CITY OF SOMERVILLE, MASSACHUSETTS
LAW DEPARTMENT

June 12, 2024

Charles Femino
Chief of Police
Somerville, MA

Re: Indemnity Medical Panel Review Board Held on 6/7/2024

Dear Chief Femino:

Pursuant to the provisions of Massachusetts General Laws, Chapter, 41, § 100, the medical panel constituted thereunder on behalf of the City of Somerville hereby certifies that the following applicants have incurred indemnifiable expenses and that all findings required by M.G.L. c. 41, § 100 have been met. The panel authorizes payment from available funds in the current appropriation of the Police Department for the following active police officers:

*The invoice submitted on behalf of in the amount of $65.91 is not approved because it appears to be a duplicate invoice. The remaining invoice submitted on behalf of is approved for payment.

**The invoices submitted on behalf of are on hold pending submission of documentation from the Cambridge Public Health Commission demonstrating that the expenses incurred were reasonable and a natural and proximate result of an injury incurred in the line of duty.

Please do not hesitate to contact me if you have any questions.

Sincerely,

/s/ *Matt Sirigu*

Matt Sirigu
Assistant City Solicitor/Labor Counsel

cc: Jay M. Burstein, M.D.
Paul Anderson, SPD
James Stanford, SPD
Betsy Mercado, SPD

CITY HALL • 93 HIGHLAND AVENUE • SOMERVILLE, MASSACHUSETTS 02143
(617) 625-6600 EXT. 4400 • TTY: (617) 666-0001 • FAX: (617) 776-8847
EMAIL: law@somervillema.gov • **www.somervillema.gov**

City of Somerville - Police

Check Number
1195
Issue Date: **04/17/2024**
VOID After 180 Days

93 Highland Avenue
Somerville, MA 02143

For 2023/11/29 - 2023/11/29

Pay *Two Hundred Thirty Nine and 50/100 Dollars* $ *******239.50

To The Order Of MASS GENERAL PHYSICIANS ORG
PO BOX 419095
BOSTON, MA 02241

NON-NEGOTIABLE
Authorized Signature

⑈0000001195⑈ ⑆00000⑆ ⑈

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Claim: 7250922 / [redacted] , [redacted] Jurisdiction State: Massachusetts.

The payment is for Physician - Treating from 11/29/2023 to 11/29/2023.
Check: 1195, issued: 04/17/2024, for: $239.50, for:  2023/11/29 - 2023/11/29, Invoice:

To the Order of: MASS GENERAL PHYSICIANS ORG
               : PO BOX 419095
               : BOSTON, MA 02241

Please refer to the attached explanation of review number:
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Special Handling
 2023/11/29 - 2023/11/29
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USICUSTCK 6

careworks

MASSACHUSETTS WORKERS' COMPENSATION
**** EXPLANATION OF REVIEW ****

Provider : 042807148-00NX
EVAN ODONNELL
275 CAMBRIDGE ST
BOSTON, MA 021384308

Bill ID : 20240328083310720WOCP08
Claim : 7250922
SSN : 002546972
Audit St/Cov : MAWC
Claimant : [redacted]
Injured :
Insured : CITY OF SOMERVILLE
93 HIGHLAND AVENUE
SOMERVILLE, MA 02143

Payee : 042807148-0002
MASS GENERAL PHYSICIANS ORG
PO BOX 419095
BOSTON, MA 02241

Ref. Bill ID : FCP100000124087467-048
Recon ID : N/A
Account : P1967638521
Adjustor ID : 0000307916
Adjustor : CHERYL MCCARTHY
Adj. Phone : 7819392026
Pay Kind Code : BR

Svc Dates : 11-29-2023 to 11-29-2023
Received : 03-27-2024
Reviewed : 04-09-2024

DX:M25.512 PAIN IN LEFT SHOULDER

Date	Service & Description	Mods	Qty	Charge	Reduction	Allowance	Reasons
11-29-2023	99245 CONSULTATION		1	500.00	260.50	239.50	01
			Totals:	**500.00**	**260.50**	**239.50**	

Reduction Explanations:

RC 01 The charge for the procedure exceeds the amount indicated in the fee schedule.

COMMENTS

WCED WorkCompEDI Clearinghouse E-Bill
WOCR WorkCompEDI OCR/Data Capture of bill

Check # / EFT # :
Check Date / EFT Date :
Payer Name : CITY OF SOMERVILLE
Payer Address : 93 HIGHLAND AVENUE
SOMERVILLE,MA 02143
Payer ID : 046001414
Payment ID :

Direct inquiries regarding this review to:

FUTURECOMP (ELECTRONIC PAYOR ID: LT795)
PO BOX 63929
IRVINE, CA 92602
CONTACT CAREWORKS AT:
(888) 350-1150

99999

CITY OF SOMERVILLE POLICE DEPA
220 WASHINGTON ST
SOMERVILLE, MA 021433117

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA — PICA

1. MEDICARE (Medicare#) ☐ MEDICAID (Medicaid#) ☐ TRICARE (ID#/DoD#) ☐ CHAMPVA (Member ID#) ☐ GROUP HEALTH PLAN (ID#) ☒ FECA BLK LUNG (ID#) ☐ OTHER (ID#) ☐

1a. INSURED'S I.D. NUMBER (For Program in Item 1): [redacted]

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted]

3. PATIENT'S BIRTH DATE: [redacted] SEX: M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted]

5. PATIENT'S ADDRESS (No., Street): [redacted]

CITY: SOMERVILLE STATE: MA

ZIP CODE: 021431602 TELEPHONE (Include Area Code): ( )

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☒

7. INSURED'S ADDRESS (No., Street)

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

8. RESERVED FOR NUCC USE

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): CITY OF SOMERVILLE,

a. OTHER INSURED'S POLICY OR GROUP NUMBER: 7250922 617-625-7206 X7206

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME: FUTURE COMP

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous) ☒ YES ☐ NO

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

c. OTHER ACCIDENT? ☐ YES ☐ NO

10d. CLAIM CODES (Designated by NUCC)

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME: CHRISTINE MASIELLO

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☒ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 20231129

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. 439 MM 02 DD 12 YY 2020

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. M25512 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	11 29 23	11 29 23	11		99245		A	50000	1		ZZ / NPI	208D00000X / 1851710487
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	

MEDATA
MAR 27 2024
BILL REVIEW

25. FEDERAL TAX I.D. NUMBER: 042807148 SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: P1967638521

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE: $ 500 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

EVAN ODONNELL

SIGNED 01/06/2024 DATE

32. SERVICE FACILITY LOCATION INFORMATION

MGH PROF OFFICE BLDG OFFICE
275 CAMBRIDGE ST
BOSTON, MA 021384308

a. 1801874573 b.

33. BILLING PROVIDER INFO & PH # (857) 2820421

MASS GENERAL PHYSICIANS ORG
PO BOX 419095
BOSTON, MA 022419095

a. 1801874573 b. 207X00000X

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION