



Clinic Name: **Your Clinic Name**

**Clinic Code: (Provided to you during training or located on your RevFlow access form)**

Clinic Contact: **Your name**

[illegible]

## EFTs

[illegible]

VENDOR NO: CALI0035

NAME: [REDACTED] n

CHECK DATE: 5/25/2012

REFERENCE	INVOICE DATE	GROSS AMOUNT	DISCOUNT TAKEN	NET AMOUNT PAID
AP5984919	5/16/2012	75.00	0.00	75.00
AP5985261	5/16/2012	75.00	0.00	75.00
AP5985264	5/16/2012	75.00	0.00	75.00
AP5988032	5/16/2012	75.00	0.00	75.00
TOTAL >		300.00	0.00	300.00

\*\*If you would prefer to receive your payment via Direct Deposit please send email request to EFTInfo@universalsmartcomp.com\*\*

THIS CHECK IS VOID WITHOUT A BLUE BACKGROUND AND A WATERMARK. HOLD UP TO THE LIGHT TO VERIFY

Universal SmartComp  
480 Johnson Road  
Suite 200  
Washington, PA 15301

Citizens Bank  
3907 Washington Road, 15B-006B  
McMurray, PA 15317  
32615-4660

DATE	5/25/2012
AMOUNT	300.00

PAY Three Hundred and 00/100 \*\*\*\*\*

TO THE ORDER OF [REDACTED]  
[REDACTED]  
[REDACTED]  
USA

CHECK IS PRINTED ON SECURITY PAPER WHICH INCLUDES A MICROPRINT BORDER &amp; FLUORESCENT FIBERS

031151 1010011501 0110111511



Explanation of  
Payment Analysis

Report #: [REDACTED]  
Preparation Date: 05/16/2012  
EOS #: [REDACTED]  
Date of Injury: 09/19/2008

P.O. Box 800  
Meadowlands, PA 15347  
Telephone 724-206-1500  
Facsimile 724-206-1555

Provider: [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Employer:

Patient: [REDACTED]

Provider ID: CALI0035

Provider Tax ID: [REDACTED]

Insurer: Gallagher Bassett  
PO Box 23812  
Tucson AZ 85734

Claim: [REDACTED]

Service ZIP: 94558

ICD9 Code: 724.5 Backache

Insurer ID: [REDACTED]

Date of Service	Procedure Code	Units	Provider Charge	FS/UC/BR/ Reductions	SmartComp Reductions	Allow Amount	Reason Code
03/27/12	97018 APPLIC MODAL 1/> AREAS; PARAFN BATH	1	\$ 25.00	\$ 20.39	\$ 1.50	\$ 3.11	USC,G1
03/27/12	97014 APPLIC MODAL 1/> AREAS; ELEC STIM	1	\$ 35.00	\$ 25.77	\$ 2.99	\$ 6.24	USC,G1
03/27/12	97620 INDIVIDUALIZED PROCED REQ CUMPUTER EQUIP 30 MIN+	1	\$ 63.96	\$ 0.00	\$ 20.75	\$ 43.21	USC
03/27/12	97250 MYOFASC RELEAS/SOFT TISS MOBILIZ	1	\$ 60.00	\$ 26.79	\$ 10.77	\$ 22.44	USC,G1
Analysis Totals:			\$ 183.96	\$ 72.95	\$ 36.01	75.00	

Explanation of Reason Codes

USC: Payment according to Universal SmartComp contractual agreement

G1: The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.

When calculating payments to match your contracted rate with SmartComp, your contracted rate is distributed across all lines. Please call Customer Service at 724-206-1500 for any questions you might have regarding this analysis.

To sign up for SmartLink and have 24 hour real time access to Claim Search, Payment Status, Payment Information and SmartComp information please visit our website at [www.universalsmartcomp.com](http://www.universalsmartcomp.com) and click on SmartLink.  
To expedite payments to your facility sign up for EFT Payments by e-mailing [EFTinfo@universalsmartcomp.com](mailto:EFTinfo@universalsmartcomp.com)

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JUN 04 2012



Explanation of  
Payment Analysis

Report #: 712100  
Preparation Date: 05/16/2012  
EOS #: 5061  
Date of Injury: 09/19/2008

P.O. Box 800  
Meadowlands, PA 15347  
Telephone 724-206-1500  
Facsimile 724-206-1555

Provider: [REDACTED]

Employer: [REDACTED]

Patient: [REDACTED]

Provider ID: CALI0035

Provider Tax ID: [REDACTED]

Insurer: Gallagher Bassett  
PO Box 23812  
Tucson AZ 85734

Claim: [REDACTED]

Service ZIP: 94558

ICD9 Code: 724.5 Backache

Insurer ID: [REDACTED]

Date of Service	Procedure Code	Units	Provider Charge	FS/UC/BR/ Reductions	SmartComp Reductions	Allow Amount	Reason Code
03/23/12	97620	1	\$ 63.96	\$ 0.00	\$ 18.88	\$ 45.08	USC
	INDIVIDUALIZED PROCED REQ CUMPUTER EQUIP 30 MIN+						
03/23/12	97014	1	\$ 35.00	\$ 25.77	\$ 2.72	\$ 6.51	USC,G1
	APPLIC MODAL 1/> AREAS; ELEC STIM						
03/23/12	97250	1	\$ 60.00	\$ 26.79	\$ 9.80	\$ 23.41	USC,G1
	MYOFASC RELEAS/SOFT TISS MOBILIZ						
Analysis Totals:			\$ 158.96	\$ 52.56	\$ 31.40	75.00	

**Explanation of Reason Codes**

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G1: The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.

