LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

COMMUNICATION LOG

PATIENT NAME: [redacted] [redacted]

DATE/TIME	NOTES
	A few Months ago Carescone blocked my Access to Dr. Margolin office for Pain Management and I'm working 2 Jobs to Support my family. Dr Margolin Carried me for 2 Months to help me out & I believe without his help I would not have been able to make it. I Really appreciate the kindness Dr Margolin & his staff showed me during that time. And It was NOT Fair to Cut Payments to him.
	[redacted]

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

COMMUNICATION LOG

[redacted]

As a patient of Dr margolin [redacted] 2017
Caresource insurance since in [redacted]
I was refused necessary services [redacted]
with everyday activities of life.

Within not receiving care for over 30 days
I have been affected negatively due to
having to wait long period of time
for change of insurance. Now I am
having hardships & having to pay for
meds that I did not before all due
to Caresource refusing payments to
Dr margolin.

This is an unacceptable way to
practice. Blessings to Dr. Margolin
for not dropping as a patient due
to the inconvenience of non payment by
Caresource.
Please rectify the matter

Thank you

[redacted]

PATIENT NAME: [redacted]

DATE/TIME

[redacted]

I'm Rather dismayed with Caresource
I'm having major interruption on
my care, including in my medications
And in ~~y~~ now my injections this
now caused issues with effective
pain control that is beyond the scope
of of control of your my Medical
Provider as Caresource has also
denied service at my compounding pharmacy
I am very concerned about this
I filed a Complaint About Caresource
Once Already. The issue is with Caresource
And their continuing to Restrict access
and deny continuee to pain control
medicine And procedures. My doctor
(Leon Marsolin) has gone above and
beyond to try to help me through
what Caresource has done. I am
very happy with my doctor. I'm
thankful that he's been there for
his staff to help [redacted] when
Caresource keeps denying and
shutting me out of care. What
they do is totally unethical and
illegal. What happed to continuance
of Care?

[redacted]

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

[redacted]

COMMUNICATION LOG

DATE/TIME	NOTES
	[redacted] AM A PATIENT OF DR MARGOLIN AND I HAVE SEVERE LUNG DISEASE AND HAVE OUTHER DISABILITIES I am very UPSET THAT care source QUITE PAYING FOR my DOCTORS APPOINTMENTS AND my DOCTOR WAS NICE ENOUGHT TO ALLOW ME TO LET me BE A PATIENT FOR 2 MOUNTHS WITHOUT PAYMENT Because I HAD PROBLEMS CHanging From care source To MEDICARE
	[redacted]

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

[redacted]

COMMUNICATION LOG

[redacted]

DATE/TIME	NOTES
[redacted]	
	My care with Dr. Margolin is very important to my daily care. I've multiple health issues and it was an issue to switch to another health insurance. It was a hardship on my health to stop treatment in the middle of my treatment plan and have me switch to another. I really appreciate Dr. Margolin for the help I receive but I don't understand why Caresource would just tell him to drop his patients and make us switch in the middle. I had difficulty switch which left me uncovered a few days until the switch could be made. My care with Dr. Margolin was and is good until Caresource stopped paying for my treatments. That wasn't nice to stop payment on treatment for so many people.

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

COMMUNICATION LOG

PATIENT NAME: [redacted]

DATE/TIME	NOTES
[redacted]	With the change of the insurance it was troublesome and a hastle, not only for me but for my doctor as well. For me some medications were covered and some were not. therefore out of pocket expenses had to have been paid for me as well as my doctor, my Physician carried me for 2 months out of pocket, while issues with insurance were (taken care of)
	[redacted]

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

[redacted] COMMUNICATION LOG

DATE/TIME	NOTES
[redacted]	I learned that Care Source stricht me to My Care Ohio plan without my permission and blokt my access to care with Dr Morgolin I think this is not right. [redacted]

Exhibit WW

Ohio drug overdose deaths jumped 26% in a year

BY JUSTIN BOGGS OHIO
PUBLISHED 1:50 PM ET NOV. 17, 2021

OHIO — The state of Ohio saw a 26.6% increase in drug overdose deaths in the 12-month period ending April 2021 compared to the 12-month period ending April 2020, the National Center for Health Statistics reported.

What You Need To Know

- The U.S. had more than 100,000 drug overdose deaths for the first time in a 12-month period, federal officials said
- Nationally, there was an over 28% increase in drug overdose deaths in the one-year period ending April 2021 compared to April 2020
- Ohio had more than a 26% jump in overdose deaths
- Ohio's most populous county Franklin had a noticeable increase in drug overdose deaths, according to federal data

The updated statistics come as federal officials said Wednesday that the number of drug overdose deaths climbed above 100,000 for the first time in the U.S. in a 12-month period.

During the period of May 2020 to April 2021, Ohio had an estimated 5,585 overdose deaths. A year prior, there were 4,410 overdose deaths reported, according to the NCHS.

Drug overdose deaths previously peaked from July 2016 to June 2017 in Ohio. The NCHS estimated there were 5,293 overdose deaths in Ohio from July 2016 through June 2017. After a drop in drug overdose deaths late in 2017 and in 2018, figures began to rise again in 2020.

Nationally, there was a 28.5 rise in drug overdose deaths from May 2020 to April 2021 compared to the prior year, the NCHS reported.

While county-level data has not been released for April 2021, data from prior months show a rise in drug overdose deaths. Franklin County, the state's most populous county, had the most estimated overdose deaths with 852 during the period of April 2020 to March 2021, the National Center for Health Statistics reported.

While most counties in Ohio saw increases in drug overdose deaths, Hamilton County has not seen an increase. The county had a peak of 392 overdose deaths in the 12-month period ending April 2020. In the one-year period ending March 2021, there were an estimated 376 overdose deaths, the NCHS reported.

"Today, new data reveal that our nation has reached a tragic milestone: more than 100,000 lives were lost to the overdose epidemic from April of last year to April of this year," President Joe Biden said in a statement. "As we continue to make strides to defeat the COVID-19 pandemic, we cannot overlook this epidemic of loss, which has touched families and communities across the country."

Experts believe that the prevalence of fentanyl is driving the surge in overdose deaths, as well as the COVID-19 pandemic, which has left many Americans isolated and unable to find support. Synthetic

opioids such as fentanyl accounted for nearly two-thirds of those deaths.

According to the Ohio Department of Health, fentanyl was involved in 76% of overdose deaths in 2019, often in combination with other drugs.

Exhibit XX

Issue brief: Nation's drug-related overdose and death epidemic continues to worsen

***Updated May 12, 2022**

The nation's drug overdose epidemic continues to change and become worse. The epidemic affects every state and now is driven by illicit fentanyl, fentanyl analogs, methamphetamine, and cocaine, often in combination or in adulterated forms. More than 107,000 deaths were reported in the United States between December 2020 to December 2021. The AMA continues to urge policymakers' action to increase access to evidence-based care for substance use disorders, pain and harm reduction measures. The news articles and reports below cite data from multiple and varied sources, including national, state and local public health agencies, law enforcement, emergency medical services, hospitals, treatment centers, and journals. Recent AMA advocacy, resources and recommendations to end the epidemic:

- AMA-Manatt Health 2022 state policy toolkit provides more than 400 specific laws, regulations, policy guidance and other actions being implemented to help reduce mortality and improve outcomes. The toolkit builds on the 2020 AMA-Manatt Health national policy roadmap use of best practices to increase access to evidence-based care for mental illness, substance use disorders, comprehensive pain care and harm reduction initiatives.
- The U.S. Centers for Disease Control and Prevention on February 10, 2022, released a draft revision to its 2016 opioid prescribing guideline. In comments to the Federal Register on April 11, 2022, the AMA said that the CDC's new draft guideline—if followed by policymakers, health insurance companies and pharmacy chains—provides a path to remove arbitrary prescribing thresholds, restore balance and support comprehensive, compassionate care.
- AMA letter urging Congress to hold health plans accountable for nearly 15 years of failures in complying with the 2008 Mental Health Parity And Equity Addiction Act.
- AMA comments on Biden Administration's 2022 National Drug Control Strategy. Reduce barriers to medications to treat substance use disorders; broaden access to a wide range of harm reduction services, including naloxone, sterile needle and syringe exchange services, and drug checking supplies; require all health insurance programs to remove arbitrary restrictions for care for patients with pain; and take steps to develop and support a national, standardized reporting system for key metrics related to drug use. July 2021.
- Recommendations from the AMA Substance Use and Pain Care Task Force and AMA 2021 Overdose Epidemic national report Updated recommendations that highlight physicians' actions as well as additional steps that must be taken to have a meaningful impact on reducing drug-related mortality and improving patient outcomes. September 2021
- AMA issue brief on key considerations for employers during the drug overdose epidemic. This includes reviewing benefit plans for patients and families with substance use disorders, mental illness and/or pain; promoting harm reduction at work; and reducing stigma.

See below for national news and other reports from all 50 states and the District of Columbia.

For more information, please contact Daniel Blaney-Koen, JD, Senior Legislative Attorney, AMA Advocacy Resource Center, at daniel.blaney-koen@ama-assn.org

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https://www.newsdakota.com/2020/03/10/drug-overdose-death-raises-concerns-in-the-area/ March 10, 2020

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- **Opioid crackdown had 'tremendous fallout,' with more suicides, drug overdoses among patients, lawmakers told.** https://tulsaworld.com/news/state-and-regional/govt-and-politics/opioid-crackdown-had-tremendous-fallout-with-more-suicides-drug-overdoses-among-patients-lawmakers-told/article_ae3ff49e-3b2d-11ec-b2e3-b74d9a33a2b9.html November 2, 2021
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Exhibit YY



News Releases

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Record Surges in Opioid Overdoses Prompts AG Yost to Urge Vigilance

1/11/2021

(COLUMBUS, Ohio) — More Ohioans died of an opioid overdose during a three-month period last year than at any time since the epidemic began, according to an analysis by a task force created by Ohio Attorney General Dave Yost.

The analysis by Yost's Scientific Committee on Opioid Prevention and Education (SCOPE) found the death rate in Ohio from opioid overdose at 11.01 per 100,000 population in the second quarter of 2020 – the highest rate in 10 years. The previous 10-year high was in the first quarter of 2017 at 10.87 opioid overdoses per 100,000 population.

"Opioid overdoses might have taken a backseat in our minds last year because of COVID-19, but make no mistake: Ohioans are dying at a devastating rate because of opioid overdoses," Yost said, urging vigilance about how prescription drugs are stored and encouraging people to seek medical care in the event of an overdose – despite concerns about COVID-19.

Surprisingly, the record-setting spike came after Ohio experienced a significant drop in its opioid-related death rate, which had fallen to between 6 and 8 overdose deaths per 100,000 people over the prior 24-month period.

"This is alarming data, and while COVID has rightly captured our attention, we cannot lose sight of the threat the opioid epidemic brings to all areas of Ohio," Yost said.

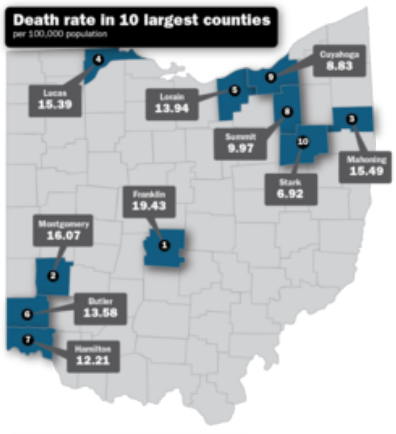
The hardest hit counties in the second quarter of 2020 were Scioto (35.22), Fayette (20.67) and Franklin (19.43).

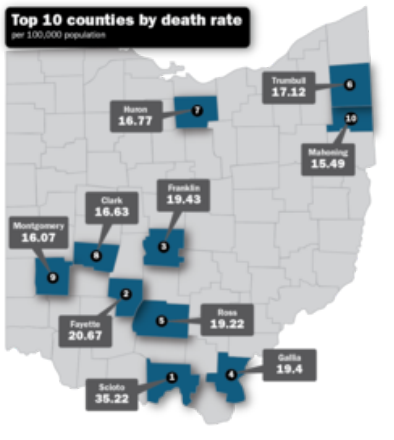
The analysis, which found an increase of deaths in 67 percent of Ohio's counties, can be found here.

The data is gathered by the Ohio Department of Health, which collects opioid overdose numbers. The data may lag by up to six months.

Addiction to opioids can start with a prescription being brought inside the home. Yost's office has released guidelines on how to safely store prescription drugs inside your residence.

Unsure about the signs of opioid abuse or addiction? More info can be found here.





MEDIA CONTACT:
Luke Sullican: 614-270-2662

-30-

SHARE

Exhibit ZZ

United States Senate

WASHINGTON, DC 20510

March 1, 2018

Pamela B. Morris
President & Chief Executive Officer
CareSource
230 North Main Street
Dayton, Ohio 45402

Dear Ms. Morris:

We write to share our concern over the reported utilization of several industry practices that, when used in the context of pain management and substance use disorder treatment and recovery, may be counterproductive to efforts to address our nation's opioid epidemic. We urge you to reexamine CareSource's current policies and procedures to identify and, more importantly, rectify, any practices that could be contributing to or exacerbating our country's drug addiction crisis.

Our country continues to fight back against the worst drug overdose epidemic in its history. According to the Centers for Disease Control and Prevention (CDC), drug overdoses accounted for more than 63,600 deaths in 2016 – an average of 174 drug overdose deaths per day. These tragedies are not limited to one group of individuals; rather, deaths resulting from drug overdose continue to increase across all populations – men and women, young and old, urban and rural, and across all races. And the cost of this epidemic extends beyond the loss of human lives – according to a recent economic analysis conducted by the Council of Economic Advisors, the economic impact of this addiction crisis represents a loss of nearly $504 billion annually, a number roughly equivalent to three percent of the entire country's gross domestic product (GDP). Without additional investments and changes to the status quo, these numbers will only continue to increase at an exponential rate.

Despite these devastating statistics, the pain that drives many individuals to these addictive drugs in the first place remains a problem. A 2015 analysis by the National Institutes of Health (NIH) estimated that more than 25 million adults experience chronic pain and nearly 40 million adults experience severe levels of pain. These numbers will only continue to increase as our nation grows older. In order to make progress in our nation's fight against the addiction epidemic, we must do more to ensure all Americans – whether they are suffering from chronic or acute pain – have access to non-addictive pain management options.

