DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers / Burton	9-14-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000153	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR *Note: Prepare for Dr. Burton's Signature Cleared 10/22/07 ✓	[X] Prepare reply for appropriate signature DATE DUE 9-25-07 [ ] 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.			

#153

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

October 22, 2007

Thomas S. Hughes, MD
Tidewater Neurology
1300 Hospital Drive, Suite 310
Mt. Pleasant, South Carolina 29464

Dear Dr. Hughes:

Thank you for the letter regarding your patient Ms. Ethel Joy, who is receiving treatment for back and leg pain. We appreciate the opportunity to be of assistance. However, as of October 1, 2007 the recipient is no longer eligible for South Carolina Medicaid.

Again, thank you for contacting the South Carolina Department of Health and Human Services. If you have additional questions, please do not hesitate to contact Ms. Erica A. Dimes, Team Leader in Physicians Services, at (803) 898-2660.

Sincerely,

O. Marion Burton
Medical Director

OMB/bk

Office of Medical Director
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2500 • Fax (803) 255-8235

Tidewater Neurology

Thomas S. Hughes, M.D.
Brooke Monroe, PA-C

O.Marion Burton, MD
Office of the Director
P.O. Box 8206
Columbia, SC 29202-8206

Recipient: Ethel Joy
Recipient Id: 9630200745

August 9, 2007

Dear Dr. Burton:

I am writing on behalf of our patient, Ethel Joy, that is receiving treatment from our office for back pain and extreme leg pain. This patient has failed to improve with the medicinal therapy and surgical intervention that she has been through.

Mrs. Joy has been diagnosed as having Lumbar disc herniation, chronic S1 radiculopathy and moderate changed seen in L4 and L5.

She has had and MRI as well as an EMG this year. Both results are attached.

It is being recommended by our office as well as her Neurosurgeon, Dr. Khoury, that this patient starts Physical Therapy. The patient has applied for Disability but has not been approved yet.

Sincerely,

Shannon Lott
Tidewater Neurology Billing

Thomas S. Hughes, MD

Tidewater Neurology

8-9-07	Joy Ethel	Drs	

Hx

FU pt cont to have ® leg pain unchanged - taking Darvocet for pain by Dr Khoury
Medicaid won't pay for PTx & pt cannot afford
Waiting on her disability
here for review of EMG + MRI

Lab

MRI Lspine - scarring @ L5 from prior surg
EMG - chronic S1 rad.

Imp

① ® leg pain c S1 radiculopathy

Plan

① Aleve - use Darvocet sparingly
② Will try to get PTx for Pt
③ FU 2 months or sooner PRN

H Miller PA-C

*PMH, FH,SH, ALLG, MEDS, ROS,EXAM IN CHART

Thomas S. Hughes, M.D.
Holly Miller, PA-C

NAME Ivy Ethel | DATE 8-9-07

GENERAL EXAM

NECK	CARDIAC	EARS	SKIN
SPINE	CAROTIDS	EYES	LUNGS
JOINTS	PULSES	FUNDUS	ABD

MENTAL STATUS

ALERT	SPEECH
ORIENTED	LANGUAGE
ATTENTION	APPROPRIATE
INTELLECT	NEGLECT
WELL GROOMED	EXTINCTION

CRANIAL NERVES

I nl	II	III	VII	IX, XII, X
V	PERRLA	IV		
VIII	VFF	VI	X1	

POWER

AGE APPROPRIATE
DIFFUSE WEAKNESS
LOCAL WEAKNESS
ATROPHY
HYPERTROPHY

DTR

BRISK
SPASTIC
DIMINISHED
ABSENT
NORMAL

SENSORY

PP
VIB
LT
PROP
TEMP

MISC

SNOUT
GLABBELAR
PALM-MENT
TINELS
PHALENS

COORDINATION

BRADYKINESIA	COGWHEELING	RIGIDITY	DYSTONIC
RESTING TREMOR	POSTURAL TREMOR	PARAPLEGIC	QUADRAPLEGIC
DYSMETRIA	HEMIPLEGIC	POST.RFLX	RHOMBERG
SHUFFLING	ARMSWING	NARROWBASE	SPASTIC GAIT
NORMAL GAIT	TANDEM	ATAXIC	ENTALGIC

