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Attorney at Law
 Dallas, Texas

Re: Cause No.
vs.

Dear Mr.:

I am in receipt of your request for file review on the above-named case and cause number. Please be advised that the following records have been provided and reviewed:

Two-page medical record affidavit Dr . with eight pages of medical record attachments.

Two-page affidavit of cost of services by custodian Dr . with two-page attachment.

Two-page affidavit of cost of services by custodian M.D. with a one-page attachment.

Two-page medical record affidavit Dr. with two-page medical record Attachment.

Two-page medical record affidavit from with 122 pages of records consisting of the following:

Five-page initial narrative report dated

Eight-page final narrative report dated

One-page questionnaire, past medical history.

Three-page PI personal history form.

Two-page consultation form.

Four one-page musculoskeletal examination forms dated

and

Four one-page extremity examination forms dated , and

Four one-page common ICD-9 codes.

Two-page diagnosis and treatment sheets.

One-page treatment plan.

Three-page report of medical consultation from M.D. dated

with a three-page worksheet attachment.

One-page informed consent.

One-page release of records request.

One-page fee schedule.

One-page certification of treatment and fees.

Two one-page verifications of non-pregnancy forms.

One-page legend of service codes.

Two one-page patient satisfaction survey.

One-page physical activity readiness questionnaire.

Three one-page attending doctor's recommendation forms.

Two one-page patient compliance worksheets.

Two one-page referral forms.

Twenty nine pages of daily treatment records for dates of service through

Four pages exercises with dates.

Two copies of a two-page statement form.

Thirty five pages of health insurance claim forms for dates of services through

Two-page affidavit of cost of services by custodian with a one-page attachment.

Two-page affidavit of cost of services by custodian Pharmacy with a one-page attachment.

Two-page medical record affidavit MRI with three pages of medical records attachment.

Affidavit of cost of services by custodian with a one-page statement dated

Two-page medical record affidavit from with a five-page medical record attachment.

Two-page affidavit of cost of services by custodian with a one-page attachment.

Two-page medical record affidavit with a two-page attachment.

Two-page affidavit of cost of services by custodian with a three-page itemized statement attached dated

Two-page police accident report, City of Dallas, dated

Twelve-page transcription of a recorded statement of dated

Five-page repair estimate on plaintiff's vehicle prepared by dated with four pages of copies of black and white photographs.

One-page health insurance claim form from regarding date of service

BRIEF OVERVIEW

This claimant is a 28-year-old female who was allegedly injured in a motor vehicle accident on or about . She began treatment with the attending chiropractor on and was treated over a period of 13 weeks for a total of approximately 33 visits, with the last visit occurring on or about . The claimant's complaints, according to the recorded statement taken on included whiplash, back injury, right wrist, and right ankle. According to the consultation record of the attending chiropractor, the claimant's complaints listed in the order of priority included headache, neck pain, mid back pain, low back pain, right wrist, and right ankle. It is noted that the attending chiropractor has set forth the treating diagnoses in both the initial narrative report dated and the final narrative report dated

OBSERVATIONS

Based upon the medical records provided at this time, the following observations are noted:

1. This claimant is a 28-year-old female who was allegedly injured in motor vehicle accident on or about . According to the police department, City of Dallas, accident

report dated _____, the claimant was the restrained driver, wearing a seat belt and shoulder strap, of a _____ that was involved in a collision with another vehicle that left the scene. It is noted that she was assessed an injury code of N, which means not injured. She was apparently evaluated by paramedics at the scene of the incident but was not transported to an emergency room. The claimant's vehicle was towed from the scene to