Unfortunately, it is often much harder for an individual to seek non-addictive pain medications or non-pharmacologic treatment options at the outset of treatment than it is to get a prescription opioid. We understand that there are many reasons for this, including restrictions on benefit design, the high cost of alternative pain treatments, the limited availability and effectiveness of clinically proven alternatives, a lack of clinician awareness regarding alternatives, and ingrained prescribing practices. However, it is important to note that opioid prescribing decisions are not governed solely by clinicians. Health insurance coverage policies play a significant role when it comes to accessing non-addictive pain treatment options, which is why we are urging CareSource to look into its benefit design and internal practices and take a more active role as it relates to preventing and treating addiction. If a clinician chooses to prescribe a non-addictive therapy to treat chronic pain, which is simply overridden by an insurance algorithm that defaults to the cheapest opioid alternative, an opportunity to turn the tide against addiction may be missed.

Recent news reports have raised serious concerns over a lack of insurer accountability when it comes to this epidemic. Take Ms. Lauren Kafka, for example. Ms. Kafka recently wrote about her experience recovering from surgery to correct a torn rotator cuff.[1] Her surgeon and two separate physical therapists recommended renting a cool-therapy device to help manage her pain throughout her recovery. Coverage for this device was denied by her insurance plan, leaving Ms. Kafka with two options: (1) pay out-of-pocket for the device rental; or (2) resort to the opioid painkillers covered by her insurance. Ms. Kafka made the decision to try to take the minimum number of pills necessary to aid in her recovery, and while she was able to pay out-of-pocket for the device rental fees to help decrease her dependence on opioids throughout her recovery, others in her situation may opt to elect only the covered drugs and find themselves at a higher risk for dependence.

Ms. Alisa Erkes, a patient with chronic abdominal pain, was forced to switch from using Butrans, a pre-dosed buprenorphine painkiller patch, to morphine when her insurance provider stopped covering the patch.[2] Though both buprenorphine and morphine are opioids, morphine is categorized as having a higher risk of abuse, dependence, and overdose. Similarly, Ms. Amanda Jantzi, a patient with a painful bladder condition, weaned herself off opioids using the non-opioid painkiller drug Lyrica, only to find that it was not covered by her new insurance policy when she switched employers.[3] While we recognize that Lyrica remains an expensive option with its own set of risks, this example highlights how substituting a traditional opioid may not always be appropriate in circumstances where another option may exist – whether it be pharmacologic or non-pharmacologic. In each of these examples, despite the efforts by both patients and providers to seek out non-addictive pain management options, it was the default policies of the insurers that dictated the available therapy – pushing each individual toward the cheapest and easiest fix: a potentially addictive opioid. Whenever possible, non-addictive options and drugs with a lower risk of addiction and/or abuse should be utilized.

An insurance policy's benefit design may also hinder access to non-pharmacological, or nondrug, pain management alternatives, which can provide valuable support and relief for patients in lieu of narcotics. Mr. Douglas Scott is one such patient who experienced opioid dependence following back and spine injuries from two car accidents.[4] Luckily, Mr. Scott's insurance covered treatment at a local clinic specializing in alternative pain management techniques, and he was able to be successfully weaned off of opioids. Evidence has shown that patients participating in such comprehensive pain rehabilitation programs can experience significant and sustained improvement in pain severity and functioning.[5] Unlike Mr. Scott, however, not all patients have coverage for such programs, which can cost upwards of $20,000; and we encourage CareSource to explore such options and offer them to beneficiaries where clinically appropriate.

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[1] https://www.npr.org/sections/health-shots/2017/11/25/566032620/the-insurance-company-paid-for-opioids-but-not-cold-therapy
[2] https://www.nytimes.com/2017/09/17/health/opioid-painkillers-insurance-companies.html?_r=0
[3] https://www.nytimes.com/2017/09/17/health/opioid-painkillers-insurance-companies.html?_r=0
[4] https://www.nytimes.com/2016/06/23/business/new-ways-to-treat-pain-without-opioids-meet-resistance.html
[5] https://insights.ovid.com/pubmed?pmid=18804915

Lastly, we note reports that some insurance coverage plans appear to act as a barrier to accessing medication-assisted treatment (MAT) for individuals who are working to overcome addiction. Medical necessity requirements, high deductibles and copayments, prior authorization rules, and low reimbursement rates can delay and deter treatment, despite the wealth of evidence demonstrating the effectiveness of MAT. Furthermore, insurers that do cover MAT seldom cover all three Food and Drug Administration (FDA)-approved medications - methadone, buprenorphine and naltrexone – which are not interchangeable in their indications and uses. Similar hurdles exist for access to residential rehabilitation centers and detox facilities, for which insurers will often require "medical necessity" before covering care.

For example, Mr. Sean Mattos, a patient struggling with addiction, unsuccessfully went through two outpatient addiction programs before entering a residential facility, only to find that his insurer would not cover the full duration of treatment he required.[6] Despite agreement by his overseeing clinicians that he was not ready to leave the facility, Mr. Mattos was forced to call his insurer while in treatment to request coverage to remain under the facility's care, before ultimately paying $8000 of the $23,000 bill out of pocket. In response to such unfortunate situations and a desire to remedy them, we appreciate that multiple major insurers have recently lifted their prior authorization requirements for MAT – a step forward in reducing barriers to care. However, such efforts must be replicated and expanded across the industry in order for them to make a meaningful difference.

While we appreciate the work CareSource is already doing to help address this epidemic, and we are encouraged by recent industry led efforts to reevaluate some policies in light of the addiction epidemic, we remain concerned by the rules and authorization requirements that may be employed by insurance companies that could potentially limit beneficiary access to non-addictive and alternative pain management options as well as addiction treatment options. In order to effectively address this ongoing epidemic, we believe insurance companies must take additional steps to ensure they are playing a more active role in addiction prevention and treatment and providing beneficiaries full access to the range of clinically appropriate services available. Eliminating cost-sharing requirements for overdose reversal drugs is not enough. Insurer policies such as prior authorization, drug tiering, abrupt formulary changes, preferred pricing lists, restrictions or additional cost-sharing requirements for non-pharmaceutical interventions, lengthy and burdensome appeals process, and other clinician incentives can be insurance tools that, when used improperly, may harm efforts to combat addiction and should be reviewed to avoid furthering the current epidemic.

It is time for insurance industry leaders like CareSource to reexamine these policies in light of the substance/opioid use disorder and update your coverage policies in a way that maximizes the accessibility and affordability of a wide range of safe alternatives to narcotics. The insurance industry is on the front line of this epidemic, and we need your help identifying what policies are working and what barriers to less-addictive pain treatment options and substance use disorder treatments exist.

[6] http://www.modernhealthcare.com/special/opioid-addiction

Recognizing there is a difference in the way insurers are able to design their benefits across commercial, Medicare, and Medicaid books of business, we respectfully request that you respond to the following questions by March 30, 2018:

1. What internal policies and procedures does CareSource have in place that may create a barrier to accessing affordable non-addictive or less addictive pain treatments, including those that are non-pharmacological?

2. What flexibilities does CareSource offer to ensure that individuals struggling with acute or chronic pain receive the least addictive pain treatment option, in a timely manner?

3. What internal policies and procedures does CareSource have in place that may create a barrier to accessing affordable options for medication-assisted treatment and other behavioral therapy options for addicted individuals?

4. What flexibilities does CareSource offer to ensure that individuals struggling with substance use disorder receive the proper treatment, in a timely manner?

5. What non-pharmacological alternative pain therapies, such as acupuncture, does CareSource offer to beneficiaries? Do alternative pain therapy options vary by benefit design? If so, are there any barriers or restrictions preventing the use of alternative or innovative pain therapy options in federal programs, such as Medicare or Medicaid?

6. How often does CareSource review and update its list of approved pain management options and services, both pharmacological and non-pharmacological? As less addictive treatment options become available, how quickly are you able to cover them?

7. How often does CareSource review and update its list of approved addiction treatment options and services, both pharmacological and non-pharmacological? As additional substance use disorder treatments become available, how quickly are you able to cover them?

8. Does CareSource have a fail-first, stepped, or medical necessity standard for non-addictive, including non-pharmacological, or abuse-deterrent options for pain management?

9. Does CareSource have a fail-first or medical necessity standard for medication-assisted treatment or other behavioral therapy options for individuals who have a substance use disorder?

10. When reviewing coverage appeals from beneficiaries, members, or providers, at what level of appeal does CareSource implement a clinician review? How quickly are appeals escalated for individuals struggling with severe pain needs? How quickly are appeals escalated for individuals struggling with access to addiction services?

11. When it comes to opioids and other controlled substances, does CareSource implement a unique set of internal policies or controls?

12. What is the typical difference, if any, in cost-sharing for members/beneficiaries using non-addictive, including non-pharmacological pain management approaches vs. potentially addictive therapies?

13. What are the typical cost-sharing amounts for members/beneficiaries using medication-assisted treatment options or other behavioral therapy options offered by CareSource? Are any addiction treatment options offered to beneficiaries without cost-sharing requirements?

14. Does CareSource cover all three medication-assisted treatment drug options (methadone, buprenorphine and naltrexone) and if not, what is the rationale for exclusion?

15. How does CareSource identify individual members/beneficiaries who may already be struggling with substance use disorder? Are any policies or procedures waived for these individuals when it comes to accessing alternative options for pain management?

16. Is it your belief that all of CareSource's internal policies and procedures live up to both the letter and the spirit of the *Mental Health Parity Act*, as intended by Congress?

17. Recognizing there are always ways to improve these processes, are there other plan designs or benefit flexibilities you could implement to improve access to less addictive pain management options or the full range of treatment options?

18. Are there any additional factors that Congress should be aware of as it considers the nation's substance abuse/opioid crisis?

It is critical that we ensure access to clinically appropriate, non-addictive pain management options for all Americans across all payers as well as comprehensive coverage for the full range of addiction treatment services, from medication-assisted treatment options to inpatient and outpatient therapy.

Thank you for your attention to this matter. We look forward to working with you on policies that will make it as easy for an individual to access addiction treatment and non-addictive remedies for pain as it is for them to access opioids in the first place.

Sincerely,

Sherrod Brown
United States Senator

Edward J. Markey
United States Senator

Jeanne Shaheen
United States Senator

Tammy Baldwin
United States Senator

Margaret Wood Hassan
United States Senator

Sheldon Whitehouse
United States Senator

Chris Van Hollen
United States Senator

Richard Blumenthal
United States Senator

Cory A. Booker
United States Senator

Christopher Murphy
United States Senator

Tim Kaine
United States Senator

Patrick J. Leahy
United States Senator

Angus S. King, Jr.
United States Senator

Dianne Feinstein
United States Senator

Elizabeth Warren
United States Senator

Exhibit AAA

Civil Investigative Demand – Documentary Material

United States Department of Justice

Washington, D.C. 20530

TO: Leon Margolin, M.D.
5245 E. Main St.
Columbus, Ohio 43213

Civil Investigative
Demand No. 18-20

This Civil Investigative Demand is issued pursuant to the False Claims Act, 31 U.S.C. §§ 3729-3733, in the course of a False Claims Act investigation to determine whether there is or has been a violation of 31 U.S.C. § 3729. The False Claims Act investigation concerns whether Leon Margolin and Comprehensive Pain Management Institute violated the False Claims Act by knowingly submitting or causing to be submitted false claims to Medicare for nerve conduction studies and other procedures that were medically unnecessary.

This Demand requires Margolin (referred to throughout as "you") to provide documents to the Federal Government. This is the original of the Demand; no copies have been served on other parties. The information provided in response to this Demand may be shared, used, and disclosed as provided by 31 U.S.C. § 3733.

In accordance with the Definitions and Instructions set forth in Attachment A and the format specifications in Attachment C, you are required by this Demand to produce any and all of the following documents in your possession, custody or control requested in Attachment B. You must make this material available to Christopher Wilson, who has been designated as a False Claims Act custodian in this case. He may be reached at (614) 255-1630, if you have questions. These documents shall be produced no later than thirty (30) days from receipt of this Demand, at 5245 E. Main St., Columbus, Ohio 43213, or at another location to be mutually agreed upon by you and the False Claims Act custodians. The production of documentary material in response to this Demand must be made under a sworn certificate in the form printed in this Demand.

Issued at Washington, D.C., this 5th day of January, 2017.

Michael D. Granston /da
Michael D. Granston
Director
Commercial Litigation Branch

Exhibit BBB

Behavioral Health Care: Integrated



In this new era of health care CareSource is positioned to support you, our trusted partners, in delivering integrated health care to our members. CareSource believes that health care outcomes are improved if treatment is grounded in a strong relationship between patient and physician. And we know that good health means more than just taking care of physical needs.

Preventive and Comprehensive Care

At CareSource we are committed to a comprehensive, community-based health approach for our membership through strong collaboration and partnerships. Just as preventive screening for heart disease or diabetes is customary, diagnostic assessments for early detection of substance use disorder is critical to mitigate the more drastic effects on an individual's physical, behavioral, and psychosocial health. SBIRT, or Screening, Brief Intervention, and Referral to Treatment, treats behavioral health with the same importance as physical health.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

What is SBIRT?

Screening: Assessing a patient for risky substance use behaviors using standardized screening tools

Brief Intervention: Engaging a patient showing risky substance use behaviors in a short conversation, providing feedback and advice; and

Referral to Treatment: Providing a referral to brief therapy or additional treatment to patients who screen in need of additional services.

Recently Ohio has identified Medicaid payable codes* for you to bill and be reimbursed for SBIRT services.

HCPCS Code	Descriptor
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g. AUDIT, DAST), and brief intervention 15 to 30 minutes
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g. AUDIT, DAST), and intervention, greater than 30 minutes

*Advance Practice Nurses, Physicians, Physician Assistants and SBIRT provided in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are eligible for reimbursement under Ohio Medicaid.

ADDITIONAL BEHAVIORAL HEALTH AND CARE MANAGEMENT SERVICES

Health Home – CareSource is a key member of the Health Home team in Ohio. Our goal is to strengthen the communication with you and enhance care coordination to ease service delivery and improve the lives of our membership.

