DEPARTMENT OF HEALTH AND HUMAN SERVICES
*OFFICE OF DIRECTOR*

# ACTION REFERRAL

| TO | DATE |
|---|---|
| Supra | 1-27-14 |

| DIRECTOR'S USE ONLY | ACTION REQUESTED |
|---|---|
| 1. LOG NUMBER 000253 | [ ] Prepare reply for the Director's signature<br>DATE DUE _____ |
| 2. DATE SIGNED BY DIRECTOR<br>cleared 3/11/14, letter attached. | [X] Prepare reply for appropriate signature<br>DATE DUE 2-5-14 |
| | [ ] FOIA<br>DATE DUE _____ |
| | [ ] Necessary Action |

| APPROVALS (Only when prepared for director's signature) | APPROVE | * DISAPPROVE (Note reason for disapproval and return to preparer.) | COMMENT |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

Column1/Column 2 Edits

Column 1 Column 2 * = In existence prior to 1996 Effective Date "Deletion Date

*=no data" "Modifier

0=not allowed

1=allowed

9=not applicable"

| | | | | |
|---|---|---|---|---|
| 20600 | 99211 | 20130701 | * | 1 |
| 20600 | 99212 | 20130701 | * | 1 |
| 20600 | 99213 | 20130701 | * | 1 |
| 20600 | 99214 | 20130701 | * | 1 |
| 20600 | 99215 | 20130701 | * | 1 |
| 20600 | 99217 | 20130701 | * | 1 |
| 20600 | 99218 | 20130701 | * | 1 |

# APPENDIX 1 EDIT CODES, CARCS/RARCS, AND RESOLUTIONS

**PLEASE NOTE: We will disregard Edit Correction Forms (ECFs) with "NO CORRECTIVE ACTION" and Remittance Advice pages as they are not an acceptable form to correct claim errors.** *Effective on and after January 3, 2014, providers will no longer receive ECFs for rejected claims. SCDHHS will continue to process previously generated ECFs, until March 31, 2014.*

Review the resolution instructions below for the edit code(s) that apply to your claim. **Submit a new claim with the corrected information and attach additional documentation when necessary to complete the processing of the claim** or make corrections to the ECF by striking through the incorrect information and entering the correct information above or near the information being corrected. If the field is blank, enter the missing information in the field. Resubmit corrected ECF along with any applicable documentation. If the ECF does not require corrections, but needs to be reprocessed as a result of a system update, submit a new claim for processing after the system has been updated.

| Edit Code | Description | CARC | RARC | Resolution |
|---|---|---|---|---|
| 588 | 1ST DOS SUBSEQUENT TO ENTRY DATE | 16 – Claim/service lacks information which is needed for adjudication. | MA31- Missing/incomplete/invalid beginning and ending dates of the period billed. | **UB CLAIM or UB ECF:** Correct the "from" date of service in field 6. Be sure to check the year closely. |
| 589 | LAST DOS SUBSEQUENT TO DATE OF RECEIPT | 16 – Claim/service lacks information which is needed for adjudication. | MA31- Missing/incomplete/invalid beginning and ending dates of the period billed. | **UB CLAIM or UB ECF:** Correct the "through" date of service in field 6. Be sure to check the year closely. |
| 590 | NO DISCHARGE DATE ON FINAL BILL | 16 – Claim/service lacks information which is needed for adjudication. | N50 – Missing/incomplete/invalid discharge information. | **UB CLAIM or UB ECF:** Enter the discharge date in field 6. Submit a new claim with the corrected information. |
| 591 | NCCI – PROCEDURE CODE COMBINATION NOT ALLOWED | 236 - This procedure or procedure/modifier combination is not compatible with another procedure or procedure/ modifier combination provided on the same day according to the National Correct Coding Initiative. | | This procedure code combination is not allowed on the same date of service. Therefore, only one procedure code was paid.<br><br>Note: The National Correct Coding Initiative (NCCI) does not allow the rendering or payment of certain procedure codes on the same date of service. For NCCI guidelines and specific code combinations; please refer to Medicaid bulletins about NCCI edits or the CMS website. |
| 594 | FINAL BILL/DISCHRG DTE BEFORE LAST DOS | 16 – Claim/service lacks information which is needed for adjudication. | N50 – Missing/incomplete/invalid discharge information. | **UB CLAIM or UB ECF:** Check the occurrence code 42 and date in fields 31 through 34 A and B, and the "through" date in field 6. These dates must be the same. |

PROVIDER ID. 1366429987

000092353
DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM

PROFESSIONAL SERVICES
REMITTANCE ADVICE

PAYMENT DATE 01/03/2014



| PROVIDERS OWN REF. NUMBER | CLAIM REFERENCE NUMBER | PY IND | SERVICE DATE(S) RENDERED MMDDYY | PROC. | AMOUNT BILLED | TITLE 19 PAYMENT MEDICAID | S T S | RECIPIENT ID. NUMBER | RECIPIENT NAME F M I I LAST NAME | M O D | TLE. 18 ALLOWED CHARGES | COPAY AMT | TITLE 18 PAYMENT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 31749C3D | 1335500324870120A | | | | [illegible] | [illegible] | | | [illegible] | | | | |
| | 01 | | 121613 | 90700 | 0.01 | 0.00 | P | | | 000 | | 0.00 | 0.00 |
| | 02 | R | 121613 | 99391 | 90.00 | 90.00 | P | | | 025 | | 0.00 | 0.00 |
| | 03 | | 121613 | 4003F | 0.01 | 0.00 | R | | | 000 | | 0.00 | 0.00 |
| | | | | | | | | | EDITS: L03 709 | | | | |
| 4456C7E | 1335700852812510A | | | | 184.50 | 45.25 | P | 0884009501 | K M HUNTER | | | | |
| | 01 | | 121613 | 36415 | 6.00 | 2.43 | P | | | 000 | | 0.00 | 0.00 |
| | 02 | A | 121613 | 84460 | 16.00 | 2.31 | P | | | 000 | | 0.00 | 0.00 |
| | 03 | A | 121613 | 82550 | 22.00 | 3.17 | P | | | 000 | | 0.00 | 0.00 |
| | 04 | | 121613 | 83735 | 22.00 | 7.64 | P | | | 000 | | 0.00 | 0.00 |
| | 05 | A | 121613 | 84550 | 14.50 | 2.09 | P | | | 000 | | 0.00 | 0.00 |
| | 06 | | 121613 | 80048 | 30.00 | 9.65 | P | | | 000 | | 0.00 | 0.00 |
| | 07 | | 121613 | 80061 | 50.00 | 11.17 | P | | | 000 | | 0.00 | 0.00 |
| | 08 | | 121613 | 85027 | 24.00 | 6.79 | P | | | 000 | | 0.00 | 0.00 |
| 4456C7E | 1335700852812520A | | | | 376.00 | 70.93 | P | 0884009501 | K M HUNTER | | | | |
| | 01 | | 121613 | 83036 | 35.00 | 11.06 | P | | | 000 | | 0.00 | 0.00 |
| | 02 | | 121613 | 82044 | 25.00 | 5.22 | P | | | 000 | | 0.00 | 0.00 |
| | 03 | | 121613 | 82570 | 16.00 | 5.90 | P | | | 000 | | 0.00 | 0.00 |
| | 04 | | 121613 | 81001 | 15.00 | 3.60 | P | | | 000 | | 0.00 | 0.00 |
| | 05 | 2 | 121613 | 20600 | 75.00 | 37.79 | P | | | 000 | | 0.00 | 0.00 |
| | 06 | | 121613 | J3301 | 60.00 | 7.36 | P | | | 000 | | 0.00 | 0.00 |
| | 07 | | 121613 | 99215 | 150.00 | 0.00 | R | | | 025 | | 0.00 | 0.00 |
| | | | | | | | | | EDITS: L07 591 | | | | |
| 7209C7F | 1335700853812500A | | | | [illegible] | [illegible] | | [illegible] | [illegible] | | | | |
| | 01 | | 121913 | [illegible] | 25.00 | 3.72 | P | | | 000 | | 0.00 | 0.00 |
| 7546C7G | 1335700854812500A | | | | 192.00 | [illegible] | | | | | | | |
| | 01 | | 121213 | 36415 | [illegible] | 2.43 | P | | | 000 | | 0.00 | 0.00 |
| | 02 | | 121213 | 80053 | 35.00 | 10.89 | P | | | 000 | | 0.00 | 0.00 |
| | 03 | | 121213 | 80061 | 50.00 | 11.17 | P | | | 000 | | 0.00 | 0.00 |
| | 04 | | 121213 | 84439 | 20.00 | 7.01 | P | | | 000 | | 0.00 | 0.00 |
| | 05 | | 121213 | 84443 | 55.00 | 19.15 | P | | | 000 | | 0.00 | 0.00 |
| | 06 | | 121213 | 85025 | 26.00 | 8.45 | P | | | 000 | | 0.00 | 0.00 |

$269.00

CERT. PG TOT

MEDICAID PG TOT

FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".

IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.