Tidewater Neurology

1300 Hospital Drive
Suite 310
Mount Pleasant SC 29464
843 856 9530

Test Date: 7/26/2007

Patient:	Ethel Joy	**DOB:**	4/12/1964	**Physician:**	Thomas S Hughes, MD
Sex:	Female	**Height:**		**Ref Phys:**	khoury
ID#:		**Weight:**		**Technician:**	T Hughes

Patient Complaints:

Patient is a 43 year-old female who presents with pain in the right hip radiating to the right leg. S/P lumbar decompression in 2006.

EMG & NCV Findings:
All nerve conduction studies (as indicated in the following tables) were within normal limits.

All F Wave latencies were within normal limits.

The muscle scoring table definition stored in the current test does not match the sentence generator setup. The sentence could not be generated.

Impression:

The above electrodiagnostic study reveals evidence of moderate chronic S1 radiculopathy on the right. Modest changes also seen in L4 and L5.

Thomas S Hughes, MD

Patient: Joy, Ethel

Test Date: 7/26/2007

Nerve Conduction Studies

Anti Sensory Summary Table

Site	NR	Peak (ms)	Norm Peak (ms)	P-T* Amp (µV)	Norm P-T Amp	Site1	Site2	Delta-P (ms)	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Right Sup Peron Anti Sensory (Ant Lat Mall)											
14 cm		4.4	<4.6	14.5	>5.0	14 cm	Ant Lat Mall	4.4	14.0	31.8	
Right Sural Anti Sensory (Med Mall)											
14 cm		3.4	<4.0	21.8	>5.0	14 cm	Med Mall	3.4	14.0	41.2	>35

Motor Summary Table

Site	NR	Onset (ms)	Norm Onset (ms)	O-P* Amp (mV)	Norm O-P Amp	Neg Dur (ms)	Amp% (Prev)	Neg Area% (1st)	Amp% (1st)	Site1	Site2	Dist (cm)	Vel (m/s)	Norm Vel (m/s)
Right Peroneal Motor (Ext Dig Brev)														
Ankle		4.4	<5.5	9.0	>2.5	5.63	100.0	100.0	100.0	B Fib	Ankle	29.0	49.2	>40
B Fib		10.3		7.7		5.94	85.6	89.4	85.6					
Right Tibial Motor (Abd Hall Brev)														
Ankle		4.8	<6.0	6.3	>3.0	3.28	100.0	100.0	100.0	Knee	Ankle	39.0	52.0	>41
Knee		12.3		6.1		4.06	96.8	113.3	96.8					