Community Behavioral Health Care Coordinator (CBHCC) – This role was developed with you, our providers, in mind. The goal of the CBHCC is to reduce your workload and establish a single point of contact to collectively serve our shared member.

Care Transitions – CareSource prides itself in working to facilitate smooth transitions between various care systems and the home. This helps reduce the member's burden of navigating the complex health care system and enables them to focus on their well-being.

Behavioral Health 7-Day Post Discharge Follow-Up – Behavioral Health nurses reach out to members to coordinate post discharge care, medications, and access to Community Mental Health Centers (CMHC). Our aim is to decrease psychiatric readmissions and avoid unnecessary Emergency Room visits.

Behavioral Health Provider Inpatient – CareSource Behavioral Health representatives notify you of a shared member's hospital admission and assist with post discharge follow-up appointments. Our strong community partners and established ties with Community Mental Health Centers ensure the proper transitions and support network for our members.

CareSource24® Nurse Advice Line – This 24-hour nurse triage line provides an avenue for members to speak with a registered nurse at any time about health concerns and be directed to an appropriate level of care or supported with health education.

Medication Therapy Management (MTM) – Designed to help ensure members are taking the most effective medications, CareSource aims to increase understanding of safe medication use and engage members with their local pharmacist.

Care4U Case Management – This program manages care by focusing on the multifaceted, chronic and relapsing nature of substance use disorders. A community-based approach is used and addresses physical, behavioral, psychosocial and safety concerns.

Coordinated Services Program (CSP) – In the CSP, select Ohio Medicaid consumers are limited to the use of one pharmacy and receiving medical services through their primary care physician.

CareSource Transportation Assistance – CareSource provides help to members who have transportation needs to various medical appointments. This is one less barrier for your patient to overcome.

For more information:
1-855-708-4840
OhioBHInfo@CareSource.com

CareSource™
Health Care with Heart

CareSource.com

ACCREDITED
HEALTH PLAN (for Medicaid)
HEALTH CALL CENTER

January 2014

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OH-P-814

Exhibit CCC

SETTLEMENT AGREEMENT

This Settlement Agreement ("Agreement") is entered into among the United States of America, acting through the United States Department of Justice and on behalf of the Office of Inspector General (OIG-HHS) of the Department of Health and Human Services (HHS) (collectively, the "United States"), and Leon Margolin, M.D. and Comprehensive Pain Management Institute, LLC (CPMI) (together, Defendants) (hereafter collectively referred to as "the Parties"), through their authorized representatives.

RECITALS

A. Leon Margolin is an interventional pain physician in Columbus, Ohio. He owns and operates CPMI. Margolin performs a variety of pain management and diagnostic procedures, including nerve conduction studies (NCS) and alcohol/substance abuse structured assessments and brief interventions of 30 minutes of longer, under code G0397 (referred to below as, "SBIRT").

B. The United States contends that Margolin submitted or caused to be submitted claims for payment to the Medicare Program, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395lll ("Medicare").

C. The United States contends that it has certain civil claims against Defendants arising from their knowingly submitting, or causing to be submitted, false claims to Medicare during the period from January 1, 2013 through September 19, 2019 for: (1) NCS that were medically unnecessary because the patients did not need them and/or the studies were performed without electromyography, and (2) SBIRTs that were medically unnecessary and/or not provided as billed. That conduct is referred to below as the "Covered Conduct."

D. This Settlement Agreement is neither an admission of liability by Defendants nor a concession by the United States that its claims are not well founded.

To avoid the delay, uncertainty, inconvenience, and expense of protracted litigation of the above claims, and in consideration of the mutual promises and obligations of this Settlement Agreement, the Parties agree and covenant as follows:

TERMS AND CONDITIONS

1. Defendants shall pay to the United States $650,000 ("Settlement Amount") plus interest at a rate of 1.75 percent *per annum* from January 1, 2020, of which $325,849.00 is restitution. Defendants shall pay $450,000 of the total Settlement Amount no later than ten days after the Effective Date of this Agreement and shall pay the remaining $200,000 plus interest within four months of the Effective Date of this Agreement. Defendants shall make these payments by check pursuant to written instructions to be provided by the Civil Division of the United States Department of Justice.

2. Subject to the exceptions in Paragraph 3 (concerning excluded claims) below, and conditioned upon Defendants' full payment of the Settlement Amount, the United States releases Defendants, together with CPMI's current and former parent corporations; direct and indirect subsidiaries; brother or sister corporations; divisions; current or former corporate owners; and the corporate successors and assigns of any of them, from any civil or administrative monetary claim the United States has for the Covered Conduct under the False Claims Act, 31 U.S.C. §§ 3729-3733; the Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a; the Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801-3812; or the common law theories of payment by mistake, unjust enrichment, and fraud.

3. Notwithstanding the release given in Paragraph 2 of this Agreement, or any other term of this Agreement, the following claims of the United States are specifically reserved and are not released:

a. Any liability arising under Title 26, U.S. Code (Internal Revenue Code);

b. Any criminal liability;

c. Except as explicitly stated in this Agreement, any administrative liability, including mandatory or permissive exclusion from Federal health care programs;

d. Any liability to the United States (or its agencies) for any conduct other than the Covered Conduct;

e. Any liability based upon obligations created by this Agreement;

f. Except as explicitly stated in this Agreement, any liability of individuals; and

g. Any liability for personal injury or property damage or for other consequential damages arising from the Covered Conduct.

4. Defendants waive and shall not assert any defenses Defendants may have to any criminal prosecution or administrative action relating to the Covered Conduct that may be based in whole or in part on a contention that, under the Double Jeopardy Clause in the Fifth Amendment of the Constitution, or under the Excessive Fines Clause in the Eighth Amendment of the Constitution, this Agreement bars a remedy sought in such criminal prosecution or administrative action.

5. Defendants fully and finally release the United States, its agencies, officers, agents, employees, and servants, from any claims (including attorney's fees, costs, and expenses of every kind and however denominated) that Defendants have asserted, could have asserted, or may assert in the future against the United States, and its agencies, officers, agents, employees, and servants related to the Covered Conduct and the United States' investigation and prosecution thereof.

6. The Settlement Amount shall not be decreased as a result of the denial of claims for payment now being withheld from payment by any Medicare contractor (e.g., Medicare Administrative Contractor, fiscal intermediary, carrier) or any state payer, related to the Covered Conduct; and Defendants agree not to resubmit to any Medicare contractor or any state payer any previously denied claims related to the Covered Conduct, agree not to appeal any such denials of claims, and agree to withdraw any such pending appeals.

7. Defendants agree to the following:

a. Unallowable Costs Defined: All costs (as defined in the Federal Acquisition Regulation, 48 C.F.R. § 31.205-47; and in Titles XVIII and XIX of the Social Security Act, 42 U.S.C. §§ 1395-1395lll and 1396-1396w-5; and the regulations and official program directives promulgated thereunder) incurred by or on behalf of Defendants, including CPMI's present or former officers, directors, employees, shareholders, and agents in connection with:

(1) the matters covered by this Agreement;

(2) the United States' audit(s) and civil investigation(s) of the matters covered by this Agreement;

(3) Defendants' investigation, defense, and corrective actions undertaken in response to the United States' audit(s) and civil investigation(s) in connection with the matters covered by this Agreement (including attorney's fees);

(4) the negotiation and performance of this Agreement; and

(5) the payments Defendants make to the United States pursuant to this Agreement

are unallowable costs for government contracting purposes and under the Medicare Program, Medicaid Program, TRICARE Program, and Federal Employees Health Benefits Program (FEHBP) (hereinafter referred to as Unallowable Costs).

b. Future Treatment of Unallowable Costs: Unallowable Costs shall be separately determined and accounted for by Defendants, and Defendants shall not charge such Unallowable Costs directly or indirectly to any contracts with the United States or any State Medicaid program, or seek payment for such Unallowable Costs through any cost report, cost statement, information statement, or payment request submitted by Defendants or any of CPMI's subsidiaries or affiliates to the Medicare, Medicaid, TRICARE, or FEHBP Programs.

c. Treatment of Unallowable Costs Previously Submitted for Payment: Defendants further agree that within 90 days of the Effective Date of this Agreement they shall identify to applicable Medicare and TRICARE fiscal intermediaries, carriers, and/or contractors, and Medicaid and FEHBP fiscal agents, any Unallowable Costs (as defined in this Paragraph) included in payments previously sought from the United States, or any State Medicaid program, including, but not limited to, payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by Defendants or any of CPMI's subsidiaries or affiliates, and shall request, and agree, that such cost reports, cost statements, information reports, or payment requests, even if already settled, be adjusted to account for the effect of the inclusion of the unallowable costs. Defendants agree that the United States, at a minimum, shall be entitled to recoup from Defendants any overpayment plus applicable interest and penalties as a result of the inclusion of such Unallowable Costs on previously-submitted cost reports, information reports, cost statements, or requests for payment.

Any payments due after the adjustments have been made shall be paid to the United States pursuant to the direction of the Department of Justice and/or the affected agencies. The

United States reserves its rights to disagree with any calculations submitted by Defendants or any of CPMI's subsidiaries or affiliates on the effect of inclusion of Unallowable Costs (as defined in this Paragraph) on Defendants' or any of CPMI's subsidiaries or affiliates' cost reports, cost statements, or information reports.

d. Nothing in this Agreement shall constitute a waiver of the rights of the United States to audit, examine, or re-examine Defendants' books and records to determine that no Unallowable Costs have been claimed in accordance with the provisions of this Paragraph.

8. Defendants agree to cooperate fully and truthfully with the United States' investigation of individuals and entities not released in this Agreement. Upon reasonable notice, Defendants shall encourage, and agree not to impair, the cooperation of CPMI's directors, officers, and employees, and shall use its best efforts to make available, and encourage, the cooperation of former directors, officers, and employees for interviews and testimony, consistent with the rights and privileges of such individuals. Defendants further agree to furnish to the United States, upon request, complete and unredacted copies of all non-privileged documents, reports, memoranda of interviews, and records in its possession, custody, or control concerning any investigation of the Covered Conduct that they have undertaken, or that has been performed by another on their behalf.

9. This Agreement is intended to be for the benefit of the Parties only. The Parties do not release any claims against any other person or entity, except to the extent provided for in Paragraph 10 (waiver for beneficiaries paragraph), below.

10. Defendants agree that it waives and shall not seek payment for any of the health care billings covered by this Agreement from any health care beneficiaries or their parents, sponsors, legally responsible individuals, or third party payors based upon the claims defined as Covered Conduct.

11. Each Party shall bear its own legal and other costs incurred in connection with this matter, including the preparation and performance of this Agreement.

12. Each Party and signatory to this Agreement represents that it freely and voluntarily enters in to this Agreement without any degree of duress or compulsion.

13. This Agreement is governed by the laws of the United States. The exclusive jurisdiction and venue for any dispute relating to this Agreement is the United States District Court for the Southern District of Ohio. For purposes of construing this Agreement, this Agreement shall be deemed to have been drafted by all Parties to this Agreement and shall not, therefore, be construed against any Party for that reason in any subsequent dispute.

14. This Agreement constitutes the complete agreement between the Parties. This Agreement may not be amended except by written consent of the Parties.

15. The undersigned counsel represent and warrant that they are fully authorized to execute this Agreement on behalf of the persons and entities indicated below.

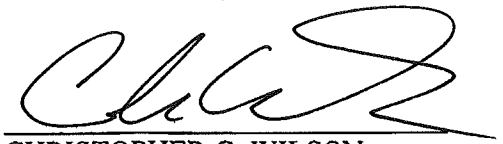
16. This Agreement may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same Agreement.

17. This Agreement is binding on Defendants' successors, transferees, heirs, and assigns.

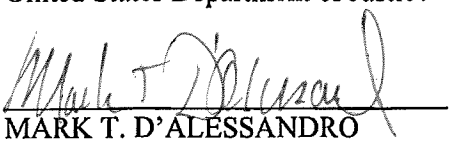
18. All Parties consent to the United States' disclosure of this Agreement, and information about this Agreement, to the public.

19. This Agreement is effective on the date of signature of the last signatory to the Agreement (Effective Date of this Agreement). Facsimiles and electronic transmissions of signatures shall constitute acceptable, binding signatures for purposes of this Agreement.

THE UNITED STATES OF AMERICA

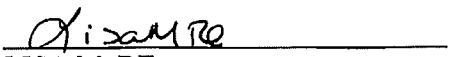
DATED: 1/22/2020 BY: 

CHRISTOPHER G. WILSON
Trial Attorney
Commercial Litigation Branch
Civil Division
United States Department of Justice

DATED: 1/22/2020 BY: 

MARK T. D'ALESSANDRO
Civil Chief

ANDREW M. MALEK
Assistant United States Attorney
United States Attorney's Office
for the Southern District of Ohio

DATED: 01/21/20 BY: 

LISA M. RE
Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
United States Department of Health and Human Services

MARGOLIN AND CMPI - DEFENDANTS

DATED: 01/15/2020 BY: _____
LEON MARGOLIN, M.D.

Individually and on behalf of Comprehensive Pain Management Institute, LLC

DATED: 1.15.20 BY: _____
NICK OBERHEIDEN

Counsel for Margolin and Comprehensive Pain Management Institute, LLC

AMENDMENT TO THE SETTLEMENT AGREEMENT BETWEEN THE UNITED STATES OF AMERICA, LEON MARGOLIN, AND COMPREHENSIVE PAIN MANAGEMENT INSTITUTE, LLC

Pursuant to Paragraph 14 of the Settlement Agreement between the United States of America (the "United States"), and Leon Margolin, M.D., and Comprehensive Pain Management Institute, LLC (together, Defendants), executed on January 22, 2020, the parties hereby in writing amend the Settlement Agreement as follows:

A. Paragraph 1 of the Settlement Agreement shall be amended to read as follows (emphasis added only to show change):

1. Defendants shall pay to the United States $650,000 ("Settlement Amount") plus interest at a rate of 1.75 percent per annum from January 1, 2020, of which $325,839.00 is restitution. Defendants shall pay $450,000 of the total Settlement Amount no later than ten days after the Effective Date of this Agreement and shall pay the remaining $200,000 plus interest on or before October 1, 2020. Defendants shall make these payments by check pursuant to written instructions to be provided by the Civil Division of the United States Department of Justice.

