11**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.
Past Medical History:	Hypertension Back Disease
Social History:	Marital Status: Married Children Employment: Retired: Physician for 40 years. Education: Graduate Degree: 4 years. Other: Back. Healthy Decrease in strength and/or endurance

Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain, pins/needles and problems with balance.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	116 / 70	BMI: 29.5	
	Weight. 200		Pulse:	81	O2 Sat:	93

Physical Examination The patient is a pleasant and cooperative 73-year-old male.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic and slow.
There is no evidence of symptom magnification.
HEENT: Normocephalic, atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M70.60 Trochanteric bursitis, unspecified hip
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
M54.5 Low back pain
F32.9 Major depressive disorder, single episode, unspecified

Discussion: I will continue the Suboxone and gabapentin. He will continue the testosterone injection therapy. He will use the gabapentin on an as needed basis. The patient understood and has agreed to our plan. The patient does not show signs of clinical depression and denies any suicidal ideation. I discussed the risks, benefits and options of the therapy with the patient.

The Nevada Prescription Monitoring Program (NV PMP) database was queried regarding this patient's prescription history. The PMP Awar(x)e program has related, interconnected searches in multiple adjacent and noncontiguous states including but not limited to Arizona, Utah, Idaho, Colorado. The search is unable to query California, or local federal pharmacies including the VA hospital, Nellis Air Force base. Queries detail patient information, location, prescriptions filled, pharmacies and providers writing prescriptions. The patient's NV PMP was queried and reviewed prior to prescribing any controlled substances. The role of the NV PMP is to detect patients obtaining simultaneous prescriptions for controlled substances. There is no evidence that the patient is engaging in doctor shopping at this time.

Urine drug testing (UDT) results were reviewed from May of 2016. The initial testing with immunoanalysis on a V-Twin Analyzer included several drug classes: Amphetamine, barbiturates, benzodiazepines, opiates and specific agents: Propoxyphene, methadone, methaqualone, ethanol glucuronidate, as well as illicit drugs: Cocaine, and PCP. Pertinent positives and negatives were then tested with liquid chromatography/mass spectrometry ensuring accuracy and minimizing the likelihood of false positives/false negatives inherent in immunoassay testing. The UDT results were consistent with the prescribed medication(s). There was no evidence of illicit drug use, drug diversion, additional opiate

or other drugs ingested (other than the prescribed medications). In summary there was no evidence of aberrant drug behavior that fell outside the narcotic agreement.

Plan:

1. Suboxone refill at the current dosage
2. UDT at next visit

Follow up: Return to clinic in four weeks.

Prescriptions:

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

' Steven Kozmary MD'. 09/18/2016 07:22:51 PM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695
CPT Coding: 99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	07/05/2016

Subjective:

Chief Complaint:	The patient complains of the same pain in the low back and bilateral legs.
Reason for Visit:	Simone Russo returns for a follow up evaluation and medication refills.
Interim History:	The patient returns for a follow up office visit with continued low back and bilateral sciatica pain. He is having difficulty with urinary retention secondary to neuropathy. The pain is unchanged since the last visit. He denies any medication side effects. He taking Prozac and suboxone. He has discontinued the Elavil. He is using gabapentin on an occasional basis for neuropathic pain. He had difficulty with the sustained release gabapentin. He denies any fevers or chills. The patient denies any other significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today. He denies any fevers or chills. Location: Pain is located in the lower back and bilateral legs. Quality: Patient describes pain as tingling, electric shock and pins/needles. Severity: Patient describes current pain level as a 5 on a visual analog scale from 1-10 Duration: Pain since 1/2012. Timing: Pain is unpredictable in the evening. Adverse Events: not noted. Aberrant Drug Related Behavior: None. ADL: Uses walker at home.
Reviewed Data:	KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.
Oswestry Disability Index (ODI):	ODI Score **10**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.
Past Medical History:	Hypertension Back Disease
Social History:	Marital Status: Married Children Employment: Retired: Physician for 40 years. Education: Graduate Degree: 4 years. Other: Back. Healthy Decrease in strength and/or endurance Hobbies/Recreational Activities: Before pain: Tennis. Goals: Not noted.

Past Treatments:	Physical Therapy: Last was on 12/13. Surgery
Family History:	Diabetes Hypertension Kidney Disease
Allergies:	.No Known Drug Allergies
Review of Systems:	The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart. The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain, pins/needles and problems with balance.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	118 / 72	BMI: 29.5	
	Weight. 200		Pulse:	81	O2 Sat:	96

Physical Examination

The patient is a pleasant and cooperative 73-year-old male.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic and slow.
There is no evidence of symptom magnification.
HEENT: Normocephalic, atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:

M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M70.60 Trochanteric bursitis, unspecified hip
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
M54.5 Low back pain
F32.9 Major depressive disorder, single episode, unspecified

Discussion:

I will continue the Suboxone and gabapentin. He will continue the testosterone. He will use the gabapentin on an as needed basis. The patient understood and has agreed to our plan. The patient does not show signs of clinical depression and denies any suicidal ideation. I discussed the risks, benefits and options of the therapy with the patient.

Plan:

1. Suboxone refill at the current dosage
2. UDT at next visit

Follow up:

Return to clinic in four weeks.

Prescriptions:

Gabapentin 100MG Capsule Oral, Sig: 1 po qhs maximum one per day, 30 Days, Qty: 30 Capsule, Ref: 0
Suboxone 8-2MG Film Sublingual, Sig: 1 SL qd, discontinue all other opiates, 30 Days, Qty: 30 Film, Ref: 0
NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals:

None

S. Kozmary MD

' Steven Kozmary MD'. 07/05/2016 01:48:41 PM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding: 99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	05/17/2016

Subjective:

Chief Complaint:	The patient complains of pain in the lower back and bilateral legs is the same.
Reason for Visit:	Simone Russo returns for a follow up evaluation and medication refills.
Interim History:	The patient returns for a follow up office visit with continued low back and bilateral sciatica pain. The pain is unchanged since the last visit. He denies any medication side effects. He is using gabapentin on an occasional basis for neuropathic pain. He does have some sedation with the gabapentin. He states it affects his mentation. He denies any fevers or chills. The patient denies any other significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today. He denies any fevers or chills. Location: lower back and bilateral legs. Quality: Patient describes pain as tingling, electric shock, stabbing, pins/needles and exhausting. Severity: Patient describes current pain level as a 6-10 on a visual analog scale from 1-10 Duration: Pain since 1/2012. Timing: Pain is intermittent and unpredictable. Adverse Events: not noted. Aberrant Drug Related Behavior: None. ADL: Uses walker at home.
Reviewed Data:	KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.
Oswestry Disability Index (ODI):	ODI Score **9**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.
Past Medical History:	Hypertension Back Disease
Social History:	Marital Status: Married Children Employment: Retired: Physician for 40 years. Education: Graduate Degree: 4 years. Other: Back. Healthy Decrease in strength and/or endurance Hobbies/Recreational Activities: Before pain: Tennis. Goals: Not noted.
Past Treatments:	Physical Therapy: Last was on 12/13.

Family History:	Surgery Diabetes Hypertension Kidney Disease
Allergies:	.No Known Drug Allergies
Review of Systems:	The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart. The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain, pins/needles and problems with balance.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	120 / 66	BMI: 31.7	
	Weight. 215		Pulse:	87	O2 Sat:	90

Physical Examination

The patient is a pleasant and cooperative 73-year-old male.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic and slow.
There is no evidence of symptom magnification.
HEENT: Normocephalic, atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:

M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M70.60 Trochanteric bursitis, unspecified hip
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
M54.5 Low back pain
F32.9 Major depressive disorder, single episode, unspecified

Discussion:

I will continue the Suboxone. I had a long and detailed discussion with the patient and his wife regarding restarting opiates. We collectively decided to continue the suboxone. He will use the gabapentin on an as needed basis. The patient understood and has agreed to our plan. The patient does not show signs of clinical depression and denies any suicidal ideation. I discussed the risks, benefits and options of the therapy with the patient.

Aberrant Drug Behavior Assessment: The patient appears to be taking their medication as prescribed. There is ongoing urine drug testing, pharmacy profiles and psychological testing in an effort to uncover aberrant drug behavior. At this time there is no evidence of aberrant drug behavior. I will continue to prescribe opiates for chronic pain syndrome in an effort to reduce painful symptoms, improve function and minimize the side effects of therapy.

Plan:

1. Suboxone refill at the current dosage
2. UDT at next visit

Follow up: Return to clinic in four weeks.

Prescriptions: Suboxone 8-2MG Film Sublingual, Sig: 1 SL qd, discontinue all other opiates, 30 Days, Qty: 30 Film, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

'Steven Kozmary MD'. 05/17/2016 02:55:52 PM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695
CPT Coding: 99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	04/07/2016

Subjective:

Chief Complaint:	The patient complains of pain in the lower back and legs are the same.
Reason for Visit:	Simone Russo returns for a follow up evaluation and medication refills.
Interim History:	The patient returns for a follow up office visit with continued low back and bilateral sciatica pain. He also complains of foot spasms. He has continued pain that is worsened when he is walking. He recently travelled to New York for the birth of his grandchild. His pain worsened with the air travel. He is using gabapentin on an occasional basis for neuropathic pain. He does have some sedation with the gabapentin. He denies any fevers or chills. The patient denies any significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today. He denies any fevers or chills. Location: lower back and bilateral legs. Quality: Patient describes pain as tingling, electric shock, stabbing, pins/needles and exhausting. Severity: Patient describes current pain level as a 5-10 on a visual analog scale from 1-10 Duration: not noted. Timing: Pain is intermittent. Adverse Events: not noted. Aberrant Drug Related Behavior: None. ADL: Uses walker at home.
Reviewed Data:	KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.
Oswestry Disability Index (ODI):	ODI Score **9**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.
Past Medical History:	Hypertension Back Disease
Social History:	Marital Status: Married Children Employment: Retired: Physician for 40 years. Education: Graduate Degree: 4 years. Other: Back. Healthy Decrease in strength and/or endurance Hobbies/Recreational Activities: Before pain: Tennis. Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain and pins/needles.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	140 / 76	BMI: 31.7	
	Weight. 215		Pulse:	82	O2 Sat:	93

Physical Examination The patient is a pleasant and cooperative 73-year-old male.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic and slow.
There is no evidence of symptom magnification.
HEENT: Normocephalic, atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M70.60 Trochanteric bursitis, unspecified hip
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
M54.5 Low back pain
F32.9 Major depressive disorder, single episode, unspecified

Discussion: I will continue the Suboxone. I will start Lyrica which he has taken in the past. His overall function has improved markedly since lumbar decompressing. I had a long and detailed discussion with the patient and his wife regarding restarting opiates. We collectively decided to continue the suboxone. The patient understood and has agreed to our plan. The patient does not show signs of clinical depression and denies any suicidal ideation. I discussed the risks, benefits and options of the therapy with the patient.

Plan:
1. Suboxone
2. Continue Elavil
3. Medrol Dosepak
4. Start Lyrica

Follow up: Return to clinic in four weeks.

Prescriptions:
Amitriptyline hcl 50MG Tablet Oral, Sig: 1-2 po qhs, 30 Days, Qty: 60 Tablet, Ref: 0
Lyrica 50MG Capsule Oral, Sig: 1 po bid, maximum two tablets per day, 30 Days, Qty: 60 Capsule, Ref: 0
Medrol (pak) 4MG Tablet Oral, Sig: take as directed, 6 Days, Qty: 1 Package, Ref: 0
Metanx 3-35-2MG Tablet Oral, Sig: 1 PO BID, 30 Days, Qty: 60, Ref: 0
Suboxone 8-2MG Film Sublingual, Sig: 1 SL qd, discontinue all other opiates, 30 Days, Qty: 30 Film, Ref: 0
NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

' Steven Kozmary MD'. 04/07/2016 09:55:14 AM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695
CPT Coding:
99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	03/15/2016

Subjective:

Chief Complaint:	The patient complains of pain in the lower back and bilateral legs is the same.
Reason for Visit:	Simone Russo returns for a follow up evaluation.
Interim History:	The patient returns for a follow up office visit with continued low back and left sciatica pain. He has continued pain that is worse when he is walking. He is using gabapentin on an occasional basis for neuropathic pain. He does have some sedation with the gabapentin. He denies any fevers or chills. The patient denies any significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today. He denies any fevers or chills. Location: lower back and bilateral legs. Quality: Patient describes pain as electric shock, stabbing and pins/needles. Severity: Patient describes current pain level as a 6 on a visual analog scale from 1-10 Duration: not noted. Timing: Pain is unpredictable. Adverse Events: not noted. Aberrant Drug Related Behavior: None. ADL: Uses walker at home.
Reviewed Data:	KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.
Oswestry Disability Index (ODI):	ODI Score **10**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.
Past Medical History:	Hypertension Back Disease
Social History:	Marital Status: Married Children Employment: Retired: Physician for 40 years. Education: Graduate Degree: 4 years. Other: Back. Healthy Decrease in strength and/or endurance Hobbies/Recreational Activities: Before pain: Tennis. Goals: Not noted.
Past Treatments:	Physical Therapy: Last was on 12/13.

Family History:	Surgery Diabetes Hypertension Kidney Disease
Allergies:	.No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain and pins/needles.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	110 / 70	BMI:	
	Weight 200lbs.		Pulse:	85	O2 Sat:	93

Physical Examination
The patient is a pleasant and cooperative 73-year-old male.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic and slow.
There is no evidence of symptom magnification.
HEENT: Normocephalic, atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M70.60 Trochanteric bursitis, unspecified hip
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
M54.5 Low back pain
F32.9 Major depressive disorder, single episode, unspecified

Discussion: I will continue the Suboxone. The patient understood and has agreed to our plan. The patient does not show signs of clinical depression and denies any suicidal ideation. I discussed the risks, benefits and options of the therapy with the patient.

Plan:
1. Discontinue oxycodone
2. Start suboxone

Follow up: Return to clinic in four weeks.

Prescriptions:
Amitriptyline hcl 50MG Tablet Oral, Sig: 1-2 po qhs, 30 Days, Qty: 60 Tablet, Ref: 0
Suboxone 8-2MG Film Sublingual, Sig: 1 SL qd, discontinue all other opiates, 30 Days, Qty: 30 Film, Ref: 0
NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

' Steven Kozmary MD'. 03/15/2016 04:18:17 PM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695
CPT Coding:
99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	02/16/2016

Subjective:

Chief Complaint:	The patient complains of the same pain in his lower back.
Reason for Visit:	Simone Russo returns for a follow up evaluation.
Interim History:	The patient returns for a follow up office visit with continued low back and left sciatica pain. He has developed a productive cough. He denies any fevers or chills. He is using a walker on occasion. He would like to discontinue oxycodone and restart suboxone. He denies any fevers or chills. The patient denies any significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today. He denies any fevers or chills. Location: lower back. Quality: Patient describes pain as stabbing, electric shock, and pins/needles Severity: Patient describes current pain level as a 5 on a visual analog scale from 1-10 Duration: Jan 2012 Timing: Pain is intermittent Adverse Events: Constipation. Aberrant Drug Related Behavior: None. ADL: Uses walker at home.
Reviewed Data:	KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.
Oswestry Disability Index (ODI):	ODI Score **10**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.
Past Medical History:	Hypertension Back Disease
Social History:	Marital Status: Married Children Employment: Retired: Physician for 40 years. Education: Graduate Degree: 4 years. Other: Back. Healthy Decrease in strength and/or endurance Hobbies/Recreational Activities: Before pain: Tennis. Goals: Not noted.
Past Treatments:	Physical Therapy: Last was on 12/13.

Family History:
Surgery
Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain and pins/needles.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	120 / 70	BMI:	
	Weight 200lbs.		Pulse:	86	O2 Sat:	92

Physical Examination
The patient is a pleasant and cooperative 73-year-old male.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic and slow.
There is no evidence of symptom magnification.
HEENT: Normocephalic, atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M70.60 Trochanteric bursitis, unspecified hip
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
M54.5 Low back pain
F32.9 Major depressive disorder, single episode, unspecified

Discussion:
I will discontinue the oxycodone and restart the Suboxone. The patient understood and has agreed to our plan. The patient does not show signs of clinical depression and denies any suicidal ideation. I discussed the risks, benefits and options of the therapy with the patient.

Aberrant Drug Behavior Assessment: The patient appears to be taking their medication as prescribed. There is ongoing urine drug testing, pharmacy profiles and psychological testing in an effort to uncover aberrant drug behavior. At this time there is no evidence of aberrant drug behavior. I will continue to prescribe opiates for chronic pain syndrome in an effort to reduce painful symptoms, improve function and minimize the side effects of therapy.

Side effects of chronic opiate therapy: I have enquired about side effects of chronic opiate therapy specifically nausea, vomiting, sedation, itching, constipation, respiratory depression, altered mental status, addiction, abuse or overdose. The patient has reported none of the side effects of chronic opiate therapy. The side effects at this point are minimal and do not contraindicate the use of chronic opiate therapy. I will continue to monitor for any evidence of side effects of chronic opiate therapy. I will continue my vigilance regarding abuse and/or addiction of opiates. I will also continue to monitor the State of Nevada Board of Pharmacy profiles and urine drug testing on a regular basis in addition to the monthly evaluations.

Plan:
1. Discontinue oxycodone
2. Start suboxone
3. Start Zithromycin for URI

Follow up: Return to clinic in four weeks.

Prescriptions: Suboxone 8-2MG Film Sublingual, Sig: 1 SL qd, discontinue all other opiates, 30 Days, Qty: 30 Film, Ref: 0
NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

' Steven Kozmary MD'. 05/15/2016 04:50:44 PM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding:
99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	01/21/2016

Subjective:

Chief Complaint:	The patient complains of bilateral leg pain and low back pain.
Reason for Visit:	Simone Russo returns for a follow up evaluation.
Interim History:	The patient returns for a follow up office visit with varying low back and left posterior sciatica pain. The patient has a SCS consult with Dr. Thalgott 2/2/2016. He has had a trial of spinal cord stimulation in the past. He denies any fevers or chills. The patient denies any significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today. He denies any fevers or chills. Location: low Back and bilateral legs Quality: Patient describes pain as tingling, electric shock and pins/needles Severity: Patient describes current pain level as a 8 on a visual analog scale from 1-10 Duration: Jan 2012 Timing: Pain is unpredictable and intermittent Adverse Events: Constipation. Aberrant Drug Related Behavior: None ADL: Uses walker.
Reviewed Data:	KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.
Oswestry Disability Index (ODI):	ODI Score **16**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.
Past Medical History:	Hypertension Back Disease
Social History:	Marital Status: Married Children Employment: Retired: Physician for 40 years. Education: Graduate Degree: 4 years. Other: Back. Healthy Decrease in strength and/or endurance Hobbies/Recreational Activities: Before pain: Tennis. Goals: Not noted.
Past Treatments:	Physical Therapy: Last was on 12/13. Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include numbness, weakness, numbness in legs and feet, pins/needles in legs and feet, problem with balance.

Objective:

Vitals:	Height: 5'9"	Blood Pressure:	120 / 70	BMI:	
	Weight 200lbs.	Pulse:	89	O2 Sat:	93

Physical Examination

The patient is a pleasant and cooperative 72-year-old male.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic. He uses a walker for ambulation.
There is no evidence of symptom magnification.
HEENT: Normocephalic, atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.
Left posterior sciatic tenderness.

Assessment:

Diagnoses:

M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M70.60 Trochanteric bursitis, unspecified hip
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
M54.5 Low back pain
F32.9 Major depressive disorder, single episode, unspecified

Discussion: The patient's pain is poorly controlled. He is indicated for oxycodone and discontinue Opana. I will continue testosterone therapy for hypogonadism. The patient understood and has agreed to our plan. The patient does not show signs of clinical depression and denies any suicidal ideation. I discussed the risks, benefits and options of the injection therapy with the patient.

Plan:

1. Start oxycodone
2. Discontinue Opana
3. Testosterone therapy

Follow up: Return to clinic in four weeks.

Prescriptions: Oxycodone hcl 20MG Tablet Oral, Sig: 1 po q4-6 prn pain, maximum three tablets per day, discontinue opana, 30 Days, Qty: 90 Tablet, Ref: 0
Testosterone cypionate 200MG/ML Solution Intramuscular, Sig: 1 ml IM q weekly, 30 Days, Qty: 1 Bottle, Ref: 5
NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

' Steven Kozmary MD'. 05/10/2016 03:43:41 PM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding:
99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	12/23/2015

Subjective:

Chief Complaint: The patient complains of a worsening pain in his back, legs, and feet.

Reason for Visit: Simone Russo returns for a follow up evaluation.

Interim History: The patient returns for a follow up office visit with worsening low back and left posterior sciatica pain. He has difficulty walking for more than ten feet before the onset of severe pain. He is using a walker. He would like to increase the Opana to 10 mg BID. He denies any fevers or chills. The patient denies any significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today. He denies any fevers or chills. He has GI upset from the ibuprofen. He will discontinue this medication.

Location: Back and bilateral legs
Quality: Patient describes pain as sharp, tingling, electric shock, stabbing and pins/needles
Severity: Patient describes current pain level as a 10 on a visual analog scale from 1-10
Duration: Jan 2012
Timing: Pain is unpredictable.
Adverse Events: Constipation.
Aberrant Drug Related Behavior: UDT today.
ADL: Uses walker.

Reviewed Data: KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.

Oswestry Disability Index (ODI): ODI Score **20**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.

Past Medical History: Hypertension
Back Disease

Social History: Marital Status: Married
Children
Employment: Retired: Physician for 40 years.
Education: Graduate Degree: 4 years.
Other: Back.
Healthy
Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain and pins/needles.

Objective:

Vitals:

Height:	5'9"	Blood Pressure:	140 / 86	BMI:	
Weight 200lbs.		Pulse:	75	O2 Sat:	95

Physical Examination The patient is a pleasant and cooperative 72-year-old male.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic. He uses a walker for ambulation.
There is no evidence of symptom magnification.
HEENT: Normocephalic, atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.
Left posterior sciatic tenderness.

Assessment:

Diagnoses:
M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M70.60 Trochanteric bursitis, unspecified hip
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
M54.5 Low back pain
F32.9 Major depressive disorder, single episode, unspecified

Discussion: The patient's pain is poorly controlled. I will increase the Opana and order a Medrol dose Pak. He is indicated for a sciatic nerve injection. The patient understood and has agreed to our plan. The patient does not show signs of clinical depression and denies any suicidal ideation. I discussed the risks, benefits and options of the injection therapy with the patient.

Plan:
1. Increase Opana
2. Left sciatic nerve injection
3. Medrol dose Pak

Follow up: Return to clinic in four weeks.

