INTERNAL MEDICINE ASSOCIATES, LTD.

REDACTED

INTERNAL MEDICINE
John A. Wood, M.D.
Jay P. Marshall II, M.D., F.A.C.P.
Keith A. Bernstein, M.D.
Charlotte J. Kennedy, M.D., Ph.D.
Barbara C. Jost, M.D.

ALLERGY—IMMUNOLOGY
John A. Wood, M.D.
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GASTROENTEROLOGY
Jay P. Marshall II, M.D., F.A.C.P.

PULMONARY MEDICINE
John A. Wood, M.D.

RHEUMATOLOGY
Linda M. Hunt, M.D.
Keith A. Bernstein, M.D.

Business Manager:
Kim Kaemmerlen

Hospital Affiliations: St. Luke's and Barnes-Jewish

January 16, 2013

US Department of Health and Human Services
Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS
PO Box 23489
Washington, D.C. 20026

To Whom It May Concern:

Attached please find faxed requests for prescriptions for assorted medical equipment and medical testing products. Please be advised that every single one of these patients did not request any of these devices or products. These were cold calls to their homes and, in fact at one point, one patient was badgered several times over several days to try to get her to agree to take what the particular company was offering.

I would appreciate it if you would investigate these companies and hopefully put them out of business as I believe they are defrauding both the taxpayers of our country and our state and the insurance companies as well as the patients themselves who are paying the premiums and the taxpayers who are paying for Medicare and Medicaid. Thank you very much.

Sincerely,

Charlotte J. Kennedy

Charlotte J. Kennedy, M.D., Ph.D.

CJK/cmc

cc Senator Roy Blunt
Senator Claire McCaskill

Attachments:
US Healthcare Supply, LLC
Carepoint Pharmacy
Eastern Arkansas Diabetic and Medical
Med-Care Diabetic & Medical Supplies, Inc.

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REDACTED

January 16, 2013

Missouri Attorney General's Office
Supreme Court Building
207 W. High Street
P.O. Box 899
Jefferson City, MO 65102

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January 16, 2013

Missouri Department of Insurance
P.O. Box 690
Jefferson City, MO 65102-0690

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Senator Claire McCaskill

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US Healthcare Supply, LLC
Carepoint Pharmacy
Eastern Arkansas Diabetic and Medical
Med-Care Diabetic & Medical Supplies, Inc.

Physician Order for Lumbar Orthosis Brace (L0631)

US HEALTHCARE SUPPLY, LLC
14 BRIDGE STREET
PO BOX 372
MILFORD, NJ 08848

PATIENT HAS REQUESTED THESE SUPPLIES

PLEASE FAX BACK TO

** (877) 641-1777 **

Questions? Call us!! (877) 521-1555

PATIENT INFORMATION	PHYSICIAN INFORMATION
NAME: REDACTED	DR: CHARLOTTE KENNEDY
ADDRESS: REDACTED	ADDRESS: REDACTED
, MC	, MO
DOB:	PHONE: FAX:

IMPORTANT INSTRUCTIONS: *Please complete all sections below* to reflect the current treatment regimen prescribed for your beneficiary.

1 **ICD-9 CODE:**
- ☐ SPINAL STENOSIS - 724.00
- ☐ DEGENERATIVE DISC DISEASE - 722.6
- ☐ SPONDYLOLYSIS (CONGENITAL) - 756.11
- ☐ HERNIATED DISC (LUMBAR) - 722.10
- ☐ SPONDYLOLISTHESIS (LUMBAR) - 756.12
- ☐ OTHER (PLEASE SPECIFY) ___ ___ ___ . ___ ___

2 **PATIENT SIZING:** Choose size relative to measurement around patient's naval.
- ☐ X-SMALL 23-26 inches
- ☐ SMALL 27-30 inches
- ☐ MEDIUM 31-35 inches
- ☐ LARGE 36-40 inches
- ☐ X-LARGE 41-44 inches
- ☐ 2X-LARGE 45-48 inches
- ☐ 3X-LARGE 49-53 inches
- ☐ 4X-LARGE 54-59 inches
- ☐ 5X-LARGE 60-65 inches

ITEM DESCRIPTION & HCPCS CODE: LSO - LUMBAR ORTHOSIS BRACE - L0631
Lumbar Sacral Orthosis, Sagittal-Coronal Control, with Rigid Anterior and Posterior panels, Posterior Extends from Sacrococcygeal Junction to T-9 Vertebra.