B. The sole purpose of this amendment is to extend the time for making the second, final payment of $200,000, plus interest. This amendment does not modify any other term of the Settlement Agreement.

IN WITNESS WHEREOF, the parties have executed this Amendment to the Settlement Agreement, intending to be bound.

THE UNITED STATES OF AMERICA

DATED: _____ BY: _____

CHRISTOPHER G. WILSON
Trial Attorney
Commercial Litigation Branch
Civil Division
United States Department of Justice

DATED: _____ BY: _____

MARK T. D'ALESSANDRO
Civil Chief

ANDREW M. MALEK
Assistant United States Attorney
United States Attorney's Office
for the Southern District of Ohio

DATED: 05/14/2025 BY: Lisa M. Re

LISA M. RE
Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
United States Department of Health and Human Services

THE UNITED STATES OF AMERICA

DATED: 5/18/2020 BY: 

CHRISTOPHER G. WILSON
Trial Attorney
Commercial Litigation Branch
Civil Division
United States Department of Justice

DATED: _____ BY: _____

MARK T. D'ALESSANDRO
Civil Chief

ANDREW M. MALEK
Assistant United States Attorney
United States Attorney's Office
for the Southern District of Ohio

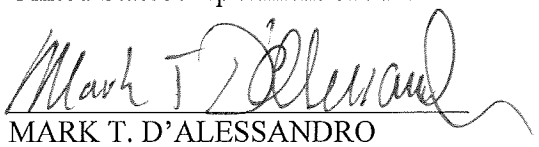
DATED: _____ BY: _____

LISA M. RE
Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
United States Department of Health and Human Services

THE UNITED STATES OF AMERICA

DATED: _____ BY: _____

CHRISTOPHER G. WILSON
Trial Attorney
Commercial Litigation Branch
Civil Division
United States Department of Justice

DATED: 5/13/2020 BY: 

MARK T. D'ALESSANDRO
Civil Chief

ANDREW M. MALEK
Assistant United States Attorney
United States Attorney's Office
for the Southern District of Ohio

DATED: _____ BY: _____

LISA M. RE
Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
United States Department of Health and Human Services

MARGOLIN AND CMPI - DEFENDANTS

DATED: 05/13/20 BY: _____
LEON MARGOLIN, M.D.

Individually and on behalf of Comprehensive Pain Management Institute, LLC

DATED: 5/13/20 BY: _____
KATE HICKNER
SEAN MALONE

Counsel for Margolin and Comprehensive Pain Management Institute, LLC

Exhibit DDD

Federal Rules of Evidence Rule 702, 28 U.S.C.A.

Rule 702. Testimony by Expert Witnesses [Rule Text & Notes of Decisions subdivisions I, II]

Currentness

<Notes of Decisions for 28 USCA Federal Rules of Evidence Rule 702 are displayed in multiple documents.>

A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if:

(a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue;

(b) the testimony is based on sufficient facts or data;

(c) the testimony is the product of reliable principles and methods; and

(d) the expert has reliably applied the principles and methods to the facts of the case.

CREDIT(S)
(Pub.L. 93-595, § 1, Jan. 2, 1975, 88 Stat. 1937; Apr. 17, 2000, eff. Dec. 1, 2000; Apr. 26, 2011, eff. Dec. 1, 2011.)

ADVISORY COMMITTEE NOTES
1972 Proposed Rules

An intelligent evaluation of facts is often difficult or impossible without the application of some scientific, technical, or other specialized knowledge. The most common source of this knowledge is the expert witness, although there are other techniques for supplying it.

Most of the literature assumes that experts testify only in the form of opinions. The assumption is logically unfounded. The rule accordingly recognizes that an expert on the stand may give a dissertation or exposition of scientific or other principles relevant to the case, leaving the trier of fact to apply them to the facts. Since much of the criticism of expert testimony has centered upon the hypothetical question, it seems wise to recognize that opinions are not indispensable and to encourage the use of expert testimony in non-opinion form when counsel believes the trier can itself draw the requisite inference. The use of opinions is not abolished by the rule, however. It will continue to be permissible for the experts to take the further step of suggesting the inference which should be drawn from applying the specialized knowledge to the facts. See Rules 703 to 705.

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Whether the situation is a proper one for the use of expert testimony is to be determined on the basis of assisting the trier. "There is no more certain test for determining when experts may be used than the common sense inquiry whether the untrained layman would be qualified to determine intelligently and to the best possible degree the particular issue without enlightenment from those having a specialized understanding of the subject involved in the dispute." Ladd, Expert Testimony, 5 Vand.L.Rev. 414, 418 (1952). When opinions are excluded, it is because they are unhelpful and therefore superfluous and a waste of time. 7 Wigmore § 1918.

The rule is broadly phrased. The fields of knowledge which may be drawn upon are not limited merely to the "scientific" and "technical" but extend to all "specialized" knowledge. Similarly, the expert is viewed, not in a narrow sense, but as a person qualified by "knowledge, skill, experience, training or education." Thus, within the scope of the rule are not only experts in the strictest sense of the word, e.g., physicians, physicists, and architects, but also the large group sometimes called "skilled" witnesses, such as bankers or landowners testifying to land values.

2000 Amendments

Rule 702 has been amended in response to *Daubert v. Merrell Dow Pharmaceuticals, Inc*., 509 U.S. 579 (1993), and to the many cases applying *Daubert*, including *Kumho Tire Co. v. Carmichael*, 119 S.Ct. 1167 (1999). In *Daubert* the Court charged trial judges with the responsibility of acting as gatekeepers to exclude unreliable expert testimony, and the Court in *Kumho* clarified that this gatekeeper function applies to all expert testimony, not just testimony based in science. *See also Kumho*, 119 S.Ct. at 1178 (citing the Committee Note to the proposed amendment to Rule 702, which had been released for public comment before the date of the *Kumho* decision). The amendment affirms the trial court's role as gatekeeper and provides some general standards that the trial court must use to assess the reliability and helpfulness of proffered expert testimony. Consistently with *Kumho*, the Rule as amended provides that all types of expert testimony present questions of admissibility for the trial court in deciding whether the evidence is reliable and helpful. Consequently, the admissibility of all expert testimony is governed by the principles of Rule 104(a). Under that Rule, the proponent has the burden of establishing that the pertinent admissibility requirements are met by a preponderance of the evidence. *See Bourjaily v. United States*, 483 U.S. 171 (1987).

Daubert set forth a non-exclusive checklist for trial courts to use in assessing the reliability of scientific expert testimony. The specific factors explicated by the *Daubert* Court are (1) whether the expert's technique or theory can be or has been tested---that is, whether the expert's theory can be challenged in some objective sense, or whether it is instead simply a subjective, conclusory approach that cannot reasonably be assessed for reliability; (2) whether the technique or theory has been subject to peer review and publication; (3) the known or potential rate of error of the technique or theory when applied; (4) the existence and maintenance of standards and controls; and (5) whether the technique or theory has been generally accepted in the scientific community. The Court in *Kumho* held that these factors might also be applicable in assessing the reliability of non-scientific expert testimony, depending upon "the particular circumstances of the particular case at issue." 119 S.Ct. at 1175.

No attempt has been made to "codify" these specific factors. *Daubert* itself emphasized that the factors were neither exclusive nor dispositive. Other cases have recognized that not all of the specific *Daubert* factors can apply to every type of expert testimony. In addition to *Kumho*, 119 S.Ct. at 1175, *see Tyus v. Urban Search Management*, 102 F.3d 256 (7th Cir. 1996) (noting that the factors mentioned by the Court in *Daubert* do not neatly apply to expert testimony from a sociologist). *See also Kannankeril v. Terminix Int'l, Inc*., 128 F.3d 802, 809 (3d Cir. 1997) (holding that lack of peer review or publication was not dispositive where the expert's opinion was supported by "widely accepted scientific knowledge"). The standards set forth in the amendment are broad enough to require consideration of any or all of the specific *Daubert* factors where appropriate.

Courts both before and after *Daubert* have found other factors relevant in determining whether expert testimony is sufficiently reliable to be considered by the trier of fact. These factors include:

(1) Whether experts are "proposing to testify about matters growing naturally and directly out of research they have conducted independent of the litigation, or whether they have developed their opinions expressly for purposes of testifying." *Daubert v. Merrell Dow Pharmaceuticals, Inc*., 43 F.3d 1311, 1317 (9th Cir. 1995).

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(2) Whether the expert has unjustifiably extrapolated from an accepted premise to an unfounded conclusion. *See General Elec. Co. v. Joiner*, 522 U.S. 136, 146 (1997) (noting that in some cases a trial court "may conclude that there is simply too great an analytical gap between the data and the opinion proffered").

(3) Whether the expert has adequately accounted for obvious alternative explanations. *See Claar v. Burlington N.R.R.*, 29 F.3d 499 (9th Cir. 1994) (testimony excluded where the expert failed to consider other obvious causes for the plaintiff's condition). *Compare Ambrosini v. Labarraque*, 101 F.3d 129 (D.C. Cir. 1996) (the possibility of some uneliminated causes presents a question of weight, so long as the most obvious causes have been considered and reasonably ruled out by the expert).

(4) Whether the expert "is being as careful as he would be in his regular professional work outside his paid litigation consulting." *Sheehan v. Daily Racing Form, Inc.*, 104 F.3d 940, 942 (7th Cir. 1997). *See Kumho Tire Co. v. Carmichael*, 119 S.Ct. 1167, 1176 (1999) (*Daubert* requires the trial court to assure itself that the expert "employs in the courtroom the same level of intellectual rigor that characterizes the practice of an expert in the relevant field").

(5) Whether the field of expertise claimed by the expert is known to reach reliable results for the type of opinion the expert would give. *See Kumho Tire Co. v. Carmichael*, 119 S.Ct.1167, 1175 (1999) (*Daubert's* general acceptance factor does not "help show that an expert's testimony is reliable where the discipline itself lacks reliability, as for example, do theories grounded in any so-called generally accepted principles of astrology or necromancy."), *Moore v. Ashland Chemical, Inc.*, 151 F.3d 269 (5th Cir. 1998) (en banc) (clinical doctor was properly precluded from testifying to the toxicological cause of the plaintiff's respiratory problem, where the opinion was not sufficiently grounded in scientific methodology); *Sterling v. Velsicol Chem. Corp.*, 855 F.2d 1188 (6th Cir. 1988) (rejecting testimony based on "clinical ecology" as unfounded and unreliable).

All of these factors remain relevant to the determination of the reliability of expert testimony under the Rule as amended. Other factors may also be relevant. *See Kumho*, 119 S.Ct. 1167, 1176 ("[W]e conclude that the trial judge must have considerable leeway in deciding in a particular case how to go about determining whether particular expert testimony is reliable."). Yet no single factor is necessarily dispositive of the reliability of a particular expert's testimony. *See, e.g., Heller v. Shaw Industries, Inc.*, 167 F.3d 146, 155 (3d Cir. 1999) ("not only must each stage of the expert's testimony be reliable, but each stage must be evaluated practically and flexibly without bright-line exclusionary (or inclusionary) rules."); *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 43 F.3d 1311, 1317, n.5 (9th Cir. 1995) (noting that some expert disciplines "have the courtroom as a principal theatre of operations" and as to these disciplines "the fact that the expert has developed an expertise principally for purposes of litigation will obviously not be a substantial consideration.").

A review of the caselaw after *Daubert* shows that the rejection of expert testimony is the exception rather than the rule. *Daubert* did not work a "seachange over federal evidence law," and "the trial court's role as gatekeeper is not intended to serve as a replacement for the adversary system." *United States v. 14.38 Acres of Land Situated in Leflore County, Mississippi*, 80 F.3d 1074, 1078 (5th Cir. 1996). As the Court in *Daubert* stated: "Vigorous cross-examination, presentation of contrary evidence, and careful instruction on the burden of proof are the traditional and appropriate means of attacking shaky but admissible evidence." 509 U.S. at 595. Likewise, this amendment is not intended to provide an excuse for an automatic challenge to the testimony of every expert. *See Kumho Tire Co. v. Carmichael*, 119 S.Ct.1167, 1176 (1999) (noting that the trial judge has the discretion "both to avoid unnecessary 'reliability' proceedings in ordinary cases where the reliability of an expert's methods is properly taken for granted, and to require appropriate proceedings in the less usual or more complex cases where cause for questioning the expert's reliability arises.").

When a trial court, applying this amendment, rules that an expert's testimony is reliable, this does not necessarily mean that contradictory expert testimony is unreliable. The amendment is broad enough to permit testimony that is the product of competing principles or methods in the same field of expertise. *See, e.g., Heller v. Shaw Industries, Inc.*, 167 F.3d 146, 160 (3d Cir. 1999) (expert testimony cannot be excluded simply because the expert uses one test rather than another, when both

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tests are accepted in the field and both reach reliable results). As the court stated in *In re Paoli R.R. Yard PCB Litigation*, 35 F.3d 717, 744 (3d Cir. 1994), proponents "do not have to demonstrate to the judge by a preponderance of the evidence that the assessments of their experts are correct, they only have to demonstrate by a preponderance of evidence that their opinions are reliable.... The evidentiary requirement of reliability is lower than the merits standard of correctness." *See also Daubert v. Merrell Dow Pharmaceuticals, Inc*., 43 F.3d 1311, 1318 (9th Cir. 1995) (scientific experts might be permitted to testify if they could show that the methods they used were also employed by "a recognized minority of scientists in their field."); *Ruiz-Troche v. Pepsi Cola*, 161 F.3d 77, 85 (1st Cir. 1998) ("*Daubert* neither requires nor empowers trial courts to determine which of several competing scientific theories has the best provenance.").