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Explanation of  
Payment Analysis

Report #: [REDACTED]  
Preparation Date: 05/16/2012  
EOS #: [REDACTED]  
Date of Injury: 09/19/2008

P.O. Box 800  
Meadowlands, PA 15347  
Telephone 724-206-1500  
Facsimile 724-206-1555

Provider: [REDACTED]  
[REDACTED]  
[REDACTED]

Employer:

Patient: [REDACTED]  
[REDACTED]  
[REDACTED]

Provider ID: CALI0035

Provider Tax ID: [REDACTED]

Insurer: Gallagher Bassett  
PO Box 23812  
Tucson AZ 85734

Claim: 003519000031WC01

Service ZIP: 94558

ICD9 Code: 724.5 Backache

Insurer ID: [REDACTED]

Date of Service	Procedure Code	Units	Provider Charge	FS/UC/BR/ Reductions	SmartComp Reductions	Allow Amount	Reason Code
03/29/12	97014 APPLIC MODAL 1/> AREAS; ELEC STIM	1	\$ 35.00	\$ 25.77	\$ 2.72	\$ 6.51	USC,G1
03/29/12	97250 MYOFASC RELEAS/SOFT TISS MOBILIZ	1	\$ 60.00	\$ 26.79	\$ 9.80	\$ 23.41	USC,G1
03/29/12	97620 INDIVIDUALIZED PROCED REQ CUMPUTER EQUIP 30 MIN+	1	\$ 63.96	\$ 0.00	\$ 18.88	\$ 45.08	USC
			<b>Analysis Totals:</b>	\$ 52.56	\$ 31.40	<b>75.00</b>	

**Explanation of Reason Codes**

USC: Payment according to Universal SmartComp contractual agreement

G1: The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance.

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Explanation of  
Payment Analysis

Report #: [REDACTED]  
Preparation Date: 05/16/2012  
EOS #: [REDACTED]  
Date of Injury: 11/20/2010

P.O. Box 800  
Meadowlands, PA 15347  
Telephone 724-206-1500  
Facsimile 724-206-1555

Provider: [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Employer:

Patient: [REDACTED]  
[REDACTED]  
[REDACTED]

Provider ID: CALI0035

Provider Tax ID: [REDACTED]

Insurer: Gallagher Bassett  
PO Box 23812  
Tucson AZ 85734

Claim: 000541008871WC01

Service ZIP: 94558

ICD9 Code: 732.3 Juvenile osteochondrosis of uppe

Insurer ID: [REDACTED]

Date of Service	Procedure Code	Units	Provider Charge	FS/UC/BR/ Reductions	SmartComp Reductions	Allow Amount	Reason Code
03/16/12	97014	1	\$ 35.00	\$ 35.00	\$ 0.00	\$ 0.00	G1
	APPLIC MODAL 1/> AREAS; ELEC STIM						
03/16/12	97250	1	\$ 60.00	\$ 26.79	\$ 7.58	\$ 25.63	USC,G1
	MYOFASC RELEAS/SOFT TISS MOBILIZ						
03/16/12	97620	1	\$ 63.96	\$ 0.00	\$ 14.59	\$ 49.37	USC
	INDIVIDUALIZED PROCED REQ COMPUTER EQUIP 30 MIN+						
			<b>Analysis Totals:</b>	\$ 158.96	\$ 61.79	\$ 22.17	<b>75.00</b>

**Explanation of Reason Codes**

USC: Payment according to Universal SmartComp contractual agreement

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Provider Number: [REDACTED]

Check #: CA-005700

Issue Date: 05/31/12

Doc #: [REDACTED]

## Medical

Page 1 of 2

Line #	Bill ID.	DOS	Billed Proc.	Service Description	Units	Charges	Amount Reduced	Reduction Codes	Allowances
Patient Name: [REDACTED] Claim #: [REDACTED] Date of Injury: 01/06/11 SSN: XXX-XX-9977 Employer name: [REDACTED] Employer ID: [REDACTED] ICD-9 Code: 816.01 FX MID/PRX PHAL, HAND-CL									
1	SF1-SFCA-9984285	05/02/12	97620	Indivi Proc Req Appl	1	63.96	.00		63.96
2	SF1-SFCA-9984285	05/02/12	97250	Myofascial Release	1	60.00	26.79	326 PM8	33.21
3	SF1-SFCA-9984285	05/02/12	97014	Electric Stimulation	1	35.00	25.77	325 PM8	9.23
4	SF1-SFCA-9993490	05/07/12	97250	Myofascial Release	1	60.00	26.79	326 397 465 G1	33.21
5	SF1-SFCA-9993490	05/07/12	97014	Electric Stimulation	1	35.00	25.77	G5 PM8	
6	SF1-SFCA-9993490	05/07/12	97620	Indivi Proc Req Appl	1	63.96	.00	325 PM8	9.23
Total Allowances:									\$212.80

