DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Bowling	7-17-06

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 060097	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR Cleared 7/24/06, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 7-26-06 [ ] FOIA 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.			

South Carolina Sports Medicine & Orthopaedic Center

Seth P. Kupferman, MD — Orthopaedic Surgery, Sports Medicine
William E. Wilson, MD — Orthopaedic Surgery, Spine Surgery
James D. Dalton, Jr., MD — Orthopaedic Surgery, Sports Medicine
Jon P. DeVries, MD — Orthopaedic Surgery, Hand Surgery
Matthew T. Kneidel, MD — Orthopaedic Surgery, Foot and Ankle Surgery
Eric S. Stem, MD — Orthopaedic Surgery, Joint Replacement & Reconstruction
Christopher S. Schafer, PA-C — Licensed Physician Assistant, Certifed Athletic Trainer
Michael R. Byers, PA-C — Licensed Physician Assistant, Certified Athletic Trainer

July 11, 2006

SCDHHS
ATTN: MEDICAL DIRECTOR
PO BOX 8206
COLUMBIA, SC 29202

RE: JOYCE MITCHELL
ID#: 2323653001

OUR TAX ID#: 570886946
GRP MCAID #: GP0078

LETTER OF MEDICAL NECESSITY ATTACHED

To Whom It May Concern:

Please review the attached documentation. We are requesting 3 additional visits to cover Ms. Mitchell's care.

Thank you,

Maggie Rowe
Financial Counselor
(843) 569-3367 x1271

Attachments

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June 30, 2006

RE: Joyce Mitchell

To Whom It May Concern:

Ms. Joyce Mitchell underwent anterior cervical discectomy and fusion which requires additional follow-up visits in our office. She has significant osteoporosis and therefore we have had to follow her for quite some time for evaluation of her neck fusion. She has also been followed by one of my partners, Dr. Seth Kupferman, for delayed union of a pelvic fracture.

Please assist Ms. Mitchell by authorizing additional visits in our office as they are necessary to her care.

If you require additional information, please do not hesitate to contact my office.

Sincerely,

William E. Wilson, MD

WEW:mjs

9100 Medcom Street, N. Charleston, South Carolina 29406-9167 • Website: www.scsportsmedicine.com
Phone: Patient (843) 572-BONE (2663) Bus. 569-3367 • Fax: Clinical (843) 572-3662 Bus. 764-3577

PATIENT NAME:	MITCHELL, JOYCE M
DATE OF SURGERY:	04/27/2006
SURGEON:	WILLIAM E. WILSON, M.D.
ASSISTANT:	NONE.
ANESTHESIA:	GENERAL ENDOTRACHEAL.
PREOPERATIVE DIAGNOSIS:	C3-4 AND C4-5 FUSION WITH LOSS OF FIXATION AT C3 AND C4.
POSTOPERATIVE DIAGNOSIS:	C3-4 AND C4-5 FUSION WITH LOSS OF FIXATION AT C3 AND C4.
OPERATION:	1. EXPLORATION OF ANTERIOR CERVICAL FUSION. 2. REMOVAL OF ANTERIOR CERVICAL PLATE. 3. BONE GRAFTING WITH DBX PUTTY.
ESTIMATED BLOOD LOSS:	100 CC.
COMPLICATIONS:	NONE.
DRAINS:	HEMOVAC X1.

INDICATIONS:
Ms. Mitchell is a 57-year-old lady who underwent a C3-4 and C4-5 anterior cervical discectomy and fusion. She was noted to have osteoporotic bone. Postoperatively she has done well although her most recent postoperative x-rays have revealed loss of fixation of the plate at the C3 and C4 levels. She had some collapse of the C3 vertebral body. She is now scheduled for exploration of her fusion and removal of her plate. The risks, benefits, and options were all explained to the patient preoperatively.

OPERATIVE PROCEDURE IN DETAIL:
The patient was taken to the operating room at Trident Medical Center. She received preoperative IV antibiotics. She was carefully placed supine on the operating room table. After an adequate general endotracheal anesthetic was obtained, a Foley catheter was placed and she was carefully positioned. Care was taken in positioning of all of her extremities. An interscapular roll was placed. Preoperative x-ray was obtained. Appropriate positioning of her head and neck was done. The anterior aspect of her neck was then prepped and draped in a sterile manner. A left-sided approach to the upper cervical spine was performed using a transverse incision.