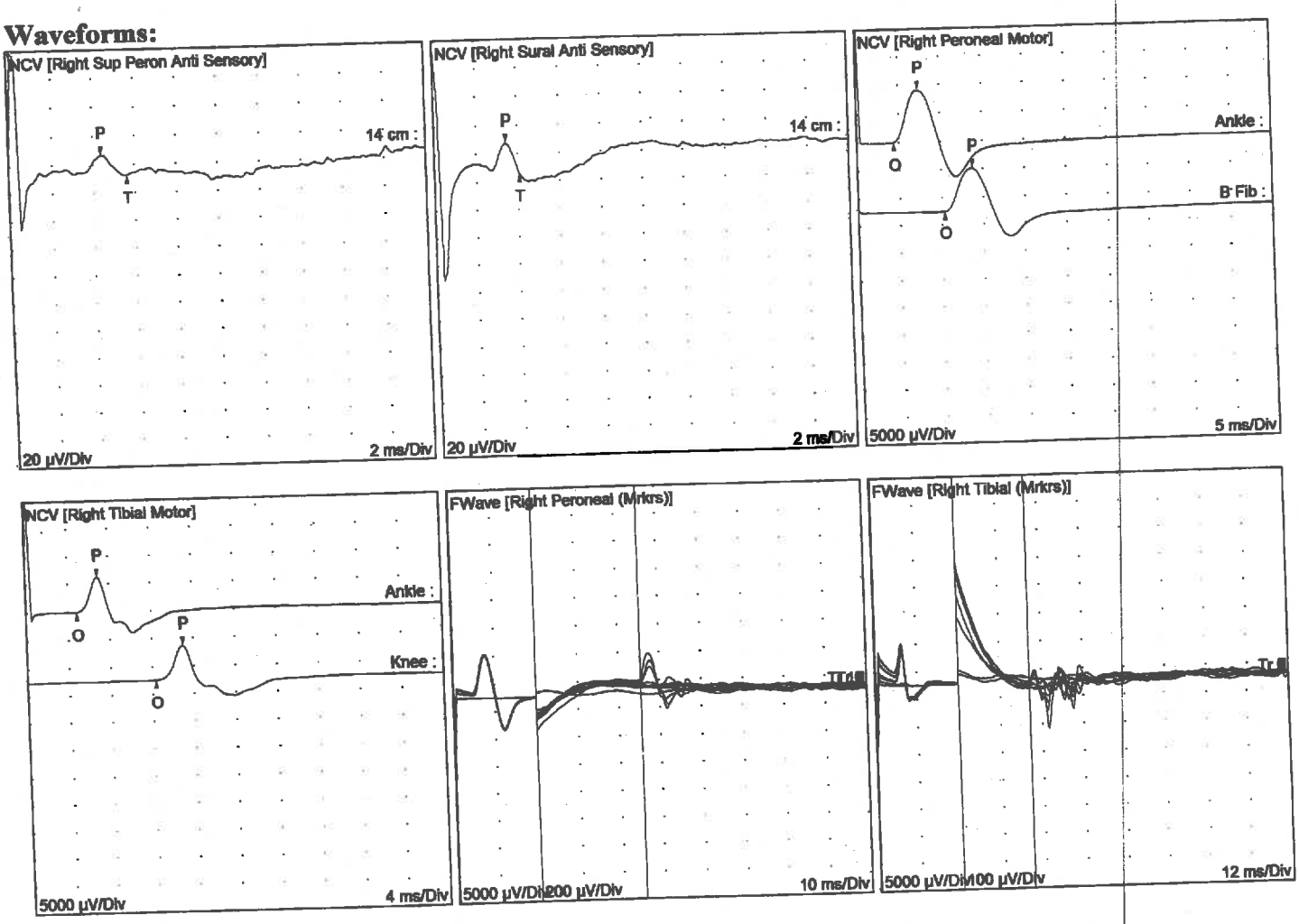
F Wave Studies

NR	F-Lat (ms)	Lat Norm (ms)	L-R F-Lat (ms)	L-R Lat Norm
Right Peroneal (Mrkrs) (EDB)				
	45.43	<60		<5.1
Right Tibial (Mrkrs) (Abd Hallucis)				
	44.43	<61		<5.7

EMG

Side	Muscle	Nerve	Root	Ins Act	Fibs	Psw	Amp	Dur	Poly	Recrt	Int Pat	Comment
Right	VastusMed	Femoral	L2-4	Nml	Nml	Nml	Nml	Nml		Nml		
Right	AntTibialis	Dp Br Peron	L4-5	Nml	Nml	Nml	Nml	Nml		Nml		
Right	Peroneus Long	Sup Br Peron	L5-S1	Nml	Nml	Nml	Nml	Nml		Nml		
Right	MedGastroc	Tibial	S1-2	Nml	Nml	Nml	Nml	Nml		Nml		
Right	BicepsFemS	Sciatic	L5-S1	Nml	Nml	Nml	Nml	Nml		Nml		