CERTIFIED AMT

MEDICAID TOTAL

CHECK TOTAL

STATUS CODES:

P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER

CHECK NUMBER

PROVIDER NAME AND ADDRESS

LOVELACE FAMILY MEDICINE C

PO BOX 630
PROSPERITY SC 29127

12/16/2013

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**Date:** 12/16/13 : 09:54am
**Title:** Review of Chronic Problems

**Providers:** OFL
Nurse WWC

Current Medications:
Rx: DUONEB unit dos 1 inhal every 4 hours PRN - days, 120, Ref: 11
Rx: NEBULIZER - days, 1, Ref: 0
Rx: FERROUS SULFATE 325mg 1 cap daily - days, 30, Ref: 11
Rx: FLONASE 1 spray inhal daily each nostril - days, 1, Ref: 11
Rx: PEPCID 20 mg 1CAP once daily - days, 30, Ref: 11
Rx: SIMVASTATIN 40mg 1TAB at bedtime - days, 30, Ref: 11
Rx: ADVAIR DISKUS 250/50 1 inhal twice daily - days, 3, Ref: 11
Rx: CALTRATE 600+D 600mg 1 twice daily - days, 60, Ref: 11
Rx: ERGOCALCIFEROL 50,000 units 1CAP 3 times weekly - days, 12, Ref: 11
Rx: FLEXERIL 10MG 1 TAB three times daily PRN - days, 90, Ref: 11
Rx: SINGULAIR 10 mg 1 tab daily - days, 30, Ref: 11
Rx: METFORMIN HCL 1000MG 1 TAB twice daily - days, 180, Ref: 3
Rx: PRO AIR HFA 2 puffs q4-6hours PRN - days, 1, Ref: 11
Rx: CARDIZEM 60MG 1 TAB three times daily - days, 90, Ref: 11
Rx: VALIUM 10MG 1 TAB three times daily - days, 30, Ref: 5
Rx: GLIPIZIDE 5mg 1-2 tab daily - days, 30, Ref: 1
Rx: BYETTA 5 MCG PEN 5mcg INJ twice daily 30 days, 300mcg, Ref: 11

Allergies:
CHLORZOXAZONE (PARAFON FORTE), CODEINE, DAYPRO, DYES, PENICILLIN

SUBJECTIVE AND REVIEW OF SYSTEMS
54 year old female presented 12/16/13 for review of chronic medical problems with BMP, Mg2+, HGBA1C, UA q 4 months, Urine Microalbumin q 12 months (250.00) Peak Flow (519.1) FLP, CK, ALT (272.0) CBC (285.9) Vit D (268.9) after follow up consultation with Dr. Madden, completion of XRT with Dr. Ezekial, and consultation wtih Dr. Strickland in regard to hiradenitis supprativa and possible hysterectomy and oophorectomy

She is scheduled for follow up with Dr. Madden 12/16/13. She has lost 10# but states she is intentional.

She has completed XRT with Dr. Ezekial and plans to follow up in January 2014.

Per Katies report she has not had recent follow up with Dr. Strickland in regard to hiradentis supprativa and possible hysterectomy and oophorectomy.

She had arthroscopic surgery on her left knee by Dr. Hibbits after being seen in the ER with a large effusion in the knee over Thanksgiving 2013 and she has noticed some improvement in her pain. Apparently she had been given a shot in her knee 11/21/13 by Dr. Milner with Lidocaine and Depomedrol. She then presented to NCMH ER 11/23/13 with a marked swollen knee and 35 cc of fluid was taken off and then admitted to NCMH and discharged 11/27/13 with a diagnosis of Septic arthritis, left knee after irrigation debridement, left knee. She carried out on the day of admission. She had rapidly worsening left knee pain and aspiration in the emergency department demonstrated a gram-positive cocci with 40,000 WBC count,
with 89% polymorphonucleocytes. Given this fact, she underwent surgical irrigation and debridement. She was treated with Vancomycin and Rocephin after her surgery and remained afebrile. Given the fact
that she was ambulatory, pain was well controlled, she has no effusion and was not systemically ill, she was discharged on Bactrim DS 1 by mouth twice daily and Cipro 750 mg twice daily for 2 weeks Joint fluid cultures returned negative.

She was seen in consultaiton at NCMH 11/23/13.

REVIEW OF SYSTEMS: (Asked)

Constitutional: denies night sweats, fever, chills, or change in sleeping habit.

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Neurological: denies syncope, seizures, paralysis, paresthesias, recurring headaches
Respiratory: denies cough, wheezing, dyspnea, sinus congestion.
Cardiovascular: denies chest pain, palpitations, PND, orthopnea.
Gastrointestinal: denies pain, nausea, vomiting, diarrhea, melena, bleeding, constipation.
Genitourinary: denies irregularity, frequency, urgency, or dysuria.
Endocrinological: denies polyuria, polydipsia, weight change.
Musculoskeletal: she continues to have pain, swelling and stiffness in left knee.
Hematological/Immunological: denies bruising, adenopathy, chills, sweats, fevers.
Psychiatric: denies depression, anxiety, unusual stress.
Dermatologic: denies any lesion changes or concerning rash but occasionally she has vaginal bleeding and she is not sure if it is coming from her vagina or her boils. She noted bleeding lasting 2 days at at time sometimes having to wear a pad.

PAST MEDICAL HISTORY:
1. BREAST CARCINOMA with HEREDITARY BREAST AND OVARY CANCER SYNDROME (BRCA1)- patient presented 8/92 with right breast lump. Mammogram revealed 2 cm. lesion. Aspiration revealed suspicious cells. Subsequent excisional biopsy revealed medullary carcinoma, negative receptors. She underwent modified right radical mastectomy 9/92. Large tumor, 3.5 cms., 19 nodes, all negative. She then underwent 6 months of adjuvant chemotherapy, complicated by hospital admission in 1/93 with fever and rigors. Discharge diagnosis was viral pneumonia. Patient then noted left breast lump and underwent left mastectomy late 1993/early 1994 (records unavailable). Followed again by 6 months of chemotherapy. Since that time, she says in 1998 there was evidence of recurrent disease when a mass was observed under her scar following a fall,and that she had further radiation therapy. She had been followed by Dr Carroll and followed by Dr. Steve Madden at least yearly, with periodic chest X-rays ,most recently 10/09/02 which was reported as normal other than the post mastectomy changes. She has been having yearly bone scans and chest X-rays which have been negative to date. She has been seeing Dr. Dyke, gynecologist in Newberry, who has been giving her Zoladex injections as recommended by Dr. Carroll. However since Dr. Carroll has left the Newberry area she has not been following up with her oncologist including Dr. Madden and has agreed to do this.Ordered Bone Scan 01/25/07 due to her complaint of continued neck and back pain but no results in practice partner Bone DEXA ordered once again 12/21/07 but not doneFollowed by Dr. Madden - last seen in June/July 2008 follow up q6 months
Continues to be seen by Dr. Madden- seen in June/ July 2009 and January 2010- good report.
Referred to Genetic Center at RMH for genetic testing as she and 3 of her sisters have had breast cancer 08/24/10 and she was seen 09/20/11 and underwent BRACAnaiysis, and was found to carry a
deleterious BRCA1 mutation, the M1775R. This mutation confirms the presence of
Hereditary Breast and Ovary Cancer susceptibility syndrome within the family. At follow up 02/13/13 Dr. Madden recommended proceeding with a hysterectomy and oophorectomy. The patient is still hesitant to proceed in this direction. As a temporizing measure. An ultrasound of her uterus and ovaries 02/18/13 was normal and he sent a CA 125 level which was normal by her report 02/27/13

2. HISTORY OF CHOLELITHIASIS - S/P cholecystectomy 1988.

3. HISTORY OF GALLSTONE PANCREATITIS - secondary to above.

4. PEPTIC ULCER DISEASE - This was documented 3/90 and treated with H2 blockers. Problem on and off. She is currently on Pepcid 20 mg qd for this.

5. HISTORY OF ESOPHAGEAL REFLUX DISEASE - upper GI 4/92 revealed GERD with hiatal hernia. Patient underwent EGD by gastroenterologist 8/92 which revealed findings consistent with reflux disease. H. pylori negative. Patient was seen 7/95 complaining of increased heartburn,when she was changed to Prilosec 20 mg.s po q.d. Currently using Pepcid prn.

6. HISTORY OF HIDRADENITIS SUPPURATIVA - She has had lesions removed from both axillae and groin. There is some residual hyperpigmentation and edema of abdominal wall. With better control of her diabetes, the lesions she is having are not as severe.

7. ABNORMAL PAP SMEARS - Pap smear March 1991 revealed high-grade SIL, moderate dysplasia. Repeat Pap in 8/92 revealed low-grade SIL. Patient underwent colposcopy September 1991, by Dr. Cari Foster. ECC negative. Biopsy of uterus/cervix showed focal mild dysplasia. Her pap smear on 5/25/00 was reported as normal, but a repeat pap smear done 7/12/01 however had shown ASCUS. She had a colposcopy scheduled and did not show for this in 2001 and has been noncompliant since then. She however states that she went to see Dr. Dyke though we do not have any records from him regarding her visit. She states that the pap smear he did was normal and on 11/12/02 a repeat pap smear was obtained. PAP in January 2005 normal at Dr. Dyke's office per Katie's report.
Pelvic exam by Dr. Dyke 12/18/07 - records requested 12/21/07
Pap smear normal on 09/10/09.

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8. HISTORY OF HEADACHES - patient presented 7/95 complaining of increased headaches for several months. These are frontal, pounding, throbbing. Head CT at that time was negative,though 6/97 sinus CT did show evidence of right sided maxillary sinusitis with mild patchy etmoid thickening. She calls these sinus headaches and these have no longer been a significant problem. More recently she had a CT of her head on 10/9/02 which was reported as normal.

9. ANXIOUS DEPRESSION - patient was noted 3/96 to have more anxiety, emotional upset. She was started on Trazodone 50 mg. po t.i.d. as well as Xanax .25 mg. po t.i.d. prn. Currently, patient states her emotional symptoms have resolved. She denies fatigue, sleep difficulty, emotional lability, tearfulness or depressed mood. More recently she was started in 10/02 on Zoloft but has not been compliant with this and states that she is not feeling as depressed currently. She has been under a lot of stress related to her breast cancer and also the fact that her husband had left her in 2001 for another woman.