3 **LENGTH OF NEED IS:** 99 MONTHS (Unless Specified): ☐ OTHER: _____ MONTH(S)

4 **MEDICARE REQUIRES A REASON for using a Lumbar Orthosis - SPINAL SUPPORT BRACE.** I confirmed that I have seen this patient within the last six (6) months to evaluate their above mentioned diagnosis and have identified the reason for using this support below. ***By signing below, I am confirming one or more of the reasons is/are denoted in my patient's medical records.***
- ☐ Reduce pain by restricting mobility of the trunk
- ☐ Support weak spinal muscles and/or a deformed spine
- ☐ Facilitate healing from spinal or soft tissue injury or surgical procedure
- ☐ Other (please specify): _____

Please document this exact reason in medical records.

5 **PHYSICIAN SIGNATURE:** _____ CHARLOTTE KENNEDY **DATE:** ____/____/____ INDICATES START DATE

NPI # (for Validation): _____ _____ _____

WE NEED MEDICAL RECORDS!!!

BY SIGNING ABOVE, I agree to obtain the original, signed copy of this document in my medical records. My medical records and recent charts substantiate I am treating this patient under a comprehensive care plan for the above mentioned diagnosis and the patient is able to use this item herein ordered to manage his/her condition. This order accurately reflects the patient documented diagnosis, condition and prescribed treatment.

The information contained in this facsimile message contains confidential patient health information intended for the sole use of the individual named above. If you are not the intended recipient listed above, you are hereby notified that any disclosure, duplication or distribution of this information or the taking of any action in reliance on the contents of this transmission without the express written consent of our office is strictly prohibited. If you have received this fax transmission in error, please notify our office immediately at (877) 521-1555.

US HEALTHCARE SUPPLY, LLC
14 BRIDGE STREET
PO BOX 372
MILFORD, NJ 08848

To: Dr. CHARLOTTE KENNEDY From: Medical Records Team Re: Patient ID: REDACTED	Fax: (Date: 12/24/2012 REDACTED Tel: (

PLEASE REPLY - YOUR RESPONSE IS URGENT

Your patient has requested to receive his/her **Back Brace** (Lumbar-Sacral Orthosis) from our company. **Medicare is requesting Medical Records** supporting the need for this supply. **Without these records, patient may be responsible for additional out-of-pocket costs**, which we want to avoid. A Back Brace (Lumbar-Sacral Orthosis (L0627-L0631)) is covered when it is ordered for one of the following indications:

1. **To reduce pain by restricting mobility of the trunk; or**
2. **To facilitate healing following an injury to the spine or related soft tissues; or**
3. **To facilitate healing following a surgical procedure on the spine or related soft tissue; or**
4. **To otherwise support weak spinal muscles and/or a deformed spine.**

It is imperative that your patient medical records include an entry that contains the diagnosis reason as well as one of the above criteria. This should exactly support your order for this supply.

An example of this might be: "Patient visited office regarding pain & degenerative disk disease in the lumbar region. Back brace was ordered to reduce pain by restricting movement of the trunk."

If this medical indication or something similar is not currently reflected, please add to the medical records, date, initial, and fax back only the supporting documentation to:

FAX TO: *(877) 641-1777*

We appreciate having the opportunity to serve you and provide for your patient's needs. If you have any further questions please contact our help line toll-free at (877) 521-1555.
Thank you,
Medical Records Team
US HEALTHCARE SUPPLY, LLC

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Physician Order for Blood Glucose Testing

US HEALTHCARE SUPPLY, LLC
14 BRIDGE STREET
PO BOX 372
MILFORD, NJ 08848

PATIENT HAS REQUESTED THESE SUPPLIES

PLEASE FAX BACK TO
** (877) 641-1777 **

Questions?
Call us!!
(877) 521-1555
FAX ID:

PATIENT INFORMATION	PHYSICIAN INFORMATION
NAME: REDACTED ADDRESS: , MO DOB:	DR: CHARLOTTE KENNEDY (NPI: ADDRESS: REDACTED MO PHONE: FAX:

IMPORTANT INSTRUCTIONS: *Please complete all sections below* to reflect the current treatment regimen prescribed for your patient.