Waveforms:


NCV [Right Sup Peron Anti Sensory]
P
T
14 cm :
20 µV/Div
2 ms/Div
NCV [Right Sural Anti Sensory]
P
T
14 cm :
20 µV/Div
2 ms/Div
NCV [Right Peroneal Motor]
P
O
P
O
Ankle :
B Fib :
5000 µV/Div
5 ms/Div
NCV [Right Tibial Motor]
P
O
P
O
Ankle :
Knee :
5000 µV/Div
4 ms/Div
FWave [Right Peroneal (Mrkrs)]
5000 µV/Div
200 µV/Div
10 ms/Div
FWave [Right Tibial (Mrkrs)]
5000 µV/Div
100 µV/Div
12 ms/Div

Tidewater Neurology

7-26-07	Drs
Hx	- EMG today (see report) - MRI not back yet - reports frequent hypnagogic paralysis
Lab	
Imp	(1) Chronic Δ's ~ multiple level radiculopathy with ... which is moderate
Plan	F/u to discuss results, expect to ... + discuss hypnagogic paralysis

Thomas S. Hughes, M.D.   Holly Miller, PA-C

*PMH, FH,SH, ALLG, MEDS, ROS,EXAM IN CHART

NAME		DATE	

GENERAL EXAM

NECK	CARDIAC	EARS	SKIN
SPINE	CAROTIDS	EYES	LUNGS
JOINTS	PULSES	FUNDUS	ABD

MENTAL STATUS

ALERT	SPEECH
ORIENTED	LANGUAGE
ATTENTION	APPROPRIATE
INTELLECT	NEGLECT
WELL GROOMED	EXTINCTION

CRANIAL NERVES

I nl	II	III	VII	IX, XII, X
V	PERRLA	IV		
VIII	VFF	VI	X1	

POWER	**DTR**
AGE APPROPRIATE	BRISK
DIFFUSE WEAKNESS	SPASTIC
LOCAL WEAKNESS	DIMINISHED
ATROPHY	ABSENT
HYPERTROPHY	NORMAL

SENSORY	**MISC**
PP	SNOUT
VIB	GLABBELAR
LT	PALM-MENT
PROP	TINELS
TEMP	PHALENS

COORDINATION

BRADYKINESIA	COGWHEELING	RIGIDITY	DYSTONIC
RESTING TREMOR	POSTURAL TREMOR	PARAPLEGIC	QUADRAPLEGIC
DYSMETRIA	HEMIPLEGIC	POST.RFLX	RHOMBERG
SHUFFLING	ARMSWING	NARROWBASE	SPASTIC GAIT
NORMAL GAIT	TANDEM	ATAXIC	ENTALGIC

Tidewater Neurology

7-10-07	Ethel Jay	**Drs**	George Klarth, Fermo, [illegible]

Hx	pain - (R) leg c̄ numbness. from buttocks to back of leg + foot "goes dead", pain as well daily, constant but waxes + wanes. worse c̄ activity. spine surgery Sept 2006, after two years of symptoms. initially tx c̄ epidural, then subsequent surgery. denies any relief c̄ surgery. no physical Tx since surgery (can't afford it) medication: was on Lortab + cyclobenzaprine 30mg not sure if any power loss but when pain worse difficult to walk, pain in vagina with sexual activity.
Lab	MRI April/may @ hospital. hx of Osgood Schlatters also seen by Dr. [illegible] → Fibromyalgia.
Imp	(1) persistent (R) leg pain / sciatica x 3yrs, no improvement p̄ L/S spine surgery
Plan	(1) needs EMG/NCS (2) need Physical Therapy but can't afford it (3) cont cyclobenzaprine ↑ to 30mg [illegible] - 60mg (4) get MRI L/S spine results