10. ALLERGIC RHINITIS / SINUSITIS - had been started on Zyrtec 10 mgs. po q.d. in 3/96,and these have helped her symptoms including her sinus headaches. More recently she has been treated with Flonase and Allegra. Advised to continue Flonase as directed and OTC meds on 12/04/04.
returned 12/06/07 with sinus congestion/ HA - not taking Flonase refilled Flonase 12/06/07 and 09/15/08
Started on Singulair 10 mg PO qd on 09/15/08 (samples given). Continues with Advair, Singulair and Flonase with intermittent symptoms on 09/10/09

11. PNEUMONIA WITH HOSPITALIZATION 1/93 - for evaluation of headache, fever, chills. Discharge diagnosis was viral pneumonia.

12. SECONDARY AMENORRHEA -- it is believed that this is due to her chemotherapy. She is not on hormone replacement therapy because of her h/o breast cancer. Last check of FSH and LH on 06/01/00 did not confirm that she is menopausal. She also has received Zoledex injections to induce menopause as recommended by Dr. Carroll as part of the treatment for her breast CA.

13. ANEMIA / MICROCYTOSIS - During the year between 2000 to 2001 ,there has been a significant drop in her hgb from 14.1 in 5/00 to 12.4 in 04/01 and and then to 11.1 on 4/24/02. During her time her MCV also fell from 91.3 to 83. This is likely iron deficiency anemia. Had also checked iron studies on 4/6/01 but these were only borderline but had empirically commenced her on Ferrous Sulfate 325 mg bid. With guaiac positive stool on 07/12/01, she did have a colonoscopy done by Dr. Davis on 7/27/01 and this showed no evidence of colonic malignancy though she did have some hemorrhoids. She has been using Iron on and off and there was an improvement in her Hgb to 12.3 on 11/12/02.

14. CELLULITIS - She has had several episodes of cellulitis. Some of this has been related to her hidradenitis suppurativa, and on 06/30/01 she did have cellulitis involving her scar of her right mastectomy. Despite the fact that she had listed Penicillin as an allergy, she has tolerated Augmentin for treatment of cellulitis on a couple of occasions without a problem.

15. DIABETES TYPE II - This was newly diagnosed prior to her visit in 06/00. She had been commenced on Glucophage 500 mg bid in June 2000 and her Hgb A1c was excellent at 5.6 on check 04/11/02 when checked at NCMH. She did state that she had not been taking the Zestril as she was told it was a blood pressure medication and she did not have hypertension. She however was advised to recommence to help prevent diabetic nephropathy and did have a trace of proteinuria on 4/24/02 check. With the use of Glucophage there has been significant improvement in her glycemic control and glucose was 81 on 11/12/02. She also had a normal renal function with CR of 0.9, BUN of 9, and K+ of 3.9 on 11/12/02.
Dr. Stafford for eye exams on a regular basis. Continue Glucophage 500mg po BID and given Sliding Scale Insulin while in NCMH for elevated glucose readings based on FSBS AC and QHS 11/07/04 reports that FBS runs 80-120 q am 11/20/04 Sugar busters and Sugar Busters Shoppers guide recommended 03/21/05 Wanted diet pills 03/21/05 but advised treatment of depression, exercise, and Sugar Busters diet and shoppers guide 03/21/05 Discussed weight loss basics once again 05/02/05 - regular walking TSH: 0.79 on 12/29/2006 discussed need for tight controll with infection -add Glipizide 10mg po bid 01/18/07 HGB-A1C: 8.9, GLUCOSE: 267 on 08/11/2008 Not taking Actos daily- encouraged to start taking Actos daily on 08/13/08 Referred to Wellness Center for DM education on 08/13/08- has been going regularly.GLUCOSE: 102 hq on 09/15/2008- BS diary ranging from 70's-low 100's. Congratulated!1800 cal ADA diet in the hospital, ISS, monitor FSBGs Unable to afford Actos. On 02/18/10, 112 tablets of Actoplusmet 15/850 started. She was instructed verbally and via a written medication list to discontinue Actos and Glucophage because Actosplusmet replaces both of these medications, and also instructed to continue Glipizide 10 mg BID. HGB-A1C: 5.3 GLUCOSE: 64 on 02/18/2010 Advised to change Actos Plus Met 15/500 1 po BID and decrease Glipizide to 10m po qday 03/22/10 Ms Hunter called in to inform us that she is unable to afford the ActoPlus Met Rx that was written for her 03/22/10, thus topped Acos Plus Met 15/500mg po BID due to cost and started Glucophage 1000mg po BID with Glipizide 10mg po qday 04/06/10. Katie then called on 06/15/10, states she continues to have on/off diarrhea , she is aware from the Metformin 1000mg , but she states she is getting tired of it. Her glucose ranges from 98-130. Advised to decrease Metformin to 1000mg po qday and see if diarrhea improves. Follow blood sugar daily - call if over 200. OFL FSBS at home 140 on 08/19/10

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16. PYELONEPHRITIS - She had been admitted from the 11th to the 12th of April 2002 with significant fever and urine culture had confirmed a UTI she had initially been treated with Cipro but on discharge was switched to Macrobid which she completed a 7 day course. UA on 11/12/02 was completely normal.

17. HYPERCHOLESTEROLEMIA - Cholesterol elevated at 216 and LDL however was normal at 132 04/12/00. Advised that diabetes makes this even more important to keep under control and she was warned about increased risk of coronary artery disease and stroke. Check of her lipid profile 04/24/02 was however satisfactory with Cholesterol at 149, LDL 95, and HDL 43.7 and the improvement was maintained with a diet on 11/12/02 when Cholesterol was 165 with LDL of 100 and HDL up to 51.5. She also has hypercholesterolemia and a prior history of tobacco abuse. FLP: CHOL: 156 select: TRIG: 108: DHDL: 50.0: LDL 81 TC/HDL: 2.9 on 12/06/07 Started Simvastatin 20mg po qhs due to literature showing risk reduction benefit in diabetics 12/21/07 LDL CHOL: 47: ALT: 26 :CK: 117 on 08/11/2008
FLP:CHOL: 137 : TRIG: 93: HDL: 50: TC/HDL: 2.7: LDL: 68 on 09/10/09 TSH 2.16 on 12/16/09
CMP, CK normal on 02/18/10. Continue Simvastatin 20 mg qhs. FLP:CHOL: 112: TRIG: 86: HDL: 49: TC/HDL: 2.3: LDL: 46 on 02/18/2010 CK: 140 AST: 22 ALT: 14 on 02/18/2010 Meeting goal of LDL < 100 and continued on Simvastatin 20 mg qhs on 03/22/10.

18. REACTIVE AIRWAY DISEASE - she has had a couple of exacerbations of this, most recently 04/00. At check on 11/12/02 her peak flow was 250 with an O2 sat of 98%.

19. HYPONATREMIA - During her hospitalization in 4/02 she did have significant hyponatremia with sodium as low as 128. This responded to treatment of her infection with IV fluids. Sodium was back up at 141 on 4/24/02 check and potassium that was also low is back up at 4.3. There was no recurrence at check 11/12/02 with sodium of 143 and K+ of 3.9.

20. INTERTRIGO-OTHER SPECIFIED ERYTHMATOUS CONDITIONS/ FEVER UNSPECIFIED-
Chronic warmth and tenderness in large abdominal panniculus - Cipro 500mg po BID X 2 wks 12/21/07
Stop SMZ/TMP DS 1 po BID while taking Cipro 12/21/07Apply Lotrisone Cream to abraded groin areas BID 12/21/07 Referred to Dr. Barwick for panniculectomy in January 2008 Evaluated by Dr. Glenn Strickland on 04/23/08 for a large pannus and recurrent panniculitis, which has failed medical therapy. Dr. Strickland discussed with her the difficulties that would be involved in getting her to heal after a panniculectomy. He advised her that she woudld probably lose her umbilicus and possibly have lots of wound infections. Despite that the patient wishes to proceed with a panniculectomy. However, Donna from Riverside Surgical called on 08/19/08 stating that her insurance denied coverage for removal of excess skin after bariatric procedure. She needed a statement , medically necessity, expecially with her diabetes , having to use prescription creams and ointments for folds of her skin. Her dermatologist, Dr. McElveen, recommended that she undergo panniculectomy Her surgeon, Dr. Strickland, advised her that she should undergo panniculectomy.
OFL wrote letter and pictures to UnitedHealthcare re denial of coverage for panniculectomy 11/03/08
Also copy of letter sent to Senators Demint and Graham, Rep. Wilson with pictures 11/03/08
Insurance denial for panniculectomy- per Katie, needed OFL to write another letter to insurance company regarding medical necessity and not cosmetic (message sent) on 09/10/09 Admitted for fever and elevated WBC on 12/01/09 - only source appears to be panniculitis - consult Dr Brown for wound management 12/01/09 Started Rocephin 1gm IV qd 12/01/09 Monitor on 3rd floor, IVF, blood culture negative12/01/09
CXR NAD on 12/01/09 Consulted Dr. Brown on 12/01/09:
1. Acute panniculitis with chronic cellulitis and impending sepsis.
2. Diabetes mellitus, insulin dependent.
3. Remote history of carcinoma of the breast.
4. Hypertensive vascular disease..
CT of the abdomen 12/01/09 demonstrates a huge, chronically edematous and infected panniculus which extends below her symphysis pubis almost to her knees. There is no gas in the panniculus.
Her abdominal wall is quite thinned out, although she has no true ventral hernia.
It is clearly indicated that she should have plastic surgical referral for consideration of an extensive panniculectomy with appropriate flap reconstruction of her anterior abdominal wall.
This may well be a life-saving procedure and should be authorized by her insurance carrier.
This clearly is not a cosmetic procedure. Wound culture grew out MRSA and she was switched to SMZ/TMP DS 1 po BID X 30 days 12/16/09 Consulted with Dr. Glen Strickland with Riverside Surgical on 01/04/10 after being denied a panniculectomy by her insurance company despite the fact this is not cosmetic. She has a pannus down to her knees, chronic MRSA infection, and chronic hospital admissions for wounds. Resecting this may, in large portion, improve her quality of life significantly and allow her to ambulate with less complication. He planned to speak with United HealthCare to overrule the decision She is awaiting insurance approval on 03/22/10 and then will proceed with paniculectomy by Dr. Strickland which has been approved for surgical intervention on 05/18/10 at LMC Panniculectomy and incarcerated ventral hernia repair on 05/18/10 with Dr. Strickland--operative note was received and in PP - healing nicely 06/29/10
Rocephin 2gm IM now then Cephalexin Susp 500mg QID X 10 days 08/20/10

Improved on 08/24/10, continue on Cephalexin.