Prescriptions: Medrol (pak) 4MG Tablet Oral, Sig: take as directed, 6 Days, Qty: 1 Package, Ref: 0
Opana er 10MG Tablet Extended Release 12 Hour Oral, Sig: 1 po bid, maximum two tablets per day, discontinue opana 5 mg tablets, 30 Days, Qty: 60 Tablet, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

' Steven Kozmary MD'. 12/23/2015 05:08:16 PM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding:
99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	12/08/2015

Subjective:

Chief Complaint:	The patient complains of lower back pain.
Reason for Visit:	Simone Russo returns for a follow up evaluation.
Interim History:	The patient returns for a follow up office visit with worsening low back and bilateral lower extremity radicular pain. He has difficulty walking for more than ten feet before the onset of severe pain. He would like to restart opiate therapy and discontinue the Suboxone. His depression and discouragement have become significant. The patient denies any significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today. He denies any fevers or chills. He has GI upset from the ibuprofen. He will discontinue this medication. Location: Back and bilateral legs Quality: Patient describes pain as electric shock, stabbing and dull ache Severity: Patient describes current pain level as a 1 on a visual analog scale from 1-10 Duration: Jan 2012 Timing: Pain is unpredictable. Adverse Events: Constipation. Aberrant Drug Related Behavior: UDT today. ADL: Uses walker.
Reviewed Data:	KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.
Oswestry Disability Index (ODI):	ODI Score **16**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.
Past Medical History:	Hypertension Back Disease
Social History:	Marital Status: Married Children Employment: Retired: Physician for 40 years. Education: Graduate Degree: 4 years. Other: Back. Healthy Decrease in strength and/or endurance Hobbies/Recreational Activities: Before pain: Tennis. Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain and pins/needles.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	118 / 66	BMI:	
	Weight in lbs.:213		Pulse:	83	O2 Sat:	97

Physical Examination The patient is a pleasant and cooperative 72-year-old male.
He is seen with his wife in the office today.
He is awake and alert with normal speech and affect.
His gait is antalgic. He uses a walker for ambulation. There is no evidence of symptom magnification.
HEENT: Normocephalic, atraumatic.
SKIN: There are no rashes, lesions or discolorations.
EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M70.60 Trochanteric bursitis, unspecified hip
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
M54.5 Low back pain
F32.9 Major depressive disorder, single episode, unspecified

Discussion: The patient's pain is poorly controlled. I will stop the Suboxone and start Opana.
The patient understood and has agreed to our plan. The patient does not show signs of clinical depression and denies any suicidal ideation.

Plan:
1. Discontinue Suboxone
2. Start Opana
3. Discontinue ibuprofen

Follow up: Return to clinic in four weeks.

Prescriptions:

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

' Steven Kozmary MD'. 12/08/2015 01:55:10 PM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding:
99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	11/04/2015

Subjective:

Chief Complaint:	The patient complains of lower back and bilateral leg pain.
Reason for Visit:	Simone Russo returns for a follow up evaluation.
Interim History:	The patient returns for a follow up office visit with unchanged low back and radicular pain. The patient denies any significant adverse effects to the medications prescribed. There have been no recent hospitalizations or ER visits since the last exam. The body pain map was reviewed today. Location: Back and bilateral legs Quality: Patient describes pain as electric shock, stabbing and dull ache Severity: Patient describes current pain level as a 1 on a visual analog scale from 1-10 Duration: Jan 2012 Timing: Pain is unpredictable. Adverse Events: Constipation. Aberrant Drug Related Behavior: UDT today. ADL: Uses walker.
Reviewed Data:	KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.
Oswestry Disability Index (ODI):	ODI Score **16**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.
Past Medical History:	Hypertension Back Disease
Social History:	Marital Status: Married Children Employment: Retired: Physician for 40 years. Education: Graduate Degree: 4 years. Other: Back. Healthy Decrease in strength and/or endurance Hobbies/Recreational Activities: Before pain: Tennis. Goals: Not noted.
Past Treatments:	Physical Therapy: Last was on 12/13. Surgery
Family History:	Diabetes

Hypertension
Kidney Disease

Allergies: No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain and pins/needles.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	108 / 64	BMI:
	Weight in lbs.:		Pulse:	91	O2 Sat: 97

Physical Examination The patient is a pleasant and cooperative 72-year-old male. He is seen with his wife in the office today. He is awake and alert with normal speech and affect. His gait is antalgic. He uses a walker for ambulation. There is no evidence of symptom magnification. HEENT: Normocephalic, atraumatic. SKIN: There are no rashes, lesions or discolorations. EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
M96.1 Postlaminectomy syndrome, not elsewhere classified
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M70.60 Trochanteric bursitis, unspecified hip
G60.9 Hereditary and idiopathic neuropathy, unspecified
K59.09 Other constipation
M47.817 Spondyls w/o myelopathy or radiculopathy, lumbosacr region
M54.5 Low back pain
F32.9 Major depressive disorder, single episode, unspecified

Discussion: The patient's pain is moderately controlled on the medication regimen and I will refill the medications today. The patient understood and has agreed to our plan. The patient does not show signs of clinical depression and denies any suicidal ideation.

Plan:
1. Refill Suboxone.

Follow up: Return to clinic in four weeks.

Prescriptions: Linzess 290MCG Capsule Oral, Sig: Take 1 tab po qd, 30 Days, Qty: 30, Ref: 0
Suboxone 8-2MG Film Sublingual, Sig: 1 SL qd, discontinue all other opiates, 30 Days, Qty: 30 Film, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

' Steven Kozmary MD'. 11/24/2015 10:26:50 AM (SKozmary)Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding:
99213 OFFICE OUTPT EXPANDED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	09/15/2015

Subjective:

Chief Complaint:	The patient complains of leg pain.
Reason for Visit:	Simone Russo returns for a follow up evaluation.
Interim History:	73 y.o. male presents with neuropathic pain that remains unchanged since last visit. He reports bilateral lower extremity pain with swelling. He reports improved sacral pain with prescribed solu-medrol dose pack. The patient also started Elavil this past month. He also presents for a refill of medications. He reports constipation as a side effect. There have been no ER visits or hospitalizations since last visit. He denies suicidal ideation. The patient denies withdrawal symptoms or effects from Suboxne and reports good relief. Location: Back and bilateral legs Quality: Patient describes pain as electric shock, stabbing and dull ache Severity: Patient describes current pain level as a 1 on a visual analog scale from 1-10 Duration: Jan 2012 Timing: Pain is unpredictable. Adverse Events: Constipation. Aberrant Drug Related Behavior: UDT today. ADL: Uses walker.
Reviewed Data:	KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.
Oswestry Disability Index (ODI):	ODI Score **8**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.
Past Medical History:	Hypertension Back Disease
Social History:	Marital Status: Married Children Employment: Retired: Physician for 40 years. Education: Graduate Degree: 4 years. Other: Back. Healthy

Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain and pins/needles.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	108 / 64	BMI:	
	Weight in lbs.:		Pulse:	91	O2 Sat:	97

Physical Examination The patient is a pleasant and cooperative 72-year-old male. He is seen with his wife in the office today. He is awake and alert with normal speech and affect. His gait is antalgic. He uses a walker for ambulation. There is no evidence of symptom magnification. HEENT: Normocephalic, atraumatic. SKIN: There are no rashes, lesions or discolorations. EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
722.83 POSTLAMINECTOMY SYND LUMBAR REGION
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
726.5 ENTHESOPATHY HIP REGION
356.9 UNS IDIOPATHIC PERIPH NEUROPATHY
564.09 other unspec constipation
721.3 LUMBOSACRAL SPONDYLOSIS
724.2 LUMBAGO
311 DEPRESSIVE DISORDER OTHER

Discussion:
We discussed the patient's chronic pain in detail today. He continues to have pain in his back, legs and feet. He reports no changes in his symptoms since the last visit. The patient's pain is moderately controlled with the current pain regimen. I will refill Suboxne at 1 SL film per day. I will also request recent medical records from Dr. Thalgott for clinical review.

Aberrant Drug Behavior Assessment: The patient appears to be taking their medication as prescribed. There is ongoing urine drug testing, pharmacy profiles and psychological testing in an effort to uncover aberrant drug behavior. At this time there is no evidence of aberrant drug behavior. I will continue to prescribe opiates for chronic pain syndrome in an effort to reduce painful symptoms, improve function and minimize the side effects of therapy.

Plan:
1. Refill Suboxne.
2. Request medical records from Dr. Thalgott.

Follow up: Return to clinic in four weeks.

Prescriptions: Linzess 290MCG Capsule Oral, Sig: Take 1 tab po qd, 30 Days, Qty: 30, Ref: 0
Suboxone 8-2MG Film Sublingual, Sig: 1 SL qd, discontinue all other opiates, 30 Days, Qty: 30 Film, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

' Steven Kozmary MD'. 10/06/2015 11:21:34 AM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding:
99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	07/28/2015

Subjective:

Chief Complaint:	The patient complains of back pain.
Reason for Visit:	Simone Russo returns for a follow up evaluation.
Interim History:	The patient continues to experience pain in his back, legs and feet. He reports no changes in his symptoms since the last visit. The patient also complains of depression that is worsening. He states that that he has been on depression medications for 25 years and has tried going without medications and his depression continues to worsen. The patient states that he has a cystoscopy scheduled for Monday. The patient denies suicidal ideation, overtaking medications or any concerns by family or friends about the medications prescribed. Location: Back and bilateral legs Quality: Patient describes pain as electric shock, stabbing and dull ache Severity: Patient describes current pain level as a 5 on a visual analog scale from 1-10 Duration: Jan 2012 Timing: Pain is unpredictable and intermittent. Adverse Events: Constipation. Aberrant Drug Related Behavior: UDT today. ADL: Uses walker.
Reviewed Data:	KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.
Oswestry Disability Index (ODI):	ODI Score **12.** The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.
Past Medical History:	Hypertension Back Disease
Social History:	Marital Status: Married Children Employment: Retired: Physician for 40 years. Education: Graduate Degree: 4 years. Other: Back. Healthy

Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain and pins/needles.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	134 / 84	BMI:		
	Weight in lbs.:		Pulse:	69	O2 Sat:	96	

Physical Examination The patient is a pleasant and cooperative 72-year-old male. He is seen with his wife in the office today. He is awake and alert with normal speech and affect. His gait is antalgic. He uses a walker for ambulation. There is no evidence of symptom magnification. HEENT: Normocephalic, atraumatic. SKIN: There are no rashes, lesions or discolorations. EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
722.83 POSTLAMINECTOMY SYND LUMBAR REGION
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
726.5 ENTHESOPATHY HIP REGION
356.9 UNS IDIOPATHIC PERIPH NEUROPATHY
564.09 other unspec constipation
721.3 LUMBOSACRAL SPONDYLOSIS
724.2 LUMBAGO
311 DEPRESSIVE DISORDER OTHER

Discussion:
We discussed the patient's chronic pain in detail today. He continues to have pain in his back, legs and feet. He reports no changes in his symptoms since the last visit. The patient's pain is moderately controlled with the current pain regimen. I will start him on Prozac 20 mg once a day. I will refill his other medications at the current dosages. I reviewed the patient with Dr. Kozmary in the office today and he approves of the plan for his medications. The patient is indicated for a urine toxicology test today in compliance with the narcotic agreement. I reviewed the patient's pharmacy profile in the office today. He received Norco from his dentist in June. I updated Dr. Kozmary.

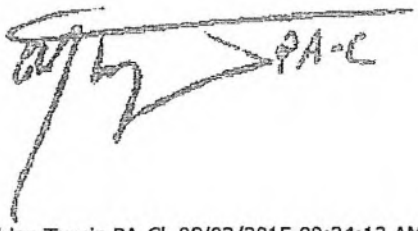
Plan:
1. Urine toxicology test today.
2. Pharmacy profile reviewed.
3. Start Prilosec 20 mg once a day.
4. Refill medications.

Follow up: Return to clinic in four weeks.

Prescriptions: Linzess 290MCG Capsule Oral, Sig: Take 1 tab po qd, 30 Days, Qty: 30, Ref: 0
Prozac 20MG Capsule Oral, Sig: Take one po QAM; max one per day, 30 Days, Qty: 30 Capsule, Ref: 0
Suboxone 8-2MG Film Sublingual, Sig: 1 SL qd, discontinue all other opiates, 30 Days, Qty: 30 Film, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None



' Adrian Turpin PA-C'. 08/03/2015 09:34:12 AM (aturpin)
Adrian Turpin
NPI: 1447697735
License: PA1429

CPT Coding:
99214 OFFICE OUTPT DETAILED
The above medical care was provided by a physician assistant and meets the requirements for "incident to" services. The patient on the initial evaluation by Dr. Steven Kozmary. The physician assistant was under the direct supervision of Dr. Kozmary who has an active part in the ongoing care of the patient. Dr. Kozmary was present in the office suite and immediately available to provide assistance and direction while the physician assistant was performing the services.

Steven Kozmary M.D.
Supervising Physician
Medical Director,
Kozmary Center for Pain Management

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	06/23/2015

Subjective:

Chief Complaint:	The patient complains of lowerback pain.
Reason for Visit:	Simone Russo returns for a follow up evaluation.
Interim History:	The patient continues to experience pain in his low back. The patient reports no changes in symptoms since the last visit. The patient recently had a right lumbar rhizotomy at L2-S1 with 100% improvement post procedure. The patient denies suicidal ideation, overtaking medications or any concerns by family or friends about the medications prescribed. Location: Back and bilateral legs Quality: Patient describes pain as electric shock, stabbing and dull ache Severity: Patient describes current pain level as a 5 on a visual analog scale from 1-10 Duration: Jan 2012 Timing: Pain is unpredictable and intermittent. Adverse Events: Constipation. Aberrant Drug Related Behavior: I reviewed last UDT today. No aberrant behavior. ADL: Uses walker.
Reviewed Data:	KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.
Oswestry Disability Index (ODI):	ODI Score **9**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.
Past Medical History:	Hypertension Back Disease
Social History:	Marital Status: Married Children Employment: Retired: Physician for 40 years. Education: Graduate Degree: 4 years. Other: Back. Healthy Decrease in strength and/or endurance Hobbies/Recreational Activities: Before pain: Tennis.

	Goals: Not noted.
Past Treatments:	Physical Therapy: Last was on 12/13. Surgery
Family History:	Diabetes Hypertension Kidney Disease
Allergies:	.No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain and pins/needles.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	124 / 92	BMI: 31.5	
	Weight in lbs.:	213	Pulse:	76	O2 Sat:	96

Physical Examination The patient is a pleasant and cooperative 72-year-old male. He is seen with his wife in the office today. He is awake and alert with normal speech and affect. His gait is antalgic. He uses a walker for ambulation. There is no evidence of symptom magnification. HEENT: Normocephalic, atraumatic. SKIN: There are no rashes, lesions or discolorations. EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
722.83 POSTLAMINECTOMY SYND LUMBAR REGION
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
726.5 ENTHESOPATHY HIP REGION
356.9 UNS IDIOPATHIC PERIPH NEUROPATHY
564.09 other unspec constipation
721.3 LUMBOSACRAL SPONDYLOSIS
724.2 LUMBAGO

Discussion:
We discussed the patient's chronic pain in detail today. He continues to have pain in his low back. The patient reports no changes in symptoms since the last visit. The patient's pain is moderately controlled with the current pain regimen. I will refill the patient's medications at the current dosages. The patient recently had a right lumbar rhizotomy at L2-S1 with 100% improvement post procedure.

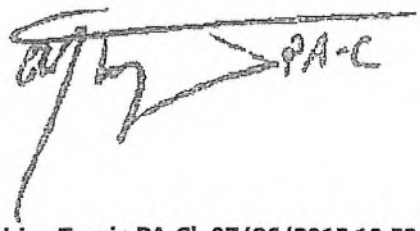
Plan:
1. Refill medications.

Follow up: Return to clinic in four weeks.

Prescriptions:
Linzess 290MCG Capsule Oral, Sig: Take 1 tab po qd, 30 Days, Qty: 30, Ref: 0
Suboxone 8-2MG Film Sublingual, Sig: 1 SL qd, discontinue all other opiates, 30 Days, Qty: 30 Film, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None



' Adrian Turpin PA-C'. 07/06/2015 10:53:08 AM (aturpin)

Adrian Turpin
NPI: 1447697735
License: PA1429

CPT Coding:
99214 OFFICE OUTPT DETAILED
The above medical care was provided by a physician assistant and meets the requirements for "incident to" services. The patient on the initial evaluation by Dr. Steven Kozmary. The physician assistant was under the direct supervision of Dr. Kozmary who has an active part in the ongoing care of the patient. Dr. Kozmary was present in the office suite and immediately available to provide assistance and direction while the physician assistant was performing the services.

Steven Kozmary M.D.
Supervising Physician
Medical Director,
Kozmary Center for Pain Management

KOZMARY CENTER FOR PAIN MANAGEMENT
2851 El Camino Ave., Suite 101
LAS VEGAS, NEVADA 89102

PROCEDURE NOTE

SURGEON: Steven V. Kozmary, M.D.

PROCEDURE PERFORMED:
1. Right lumbar radiofrequency rhizotomy L2, L3, L4, L5, S1
2. Fluoroscopy

PREOPERATIVE DIAGNOSIS:
724.2 LUMBAGO
721.3 LUMBOSACRAL SPONDYLOSIS

POSTOPERATIVE DIAGNOSIS:
724.2 LUMBAGO
721.3 LUMBOSACRAL SPONDYLOSIS
100% relief of pain post procedure.
Procedure start time: 8:13 AM
Procedure end time: 8:26 AM
Fluoroscopy time: 27 seconds

Informed consent was obtained after discussion of the risks, benefits and options of the procedures to be performed. A consent form was signed by the patient.

LUMBAR FACET RHIZOTOMY PROCEDURE IN DETAIL: The patient was placed in the prone position with padding under the head, abdomen and ankles. Patient comfort was checked prior to the start of the procedure. The skin overlying the needle entry zone was prepped with sterile surgical prep. A sterile 1010 surgical drape was placed covering the skin. Strict aseptic surgical technique was observed throughout the entirety of the procedure. The skin overlying the needle entry zone was anesthetized with 5ccs Lidocaine 2%. Under careful and continuous fluoroscopic guidance, a 20-gauge 100 mm/10 mm active tip curved radiofrequency needle was placed at the medial nerve. Stimulation at 2 Hz evoked contraction of ipsilateral paraspinal muscles below 2 volts, without contractions in the ipsilateral limb musculature. If there were unsuitable responses to initial stimulation, electrode position was changed and stimulation repeated until suitable responses occurred. Neurolysis was undertaken with radiofrequency at 80 degrees centigrade for 90 seconds at right L2, L3, L4, L5, and S1. Before neurolysis, a total of 1 ccs of Omnipaque was injected. Then, 1 ml of Lidocaine 2% was injected. Then, 1 ml of Marcaine 0.5% without epinephrine and 1.2 mg Celestone solution was injected through the RF needle. The needles were removed and the skin was cleansed and dressed. Fluoroscopy images were obtained and placed in the patient's chart.

MONITORING: The patient was monitored with continuous ECG, automatic blood pressure cuff and continuous pulse oximetry during the entirety of the procedure. Vital signs were recorded.

DISCHARGE CONDITION: The patient was stable and ambulatory, neurologically intact, with a driver and with written discharge instructions.

PLAN: The patient is instructed to return to Dr. Kozmary's office at scheduled appointment for follow up.

S. Kozmary MD

' Steven Kozmary MD'. 06/01/2015 12:44:10 PM (SKozmary)
Steven V. Kozmary, M.D.
Director, Kozmary Center for Pain Management
Diplomate, American Board of Anesthesiology
Subspecialty Certification in Pain Management
Diplomate, American Academy of Pain Management

Date of Dictation: 5/19/2015
Date of Procedure: 5/15/2015

Patient: Simone Russo
Date of Birth: 09/05/1942
Provider: Steven V Kozmary, MD

RUSSO-01654

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	05/12/2015

Subjective:

Chief Complaint: The patient complains of lower back pain.

Reason for Visit: Simone Russo returns for a follow up evaluation.

Interim History: The patient continues to experience pain in his low back. The patient reports no changes in symptoms since the last visit. The patient recently had a right lumbar medial branch block injection at L2-S1 with 100% relief post procedure. The patient denies suicidal ideation, overtaking medications or any concerns by family or friends about the medications prescribed.

Location: Back and bilateral legs
Quality: Patient describes pain as electric shock, stabbing and dull ache
Severity: Patient describes current pain level as a 5 on a visual analog scale from 1-10
Duration: Jan 2012
Timing: Pain is unpredictable and intermittent.
Adverse Events: None.
Aberrant Drug Related Behavior: I reviewed last UDT today. No aberrant behavior.
ADL: Uses walker.

Reviewed Data: KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.

Oswestry Disability Index (ODI): ODI Score **5**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.

Past Medical History: Hypertension
Back Disease

Social History: Marital Status: Married
Children
Employment: Retired: Physician for 40 years.
Education: Graduate Degree: 4 years.
Other: Back.
Healthy
Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.

Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain and pins/needles.

Objective:

Vitals:

Height:	5'9"	Blood Pressure:	118 / 62	BMI: 31.5	
Weight in lbs.:	213	Pulse:	67	O2 Sat:	93

Physical Examination The patient is a pleasant and cooperative 72-year-old male. He is seen with his wife in the office today. He is awake and alert with normal speech and affect. His gait is antalgic. He uses a walker for ambulation. There is no evidence of symptom magnification. HEENT: Normocephalic, atraumatic. SKIN: There are no rashes, lesions or discolorations. EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
722.83 POSTLAMINECTOMY SYND LUMBAR REGION
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
726.5 ENTHESOPATHY HIP REGION
356.9 UNS IDIOPATHIC PERIPH NEUROPATHY
564.09 other unspec constipation
721.3 LUMBOSACRAL SPONDYLOSIS
724.2 LUMBAGO

Discussion:

We discussed the patient's chronic pain in detail today. He continues to have pain in his low back. The patient reports no changes in symptoms since the last visit. The patient's pain is moderately controlled with the current pain regimen. I will refill the patient's medications at the current dosages. The patient recently had a right lumbar medial branch block injection at L2-S1 with 100% improvement post procedure. He is indicated for a right lumbar rhizotomy at L2-S1.

Plan:

1. Refill medications.
2. Right lumbar rhizotomy at L2-S1.

I had a long and detailed discussion with the patient regarding the proposed pain management procedure and treatment plan. The patient was informed and acknowledges understanding that there are risks associated with any type of medical procedure and specifically pain management procedures. Specific complications discussed included: Nerve damage, spinal cord injury, loss of nerve function, loss of sensation, loss of motor function, inability to control or coordinate motion, worsening pain, loss of use of one or more extremity, headache, bleeding, infection, pneumothorax, loss of bladder or bowel control, paralysis and death. No guarantees were given regarding sedation or lack of awareness during the procedure. No guarantees were given or implied regarding the efficacy or outcome of the recommended procedure or treatment. Anatomic models were used in the explanation and discussion of the patient's condition and the proposed treatment. The treatment options were discussed including the option for no therapy. The patient was given an opportunity to ask and have all questions answered regarding the procedure and the risks, benefits and options for treatment. I believe the patient understands the information presented. I believe the patient's ultimate decision regarding the procedure is voluntary. The patient stated that they understood and accepted the proposed pain management procedure(s) and all associated risks prior to the end of the discussion.

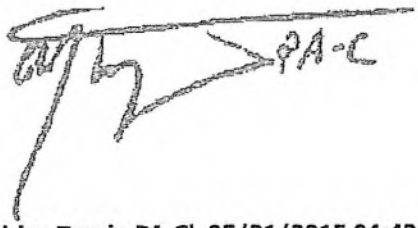
Follow up: Return to clinic in four weeks.

Prescriptions: Linzess 290MCG Capsule Oral, Sig: Take 1 tab po qd, 30 Days, Qty: 30, Ref: 0

Suboxone 8-2MG Film Sublingual, Sig: 1 SL qd, discontinue all other opiates, 30 Days, Qty: 30 Film, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None



' Adrian Turpin PA-C'. 05/21/2015 04:42:34 PM (aturpin)
Adrian Turpin
NPI: 1447697735
License: PA1429

CPT Coding:
99214 OFFICE OUTPT DETAILED
The above medical care was provided by a physician assistant and meets the requirements for "incident to" services. The patient on the initial evaluation by Dr. Steven Kozmary. The physician assistant was under the direct supervision of Dr. Kozmary who has an active part in the ongoing care of the patient. Dr. Kozmary was present in the office suite and immediately available to provide assistance and direction while the physician assistant was performing the services.

Steven Kozmary M.D.
Supervising Physician
Medical Director,
Kozmary Center for Pain Management

KOZMARY CENTER FOR PAIN MANAGEMENT
2851 El Camino Ave., Suite 101
LAS VEGAS, NEVADA 89102

PROCEDURE NOTE

SURGEON: Steven V. Kozmary, M.D.