JUN 04 2012

To read and download the new paper medical billing regulations go to:  
[http://www.dir.ca.gov/dwc/DWCPropRegs/Ebilling/EBilling\\_Regulations.htm](http://www.dir.ca.gov/dwc/DWCPropRegs/Ebilling/EBilling_Regulations.htm)

ERMARK

01382308024823639012



Provider Number: [REDACTED]

Claim # [REDACTED]

Issue Date: 05/31/12  
Doc #: 024823639

Medical

Page 1 of 2

Line #	Bill ID.	DOS	Billed Proc.	Service Description	Units	Charges	Amount Reduced	Reduction Codes	Allowances
Patient Name: [REDACTED] Claim #: [REDACTED] Date of Injury: 01/06/11 SSN: XXX-XX-9977 Employer name: [REDACTED] Employer ID: [REDACTED] ICD-9 Code: 816.01 FX MID/PRX PHAL, HAND-CL									
1	SF1-SFCA-9984285	05/02/12	97620	Indivi Proc Req Appl	1	63.96	.00		63.96
2	SF1-SFCA-9984285	05/02/12	97250	Myofascial Release	1	60.00	26.79	326 PM8	33.21
3	SF1-SFCA-9984285	05/02/12	97014	Electric Stimulation	1	35.00	25.77	325 PM8	9.23
4	SF1-SFCA-9993490	05/07/12	97250	Myofascial Release	1	60.00	26.79	326 397 465 G1 G5 PM8	33.21
5	SF1-SFCA-9993490	05/07/12	97014	Electric Stimulation	1	35.00	25.77	325 PM8	9.23
6	SF1-SFCA-9993490	05/07/12	97620	Indivi Proc Req Appl	1	63.96	.00		63.96
Total Allowances:									\$212.80

JUN 04 2012

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[http://www.dir.ca.gov/dwc/DWCPropRegs/Ebilling/EBilling\\_Regulations.htm](http://www.dir.ca.gov/dwc/DWCPropRegs/Ebilling/EBilling_Regulations.htm)

THIS IS WATERMARKED PAPER — HOLD TO LIGHT TO VERIFY WATERMARK

State Compensation Insurance Fund

San Francisco District Office  
P.O. Box 63005  
Pineale, CA 93650-3005

Union Bank  
Los Angeles, California

01-4156  
122

Payee IRS Number [REDACTED]

VOID After 365 Days

Check Date	Check Amount
May 31, 2012	\$*****212.80

PAY \*\*\*Two Hundred Twelve and 80/100 Dollars\*\*\*ONLY

To The  
Order Of [REDACTED]

[Signature]

State Compensation Insurance Fund  
 P.O. Box 5500  
 Sacramento, CA 95833-5000  
 Questions & Appeals: 1-800-977-7300

Provider Number: [REDACTED]

Check #: [REDACTED]

Issue Date: 05/31/12

Doc #: [REDACTED]

## Summary

Page 2 of 2

Bill ID.	Claim Number	Invoice / Account Number	Billed Amounts	Reductions	Allowances	Penalty & Interest	Totals
[REDACTED]	[REDACTED]	[REDACTED]	158.96	52.56	106.40	.00	106.40
Provider NPI: [REDACTED] Rendering Provider NPI: [REDACTED] 3 Rendering Provider: [REDACTED] Patient Acct #: [REDACTED] ReviewerID: 4B Carrier Receive Date: 05/17/12 Review Date: 05/30/12 Payment Code: 1 UB04: [REDACTED] 85 [REDACTED] [REDACTED] 158.96 52.56 106.40 .00 106.40 Provider NPI: [REDACTED] Rendering Provider NPI: [REDACTED] 9 Rendering Provider: [REDACTED] Patient Acct #: [REDACTED] ReviewerID: P2 Carrier Receive Date: 05/15/12 Review Date: 05/30/12 Payment Code: 1 UB04:							

The preceding invoice totals reflect the amount of reviewed and/or approved billing items from the associated invoices that are included in this payment and are generated to assist your organization to balance your paperwork.

Charges that are either denied payment or found in excess of the allowance are objected to for the above reasons. If you disagree with the reductions, you may contact us at the address and phone number listed, or you may file an application or lien with the Workers' Compensation Appeals Board. Liens are subject to the statute of limitations spelled out in Labor Code Section 4903.5. California Labor Code Section 3751(b) prohibits attempts to collect any balance due from the injured worker.

## EOR Reduction Code Explanation:

- 325 : ALLOWANCE IS MADE AT 50% OF THE OMFS OR THE BILLED CHARGE, WHICHEVER IS LOWER, AS PER THE MULTIPLE PHYSICAL MEDICINE PROCEDURES RULE.
- 326 : ALLOWANCE IS MADE AT 75% OF THE OMFS OR THE BILLED CHARGE, WHICHEVER IS LOWER, AS PER THE MULTIPLE PHYSICAL MEDICINE PROCEDURES RULE.
- 397 : ALLOWANCE IS BASED ON UTILIZATION REVIEW PRE-AUTHORIZATION.
- 465 : Reimbursement allowed for services exceeding treatment limitations scheduled allowance.
- G5 : This charge was adjusted for the reasons set forth in the attached letter.
- PM8 : Physical Medicine rule 1 (e) regarding multiple services (cascade) was applied to this service.