21. TACHYCARDIA -EKG showed rate sinus tachycardia at 110 but no symptoms, fibrillation or arrhythmia 11/03/08Sinus Tachycardia IVF, monitor on Telemetry serial Cardiac enzymes ordered 12/01/09
Consult Cardiology ordered 12/01/09 TSH wnl in the ER on 12/01/09 Resolved since taking Cardizem 60mg po TID 12/04/09 On 02/18/10 continue Cardizem 60 mg po TID. Continued on Cardizem 60 mg TID on 03/22/10. Sinus Tachycardia with HR of 109 on 08/20/10 but she had not taken Cardizem - thus encouraged

22. BACK PAIN- c/o LBP w/ radiation to hips only on 12/04/04. Reassured based on subjective data and exam should gradually improve over 4-6 week period on 12/04/04. Advised Naprosyn 500mg 1 po bid prn for back pain. Advised may dose Tylenol ES as directed prn for breakthrough pain. Given back pain educational handout and LBP exercise teaching sheet on 12/04/04. Advised if no sx improvement in 4-6 weeks would proceed with x-rays espec. as hx of breast CA. Thoracic and LS spine films requested 03/21/05, but never obtained thus rescheduled once again 05/02/05 (she still did not go for these) advised that weight loss would improve back pain Naproxyn refilled 11/03/08 per her request - did not take due to SE / stomach pain changed to Voltaran XR 100mg po qd 12/20/08 with food Panniculus leads to back pain - continues with pain on 09/10/09 Disability evaluation and form completed on 05/17/10. Form copied and scanned into PP.

23. ASTHMA - Presented to NCMH ER 11/07/04 with acute exacerbation of asthma and or COPD
CXR negative 11/08/04 discharged on Advair Diskus 250/50 - one inhalation twice a day, DuoNeb unit dose every 4-6 hours as needed for breathing difficulties refractory to Combivent MDI 2 puffs four times a day with aerochamber. Advair has helped remarkably Letter written to Mid-Carolina Electric Cooperative 05/02/05 that she is in need of electric power at all times for this condition CXR ordered 12/21/07, but had not as of 09/15/08 Refilled Albuterol and Advair on 08/21/08 Peak Flow 450 on 09/15/08 Well controlled- using Albuterol only 1-2x's a week on 09/15/08 Will start on Singular to help with asthma and allergy symptoms- 09/15/08 Continues with Advair, Singulair and Flonase with intermittent symptoms on 09/10/09
Continues to use Albuterol up to 3 x daily on 09/10/09 CXR with NAD on 12/01/09 - monitor in hospital
Discharge summary pending 12/16/09 On 02/18/10 stable on current medications. Continue Albuterol, Advair, Flonase, and Singulair. Stable on current medications on 08/20/10 and continued on Albuterol, Advair, Flonase, and Singulair.

24. HYPOKALEMIA - Low K+ noted in ER thus added 20meq KCl to each liter of normal sinus rhythm 11/07/04 K+: 3.9 on 02/18/2010

25. CERVICAL PAIN- 11/08/04 XRAY-CERVICAL SPINE showed Cervical spondylosis.
11/08/04 X-RAY C-SPINE -Films of the thoracic spine show some mild degenerative changes. No acute fracture or subluxation is noted. On 11/07/04, cardiac isoenzymes from 11/07/04 were also negative.
Skelaxin 800mg po QID given at discharge, but she was unable to fill due to finances. EHO on neck exercises given Exacerbation of neck pain treated once again with Skelaxin 800mg po QID and Tylenol ES 2 po QID

PAST SURGICAL HISTORY
1. Extensive debridement and gland resection, bilateral axilla and inguinal areas, S/P skin graft right axilla - 1985, 1987.
2. Open cholecystectomy - 1988.
3. Bilateral mastectomies - 1992, 1993. Modified radical.
4. Porta-Cath placement - February 1994. Patient underwent removal of Porta-Cath in summer of 1994 w/o complications.
5. Panniculectomy and incarcerated ventral hernia repair - Dr. Glen Strickland, LMC 05/18/10
6. Surical excision of mass left preaxillary area noted as metastatic carcinoma to the chest wall done 06/19/13 by Dr. Barrinuea

Bone Dexa Scan-Hip: 07/29/13 : Normal : 77080.
Neck (-1.12 )
Troch (+0.24 )
Inter (+0.61 )
T Score Femoral TOTAL (+0.58) with +2.05 % increase /yr since 04/01/11

Bone Dexa Scan-Spine: 07/29/13 : Osteopenia : 77080.
L1 (-1.22 )
L2 (-1.24 )
L3 (-1.03 )
L4 (-1.49 )
T Score L1-L4 (-1.29) with -0.18 % decrease/yr since 04/01/11

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SOCIAL HISTORY
She was born and raised in Newberry, SC. Her last grade completed was 10th grade. She was married to her husband in 1985. She is now separated from her husband since 2001. They both live in Newberry, but are separated and living separately. They have five children. She notes that 4 of her children now live at home. The oldest daughter does not live at home.

OCCUPATIONAL HISTORY
Patient is a homemaker. She received a 10th grade education. Estranged husband works at International Paper .

FAMILY HISTORY
Father is age late 80's with history of hypertension and prostate CA. Mother died at age 54 with heart disease. Patient has one brother deceased at age 61 years old with a history of COPD,CHF, Renal problems and Anemia, and one surviving sister, age 44 in reported good health. Patient had two other sisters, both of whom died from breast carcinoma in their 30's. Patient's remaining sister diagnosed at age 36 with breast cancer. This sister is currently S/P mastectomy and undwent chemotherapy. Family history is otherwise notable for anxiety attacks in surviving sister.

OCCUPATIONAL HISTORY
currently on disability by Medicare since December 2010

HEALTH MAINTENANCE
1. Spiritual - member of Trinity AME with a strong faith.
2. Mental - denied
3. Physical - Does not exercise like she should. Previously went to Curves but then lost transportation.
4. Nutritional

Breakfast - skips
Lunch - sandwich or leftovers
Supper - meat and vegetables.

OBJECTIVE:
Bp: 120/70, Left Arm, Pulse: 90, regular
Temperature: 97.3 F, oral, Height: 5'5.5", Weight: 172 lbs
Respirations: 18

General: Pleasant female walking with a limp due to left knee pain and left 5th toe pain
Head: Normocephalic, atraumatic.
Eyes: Conjunctivae clear, sclerae white. No drainage, no edema.
Nose: Mucosa non-inflammed, no apparent discharge.
Mouth: No mucosal lesions.
Throat: Tonsils normal. Posterior pharynx pink and clear.
Neck: Supple, no adenopathy, no masses.
Chest: Lungs clear in all fields.
Heart: Regular rate and rhythm, no murmur.
Abdomen: Normal Bowel sounds, soft, nontender, nondistended, no organomegaly or masses.
Extremities: Left knee no longer swollen or warm with healing scars from arthroscopy. Left distal foot pain and point tenderness at the left 5th MTP joint.
Skin: No rash or prominent lesions.

Labs: Vit D (268.9) cmi 12/16/13 ofl pending drawn time of appt.

FLP:CHOL: 182
TRIG: 175
HDL: 52.2
TC/HDL: 3.47
LDL: 94.19 on 12/16/2013

CK: 95 on 12/16/2013
ALT: 14 on 12/16/2013

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CBC:HGB: 11.8 on 12/16/2013
HCT: 38.5
WBC: 5.8
PLT: 350
MCV: 86

**Health Maintenance:** FLP X

BMP: CALCIUM: 10.2 on 12/16/2013
CREATININE: 0.7
GLUCOSE: 130
NA: 138
K+: 3.8
CL: 103
BUN: 10
ANIONGAP: 13
EGFR: 89.09

MAG: 1.85 on 12/16/2013

CO2: 24

HGB-A1C: 7.0 on 12/16/2013

URINALYSIS: COLOR-UA: Yellow on 12/16/2013
CLARITY-UA: Clear
GLUCOSE-UA: Negative
BILIRUBIN-UA: Negative
KETONES-UA: Negative
SPEC GRAV-UA: 1.025
PH-UA: 6.0
PROTEIN-UA: Negative
UROBILIN: 0.2
NITRITE-UA: Negative
BLOOD-UA: 1+
LEUK-UA: 1+

U/A Microscopic: RBC-UA: 2-5, WBC-UA: 2-5, BACTERIA-UA: Trace, EPITH-UA: Few, MUCUS-UA: 0, CASTS-UA: 0, CRYSTALS-UA: 0, OTHER: See Comments on 12/16/2013.