The Court in *Daubert* declared that the "focus, of course, must be solely on principles and methodology, not on the conclusions they generate." 509 U.S. at 595. Yet as the Court later recognized, "conclusions and methodology are not entirely distinct from one another." *General Elec. Co. v. Joiner*, 522 U.S. 136, 146 (1997). Under the amendment, as under *Daubert*, when an expert purports to apply principles and methods in accordance with professional standards, and yet reaches a conclusion that other experts in the field would not reach, the trial court may fairly suspect that the principles and methods have not been faithfully applied. *See Lust v. Merrell Dow Pharmaceuticals, Inc*., 89 F.3d 594, 598 (9th Cir. 1996). The amendment specifically provides that the trial court must scrutinize not only the principles and methods used by the expert, but also whether those principles and methods have been properly applied to the facts of the case. As the court noted in *In re Paoli R.R. Yard PCB Litig.*, 35 F.3d 717, 745 (3d Cir. 1994), "*any* step that renders the analysis unreliable ... renders the expert's testimony inadmissible. *This is true whether the step completely changes a reliable methodology or merely misapplies that methodology*."

If the expert purports to apply principles and methods to the facts of the case, it is important that this application be conducted reliably. Yet it might also be important in some cases for an expert to educate the factfinder about general principles, without ever attempting to apply these principles to the specific facts of the case. For example, experts might instruct the factfinder on the principles of thermodynamics, or blood clotting, or on how financial markets respond to corporate reports, without ever knowing about or trying to tie their testimony into the facts of the case. The amendment does not alter the venerable practice of using expert testimony to educate the factfinder on general principles. For this kind of generalized testimony, Rule 702 simply requires that: (1) the expert be qualified; (2) the testimony address a subject matter on which the factfinder can be assisted by an expert; (3) the testimony be reliable; and (4) the testimony "fit" the facts of the case.

As stated earlier, the amendment does not distinguish between scientific and other forms of expert testimony. The trial court's gatekeeping function applies to testimony by any expert. *See Kumho Tire Co. v. Carmichael*, 119 S.Ct. 1167, 1171 (1999) ("We conclude that *Daubert's* general holding--setting forth the trial judge's general 'gatekeeping' obligation--applies not only to testimony based on 'scientific' knowledge, but also to testimony based on 'technical' and 'other specialized' knowledge."). While the relevant factors for determining reliability will vary from expertise to expertise, the amendment rejects the premise that an expert's testimony should be treated more permissively simply because it is outside the realm of science. An opinion from an expert who is not a scientist should receive the same degree of scrutiny for reliability as an opinion from an expert who purports to be a scientist. *See Watkins v. Telsmith, Inc*., 121 F.3d 984, 991 (5th Cir. 1997) ("[I]t seems exactly backwards that experts who purport to rely on general engineering principles and practical experience might escape screening by the district court simply by stating that their conclusions were not reached by any particular method or technique."). Some types of expert testimony will be more objectively verifiable, and subject to the expectations of falsifiability, peer review, and publication, than others. Some types of expert testimony will not rely on anything like a scientific method, and so will have to be evaluated by reference to other standard principles attendant to the particular area of expertise. The trial judge in all cases of proffered expert testimony must find that it is properly grounded, well-reasoned, and not speculative before it can be admitted. The expert's testimony must be grounded in an accepted body of learning or experience in the expert's field, and the expert must explain how the conclusion is so grounded. *See, e.g*., American College of Trial Lawyers, Standards and Procedures for Determining the Admissibility of Expert Testimony after *Daubert*, 157 F.R.D. 571, 579 (1994) ("[W]hether the testimony concerns economic principles, accounting standards, property valuation or other non-scientific subjects, it should be evaluated by reference to the 'knowledge and experience' of that particular field.").

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The amendment requires that the testimony must be the product of reliable principles and methods that are reliably applied to the facts of the case. While the terms "principles" and "methods" may convey a certain impression when applied to scientific knowledge, they remain relevant when applied to testimony based on technical or other specialized knowledge. For example, when a law enforcement agent testifies regarding the use of code words in a drug transaction, the principle used by the agent is that participants in such transactions regularly use code words to conceal the nature of their activities. The method used by the agent is the application of extensive experience to analyze the meaning of the conversations. So long as the principles and methods are reliable and applied reliably to the facts of the case, this type of testimony should be admitted.

Nothing in this amendment is intended to suggest that experience alone--or experience in conjunction with other knowledge, skill, training or education--may not provide a sufficient foundation for expert testimony. To the contrary, the text of Rule 702 expressly contemplates that an expert may be qualified on the basis of experience. In certain fields, experience is the predominant, if not sole, basis for a great deal of reliable expert testimony. *See, e.g., United States v. Jones*, 107 F.3d 1147 (6th Cir. 1997) (no abuse of discretion in admitting the testimony of a handwriting examiner who had years of practical experience and extensive training, and who explained his methodology in detail); *Tassin v. Sears Roebuck*, 946 F.Supp. 1241, 1248 (M.D.La. 1996) (design engineer's testimony can be admissible when the expert's opinions "are based on facts, a reasonable investigation, and traditional technical/mechanical expertise, and he provides a reasonable link between the information and procedures he uses and the conclusions he reaches"). *See also Kumho Tire Co. v. Carmichael*, 119 S.Ct. 1167, 1178 (1999) (stating that "no one denies that an expert might draw a conclusion from a set of observations based on extensive and specialized experience.").

If the witness is relying solely or primarily on experience, then the witness must explain how that experience leads to the conclusion reached, why that experience is a sufficient basis for the opinion, and how that experience is reliably applied to the facts. The trial court's gatekeeping function requires more than simply "taking the expert's word for it." *See Daubert v. Merrell Dow Pharmaceuticals, Inc*., 43 F.3d 1311, 1319 (9th Cir. 1995) ("We've been presented with only the experts' qualifications, their conclusions and their assurances of reliability. Under *Daubert*, that's not enough."). The more subjective and controversial the expert's inquiry, the more likely the testimony should be excluded as unreliable. *See O'Conner v. Commonwealth Edison Co*., 13 F.3d 1090 (7th Cir. 1994) (expert testimony based on a completely subjective methodology held properly excluded). *See also Kumho Tire Co. v. Carmichael*, 119 S.Ct. 1167, 1176 (1999) ("[I]t will at times be useful to ask even of a witness whose expertise is based purely on experience, say, a perfume tester able to distinguish among 140 odors at a sniff, whether his preparation is of a kind that others in the field would recognize as acceptable.").

Subpart (1) of Rule 702 calls for a quantitative rather than qualitative analysis. The amendment requires that expert testimony be based on sufficient underlying "facts or data." The term "data" is intended to encompass the reliable opinions of other experts. See the original Advisory Committee Note to Rule 703. The language "facts or data" is broad enough to allow an expert to rely on hypothetical facts that are supported by the evidence. *Id*.

When facts are in dispute, experts sometimes reach different conclusions based on competing versions of the facts. The emphasis in the amendment on " sufficient facts or data" is not intended to authorize a trial court to exclude an expert's testimony on the ground that the court believes one version of the facts and not the other.

There has been some confusion over the relationship between Rules 702 and 703. The amendment makes clear that the sufficiency of the basis of an expert' s testimony is to be decided under Rule 702. Rule 702 sets forth the overarching requirement of reliability, and an analysis of the sufficiency of the expert's basis cannot be divorced from the ultimate reliability of the expert's opinion. In contrast, the "reasonable reliance" requirement of Rule 703 is a relatively narrow inquiry. When an expert relies on inadmissible information, Rule 703 requires the trial court to determine whether that information is of a type reasonably relied on by other experts in the field. If so, the expert can rely on the information in reaching an opinion. However, the question whether the expert is relying on a *sufficient* basis of information--whether admissible information or not--is governed by the requirements of Rule 702.

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The amendment makes no attempt to set forth procedural requirements for exercising the trial court's gatekeeping function over expert testimony. *See* Daniel J. Capra, *The Daubert Puzzle*, 38 Ga.L.Rev. 699, 766 (1998) [*sic*, should be "32 Ga.L.Rev. 699, 766 (1998)"] ("Trial courts should be allowed substantial discretion in dealing with *Daubert* questions; any attempt to codify procedures will likely give rise to unnecessary changes in practice and create difficult questions for appellate review."). Courts have shown considerable ingenuity and flexibility in considering challenges to expert testimony under *Daubert*, and it is contemplated that this will continue under the amended Rule. *See, e.g., Cortes-Irizarry v. Corporacion Insular*, 111 F.3d 184 (1st Cir. 1997) (discussing the application of *Daubert* in ruling on a motion for summary judgment); *In re Paoli R.R. Yard PCB Litig*., 35 F.3d 717, 736, 739 (3d Cir. 1994) (discussing the use of *in limine* hearings); *Claar v. Burlington N.R.R*., 29 F.3d 499, 502-05 (9th Cir. 1994) (discussing the trial court's technique of ordering experts to submit serial affidavits explaining the reasoning and methods underlying their conclusions).

The amendment continues the practice of the original Rule in referring to a qualified witness as an "expert." This was done to provide continuity and to minimize change. The use of the term "expert" in the Rule does not, however, mean that a jury should actually be informed that a qualified witness is testifying as an "expert." Indeed, there is much to be said for a practice that prohibits the use of the term "expert" by both the parties and the court at trial. Such a practice "ensures that trial courts do not inadvertently put their stamp of authority" on a witness's opinion, and protects against the jury's being "overwhelmed by the so-called 'experts'." Hon. Charles Richey, *Proposals to Eliminate the Prejudicial Effect of the Use of the Word "Expert" Under the Federal Rules of Evidence in Criminal and Civil Jury Trials*, 154 F.R.D. 537, 559 (1994) (setting forth limiting instructions and a standing order employed to prohibit the use of the term " expert" injury trials).

GAP Report--Proposed Amendment to Rule 702

The Committee made the following changes to the published draft of the proposed amendment to Evidence Rule 702:

1. The word "reliable" was deleted from Subpart (1) of the proposed amendment, in order to avoid an overlap with Evidence Rule 703, and to clarify that an expert opinion need not be excluded simply because it is based on hypothetical facts. The Committee Note was amended to accord with this textual change.

2. The Committee Note was amended throughout to include pertinent references to the Supreme Court's decision in *Kumho Tire Co. v. Carmichael*, which was rendered after the proposed amendment was released for public comment. Other citations were updated as well.

3. The Committee Note was revised to emphasize that the amendment is not intended to limit the right to jury trial, nor to permit a challenge to the testimony of every expert, nor to preclude the testimony of experience-based experts, nor to prohibit testimony based on competing methodologies within a field of expertise.

4. Language was added to the Committee Note to clarify that no single factor is necessarily dispositive of the reliability inquiry mandated by Evidence Rule 702.

2011 Amendments

The language of Rule 702 has been amended as part of the restyling of the Evidence Rules to make them more easily understood and to make style and terminology consistent throughout the rules. These changes are intended to be stylistic only. There is no intent to change any result in any ruling on evidence admissibility.

Notes of Decisions (1437)

Fed. Rules Evid. Rule 702, 28 U.S.C.A., FRE Rule 702

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Including Amendments Received Through 5-1-22

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Exhibit EEE

Baldwin's Ohio Revised Code Annotated
Ohio Rules of Evidence (Refs & Annos)
Article VI Witnesses

Evid. R. Rule 601

Evid R 601 General rule of competency

Effective: July 1, 2021
Currentness

(A) General Rule. Every person is competent to be a witness except as otherwise provided in these rules.

(B) Disqualification of Witness in General. A person is disqualified to testify as a witness when the court determines that the person is:

(1) Incapable of expressing himself or herself concerning the matter as to be understood, either directly or through interpretation by one who can understand him or her; or

(2) Incapable of understanding the duty of a witness to tell the truth.

(3) A spouse testifying against the other spouse charged with a crime except when either of the following applies:

(a) a crime against the testifying spouse or a child of either spouse is charged;

(b) the testifying spouse elects to testify.

(4) An officer, while on duty for the exclusive or main purpose of enforcing traffic laws, arresting or assisting in the arrest of a person charged with a traffic violation punishable as a misdemeanor where the officer at the time of the arrest was not using a properly marked motor vehicle as defined by statute or was not wearing a legally distinctive uniform as defined by statute.

(5) A person giving expert testimony on the issue of liability in any medical claim, as defined in R.C. 2305.113, asserted in any civil action against a physician, podiatrist, or hospital arising out of the diagnosis, care, or treatment of any person by a physician or podiatrist, unless:

(a) The person testifying is licensed to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery by the state medical board or by the licensing authority of any state;

(b) The person devotes at least one-half of his or her professional time to the active clinical practice in his or her field of licensure, or to its instruction in an accredited school and

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(c) The person practices in the same or a substantially similar specialty as the defendant. The court shall not permit an expert in one medical specialty to testify against a health care provider in another medical specialty unless the expert shows both that the standards of care and practice in the two specialties are similar and that the expert has substantial familiarity between the specialties.

If the person is certified in a specialty, the person must be certified by a board recognized by the American board of medical specialties or the American board of osteopathic specialties in a specialty having acknowledged expertise and training directly related to the particular health care matter at issue.

Nothing in this division shall be construed to limit the power of the trial court to adjudge the testimony of any expert witness incompetent on any other ground, or to limit the power of the trial court to allow the testimony of any other witness, on a matter unrelated to the liability issues in the medical claim, when that testimony is relevant to the medical claim involved.

This division shall not prohibit other medical professionals who otherwise are competent to testify under these rules from giving expert testimony on the appropriate standard of care in their own profession in any claim asserted in any civil action against a physician, podiatrist, medical professional, or hospital arising out of the diagnosis, care, or treatment of any person.

(6) As otherwise provided in these rules.

CREDIT(S)
(Adopted eff. 7-1-80; amended eff. 7-1-91, 7-1-16, 7-1-20, 7-1-21)

STAFF NOTES
2016:

Nonsubstantive revisions are made to Evid.R. 601(D) to make clear that the rule applies only to expert testimony as to liability in any medical claim, as defined by R.C. 2305.113, asserted against a physician, podiatrist, or hospital arising out of the diagnosis, care, or treatment of any person by a physician or podiatrist. The rule does not apply to expert testimony for any other medical claims, or for any dental, optometric, or chiropractic claims, as defined by R.C. 2305.113.

The structure and provisions of Evid.R. 601(D) are also revised to more-closely resemble the structure of R.C. 2743.43 and to incorporate the provisions of that statute that are not inconsistent with the provisions of the current rule. Pursuant to authority of Article IV, Section 5(B) of the Ohio Constitution, the provisions of R.C. 2743.43 are superseded in their entirety by the amended rule.