PROCEDURE PERFORMED:
1. Right lumbar medial branch blocks L2, L3, L4, L5, S1
2. Fluoroscopy

PREOPERATIVE DIAGNOSIS:
724.2 LUMBAGO
721.3 LUMBOSACRAL SPONDYLOSIS

POSTOPERATIVE DIAGNOSIS:
724.2 LUMBAGO
721.3 LUMBOSACRAL SPONDYLOSIS
100% relief of pain post procedure.
Procedure start time: 2:08 PM
Procedure end time: 2:11 PM
Fluoroscopy time: 14 seconds

Informed consent was obtained after discussion of the risks, benefits and options of the procedures to be performed. A consent form was signed by the patient.

LUMBAR FACET MEDIAL BRANCH INJECTIONS PROCEDURE IN DETAIL: The patient was placed in the prone position with padding under the head, chest and legs. Patient comfort was checked prior to the start of the procedure. The skin overlying the target entry zone was prepped with sterile surgical prep. A sterile 1010 surgical drape was placed covering the skin. Strict aseptic surgical technique was observed throughout the entirety of the procedure. The skin overlying the needle entry zone was anesthetized with 8 cc of Lidocaine 2%. Fluoroscopy was used to identify the lumbar facet joint. Then, a #22 gauge 5-inch modified spinal needle was placed adjacent to the facet joint at right L2, L3, L4, L5 and S1 under careful and continuous fluoroscopic guidance. On aspiration there was no evidence of intravascular or intrathecal injection. Then 1 cc of Lidocaine 2% was injected at each of the above levels. Then 1 cc of Omnipaque dye was injected. Then, 1.0 cc of Marcaine 0.5% and 1.2 mg of Celestone was injected at each of the above levels. The needles were withdrawn and the area was cleansed and dressed.

MONITORING: The patient was monitored with continuous ECG, automatic blood pressure cuff and continuous pulse oximetry during the entirety of the procedure. Vital signs were recorded.

DISCHARGE CONDITION: The patient was stable and ambulatory, neurologically intact, with a driver and with written discharge instructions.

PLAN: The patient is instructed to return to Dr. Kozmary's office at scheduled appointment for follow up.

S. Kozmary MD

' Steven Kozmary MD'. 04/24/2015 05:25:31 PM (SKozmary)
Steven V. Kozmary, M.D.
Director, Kozmary Center for Pain Management
Diplomate, American Board of Anesthesiology
Subspecialty Certification in Pain Management
Diplomate, American Academy of Pain Management

Date of Dictation:	4/24/2015	Patient:	Simone Russo
Date of Procedure:	4/23/2015	Date of Birth:	09/05/1942
		Provider:	Steven V Kozmary, MD

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	04/07/2015

Subjective:

Chief Complaint:	The patient complains of lower back pain.
Reason for Visit:	Simone Russo returns for a follow up evaluation.
Interim History:	The patient continues to experience pain in his low back. The patient reports no changes in symptoms since the last visit. The patient recently had a left lumbar medial branch block injection at L2-S1 and had 100% relief post procedure. The patient recently had a left lumbar rhizotomy at L2-S1 and had 100% relief post procedure. The patient denies suicidal ideation, overtaking medications or any concerns by family or friends about the medications prescribed. Location: Back and bilateral legs Quality: Patient describes pain as electric shock, stabbing and dull ache Severity: Patient describes current pain level as a 5 on a visual analog scale from 1-10 Duration: Jan 2012 Timing: Pain is unpredictable and intermittent. Adverse Events: None. Aberrant Drug Related Behavior: UDT today. ADL: Uses walker.
Reviewed Data:	KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.
Oswestry Disability Index (ODI):	ODI Score **12.** The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.
Past Medical History:	Hypertension Back Disease
Social History:	Marital Status: Married Children Employment: Retired: Physician for 40 years. Education: Graduate Degree: 4 years. Other: Back. Healthy Decrease in strength and/or endurance

Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain and pins/needles.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	140 / 76	BMI: 31.5	
	Weight in lbs.:	213	Pulse:	74	O2 Sat:	97

Physical Examination The patient is a pleasant and cooperative 72-year-old male. He is seen alone in the office today. He is awake and alert with normal speech and affect. His gait is antalgic. He uses a walker for ambulation. There is no evidence of symptom magnification. HEENT: Normocephalic, atraumatic. SKIN: There are no rashes, lesions or discolorations. EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
722.83 POSTLAMINECTOMY SYND LUMBAR REGION
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
726.5 ENTHESOPATHY HIP REGION
356.9 UNS IDIOPATHIC PERIPH NEUROPATHY
564.09 other unspec constipation
721.3 LUMBOSACRAL SPONDYLOSIS
724.2 LUMBAGO

Discussion:
We discussed the patient's chronic pain in detail today. He continues to have pain in his low back. The patient reports no changes in symptoms since the last visit. The patient recently had a left lumbar medial branch block injection at L2-S1 and had 100% relief post procedure. He recently had a left lumbar rhizotomy at L2-S1 and had 100% relief post procedure. The patient is scheduled for a right lumbar medial branch block injection at L2-S1 under fluoroscopy. The patient's pain is moderately controlled with the current pain regimen. I will refill the patient's medications at the current dosages. The patient is indicated for a urine toxicology test today in compliance with the narcotic agreement. I reviewed the patient's pharmacy profile in the office today. There is no evidence of aberrant behavior.

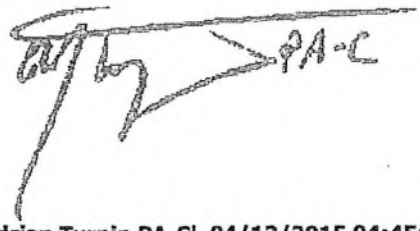
Plan:
1. Right lumbar medial branch block injections at L2-S1 under fluoroscopy are scheduled.
2. Refill medications.
3. Urine toxicology test today
4. Pharmacy profile reviewed.

Follow up: Return to clinic in four weeks.

Prescriptions: Linzess 290MCG Capsule Oral, Sig: Take 1 tab po qd, 30 Days, Qty: 30, Ref: 0
Suboxone 8-2MG Film Sublingual, Sig: 1 SL qd, discontinue all other opiates, 30 Days, Qty: 30 Film, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None



' Adrian Turpin PA-C'. 04/13/2015 04:45:38 PM (aturpin)
Adrian Turpin
NPI: 1447697735
License: PA1429

CPT Coding:
99214 OFFICE OUTPT DETAILED
The above medical care was provided by a physician assistant and meets the requirements for "incident to" services. The patient on the initial evaluation by Dr. Steven Kozmary. The physician assistant was under the direct supervision of Dr. Kozmary who has an active part in the ongoing care of the patient. Dr. Kozmary was present in the office suite and immediately available to provide assistance and direction while the physician assistant was performing the services.

Steven Kozmary M.D.
Supervising Physician
Medical Director,
Kozmary Center for Pain Management

KOZMARY CENTER FOR PAIN MANAGEMENT
2851 El Camino Ave., Suite 101
LAS VEGAS, NEVADA 89102

PROCEDURE NOTE

SURGEON: Steven V. Kozmary, M.D.

PROCEDURE PERFORMED:
1. Left radiofrequency rhizotomy L2, L3, L4, L5, S1
2. Fluoroscopy

PREOPERATIVE DIAGNOSIS:
724.2 LUMBAGO
721.3 LUMBOSACRAL SPONDYLOSIS

POSTOPERATIVE DIAGNOSIS:
724.2 LUMBAGO
721.3 LUMBOSACRAL SPONDYLOSIS
100% relief of pain post procedure.
Procedure start time:2:01 PM
Procedure end time: 2:12 PM
Fluoroscopy time: 19 seconds

Informed consent was obtained after discussion of the risks, benefits and options of the procedures to be performed. A consent form was signed by the patient.

LUMBAR FACET RHIZOTOMY PROCEDURE IN DETAIL: The patient was placed in the prone position with padding under the head, abdomen and ankles. Patient comfort was checked prior to the start of the procedure. The skin overlying the needle entry zone was prepped with sterile surgical prep. A sterile 1010 surgical drape was placed covering the skin. Strict aseptic surgical technique was observed throughout the entirety of the procedure. The skin overlying the needle entry zone was anesthetized with 10ccs Lidocaine 2%. Under careful and continuous fluoroscopic guidance, a 20-gauge 100 mm/10 mm active tip curved radiofrequency needle was placed at the medial nerve. Stimulation at 2 Hz evoked contraction of ipsilateral paraspinal muscles below 2 volts, without contractions in the ipsilateral limb musculature. If there were unsuitable responses to initial stimulation, electrode position was changed and stimulation repeated until suitable responses occurred. Neurolysis was undertaken with radiofrequency at 80 degrees centigrade for 90 seconds at left L2, L3, L4, L5, and S1. Before neurolysis, a total of 1 ccs of Omnipaque was injected. Then, 1 ml of Lidocaine 2% was injected. Then, 1 ml of Marcaine 0.5% without epinephrine and 1.2 mg Celestone solution was injected through the RF needle. The needles were removed and the skin was cleansed and dressed. Fluoroscopy images were obtained and placed in the patient's chart.

MONITORING: The patient was monitored with continuous ECG, automatic blood pressure cuff and continuous pulse oximetry during the entirety of the procedure. Vital signs were recorded.

DISCHARGE CONDITION: The patient was stable and ambulatory, neurologically intact, with a driver and with written discharge instructions.

PLAN: I will order a nerve conduction studies and an EMG for S1-S3 to rule out pudental neuropathy/radiculopathy. The patient is instructed to return to Dr. Kozmary's office at scheduled appointment for follow up.

S. Kozmary MD

' Steven Kozmary MD'. 04/02/2015 07:00:11 PM (SKozmary)Steven V. Kozmary, M.D.
Director, Kozmary Center for Pain Management
Diplomate, American Board of Anesthesiology
Subspecialty Certification in Pain Management
Diplomate, American Academy of Pain Management

Date of Dictation: 3/31/2015
Date of Procedure: 3/26/2015
Patient: Simone Russo
Date of Birth: 09/05/1942

RUSSO-01663

Provider: Steven V Kozmary, MD

KOZMARY CENTER FOR PAIN MANAGEMENT
2851 El Camino Ave., Suite 101
LAS VEGAS, NEVADA 89102

PROCEDURE NOTE

SURGEON: Steven V. Kozmary, M.D.

PROCEDURE PERFORMED:
1. Left lumbar medial branch blocks L2, L3, L4, L5, S1
2. Fluoroscopy

PREOPERATIVE DIAGNOSIS:
724.2 LUMBAGO
721.3 LUMBOSACRAL SPONDYLOSIS

POSTOPERATIVE DIAGNOSIS:
724.2 LUMBAGO
721.3 LUMBOSACRAL SPONDYLOSIS
100% relief of pain post procedure.
Procedure start time: 1:28 PM
Procedure end time: 1:29 PM
Fluoroscopy time: 16 seconds

Informed consent was obtained after discussion of the risks, benefits and options of the procedures to be performed. A consent form was signed by the patient.

LUMBAR FACET MEDIAL BRANCH INJECTIONS PROCEDURE IN DETAIL: The patient was placed in the prone position with padding under the head, chest and legs. Patient comfort was checked prior to the start of the procedure. The skin overlying the target entry zone was prepped with sterile surgical prep. A sterile 1010 surgical drape was placed covering the skin. Strict aseptic surgical technique was observed throughout the entirety of the procedure. The skin overlying the needle entry zone was anesthetized with 8 cc of Lidocaine 2%. Fluoroscopy was used to identify the lumbar facet joint. Then, a #22 gauge 5-inch modified spinal needle was placed adjacent to the facet joint at left L2, L3, L4, L5 and S1 under careful and continuous fluoroscopic guidance. On aspiration there was no evidence of intravascular or intrathecal injection. Then 1 cc of Lidocaine 2% was injected at each of the above levels. Then 1 cc of Omnipaque dye was injected. Then, 1.0 cc of Marcaine 0.5% and 1.2 mg of Celestone was injected at each of the above levels. The needles were withdrawn and the area was cleansed and dressed.

MONITORING: The patient was monitored with continuous ECG, automatic blood pressure cuff and continuous pulse oximetry during the entirety of the procedure. Vital signs were recorded.

DISCHARGE CONDITION: The patient was stable and ambulatory, neurologically intact, with a driver and with written discharge instructions.

PLAN: The patient is instructed to return to Dr. Kozmary's office at scheduled appointment for follow up.

S. Kozmary MD

' Steven Kozmary MD'. 03/17/2015 01:46:47 PM (SKozmary)
Steven V. Kozmary, M.D.
Director, Kozmary Center for Pain Management
Diplomate, American Board of Anesthesiology
Subspecialty Certification in Pain Management
Diplomate, American Academy of Pain Management

Date of Dictation:	3/17/2015	Patient:	Simone Russo
Date of Procedure:	3/12/2015	Date of Birth:	09/05/1942
		Provider:	Steven V Kozmary, MD

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD Steven Kozmary
Primary Insurance:	Medicare
Exam Date:	02/19/2015

Subjective:

Chief Complaint:	The patient complains of back pain.
Reason for Visit:	Simone Russo returns for a follow up evaluation.
Interim History:	The patient continues to experience chronic pain in his low back and legs. He reports worsening of the pain in his back since the last visit. The patient denies suicidal ideation, overtaking medications or any concerns by family or friends about the medications prescribed. Location: Back and bilateral legs Quality: Patient describes pain as electric shock, stabbing and dull ache Severity: Patient describes current pain level as a 5 on a visual analog scale from 1-10 Duration: Jan 2012 Timing: Pain is unpredictable and intermittent. Adverse Events: None. Aberrant Drug Related Behavior: UDT today. ADL: Uses walker.
Reviewed Data:	KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.
Oswestry Disability Index (ODI):	ODI Score **9**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.
Past Medical History:	Hypertension Back Disease
Social History:	Marital Status: Married Children Employment: Retired: Physician for 40 years. Education: Graduate Degree: 4 years. Other: Back. Healthy Decrease in strength and/or endurance Hobbies/Recreational Activities: Before pain: Tennis. Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, muscle pain, numbness, spine pain, swelling, weakness, loss of balance, muscle pain and pins/needles.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	132 / 90	BMI: 31.5	
	Weight in lbs.:	213	Pulse:	77	O2 Sat:	91

Physical Examination The patient is a pleasant and cooperative 72-year-old male. He is seen with his wife in the office today. He is awake and alert with normal speech and affect. His gait is antalgic. He uses a walker for ambulation. There is no evidence of symptom magnification. HEENT: Normocephalic, atraumatic. SKIN: There are no rashes, lesions or discolorations. EXTREMITIES: No evidence of trauma or deformity. Spine: Painful lumbar extension.

Assessment:

Diagnoses:
722.83 POSTLAMINECTOMY SYND LUMBAR REGION
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
726.5 ENTHESOPATHY HIP REGION
356.9 UNS IDIOPATHIC PERIPH NEUROPATHY
564.09 other unspec constipation
721.3 LUMBOSACRAL SPONDYLOSIS
724.2 LUMBAGO

Discussion:

We discussed the patient's chronic pain in detail today. He continues to have pain in his low back and legs. He reports worsening of his symptoms since the last visit. The patient's pain is moderately controlled with the current pain regimen. I will refill the patient's medications at the current dosages. The patient is indicated for a urine toxicology test today in compliance with the narcotic agreement. I reviewed the patient's pharmacy profile in the office today. There is no evidence of aberrant behavior. The patient recently followed up with his spine surgeon, Dr. Thalgott. I will request those records today. I reviewed the patient's last CT scan of his lumbar spine from 6/4/2014. It reveals postsurgical changes and multilevel facet arthropathy. The patient is indicated for bilateral lumbar medial branch block injections at L2-S1 under fluoroscopy.

Plan:

1. Urine toxicology test today.
2. Pharmacy profile reviewed.
3. Refill medications.
4. Request records from Dr. Thalgott.
5. Bilateral lumbar medial branch block injections at L2-S1 under fluoroscopy.

I had a long and detailed discussion with the patient regarding the proposed pain management procedure and treatment plan. The patient was informed and acknowledges understanding that there are risks associated with any type of medical procedure and specifically pain management procedures. Specific complications discussed included: Nerve damage, spinal cord injury, loss of nerve function, loss of sensation, loss of motor function, inability to control or coordinate motion, worsening pain, loss of use of one or more extremity, headache, bleeding, infection, pneumothorax, loss of bladder or bowel control, paralysis and death. No guarantees were given regarding sedation or lack of awareness during the procedure. No guarantees were given or implied regarding the efficacy or outcome of the recommended procedure or treatment. Anatomic models were used in the explanation

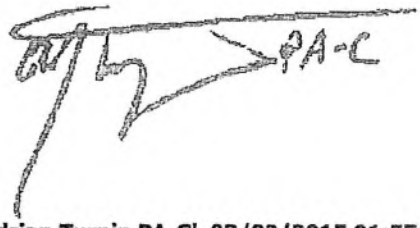
and discussion of the patient's condition and the proposed treatment. The treatment options were discussed including the option for no therapy. The patient was given an opportunity to ask and have all questions answered regarding the procedure and the risks, benefits and options for treatment. I believe the patient understands the information presented. I believe the patient's ultimate decision regarding the procedure is voluntary. The patient stated that they understood and accepted the proposed pain management procedure(s) and all associated risks prior to the end of the discussion.

Follow up: Return to clinic in four weeks.

Prescriptions:

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None



' Adrian Turpin PA-C'. 03/02/2015 01:57:24 PM (aturpin)
Adrian Turpin
NPI: 1447697735
License: PA1429

CPT Coding:
99214 OFFICE OUTPT DETAILED
The above medical care was provided by a physician assistant and meets the requirements for "incident to" services. The patient on the initial evaluation by Dr. Steven Kozmary. The physician assistant was under the direct supervision of Dr. Kozmary who has an active part in the ongoing care of the patient. Dr. Kozmary was present in the office suite and immediately available to provide assistance and direction while the physician assistant was performing the services.

Steven Kozmary M.D.
Supervising Physician
Medical Director,
Kozmary Center for Pain Management

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD
Primary Insurance:	Medicare
Exam Date:	01/22/2015

Subjective:

Chief Complaint: The patient complains of back and bilateral leg pain.

Reason for Visit: Simone Russo returns for a follow up evaluation.

Interim History: The patient continues to experience pain in his low back and legs. He reports improvement of his symptoms since the last visit. The patient states that he has been taking ibuprofen for his back pain that occurs with increased activity. The patient denies suicidal ideation, overtaking medications or any concerns by family or friends about the medications prescribed.

Location: Back and bilateral legs
Quality: Patient describes pain as electric shock, stabbing and dull ache
Severity: Patient describes current pain level as a 4 on a visual analog scale from 1-10
Duration: Jan 2012
Timing: Pain is unpredictable.
Adverse Events: None.
Aberrant Drug Related Behavior: UDT today.
ADL: Uses walker.

Reviewed Data: KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.

Oswestry Disability Index (ODI): ODI Score **9**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.

Past Medical History: Hypertension
Back Disease

Social History: Marital Status: Married
Children
Employment: Retired: Physician for 40 years.
Education: Graduate Degree: 4 years.
Other: Back.
Healthy
Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.
The pertinent positives include limited joint movement, numbness, spine pain, swelling, weakness, loss of balance, muscle pain and pins/needles.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	126 / 86	BMI: 31.5	
	Weight in lbs.:	213	Pulse:	74	O2 Sat:	94

Physical Examination The patient is a pleasant and cooperative 72-year-old male. He is seen with his wife in the office today. He is awake and alert with normal speech and affect. His gait is antalgic. He uses a cane for ambulation. There is no evidence of symptom magnification. HEENT: Normocephalic, atraumatic. SKIN: There are no rashes, lesions or discolorations. EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
722.83 POSTLAMINECTOMY SYND LUMBAR REGION
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
726.5 ENTHESOPATHY HIP REGION
356.9 UNS IDIOPATHIC PERIPH NEUROPATHY
564.09 other unspec constipation

Discussion: We discussed the patient's chronic pain in detail today. He continues to have pain in his back and legs. He reports improvement of his pain since the last visit. The patient's pain is moderately controlled with the current pain regimen. I will refill the patient's Suboxone and Linzess at the current dosages. The patient has a scheduled appointment with his spine surgeon later today. The patient is indicated for a urine toxicology test today in compliance with the narcotic agreement. I reviewed the patient's pharmacy profile in the office today. There is no evidence of aberrant behavior.

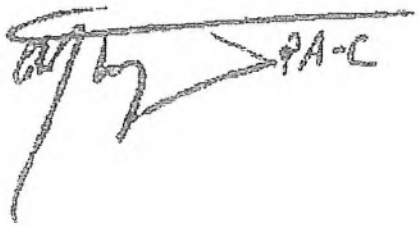
Plan:
1. Urine toxicology test today.
2. Pharmacy profile reviewed.
3. Refill medications.
4. The patient has a scheduled appointment with a spine surgeon.

Follow up: Return to clinic in four weeks.

Prescriptions:

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None



' Adrian Turpin PA-C'. 02/02/2015 11:03:16 AM (aturpin)
Adrian Turpin
NPI: 1447697735
License: PA1429

CPT Coding:
99213 OFFICE OUTPT EXPANDED
The above medical care was provided by a physician assistant and meets the requirements for "incident to" services. The patient on the initial evaluation by Dr. Steven Kozmary. The physician assistant was under the direct supervision of Dr. Kozmary who has an active part in the ongoing care of the patient. Dr. Kozmary was present in the office suite and immediately available to provide assistance and direction while the physician assistant was performing the services.

Steven Kozmary M.D.
Supervising Physician
Medical Director,
Kozmary Center for Pain Management

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD
Primary Insurance:	Medicare
Exam Date:	12/15/2014

Subjective:

Chief Complaint: The patient complains of lower back and paini in both legs

Reason for Visit: Simone Russo returns for a follow up evaluation.

Interim History: The patient returns for a follow up office visit with improved low back and legs pain. He has had some constipation but denies any other significant adverse effects. There have been no recent hospitalizations or ER visit since his last exam. He is currently going to PT for his bilateral gastrocnemius muscular atrophy. His body pain map was reviewed today.

Location: Back and legs
Quality:
Severity: The patient describes the pain as tingling, electric shock, pins/needles and shooting.
Duration: Jan 2012
Timing: Unpredictable.
Adverse Events: None.
Aberrant Drug Related Behavior: UDS is consistent for medications prescribed.
ADL: Uses walker.

Reviewed Data: KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.

Oswestry Disability Index (ODI): ODI Score **14**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.

Past Medical History: Hypertension
Back Disease

Social History: Marital Status: Married
Children
Employment: Retired: Physician for 40 years.
Education: Graduate Degree: 4 years.
Other: Back.
Healthy
Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.

Family History:	Surgery Diabetes Hypertension Kidney Disease
Allergies:	.No Known Drug Allergies
Review of Systems:	The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart. The pertinent positives have been noted.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	139 / 78	BMI: 31.5	
	Weight in lbs.:	213	Pulse:	74	O2 Sat:	92

Physical Examination

Dr. Russo is a pleasant and cooperative 72 years old retired physician in no acute distress.
The patient is seen alone today in the office. Affect is appropriate.
There is no evidence of symptom magnification.
Gait is normal. No assistive devices are used for ambulation.
HEENT is within normal limits.
Extremities show no evidence of trauma or deformity.
Skin shows no rash or discoloration.