01382308024823639012



Provider Number: 000014000

Check #: 00000005

Issue Date: 06/01/12

Doc #: 00000005

## Medical

Page 1 of 2

Line #	Bill ID.	DOS	Billed Proc.	Service Description	Units	Charges	Amount Reduced	Reduction Codes	Allowances
Patient Name: [REDACTED] Claim #: [REDACTED] Date of Injury: 06/29/11 SSN: XXX-XX-4982 Employer name: [REDACTED] Employer ID: STATE ICD-9 Code: 726.32 LATERAL EPICONDYLITIS ICD-9 Code: 726.31 MEDIAL EPICONDYLITIS									
1	SF1-SFSC-4699614	04/20/12	97014	Electric Stimulation	1	35.00	25.77	325 PM8	9.23
2	SF1-SFSC-4699614	04/20/12	97620	Indivi Proc Req Appl	1	63.96	.00		63.96
3	SF1-SFSC-4699614	04/20/12	97250	Myofascial Release	1	60.00	26.79	326 PM8	33.21
Subtotal:									106.40
Patient Name: [REDACTED] Claim #: [REDACTED] Date of Injury: 05/08/11 SSN: XXX-XX-1638 Employer name: [REDACTED] Employer ID: [REDACTED] ICD-9 Code: 959.4 HAND INJURY NOS ICD-9 Code: 719.44 JOINT PAIN-HAND									
4	SF1-SFSC-4755246	05/13/11	098774	Training Checkout	1	115.00	70.10	790 G1	44.90
				Reviewed As 97700					
5	SF1-SFSC-4755246	05/13/11	97620	Indivi Proc Req Appl	1	63.96	.00		63.96
6	SF1-SFSC-4755246	05/13/11	97612	Pm Tx 1 Area Ind. Ins	1	55.00	30.09	326 PM8	24.91
Sub-Totals:						233.96	100.19		133.77
Adjustment:						-233.96	-145.09		-88.87
Adj-Totals:						.00	-44.90		44.90
7	SF1-SFSC-4755246			Medical Penalty					6.74
8	SF1-SFSC-4755246			Medical Interest					1.33
Subtotal:									52.97
Total Allowances:									\$159.37

01382352024828470012

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[http://www.dir.ca.gov/dwc/DWCPpropRegs/EBilling/EBilling\\_Regulations.htm](http://www.dir.ca.gov/dwc/DWCPpropRegs/EBilling/EBilling_Regulations.htm)

Provider Number: [REDACTED]

Check #: [REDACTED]

Issue Date: 06/01/12

Doc #: [REDACTED]

**Medical**

Page 1 of 2

Line #	Bill ID.	DOS	Billed Proc.	Service Description	Units	Charges	Amount Reduced	Reduction Codes	Allowances
Patient Name: ██████████ Claim #: ██████████ Date of Injury: 06/29/11									
SSN: XXX-XX-4982 Employer name: ██████████ EMPLOYER ID: ST111111111111									
ICD-9 Code:726.32 LATERAL EPICONDYLITIS									
ICD-9 Code:726.31 MEDIAL EPICONDYLITIS									
1	SF1-SFSC-4699614	04/20/12	97014	Electric Stimulation	1	35.00	25.77	325 PM8	9.23
2	SF1-SFSC-4699614	04/20/12	97620	Indivi Proc Req Appl	1	63.96	.00		63.96
3	SF1-SFSC-4699614	04/20/12	97250	Myofascial Release	1	60.00	26.79	326 PM8	33.21
Subtotal:									106.40
Patient Name: ██████████ Claim #: ██████████ Date of Injury: 05/08/11									
SSN: XXX-XX-1638 Employer name: ██████████ EMPLOYER ID: ST111111111111									
ICD-9 Code:959.4 HAND INJURY NOS									
ICD-9 Code:719.44 JOINT PAIN-HAND									
4	SF1-SFSC-4755246	05/13/11	098774	Training Checkout	1	115.00	70.10	790 G1	44.90
				Reviewed As 97700					
5	SF1-SFSC-4755246	05/13/11	97620	Indivi Proc Req Appl	1	63.96	.00		63.96
6	SF1-SFSC-4755246	05/13/11	97612	Pm Tx 1 Area Ind.Ins	1	55.00	30.09	326 PM8	24.91
Sub-Totals:						233.96	100.19		133.77
Adjustment:						-233.96	-145.09		-88.87
Adj-Totals:						.00	-44.90		44.90
7	SF1-SFSC-4755246			Medical Penalty					6.74
8	SF1-SFSC-4755246			Medical Interest					1.33
Subtotal:									52.97
Total Allowances:									\$159.37

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THIS IS WATERMARKED PAPER — HOLD TO LIGHT TO VERIFY WATERMARK

**State Compensation Insurance Fund**

Medical  
 ID#

Rohnert Park State Contracts  
 P.O. Box 3071  
 Suisun City, CA 94585

Union Bank  
 Los Angeles, California

30-A-30  
 1/12

Payee IRS Number [REDACTED]