2. Repair estimate, which is dated _____ indicates damage to the windshield, left door, left fender, front lamp, and quarter panel for a total cost of repairs at \$3,216.49.
3. On _____, the claimant was seen at the _____ Center located at _____ Texas, by D.C. The records provided do not indicate how the claimant was referred to this facility or physician. The records are also missing all forms completed by the claimant on the initial visit to this office. It is noted that the initial visit occurred on Saturday, the day following the incident. Records indicate that the service performed that day was code 99203, an evaluation and management service code on a new patient, and she was provided with an ice pack. Examination findings as noted on the musculoskeletal examination form dated _____ indicate a normal neurological examination, normal reflexes, and normal motor exam. Cervical and thoracic lumbar range of motion was entirely normal except for a minimal decrease of motion (5°) of right and left lateral flexion and lumbar extension. Examination of the shoulder and elbow were entirely normal, and examination of the ankle and foot had no significant findings other than the subjective complaint of pain. It is noted that the next visit occurred three days later on _____ consisting of an established office visit, code 99212, and x-rays of cervical, thoracic, and lumbar spine. It is noted that no x-rays were performed of the right wrist or right ankle.
4. It is noted that the treating chiropractor has set forth multiple diagnoses in his initial narrative report dated _____ which for the most part are repeated in the final report dated _____. The diagnosis of traumatic injury of the cervical spine, lumbar spine, and thoracic spine with tearing of the regional supportive tissues, including muscles, tendons, ligaments, cartilage, nerves, joint capsules, and blood vessels, with subsequent hemorrhaging is not supported by objective clinical findings. These diagnoses appear to be a gross exaggeration of the extent of injury that may have been incurred by the claimant. In addition, the following diagnoses do not appear to be supported by clinical findings: cervical disc displacement, discitis, facet capsulitis, and nerve root irritation; lumbar disc displacement, discitis, facet capsulitis, facet syndrome; thoracic discitis, facet capsulitis, and nerve root irritation; right ankle sprain/strain; and right wrist sprain/strain.
5. It is noted that the daily treatment notes are not maintained in a commonly accepted medical/chiropractic format. Although the daily forms have sections pertaining to subjective complaints, objective findings, assessment, and plan, the notations are not made in a descriptive and narrative format. In comparing these daily chart notes to the itemized bills for services, this documentation does little to support the medical necessity of the services provided, the frequency of care, or the length of care.
6. On _____, the claimant was evaluated by _____ M.D. on referral by the attending chiropractor on _____. Based upon this evaluator's experience, this procedure appears to be standard operating procedure for the _____. As is typically the case, this doctor's report is merely a typed-out version of his worksheet. Furthermore, the testing procedures are very general with no specificity, particularly as it relates to range of motion assessment. This

physician's diagnostic impression of cervical, thoracic, lumbar strain/sprain is not supported by clinical findings. The impression to rule out cervical herniated disc and lumbar herniated disc and the recommendations for MRI scanning of the lumbar and cervical spine are not medically necessary, nor are they supported by clinical documentation. This recommendation serves no purpose other than to add unnecessary charges for services that are not medically necessary and subjects the claimant to unneeded diagnostic procedures. It is noted that in his doctor's report, he stated that x-rays were not available, but studies were actually taken two days prior to his evaluation. In addition, this physician also recommends MRI studies, even though the studies had actually been performed on [redacted], which was the day prior to his evaluation. Finally, it is noted that this physician billed code 99243, but the records do not support that a detailed history or a detailed examination was performed on this claimant.

7. On [redacted], D.C., a board certified chiropractic radiologist associated with [redacted], submitted a radiology report on the x-rays which were performed on [redacted] at the [redacted]. This procedure also appears to be a standard operating procedure for the [redacted]. Although having the films read by a board certified radiologist is an acceptable procedure, it is noted that [redacted] had already included the charge for both the technical and professional component in its billing for services on [redacted]. Consequently, this service would constitute a duplication of charges.
8. On [redacted], the claimant underwent an MRI study of the cervical and lumbar spine at the MRI Center. These studies were interpreted by [redacted], and are reported to be essentially negative. He notes that the cervical spine MRI was compromised due to metallic artifacts from dental braces. According to the final billing statement dated [redacted], it is noted that there was no charge for these studies. However, a medical record affidavit from M.D., which consists of the same reports signed by the [redacted], also contains an itemized bill for the professional reading component of these MRI studies.
9. On [redacted], the claimant underwent a CT scan of the cervical spine at the [redacted] Center. It is noted that the custodian of records for this facility is also the custodian of the records for the [redacted] Center as well. This study is also interpreted by the [redacted] physician and is also read as being normal. It is noted that the referral form from the attending chiropractor is dated for this procedure, but there are no notations made in the daily treatment records of regarding the medical necessity for this procedure. In fact, the notation is made that the subjective complaints were decreasing, and the overall assessment was that of progressing. The documentation provided does not substantiate the medical necessity of this CAT scan procedure.
10. Records include an affidavit of cost of services from the [redacted] Pharmacy. It appears that the claimant was prescribed medication by Dr. [redacted] on [redacted] and it was filled at this pharmacy. It is noted that the statement gives a post office box address in [redacted] Texas, and the actual physical address of this facility is unknown. It appears that the fees for these medications are not usual or reasonable and would be considered excessively high.

RECOMMENDATIONS

Based upon reasonable medical probability, my education, training, and experience, as well as my review of the available medical records, it is my opinion that it would not be unreasonable to