Assessment:

Diagnoses:

722.83 POSTLAMINECTOMY SYND LUMBAR REGION
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
726.5 ENTHESOPATHY HIP REGION
356.9 UNS IDIOPATHIC PERIPH NEUROPATHY
564.09 other unspec constipation

Discussion:

The patient's pain is moderately well controlled on the medication regimen and I will fill his Suboxone today. I will discontinue the Amitiza and will replace it with Linzess in an effort to better control his opioid induced constipation.

Plan:

1. Refill Suboxone.
2. Start Linzess.
3. D/C Amitiza.

Follow up: Return to clinic in four weeks.

Prescriptions:

Amitiza 24MCG Capsule Oral, Sig: Take 1 tab po bid, 30 Days, Qty: 60, Ref: 0
Linzess 290MCG Capsule Oral, Sig: Take 1 tab po qd, 30 Days, Qty: 30, Ref: 0
Suboxone 8-2MG Film Sublingual, Sig: 1 SL qd, discontinue all other opiates, 30 Days, Qty: 30, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

' Steven Kozmary MD'. 01/06/2015 09:42:38 AM (SKozmary)

Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding:
99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD
Primary Insurance:	Medicare
Exam Date:	11/11/2014

Subjective:

Chief Complaint: The patient complains of back and leg pain.

Reason for Visit: Simone Russo returns for a follow up evaluation and medication refills.

Interim History: The patient continues to experience pain in his back and legs. He reports improvement of his pain since the last visit. The patient states that the Amitiza is working well for him. The patient denies suicidal ideation, overtaking medications or any concerns by family or friends about the medications prescribed.

ODI is 16 indicating moderate disability.
Location: Low back.
Quality: Patient describes pain as throbbing, annoying and exhausting.
Severity: Pain reports a pain level of 3 on a visual analog scale of 1-10.
Duration: Pain since 2012.
Timing: Pain is not noted.
Adverse Events: None.
Aberrant Drug Related Behavior: I reviewed last UDT today. No aberrant behavior.
ADL: Uses walker to ambulate

Reviewed Data: KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.

Oswestry Disability Index (ODI): ODI Score **13**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.

Past Medical History: Hypertension
Back Disease

Social History: Marital Status: Married
Children
Employment: Retired: Physician for 40 years.
Education: Graduate Degree: 4 years.
Other: Back.
Healthy
Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.

Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart. The pertinent positives include numbness, back pain and weakness.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	110 / 78	BMI: 31.7	
	Weight in lbs.:	215	Pulse:	89	O2 Sat:	94

Physical Exam: The patient is a pleasant and cooperative 72-year-old male. He is seen with his wife in the office today. He is awake and alert with normal speech and affect. His gait is normal. He uses a walker for ambulation. There is no evidence of symptom magnification. HEENT: Normocephalic, atraumatic. SKIN: There are no rashes, lesions or discolorations. EXTREMITIES: No evidence of trauma or deformity.

Assessment:

Diagnoses:
722.83 POSTLAMINECTOMY SYND LUMBAR REGION
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
726.5 ENTHESOPATHY HIP REGION
564.00 UNSPEC CONSTIPATION
356.9 UNS IDIOPATHIC PERIPH NEUROPATHY

Discussion: We discussed the patient's chronic pain in detail today. He continues to have pain in his back and legs. He reports improvement of his pain since the last visit. The patient's pain is well-controlled with the current pain regimen. I will refill the medications at the current dosages. The patient is indicated for CES-D today. I reviewed the patient's pharmacy profile today. There is no evidence of aberrant behavior. I reviewed the patient's EMG/NCV of the lower extremities with him in the office today. It reveals severe mixed axonal and demyelinating sensory motor peripheral neuropathy with formation of the dying-back component. The patient has an appointment scheduled with his neurologist.

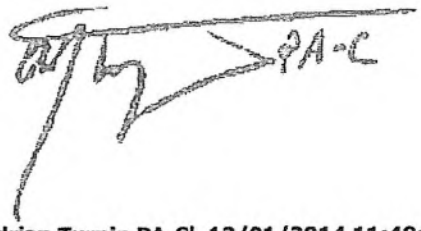
Plan:
1. Refill medications.
2. CES-D today.
3. The patient has a scheduled appointment with the neurologist.

Follow up: Return to clinic in four weeks.

Prescriptions: Amitiza 24MCG Capsule Oral, Sig: Take 1 tab po bid, 30 Days, Qty: 60, Ref: 0
Suboxone 8-2MG Film Sublingual, Sig: 1 SL qd, discontinue all other opiates, 30 Days, Qty: 30, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None



' Adrian Turpin PA-C'. 12/01/2014 11:48:05 AM (aturpin)
Adrian Turpin
NPI: 1447697735
License: PA1429

CPT Coding:
99214 OFFICE OUTPT DETAILED
The above medical care was provided by a physician assistant and meets the requirements for "incident to" services. The patient on the initial evaluation by Dr. Steven Kozmary. The physician assistant was under the direct supervision of Dr. Kozmary who has an active part in the ongoing care of the patient. Dr. Kozmary was present in the office suite and immediately available to provide assistance and direction while the physician assistant was performing the services.

Steven Kozmary M.D.
Supervising Physician
Medical Director,
Kozmary Center for Pain Management

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD
Primary Insurance:	Medicare
Exam Date:	09/30/2014

Subjective:

Chief Complaint:	The patient complains of numbness in both legs.
Reason for Visit:	Simone Russo returns for a follow up evaluation and medication refills.
Interim History:	Dr. Russo returns for a follow up office visit. He has noted onset of panic attacks which seem to be related to attempts to wean the suboxone. He has tried Xanax for anxiety and the panic attacks. ROS is positive for constipation. His leg pain has improved since the last visit. There have been no recent hospitalizations or ER visits since his last exam. Body pain map was reviewed today. ODI is 16 indicating moderate disability. Location: Bilateral leg. Quality: Patient describes pain as electric shock and pins/needles. Severity: Pain reports a pain level of 3 on a visual analog scale of 1-10. Duration: Pain since 2012. Timing: Pain is not noted. Adverse Events: None. Aberrant Drug Related Behavior: None ADL: Uses walker to ambulate
Reviewed Data:	KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.
Oswestry Disability Index (ODI):	ODI Score **16**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.
Past Medical History:	Hypertension Back Disease
Social History:	Marital Status: Married Children Employment: Retired: Physician for 40 years. Education: Graduate Degree: 4 years. Other: Back. Healthy Decrease in strength and/or endurance Hobbies/Recreational Activities: Before pain: Tennis. Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart. The pertinent positives include numbness, back pain and weakness.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	136 / 89	BMI: 29.5	
	Weight in lbs.:	200	Pulse:	72	O2 Sat:	91

Physical Exam: The patient is a pleasant and cooperative 71 year old physician in no apparent distress.
The patient is seen alone today in the office. His affect is appropriate.
There is no evidence of symptom magnification.
He walks with a wheeled walker.
HEENT is within normal limits.
Extremities show no evidence of trauma or deformity.
Skin shows no rash or discoloration.

Assessment:

Diagnoses:
722.83 POSTLAMINECTOMY SYND LUMBAR REGION
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
726.5 ENTHESOPATHY HIP REGION
564.00 UNSPEC CONSTIPATION

Discussion:

I will continue the Suboxone therapy. He tried to wean the suboxone and developed anxiety and panic attacks. I will start him on Amitiza and will provide him with samples for it. The patient understood and has agreed to our plan. He does not show signs of clinical depression and denies any suicidal ideation.

Plan:

1. Continue Suboxone therapy.
2. Amitiza for constipation, samples provided.
3. Follow up with Dr. Germin, neurologist , for EMG/NCS of lower extremities
4. Consider hyperbaric oxygen therapy

Follow up: Return to clinic in four weeks.

Prescriptions: Amitiza 24MCG Capsule Oral, Sig: Take 1 tab po bid, 30 Days, Qty: 60, Ref: 0
Suboxone 8-2MG Film Sublingual, Sig: 1 SL qd, discontinue all other opiates, 30 Days, Qty: 30, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S Kozmary MD

' Steven Kozmary MD'. 09/30/2014 02:37:01 PM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding:
99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD
Primary Insurance:	Medicare
Exam Date:	09/08/2014

Subjective:

Chief Complaint: The patient complains of pain in right thigh and right calf.

Reason for Visit: Simone Russo returns for a follow up evaluation and medication refills.

Interim History: Dr. Russo returns for a follow up office visit. His leg pain has improved. He continues to complain of constipation controlled with OTC remedies. He would like to discontinue the opioid medications. He had a recent panic attack but there have been no recent hospitalizations or ER visits since his last exam. Body pain map was reviewed today.

ODI is 22 indicating severe disability.
Location: Right thigh and right calf.
Quality: Patient describes pain as electric shock, annoying, pins/needles and exhausting.
Severity: Pain reports a pain level of 3 on a visual analog scale of 1-10.
Duration: Pain since 2012.
Timing: Pain is not noted.
Adverse Events: None.
Aberrant Drug Related Behavior: None
ADL: uses walker to ambulate

Reviewed Data: KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.

Oswestry Disability Index (ODI): ODI Score **14**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.

Past Medical History: Hypertension
Back Disease

Social History: Marital Status: Married
Children
Employment: Retired: Physician for 40 years.
Education: Graduate Degree: 4 years.
Other: Back.
Healthy
Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart. The pertinent positives include none noted.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	142 / 92	BMI: 29.5	
	Weight in lbs.:	200	Pulse:	82	O2 Sat:	90

Physical Exam: The patient is a pleasant and cooperative 71 year old physician in no apparent distress.
The patient is seen alone today in the office. His affect is appropriate.
There is no evidence of symptom magnification.
He walks with a wheeled walker.
HEENT is within normal limits.
Extremities show no evidence of trauma or deformity.
Skin shows no rash or discoloration.

Assessment:

Diagnoses: 722.83 POSTLAMINECTOMY SYND LUMBAR REGION
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
726.5 ENTHESOPATHY HIP REGION

Discussion: I will start him on Suboxone therapy and he is to discontinue all of his opioid medications. The patient understood and has agreed to our plan. He does not show signs of clinical depression and denies any suicidal ideation.

Plan:
1. Discontinue opioid medications.
2. Start on Suboxone therapy.

Follow up: Return to clinic in four weeks.

Prescriptions: Suboxone 8-2MG Film Sublingual, Sig: 2 SL qd, discontinue all other opiates, 14 Days, Qty: 28, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

' Steven Kozmary MD'. 10/01/2014 11:22:08 AM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding:
99214 OFFICE OUTPT DETAILED

Kozmary Center

Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD
Primary Insurance:	Medicare
Exam Date:	08/19/2014

Subjective:

Chief Complaint: The patient complains of left buttocks and thigh pain.

Reason for Visit: Simone Russo returns for a follow up evaluation and medication refills.

Interim History: Dr. Russo returns for a follow up office visit complaining of unchanged leg pain. His pain has improved since the last visit. He continues to complain of constipation controlled with OTC remedies. He would like inquire about Suboxone therapy. There have been no recent hospitalizations or ER visits since his last exam. Body pain map was reviewed today.

ODI is 22 indicating severe disability.
Location: Right buttocks and right thigh.
Quality: Patient describes pain as electric shock, annoying, pins/needles and exhausting.
Severity: Pain reports a pain level of 10 on a visual analog scale of 1-10.
Duration: Pain since 2011.
Timing: Pain is intermittent.
Adverse Events: None.
Aberrant Drug Related Behavior: None
ADL: uses walker to ambulate

Reviewed Data: KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.

Oswestry Disability Index (ODI): ODI Score **22**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.

Past Medical History: Hypertension
Back Disease

Social History: Marital Status: Married
Children
Employment: Retired: Physician for 40 years.
Education: Graduate Degree: 4 years.
Other: Back.
Healthy
Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart. The pertinent positives include none noted.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	153 / 87	BMI: 296.5	
	Weight in lbs.:	2008	Pulse:	93	O2 Sat:	93

Physical Exam: The patient is a pleasant and cooperative 71 year old physician in no apparent distress.
The patient is seen alone today in the office. His affect is appropriate.
There is no evidence of symptom magnification.
He walks with a wheeled walker.
HEENT is within normal limits.
Extremities show no evidence of trauma or deformity.
Skin shows no rash or discoloration.

Assessment:

Diagnoses:
722.83 POSTLAMINECTOMY SYND LUMBAR REGION
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
726.5 ENTHESOPATHY HIP REGION

Discussion: Dr. Russo is improving after lumbar spine surgery. He is doing well on the current medication regimen. I discussed weaning opiates with and without suboxone with him in detail. I have offered to start him on Amitiza for his opioid induced constipation.

Plan:
1. Refill medications.
2. Will consider Amitiza for constipation
3. Consider suboxone therapy

Follow up: Return to clinic in four weeks.

Prescriptions: Opana er 10MG Tablet Extended Release 12 Hour Oral, Sig: 1 po bid, maximum two tablets per day, discontinue opana 5 mg tablets, 30 Days, Qty: 60, Ref: 0
Oxycodone hcl 15MG Tablet Oral, Sig: 1 po q4 prn pain, maximum four tablets per day, 30 Days, Qty: 120, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

' Steven Kozmary MD'. 08/20/2014 12:06:23 PM (SKozmary)
Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding:
99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD
Primary Insurance:	Medicare
Exam Date:	07/16/2014

Subjective:

Chief Complaint:	The patient complains of low back and right upper leg pain.
Reason for Visit:	Simone Russo returns for a follow up evaluation and medication refills.
Interim History:	The patient returns for follow-up. He has undergone lumbar spine surgery with reconstruction He would like me to take over his pain management. He has continued left lower extremity pain. His pain has improved after the lumbar spine surgery with Dr. Thalgott. He is taking opana 10 bid, and oxycodone 20 mg up to four tablets per day. He has some continued constipation. He rates the pain as a 4 to 10 on a visual analog scale of 1-10. He has had marked improvement in his lower extremity pain after the lumbar reconstruction. Body pain map was reviewed. ODI is 30 indicating severe disability. Location: Lower back and right upper leg. Quality: Patient describes pain as electric shock and stabbing. Severity: Pain reports a pain level of 10 on a visual analog scale of 1-10. Duration: On-going for years. Timing: Pain is constant. Adverse Events: None. Aberrant Drug Related Behavior: None ADL: uses walker to ambulate
Reviewed Data:	KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.
Oswestry Disability Index (ODI):	ODI Score **30**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.
Past Medical History:	Hypertension Back Disease
Social History:	Marital Status: Married Children Employment: Retired: Physician for 40 years. Education: Graduate Degree: 4 years. Other: Back. Healthy Decrease in strength and/or endurance

Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.

Objective:

Vitals:	Height:	5'9"	Blood Pressure:	114 / 70	BMI: 30.3	
	Weight in lbs.:	205	Pulse:	74	O2 Sat:	94

Physical Exam: The patient is a pleasant and cooperative 71 year old physician in no apparent distress.
The patient is seen with his wife today in the office. His affect is appropriate.
There is no evidence of symptom magnification.
He walks with a wheeled walker.
HEENT is within normal limits.
Extremities show no evidence of trauma or deformity.
Skin shows no rash or discoloration.

Assessment:

Diagnoses: 722.83 POSTLAMINECTOMY SYND LUMBAR REGION
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
726.5 ENTHESOPATHY HIP REGION

Discussion: I will take over medication management for this patient. He had significant reduction in his pain after lumbar spine reconstruction surgery.

Plan:
1. Refill medications

Follow up: Return to clinic in four weeks.

Prescriptions: Opana er 10MG Tablet Extended Release 12 Hour Oral, Sig: 1 po bid, maximum two tablets per day, discontinue opana 5 mg tablets, 30 Days, Qty: 60, Ref: 0
Oxycodone hcl 15MG Tablet Oral, Sig: 1 po q4 prn pain, maximum four tablets per day, 30 Days, Qty: 120, Ref: 0

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

' Steven Kozmary MD'. 06/04/2014 09:04:37 AM (SKozmary)

Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding:
99214 OFFICE OUTPT DETAILED

Kozmary Center
Steven V. Kozmary, M.D.

Patient:	Simone Russo
DOB:	09/05/1942
Gender:	Male
PCP:	
Referring Physician:	John S Thalgott MD
Primary Insurance:	Medicare
Exam Date:	06/03/2014

Subjective:

Chief Complaint: The patient complains of back and bilateral leg pain.

Reason for Visit: Simone Russo returns for a follow up evaluation.

Interim History: The patient returns after his spinal cord stimulator another trial. Initially had significant relief of his bilateral lower extremity pain however on Sunday the patient had worsening pain with stimulation. He has seen Dr. Thalgott who has diagnosed him with a further collapse of L5-S1 and is considering lumbar reconstructive surgery. He denies any medication side effects. He denies any fevers or chills. He rates the pain as a 10 on a visual analog scale of 1-10. Body pain map was reviewed. ODI is 33 indicating severe disability.
Location: Lower back and bilateral leg.
Quality: Patient describes pain as electric shock, throbbing, stabbing, pins/needles and exhausting.
Severity: Pain reports a pain level of on a visual analog scale of 1-10.
Duration: Pain since 01/06/2012.
Timing: Not noted.
Context:
Modifying Factors:
Associated signs and symptoms:

Adverse Events: None.
Aberrant Drug Related Behavior: None

Reviewed Data: KCPM follow up questionnaire, last visit progress note, diagnoses, medications, vital signs, Oswestry Disability Index, Pain Diagram and extensive review of systems.

Oswestry Disability Index (ODI): ODI Score **33**. The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52) The ODI score of 0-4 indicates no disability, 5-14 mild disability, 15-24 moderate disability, 25-34 severe disability, greater than 34 complete disability.

Past Medical History: Hypertension
Back Disease

Social History: Marital Status: Married
Children
Employment: Retired: Physician for 40 years.
Education: Graduate Degree: 4 years.
Other: Back.
Healthy

Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Family History: Diabetes
Hypertension
Kidney Disease

Allergies: .No Known Drug Allergies

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. ROS questionnaire is filed in chart.

Objective:

Vitals:

Height:	5'9"	Blood Pressure:	152 / 82	BMI: 30.1	
Weight in lbs.:	204	Pulse:	70	O2 Sat:	92

Physical Exam: The patient is a pleasant and cooperative 71 year old physician in no apparent distress.
The patient is seen with his wife today in the office. His affect is appropriate.
There is no evidence of symptom magnification.
He walks with difficulty with a walker.
HEENT is within normal limits.
Extremities show no evidence of trauma or deformity.
Skin shows no rash or discoloration.
The leads were removed without difficulty. No evidence of infection.

TROCHANTERIC BURSA INJECTION PROCEDURE IN DETAIL: The patient was positioned with appropriate padding. The skin overlying the needle entry zone was prepped with sterile alcohol prep. After identifying the appropriate landmarks, a #22 gauge 3.5 inch needle was placed in the trochanteric bursa. After aspiration, 3 cc 0.5% Marcaine and 3 mg Celestone was injected into the joint space and the needle was withdrawn.

LEFT PERONAL NERVE INJECTION PROCEDURE IN DETAIL:
The patient was placed in the standing position. The skin was prepped with alcohol. The skin was anesthetized with ethyl chloride topical spray. Using a 22 g 1.5 inch needle the following nerves were infiltrated on the left lower extremity: Left peroneal nerve at the lateral superior fibula. The Bupivacaine and 0.5% without epinephrine and 2 mg Celestone were used to infiltrate the nerve.

Assessment:

Diagnoses:
722.83 POSTLAMINECTOMY SYND LUMBAR REGION
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
726.5 ENTHESOPATHY HIP REGION

Discussion: The patient had an equivocal spinal cord stimulator trial. He had good coverage of the pain and good relief initially however three days into the trial the patient had worsening pain with stimulation. The leads were removed without difficulty. I will have him follow-up with Dr. Thalgott for lumbar reconstructive surgery. I discussed pain management with the patient. I will take over medication management for this patient.

Plan:
1. Equivocal spinal cord stimulator trial
2. Follow up with Dr. Thalgott for surgical consideration
3. Pain management in the future
4. Left greater trochanter bursa and left peroneal nerve injection

Follow up: Return to clinic in four weeks.

Prescriptions:

NARCOTIC MEDICATION RESPONSIBILITY: I have assumed responsibility for all prescribing all narcotic medications per the narcotic agreement. The patient has signed a narcotic agreement with KCPM.

Referrals: None

S. Kozmary MD

' Steven Kozmary MD'. 06/04/2014 09:04:37 AM (SKozmary)

Steven Kozmary
NPI: 1659337459
License: 5695

CPT Coding:
64450 NJX ANES OTH PRPH NRV/BRANCH
20615 ASPIRATION&INJECTION TREATMENT BONE CYST
99213 OFFICE OUTPT EXPANDED

VALLEY VIEW SURGERY CENTER
1330 S. VALEY VIEW BLVD
LAS VEGAS, NEVADA 89102
(702) 477-7000 FAX (702) 851-0473

PROCEDURE NOTE

SURGEON: Steven V. Kozmary, M.D.

ANESTHESIOLOGIST: Gregson Porteous, D.O.

PROCEDURE PERFORMED:
1. Spinal cord stimulator trial, bilateral octrode leads
2. Fluoroscopy

PREOPERATIVE DIAGNOSIS:
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
722.83 POSTLAMINECTOMY SYND LUMBAR REGION
338.4 CHRONIC PAIN SYNDROME

POSTOPERATIVE DIAGNOSIS:
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
722.83 POSTLAMINECTOMY SYND LUMBAR REGION
338.4 CHRONIC PAIN SYNDROME

Informed consent was obtained after discussion of the risks, benefits and options of the procedures to be performed. A consent form was signed by the patient. An intravenous catheter was placed in the Pre op. The patient was brought to the fluoroscopy suite after having been NPO for greater than six hours by patient history.

SPINAL CORD STIMULATOR TRIAL PROCEDURE IN DETAIL: The patient was placed in the prone position with padding under the abdomen and legs. Patient comfort was checked prior to the start of the procedure. The skin overlying the needle entry zone was prepped with sterile surgical prep. A sterile 1010 surgical drape was placed covering the skin. Strict aseptic surgical technique was observed throughout the entirety of the procedure. Fluoroscopy was used to identify the appropriate vertebral bodies. Then, a 14g Tuohy needle was placed in the epidural space at L1-2 with loss of resistance technique under fluoroscopic guidance. Continuous fluoroscopic guidance was used while advancing the needle into the epidural space in AP view. Then, Omnipaque 300 dye was injected confirming needle tip placement in the epidural space. The flow of dye in the epidural space was noted to extend both cephalad and caudal. There was no evidence of intravascular or intrathecal injection. A Medtronic octrode lead spinal cord stimulator lead was threaded into the posterior epidural space under continuous fluoroscopy. It was positioned on the ipsilateral side to the patient's dominant pain. A second lead was placed in the same fashion on the contralateral side. Two octrode leads were placed. The leads were placed bilaterally from the top of T-8 to the top of T-10. The stimulator leads were connected to the generator and testing was undertaken to determine the site of stimulation. The trial leads were maneuvered to cover the painful areas. The lead positions were recorded with fluoroscopic hard copy and the needles and guide wires were withdrawn. The leads were secured with the Medtronic locking device. The skin was cleansed and sterilely dressed. The final fluoroscopy images were obtained and placed in the patient's chart.

MONITORING: The patient was monitored with continuous ECG, automatic blood pressure cuff and continuous pulse oximetry during the entirety of the procedure. Vital signs were recorded by the attending anesthesiologist. No airway management was needed.

IV SEDATION: The patient received intravenous Propofol under the direct supervision of anesthesiologist.

DISCHARGE CONDITION: The patient was stable and ambulatory, neurologically intact, with a driver and with written discharge instructions.

Date of Dictation: 6/03/2014
Date of Procedure: 5/28/2014

Patient: Simone Russo
Date of Birth: 09/05/1942
Provider: Steven V Kozmary, MD

PLAN: The patient is instructed to return to Dr. Kozmary's office at scheduled appointment for follow up.