Thomas S. Hughes, M.D. Holly Miller, PA-C

*PMH, FH,SH, ALLG, MEDS, ROS,EXAM IN CHART

DR.HUGHES:ST. FRANCIS RADIOLOGY - SMS:8439711345

Bon Secours St. Francis Hospital

Name: JOY,ETHEL
Exam Date: 03/27/07 1616
Ord. Phy.: KHOURY-MD,GEORGE H

MR#: C000923189
DOB: 04/12/64
Pt. Phone#: (843)330-8927
Ord. Phy.#: (843)553-9300
Phy. Fax #: (843)569-7651

KHOURY-MD,GEORGE H
2145 HENRY TECKLENBURG DR
SUITE 220
CHARLESTON SC 29414

Acct_Nbr : C0708600294
Pat_Type : OPC

Chk-in #	Order	Exam	
1699373	0001	36160	MR SPINE LUMBAR W/WO CTRST MRI

Ord Diag: LUMBAR DISC HERNIATION

MRI SCAN OF THE LUMBAR SPINE: 3/27/07

CLINICAL HISTORY: Low back pain, bilateral leg pain/numbness, weakness; history of lumbar spine surgery.

The lumbar spine was imaged utilizing the following pulse sequences: Sagittal plane-pre and postcontrast T1-weighted spin-echo and T2-weighted fast spin-echo; axial plane-pre and postcontrast T1-weighted spin-echo images, and T2-weighted fast spin-echo images, from L3 to S1. Correlation with previous MRI scan of the lumbar spine of 5/10/06, and with current plain radiographs of 3/27/07.

The lumbar vertebrae appear of normal height. There is intermediate T1 signal intensity throughout the visualized vertebrae, reflecting preponderance of red marrow elements rather than fatty elements. There was similar appearance on 5/10/06 exam. There is diminished T2 signal intensity in the L4-5 disc with mild disc space narrowing-this disc space appears slightly narrower than on 5/10/06 exam. There is also diminished T2 signal intensity in the L5-S1 disc space, less signal than was present on 5/10/06 exam. More superiorly, the lumbar disc spaces are relatively well preserved in width and signal intensity. The conus appears uncompromised. On AP plain radiograph there is noted to be mild curvature to the lumbosacral spine convex left.

2095 Henry Tecklenburg Drive, Charleston, S.C. 29414 * (843) 402-1079

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Pat_Type : OPC

Checkin-Exam Code Summary
1699373-36160

L1-2 and L2-3: There is no evidence of significant compromise of the thecal sac or nerve roots. On sagittal images there is appearance of mild disc bulging posterolaterally to the left at L2-3, with similar appearance on 5/06 exam. Posterior ligament hypertrophy and mild facet joint degenerative changes are noted at L2-3. What may be a small subcortical cyst is noted posteriorly at the left inferior facet of L2.

L3-4: There is no evidence of disc herniation or other significant compromise of the thecal sac and nerve roots. On sagittal images, there is appearance of mild disc bulging posterolaterally to the left at this level, similar to prior exam. Mild facet joint degenerative changes are noted with moderate posterior ligament hypertrophy.

L4-5: Bulging of the posterior disc contour; enhancement at the posterior aspect of the disc reflecting postsurgical changes, with adjoining enhancement within the right lateral recess and extending around the right aspect of the thecal sac into the right laminectomy defect, including along side the proximal right L5 nerve root at the lateral recess; no evidence of significant compromise of the thecal sac or extrathecal nerve roots otherwise; mild narrowing toward the inferior aspects of the L4 neural foramina, more so on the right, with asymmetrically greater right facet joint degenerative changes, which were also present on 5/06 exam; the thecal sac is of greater caliber anteroposteriorly on the current exam compared with 5/06 exam as a result of alleviation of disc impression upon the thecal sac present on the prior preoperative exam.