VOID AFTER 365 Days

Check Date	Check Amount
June 01, 2012	\$*****159.37

PAY \*\*\*\*One Hundred Fifty-Nine and 37/100 Dollars\*\*\*\*ONLY

To The  
 Order Of

[REDACTED]

[Signature]

State Compensation Insurance Fund

P.O. Box 1111

San Francisco, CA 94111

Questions &amp; Appeals: 051099-7300

Provider Number: [REDACTED]

Check #: [REDACTED]

Issue Date: 06/01/12

Doc #: [REDACTED]

## Summary

Page 2 of 2

Bill ID	Claim Number	Invoice / Account Number	Billed Amounts	Reductions	Allowances	Penalty & Interest	Totals
[REDACTED]	[REDACTED]	[REDACTED]	233.96	100.19	133.77	8.07	141.84
Provider NPI: [REDACTED] Rendering Provider NPI: [REDACTED] Rendering Provider: [REDACTED] Patient Acct #: [REDACTED] ReviewerID: XL Carrier Receive Date: 02/28/12 Review Date: 05/31/12 Payment Code: 1 UB04: SF1-SFSC-4699614 05714090 C21930437 158.96 52.56 106.40 .00 106.40 Provider NPI: [REDACTED] Rendering Provider NPI: [REDACTED] Rendering Provider: [REDACTED] Patient Acct #: [REDACTED] ReviewerID: RX Carrier Receive Date: 05/03/12 Review Date: 05/31/12 Payment Code: 1 UB04:							
Adjustment:							-88.87
Totals:							44.90

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## EOR Reduction Code Explanation:

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- 326 : ALLOWANCE IS MADE AT 75% OF THE OMFS OR THE BILLED CHARGE, WHICHEVER IS LOWER, AS PER THE MULTIPLE PHYSICAL MEDICINE PROCEDURES RULE.
- 790 : THIS BILL WAS REVIEWED USING THE OFFICIAL MEDICAL FEE SCHEDULE OF CA. scheduled allowance.
- PM8 : Physical Medicine rule 1 (e) regarding multiple services (cascade) was applied to this service.

01382352024628470012



Provider Number: [REDACTED]

Check #: [REDACTED]

Issue Date: 05/31/12

Doc #: [REDACTED]

**CALIFORNIA WORKERS' COMPENSATION**  
[REDACTED]  
[REDACTED]

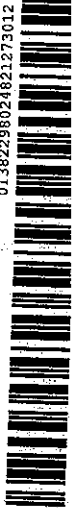
**Medical**

Page 1 of 2

Line #	Bill ID	DOS	Billed Proc.	Service Description	Units	Charges	Amount Reduced	Reduction Codes	Allowances
SSN: XXX-XX-9585    Patient Name: [REDACTED]    Claim #: [REDACTED]    Date of Injury: 05/14/07 Employer name: [REDACTED]    Employer ID: [REDACTED]									
ICD-9 Code: 727.03 TRIGGER FINGER									
1	SF1-SFSC-4754318	12/05/11	97014	Electric Stimulation	1	35.00	25.77	325 PM8	9.23
2	SF1-SFSC-4754318	12/05/11	97250	Myofascial Release	1	60.00	26.79	326 PM8	33.21
3	SF1-SFSC-4754318	12/05/11	97620	Indivi Proc Req Appl	1	63.96	.00		63.96
4	SF1-SFSC-4754318			Medical Penalty					15.96
5	SF1-SFSC-4754318			Medical Interest					3.02
<b>Total Allowances:</b>									<b>\$125.38</b>

JUN 04 2012

To read and download the new paper medical billing regulations go to:  
[http://www.dir.ca.gov/dwc/DWCPropRegs/EBilling/EBilling\\_Regulations.htm](http://www.dir.ca.gov/dwc/DWCPropRegs/EBilling/EBilling_Regulations.htm)





Provider Number: 00014282

Check #: 66-525696

Issue Date: 05/31/12

Doc #: 00014282

Medical

Page 1 of 2

Line #	Bill ID.	DOS	Billed Proc.	Service Description	Units	Charges	Amount Reduced	Reduction Codes	Allowances
Page 1 of 2									
SSN: XXX-XX-9585			Patient Name: [REDACTED]		Claim #: [REDACTED]		Date of Injury: 05/14/07		
Employer name: [REDACTED]			RTW COORDIN Employer ID: ST [REDACTED]						
ICD-9 Code: 727.03 TRIGGER FINGER									
1	SF1-SFSC-4754318	12/05/11	97014	Electric Stimulation	1	35.00	25.77	325 PM8	9.23
2	SF1-SFSC-4754318	12/05/11	97250	Myofascial Release	1	60.00	26.79	326 PM8	33.21
3	SF1-SFSC-4754318	12/05/11	97620	Indivi Proc Req Appl	1	63.96	.00		63.96
4	SF1-SFSC-4754318			Medical Penalty					15.96
5	SF1-SFSC-4754318			Medical Interest					3.02
Total Allowances:									\$125.38