S. Kozmary MD

' Steven Kozmary MD'. 06/03/2014 06:27:38 PM (SKozmary)

Steven V. Kozmary, M.D.
Director, Kozmary Center for Pain Management
Diplomate, American Board of Anesthesiology
Subspecialty Certification in Pain Management
Diplomate, American Academy of Pain Management

Date of Dictation:	6/03/2014	Patient:	Simone Russo
Date of Procedure:	5/28/2014	Date of Birth:	09/05/1942
		Provider:	Steven V Kozmary, MD

VALLEY VIEW SURGERY CENTER
1330 S. VALEY VIEW BLVD
LAS VEGAS, NEVADA 89102
(702) 477-7000 FAX (702) 851-0473

PROCEDURE NOTE

SURGEON: Steven V. Kozmary, M.D.

ANESTHESIOLOGIST: Gregson Porteous, D.O.

PROCEDURE PERFORMED:
1. Bilateral L5-S1 selective nerve block and selective epidural steroid injection
2. Bilateral S1 selective nerve block and selective epidural steroid injection
3. Fluoroscopy

PREOPERATIVE DIAGNOSIS:
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
722.83 POSTLAMINECTOMY SYND LUMBAR REGION

POSTOPERATIVE DIAGNOSIS:
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
722.83 POSTLAMINECTOMY SYND LUMBAR REGION
30% relief of pain post procedure.

Informed consent was obtained after discussion of the risks, benefits and options of the procedures to be performed. A consent form was signed by the patient. An intravenous catheter was placed in the Pre op. The patient was brought to the fluoroscopy suite after having been NPO for greater than six hours by patient history.

LUMBAR SELECTIVE NERVE ROOT BLOCK PROCEDURE IN DETAIL: The patient was placed in the prone position with padding under the head, abdomen and ankles. Patient comfort was checked prior to the start of the procedure. The skin overlying the needle entry zone was prepped with sterile surgical prep. A sterile 1010 surgical drape was placed covering the skin. Strict aseptic surgical technique was observed throughout the entirety of the procedure. Fluoroscopy was used to identify the appropriate vertebral bodies. A #22 gauge 5-inch spinal needle was placed at the appropriate neural foramina. Omnipaque 300 dye was injected confirming needle tip placement in the nerve root sheath. There was no evidence of intravascular or intrathecal injection. The dye was observed to flow along into the epidural space under fluoroscopic guidance. After negative aspiration, 1.0 cc of Marcaine 0.5% without Epinephrine and 0.6 mg Celestone solution was injected around the nerve root and transforaminally into the epidural space at L5-S1 bilaterally. The needle was withdrawn. In the same fashion the bilateral S1 nerve roots were injected with dye, Marcaine and celestone solution. The fluoroscopy images were recorded and transferred to the patient's chart.

MONITORING: The patient was monitored with continuous ECG, automatic blood pressure cuff and continuous pulse oximetry during the entirety of the procedure. Vital signs were recorded by the attending anesthesiologist. No airway management was needed.
IV SEDATION: The patient received intravenous Propofol under the direct supervision of anesthesiologist.
DISCHARGE CONDITION: The patient was stable and ambulatory, neurologically intact, with a driver and with written discharge instructions.
PLAN: The patient is instructed to return to Dr. Kozmary's office at scheduled appointment for follow up.

S. Kozmary MD

' Steven Kozmary MD'. 05/20/2014 04:37:10 PM (SKozmary)
Steven V. Kozmary, M.D.
Director, Kozmary Center for Pain Management
Diplomate, American Board of Anesthesiology
Subspecialty Certification in Pain Management
Diplomate, American Academy of Pain Management

Date of Dictation: 5/20/2014
Date of Procedure: 5/14/2014

Patient: Simone Russo
Date of Birth: 09/05/1942
Provider: Steven V Kozmary, MD

Addended by - 'Steven Kozmary' 5/25/2014 5:10:58 PM

BILATERAL S1 SELECTIVE NERVE ROOT BLOCK PROCEDURE IN DETAIL: Fluoroscopy was used to identify the S1 foramina. A #22 gauge 5-inch spinal needle was placed at the S1 foramina on the left. Omnipaque 300 dye was injected confirming needle tip placement. There was no evidence of intravascular or intrathecal injection. The dye was observed to flow along into the epidural space under fluoroscopic guidance. After negative aspiration 1.0 cc of Lidocaine with Epinephrine was injected, then 1.0 cc of Marcaine with Epinephrine and 1 mg. Celestone solution was injected around the nerve root and transforaminally into the epidural space. The needle was withdrawn. In the same fashion the contralateral S1 nerve root was injected utilizing fluoroscopy and the identical volume of injectate. The fluoroscopy images were recorded and transferred to the patient's chart.

S. Kozmary MD

' Steven Kozmary MD'. 05/25/2014 05:10:55 PM (SKozmary)

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LAS VEGAS, NEVADA 89102
(702) 477-7000 FAX (702) 851-0473

PROCEDURE NOTE

SURGEON: Steven V. Kozmary, M.D.

ANESTHESIOLOGIST: Gregson Porteous, D.O.

PROCEDURE PERFORMED:
1. Bilateral L5-S1 selective nerve block and selective epidural steroid injection
2. Fluoroscopy

PREOPERATIVE DIAGNOSIS:
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
722.83 POSTLAMINECTOMY SYND LUMBAR REGION

POSTOPERATIVE DIAGNOSIS:
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
722.83 POSTLAMINECTOMY SYND LUMBAR REGION
60% relief of pain post procedure.

Informed consent was obtained after discussion of the risks, benefits and options of the procedures to be performed. A consent form was signed by the patient. An intravenous catheter was placed in the Pre op. The patient was brought to the fluoroscopy suite after having been NPO for greater than six hours by patient history.

LUMBAR SELECTIVE NERVE ROOT BLOCK PROCEDURE IN DETAIL: The patient was placed in the prone position with padding under the head, abdomen and ankles. Patient comfort was checked prior to the start of the procedure. The skin overlying the needle entry zone was prepped with sterile surgical prep. A sterile 1010 surgical drape was placed covering the skin. Strict aseptic surgical technique was observed throughout the entirety of the procedure. Fluoroscopy was used to identify the appropriate vertebral bodies. A #22 gauge 5-inch spinal needle was placed at the appropriate neural foramina. Omnipaque 300 dye was injected confirming needle tip placement in the nerve root sheath. There was no evidence of intravascular or intrathecal injection. The dye was observed to flow along into the epidural space under fluoroscopic guidance. After negative aspiration, 1.0 cc of Marcaine 0.5% without Epinephrine and 0.6 mg Celestone solution was injected around the nerve root and transforaminally into the epidural space at L5-S1 bilaterally. The needle was withdrawn. The fluoroscopy images were recorded and transferred to the patient's chart.

MONITORING: The patient was monitored with continuous ECG, automatic blood pressure cuff and continuous pulse oximetry during the entirety of the procedure. Vital signs were recorded by the attending anesthesiologist. No airway management was needed.

IV SEDATION: The patient received intravenous Propofol under the direct supervision of anesthesiologist.

DISCHARGE CONDITION: The patient was stable and ambulatory, neurologically intact, with a driver and with written discharge instructions.

PLAN: The patient is instructed to return to Dr. Kozmary's office at scheduled appointment for follow up.

S. Kozmary MD

' Steven Kozmary MD'. 05/14/2014 10:48:46 AM (SKozmary)
Steven V. Kozmary, M.D.
Director, Kozmary Center for Pain Management
Diplomate, American Board of Anesthesiology
Subspecialty Certification In Pain Management
Diplomate, American Academy of Pain Management

Date of Dictation: 5/13/2014
Date of Procedure: 5/7/2014

Patient: Simone Russo
Date of Birth: 09/05/1942
Provider: Steven V Kozmary, MD

14A.App.3173

Addended by - 'Steven Kozmary' 5/25/2014 5:10:33 PM

BILATERAL S1 SELECTIVE NERVE ROOT BLOCK PROCEDURE IN DETAIL: Fluoroscopy was used to identify the S1 foramina. A #22 gauge 5-inch spinal needle was placed at the S1 foramina on the left. Omnipaque 300 dye was injected confirming needle tip placement. There was no evidence of intravascular or intrathecal injection. The dye was observed to flow along into the epidural space under fluoroscopic guidance. After negative aspiration 1.0 cc of Lidocaine with Epinephrine was injected, then 1.0 cc of Marcaine with Epinephrine and 1 mg. Celestone solution was injected around the nerve root and transforaminally into the epidural space. The needle was withdrawn. In the same fashion the contralateral S1 nerve root was injected utilizing fluoroscopy and the identical volume of injectate. The fluoroscopy images were recorded and transferred to the patient's chart.

S. Kozmary MD

' Steven Kozmary MD'. 05/25/2014 05:10:25 PM (SKozmary)

VALLEY VIEW SURGERY CENTER
1330 S. VALEY VIEW BLVD
LAS VEGAS, NEVADA 89102
(702) 477-7000 FAX (702) 851-0473

PROCEDURE NOTE

SURGEON: Steven V. Kozmary, M.D.

ANESTHESIOLOGIST: Gregson Porteous, D.O.

PROCEDURE PERFORMED:
1. Bilateral L5-S1 selective nerve block and selective epidural steroid injection
2. Bilateral S1 selective nerve block and selective epidural steroid injection
3. Fluoroscopy

PREOPERATIVE DIAGNOSIS: 722.83 POSTLAMINECTOMY SYND LUMBAR REGION
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL

POSTOPERATIVE DIAGNOSIS: 722.83 POSTLAMINECTOMY SYND LUMBAR REGION
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
40% relief of pain post procedure.

Informed consent was obtained after discussion of the risks, benefits and options of the procedures to be performed. A consent form was signed by the patient. An intravenous catheter was placed in the Pre op. The patient was brought to the fluoroscopy suite after having been NPO for greater than six hours by patient history.

LUMBAR SELECTIVE NERVE ROOT BLOCK PROCEDURE IN DETAIL: The patient was placed in the prone position with padding under the head, abdomen and ankles. Patient comfort was checked prior to the start of the procedure. The skin overlying the needle entry zone was prepped with sterile surgical prep. A sterile 1010 surgical drape was placed covering the skin. Strict aseptic surgical technique was observed throughout the entirety of the procedure. Fluoroscopy was used to identify the appropriate vertebral bodies. A #22 gauge 5-inch spinal needle was placed at the appropriate neural foramina. Omnipaque 300 dye was injected confirming needle tip placement in the nerve root sheath. There was no evidence of intravascular or intrathecal injection. The dye was observed to flow along into the epidural space under fluoroscopic guidance. After negative aspiration, 1.0 cc of Marcaine 0.5% without Epinephrine and 0.6 mg Celestone solution was injected around the nerve root and transforaminally into the epidural space at L5-S1 bilaterally. The needle was withdrawn. The fluoroscopy images were recorded and transferred to the patient's chart.

MONITORING: The patient was monitored with continuous ECG, automatic blood pressure cuff and continuous pulse oximetry during the entirety of the procedure. Vital signs were recorded by the attending anesthesiologist. No airway management was needed.

IV SEDATION: The patient received intravenous Propofol under the direct supervision of anesthesiologist.

DISCHARGE CONDITION: The patient was stable and ambulatory, neurologically intact, with a driver and with written discharge instructions.

PLAN: The patient is instructed to return to Dr. Kozmary's office at scheduled appointment for follow up.

S. Kozmary MD

' Steven Kozmary MD'. 05/01/2014 05:12:35 PM (SKozmary)
Steven V. Kozmary, M.D.
Director, Kozmary Center for Pain Management
Diplomate, American Board of Anesthesiology
Subspecialty Certification in Pain Management
Diplomate, American Academy of Pain Management

Date of Dictation: 5/01/2014
Date of Procedure: 4/30/2014

Patient: Simone Russo
Date of Birth: 09/05/1942
Provider: Steven V Kozmary, MD

Addended by - 'Steven Kozmary' 5/25/2014 5:09:57 PM

BILATERAL S1 SELECTIVE NERVE ROOT BLOCK PROCEDURE IN DETAIL: Fluoroscopy was used to identify the S1 foramina. A #22 gauge 5-inch spinal needle was placed at the S1 foramina on the left. Omnipaque 300 dye was injected confirming needle tip placement. There was no evidence of intravascular or intrathecal injection. The dye was observed to flow along into the epidural space under fluoroscopic guidance. After negative aspiration 1.0 cc of Lidocaine with Epinephrine was injected, then 1.0 cc of Marcaine with Epinephrine and 1 mg. Celestone solution was injected around the nerve root and transforaminally into the epidural space. The needle was withdrawn. In the same fashion the contralateral S1 nerve root was injected utilizing fluoroscopy and the identical volume of injectate. The fluoroscopy images were recorded and transferred to the patient's chart.

S. Kozmary MD

' Steven Kozmary MD'. 05/25/2014 05:09:25 PM (SKozmary)

Addended by - 'slindstrom ' 9/17/2014 5:16:25 PM

The patient also was injected at S1 with 1 cc Marcaine 0.5% without Epinephrine and 0.6 ccs of Celestone.

Kozmary Center
for Pain Management
2851 El Camino Ave, Ste 101
Las Vegas, NV 89102
702.380.3210 fax 702.380.3212

COMPREHENSIVE CONSULTATION

Exam Date: 04/28/2014
Patient Name: Simone Russo
DOB: 09/05/1942
Referred by: John S Thalgott MD
PCP:

Simone Russo was seen on 04/28/2014 for a comprehensive consultation.

Chief Complaint: The patient complains of lumbar, down left thigh and left leg pain.

History of Present Illness: The patient is a 71-year-old male who complains of low back pain and bilateral lower extremity pain, left greater than right. Two years ago he underwent lumbar spine decompression and fusion at L2-3 and had marked improvement in his pain symptoms. Three to four months later, he underwent L5-S1. On November 22, 2013 he became septic. He had a wound dehiscence. He underwent extensive wound revision. Since that time, he has developed bilateral lower extremity pain, left greater than right, as well as atrophy of the bilateral lower extremities. He has undergone extensive physical therapy. He walks with a walker. The pain is worsened by standing, lying, twisting, sitting, and walking. The pain is decreased by lying down and sitting. He has stopped all activities. He rates the pain as a 5-10 on a visual analog scale of 1-10. Body pain map was reviewed. He has undergone physical therapy, surgery. Prior to the lumbar spine surgery in 2012, he underwent injection therapy.

Review of Systems: Positive for fatigue, hypertension. ODI is 30, indicating severe disability. Opiate risk assessment questionnaire was reviewed.

Medications: Pharmacy profile was reviewed.

Pain Level: 5
Pain Level With Medication:
Pain Level Without Medication:
Pain Level Worst: 10

Allergies: .No Known Drug Allergies

Past Medical History: Hypertension
Back Disease

Family History: Diabetes

14A.App.3177

Hypertension
Kidney Disease

Social History: Marital Status: Married
Children
Employment: Retired: Physician for 40 years.
Education: Graduate Degree: 4 years.
Other: Back.
Healthy
Decrease in strength and/or endurance
Hobbies/Recreational Activities: Before pain: Tennis.
Goals: Not noted.
Alcohol Use:

Past Treatments: Physical Therapy: Last was on 12/13.
Surgery

Surgical History: Rotator Cuff Right: 1992.
Lumbar: L3-L4: 2012.
Lumbar: L5-Si: 2013.

Body Pain Map: Please refer to pain diagram in the intake questionnaire.

Review of Systems: The following systems were reviewed: Allergic/Immunologic, Cardiovascular. Constitutional, ENT, Endocrine, Eyes, Gastrointestinal, Respiratory, Genitourinary, Hematological, Integumentary, Musculoskeletal, Neurological, and Psychological. Pertinent positives noted.

Vitals:

Height:	5'9"	Weight in lbs:	165		
Blood Pressure:	121 / 70	Pulse:	78	PulseOx :	91

Physical Examination The patient is a pleasant and cooperative 71-year-old male in no apparent distress. He is seen with his wife today in the office. He walks with the aid of a walker. He is awake, alert and oriented. His affect is appropriate. HEENT: Normocephalic and atraumatic. Lumbar spine shows well-healed lumbar surgical scar. There is no evidence of erythema or infection. There is marked atrophy in the lower extremities, particularly the calves. Extremities are otherwise within normal limits. Skin shows no rash or discoloration.

Diagnosis: 722.83 POSTLAMINECTOMY SYND LUMBAR REGION
724.4 UNS THORACIC/LUMB NEURITIS/RADICUL
338.4 CHRONIC PAIN SYNDROME

Discussion: Lumbar post laminectomy syndrome; lumbar radiculitis, left greater than right.

The patient is indicated for L5 and S1 selective transforaminal epidural steroid injection under fluoroscopic guidance. I discussed the risks, benefits, and options of the procedure with him in detail. Specific risks discussed included bleeding, infection, nerve damage, headache, paralysis, and death. The patient understands and agrees to proceed.

I spoke with Dr. John Thalgott. He confirmed that patient did have collapse at L5-S1 and he felt that the nerve roots at L5 and S1 were adequately decompressed. He has requested bilateral L5

and S1 selective transforaminal epidural steroid injections and I concur.

Oswestry Disability Index

The Oswestry Disability Index is **30.** The Oswestry Disability Index (ODI) has become one of the principal condition specific outcome measures used in the management of spinal disorders. It has been validated and is a useful measure of outcome. (Spine 2000 Nov 1;25(21):2846-52)

Prescriptions:

Opana er 5MG Tablet Extended Release 12 Hour Oral, Sig: 1 po bid, maximum two tablets per day, 30 Days, Qty: 60, Ref: 0
Oxycodone hcl 15MG Tablet Oral, Sig: 1 po q4 prn pain, maximum four tablets per day, 30 Days, Qty: 120, Ref: 0

Toxicology Ordered:

The patient is indicated for urine drug testing on initial evaluation.

S. Kozmary MD

' Steven Kozmary MD'. 05/13/2014 06:33:38 PM (SKozmary)
Diplomate, American Board of Anesthesiology
Subspecialty Certification in Pain Medicine
Diplomate, American Academy of Pain Management
NPI: 1659337459
License: 5695

CPT 99204 OFFICE OUTPT NEW COMPREHENSIVE

160518004

Kozmary Center
2851 El Camino Ave. Las Vegas, NV 89102
Toxicology Test Requisition Form & Superbill

Patient: Simone Russo
DOB: 09/05/1942

Primary Ins: Medicare
Secondary Ins: AMA

Chart# 8282
Sample Date: 05/17/2016

Gender: Male

PRESCRIBED MEDICATIONS

CIRCLE ALL MEDICATIONS THAT YOU TAKE FROM ANY PROVIDER

IF YOU TAKE ANY MEDICATIONS NOT LISTED, WRITE THEM ON THE OTHER LINE.

Adderall	Darvocet	Klonopin	Neurontin	Roxicodone
Albuterol	Demerol	Lexapro	Nexium	Silenor
Alprazolam	Diazepam	Lidoderm	Norco	Skelaxin
Ambien	Dilaudid	Lipitor	Nucynta	Soma
Ambien CR	Duragesic	Lorazepam	Opana	Subsys
Amitriptyline	Effexor	Lortab	Oxycodone	Suboxone
Atenolol	Elavil	Lunesta	Oxycontin	Topamax
Ativan	Fentanyl	Lyrica	Paxil	Tramadol
Avinza	Fioricet	Marinol	Pennsaid	Trazodone
Baclofen	Flector Patch	Metformin	Percocet	Ultram
Celebrex	Flexeril	Methadone	Phenergan	Valium
Celexa	Gabapentin	Metoprolol	Prevacid	Vicodin
Clonazepam	Hydrocodone	Mobic	Prilosec	Vicoprofen 17 2:12PM
Clonidine	Ibuprofen	Morphine	Prozac	Voltaren Gel
Codeine	Imitrex	MS Contin	Restoril	Wellbutrin
Cymbalta	Kadian	MSIR	Robaxin	Xanax

Other:_____

I certify that I have voluntarily provided my own fresh and unadulterated urine specimen for analytical testing. The information provided on this form and on the label affixed to the specimen bottle is accurate and truthful. I understand that Dr. Steven Kozmary is the owner of Lux Laboratories and that I may use any certified lab for my testing. I am not required to utilize LUX Laboratories.

Patients Signature: C F Russo

DX Code: DX: Chronic Pain Z79.891

- ☐ Consistent / Inconsistent _____
- ☐ High pretest suspicion of aberrant drug use
- ☐ Non-compliant in past
- ☐ First Visit / Last UDT _____
- ☐ Early Refill
- ☐ Pharmacy profile inconsistency
- ☐ Unexpected UDT results in past
- ☐ Random

RISK Level ☐ Low ☐ Moderate ☐ High

ORDER

- ☐ UDT IA HIGH COMPLEX
- ☐ MS/LC CONFIRMATIONS
- ☐ UA exam non microscopic

_____
Physician's Signature Date

Comments:

170113020

Kozmary Center
2851 El Camino Ave. Las Vegas, NV 89102
Toxicology Test Requisition Form & Superbill

Patient: Simone Russo
DOB: 09/05/1942

Primary Ins: Medicare
Secondary Ins: AMA

Chart# 8282
Sample Date: 01/13/2017

Gender: Male

PRESCRIBED MEDICATIONS
CIRCLE ALL MEDICATIONS THAT YOU TAKE FROM ANY PROVIDER
IF YOU TAKE ANY MEDICATIONS NOT LISTED, WRITE THEM ON THE OTHER LINE.

Adderall	Darvocet	Klonopin	Neurontin	Roxicodone
Albuterol	Demerol	Lexapro	Nexium	Silenor
Alprazolam	Diazepam	Lidoderm	Norco	Skelaxin
Ambien	Dilaudid	Lipitor	Nucynta	Soma
Ambien CR	Duragesic	Lorazepam	Opana	Subsys
Amitriptyline	Effexor	Lortab	Oxycodone	Suboxone
Atenolol	Elavil	Lunesta	Oxycontin	Topamax
Ativan	Fentanyl	Lyrica	Paxil	Tramadol
Avinza	Fioricet	Marinol	Pennsaid	Trazodone
Baclofen	Flector Patch	Metformin	Percocet	Ultram
Celebrex	Flexeril	Methadone	Phenergan	Valium
Celexa	Gabapentin	Metoprolol	Prevacid	Vicodin
Clonazepam	Hydrocodone	Mobic	Prilosec	Vicoprofen
Clonidine	Ibuprofen	Morphine	Prozac	Voltaren Gel
Codeine	Imitrex	MS Contin	Restoril	Wellbutrin
Cymbalta	Kadian	MSIR	Robaxin	Xanax

Other: 0 of 3 doses

I certify that I have voluntarily provided my own fresh and unadulterated urine specimen for analytical testing. The information provided on this form and on the label affixed to the specimen bottle is accurate and truthful. I understand that Dr. Steven Kozmary is the owner of Lux Laboratories and that I may use any certified lab for my testing. I am not required to utilize LUX Laboratories.

Patients Signature: [signature]

DX Code: DX: Chronic Pain Z79.891

☐ Consistent / Inconsistent alprazolam
☐ High pretest suspicion of aberrant drug use
☐ Non-compliant in past
☐ First Visit / Last UDT 9/20/16
☐ Early Refill
RISK Level ☐ Low ☐ Moderate ☐ High

☐ Pharmacy profile inconsistency
☐ Unexpected UDT results in past
☐ Random

ORDER
☐ UDT IA HIGH COMPLEX
☐ MS/LC CONFIRMATIONS
☐ UA exam non microscopic

Physician's Signature Date

Comments:

17 JAN 13 2:20PM

150407025

Kozmary Center
2851 El Camino Ave. Las Vegas, NV 89102
Toxicology Test Requisition Form & Superbill

Patient: Simone Russo
DOB: 09/05/1942
Gender: Male

Primary Ins: Medicare
Secondary Ins: AMA

Chart# 8282
Sample Date: 04/07/2015

PRESCRIBED MEDICATIONS
CIRCLE ALL MEDICATIONS THAT YOU TAKE FROM ANY PROVIDER
IF YOU TAKE ANY MEDICATIONS NOT LISTED, WRITE THEM ON THE OTHER LINE.