ASSESSMENT/PLAN:
**Major Problem:** INTERTRIGO-OTHER SPECIFIED ERYTHMATOUS CONDITIONS : 695.89
**Other Problem:** FEVER UNSPECIFIED : 780.60
**Major Problem:** CELLULITIS/ABSCESS TRUNK /ABDOMINAL WALL, GROIN, CHEST WALL : 682.2
Chronic warmth and tenderness in large abdominal panniculus - Cipro 500mg po BID X 2 wks 12/21/07
Stop SMZ/TMP DS 1 po BID while taking Cipro 12/21/07
Apply Lotrisone Cream to abraded groin areas BID 12/21/07
Referred to Dr. Barwick for panniculectomy in January 2008
Evaluated by Dr. Glenn Strickland on 04/23/08 for a large pannus and recurrent panniculitis, which has failed medical therapy. Dr. Strickland discussed with her the difficulties that would be involved in getting her to heal after a panniculectomy. He advised her that she woudld probably lose her umbilicus and possibly have lots of wound infections. Despite that the patient wishes to proceed with a panniculectomy.
However, Donna from Riverside Surgical called on 08/19/08 stating that her insurance denied coverage for removal of excess skin after bariatric procedure. She needed a statement , medically necessity, expecially with her diabetes , having to use prescription creams and ointments for folds of her skin.

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Her dermatologist, Dr. McElveen, recommended that she undergo panniculectomy
Her surgeon, Dr. Strickland, advised her that she should undergo panniculectomy.
OFL wrote letter and pictures to UnitedHealthcare re denial of coverage for panniculectomy 11/03/08
Also copy of letter sent to Senators Demint and Graham, Rep. Wilson with pictures 11/03/08
Insurance denial for panniculectomy- per Katie, needed OFL to write another letter to insurance company regarding medical necessity and not cosmetic (message sent) on 09/10/09
Admitted for fever and elevated WBC on 12/01/09 - only source appears to be panniculitis - consult Dr Brown for wound management 12/01/09
Started Rocephin 1gm IV qd 12/01/09
Monitor on 3rd floor, IVF, blood culture negative12/01/09
CXR NAD on 12/01/09
Consulted Dr. Brown on 12/01/09:
1. Acute panniculitis with chronic cellulitis and impending sepsis.
2. Diabetes mellitus, insulin dependent.
3. Remote history of carcinoma of the breast.
4. Hypertensive vascular disease..
CT of the abdomen 12/01/09 demonstrates a huge, chronically edematous and infected panniculus which extends below her symphysis pubis almost to her knees. There is no gas in the panniculus.
Her abdominal wall is quite thinned out, although she has no true ventral hernia.
It is clearly indicated that she should have plastic surgical referral for consideration of an extensive panniculectomy with appropriate flap reconstruction of her anterior abdominal wall.
This may well be a life-saving procedure and should be authorized by her insurance carrier.
This clearly is not a cosmetic procedure.
Wound culture grew out MRSA and she was switched to SMZ/TMP DS 1 po BID X 30 days 12/16/09
Consulted with Dr. Glen Strickland with Riverside Surgical on 01/04/10 after being denied a panniculectomy by her insurance company despite the fact this is not cosmetic. She has a pannus down to her knees, chronic MRSA infection, and chronic hospital admissions for wounds. Resecting this may, in large portion, improve her quality of life significantly and allow her to ambulate with less complication.
He planned to speak with United HealthCare to overrule the decision
She is awaiting insurance approval on 03/22/10 and then will proceed with paniculectomy by Dr. Strickland which has been approved for surgical intervention on 05/18/10 at LMC
Panniculectomy and incarcerated ventral hernia repair on 05/18/10 with Dr. Strickland--operative note was received and in PP - healing nicely 06/29/10
Rocephin 2gm IM now then Cephalexin Susp 500mg QID X 10 days 08/20/10 then improved on 08/24/10, continued on Cephalexin.
Resolved

**Major Problem:** TACHYCARDIA UNSP : 785.0
EKG showed rate sinus tachycardia at 110 but no symptoms, fibrillation or arrhythmia 11/03/08
Sinus Tachycardia
IVF, monitor on Telemetry
serial Cardiac enzymes ordered 12/01/09
Consult Cardiology ordered 12/01/09
TSH wnl in the ER on 12/01/09
Resolved since taking Cardizem 60mg pc TID 12/04/09
On 02/18/10 continue Cardizem 60 mg po TID.
Continued on Cardizem 60 mg TID on 03/22/10.
Sinus Tachycardia with HR of 109 on 08/20/10 but she had not taken Cardizem - thus encouraged
EKG showing persisting mild tachycardia 12/01/10 with HR 101
TSH: 1.040 select:T4 FREE: 1.02 on 12/01/2010
Resolved

**Major Problem:** BACK PAIN, UNSPECI : 724.5
c/o LBP w/ radiation to hips only on 12/04/04.
Reassured based on subjective data and exam
should gradually improve over 4-6 week period on 12/04/04.
Advised Naprosyn 500mg 1 po bid prn for back pain. Advised may dose Tylenol ES as directed prn for breakthrough pain.
Given back pain educational handout and LBP exercise teaching sheet on 12/04/04.
Advised if no sx improvement in 4-6 weeks would proceed with x-rays espec. as hx of breast CA.
Thoracic and LS spine films requested 03/21/05, but never obtained thus rescheduled once again 05/02/05 (she still did not go for

these)
advised that weight loss would improve back pain
Naproxyn refilled 11/03/08 per her request - did not take due to SE / stomach pain
changed to Voltaran XR 100mg po qd 12/20/08 with food
Panniculus leads to back pain - continues with pain on 09/10/09
Disability evaluation and form completed on 05/17/10. Form copied and scanned into PP.
Letter written to Stacy Thompson, her attorney, re disability from continued back and knee pain 12/01/10
Received SSI disability in December 2010 and has Medicaid secondary to United Healthcare

**Major Problem:** ALLERGIC RHINITIS : 477.9
Advised to continue Flonase as directed and OTC meds on 12/04/04.
returned 12/06/07 with sinus congestion/ HA - not taking Flonase
refilled Flonase 12/06/07 and 09/15/08
Started on Singulair 10 mg PO qd on 09/15/08 (samples given).
Continues with Advair, Singulair and Flonase with only intermittent symptoms
Recommended Pre and Post Bronchodilator Spirometry in November 2011 - deferred 01/16/12

**Major Problem:** ASTHMA UNSPECIFIE : 493.90
Presented to NCMH ER 11/07/04 with acute exacerbation of asthma and or COPD
CXR negative 11/08/04
11/08/04 discharged on Advair Diskus 250/50 - one inhalation twice a day, DuoNeb unit dose every 4-6 hours as needed for breathing difficulties refractory to Combivent MDI 2 puffs four times a day with aerochamber.
Advair has helped remarkably
Letter written to Mid-Carolina Electric Cooperative 05/02/05 that she is in need of electric power at all times for this condition
CXR ordered 12/21/07, but had not as of 09/15/08
Refilled Albuterol and Advair on 08/21/08
Peak Flow 450 on 09/15/08
Well controlled- using Albuterol only 1-2x's a week on 09/15/08
Will start on Singular to help with asthma and allergy symptoms- 09/15/08
Continues with Advair, Singulair and Flonase with intermittent symptoms on 09/10/09
Continues to use Albuterol up to 3 x daily on 09/10/09
CXR with NAD on 12/01/09 - monitor in hospital
Stable on current medications on 12/01/10 and continued on Albuterol, Advair, Flonase, and Singulair.
Plan pre and post spirometry testing at follow up in November 2011 - deferred 01/16/12

**Major Problem:** HYPOKALEMIA : 276.8
Low K+ noted in ER thus added 20meq KCl to each liter of normal sinus rhythm 11/07/04
K+: 3.8 on 12/16/2013
K+ q 4 months

**Major Problem:** CERVICAL PAIN : 723.1
11/08/04 XRAY-CERVICAL SPINE CONCLUSION: Cervical spondylosis.
11/08/04 X-RAY C-SPINE -Films of the thoracic spine show some mild degenerative changes. No acute fracture or subluxation is noted.
On 11/07/04, cardiac isoenzymes from 11/07/04 were also negative.
Skelaxin 800mg po QID given at discharge, but she was unable to fill due to finances.
EHO on neck exercises given
Exacerbation of neck pain treated once again with Skelaxin 800mg po QID and Tylenol ES 2 po QID

**Major Problem:** DIABETES,T2,NOCOMP : 250.00
**Major Problem:** OBESITY, MORBID : 278.01
**Major Problem:** BMI 30.0-30.9 ADULT : V85.30
Diabetes was newly diagnosed prior to her visit in June 2000 and started Glucophage 500 mg bid .
HGB-A1C: 5.1 on 11/12/2002
The importance of using Zestril to reduce risk of diabetic nephropathy was discussed.
Sugar busters and Sugar Busters Shoppers guide recommended 03/21/05
Wanted diet pills 03/21/05 but advised treatment of depression, exercise, and Sugar Busters diet and shoppers guide 03/21/05
Discussed weight loss basics once again 05/02/05 - regular walking
TSH: 0.79 on 12/29/2006