1 **INSULIN TREATED?** ☐ YES ☐ NO

2 **ICD-9 DIAGNOSIS CODE:** ☐ 250.00 ☐ 250.01 ☐ OTHER: _____

3 **LENGTH OF NEED IS:** ☐ 99 MONTHS OR ☐ OTHER: _____ MONTH(S)

4 **PATIENT TESTING FREQUENCY:**

☐ 3X/DAY	☐ 4X/DAY	☐ 5X/DAY	☐ 6X/DAY	☐ OTHER _____ X/DAY
300 Strips	400 Strips	450 Strips	550 Strips	
300 Lancets	400 Lancets	500 Lancets	600 Lancets	

SUPPLIES ORDERED:

Blood Glucose Meter (E0607) - 5 yr. Test Strips (A4253) - 3 mo. Control Solution (A4256) - 3 mo.
Replacement Batteries (A4235/A4233) - 6 mo. Lancet Device (A4258) - 6 mo. Lancets (A4259) - 3 mo.

5 ****MEDICARE REQUIRES A REASON for testing more frequently than 1X/Day for non-insulin treated OR more than 3X/Day for insulin treated.** I confirm that I have seen this patient within the last six(6) months to evaluate their diabetes control and have indentified the reasons for high frequency testing below. ***Please ensure this reason is denoted in your patient's medical records.***

☐ Uncontrolled blood sugar ☐ Hypoglycemia ☐ Hypertension
☐ Fluctuating blood sugar ☐ Hyperglycemia ☐ Obesity
☐ Other (please specify): _____

Please document testing frequency and reason for testing in medical records.

6 **CERTIFICATE FOR VISION IMPAIRED PATIENTS - For E2100 (Speaking Meter)**

1) Patient's best corrected visual acuity: a)_____/_____ or b) ☐ 20/200 or worse
2) Physician's narrative statement supporting medical necessity for a speaking meter (E2100):

FAX ID:

_____

7 **PHYSICIAN SIGNATURE:** _____ **DATE:** _____/_____/_____
CHARLOTTE KENNEDY INDICATES START DATE

NPI # (for Validation):_____ _____

WE NEED MEDICAL RECORDS!!!

BY SIGNING ABOVE, I agree to obtain the original, signed copy of this document in my medical records and the above mentioned patient has been evaluated by me for this diagnosis within the last 6 months. My medical records substantiate I am treating this patient under a comprehensive care plan for Diabetes Mellitus and the patient is able to use the items herein ordered to manage his/her glycemic control. This order accurately reflects the patient's documented diagnosis, condition, prescribed treatment and testing regimens.

The information contained in this facsimile message contains **confidential patient health information** intended for the sole use of the individual named above. If you are not the intended recipient listed above, you are hereby notified that any disclosure, duplication or distribution of this information or the taking of any action in reliance on the contents of this transmission without the express written consent of our office is **strictly prohibited**. If you have received this fax transmission in error, please notify our office immediately at (877) 521-1555.

US HEALTHCARE SUPPLY, LLC
14 BRIDGE STREET
PO BOX 372
MILFORD, NJ 08848

IF YOU HAVE ANY QUESTIONS, PLEASE CALL
OUR CUSTOMER SERVICE DEPARTMENT TOLL FREE
MONDAY - FRIDAY 9:00 AM THRU 5:00 PM EST
(877) 521-1555

PATIENT ID: REDACTED
DOCUMENT ID:
DATE SENT: 1/8/2013

DR. CHARLOTTE KENNEDY
REDACTED MO

Dear Dr. CHARLOTTE KENNEDY
RE: REDACTED

Please be informed that U.S. Healthcare Supply, LLC will be the new Glucose Testing Supply provider for your patient . Your patient's current provider, **American Diabetes Services** will not be able to service this customer.

US HEALTHCARE SUPPLY, LLC is able to provide your patient with uninterrupted service of the same product that they are currently using. Please complete the attached Doctor Supply Order and fax it back to us at

(877) 641-1777

If you have any questions or concerns please contact us at (877) 521-1555 Monday - Friday 9:00AM to 5:00 PM EST

Kindest Regards,

Patient Care
U.S. Healthcare Supply, LLC.