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DR.HUGHES:ST. FRANCIS RADIOLOGY - SMS:8439711345

Bon Secours St. Francis Hospital

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1699373-36160

At L5-S1, there is mild disc bulging. The thecal sac is tapering at this level. There is enhancement at the anterior aspect of the L5-S1 disc compatible with anterior annular tear.

On sagittal image #8 there appears to be enhancement within a nerve root at the left posterior aspect of the thecal sac in the L4-L5 region. On axial images this enhancement is at the left lateral aspect of the thecal sac, possibly within the left S1 nerve root within the thecal sac. No significant enhancement of the extrathecal component of this nerve root is seen.

On sagittal images a portion of the superior aspect of the uterus is included, with appearance of relative prominence of the uterus. What are probably small ovarian follicular cysts are noted bilaterally.

Sagittal image #5 suggests a small annular tear at the right posterior disc margin at L5-S1.

IMPRESSION:

1. Degenerative changes in the lower lumbar spine, including facet joint degenerative changes, particularly severe on the right at L4-5, and disc desiccation at L4-5, L5-S1 with disc space narrowing at L4-5 as well.

2. Postsurgical changes at L4-5, performed in the interval from 5/10/06

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exam. The L4-5 disc space appears somewhat narrower than on the prior exam. There is bulging of the posterior disc contour with enhancement centrally reflecting the site of previous surgery and removal of disc material. There is now ample space for the thecal sac, alleviating the disc impression upon the thecal sac centrally seen on prior exam. Enhancing epidural fibrosis extends in the right lateral recess along side the proximal right L5 nerve root and posteriorly into the right laminectomy defect. No other significant extrathecal nerve root compromise at this level currently.

3. There appears to be mild enhancement within a nerve root within the left aspect of the thecal sac at the L4-L5 region-left S1 nerve root such as mild radiculitis. No significant enhancement extends into the extrathecal portion of the nerve root, however.

4. No evidence of significant compromise of the thecal sac or nerve roots at the other lumbar levels. A small anterior annular tear is noted at L5-S1.

sr

FINAL DUPLICATE

2095 Henry Tecklenburg Drive, Charleston, S.C. 29414 * (843) 402-1079

August 08, 2006

NAME OF PATIENT: MS. ETHEL JOY
5430 ANN ST
N.CHARLESTON, SC 29418

D/O/B: 04/12/64
SS#: 248-25-9972
INSURANCE: MEDICAID
REFERRING PHYSICIAN: GREGORY JONES, M.D.

CONSULTATION

CHIEF COMPLAINT: Low back pain.

HISTORY: Ms. Ethel Joy was seen in consultation today at the request of Dr. Jones. She is a 42 year old female who has had a long history of low back pain dating back some time. Recently had work up by Dr. Jones and has been treated conservatively with physical therapy, epidurals, anti-inflammatories and pain medications without really much relief. She had a MRI which I have here for review and comes in for further evaluation. She describes back and right leg pain consistent with sciatica which is worse when she sits and less so when she stands. Pertinent review of systems reveals no gait disturbance or bowel or bladder incontinence.

Past medical history indicates there is no history of hypertension, diabetes, or heart disease. She has had epidural steroids in the past. There have been no major operative procedures. Review of systems indicates she is taking Lamictal, Tramadol, Lunesta, Norvan and Lortab. There are no allergies, hematological or lymphatic symptoms, weight change or fever, integumentary problems, visual complaints, sinus or nasal symptoms, cardiovascular problems, respiratory complaints, gastrointestinal symptoms, or genitourinary problems. Patient denies any endocrine or psychiatric problems. Social history shows she does not smoke or drink. Family history shows her mother has hypertension and diabetes, a sister has hypertension and heart disease. There is some history of a heart problem.