JUN 04 2012

To read and download the new paper medical billing regulations go to:  
[http://www.dir.ca.gov/dwc/DWCPropRegs/Ebilling/EBilling\\_Regulations.htm](http://www.dir.ca.gov/dwc/DWCPropRegs/Ebilling/EBilling_Regulations.htm)

THIS IS WATERMARKED PAPER — HOLD TO LIGHT TO VERIFY WATERMARK

State Compensation Insurance Fund

Robert Park State Contracts  
 P.O. Box 3171  
 San Jose, CA 95131

Union Bank  
 Los Angeles, California

90-3130  
 1222

VOID After 365 Days

Check Date	Check Amount
May 31, 2012	\$*****125.38

PAY TO THE ORDER OF \*\*\*One Hundred Twenty-Five and 38/100 Dollars\*\*\*ONLY

*[Signature]*

State Compensation Insurance Fund

P.O. Box 1121

San Francisco, CA 94111

Inquiries &amp; Appeals (415) 692-7300

Provider Number: 00014200

Check #: 06-527090

Issue Date: 05/31/12

Doc #: 004821073

## Summary

Page 2 of 2

Bill ID.	Claim Number	Invoice / Account Number	Billed Amounts	Reductions	Allowances	Penalty & Interest	Totals
			158.96	52.56	106.40	18.98	125.38
Provider NPI: 1 Rendering Provider NPI: Rendering Provider: Patient Acct #: ReviewerID: RU Carrier Receive Date: 03/02/12 Review Date: 05/30/12 Payment Code: 1 UB04:							
<p>The preceding invoice totals reflect the amount of reviewed and/or approved billing items from the associated invoices that are included in this payment and are generated to assist your organization to balance your paperwork.</p> <p>Charges that are either denied payment or found in excess of the allowance are objected to for the above reasons. If you disagree with the reductions, you may contact us at the address and phone number listed, or you may file an application or lien with the Workers' Compensation Appeals Board. Liens are subject to the statute of limitations spelled out in Labor Code Section 4903.5. California Labor Code Section 3751(b) prohibits attempts to collect any balance due from the injured worker.</p> <p><b>EOR Reduction Code Explanation:</b></p> <p><b>325 :</b> ALLOWANCE IS MADE AT 50% OF THE OMFS OR THE BILLED CHARGE, WHICHEVER IS LOWER, AS PER THE MULTIPLE PHYSICAL MEDICINE PROCEDURES RULE.</p> <p><b>326 :</b> ALLOWANCE IS MADE AT 75% OF THE OMFS OR THE BILLED CHARGE, WHICHEVER IS LOWER, AS PER THE MULTIPLE PHYSICAL MEDICINE PROCEDURES RULE.</p> <p><b>PM8 :</b> Physical Medicine rule 1 (e) regarding multiple services (cascade) was applied to this service.</p>							

01382298024821273012





# STATE OF CALIFORNIA

WARRANT NUMBER

THE TREASURER OF THE STATE WILL PAY OUT OF THE  
FUND NO. FUND NAME

822 PERSCARE SUPPLEMENTAL 2012143GG6671999107A6775020

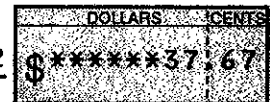
PAYEE I.D. NO.

90-1342  
1211

Cross

TO 925035

05/31/2012



JOHN CHIANG

CALIFORNIA STATE CONTROLLER



DETACH AT PERFORATION

**PERS**  
SUPPLEMENTAL

**Anthem**  
Blue Cross  
P.O. Box 60007 Los Angeles, CA 90060-0007

PHYSICIAN MEMBER: Yes  
Provider Number:  
Sequence Number:

PATIENT NAME PROCEDURE NUMBER	ID NUMBER UNITS OF SERVICE	PATIENT ACCT. DATE OF SERVICE FROM	CLAIM NUMBER DATE OF SERVICE TO	BILLED AMOUNT	AMOUNT ALLOWED	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COPAYMENT AMOUNT	AMOUNT PAID
Receipt Date: 05/22/2012 Group Number:				PARTICIPATING PROVIDER					
77140	04	05/03/2012	05/03/2012	180.00	116.52	63.48/01	0.00	0.00	23.30
						93.22/02			
90283	01	05/03/2012	05/03/2012	35.00	13.39	21.61/01	0.00	0.00	2.68
						10.71/02			
97004	01	05/03/2012	05/03/2012	65.00	58.46	6.54/01	0.00	0.00	11.69
						46.77/02			
Totals:				280.00	188.37	242.33	0.00	0.00	37.67

Messages:

- 01 This provider has accepted Medicare's allowed amount as the total amount due. The member, therefore, is not responsible for the balance.
- 02 This is the amount paid by Medicare.

For Information Call: Customer Service Department at: 1-877-737-7776



# STATE OF CALIFORNIA

WARRANT NUMBER

THE TREASURER OF THE STATE WILL PAY OUT OF THE  
FUND NO. FUND NAME

822 PERSCARE SUPPLEMENTAL 20121446D3989999701A5827940

PAYEE I.D. NO.