1991:

Rule 601(A) Children and Mental Incompetents

Evid. R. 601(A) was amended by deleting “and;” from the end of the rule. This is a technical change only.

Rule 601(B) Spouse Testifying

As adopted in 1980, Evid. R. 601(B) provided that a witness was incompetent to testify against his or her spouse in a criminal case unless the charged offense involved a crime against the testifying spouse or the children of either spouse. The rule was based

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on the policy of protecting the marital relationship from "dissension" and the "natural repugnance" for convicting a defendant upon the testimony of his or her "intimate life partner." 8 J. Wigmore, Evidence 216-17 (McNaughton rev. 1961).

The important issue is who can waive the rule--the defendant or the witness. Under the old rule, the defendant could prevent his or her spouse from testifying. In some situations the policy underlying the rule simply does not apply, but the rule does. For example, if a husband kills his mother-in-law and his wife is a witness, she could be prevented from testifying. This would be true even if they were separated and she desired to testify. Cf. *Locke v. State* (1929), 33 Ohio App. 445, 169 N.E. 833. The amendment changes this result, by permitting the wife to elect to testify.

This approach is supported by a number of commentators. As McCormick has pointed out: "The privilege has sometimes been defended on the ground that it protects family harmony. But family harmony is nearly always past saving when the spouse is willing to aid the prosecution. The privilege is an archaic survival of a mystical religious dogma and of a way of thinking about the marital relation that is today outmoded." C. McCormick, Evidence 162 (3d ed. 1984). *See also* 8 J. Wigmore, Evidence 221 (McNaughton rev. 1961) ("This marital privilege is the merest anachronism in legal theory and an indefensible obstruction to truth in practice."); Huhn, "Sacred Seal of Secrecy": The Rules of Spousal Incompetency and Marital Privilege in Criminal Cases (1987), 20 Akron L. Rev. 433.

The 1991 amendment does not abolish the spousal incompetency rule. The spouse could not be compelled to testify if he or she did not want to testify. In January 1981, the Supreme Court proposed an amendment that would have deleted Evid. R. 601(B). 54 Ohio Bar 175 (1981). This amendment subsequently was withdrawn. 54 Ohio Bar 972 (1981). The current amendment differs from the 1981 proposal. The 1981 proposal would have abolished the spousal incompetency rule in its entirety, thereby permitting the prosecution to force the spouse to testify even when he or she did not wish to testify. The 1991 amendment does not permit the prosecutor to force testimony from an unwilling spouse.

Moreover, the amendment still leaves the defendant with the protection of the confidential communication privilege, which is recognized in R.C. 2317.02(C). and R.C. 2945.42 and governed by Evid. R. 501. This privilege is not affected by Evid. R. 601(B).

Rule 601(D) Medical Experts

Evid. R. 601(D) was amended to prevent the application of the rule in cases in which a physician, podiatrist, hospital, or medical professional is sued as a result of alleged negligence on the part of a nurse or other medical professional. Some cases have held that a nurse is not competent under Evid. R. 601(D) to testify about the standard of nursing care in such a case. *See Harter v. Wadsworth-Rittman* (August 30, 1989), Medina App. No. 1790, unreported, motion to certify record overruled (December 20, 1989), 47 Ohio St.3d 715, 549 N.E.2d 170.

The amendment limits the rule to claims involving care by a physician or podiatrist, and does not prohibit other medical professionals, including nurses, from testifying as to the appropriate standard of professional care in their field.

Also, the requirement that an expert medical witness devote three-fourths of his or her time to active clinical practice or instruction was reduced to at least one-half. The phrase "accredited university" was changed to "accredited school" because some accredited medical schools are not associated with a university.

1980:

Rule 601, of necessity, varies significantly from Federal Evidence Rule 601 which declares all witnesses competent in federal matters, except as otherwise provided in the Federal Rules of Evidence, and also declares that in state matters, the competency of witnesses is to be determined by state law. Rule 601 states the general rule of witness competency for Ohio. In so doing, the rule embodies certain prior Ohio practices and discards others.

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One of the purposes of Federal Evidence Rule 601 was to preserve statutes such as the dead man's statute in state matters in those states where such a statute existed. Ohio has chosen to eliminate the exclusion. Rule 601 supersedes R.C. 2317.03, the dead man's statute. By declaring all witnesses to be competent and not providing an exception for the exclusionary provisions of the dead man's statute, a conflict between the rule and the statute is created and the statute is superseded under constitutional provision. Concomitantly, Rule 804(B)(5) provides that the statements formerly excluded by the dead man's statute are exceptions to the hearsay rule. (Editor's Note: This last sentence is incorrect. Rule 601 supersedes the "dead man" statute, thereby permitting the surviving party to testify at trial. Rule 804(B)(5) recognizes a hearsay exception for the *decedent's* statements; these statements were excluded because of the hearsay rule, not the dead man statute.)

R.C. 4733.24 is also superseded by Rule 601. That section conditioned a surveyor's testimony upon his oath, if required, that the chain used conformed to the established standard.

Rule 601(A) Children and Insane Persons

Rule 601(A), in excepting persons of unsound mind and persons under ten years of age who appear incapable of receiving or relating facts properly, restates, *verbatim,* R.C. 2317.01. Ostensibly, a provision relating to civil cases, it also applies in criminal cases. R.C. 2945.41 provides that the rules of evidence in civil causes, where applicable, govern in all criminal causes.

Rule 601(B) Spouse Testifying

R.C. 2945.42 governed the competency of a spouse to testify in a criminal prosecution involving the other spouse and continues to govern the privilege accorded to a spouse. The concepts are to be distinguished. Rule 601 is directed to competency. Rule 501 is directed to privilege and is a general rule serving to maintain R.C. 2945.42 as to privilege. Rule 601(B) modifies R.C. 2945.42 as to competency.

R.C. 2945.42 provided that a spouse could testify in behalf of the other spouse in all criminal prosecutions. That concept is preserved by declaring all persons to be competent witnesses. R.C. 2945.42 provided that a spouse could not testify against the other spouse in a criminal prosecution, but could testify against the other in actions and proceedings, for personal injury of either by the other, bigamy, failure to provide for, neglect of, or cruelty to children under eighteen, twenty-one if mentally or physically handicapped. Additionally, the statute provided that a wife could testify against her husband in a prosecution for felonious assault, aggravated assault, assault, non-support of dependent, or endangering children based upon cruelty to, neglect of, or abandonment of the wife. Rule 601(B) is less restrictive than the statute was under the former practice. The rule establishes the absence of competence in a spouse to testify against the other spouse in a criminal prosecution with the broad exception of any crime against the testifying spouse or any crime against the children of either spouse. No age limit is set for such child, and the language is broad enough to encompass all adult children as well as minors.

Rule 601(B) supersedes R.C. 2945.42 as to spousal competency, but not as to spousal privilege.

Rule 601(C) Traffic Officer

Rule 601(C) restates R.C. 4549.14 and R.C. 4549.16 and preserves the provisions of those statutes.

Rule 601(D) Expert Testimony in Malpractice Cases

Subdivision (D) incorporates into the rule on competency of witnesses the provisions of R.C. 2743.43 with respect to expert testimony on medical liability issues. The application of this subdivision is in accordance with the definition of a "medical claim" as provided in R.C. 2305.11(D)(3).

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The rule as adopted supersedes R.C. 2743.43 but does not supersede 2305.11(D)(3) which continues to have a function independent of considerations of competency of witnesses.

Rule 601(E) As Otherwise Provided in These Rules

Rule 605 provides that a judge is not competent to testify in a trial at which he presides. Rule 606(A) provides that a juror is not competent to testify in a trial in which he is serving as a juror. The rule does not exclude an attorney from testifying in a case in which he serves as counsel. Such practice is proscribed by DR5-101(B) and DR5-102 of the Code of Professional Responsibility.

Notes of Decisions (394)

Rules of Evid., Rule 601, OH ST REV Rule 601
Current with amendments received through March 1, 2022. Some rules may be more current, see credits for details.

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Exhibit FFF

KeyCite Yellow Flag - Negative Treatment
Unconstitutional or Preempted Negative Treatment Reconsidered by Florida ex rel. Atty. Gen. v. U.S. Dept. of Health and Human Services, 11th Cir.(Fla.), Aug. 12, 2011

KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

42 U.S.C.A. § 1395

§ 1395. Prohibition against any Federal interference

Currentness

Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

CREDIT(S)

(Aug. 14, 1935, c. 531, Title XVIII, § 1801, as added Pub.L. 89-97, Title I, § 102(a), July 30, 1965, 79 Stat. 291.)

Notes of Decisions (60)

42 U.S.C.A. § 1395, 42 USCA § 1395
Current through P.L. 117-120. Some statute sections may be more current, see credits for details.

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Exhibit GGG

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

QUESTIONABLE BILLING FOR MEDICARE ELECTRODIAGNOSTIC TESTS



Daniel R. Levinson
Inspector General

April 2014
OEI-04-12-00420

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS partially concurred with our first two recommendations and concurred with the third one. With regard to the first recommendation, CMS partially concurred and stated that it will evaluate the cost-effectiveness of implementing new thresholds for questionable billing and conducting medical record reviews of physicians who exceed them. CMS also provided information about its efforts to monitor Medicare billing for electrodiagnostic tests. Specifically, CMS will share this report with its Recovery Auditors for possible review and overpayment recovery. CMS will also consider including a model that monitors for unusually high billing for electrodiagnostic tests in its Fraud Prevention System. Finally, CMS will develop CBRs on electrodiagnostic testing that include neurologists and physiatrists.

With regard to the second recommendation, CMS partially concurred and stated that it established revised values for new codes that bundle needle EMG and NCT codes, which has resulted in simplified coding and savings to the Medicare program for these services. CMS noted that it is prohibited from providing guidance on the practice of medicine to physicians and, therefore, it may be a violation to emphasize the importance of providing NCTs in conjunction with needle EMGs. In response to CMS's comments, we clarified this recommendation to state that CMS should educate physicians on industry guidance regarding performing and billing for these services together. We are not recommending that CMS provide guidance on the practice of medicine to physicians.

With regard to the third recommendation, CMS concurred and will instruct the Supplemental Medical Review Contractor to review some or all of the physicians identified in this report. CMS will also ask these contractors to determine which of the seven questionable billing measures were the best predictors of improper payments. Finally, any suspicions of potential fraud will be referred to the appropriate Zone Program Integrity Contractor.

We support CMS's efforts to address these issues and encourage it to continue making progress. For the full text of CMS's comments, see Appendix G.

Exhibit HHH

Bernard M. Abrams, MD
10701 Nall Ste 120
Overland Park, KS 66211
816-322-4834
Fax: 816-322-2005
Email: babrams@kc.rr.com

February 17, 2018

To whom it may concern:

Re: review of Electrodiagnostic procedures concerning Leon Margolin, M.D., PhD.

Task: I was asked to review Dr. Margolin's policy and procedures including informed consent, training of personnel in an entity doing business as CPMI.

Qualifications: I am Clinical Professor Emeritus, University of Missouri-Kansas City School of Medicine, Past President of the AANEM (then the AAEE), a six year member of the Board of Directors of the AANEM, Board Certified in EMG by the AANEM, author of numerous textbook chapters on Electrodiagnosis in major pain textbooks and have lectured dozens of times on Clinical Neurophysiology and its use in Pain Medicine.

Disclaimer: I have not requested nor have I been paid for rendering my opinion. I am not a colleague or social friend of Dr. Margolin.

Materials reviewed: Updated CPMI NCV EMG policy, NCV 2012 policy informed consent, Pain Medicine CME, CPMI informed consent and EMG paperwork, Staff education in service sessions, NCV technician certificates, AANEM informed consent policy, 5 outside billing and coding reviews, Ohio LCD Medicare policy and EMG CME and the CMPI NCV/EMG medical indications form.

Conclusions:
1. CPMI's informed consent is appropriate and based on the AANEM informed consent policy.
2. CPMI NCV EMG policy appropriately addresses documenting medical necessity.
3. The CMPI NCV/EMG medical indications form appropriately addresses documenting medical necessity.
4. The policy description of our scope of practice according to Ohio LCD is appropriate.
5. In pain medicine practice it is reasonable to use NCV/EMG to document organic pathology as required for proper narcotic medication/ pain program management.
6. The attached CMEs, outside reviews and staff education are appropriate.

Very truly yours,

Bernard M. Abrams, M.D.

Confidential and part of settlement discussions governed by Fed. R. Evid. 408. Nothing in this presentation shall be construed as intending to waive or waiving otherwise applicable attorney-client or work product privileges.

Exhibit III

KeyCite Yellow Flag - Negative Treatment
Unconstitutional or Preempted Negative Treatment Reconsidered by Florida ex rel. Atty. Gen. v. U.S. Dept. of Health and Human Services, 11th Cir.(Fla.), Aug. 12, 2011

KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

United States Code Annotated
Title 42. The Public Health and Welfare
Chapter 7. Social Security (Refs & Annos)
Subchapter XVIII. Health Insurance for Aged and Disabled (Refs & Annos)
Part E. Miscellaneous Provisions (Refs & Annos)

42 U.S.C.A. § 1395ddd

§ 1395ddd. Medicare Integrity Program

Effective: July 22, 2016
Currentness

(a) Establishment of Program

There is hereby established the Medicare Integrity Program (in this section referred to as the "Program") under which the Secretary shall promote the integrity of the medicare program by entering into contracts in accordance with this section with eligible entities, or otherwise, to carry out the activities described in subsection (b).

(b) Activities described

The activities described in this subsection are as follows:

(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this subchapter (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this subchapter as of August 21, 1996).

(2) Audit of cost reports.

(3) Determinations as to whether payment should not be, or should not have been, made under this subchapter by reason of section 1395y(b) of this title, and recovery of payments that should not have been made.

(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

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(A) In general

In the case of a provider of services or supplier that is determined to have received an overpayment under this subchapter and that seeks a reconsideration by a qualified independent contractor on such determination under section 1395ff(b)(1) of this title, the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1395ff(b)(1) of this title (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

(B) Collection with interest

Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

(C) Medicare contractor defined

For purposes of this subsection, the term "medicare contractor" has the meaning given such term in section 1395zz(g) of this title.