OPI	OPI	BZO	AMPH	Muscle Relax	Anti Dep	Other
Avinza	Tramadol	Alprazolam	Adderall	Baclofen	Amitriptyline	Ambien
Codeine	Ultram	Ativan	Ritalin	Flexeril	Cymbalta	Ambien CR
Darvocet	Vicodin	Clonazepam		Robaxin	Effexor	Marinol
Demerol	Vicoprofen	Diazepam		Soma	Elavil	Topamax
Fentora	-	Dilaudid		Skelaxin	Lexapro	Silenor
Fioricet	-	Duragesic			Paxil	Neurontin
Hydrocodone	-	Klonopin			Prozac	Gabapentin
Kadian		Lorazepam			Trazodone	Lyrica
Lorcet		Lunesta				Neurontin
Lortab		Restoril				
Methadone		Valium				
Morphine						
MS Contin						
MSIR						
Norco						
Nucynta						
Opana						
Oxycodone						
Oxycontin						
Percocet						
Roxycodone						
Suboxone						

Other: _____

I certify that I have voluntarily provided my own fresh and unadulterated urine specimen for analytical testing. The information provided on this form and on the label affixed to the specimen bottle is accurate and truthful. I understand that Dr. Steven Kozmary is the owner of Lux Laboratories and that I may use any certified lab for my testing. I am not required to utilize LUX Laboratories.

Patients Signature: _____

DX Code: DX: Chronic Pain 338.4 V58.69

- ☐ Consistent / Inconsistent _____
- ☐ High pretest suspicion of aberrant drug use
- ☐ Non-compliant in past
- ☐ First Visit / Last UDT 9/30/14
- ☐ Early Refill
- ☐ Pharmacy profile inconsistency
- ☐ Unexpected UDT results in past
- ☐ Random

RISK Level ☐ Low ☐ Moderate ☐ High

ORDER
- ☐ UDT IA HIGH COMPLEX
- ☐ MS/LC CONFIRMATIONS
- ☐ UA exam non microscopic

Steven Kozmary, MD Date

Kozmary Center
2851 El Camino Ave. Las Vegas, NV 89102
Toxicology Test Requisition Form & Superbill

Comments:

Preliminary +	AMP	EX	BAR	BZO	COC	MTD	OPI	PHEN	Soma (SUP)
No Positives									
Confirmations				82942	82530		82942		82942
Quantifications	82145 83789 82520	82542	82205	80154	82520	83840	83925 82101	83992-x1	8305 83789

Date Run										

Preliminary	80101	G0431	83986	82570	V58.69	V58.83

ALC Alcohol AMP Amphetamine BAR Barbiturate BZO Benzodiazepines THC Cannabinoid COC Cocaine
EX Ecstasy MTD Methadone METQ Methaqualone OPI Opiates PHEN Phencyclidine PROP Propoxyphene

Collection Time:_____ Time Specimen was received in lab:_____

150728016

Kozmary Center
2851 El Camino Ave. Las Vegas, NV 89102
Toxicology Test Requisition Form & Superbill

Patient: Simone Russo
DOB: 09/05/1942

Primary Ins: Medicare
Secondary Ins: AMA

Chart# 8282
Sample Date: 07/28/2015

Gender: Male

PRESCRIBED MEDICATIONS
CIRCLE ALL MEDICATIONS THAT YOU TAKE FROM ANY PROVIDER
IF YOU TAKE ANY MEDICATIONS NOT LISTED, WRITE THEM ON THE OTHER LINE.

OPI	OPI	BZO	AMPH	Muscle Relax	Anti Dep	Other
Avinza	Tramadol	Alprazolam	Adderall	Baclofen	Amitriptyline	Ambien
Codeine	Ultram	Ativan	Ritalin	Flexeril	Cymbalta	Ambien CR
Darvocet	Vicodin	Clonazepam		Robaxin	Effexor	Marinol
Demerol	Vicoprofen	Diazepam		Soma	Elavil	Topamax
Fentora	-	Dilaudid		Skelaxin	Lexapro	Silenor
Fioricet	-	Duragesic			Paxil	Neurontin
Hydrocodone	-	Klonopin			Prozac	Gabapentin
Kadian		Lorazepam			Trazodone	Lyrica
Lorcet		Lunesta			wellbutrin	Neurontin
Lortab		Restoril			150 SR	
Methadone		Valium			BID	
Morphine						
MS Contin						
MSIR						
Norco						
Nucynta						
Opana						
Oxycodone						
Oxycontin						
Percocet						
Roxycodone						
Suboxone						

'15 JUL 28 1:52PM

Other:_____

I certify that I have voluntarily provided my own fresh and unadulterated urine specimen for analytical testing. The information provided on this form and on the label affixed to the specimen bottle is accurate and truthful. I understand that Dr. Steven Kozmary is the owner of Lux Laboratories and that I may use any certified lab for my testing. I am not required to utilize LUX Laboratories.

Patients Signature: C t Russo

DX Code: DX: Chronic Pain 338.4 V58.69

- ☐ Consistent / Inconsistent _____
- ☐ High pretest suspicion of aberrant drug use
- ☐ Non-compliant in past
- ☐ First Visit / Last UDT 4/7/15
- ☐ Early Refill
- ☐ Pharmacy profile inconsistency
- ☐ Unexpected UDT results in past
- ☐ Random

RISK Level ☐ Low ☐ Moderate ☐ High

ORDER
- ☐ UDT IA HIGH COMPLEX
- ☐ MS/LC CONFIRMATIONS
- ☐ UA exam non microscopic

Steven Kozmary, MD Date

Kozmary Center
2851 El Camino Ave. Las Vegas, NV 89102
Toxicology Test Requisition Form & Superbill

Comments:

	AMP	EX	BAR	BZO	COC	MTD	OPI	PHEN	Soma	BUP
Preliminary +										
No Positives Confirmations				82942	82530		82942		82942	
Quantifications	82145 83789 82520	82542	82205	80154	82520	83840	83925 82101	83992-x1	8305 83789	

Date Run										

Preliminary	80101	G0431	83986	82570	V58.69	V58.83

ALC Alcohol AMP Amphetamine BAR Barbiturate BZO Benzodiazepines THC Cannabinoid COC Cocaine
EX Ecstasy MTD Methadone METQ Methaqualone OPI Opiates PHEN Phencyclidine PROP Propoxyphene

Collection Time:_____ Time Specimen was received in lab:_____

Kozmary Center
2851 El Camino Ave. Las Vegas, NV 89102 170503015
Toxicology Test Requisition Form & Superbill

Patient: Simone Russo
DOB: 09/05/1942

Primary Ins: Medicare
Secondary Ins:

Chart# 8282
Sample Date: 05/03/2017

Gender: Male

02:27 PM

PRESCRIBED MEDICATIONS

CIRCLE ALL MEDICATIONS THAT YOU TAKE FROM ANY PROVIDER

IF YOU TAKE ANY MEDICATIONS NOT LISTED, WRITE THEM ON THE OTHER LINE.

Adderall	Darvocet	Klonopin	Neurontin	Roxicodone
Albuterol	Demerol	Lexapro	Nexium	Silenor
Alprazolam	Diazepam	Lidoderm	Norco	Skelaxin
Ambien	Dilaudid	Lipitor	Nucynta	Soma
Ambien CR	Duragesic	Lorazepam	Opana	Subsys
Amitriptyline	Effexor	Lortab	Oxycodone	Suboxone
Atenolol	Elavil	Lunesta	Oxycontin	Topamax
Ativan	Fentanyl	Lyrica	Paxil	Tramadol
Avinza	Fioricet	Marinol	Pennsaid	Trazodone
Baclofen	Flector Patch	Metformin	Percocet	Ultram
Celebrex	Flexeril	Methadone	Phenergan	Valium
Celexa	Gabapentin	Metoprolol	Prevacid	Vicodin
Clonazepam	Hydrocodone	Mobic	Prilosec	Vicoprofen
Clonidine	Ibuprofen	Morphine	Prozac	Voltaren Gel
Codeine	Imitrex	MS Contin	Restoril	Wellbutrin
Cymbalta	Kadian	MSIR	Robaxin	Xanax

Other: Allegra D for allergies, Prozac

I certify that I have voluntarily provided my own fresh and unadulterated urine specimen for analytical testing. The information provided on this form and on the label affixed to the specimen bottle is accurate and truthful. I understand that Dr. Steven Kozmary is the owner of Lux Laboratories and that I may use any certified lab for my testing. I am not required to utilize LUX laboratories.

Patients Signature: Ed Russo MD

DX Code: DX: Chronic Pain Z79.891

☐ Consistent / Inconsistent codeine, oxycodone, oxymorphone
☐ High pretest suspicion of aberrant drug use
☐ Non-compliant in past
☐ First Visit / Last UDT 1/13/17
☐ Early Refill
☐ Pharmacy profile inconsistency
☐ Unexpected UDT results in past
☐ Random

RISK Level ☐ Low ☐ Moderate ☐ High

ORDER
☐ UDT IA HIGH COMPLEX
☐ MS/LC CONFIRMATIONS
☐ UA exam non microscopic

Physician's Signature Date

Comments:

1U0920047

Kozmary Center
2851 El Camino Ave. Las Vegas, NV 89102
Toxicology Test Requisition Form & Superbill

Patient: Simone Russo
DOB: 09/05/1942

Primary Ins: Medicare
Secondary Ins: AMA

Chart# 8282
Sample Date: 09/20/2016

Gender: Male

PRESCRIBED MEDICATIONS

CIRCLE ALL MEDICATIONS THAT YOU TAKE FROM ANY PROVIDER

IF YOU TAKE ANY MEDICATIONS NOT LISTED, WRITE THEM ON THE OTHER LINE.

Adderall	Darvocet	Klonopin	Neurontin	Roxicodone
Albuterol	Demerol	Lexapro	Nexium	Silenor
Alprazolam	Diazepam	Lidoderm	Norco	Skelaxin
Ambien	Dilaudid	Lipitor	Nucynta	Soma
Ambien CR	Duragesic	Lorazepam	Opana	Subsys
Amitriptyline	Effexor	Lortab	Oxycodone	Suboxone
Atenolol	Elavil	Lunesta	Oxycontin	Topamax
Ativan	Fentanyl	Lyrica	Paxil	Tramadol
Avinza	Fioricet	Marinol	Pennsaid	Trazodone
Baclofen	Flector Patch	Metformin	Percocet	Ultram
Celebrex	Flexeril	Methadone	Phenergan	Valium
Celexa	Gabapentin	Metoprolol	Prevacid	Vicodin
Clonazepam	Hydrocodone	Mobic	Prilosec	Vicoprofen
Clonidine	Ibuprofen	Morphine	Prozac	Voltaren Gel
Codeine	Imitrex	MS Contin	Restoril	Wellbutrin
Cymbalta	Kadian	MSIR	Robaxin	Xanax

Other: allegra D Vitamins

I certify that I have voluntarily provided my own fresh and unadulterated urine specimen for analytical testing. The '06 SEP 20 3:40PM information provided on this form and on the label affixed to the specimen bottle is accurate and truthful. I understand that Dr. Steven Kozmary is the owner of Lux Laboratories and that I may use any certified lab for my testing. I am not required to utilize LUX Laboratories.

Patients Signature: E F. Russo

DX Code: DX: Chronic Pain Z79.891

☐ Consistent / Inconsistent _____
☐ High pretest suspicion of aberrant drug use
☐ Non-compliant in past
☐ First Visit / Last UDT 5/17/16
☐ Early Refill
RISK Level ☐ Low ☐ Moderate ☐ High

☐ Pharmacy profile inconsistency
☐ Unexpected UDT results in past
☐ Random

ORDER
☐ UDT IA HIGH COMPLEX
☐ MS/LC CONFIRMATIONS
☐ UA exam non microscopic

_____
Physician's Signature Date

Comments:

Kozmary Center for Pain Management

2851 El Camino Ave., Ste. 101
Phone: 702.380.3210 Fax: 702.380.3212

DATE: 10/18/16
PATIENT NAME: Simone F. Russo
DOB: 09/05/1942

11/15/16 -
PT declined

ELIGIBILITY & BENEFITS

PRIMARY: Medicare #1063271295A
PHONE#: (855)609-9960
PLAN TYPE: HMO PPO POS
EFFECTIVE DATE:
COPAY: _____ CO-INS: _____
DEDUCTIBLE: _____ MET: _____
MAX OOP: _____ MET: _____
REPRESENTATIVE: _____

SECONDARY: AMA #M595008923/9
PHONE#: 1(800)458-5736
PLAN TYPE: HMO PPO POS
EFFECTIVE DATE: 07.01.14
COPAY: 0 CO-INS: 0
DEDUCTIBLE: 0 MET: 0
MAX OOP: 0 MET: 0
REPRESENTATIVE: Janice

DME BENEFITS & PRIOR AUTHORIZATION

DME BENEFITS?: _____
PRIOR AUTH REQUIRED?: _____
PRIOR AUTH#: _____
PRIOR AUTH FAX: _____
PRIOR AUTH APPROVAL #: _____
DIAGNOSIS CODES: 1.) _____
2.) _____
3.) _____

HCPCS: 1(L0180) Cervicall Collar Grade PRICE: _____
HCPCS: _____ PRICE: _____
HCPCS: _____ PRICE: _____

REPRESENTATIVE: _____

Notes:
Will pick up MC excessive Charges

A. Notifier: KOZMARY CENTER FOR PAIN MANAGEMENT

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** DURABLE MEDICAL EQUIPMENT below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** DURABLE MEDICAL EQUIPMENT below.

D. Durable Medical Equipment	E. Reason Medicare May Not Pay:	F. Estimated Cost
L0650 - LUMBAR BRACE L0174 - CERVICAL BRACE	We expect Medicare to pay, this is to protect our office in the event of an issue that Medicare does not cover or if the insurance provided is not Medicare Traditional Primary.	-$1350.00 billable to Medicare and $250.00 billable to Patient. - $330.00 billable to Medicare.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** associated services listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** associated service listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** associated service listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** associated service listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information: This is a blanket protection for our office in the even that another insurance may be primary over or in place of Traditional Medicare information that you have presented to our office.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Kozmary Center
Steven V. Kozmary, M.D.

ADVANCED BENEFICIARY NOTICE (ABN)

DATE: _____

PATIENT: _____

COMMERCIAL INSURANCE: _____

- You are receiving this notice because your insurance company may not pay for all of the services that you receive during your visit.

WHAT YOU NEED TO KNOW:

- Read this notice, so you can make an informed decision about your care.
- Ask questions.

SUPPLIES AND SERVICES	REASON INSURANCE MAY NOT PAY	ESTIMATED COST

_____YES I want these services. If my commercial insurance carrier denies payment, I am completely responsible for payment in full. I understand that I can appeal this decision for nonpayment by my insurance carrier

_____ NO I have decided not to receive these services.

_____ OTHER Should I decide to request these services in the future, I understand I will be charged and am responsible for payment in full.

- By signing this notice you agree to take financial responsibility for the cost of the supplies and serviced listed above should your insurance company deny coverage for the listed items.

Guarantor Signature:	Date:

KOZMARY CENTER FOR PAIN MANAGEMENT

LUMBAR-SACRAL ORTHOSIS (LSO) and CERVICAL COLLAR BRACE
LETTER OF MEDICAL NECESSITY

Name: _____ DOB: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Insurance Information

Primary Insurance: _____

Policy ID: _____ **Group:** _____

Phone#: _____ **Rep Name:** _____

Deductible: _____ **Deductible Met:** _____

Authorization: _____ **Ref#:** _____

Lumbar-Sacral Orthosis Model and Cervical Collar Brace

Model: _____ **Size:** _____ **HCPCS: L0650, L0180**

Diagnosis Code: _____ _____ _____ _____

One of the following options must be selected for the prescription to be valid:

- **Reduce pain by restricting mobility of the trunk.**
- **Facilitate healing following an injury to the spine or related soft tissue.**
- **Facilitate healing following a surgical procedure on the spine or related soft tissue.**
- **Otherwise support weak spinal muscle and/or a deformed spine.**

I certify that the Lumbar-Sacral Orthosis (LSO) and Cervical Collar Brace I prescribed is medically necessary for this patient's rehab and is not prescribed as convenience equipment. Medical necessity for prescribed LSO is documented in patient chart notes.

Physician's Signature: _____ Date: 9/3/16

Physician's Name (Print): Steven Kozmary NPI#: 1659337459

Address: 2851 EL CAMINO AVENUE, SUITE#101, LAS VEGAS, NV 89102• Phone: (702) 380-3210•Fax: (702) 380-3212

Patient's Signature: _____ Date: _____

14A.App.3191

PROOF OF DELIVERY and RETURN POLICY ACKNOWLEDGEMENT

KOZMARY CENTER FOR PAIN MANAGEMENT
DURABLE MEDICAL EQUIPMENT

Patient Name: Simone Russo Date: _____ Provider: _____

_____ **I have received the following durable medical equipment from Kozmary Center for Pain Management.**

○ L0180 - Cervical Collar Brace $330.00

✓L0650 - Lumbar-Sacral Orthosis Brace $1350.00

I have been provided the brace(s) prescribed by my provider. I understand Kozmary Center for Pain Management return policy and that there is a 1 year manufacture warranty period. I understand that this warranty does not apply to changes in my physical weight, condition, nor any other physiological changes that may occur, or any alterations made by anyone other than Kozmary Center for Pain Management. I am satisfied with both the brace and fit of my brace and I have been fully advised as to its use and function.

Medicare DMEPOS Supplier Statement:
The products and/or services provided to you by Kozmary Center for Pain Management are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (ie. honoring warranties and hours of operation). The full text of these standards can be obtained at http://ecfr.gpoaccess.gov. Upon request we will furnish you a written copy of the standards.

Patient Signature: _____ Date: _____

Technician Signature: _____ Date: _____

PLACE LABEL

Kozmary Center
for Pain Management

2851 El Camino Ave., Ste. 101
Phone: 702.380.3210 Fax: 702.380.3212

DATE: 10/18/16
PATIENT NAME: Simone F. Russo
DOB: 09/05/1942

ELIGIBILITY & BENEFITS

PRIMARY: Medicare #1003277125A
PHONE#: (855) 609-9960
PLAN TYPE: HMO PPO POS
EFFECTIVE DATE: _____
COPAY: _____ CO-INS: _____
DEDUCTIBLE: _____ MET: _____
MAX OOP: _____ MET: _____
REPRESENTATIVE: _____

SECONDARY: AMA #M595008923/9
PHONE#: 1(800) 458-5736
PLAN TYPE: HMO PPO POS
EFFECTIVE DATE: 07.01.14
COPAY: Ø CO-INS: Ø
DEDUCTIBLE: Ø MET: Ø
MAX OOP: Ø MET: Ø
REPRESENTATIVE: Janice

DME BENEFITS & PRIOR AUTHORIZATION

DME BENEFITS?: _____
PRIOR AUTH REQUIRED?: _____
PRIOR AUTH#: _____
PRIOR AUTH FAX: _____
PRIOR AUTH APPROVAL #: _____
DIAGNOSIS CODES: 1.) _____
2.) _____
3.) _____

HCPCS: L(10180) Cervical Collar Grade PRICE: _____
HCPCS: _____ PRICE: _____
HCPCS: _____ PRICE: _____

REPRESENTATIVE: _____

Notes:
Will pick up MC
excessive charges

Kozmary Center for Pain Management

2851 El Camino Ave, Ste 101
Las Vegas, NV 89102
702.380.3210 fax 702.380.3212

Patient Name: Simone Russo
Date: 04/23/2015
Location: Kozmary Center for Pain Management
Notes: RIGHT LMBB L2/3 L3/4 L4/5 L5/S1
Diagnosis:

Start Time: 2:08 pm ✓
Finish Time: 2:11 pm ✓
Fluoro Time: :14 ✓
% Relief 100 ✓

Pump Trial Results ___%relief VAS___to___
NStim Trial Results 724.2 ✓
Pump Study Results 721.3 ✓
Comments: _____

Drug	Amount (ml)	Lot#	Expiration
❑ Marcaine 0.5%	4	4509000	9/1/16
❑Betamethasone 6mg/mL	1	410700	10/16
❑Lidocaine 2%	8,5	38-254-DK	2/1/16
❑Omnipaque 300i/mL	1	12508608	9/13/17
❑Other			

KCPM Procedure Record

Date: 04-23-15 Time: 12:34 Initials: TL Allergies Reviewed: ☐Latex ☐Betadine ☐Contrast

Patient Identified: ☒Verbal Procedure/site confirmed and patient verbalizes understanding ☒Yes ☐No

Ride: ☒Yes ☐No Name: Barbara Phone: 702-792-4077

Blood Thinners: ☐Yes ☒No Last dose:_____

☐NSAIDS ☐Aspirin ☐Persantine ☐Pletal ☐Plavix ☐Effient ☐Ticlid ☐Warfarin ☐Pradaxa ☐Xarelto

NPO Since: 7:30 am LMP:_____ Pregnancy test:_____ Hysterectomy: ☐Yes ☐No

Pain Scale: ☐0-1 ☒2-3 ☐4-5 ☐6-7 ☐8-9 ☐10

Heplock: ☐Yes ☒No

IV site:_____ Size:_____ Started by:_____ Solution_____ Removed by:_____ Site: ☐CDI ☐Red/swollen

Antibiotic: ☐Yes ☐No Drug: ☐Ancef 500mg ☐IV ☐IM Time:_____

B/P:_____ P:_____ R:_____ O2 Sat %:_____

Intra op: Time Start: 2:08 AM/PM Time Ended: 2:11 AM/PM

Procedure: Rt thumb Position: ☒Prone ☐Supine ☐Sitting ☐(R)Side ☐(L)Side

Grounding Pad Site:_____ ☒N/A Site Condition: ☐CDI ☐Red

O2 @_____ Via: ☐Nasal Cannula ☐Mask Tolerance of Procedure: ☒Well ☐Fair ☐Poor

Procedure Nurse: Sarah Lindstrom, RN **Radiology Technician:** Carlos Rios

Time: AM/PM	BP	Pulse	O2 Sat %	Time AM/PM	Medication	Site	Initials
2:08	187/97	74	93				
Post op:							
2:11	146/85	72	96				

Discharge: ☐Ambulatory ☒Wheelchair ☐Walker ☐Cane ☐Self ☒With Responsible Adult Verbalizes Understanding: ☒Y ☐N

Pain Level Upon Discharge: 0 Time Discharged: 2:20pm Copy of Discharge Instructions Given To: ☐Patient ☐Responsible Adult

Nurse'sNotes:_____

% improvement 100

Simone F Russo
09/05/1942

Patient Identification

Kozmary Center
Steven V. Kozmary, M.D.
2851 El Camino Ave., Suite 101 • Las Vegas, Nevada 89102

8 Simone Russo	12:41	1:00	Dr Kozmary	

Kozmary Center for Pain Management

2851 El Camino Ave, Ste 101
Las Vegas, NV 89102
702.380.3210 fax 702.380.3212

Patient Name: Simone Russo
Date: 05/15/2015
Location: Kozmary Center for Pain Management
Notes: RIGHT LUMBAR RFA L2/3 L3/4 L4/5 L5/S1
Diagnosis:

Start Time: 8:13am ✓
Finish Time: 8:26 am ✓
Fluoro Time: :21 ✓
% Relief 100 ✓

Pump Trial Results ___%relief VAS___to___
NStim Trial Results 724.2 ✓
Pump Study Results 721.3 ✓
Comments: _____