90-1342

1211

Cross

TO 925036

CALIFORNIA LAND REBELLION

2012 CLARENCE JAMES

2012 CLARENCE JAMES

05/31/2012

DOLLARS	CENTS
\$*****23	98

JOHN CHIANG

CALIFORNIA STATE CONTROLLER

DETACH AT PERFORATION

**PERS**  
SUPPLEMENTAL

**Anthem**  
Blue Cross  
P.O. Box 60007 Los Angeles, CA 90060-0007

PHYSICIAN MEMBER: Yes  
Provider Number:  
Sequence Number:

PATIENT NAME PROCEDURE NUMBER	ID NUMBER UNITS OF SERVICE	PATIENT ACCT. DATE OF SERVICE FROM	CLAIM NUMBER DATE OF SERVICE TO	BILLED AMOUNT	AMOUNT ALLOWED	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COPAYMENT AMOUNT	AMOUNT PAID
Receipt Date: 05/23/2012 97140	04	05/07/2012	05/07/2012	180.00	119.92	60.08/01 95.94/02	0.00	0.00	23.98
Totals:				180.00	119.92	156.02	0.00	0.00	23.98

Messages:

- 01 This provider has accepted Medicare's allowed amount as the total amount due. The member, therefore, is not responsible for the balance.
- 02 This is the amount paid by Medicare.

For Information Call: Customer Service Department at: 1-877-737-7776

JUN 04 2012

# Explanation of Payment Report

## United World Life Insurance

REPORT GW2232 PAGE 1  
PERIOD ENDING DATE 05/25/12  
DRAFT/CHECK NUMBER: [REDACTED]

DIRECT INQUIRIES TO:  
UNITED WORLD LIFE  
INSURANCE COMPANY  
3316 FARNAM ST  
OMAHA, NE 68175-0001

IF YOU HAVE ANY QUESTIONS, CALL:  
(877) 617-5587

CLAIMS PROCESSED UNDER TIN/EIN: [REDACTED]

Insured's Name Patient Policy/Plan Number Cert Number Claim Number Account Number	Date of Service		Procedure	Submitted Charges	Less Charges Not Covered		Balance	Less Deductible	Considered Charges	Benefit		Remaining Balance Due
	From	To			Amount	Note				%	Amount	

[REDACTED] /S  
[REDACTED] LF

031011 031011 97140 180.00  
031011 031011 G0283 30.00

104.06 1  
79.92 2

26.02 100 26.02

TOTAL 210.00

PAYMENT HAS BEEN ADJUSTED DUE TO PRIOR PAYMENT

26.02

- 14.73

TOTAL PAID: 11.29

### NOTES:

YOU MAY APPEAL OUR DECISION TO THE CALIFORNIA DEPARTMENT OF INSURANCE, 300 SO SPRING ST - SOUTH TOWER, LOS ANGELES 90013; PHONE (213) 897-8921, (800) 927-4357 OR TDD (800) 482-4833, HOTLINE HOURS 8:00 AM - 6:00 PM MON - FRI; WEBSITE [HTTP://WWW.INSURANCE.CA.GOV/0100-CONSUMERS](http://www.insurance.ca.gov/0100-consumers)

THIS IS THE AMOUNT PAID BY MEDICARE.

AMOUNTS IN EXCESS OF THE MEDICARE APPROVED CHARGE ARE NOT COVERED.

JUN 01 2012

# Explanation of Payment Report United World Life Insurance

REPORT GW2232 PAGE 1  
PERIOD ENDING DATE 05/25/12  
DRAFT/CHECK NUMBER: [REDACTED]

DIRECT INQUIRIES TO:  
UNITED WORLD LIFE  
INSURANCE COMPANY  
3316 FARNAM ST  
OMAHA, NE 68175-0001

IF YOU HAVE ANY QUESTIONS, CALL:  
(877) 617-5587

CLAIMS PROCESSED UNDER TIN/EIN: [REDACTED]

Insured's Name Patient Policy/Plan Number Cert Number Claim Number Account Number	Date of Service		Procedure	Submitted Charges	Less Charges Not Covered		Balance	Less Deductible	Considered Charges	Benefit		Remainin Balance Due
	From	To			Amount	Note				%	Amount	

031011 031011 97140 180.00  
031011 031011 G0283 30.00

104.06 1  
79.92 2

26.02 100 26.02

TOTAL 210.00

PAYMENT HAS BEEN ADJUSTED DUE TO PRIOR PAYMENT

26.02

14.73

ITAL PAID: 11.29

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WEBSITE HTTP://WWW.INSURANCE.CA.GOV/O100-CONSUMERS  
THIS IS THE AMOUNT PAID BY MEDICARE.  
AMOUNTS IN EXCESS OF THE MEDICARE APPROVED CHARGE ARE NOT COVERED.

JUN 01 2012

THE FACE OF THIS DOCUMENT HAS A COLORED BACKGROUND ON WHITE PAPER. THE BACK OF THIS DOCUMENT CONTAINS AN ARTIFICIAL WATERMARK. HOLD AT AN ANGLE TO VIEW.



**UNITED WORLD LIFE INSURANCE COMPANY**  
A MUTUAL of OMAHA COMPANY  
3316 Farnam St., Omaha, NE 68175

PAYABLE THRU FIRST NATIONAL BANK OF OMAHA  
OMAHA, NE 68102  
FREMONT NATIONAL BANK & TRUST CO.