The information contained in this facsimile message contains confidential beneficiary health information intended for the sole use of the individual named above. If you are not the intended recipient listed above, you are hereby notified that any disclosure, duplication or distribution of this information or the taking of any action in reliance on the contents of this transmission without the express written consent of our office is strictly prohibited. If you have received this fax transmission in error, please notify our office immediately at (877) 521-1555.

5459
K
PC

Med-Care Diabetic & Medical Supplies, Inc.
933 Clint Moore Road
Boca Raton FL 33487
1-888-777-0737 Fax # 1-866-326-7765

Your patient has asked us to contact you regarding authorization for a CPAP machine and/or supplies to help with their Obstructive Sleep Apnea. In order to supply these products to our mutual patient, under the Medicare program, we must obtain a signed order by the patient's physician. Kindly sign and fax this form to our TOLL FREE FAX # above. **Please ensure the prescription is fully completed prior to returning.** We would like to thank you in advance for your immediate attention to this matter.

Patients Name: REDACTED DOB:

, MO Policy: COMMERCIAL ID:

DIAGNOSIS: **327.23** Obstructive Sleep Apnea; Adult or Pediatric

No - already has a machine

MACHINE TYPE(S):

➔ ☐ **CPAP or APAP** (E0601) **Pressure or Pressure Range:** _____ CM/H20

➔ ☐ **BiPAP / Bi-level / VPAP** (E0470) ***Pressure:** _____ / _____ CM/H20

MASK TYPE(S): ☑ ***PATIENT PREFERENCE UNLESS OTHERWISE SPECIFIED***

Full Face Mask (A7030: 1/3M) With Full Face Mask Cushion (A7031: 3/3M)
Nasal Pillow Mask (A7034: 1/3M) With Nasal Pillow (A7033: 6/3m)
Nasal Mask (A7034: 1/3M) With Nasal Mask Interface (A7032: 6/3m)

☐ **Other** BRAND: _____ SIZE: _____

The following dispensable equipment is necessary for the proper use of the PAP equipment and is not a part of the CPAP, Bi-level, BiPAP or AVAPs machine when purchased or rented and needs to be replaced on a regular basis. The equipment listed below is supplied and replaced based on the Medicare Replacement Schedule Allowable(s):

- ☑ TUBING (A7037: 1/3M)
- ☑ DISPOSABLE FILTER (A7038: 6/3M)
- ☑ NON- DISPOSABLE FILTER (A7039: 1/6M)
- ☑ HEADGEAR (A7035: 1/6M)
- ☐ CHINSTRAP (A7036: 1/6M)
- ☐ HEATED TUBING (A7046: 1/3M)
- ☐ REPLACEMENT WATER CHAMBER FOR HUMIDIFIER (A7046: 1/6M)
- ☐ OTHER _____

The above named patient was diagnosed as indicated. Due to the potentially dangerous consequences of disturbed sleep and sleep deprivation, which include the possibility of falling asleep in critical situations, treatment of this condition is considered mandatory rather than elective, on a nightly basis for a long term to lifetime duration (99 months). *Duration of need for equipment is LIFETIME, unless otherwise indicated* _____.

➔ **Physicians Signature:** _____ **Date:** _____

NPI #

Physician Name: CHARLOTTE KENNEDY PHD **Phone #** ( )
Fax#

MO

REDACTED

Med-Care Diabetic & Medical Supplies, Inc.
933 Clint Moore Road
Boca Raton FL 33487
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Patients Name REDACTED DOB

MO Policy: COMMERCIAL ID:

DIAGNOSIS: **327.23** Obstructive Sleep Apnea; Adult or Pediatric

MACHINE TYPE(S):

➔ ☐ **CPAP or APAP** (E0601) **Pressure or Pressure Range:** _____ CM/H20

➔ ☐ **BiPAP / Bi-level / VPAP** (E0470) ***Pressure:** _____/_____ CM/H20

MASK TYPE(S): ☑ ***PATIENT PREFERENCE UNLESS OTHERWISE SPECIFIED***

Full Face Mask (A7030: 1/3M) With Full Face Mask Cushion (A7031: 3/3M)
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NPI #

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Fax# (

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