Drug	Amount (ml)	Lot#	Expiration
☐ Marcaine 0.5%	4	46-106-DK	10/16
☐Betamethasone 6mg/mL	1	411000	10/16
☐Lidocaine 2%	5,5	38-254-DK	2/16
☐Omnipaque 300i/mL	1	125686 08	9/17
☐Other			

KCPM Procedure Record

Date: 05-Feb Time: 7:46 Initials: JL Allergies Reviewed: ☐Latex ☐Betadine ☐Contrast

Patient Identified: ☒Verbal Procedure/site confirmed and patient verbalizes understanding ☒Yes ☐No

Ride: ☒Yes ☐No Name: _____ Phone: _____

Blood Thinners: ☐Yes ☒No Last dose: _____

☐NSAIDS ☐Aspirin ☐Persantine ☐Pletal ☐Plavix ☐Effient ☐Ticlid ☐Warfarin ☐Pradaxa ☐Xarelto

NPO Since: 8:00 PM LMP: _____ Pregnancy test: _____ Hysterectomy: ☐Yes ☐No

Pain Scale: ☐0-1 ☐2-3 ☒4-5 ☐6-7 ☐8-9 ☐10

Heplock: ☐Yes ☒No

IV site: _____ Size: _____ Started by: _____ Solution _____ Removed by: _____ Site: ☐CDI ☐Red/swollen

Antibiotic: ☐Yes ☐No Drug: ☐Ancef 500mg ☐IV ☐IM Time: _____

B/P: _____ P: _____ R: _____ O2 Sat %: _____

Intra op: Time Start: 8:13 AM/PM Time Ended: 8:26 AM/PM

Procedure: (R) Lumbar RF Position: ☒Prone ☐Supine ☐Sitting ☐(R)Side ☐(L)Side

Grounding Pad Site: (L) Calf ☒N/A Site Condition: ☐CDI ☐Red

O2 @ _____ Via: ☐Nasal Cannula ☐Mask Tolerance of Procedure: ☒Well ☐Fair ☐Poor

Procedure Nurse: Sarah Lindstrom, RN **Radiology Technician:** Carlos Rios

Time: AM/PM	BP	Pulse	O2 Sat %	Time AM/PM	Medication	Site	Initials
8:13	216/110	85	94				
8:16	182/102	84	96				
8:23	196/88	84	95				
Post op:							
8:27	169/87	82	94				

Discharge: ☒Ambulatory ☐Wheelchair ☐Walker ☒Cane ☐Self ☒With Responsible Adult Verbalizes Understanding: ☒Y ☐N

Pain Level Upon Discharge: 0 Time Discharged: 8:35 am Copy of Discharge Instructions Given To: ☐Patient ☐Responsible Adult

Nurse'sNotes: _____

% improvement 100

Simone F Russo
09/05/1942

Patient Identification

Kozmary Center
Steven V. Kozmary, M.D.
2851 El Camino Ave., Suite 101 • Las Vegas, Nevada 89102

3 Simone Russo	7:46	8:00	Kozmary's	

Patient Identification

Simone Russo

RADIOFREQUENCY REPORT

5/19/15

BURN 1	X Auto Temp	o Auto Pulsed	o Manual Pulsed	Temp: 80 °C	Time: 90 Seconds	
BURN 2	o Same as previous Temp:_____°C Time:_____ Seconds	o Auto Temp	o Auto Pulsed	o Manual Pulsed		
BURN 3	o Same as previous Temp:_____°C Time:_____ Seconds	o Auto Temp	o Auto Pulsed	o Manual Pulsed		

LEVEL o Left X Right	**Sensory** (50Hz)	**Motor** (2Hz)	**Cannula Gauge** x Length x Tip	**Average Impedance** (Ohms) **Burn 1**	**Average Impedance** (Ohms) **Burn 2**	**Average Impedance** (Ohms) **Burn 3**
L2	—	-2.0	20g	190		
L3	—	-2.0	20g	188		
3 L4	—	-2.0	20g	177		
L5	—	-2.0	20g	187		
1 S1	—	-2.0	20g	196		

- **For bilateral, document on the back of this sheet**
- **Grounding Pad applied to:** o **Left Thigh** X **Left Calf** o **Right Thigh** o **Right Calf**
  Lot # / Expiration: _____ X **See sticker**
  Site post-procedure: X **Clean / Intact** o **Other:** _____
- **Notes:**

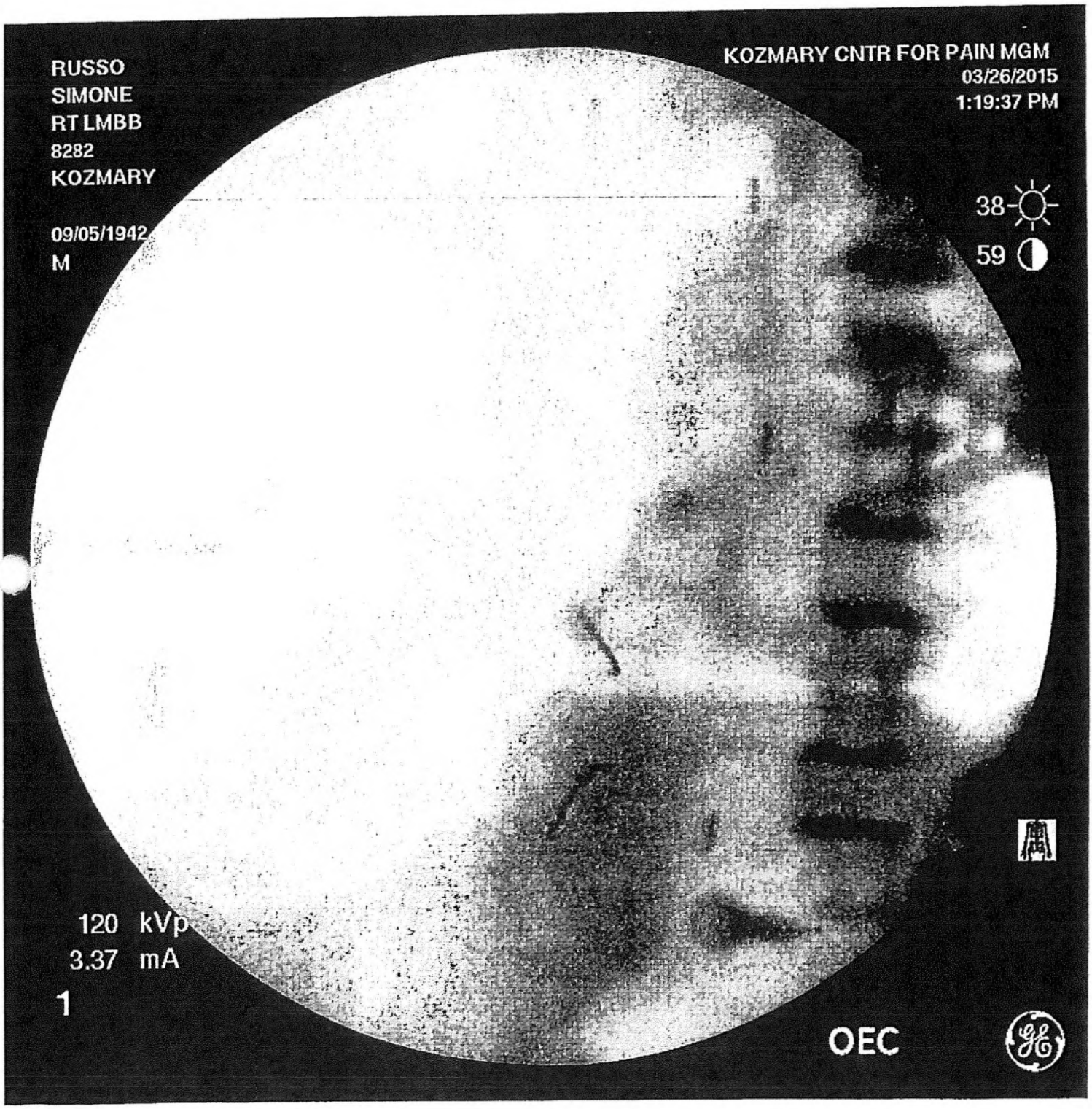
Operator Signature: [signature] **/ Initials** SR

Recording Person Signature: _____ **/ Initials** _____

- **Same as operator** N/A

Kozmary Center for Pain Management
2851 El Camino Ave, Ste 101
Las Vegas, NV 89102
702.380.3210 fax 702.380.3212

3M 8149F LOT 2017-08LG 2017-08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SIMONE
RT LMBB
8282
KOZMARY
09/05/1942
M
KOZMARY CNTR FOR PAIN MGM
03/26/2015
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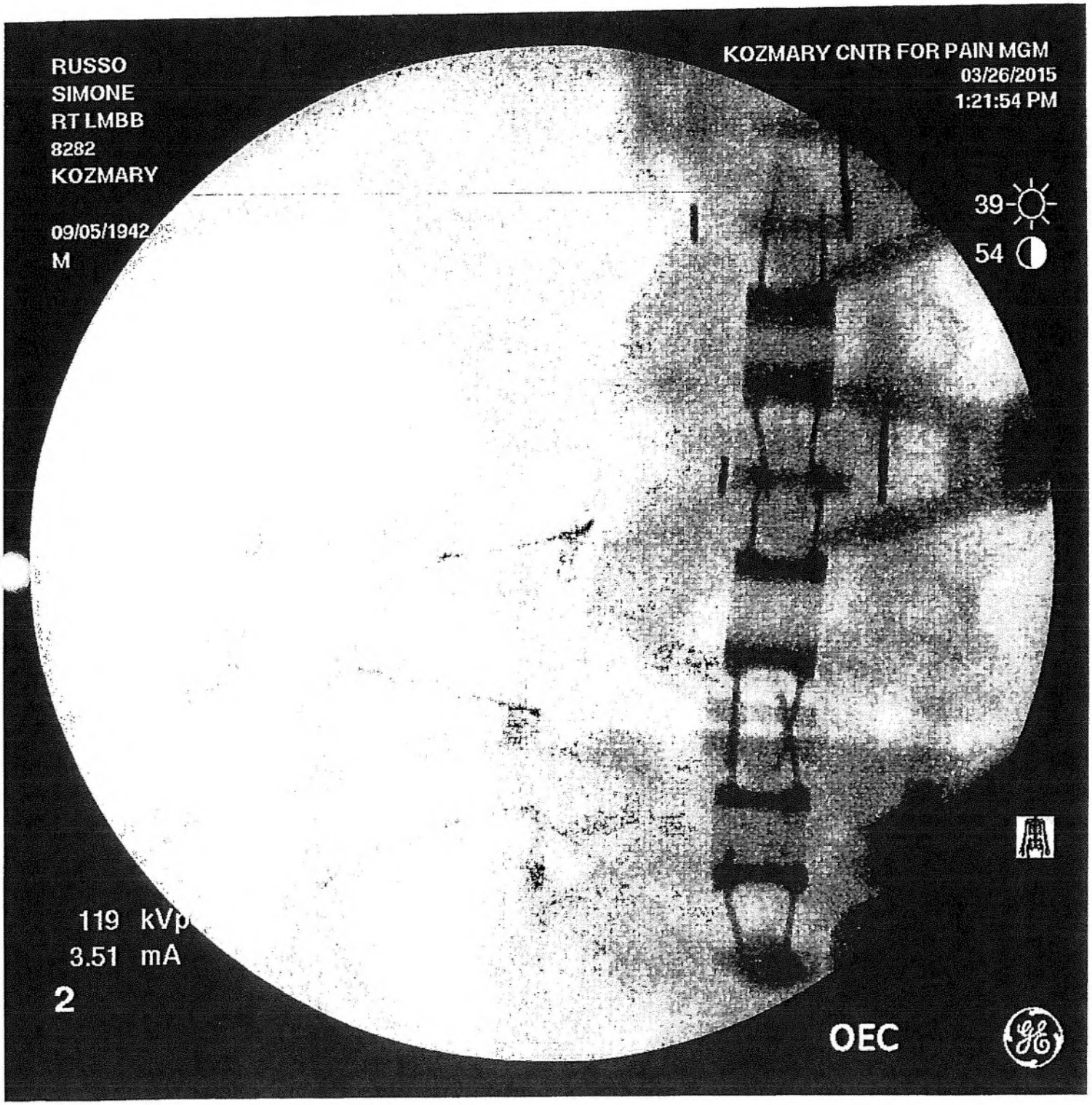
38
59
120 kVp
3.37 mA
1
OEC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09/05/1942
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03/26/2015
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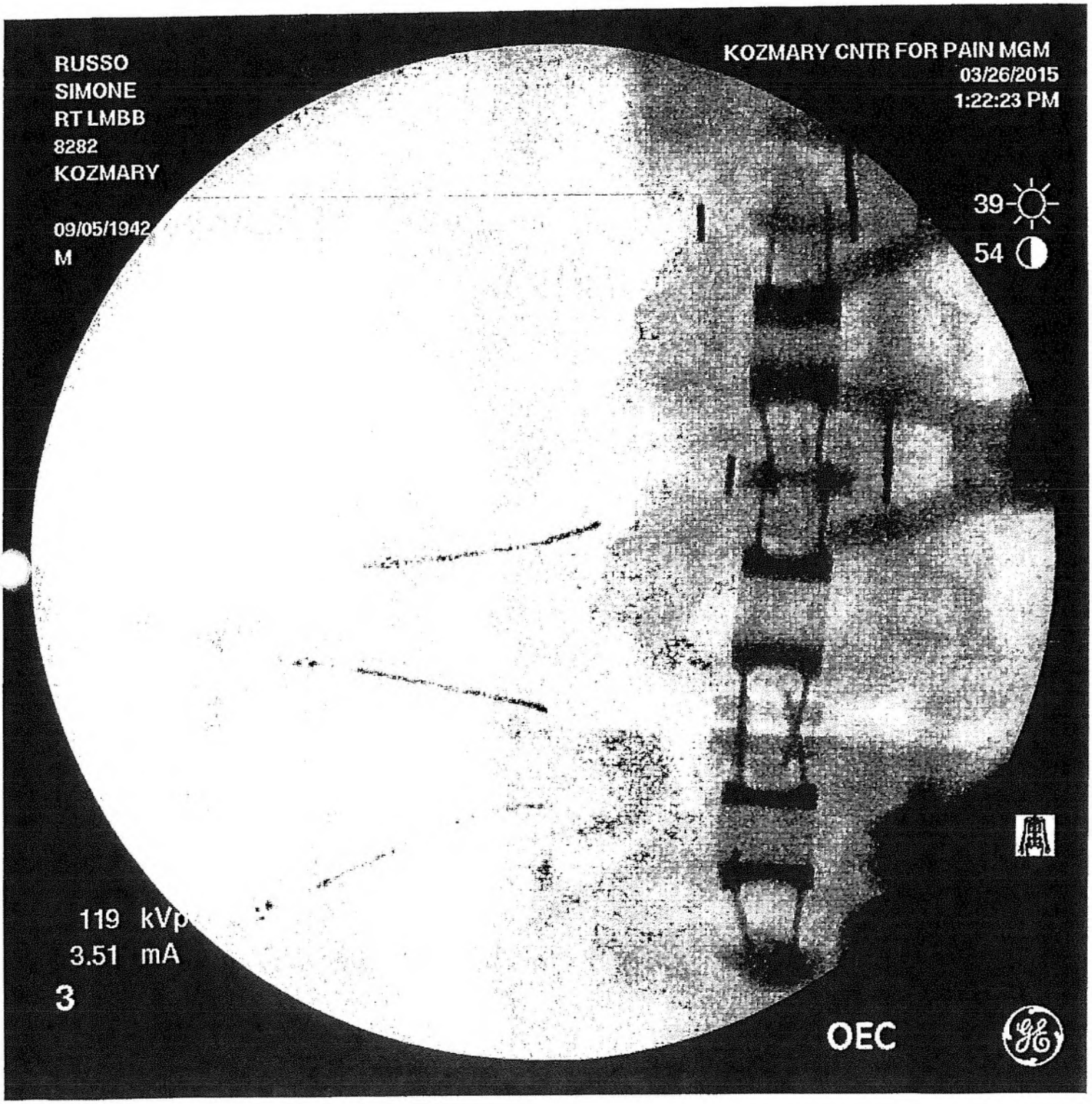
39
54
119 kVp
3.51 mA
2
OEC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8282
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09/05/1942
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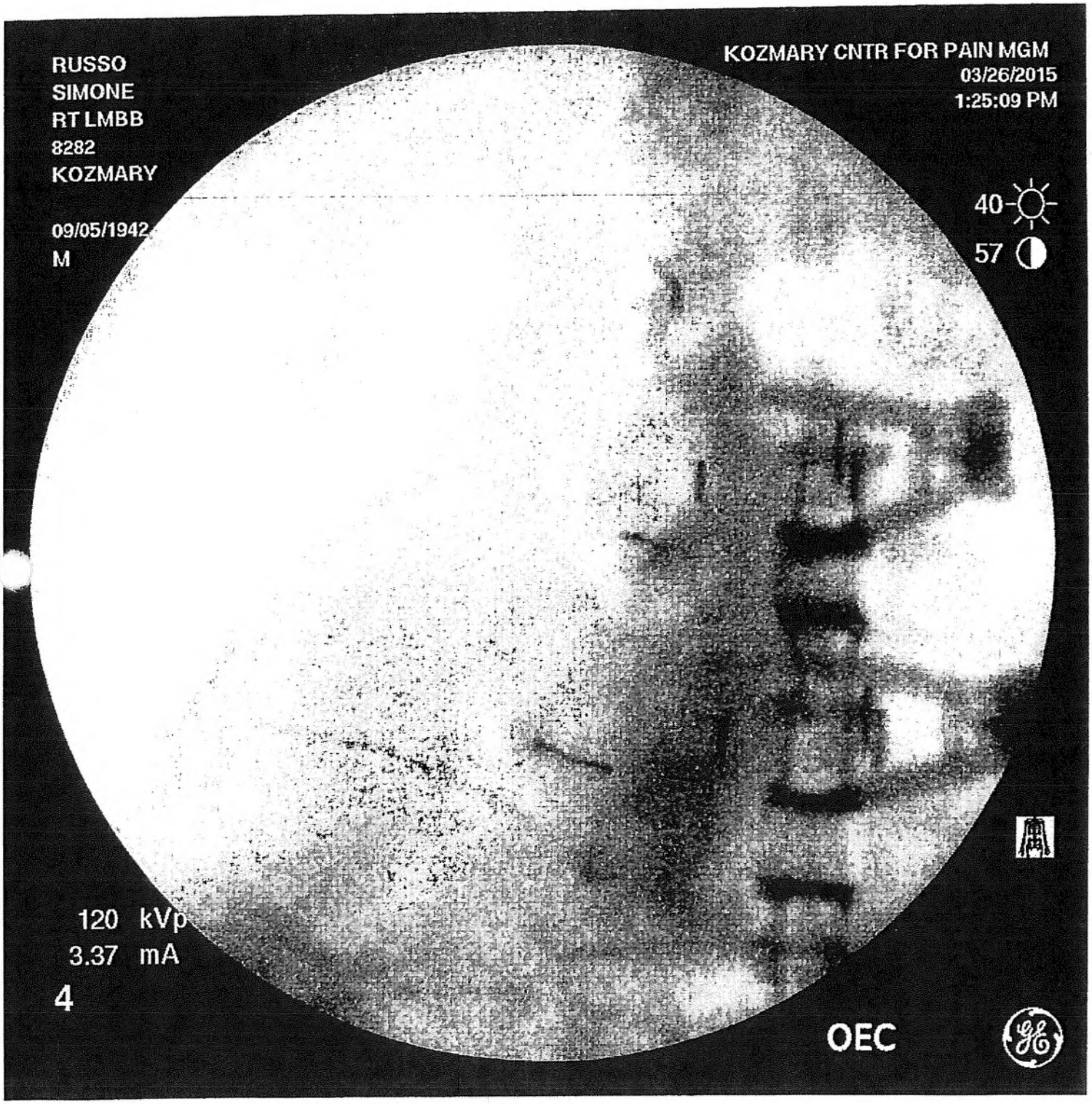
KOZMARY CNTR FOR PAIN MGM
03/26/2015
1:22:23 PM
39
54
119 kVp
3.51 mA
3
OEC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09/05/1942
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03/26/2015
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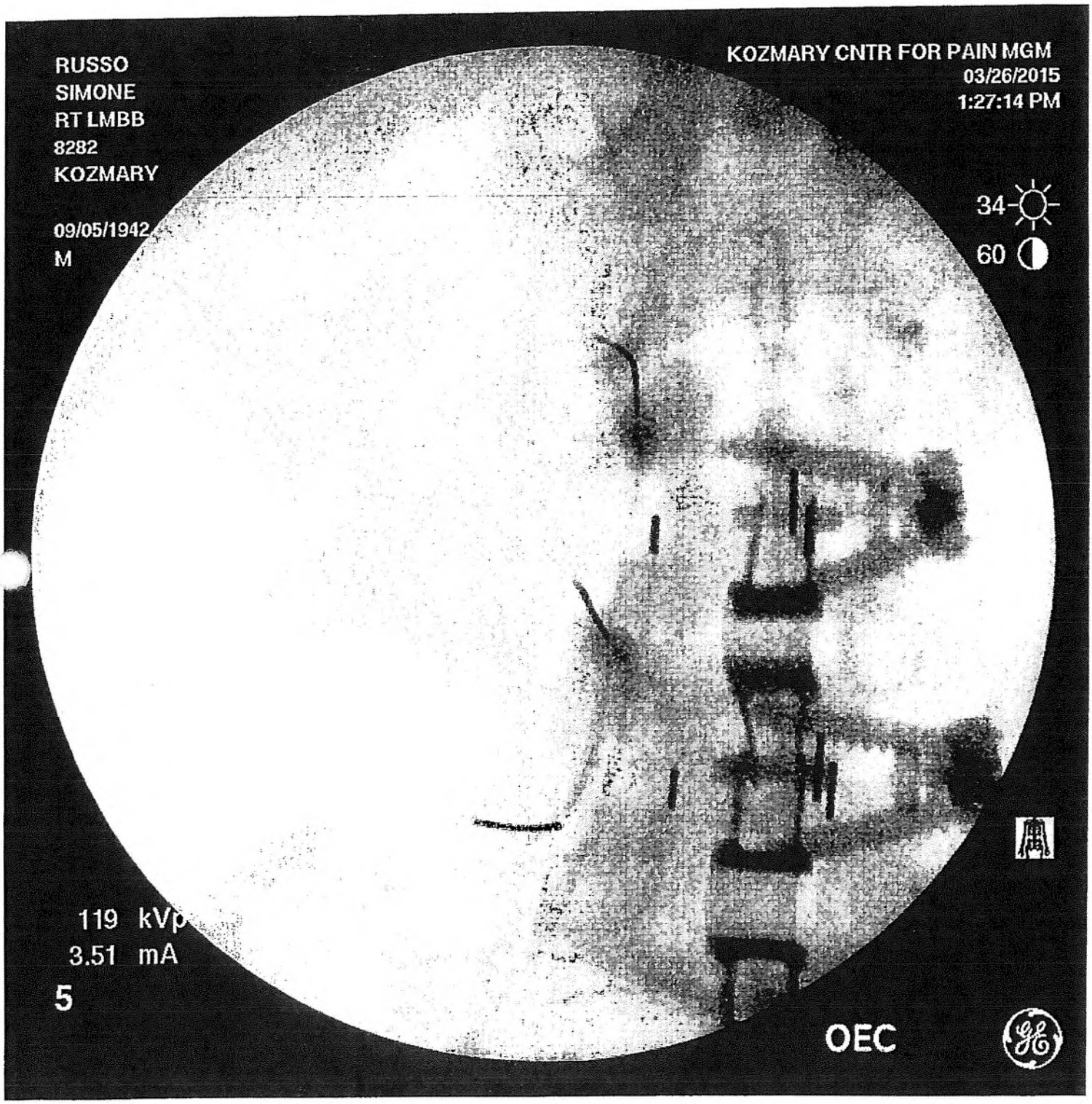
40
57
120 kVp
3.37 mA
4
OEC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03/26/2015
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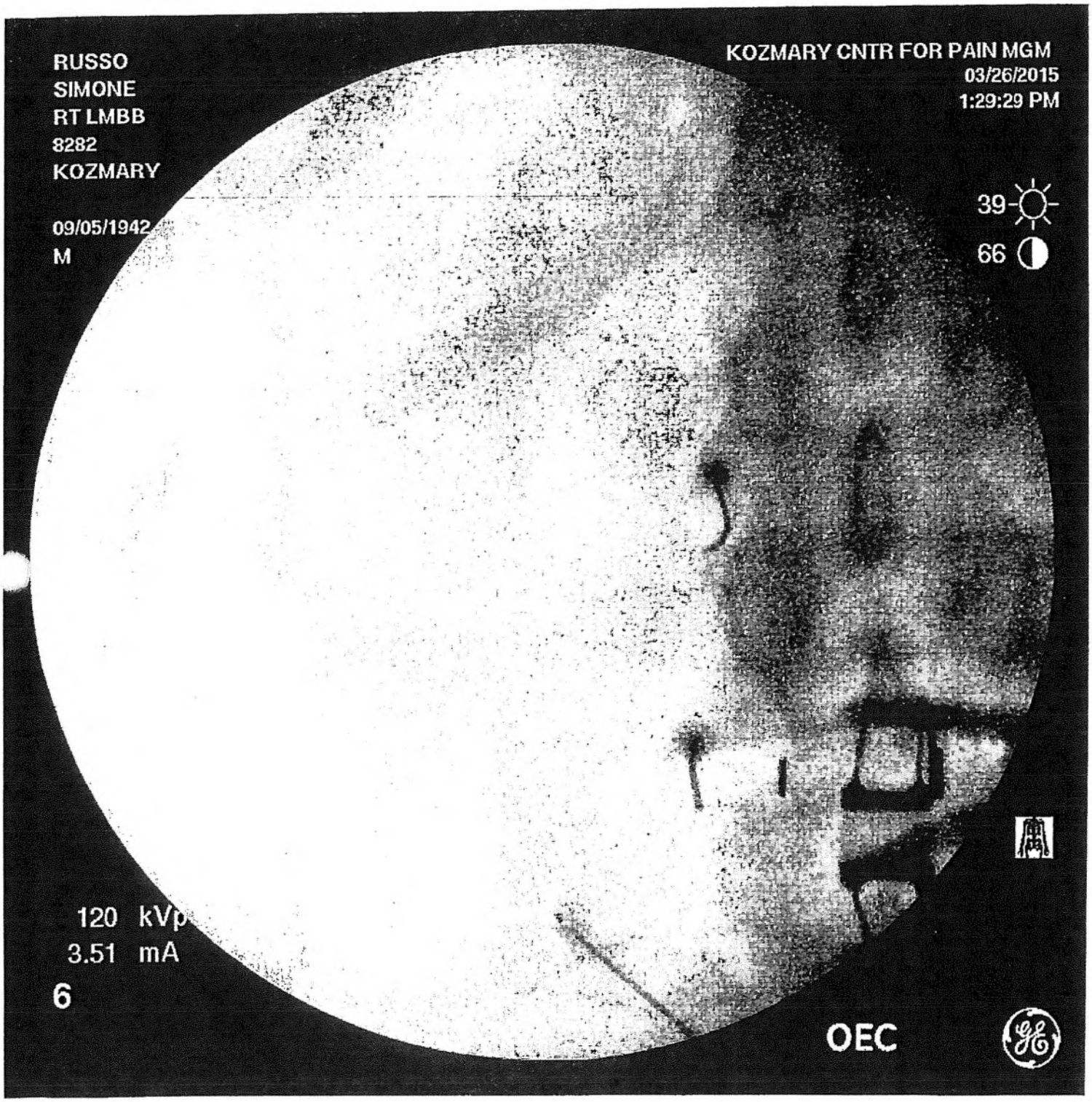
34
60
119 kVp
3.51 mA
5
OEC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09/05/1942
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KOZMARY CNTR FOR PAIN MGM
03/26/2015
1:29:29 PM
39
66
120 kVp
3.51 mA
6
OEC