(3) Limitation on use of extrapolation

A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless the Secretary determines that--

(A) there is a sustained or high level of payment error; or

(B) documented educational intervention has failed to correct the payment error.

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise, of determinations by the Secretary of sustained or high levels of payment errors under this paragraph.

(4) Provision of supporting documentation

In the case of a provider of services or supplier with respect to which amounts were previously overpaid, a medicare contractor may request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

(5) Consent settlement reforms

(A) In general

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Exhibit JJJ

386 F.Supp.3d 644
United States District Court, E.D. Virginia, Alexandria Division.

LIVINRITE, INC., Plaintiff,
v.
Alex M. AZAR, II, Secretary of the United States Department of Health and Human Services, Defendant.

Civil Action No. 1:18-cv-00603
|
Signed 06/17/2019

Synopsis

Background: Medicare-certified home health services provider sought review of decision by Medicare Appeals Council (MAC) that provider had been overpaid approximately $1 million for certain Medicare claims. Parties cross-moved for summary judgment.

Holdings: The District Court, T. S. Ellis, J., held that:

[1] MAC's decision that sampling methodology could be accurately replicated was rational and based on substantial evidence;

[2] MAC adequately explained its determination that there was no Medicare coverage for occupational therapy visit;

[3] MAC adequately explained its determination that there was no Medicare coverage for nursing services;

[4] substantial evidence supported MAC's determination that there was no Medicare coverage for physical therapy services;

[5] MAC adequately explained its determination that there was no Medicare coverage for initial period of skilled nursing services;

[6] MAC's determination that provider was not entitled to limitation of its liability to reimburse overpayments was supported by substantial evidence and not contrary to law; and

[7] MAC's determination that provider was not entitled to waiver of recoupment for overpayments was supported by substantial evidence and not contrary to law.

Plaintiff's motion denied; defendant's motion granted.

Procedural Posture(s): Review of Administrative Decision; Motion for Summary Judgment.

West Headnotes (26)

[1] **Administrative Law and Procedure** Judicial role or function in general

When a party seeks judicial review of agency action under the Administrative Procedure Act (APA), the district judge sits as an appellate tribunal. 5 U.S.C.A. § 706.

[2] **Administrative Law and Procedure** Standards and grounds for summary judgment or disposition; evidence

Given a district court's limited role in reviewing an administrative record under the Administrative Procedure Act (APA), the ordinary summary judgment standard does not apply; the key difference in an APA case is that the presence or absence of a genuine dispute of material fact is not in issue, as the facts are all set forth in the administrative record. 5 U.S.C.A. § 706.

1 Cases that cite this headnote

[3] **Administrative Law and Procedure** Questions of law or fact in general

In a review of agency action under the Administrative Procedure Act (APA), the entire case on review is a question of law. 5 U.S.C.A. § 706.

[4] **Health** Evidence

"Substantial evidence," as required to support factual findings by the Medicare Appeals Council (MAC), does not mean a large or

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that is, (i) the method must be capable of selecting a set of enumerable, distinct samples from the sampling frame and (ii) each sampling unit must have a known probability of being selected that is greater than zero.[4] Fifth, the contractors must review each unit in the selected sample and determine if an overpayment has been made. *Id.* §§ 8.4.1.3, 8.4.6.3. Sixth, the contractor must estimate the total overpayment to the provider during the review period by extrapolating the results from the selected sample to the entire sampling frame. *Id.* §§ 8.4.1.3, 8.4.5.

A provider may challenge a Medicare contractor's calculation of overpayment through the administrative appeals process.[5] The use of statistical sampling by the contractor "creates a presumption of validity as to the amount of an overpayment." CMS Ruling 86-1 at 11. It is the provider's burden to overcome this presumption by demonstrating either (i) that the sample is not statistically valid or (ii) that the contractor's determinations of overpayment with respect to specific units in the selected sample are incorrect. *Id.*

First, the provider may challenge the statistical validity of the sample selected by the contractor. A challenge to the validity of the sample "must be predicated on ***654** the actual statistical validity of the sample as drawn and conducted." MPIM § 8.4.1.1. Accordingly, "[i]f a particular probability sample design is properly executed" in accordance with the six steps set forth above, "then assertions that the sample and its resulting estimates are 'not statistically valid' cannot legitimately be made." *Id.* § 8.4.2. Put simply, "a probability sample and its results are always 'valid.' " *Id.*

Second, the provider may challenge the contractor's determination that certain sampling units in the selected sample are not covered by the Medicare Act and thus resulted in an overpayment to the provider. In this respect, home health services qualify for Medicare coverage if such services are "reasonable and necessary" and are provided to a beneficiary who is (i) confined to the home, (ii) under the care of a physician who establishes a plan of care in accordance with 42 C.F.R. § 409.43, and (iii) in need of "skilled services" as certified by a physician. 42 U.S.C. §§ 1395f(a)(2)(C), 1395y(a)(1)(A); 42 C.F.R. § 409.42. A skilled service is one that is "so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel." 42 C.F.R. § 409.32

IV.

[7] Plaintiff first argues that the MAC's decision should be set aside because the MAC's decision that AdvanceMed's sampling methodology could be accurately replicated is arbitrary and capricious, incorrectly applies the relevant legal standards, and is not supported by substantial evidence in the record. Notably, plaintiff does not challenge the MAC's determination that the sampling methodology applied by AdvanceMed was statistically valid.[6] Rather, plaintiffs argument, distilled to its essence, is that AdvanceMed's extrapolated overpayment determination must be invalidated because it is impossible to replicate the sample based on the materials in the record.

In addition to providing contractors with instructions on the proper execution of statistical sampling for overpayment calculation, the MPIM also requires Medicare contractors to document the sampling methodology, the sampling universe and frame, and the random number selection process that were used to estimate overpayment. MPIM §§ 8.4.4.2, 8.4.4.4, 8.4.4.4.1, 8.4.4.4.3. The purpose of these documentation requirements is to ensure that the sampling frame and the sample can be replicated in the event that the methodology is challenged. *Id.* §§ 8.4.4.2, 8.4.4.4.1. As previous MAC decisions have concluded, failure to supply the provider with sufficient documentation to recreate the sampling frame and sample effectively deprives the provider of its right to challenge the statistical validity of the sample and thus may constitute a ground for invalidating the overpayment extrapolation. *See William Vecchioni, D.C.*, M-13-3700 (H.H.S. Nov. 20, 2013); *Global Home Care, Inc.*, M-11-116 (H.H.S. Jan. 11, 2011); *Podiatric Medical Associates*, M-10-230 (H.H.S. June 22, 2010).

But here, as the MAC concluded, plaintiff was provided with ample documentation to enable plaintiff to replicate the sampling frame and the sample. The record confirms that the statistical sampling information CMS provided to plaintiff included, ***655** *inter alia*, an electronic spreadsheet of the frame used in the overpayment review; a memorandum explaining the universe, sampling frame, sampling unit, sample size, and sample design; the sample that was selected from the frame; and the exact random numbers that were generated and used to select the sample from the frame. And it is undisputed that applying the random numbers provided by CMS to the sampling frame provided by CMS would generate the same sample as the one selected and

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Exhibit KKK

CareSource Remittance Advice (EOB) Examples — Abruptly Denied and Recouped Claims, 2016–2017

Member names, member ID numbers, patient account numbers, payer claim numbers, claim-level reference numbers and month/day of service have been redacted (HIPAA Safe Harbor, 45 C.F.R. § 164.514(b)(2)).

Payer Information

Name : CareSource
Identifier : 31114 (XV)
Address : P.O. Box 1920
Dayton, OH 45401

Payment Information

Payee Name : Comprehensive Pain Management
Payee Identifier : 900595881 (FI)
Address : 23901 Timberlane Dr
Beachwood, OH 44122-1556

Payment Method : NON
Payment Date : 11/15/2017
Check/EFT Number : 0266746

DOS	Proc. (M)	Charges	Allowed	Payment			Reason	Remarks
Insured: [redacted]								
Service [redacted]								
Claim/Patient Account Number: [redacted]								
Status: Processed as Primary								
DOS 2017	G0397	$130.00	$69.62	$39.62	$30.00	$60.38	PR-3,OA-45	N45N381
SUBTOTAL	1	$130.00	$69.62	$39.62	$30.00	$60.38		
CLAIM ADJUSTMENTS				$0.00				
CLAIM TOTAL				$39.62				
Insured: [redacted]								
Service [redacted]								
Claim/Patient Account Number: [redacted]								
Status: Processed as Primary								
DOS 2017 [redacted]	99213	$150.00	$70.93	$60.93	$10.00	$79.07	PR-3,OA-45	N45N381
	80307	$180.00	$47.41	$47.41		$132.59	OA-45	N381
SUBTOTAL	2	$330.00	$118.34	$108.34	$10.00	$211.66		
CLAIM ADJUSTMENTS				$0.00				
CLAIM TOTAL				$108.34				
Insured: [redacted]								
Service [redacted]								
Claim/Patient Account Number: [redacted]								
Status: Processed as Primary								
DOS 2017 [redacted]	99213	$150.00	$70.93	$60.93	$10.00	$79.07	PR-3,OA-45	N45N381
	80307	$180.00	$47.41	$47.41		$132.59	OA-45	N381
SUBTOTAL	2	$330.00	$118.34	$108.34	$10.00	$211.66		
CLAIM ADJUSTMENTS				$0.00				
CLAIM TOTAL				$108.34				
Insured: [redacted]								
Service [redacted]								
Claim/Patient Account Number: [redacted]								
Product Name: Medicaid ABD (Aged, Blind or Disabled)								
Status: Processed as Primary								
DOS 2017 [redacted]	64450	$440.00	$110.29	$110.29		$329.71	OA-45	N381
	76942	$400.00	$57.76	$57.76		$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79		$104.21	OA-45	N381
	80307	$180.00	$47.29	$47.29		$132.71	OA-45	N381
	80320	$20.00	$15.48	$15.48		$4.52	OA-45	N381
	G0397	$130.00	$50.06	$50.06		$79.94	OA-45	N381
SUBTOTAL	6	$1,290.00	$296.67	$296.67		$993.33		
CLAIM ADJUSTMENTS				$0.00				
CLAIM TOTAL				$296.67				
Insured: [redacted]								
Service Provider: 1780087643 [redacted]								
Claim/Patient Account Number: [redacted]								
Product Name: Medicaid ABD (Aged, Blind or Disabled)								
Status: Processed as Primary								
DOS 2017 [redacted]	99213(25SA)	$150.00	$43.61	$43.61		$106.39	OA-45	N381
	G0397(SA)	$130.00		$0.00		$130.00	OA-B10	N390
	80307(SA)	$180.00	$45.04	$45.04		$134.96	OA-45	N381
	80320(SA)	$20.00	$14.74	$14.74		$5.26	OA-45	N381
SUBTOTAL	4	$480.00	$103.39	$103.39		$376.61		
CLAIM ADJUSTMENTS				$0.00				
CLAIM TOTAL				$103.39				
Insured: [redacted]								
Service [redacted]								
Claim/Patient Account Number: [redacted]								
Product Name: Medicaid ABD (Aged, Blind or Disabled)								
Status: Processed as Primary								
DOS 2017 [redacted]	64418(50SA)	$275.00	$80.20	$80.20		$194.80	OA-45	N381
	76942(SA)	$400.00	$55.01	$55.01		$344.99	OA-45	N381
	J3301(SA)	$120.00		$0.00		$120.00	OA-45	N381
	80307(SA)	$180.00	$45.04	$45.04		$134.96	OA-45	N381
	80320(SA)	$20.00	$14.74	$14.74		$5.26	OA-45	N381
	G0397(SA)	$130.00	$47.68	$47.68		$82.32	OA-45	N381
SUBTOTAL	6	$1,125.00	$242.67	$242.67		$882.33		
CLAIM ADJUSTMENTS				$0.00				
CLAIM TOTAL				$242.67				
Insured: [redacted]								
Service [redacted]								
Claim/Patient Account Number: [redacted]								
Product Name: Medicaid ABD (Aged, Blind or Disabled)								
Status: Processed as Primary								
DOS 2017 [redacted]	99213(SA)	$150.00		$0.00		$150.00	OA-27	N30
	80307(SA)	$180.00		$0.00		$180.00	OA-27	N30
	80320(SA)	$20.00		$0.00		$20.00	OA-27	N30
SUBTOTAL	3	$350.00		$0.00		$350.00		
CLAIM ADJUSTMENTS				$0.00				
CLAIM TOTAL				$0.00				
Insured: [redacted]								
Service [redacted]								
Claim/Patient Account Number: [redacted]								
Product Name: Medicaid ABD (Aged, Blind or Disabled)								

Status: Processed as Primary

DOS 2017	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
SUBTOTAL	1	$130.00	$50.06	$50.06	$79.94		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $50.06

Insured: [redacted]
Service Provider: 1619178308 [redacted]
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017	64418(50)	$275.00	$126.32	$126.32	$148.68	OA-59	N19
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
	80307	$180.00	$47.29	$47.29	$132.71	OA-45	N381
	80320	$20.00	$15.48	$15.48	$4.52	OA-45	N381
SUBTOTAL	6	$1,125.00	$312.70	$312.70	$812.30		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $312.70

Insured: [redacted]
Service Provider: 1619178308 [redacted]
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017	64418(50)	$275.00	$126.32	$126.32	$148.68	OA-59	N19
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	80307	$180.00	$47.29	$47.29	$132.71	OA-45	N381
	80320	$20.00	$15.48	$15.48	$4.52	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
SUBTOTAL	6	$1,125.00	$312.70	$312.70	$812.30		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $312.70

Insured: [redacted]
Service Provider: 1619178308 [redacted]
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
SUBTOTAL	1	$130.00	$50.06	$50.06	$79.94		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $50.06

Insured: [redacted]
Service Provider: 1619178308 [redacted]
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017	64450	$440.00	$110.29	$110.29	$329.71	OA-45	N381
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
SUBTOTAL	4	$1,090.00	$233.90	$233.90	$856.10		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $233.90

Insured: [redacted]
Service Provider: 1619178308 [redacted]
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
SUBTOTAL	1	$130.00	$50.06	$50.06	$79.94		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $50.06