COMPREHENSIVE EXAMINATION reveals the patient appears to be alert and oriented and in no acute distress. HEENT : Shows no neck masses, thyromegaly or lymphadenopathy. PERRLA : The fundi are negative. The TM's are normal. The chest is clear, the heart shows a normal S1,S2 without gallops or murmurs. The abdomen is non-tender. NEUROLOGIC : Cranial nerves II - XII are intact. She has markedly restricted range of motion in her back. She has weakness in her extensor hallucis longus on the right which I would rate about 4/5. She has marked tenderness of her low back and sacroiliac areas and trochanteric area. Otherwise no neurologic abnormalities are seen.

RE: Ms. Ethel Joy

X-ray and Studies Review: The following studies and reports were reviewed. Her MRI was reviewed. There is a large on the right at L4-5.

MEDICAL DECISION MAKING : Moderate Complexity - The patient's history and exam along with review of their x-rays and x-ray report is most consistent with the diagnosis of lumbar disc disease. She is ready for lumbar disc surgery. We will have to check out this heart problem and see what that is all about.

Other types of injections for lumbar are trigger point injections. The indications and procedure itself were reviewed with the patient. The expected results, pattern of pain relief, and the variation of each procedure were discussed. The risks of producing increased appetite with weight gain, alteration of diabetic management, and steroid psychosis were outlined. The possibility of incurring a wet tap necessitating epidural blood patch for control of headaches, infection, and/or nerve root injuries resulting in increasing pain, numbness, and weakness of lower extremities as well as impaired bowel, bladder, and sexual function were reviewed. The remote possibility of producing arachnoiditis with replacement of steroids intradurally was discussed.

The risks of microdiskectomy were outlined in some detail. The risks of general anesthesia, bleeding, and infection were noted. The risks of nerve root injury and cauda equina injury resulting in the loss bowel, bladder and sexual activity were noted. The possibility of re-operation for recurrent disc, lumbar instability, and scar tissue was noted. The possibility of inability to return to recreational or employment activities because of chronic pain was noted. Alternative methods of treatment were gone over and the patient has elected surgery.

Thank you very much for the referral and I will keep you informed of the patient's progress.

George H. Khoury, M.D.

GHK/smt-42

JOY, ETHEL
OFFICE NOTES
PAGE ONE

SEPTEMBER 13, 2006; The patient returns to the office today. Her bladder problem is straightened out. She is still having some back and hip discomfort. She is also complaining of some spasm like symptomatology. It sounds like partial seizures. I will set her up for evaluation with Dr. Jervey. We will send her to physical therapy. We will see her back in the office for follow up.

GHK/smt-42

c: Gregory Jones, M.D.

OCTOBER 25, 2006; The patient returns to the office today. She is two months post op lumbar disc. She has had improvement of her right leg pain; however, she still complains of numbness in her right leg and pain in her hip when she rolls over. Her exam shows a well healed Metrx incision. She has no weakness of the lower extremity muscle groups. Her bladder has straightened. She has seen Dr. Jervey for possible seizures. Prescription for Darvocet was given. We will see her back in eight weeks.

CWA/smt-42

c; Gregory Jones, M.D.

ADDENDUM: She is having some back pain but it is not too bad. I will send her for physical therapy and see her back in the office for follow up.

GHK/smt-42

DECEMBER 20, 2006: The patient returns to the office today. She complains of back and right leg pain. I will set her up for physical therapy. I will ese her back in the office for follow up.

GHK/smt-42

MARCH 21, 2007: The patient returns to the office today. She is still complaining of some back pain. Now it has gone down both legs. It only went down the right before. Her wound looks good, her exam is normal. It has been a while since she has had any x-rays. I will get a MRI scan done and see her back in the office for follow up.

GHK/smt-42

c: Gregory Jones, M.D.

MARCH 28, 2007: The patient returns to the office today. MRI was reviewed. She does have some degenerative disc disease and stenosis, particularly at 4-5, I do not see anything that wound account for bilateral discomfort. I will send her for a neuropathy evaluation. I offered her an injection but she is not ready for those yet. I will see her back in the office for follow up.

GHK/smt-42

c: Gregory Jones, M.D.