Dissection was carried down through the subcutaneous tissue to the platysma, which was divided transversely. Blunt dissection was carried along the medial border of the sternocleidomastoid. Neurovascular structures were identified. Blunt dissection was carried out medial to the carotid sheath. Careful blunt dissection was carried out to expose the anterior aspect of the cervical spine and the cervical plate. There was noted to be significant scarring, which was hypervascular. Careful retraction of the trachea and esophagus to the right was performed with blunt hand-held retractors. The plate was identified. Soft tissues were carefully stripped back to expose the plate. The plate was noted to be loose at the C3 and C4 levels and extending anteriorly. The screws were all removed and the plate was then removed. This area was then débrided. The patient was noted to have degeneration or collapse of the C3 vertebral body. Some of this material was sent for culture, aerobic and anaerobic as well as to pathology. The graft at the C4-5 level appeared to be fusing well. The graft at the C3-4 level was identified. There appeared to be some motion of the graft of the C4 interface although the graft itself was fairly immobile and I was not able to move the graft around. The wound was thoroughly irrigated out with bacitracin solution on multiple occasions. Hemostasis was maintained. At this point DBX putty was placed over the graft at the C3-4 interface. A deep Hemovac drain was placed. The trachea, esophagus, and carotid sheath were all visually inspected without any evidence of injury. The wound was then closed with interrupted 2-0 Vicryl suture for platysma closure, interrupted 3-0 Vicryl subcutaneous closure, and a running subcuticular 4-0 stitch. Steri-Strips, Xeroform, and 4x4s with tape completed the dressing. She was placed in a Miami J collar. Intraoperative x-ray was obtained after removing the plate. No complications were noted. At the end of the case the patient was sent back to the recovery room in stable condition after reversal of her anesthetic.

Job#: 360492
Dictated: 04/27/2006 1:22 PM
Transcribed: 05/02/2006 10:49 AM
WEW:lan

WILLIAM E. WILSON, M.D.

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May 10, 2006

Ms. Mitchell returns for f/u regarding pelvic fractures, l/superior and inferior rami fractures, also sacral insufficiency fractures. She reports she still has inguinal pain. Pain with motion and activity. I made recommendations for her to use an assistant device, but she has been off the use of the cane. Recent neck surgery with Dr. Wilson.

PHYSICAL EXAMINATION: Reveals tenderness about the l/groin. Pain referred to the inguinal area and ischial area with ROM of l/hip. Recent CT scan reviewed reveals evidence of healing callus at the superior and inferior ramus fractures, but no evidence of complete union. Evidence also for sacral insufficiency fractures.

ASSESSMENT AND PLAN: Lengthy discussion with Ms. Mitchell. She remains symptomatic and it has been 8-9 months post-development of these fractures, with slowed and delayed or possible non union. It is certainly an unusual situation, and I would like an opinion with Dr. Langdon Hartsock at MUSC to see if he feels any other treatment alternatives, whether surgical intervention would be a consideration. We will provide him with CT and copies of recent films for his opinion.

Seth P. Kupferman, MD/mjs
CC: Dr. Langdon Hartsock
DD: 5/10/06; DT: 5/11/06; DICTATED BUT NOT READ: 30221

May 16, 2006 – Patient called stating the Lortab was making her sick. Per Dr. Kupferman Darvocet N 100 #30 no refills 1-2 po q4-6h prn called to 572-3237. NW/mah

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May 23, 2006

Ms. Mitchell returns for f/u. She has osteoporosis and loss of fixation in the cervical spine. We removed her cervical plate and have had her in a hard collar for the past month. She is three months out from her initial surgery which was C3-4 and C4-5 ACDF. She says she is having mild recurrent symptoms of pain in the l/trapezius. Otherwise, she has had very little pain at all.

PHYSICAL EXAMINATION: Her incisions are well healed. She actually has only mild limitations with ROM. We did not put her through a full ROM today. Motor strength is intact in the upper extremities.