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discussed need for tight controll with infection -add Glipizide 10mg po bid 01/18/07
HGB-A1C: 8.9, GLUCOSE: 267 on 08/11/2008 but not taking Actos daily- encouraged to start
Referred to Wellness Center for DM education on 08/13/08- has been going regularly.
1800 cal ADA diet in the hospital, ISS, monitor FSBGs
Unable to afford Actos. On 02/18/10, 112 tablets of Actoplusmet 15/850 started. She was instructed verbally and via a written medication list to discontinue Actos and Glucophage because Actosplusmet replaces both of these medications, and also instructed to continue Glipizide 10 mg BID.
HGB-A1C: 5.3 GLUCOSE: 64 on 02/18/2010
Advised to change Actos Plus Met 15/500 1 po BID and decrease Glipizide to 10m po qday 03/22/10
Ms Hunter called in to inform us that she is unable to afford the ActoPlus Met Rx that was written for her 03/22/10, thus topped Acos Plus Met 15/500mg po BID due to cost and started Glucophage 1000mg po BID with Glipizide 10mg po qday 04/06/10. Katie then called on 06/15/10, states she continues to have on/off diarrhea , she is aware from the Metformin 1000mg , but she states she is getting tired of it. Her glucose ranges from 98-130. Advised to decrease Metformin to 1000mg po qday and see if diarrhea improves. Follow blood sugar daily - call if over 200. OFL
GLUCOSE: 137 select:HGB-A1C: 4.2 select on 12/01/2011
GLUCOSE: 234 HGB-A1C: 9.1 on 08/05/2011 thus started Byetta 5mcg sc BID and decrease Glipizide to 5mg po qday if FSBS < 100 (continue Metformin 1000mg po day)
Glucose, HGBA1C pending 01/16/12
GLUCOSE: 238:HGB-A1C: 9.8 on 05/21/2012 therefore incrased Byetta to 10mcg sc BID and continue Metoformin 1000mg po BID but continued on 5mcg sc BID and noted that her FSBS 120 - 170 10/22/12
Monofilament examination of the feet 02/27/13 revealed no sensory deficit, concerning ulceration or callus
Diabetic Eye Exam Summer of 2012 without diabetic retinopathy by Dr. Stafford and reviewed 02/27/13
GLUCOSE: 166:HGB-A1C: 8.8 on 02/27/2013 and she admitted to missing doses of medication
GLUCOSE: 106 and HGB-A1C: 7.1 on 07/29/13
GLUCOSE: 262 on 10/15/13- she has not taken her Metformin or Glipizide on 10/15/13- advised that she needed to ensure to take her medication as soon as she went home to keep BS under control on 10/15/13
advised to call LFM if BS elevates and she is unable to get BS down on 10/15/13
encouraged DM diet on 10/15/13
GLUCOSE: 130:HGB-A1C: 7.0 on 12/16/2013
HGBA1C at goal < 7.0
CHEM 7, HGBA1C, UA q 4 months and microalbuminemia (250.00)

**Major Problem:** GASTROESOPHAGEAL REFLUX NO : 530.81
She did have endoscopy in 1992 which confirmed this by Dr. Lowman.
Treated with Pepcid as needed with relief.
Well controlled with Pepcid or Zantac prn - advised to take Pepcid daily and renewed

**Major Problem:** BREAST CANCER : 174.9
**Major Problem:** HEREDITARY BREAST AND OVARIAN CANCER SYNDROME - BRCA 1
It is now over 10 yrs since the first time she had a mastectomy on the right side. At that time, path report showed no residual carcinoma and 19 nodes were negative. She then developed another breast cancer in her left breast and had another mastectomy. She did receive adjuvant chemotherapy and more recently also required radiation therapy. after there was a recurrence of disease in her right breast scar. She had been followed by Dr. Carroll in the past and has seen Dr. Madden also but has not seen him recently after Dr. Carroll left the Newberry area. The importance of follow up was discussed. She had an x-ray of her chest on 10/09/02 which was reported as normal. She states that she has also had bone dexa scan more recently than 1999 which is the most recent we have on record and states that Dr. Dyke, who has been following her also has been giving her Zoladex injections to suppress her steroids as recommended by Dr. Carroll.
Follow up visit with Dr. Madden in December 2005
Ordered Bone Scan 01/25/07 due to her complaint of continued neck and back pain but no results in practice partner
Bone DEXA ordered once again 12/21/07 but not done
Followed by Dr. Madden - last seen in June/July 2008 follow up q6 months
Continues to be seen by Dr. Madden- seen in June/ July 2009 and January 2010- good report.
Referred to Genetic Center at RMH for genetic testing as she and 3 of her sisters have had breast cancer 08/24/10
Referral was made 08/25/2010 for Consult with Karen Brooks / USC genetic in Columbia. Karen called Katie to schedule appt, Katie stated she had no way to get to Columbia and did not want to schedule anything at this time. Karen stated she did not sound too interested in coming for counseling.
Stressed importance of genetic testing with Karen Brooks 08/05/11
Dr. Madden reevaluated in February 2012 and advised no clinical evidence of recurrence
Finally went to Genetic Center and underwent BRACAnalysis, and was found to carry a

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deleterious BRCA1 mutation, the M1775R. This mutation confirms the presence of Hereditary Breast and Ovary Cancer susceptibility syndrome within the family.
OFL advised her to undergo supracervical hysterectomy and ovariectomy 10/22/12 but she wanted to think about it further - encouraged to discuss with Dr. Madden - note sent to him.
Follow up with Dr. Madden in February 2013
Follow up consultation with Dr. Madden 02/13/2013 was advised to proceed with a hysterectomy and oophorectomy. Madden recommended proceeding with a hysterectomy and oophorectomy. The patient is still hesitant to proceed in this direction. An ultrasound of her uterus and ovaries 02/18/13 was normal and he sent a CA 125 level which was normal by her report 02/27/13 Advised to return August 2013.
Consulted Dr. Barrineau / Brown for biopsy of the mass in the left preaxillary area 06/03/13
She consulted Dr. Brown 06/14/13 for excision of the mass in the left preaxillary area the mass was noted as most probably metastatic carcinoma to the chest wall and was advised would need general anesthesia and excision of the mass. Excision performed 06/19/13 showed evidence of invasive mammary carcinoma with follow up on 07/02/13 and 07/14/13 with noted
Cellulitis noted to operative site thus treated with Septra DS 1tab p.o. b.i.d. x I week 06/04/13 .
Follow up consultation with Dr. Madden July 2013 was advised would need radiation x 6 weeks with plans to start on 07/30/13 with Dr. Ezekial
Once again discussed with Katie my willingness to speak to her daughters regarding their risk of breast cancer - this time with her husband present 07/27/13
She is S/P XRT by Dr. Ezekial and has follow up with Dr. Madden 12/16/13

**Major Problem:** HYPERCHOLESTEROL : 272.0
Cholesterol elevated at 216 and LDL however was normal at 132 at check on 04/12/00.
Her main ASCVD risk factors include family history of heart disease in her mother
She also has hypercholesterolemia and a prior history of tobacco abuse.
FLP: CHOL: 156 select: TRIG: 108: DHDL: 50.0: LDL 81 TC/HDL: 2.9 on 12/06/07
Started Simvastatin 20mg po qhs due to literature showing risk reduction benefit in diabetics 12/21/07
LDL CHOL: 47: ALT: 26 :CK: 117 on 08/11/2008
FLP:CHOL: 144 TRIG: 93 HDL: 52 TC/HDL: 2.8 LDL: 73 on 12/01/2010
CK: 136 ALT: 7 select on 12/01/2010
FLP:CHOL: 201, TRIG: 120, HDL: 64, TC/HDL: 3.1, LDL: 113 on 04/01/2011
CK: 90, ALT: 26 on 04/01/2011 thus increased Simvastatin to 40mg po qhs 08/05/11 in order to achieve
LDL: 98 on 08/05/2011
FLP:CHOL: 172: TRIG: 85: HDL: 50.3: TC/HDL: 3.42: LDL: 104.93 on 07/29/2013
CK: 181, ALT: 14 on 07/29/2013
LDL:LDL: 94.19 on 12/16/2013, ALT: 14 on 12/16/2013
LDL at goal < 100
FLP, CK, ALT, CRP annually and LDL, CK, ALT q 4months (272.0)

**Other Problem:** ABNORMAL PAP : 795.0
Has had a h/o abnormal Pap smears and mild dysplasia in the distant past. Pap smear on 05/25/00 was reported as normal but a repeat pap smear done 07/12/01 however had shown atypical endocervical cells of undetermined significance-ASCUS.
She had a culposcopy scheduled and did not show for this in 2001 but however states that she went to see Dr. Dyke though we do not have any records from him regarding her visit.
She states that when Dr. Dyke had done a pap smear there were no abnormalities.
Repeat pap smear - WNL done 11/12/02.
PAP in January 2005 normal at Dr. Dyke's office per Katie's report.
Pelvic exam by Dr. Dyke 12/18/07 - records requested 12/21/07
Pap smear normal on 09/10/09, 12/01/10, and 01/16/12

**Other Problem:** ANEMIA OTHER UNS : 285.9
**Other Problem:** MICROCYTOSIS:
There had been a significant drop in her hgb from 14.1 in May 2000to 12.4 in April 2001and then to 11.1 on 04/24/02. During that time her MCV also fell from 91.3 to 84 and she likely had iron deficiency anemia. She had normal renal function with a CR of 1.0 on 04/24/02 check. She did have a colonoscopy done by Dr. Davis on 07/27/01 and this showed no evidence of colonic malignancy though she did have some hemorrhoids.
She was advised to take her Iron regularly and there had been a slight improvement in her Hgb to 12.3 when checked on 11/12/02 but she was advised to persevere with the use of the Iron.
HGB: 12.2 on 12/06/2007 and stool guaiac negative 12/21/07
HGB: 11.2 on 08/11/2008- had been skipping a few doses.