Kozmary Center for Pain Management

2851 El Camino Ave, Ste 101
Las Vegas, NV 89102
702.380.3210 fax 702.380.3212

Patient Name: Simone Russo
Date: 03/12/2015
Notes: LEFT LMBB L2/3 L3/4 L4/5 L5/S1
Diagnosis:

Location: Kozmary Center for Pain Management

Start Time: 1:28 pm ✓
Finish Time: 1:29 pm ✓
Fluoro Time: :16 ✓

% Relief 100 ✓

Pump Trial Results ___%relief VAS___to___
NStim Trial Results 724.2 ✓
Pump Study Results 721.3 ✓
Comments: _____

Drug	Amount (ml)	Lot#	Expiration
☐ Marcaine 0.5%	4	4509000	9/1/16
☐Betamethasone 6mg/mL	1	410000	9/16
☐Lidocaine 2%	8.5	38-254-DK	2/1/16
☐Omnipaque 300i/mL	1	12422059	5/5/17
☐Other			

RCPM Procedure Record

Date: 03-13-15 Time: 12:38 Initials: TL Allergies Reviewed: ☐Latex ☐Betadine ☐Contrast

Patient Identified: ☑Verbal Procedure/site confirmed and patient verbalizes understanding ☑Yes ☐No N/A

Ride: ☐Yes ☐No Name: Barbara Phone: 702-792-4077

Blood Thinners: ☐Yes ☒No Last dose: _____

☐NSAIDS ☐Aspirin ☐Persantine ☐Pletal ☐Plavix ☐Effient ☐Ticlid ☐Warfarin ☐Pradaxa ☐Xarelto

NPO Since: 8:00 PM LMP: _____ Pregnancy test: _____ Hysterectomy: ☐Yes ☐No

Pain Scale: ☒0-1 ☐2-3 ☐4-5 ☐6-7 ☐8-9 ☐10

Heplock: ☐Yes ☒No

IV site: _____ Size: _____ Started by: _____ Solution _____ Removed by: _____ Site: ☐CDI ☐Red/swollen

Antibiotic: ☐Yes ☐No Drug: ☐Ancef 500mg ☐IV ☐IM Time: _____

B/P: _____ P: _____ R: _____ O2 Sat %: _____

Intra op: Time Start: 1:28 AM/PM Time Ended: 1:29 AM/PM

Procedure: (L) LMBB Position: ☑Prone ☐Supine ☐Sitting ☐(R)Side ☐(L)Side

Grounding Pad Site: _____ ☒N/A Site Condition: ☐CDI ☐Red

O2 @ _____ Via: ☐Nasal Cannula ☐Mask Tolerance of Procedure: ☑Well ☐Fair ☐Poor

Procedure Nurse: Sarah Lindstrom, RN **Radiology Technician:** Carlos Rios

Time: AM/PM	BP	Pulse	O2 Sat %	Time AM/PM	Medication	Site	Initials
1:28	147/89	68	96				
Post op:							
1:29	169/88	68	96				

Discharge: ☑Ambulatory ☐Wheelchair ☐Walker ☐Cane ☐Self ☑With Responsible Adult Verbalizes Understanding: ☑Y ☐N

Pain Level Upon Discharge: 0 Time Discharged: 1:35PM Copy of Discharge Instructions Given To: ☐Patient ☐Responsible Adult

Nurse'sNotes: _____

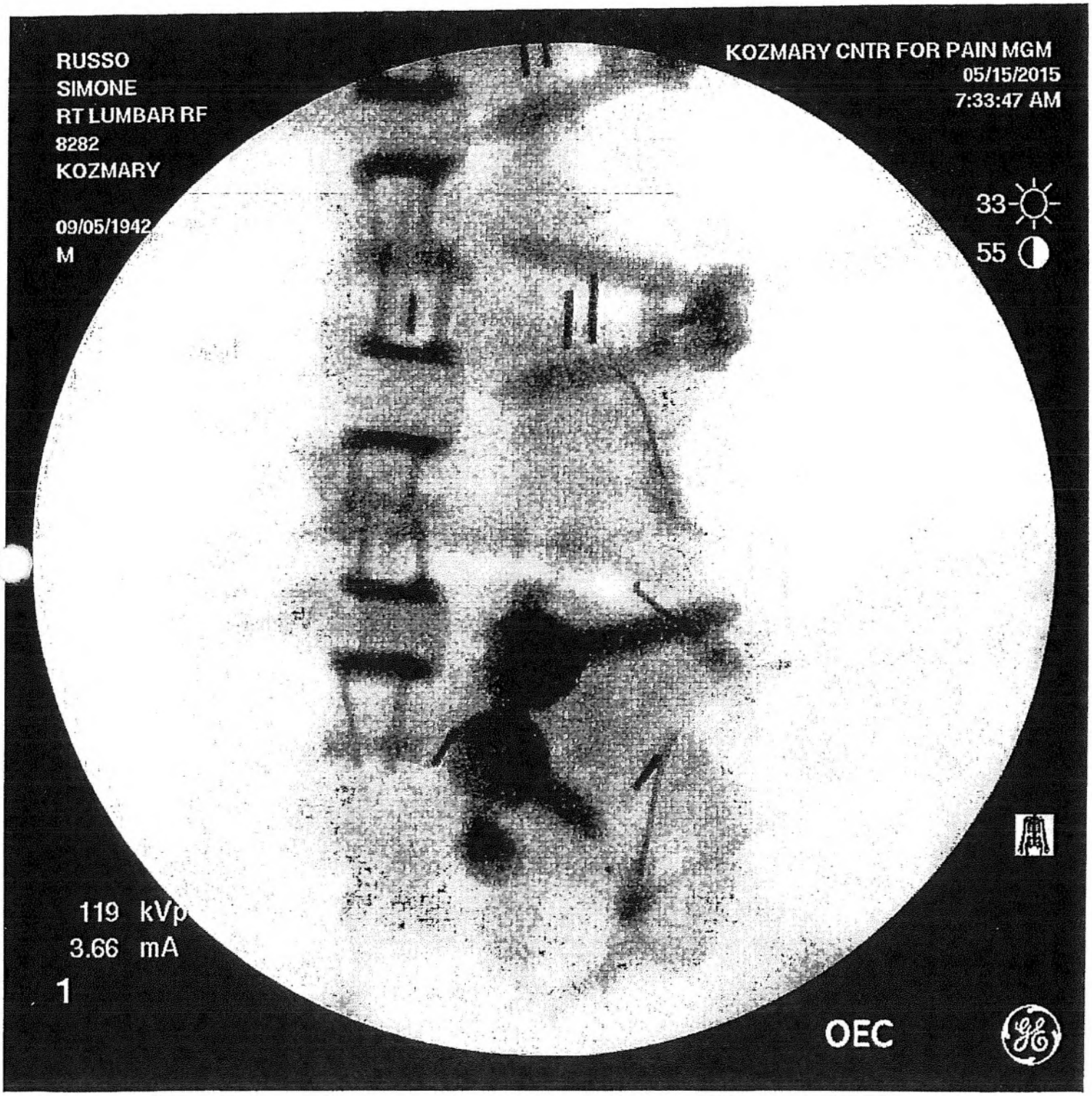
% Improvement 100

Simone F Russo
09/05/1942

Patient Identification

Kozmary Center
Steven V. Kozmary, M.D.
2851 El Camino Ave., Suite 101 • Las Vegas, Nevada 89102

8 Simone Russo		1:00				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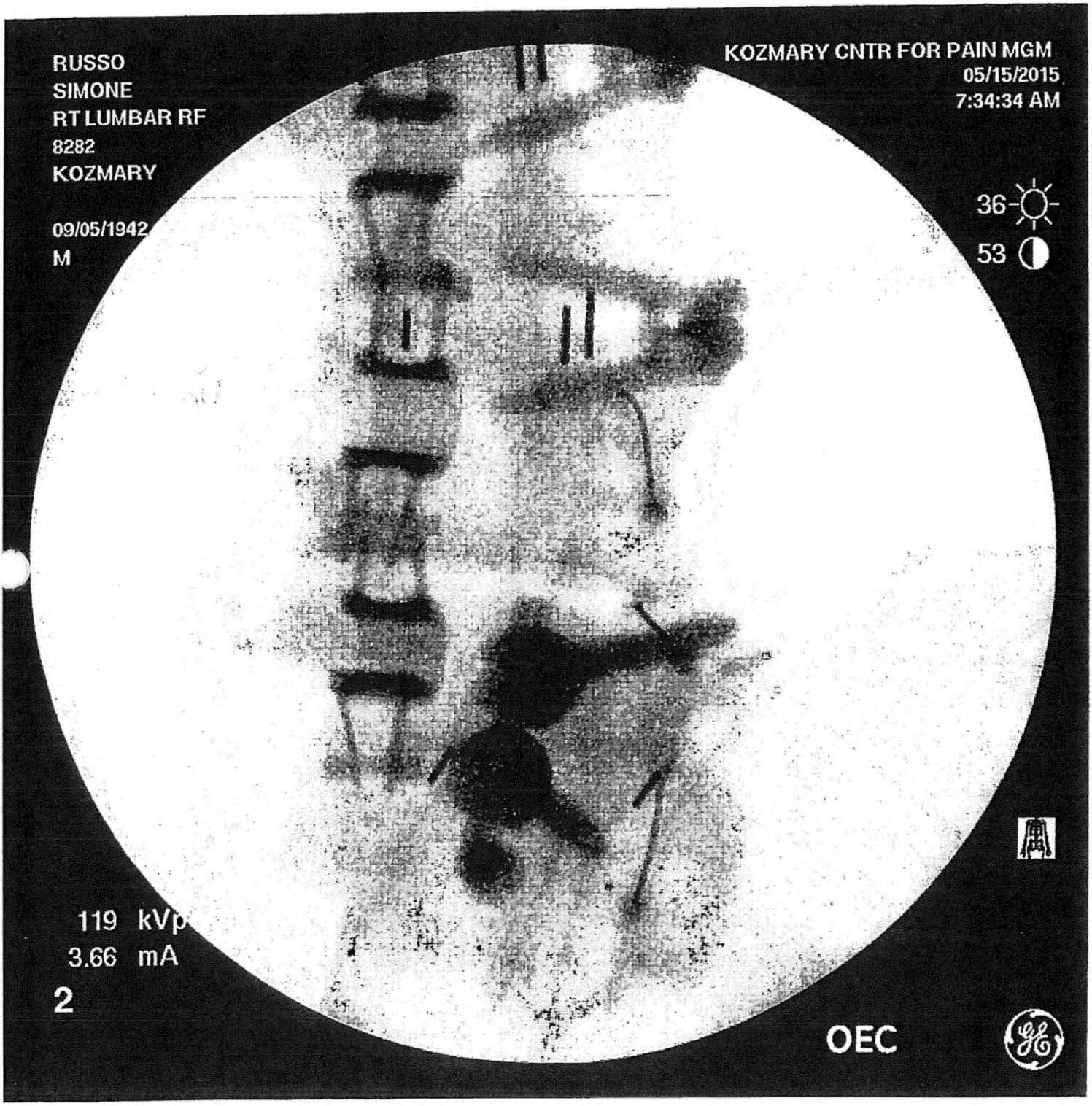
SIMONE
RT LUMBAR RF
8282
KOZMARY
09/05/1942
M
KOZMARY CNTR FOR PAIN MGM
05/15/2015
7:33:47 AM
33
55
119 kVp
3.66 mA
1
OEC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SIMONE
RT LUMBAR RF
8282
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09/05/1942
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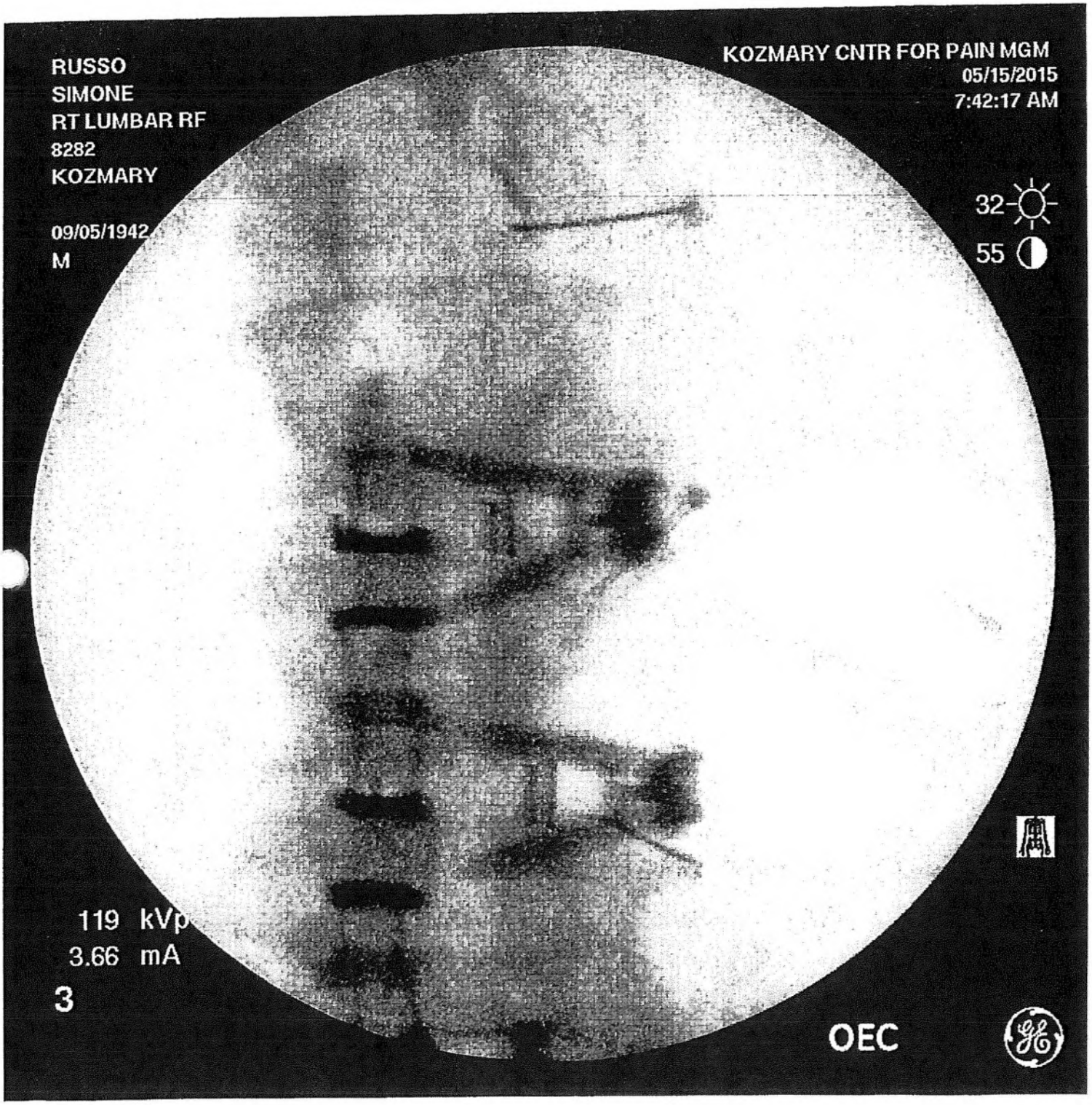
05/15/2015
7:34:34 AM
36
53
119 kVp
3.66 mA
2
OEC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05/15/2015
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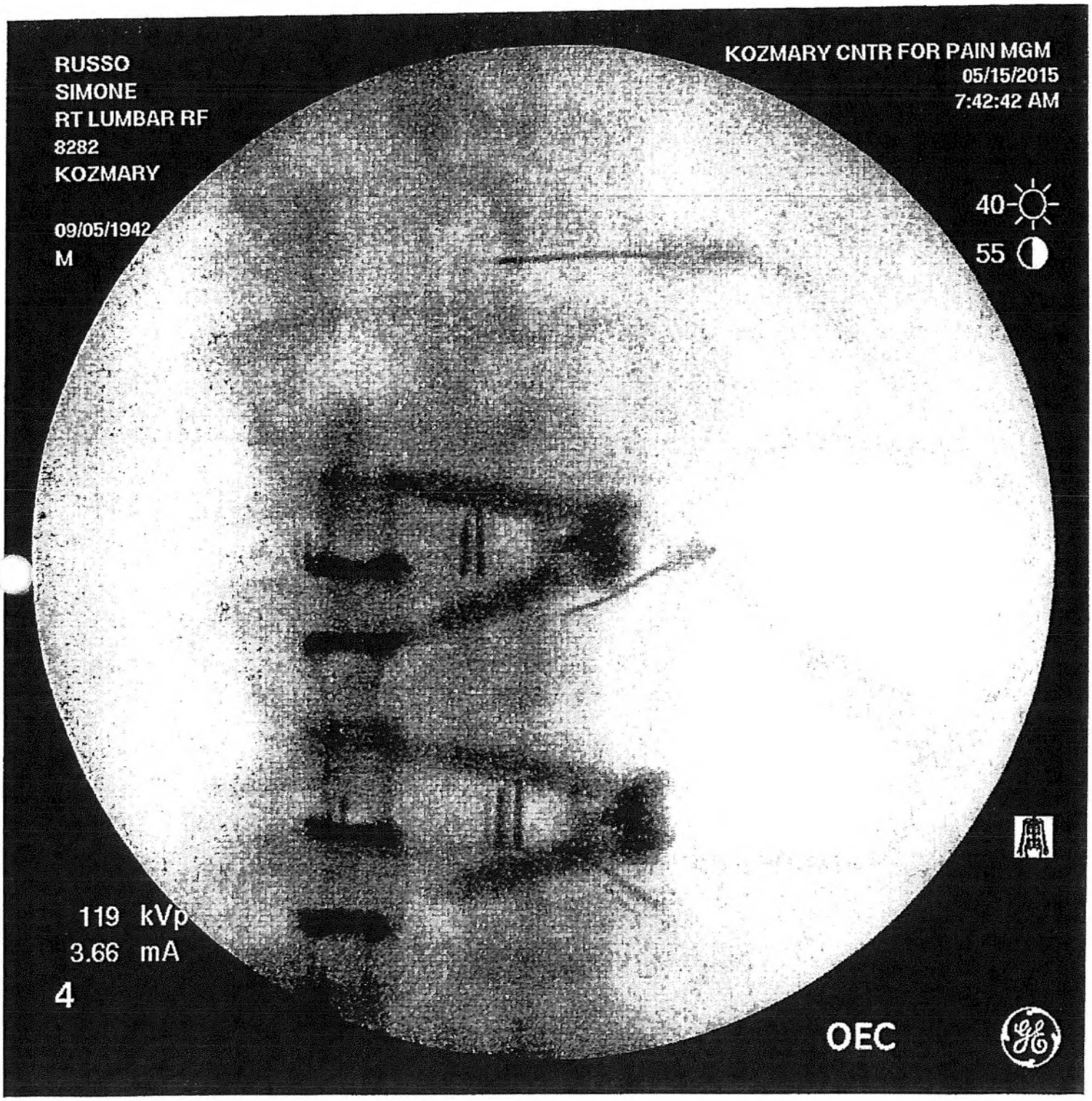
3.66 mA
3
OEC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09/05/1942
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05/15/2015
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119 kVp
3.66 mA
4
OEC