Insured: [redacted]
Service Provider: 1619178308 [redacted]
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017	64450	$440.00	$110.29	$110.29	$329.71	OA-45	N381
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
	80307	$180.00	$47.29	$47.29	$132.71	OA-45	N381
	80320	$20.00	$15.48	$15.48	$4.52	OA-45	N381
SUBTOTAL	6	$1,290.00	$296.67	$296.67	$993.33		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $296.67

Insured: [redacted]
Service Provider: 1780087643 [redacted]
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017	64450(SA)	$440.00	$105.04	$105.04	$334.96	OA-45	N381
	76942(SA)	$400.00	$55.01	$55.01	$344.99	OA-45	N381
	J3301(SA)	$120.00		$0.00	$120.00	OA-45	N381
	G0397(SA)	$130.00	$47.68	$47.68	$82.32	OA-45	N381
SUBTOTAL	4	$1,090.00	$207.73	$207.73	$882.27		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $207.73

Insured: [redacted]
Service Provider: 1619178308 [redacted]
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017	64418(50)	$275.00	$126.32	$126.32	$148.68	OA-59	N19
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381

[redacted]	80307	$180.00	$47.29	$47.29	$132.71	OA-45	N381
	80320	$20.00	$15.48	$15.48	$4.52	OA-45	N381
SUBTOTAL	6	$1,125.00	$312.70	$312.70	$812.30		
CLAIM ADJUSTMENTS					$0.00		
CLAIM TOTAL					$312.70		

Insured: [redacted]
Service Provider: 1619178308 (XX) MARCOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017 [redacted]	99213	$150.00	$45.79	$45.79	$104.21	OA-45	N381
SUBTOTAL	1	$150.00	$45.79	$45.79	$104.21		
CLAIM ADJUSTMENTS					$0.00		
CLAIM TOTAL					$45.79		

Insured: [redacted]
Service Provider: 1619178308 (XX) MARCOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017 [redacted]	64418(50)	$275.00	$126.32	$126.32	$148.68	OA-59	N19
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
SUBTOTAL	4	$925.00	$249.93	$249.93	$675.07		
CLAIM ADJUSTMENTS					$0.00		
CLAIM TOTAL					$249.93		

Insured: [redacted]
Service Provider: 1619178308 (XX) MARCOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017 [redacted]	64450	$440.00	$110.29	$110.29	$329.71	OA-45	N381
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
	80307	$180.00	$47.29	$47.29	$132.71	OA-45	N381
	80320	$20.00	$15.48	$15.48	$4.52	OA-45	N381
SUBTOTAL	6	$1,290.00	$296.67	$296.67	$993.33		
CLAIM ADJUSTMENTS					$0.00		
CLAIM TOTAL					$296.67		

Insured: [redacted]
Service Provider: 1619178308 (XX) MARCOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017 [redacted]	64418(50)	$275.00	$126.32	$126.32	$148.68	OA-59	N19
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
SUBTOTAL	4	$925.00	$249.93	$249.93	$675.07		
CLAIM ADJUSTMENTS					$0.00		
CLAIM TOTAL					$249.93		

Insured: [redacted]
Service Provider: 1619178308 (XX) MARCOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017 [redacted]	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
SUBTOTAL	1	$130.00	$50.06	$50.06	$79.94		
CLAIM ADJUSTMENTS					$0.00		
CLAIM TOTAL					$50.06		

Insured: [redacted]
Service Provider: 1619178308 (XX) MARCOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017 [redacted]	64450	$440.00	$110.29	$110.29	$329.71	OA-45	N381
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
	80307	$180.00	$47.29	$47.29	$132.71	OA-45	N381
	80320	$20.00	$15.48	$15.48	$4.52	OA-45	N381
SUBTOTAL	6	$1,290.00	$296.67	$296.67	$993.33		
CLAIM ADJUSTMENTS					$0.00		
CLAIM TOTAL					$296.67		

Insured: [redacted]
Service Provider: 1619178308 (XX) MARCOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017 [redacted]	99213	$150.00	$45.79	$45.79	$104.21	OA-45	N381
	1	$150.00	$45.79	$45.79	$104.21		
CLAIM ADJUSTMENTS					$0.00		
CLAIM TOTAL					$45.79		

Insured: [redacted]
Service Provider: 1619178308 (XX) MARCOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017 [redacted]	64450	$440.00	$110.29	$110.29	$329.71	OA-45	N381
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
	80307	$180.00	$47.29	$47.29	$132.71	OA-45	N381
	80320	$20.00	$15.48	$15.48	$4.52	OA-45	N381
SUBTOTAL	6	$1,290.00	$296.67	$296.67	$993.33		
CLAIM ADJUSTMENTS					$0.00		

CLAIM TOTAL $296.67

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017 [redacted]	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
SUBTOTAL	1	$130.00	$50.06	$50.06	$79.94		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $50.06

Insured: [redacted]
Service Provider: 1780087643 (XX) GOU, ANNG
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017 [redacted]	64450(SA)	$440.00	$105.04	$105.04	$334.96	OA-45	N381
	76942(SA)	$400.00	$55.01	$55.01	$344.99	OA-45	N381
	J3301(SA)	$120.00		$0.00	$120.00	OA-45	N381
	G0397(SA)	$130.00	$47.68	$47.68	$82.32	OA-45	N381
SUBTOTAL	4	$1,090.00	$207.73	$207.73	$882.27		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $207.73

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017 [redacted]	64450	$440.00	$110.29	$110.29	$329.71	OA-45	N381
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
	80307	$180.00	$47.29	$47.29	$132.71	OA-45	N381
SUBTOTAL	5	$1,270.00	$281.19	$281.19	$988.81		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $281.19

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017 [redacted]	64405	$460.00		$0.00	$460.00	OA-B5	N435
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$60.00	$7.90	$7.90	$52.10	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
SUBTOTAL	4	$1,050.00	$115.72	$115.72	$934.28		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $115.72

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid ABD (Aged, Blind or Disabled)
Status: Processed as Primary

DOS 2017 [redacted]	64450	$440.00	$110.29	$110.29	$329.71	OA-45	N381
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
	80307	$180.00	$47.29	$47.29	$132.71	OA-45	N381
	80320	$20.00	$15.48	$15.48	$4.52	OA-45	N381
SUBTOTAL	6	$1,290.00	$296.67	$296.67	$993.33		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $296.67

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid CFC (Covered Families and Children)
Status: Processed as Primary

DOS 2017 [redacted]	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
SUBTOTAL	1	$130.00	$50.06	$50.06	$79.94		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $50.06

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid CFC (Covered Families and Children)
Status: Processed as Primary

DOS 2017 [redacted]	64450	$440.00	$110.29	$110.29	$329.71	OA-45	N381
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
	80307	$180.00	$47.29	$47.29	$132.71	OA-45	N381
	80320	$20.00	$15.48	$15.48	$4.52	OA-45	N381
SUBTOTAL	6	$1,290.00	$296.67	$296.67	$993.33		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $296.67

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid CFC (Covered Families and Children)
Status: Processed as Primary

DOS 2017 [redacted]	64418(50)	$275.00	$126.32	$126.32	$148.68	OA-59	N19
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
SUBTOTAL	4	$925.00	$249.93	$249.93	$675.07		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $249.93

Insured: [redacted]
Service Provider: 1780087843 (XX) [redacted]
Claim/Patient Account Number: [redacted]
Product Name: Medicaid CFC (Covered Families and Children)
Status: Processed as Primary

DOS 2017 [redacted]	64418(50SA)	$275.00	$80.20	$80.20	$194.80	OA-45	N381
	76942(SA)	$400.00	$55.01	$55.01	$344.99	OA-45	N381
	G0397(SA)	$130.00	$47.68	$47.68	$82.32	OA-45	N381
	80307(SA)	$180.00	$45.04	$45.04	$134.96	OA-45	N381
	80320(SA)	$20.00	$14.74	$14.74	$5.26	OA-45	N381
	5	$1,005.00	$242.67	$242.67	$762.33		
CLAIM ADJUSTMENTS				$0.00			
CLAIM TOTAL				$242.67			

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid CFC (Covered Families and Children)
Status: Processed as Primary

DOS 2017 [redacted]	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
	1	$130.00	$50.06	$50.06	$79.94		
CLAIM ADJUSTMENTS				$0.00			
CLAIM TOTAL				$50.06			

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid CFC (Covered Families and Children)
Status: Processed as Primary

DOS 2017 [redacted]	64418(50)	$275.00	$126.32	$126.32	$148.68	OA-59	N19
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
	80307	$180.00	$47.29	$47.29	$132.71	OA-45	N381
	80320	$20.00	$15.48	$15.48	$4.52	OA-45	N381
	6	$1,125.00	$312.70	$312.70	$812.30		
CLAIM ADJUSTMENTS				$0.00			
CLAIM TOTAL				$312.70			

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid CFC (Covered Families and Children)
Status: Processed as Primary

DOS 2017 [redacted]	64450	$440.00	$110.29	$110.29	$329.71	OA-45	N381
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	80307	$180.00	$47.29	$47.29	$132.71	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
	5	$1,270.00	$281.19	$281.19	$988.81		
CLAIM ADJUSTMENTS				$0.00			
CLAIM TOTAL				$281.19			

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid CFC (Covered Families and Children)
Status: Processed as Primary

DOS 2017 [redacted]	64450	$440.00	$110.29	$110.29	$329.71	OA-45	N381
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	80307	$180.00	$47.29	$47.29	$132.71	OA-45	N381
	80320	$20.00	$15.48	$15.48	$4.52	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
	6	$1,290.00	$296.67	$296.67	$993.33		
CLAIM ADJUSTMENTS				$0.00			
CLAIM TOTAL				$296.67			

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid CFC (Covered Families and Children)
Status: Processed as Primary

DOS 2017 [redacted]	64450	$440.00	$110.29	$110.29	$329.71	OA-45	N381
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
	4	$1,090.00	$233.90	$233.90	$856.10		
CLAIM ADJUSTMENTS				$0.00			
CLAIM TOTAL				$233.90			

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid CFC (Covered Families and Children)
Status: Processed as Primary

DOS 2017 [redacted]	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
	1	$130.00	$50.06	$50.06	$79.94		
CLAIM ADJUSTMENTS				$0.00			
CLAIM TOTAL				$50.06			

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid CFC (Covered Families and Children)
Status: Processed as Primary

DOS 2017 [redacted]	64450	$220.00		$0.00	$220.00	OA-27	N30
	76942	$400.00		$0.00	$400.00	OA-27	N30
	J3301	$60.00		$0.00	$60.00	OA-27	N30
	80307	$180.00		$0.00	$180.00	OA-27	N30
	80320	$20.00		$0.00	$20.00	OA-27	N30
	G0397	$130.00		$0.00	$130.00	OA-27	N30
	6	$1,010.00		$0.00	$1,010.00		
CLAIM ADJUSTMENTS				$0.00			
CLAIM TOTAL				$0.00			

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid CFC (Covered Families and Children)
Status: Processed as Primary

DOS 2017	99213	$150.00	$45.79	$45.79	$104.21	OA-45	N381
	1	$150.00	$45.79	$45.79	$104.21		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $45.79

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid CFC (Covered Families and Children)
Status: Processed as Primary

DOS 2017	99213	$150.00	$45.79	$45.79	$104.21	OA-45	N381
	1	$150.00	$45.79	$45.79	$104.21		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $45.79

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid CFC (Covered Families and Children)
Status: Processed as Primary

DOS 2017	64418(50)	$275.00	$126.32	$126.32	$148.68	OA-59	N19
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	80307	$180.00	$47.29	$47.29	$132.71	OA-45	N381
	80320	$20.00	$15.48	$15.48	$4.52	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
	6	$1,125.00	$312.70	$312.70	$812.30		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $312.70

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid CFC (Covered Families and Children)
Status: Processed as Primary

DOS 2017	64418(50)	$275.00	$126.32	$126.32	$148.68	OA-59	N19
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
	80307	$180.00	$47.29	$47.29	$132.71	OA-45	N381
	80320	$20.00	$15.48	$15.48	$4.52	OA-45	N381
	6	$1,125.00	$312.70	$312.70	$812.30		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $312.70

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid CFC (Covered Families and Children)
Status: Processed as Primary

DOS 2017	64450	$440.00	$110.29	$110.29	$329.71	OA-45	N381
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	G0396	$130.00	$26.30	$26.30	$103.70	OA-45	N381
	80307	$180.00	$47.29	$47.29	$132.71	OA-45	N381
	80320	$20.00	$15.48	$15.48	$4.52	OA-45	N381
	6	$1,290.00	$272.91	$272.91	$1,017.09		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $272.91

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid CFC (Covered Families and Children)
Status: Processed as Primary

DOS 2017	64418(50)	$275.00	$126.32	$126.32	$148.68	OA-59	N19
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	80307	$180.00	$47.29	$47.29	$132.71	OA-45	N381
	80320	$20.00	$15.48	$15.48	$4.52	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
	6	$1,125.00	$312.70	$312.70	$812.30		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $312.70

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid CFC (Covered Families and Children)
Status: Processed as Primary

DOS 2017	64450	$440.00	$110.29	$110.29	$329.71	OA-45	N381
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
	80307	$180.00	$47.29	$47.29	$132.71	OA-45	N381
	80320	$20.00	$15.48	$15.48	$4.52	OA-45	N381
	6	$1,290.00	$296.67	$296.67	$993.33		

CLAIM ADJUSTMENTS $0.00

CLAIM TOTAL $296.67

Insured: [redacted]
Service Provider: 1619178308 (XX) MARGOLIN, LEON
Claim/Patient Account Number: [redacted]
Product Name: Medicaid CFC (Covered Families and Children)
Status: Processed as Primary

DOS 2017	64418(50)	$275.00	$126.32	$126.32	$148.68	OA-59	N19
	76942	$400.00	$57.76	$57.76	$342.24	OA-45	N381
	J3301	$120.00	$15.79	$15.79	$104.21	OA-45	N381
	80307	$180.00	$47.29	$47.29	$132.71	OA-45	N381
	80320	$20.00	$15.48	$15.48	$4.52	OA-45	N381
	G0397	$130.00	$50.06	$50.06	$79.94	OA-45	N381
	6	$1,125.00	$312.70	$312.70	$812.30		