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if continues to be anemic with consider running anemia panel
Encouraged to take iron suppliments daily.
HGB: 10.9 on 12/01/2010 thus Iron, B12, Folate, Ferritin sent 04/01/11 but did not return thus requested once more 08/05/11
VITAMIN B12: 503.0, FOLIC ACID: 8.8, IRON: 29, FERRITIN: 79 on 08/05/2011
HGB: 12.2 on 08/05/2011 and stool guaiac negative 01/16/12
HGB: 11.8 on 12/16/2013
CBC q 4months

**Other Problem:** FAMILY STRESS : 308.0
**Other Problem:** DEPRESSION,MAJOR : 296.24
Advised initiation of Lexapro 10mg poqhs and Klonopin 0.5mg po TID prn and QHS 03/21/05 until Lexapro takes effect in 1-2 weeks.
She and her husband remain separated but neither he nor her are actively pursuing divorce
TSH: 0.79 on 12/29/2006
Was separated- no longer taking her Lexapro and doing well on 09/15/08
Most stresse caused by recurring back pain and recurring panniculitis 11/03/08 until panniculectomy 05/18/10 with Dr. Strickland.
Marital stress over divorce settlement 12/16/13

**Other Problem:** CHEST WALL PAIN : 786.52
CXR ordered 03/21/05 due to chest wall tenderness and history of breast cancer but never done
CXR ordered again 12/21/07, but not done as or 09/15/08
Relieved with Skelaxin 800mgpo TID thus continues PRN use
Resolved

**Other Problem:** KNEE PAIN : 719.46
**Other Problem:** OSTEOARTHRITIS, LOCALIZED PRIMARY LOWER LEG : 715.16
Xray of left knee at NCMH requested 03/21/05 and advised use of Knee Immobilizer for 4 days but she did not get this either due to cost
Treated by Physical Therapy at Newberry PT with improvement
**Procedure:** INJECTION/MAJOR JO : 06/29/10 : : 20610
The patient was advised of the remote risk of bleeding and infection as well as the benefits of intraarticular steroid injection therapy. After verbal consent obtained for intraarticular injection, the left knee was prepped with Betadine using the lateral approach. Then the knee was injected 06/29/10 with Kenalog 40mg mixed with 1 cc. of 0.5% Marcaine and 1 cc. of 2% plain Lidocaine using sterile technique.
Advised to resume Voltaren XR 100mg po qday 08/20/10
Both left and right knees injected with Kenalog 40mg mixed with 1 cc. of 0.5% Marcaine and 1 cc. of 2% plain Lidocaine using sterile technique after Betadine prep.- injected on 03/02/11
Letter written to Stacy Thompson, her attorney, re disabiiity from continued back and knee pain 12/01/10
ANA- positive, Rheumatoid Factor- positive, SED RATE: 120 select on 12/01/2010
She started on SSI disability in December 2010 and now has a Medicaid card
Referred to rheumatology on 03/02/11 with consultation scheduled with Dr. Morthala 06/20/11
Consultation with Dr. Morthala, rheumatologist, 06/02/11 in regard to ESR 120 and positive ANA and Rheumatoid Factor and she was started on Celebrex 100mg po qday as needed 07/02/11 by Dr. Morthala - consult reports requested 08/05/11
Right knee injected 01/16/12, 05/12/12, 10/22/12, 02/27/13 with Kenalog 40mg mixed with 1 cc. of 0.5% Marcaine and 1 cc. of 2% plain Lidocaine using sterile technique after Betadine prep
Left knee injected to medial aspect with kenalog 40mg mixed with 1 cc. of 0.5% Marcaine and 1 cc. of 2% plain Lidocaine on 04/04/13- improvement reported
MRI if lower extremity denied 04/18/13
Katie left message 04/08/13 requesting an appt. for MRI that she had discussed with OFL at her last appt. in February 2013 She reported 04/08/13 it is her left knee and she feels like she needs to go ahead with the MRI as she states she did get some relief with injection but still continues with some pain. MRI of the left knee request sent to NCMH per OFL MRI L knee denied by insurance/ medicaid at this time. 04/16/13 Appointment was scheduled for consult with Dr. Milner on 4/25/13 who advised her this was arthritis and she should continued recieving steroid injections to help with the pain prn.
**Procedure:** INJECTION/MAJOR JO : 08/03/13 : : 20610
The patient was advised of the remote risk of bleeding and infection as well as the benefits of intraarticular steroid injection therapy. After verbal consent obtained for intraarticular injection, the left and right knees were prepped with Betadine using the lateral approach. Then the knee was injected 08/03/13 with Kenalog 40mg mixed with 1 cc. of 0.5% Marcaine and 1 cc. of 2% plain Lidocaine using sterile technique.
Injection of the left knee repeated on 10/15/13- stated that she was seen by Dr. Milner and advised that she had arthritis in her knees on 10/15/13- Records requested on 10/15/13

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Left knee with extreme pain since her injection by Ortho Dr. Milner on 11/21/13, reports being evaluated in NCMH ER on 11/21/13 and given a shot of pain medication.
Presented in extreme pain, 10/10 pain, to the left knee and primarly to the left posterior calf with positive Homans sign noted on 11/23/13
Discussed with LEH via phone and sent to NCMH ER (LEH spoke with Dr Price in the ER) for evaluation and management on 11/23/13
-
S/P arthroscopic drainage of left knee by Dr. Hibbits for Septic Arthritis although cultures were negative she was treated with Vancomycin,IV at NCMH 11/23/13 to 11/25/13 the Cipro orally
New ace wrap given 11/27/13

**Other Problem:** INSOMNIA UNSPECIFI : 780.52
seems to be related to leg cramps, though she notes some periods of lying awake worrying
Has been on Restoril in past and did not like how it made her feel
discussed good sleep hygene
Trazodone 50mg po qhs prn 12/30/06 but no longer using this
Started Klonopin 1mg po qhs 12/21/07 if leg pain at night not relieved by Qualaquin 324mg po qhs
Content with her sleeping patterns at present

**Other Problem:** LEG CRAMP,DUR SLEE : 327.52
**Other Problem:** LEG CRAMPS : 729.82
Notes that she gets cramps in leg, mainly at night but some during day since June 2007
Quinine has helped some in past, but does not control
advised of need to drink plenty of fluids
Lyrica 50mg po tid 12/30/06 - she has not taken as yet
ABI studies requested 07/28/07- reuslts not in PP, medical records to call hospital for resutls
K+: 4.2 on 12/06/2007
Started Klonopin 1mg po qhs 12/21/07 if leg pain at night not relieved by Qualaquin 324mg po qhs
Continues with intermittent symptoms although VIT D, 25-OH, TOTA: 35.7 on 12/01/2010
Improved with Flexeril 10mgpo TID thus renewed 04/01/11
Seen NCMH ER 07/15/2011 For cramping in feet and legs given Rx for Valium 5mg 1 Q 12hrs prn #15
Advised to start Valium 10mg po TID prn cramps 08/05/11 with improvement 01/16/12
Currently taking Mag Ox 400mg po BID
MAG: 1.76 on 02/27/2013

**Other Problem:** CELLULITIS/ABSCESS UNSPECIFIED SITE : 682.9
**Other Problem:** ABSCESS OF PERINEUM : 616.4
Perineal, near her right labia, drained in ER on 08/10/08.
Wound culture pending in ER since
Placed on Clindamycin, Darvoct and Vicodin for pain in ER on 08/10/08.
Packing (approximately 17 inches) removed on 08/11/08- purulent drainage noted.
Repacked with approximately 15 inches of iodoform packing on 08/11/08
All packing has fallen out, but thankfully abscess still opened on 08/13/08
Repacked and after serial visits - healed
Resolved 01/16/12

**Major Problem:** CELLULITIS/ABSCESS LEG, EXCEPT FOOT : 682.6
**Other Problem:** ULCER, LOWER LIMB : 707.10
Left leg with ulcer and surrounding cellulitis 12/30/08
Ceftin 500mg po bid x 14d and advised Neosporin to area bid 12/30/06
advised of the need to monitor BGs careful to promote healing
she felt that Ceftin made the infection worse (explained that it was getting worse despite the Ceftin, but that Ceftin was not causing the infection to flare)
offered her admission for IV abx on 01/18/07, she declined
offered her referal to wound clinic on 01/18/07 - she refused
Started Bactrim DS 1 po bid x 14d 01/18/07 and stopped application of Neosporin to area
Worsening celluliitis noted believed secondary to MRSA thus started Zyvox 600mg po BID X 1 week 01/25/07
Called 06/01/07 with new flare on the Left leg cellulitis - previous culture had shown MRSA 05/30/07, recomended Bactrim, she stated this did not work well in the past, recommended Zyvox, she stated she could not afford.
Evaluated in ER Clindamycin on 06/30/07 which she took until 07/27/07 even though she only was given a 10 day supply

12/16/2013

Returned to the office 07/28/07 with increased redness and warmth in the right leg which was treated with SMZ/TMP DS 1 po BID X 30 days and Bactroban TID topically
Advised to elevate her left leg above her heart as much as possible and call if worse or fever
ABI of lower extremities with NCMH xray on 08/02/07 - not in PP ,message to medical records to calfl for results
Bathe with Dial Soap
Returned 12/06/07 - ulcer on left leg - tx with SMZ/ TMP DS bid x 30 days with improvement 12/21/07
Advised to stop while taking Cipro 500mg po BID for panniculitis 12/21/07
Left lower leg- erythematous, warm, cellulitis x 1-2 weeks on 09/15/08
Started on Keflex 500 mg PO QID x 7 days on 09/15/08- monitor
Renewed Keflex 500mg po QID X 10 days 11/03/08 for left lateral leg wound which was dressed with saline moistened gauze secured with Kling - continue daily until healed.
improving but not healed 12/20/08
Continues with 2 ulcerations to right leg and 1 ulceration to left leg on 09/10/09
Treated with Bactrim DS PO BID x 14 days on 09/10/09
Referred to wound clinic on 09/10/09 - consulted Dr Brown in the hospital 12/01/09
Resolved

**Other Problem:** EDEMA,LOCALIZED NOS : 782.3
**Other Problem:** WRIST PAIN
xray right wrist 12/22/08 showed no acute osseous abnormality.
Voltaren Xr 100mg po qd x 7 days then prn pain 12/20/08 and wrist splint
Resolved but has recurrent wrist pain at times

**Other Problem:** HEMATOCHEZIA/BLOOD IN STOOL : 578.1
**Other Problem:** BENIGN NEO COLON, APPENDIX, LARGE INTEST : 211.3
Rectal hemocult positive on 09/10/09
Colonoscopy at NCMH by WMD 09/23/09 showed Polyp noted in the rectum and diverticulosis thoughout
Repeat colonoscopy in 2014

**Other Problem:** DEQUERAIN'S DZ-RADIAL STYLOID TENOSYNOVITIS : 727.04
Mild. left wrist. Given left wrist splint on 02/18/10. Ice prn. Instructed to wear wrist splint each night, and also during the day as needed.
Consulted Dr. Owen on 03/22/10 who advised her to return after her panniculectomy

**Other Problem:** SEBORRHEIC KERATOSIS/INFLAMMED : 702.11
Shave biopsy 03/22/10 of the lesion on the left medial lower leg after 1% Local Lidocaine with epi anesthesia -sent to pathology which showed irritated SK.