00136753 1129 60663 031011

DATE  
MAY 25 2012  
CLAIM NO.

DRAFT NO.  
AMOUNT  
\*\*\*\*\*11.29

PAY TO THE ORDER OF PLEASE CASH IMMEDIATELY  
GYBS-P120526012007000191

58

POLICY/PLAN NUMBER [REDACTED]

AUTHORIZED SIGNATURE

*Stephen A. Amdor*

JUN 01 2012

c/o York Risk Services Group, Inc.  
313 E. Foothill Blvd.  
Upland, CA 91786

Reviewed Date: 05/22/2012  
Claim#: [REDACTED]  
Date of Injury/Loss: 04/12/2011  
Claimant: [REDACTED]

Check#: [REDACTED]  
Check Date: 05/30/2012  
Check Total: \$74.50

Payee: [REDACTED] NC.

IRS/SSN#: [REDACTED]  
Invoice#: [REDACTED]

Diagnosis Codes:  
72705 TENOSYNOV HAND/WRIST NEC

DOS From: 05/03/2012  
DOS Thru: 05/03/2012  
Description: PHYSICAL THERAPY

PPO Name: Rockport/IHP

Page 1 of 1

Document#: [REDACTED]  
Batch#: [REDACTED]

#	Billed Code	Reviewed Code	Units	Begin DOS	End DOS	Service Description	Amount Billed	BR Reduction	PPO Reduction	Other Reductions	Net Allowed	Reason Code
1	97014	97014	1	05/03/12	05/03/12	ELECTRIC STIMULATION	\$35.00	\$25.77	\$0.46	\$0.00	\$8.77	G1
2	97250	97250	1	05/03/12	05/03/12	MYOFASCIAL RELEASE	\$60.00	\$15.72	\$2.21	\$0.00	\$42.07	
3	97620	97110	1	05/03/12	05/03/12	THERAPEUTIC EXERCISE	\$63.96	\$39.05	\$1.25	\$0.00	\$23.66	G1, G2
TOTAL:							\$158.96	\$80.54	\$3.92	\$0.00	\$74.50	

Reason Codes:

- G1 The charge exceeds the Official Medical Fee Schedule allowance and has been adjusted to the schedule  
G2 The Official Medical Fee Schedule does not list this code. An allowance has been made for a comparable service.

Charges in excess of the allowance are objected to in accordance with applicable Workers' Compensation fee schedules, California Labor Code and associated regulations. Reasons for each reduction are stated above. If you disagree with any reduction you may contact us at the address and phone number listed, or you may file an appeal or lien with Workers' Compensation Appeals Board. California Labor Code Sections 3751(b) and 4600 prohibit attempts to collect any funds from the ill/injured worker.

JUN 01 2012

c/o York Risk Services Group, Inc.  
313 E. Foothill Blvd.  
Upland, CA 91786

Reviewed Date: 05/22/2012 Check#: [REDACTED]  
Claim#: [REDACTED] Check Date: 05/30/2012  
Date of Injury/Loss: 04/12/2011 Check Total: \$74.50  
Claimant: [REDACTED]

Payee: [REDACTED]

IRS/SSN#: [REDACTED]  
Invoice#: [REDACTED]

Diagnosis Codes:  
72705 TENOSYNOV HAND/WRIST NEC

DOS From: 05/03/2012  
DOS Thru: 05/03/2012  
Description: PHYSICAL THERAPY

PPO Name: Rockport/IHP

Page 1 of 1

Document#: [REDACTED]  
Batch#: [REDACTED]

#	Billed Code	Reviewed Code	Units	Begin DOS	End DOS	Service Description	Amount Billed	BR Reduction	PPO Reduction	Other Reductions	Net Allowed	Reason Code
1	97014	97014	1	05/03/12	05/03/12	ELECTRIC STIMULATION	\$35.00	\$25.77	\$0.46	\$0.00	\$8.77	G1
2	97250	97250	1	05/03/12	05/03/12	MYOPASCIAL RELEASE	\$60.00	\$15.72	\$2.21	\$0.00	\$42.07	
3	97620	97110	1	05/03/12	05/03/12	THERAPEUTIC EXERCISE	\$63.96	\$39.05	\$1.25	\$0.00	\$23.66	G1, G2
TOTAL:							\$158.96	\$80.54	\$3.92	\$0.00	\$74.50	

**Reason Codes:**

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WellComp Managed Care Services \* 800/932-5535 \* PO Box 619079, Roseville, CA \* 95661

Napa Valley Unified School District  
c/o York Risk Services Group, Inc.  
313 E. Foothill Blvd.  
Upland, CA 91786

Umpqua Bank  
1801 Douglas Blvd.  
Roseville, CA 95661

PAY SEVENTY-FOUR AND 50/100

TO THE ORDER OF [REDACTED]

REF. NUMBER	
[REDACTED]	
DATE	CHECK NO
5/30/2012	[REDACTED]
AMOUNT	
***\$74.50	

*David Pantoja*

Not negotiable after 90 days

10125127 112111817 772248721