X-RAYS: AP & lateral of the cervical spine shows her grafts at C3-4 and C4-5. I do not appreciate any significant further collapse. Grafts do appear to be incorporating. She has some kyphosis at the C3-4 and 4-5 levels.

ASSESSMENT AND PLAN: S/P C3-4 and C4-5 ACDF. I am going to send her for a new soft collar and I will see her in four weeks with an x-ray of the cervical spine. I have given her a prescription at her request for Skelaxin and Darvocet N-100.

William E. Wilson, MD/mjs
DD: 5/23/06; DT: 5/24/06; DICTATED BUT NOT READ: 30221

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May 2, 2006

Ms. Mitchell came in today for a bone growth stimulator fitting. We obtained a cervical spine x-ray while she was here, AP & lateral views. Intraoperatively, Ms. Mitchell was noted to have significantly osteoporotic bone that we were unable to re-instrument. She appeared to be fused at the 4-5 level and was not completely fused at the 3-4 level, although her graft did not easily move at all. We placed DBX bone grafting putty and placed her in a Miami-J collar.

PHYSICAL EXAMINATION: Her incision looks good.

X-RAYS: AP and lateral views today show that she has mild spondylolisthesis at C3 on 4 which is similar to what she had preoperatively. Her graft is positioned anteriorly, although it has not really changed from her intraoperative pictures. She has approximately 15° of kyphosis at the 3-4 level. Her 2-3 disc space appears somewhat widened as well.

ASSESSMENT AND PLAN: S/P C3-4 and 4-5 fusion. We will continue her with a rigid collar and I will see her back as scheduled with a repeat x-ray of the cervical spine.

William E. Wilson, MD/mjs
DD: 5/2/06; DT: 5/4/06; DICTATED BUT NOT READ: 30221

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May 9, 2006

Ms. Mitchell returns for f/u. She is 2 ½ months out from ACDF at C3-4 and 4-5. She is approximately one week out from removal of her hardware; severe osteoporosis and failure of her hardware at the 3-4 level. She says she is having very little pain; no arm pain. Her neck is doing much better.

PHYSICAL EXAMINATION: Her incision is healing well. She has good strength in both upper extremities. No long track signs.

X-RAYS: AP & lateral of the cervical spine reveals mild kyphosis noted. At C3-4, she has approximately 5 mm spondylolisthesis which is similar to her preoperative findings. The graft appears to be incorporating well at 4-5 and does appear to be slowly incorporating at 3-4 as well. No significant change in overall alignment.

ASSESSMENT AND PLAN: S/P C3-4 and 4-5 ACDF, failure of hardware with subsequent removal of her instrumentation. We will keep her in a hard Miami J collar. I will see her in approximately two weeks with an x-ray of the cervical spine.

William E. Wilson, MD/mjs
DD: 5/9/06; DT: 5/11/06: DICTATED BUT NOT READ: 30221

Log #97

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

July 24, 2006

William E. Wilson, MD
SC Sports Medicine & Orthopaedic Ctr.
9100 Medcom Street
N. Charleston, South Carolina 29406-9167

Re: Joyce Mitchell

Dear Dr. Wilson:

Thank you for corresponding regarding this patient. The South Carolina Department of Health and Human Services (DHHS) can support five (5) additional physician office visits for this fiscal year ending June 30, 2006. Please attach a copy of this correspondence to any physician office visit claim you have that will exceed the twelve-visit limit. This will alert our staff to override the automatic system payment rejection edit and reimburse you for this care. Please assist the patient and the S.C. Medicaid program to make optimal use of these visits for medically necessary care. Additional visits should, in general, be physician directed as opposed to patient directed. Also, the 99211 code can accommodate brief encounters and does not count against the allotted number of office visits. Adult Medicaid beneficiaries are allowed twelve (12) physician office visits beginning July 1st of each year. Attending physicians can request additional visits only when these initial twelve (12) are exhausted for medically necessary care

If you would like to discuss this further, please call me 803-898-2500 or 803-255-3400. Thank you for your advocacy regarding this patient and for caring for South Carolina Medicaid beneficiaries.

Sincerely,

O. Marion Burton, MD
Medical Director

OMB/bk

Office of the Director
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2500 • Fax (803) 898-4515

bc: Melanie Giese
Val Williams