**Other Problem:** VITAMIN D DEFICIENCY; UNSPECIFIED : 268.9
VIT D, 25-OH, TOTA: 6.7 on 02/18/2010
Started Ergocalciferol 50,000 units weekly in March 2010
VIT D, 25-OH, TOTA: 38 SELECT on 01/16/2012
VIT D, 25-OH, TOTA: 39 on 02/27/2013
VIT D, 25-OH, TOTA: 26 on 07/29/2013 thus encouraged to take Ergocalciferol daily
Vit D pending 12/16/13
Check Vit D level q 4 months

**Other Problem:** SCIATICA : 724.3
Started Ultram 50mg 1-2 po QID and Flexeril 10mg po TID prn left leg and buttock pain 06/29/10
Encouraged stretching exercises 06/29/10

**Other Problem:** INSOMNIA : 780.52
**Other Problem:** MENOPAUSAL (SYMPTOMATIC) OR FEMALE CLIMACTERIC STATES : 627.2
**Other Problem:** OSTEOPENIA-DISORDER OF BONE & CARTILAGE, UNSPECIFED : 733.90
Advised she is not a candidate for hormonal therapy due to her history of breast cancer
Noted hot flushes and sleeping in 3 hour segments most nights 08/20/10
Advised to take the TV out of her room to avoid nocturnal stimulation 08/20/10
Started Trazodone 50mg po and advised to increase by 25 to 50mg po qhs every 4 nights until able to sleep 6 to 8 hrs a night 08/20/10.
Admitted to not starting Trazodone as of 08/24/10 thus encouraged to start once again as she is not a candidate for hormone

12/16/2013

replacement therapy due to her history of breast cancer
Bone DEXA showed osteopenia 04/01/11
Started Caltrate with Vit D 600mg po BID 04/01/11
Repeat Bone DEXA 07/29/13 showed osteopenia
Bone Dexa Scan-Hip: 07/29/13 : Normal : 77080.
Neck (-1.12 )
Troch (+0.24 )
Inter (+0.61 )
T Score Femoral TOTAL (+0.58) with +2.05 % increase /yr since 04/01/11
Bone Dexa Scan-Spine: 07/29/13 : Osteopenia : 77080.
L1 (-1.22 )
L2 (-1.24 )
L3 (-1.03 )
L4 (-1.49 )
T Score L1-L4 (-1.29) with -0.18 % decrease/yr since 04/01/11

**Other Problem:** BARTHOLINS GLAND CYST : 616.2
Incised and drained of serosanguinous fluid - no pus noted 12/01/10
Advised she may need excision of right labia in future due to induration and recurring swelling 12/01/10
Resolved

**Other Problem:** URINARY TRACT INFECTION SITE NOT SPECIFIED : 599.0
Advised to continue Cipro 250mg po BID X 5 days given 08/04/11 which was called in by Dr. Morthala
U/A Microscopic: RBC-UA: 2-5, WBC-UA: 0-2, BACTERIA-UA: Trace, EPITH-UA: Few, MUCUS-UA: 0, CASTS-UA: 0, CRYSTALS-UA: 0, OTHER: 0 on 02/27/2013.
UA q 4months

**Other Problem:** POSTMENOPAUSAL BLEEDING : 627.1
Endometrial Biopsy
Verbal consent for endometrial biopsy obtained 01/16/12
Vagina was wiped clean with Betadine and then sterile speculum was inserted. Betadine saturated 4X4 gauze sponges were used to wipe the cervix and vault X3. Pipelle endometrial biopsy was performed 01/16/12 without difficulty after tenaculum was placed on the anterior cervical lip. Cylindrical tissue sample was placed in a formalin container and sent to pathology.
Endometrial biopsy 01/16/12 showed - DISINTEGRATING FRAGMENTS OF DISORDERED PROLIFERATIVE PHASE ENDOMETRIUM
Resolution of vaginal bleeding noted 05/21/12
Finally went to Genetic Center and underwent BRACAnalysis, and was found to carry a deleterious BRCA1 mutation, the M1775R. This mutation confirms the presence of Hereditary Breast and Ovary Cancer susceptibility syndrome within the family.
OFL advised her to undergo supracervical hysterectomy and ovariectomy 10/22/12 but she wanted to think about it further - encouraged to discuss with Dr. Madden as well
Follow up consultation with Dr. Madden 02/13/2013 who recommended proceeding with a hysterectomy and oophorectomy. The patient is still hesitant to proceed in this direction. As a temporizing measure. An ultrasound of her uterus and ovaries 02/18/13 was normal and he sent a CA 125 level which was normal by her report 02/27/13. Advised to return August 2013.
Consultation wtih Dr. Strickland in regard to hiradenitis supprativa 11/21/2012 IMPRESSION: Presumed hydradenitis suppurativa of the right labia majora thus refered to gynecologist Dr. Greg Lyman for his opinion.A prescription for Cipro was written and Dr. Lyman recommended surgery if not improved.

**Other Problem:** JOINT PAIN ANKLE/FOOT : 719.47
**Procedure:** INJECTION/MINOR JO : 12/16/13
The patient was advised of the remote risk of bleeding and infection as well as the benefits of intraarticular steroid injection therapy. After verbal consent obtained for intraarticular injection, the left 5th toe MTP joint was prepped with Betadine using the lateral approach. Then the left 5th MTP joint was injected 12/16/13 with Kenalog 40mg mixed with 0.25 cc. of 0.25% Marcaine and 0.25 cc. of 2% plain Lidocaine using sterile technique.
Uric Acid level ordered 12/16/13
Injected the left 5th MTP joint with 0.25cc of Lidocaine, 0.25cc o Marcaine and 0.25 cc of Kenalog 40mg after Betadine prep using sterile technique

12/16/2013

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HEALTH MAINTENANCE:
PGM: UNITED
Complete Physical Exam 02/27/13
Declines Fluvac because a long time ago she said that her oncologist, Dr. Madden told her not to get the flu shot. Requested on 02/18/10 that she contact Dr. Madden for reassurance that it would be okay to get a flu shot injection, and encouraged to then receive fluvac. Declined again 12/01/2010 and 01/16/12
The importance of her follow up with her oncologist for breast CA follow up was emphasized. She has a follow-up with Dr. Madden in June.
Pap smear was normal 12/01/10 and 01/16/12
Colonoscopy 09/23/09 with benign polyp - advised repeat in 2014
Letter written to Stacy Thompson, her attorney, re disability from continued back and knee pain 12/01/10 - received SSI Disability in December 2011
Bone DEXA 07/29/13 pending
TDaP booster given 08/05/11
Fluvax 10/22/12
Prevnar 10/22/12

FOLLOW UP March 2014 for Annual Welness Visit, complete physical exam, review of chronic medical problems with BMP, Mg2+, HGBA1C, UA q 4 months, Urine Microalbumin q 12 months (250.00) Peak Flow (519.1) FLP, CK, ALT (272.0) CBC (285.9) Vit D (268.9) after follow up consultation with Dr. Madden 12/16/13 , completion of XRT with Dr. Ezekial in January 2014 , and consultation wtih Dr. Strickland in regard to hiradenitis supprativa and possible hysterectomy and oophorectomy and Uric Acid and Vit D return from 12/16/13

# SIGNED BY Oscar F Lovelace, Jr, MD (OFL) 12/16/2013 12:03PM
# REVISED BY Oscar F Lovelace, Jr, MD (OFL) 12/16/2013 12:11PM

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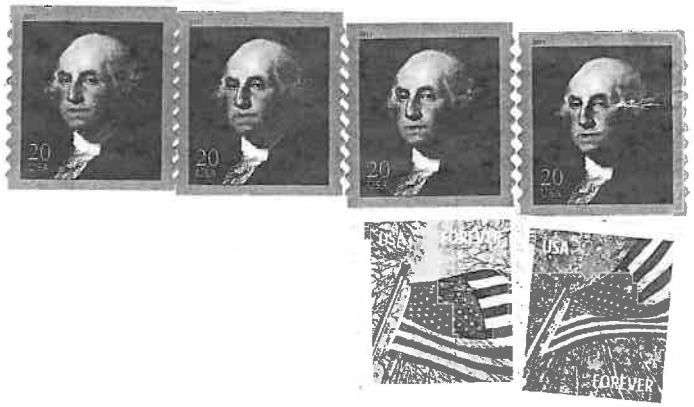

Medicaid
attn: Medical Director
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March 11, 2014

Lovelace Family Medicine, P.A.
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Dear Belinda,

This letter is in response to the correspondence received by South Carolina Department of Health and Human Services, regarding claims that were in question for Member Katie Hunter and the CPT codes 20600 and 99215 with regard to NCCI editing. We apologize for the delay in response.

We have determined that there was an outstanding issue with the bypass editing when procedures were billed appropriately with the '25' modifier. We utilized a third party company, HMS Holdings, to assist with resolving this issue and we should not see any further disruptions to the NCCI editing process.

The affected claims have been identified by the Enterprise Systems team at DHHS and will be reprocessed for appropriate claim adjudication. This process is intended for completion and outstanding claim payments to be issued by check date March 21, 2014.

Thank you for your inquiry and continued participation with the SC Medicaid program.

Respectfully,

Jason Edward Taylor

Jason E Taylor
Director, Operations and Provider Relations
803-898-1052