

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers / Buxton / Hamilton	12-11-09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOC NUMBER 000266	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR Clean & 12/21/09, letter attached.	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE 12-23-09
	<input type="checkbox"/> FOIA DATE DUE _____
	<input type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
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3.			
4.			

RECEIVED

DEC 11 2009

Department of Health & Human Services
OFFICE OF THE DIRECTOR

December 9, 2009

Dr Marion Burton
PO Box 8206
Columbia, SC 29202

Re: Sonya Morrison
DOB 03/12/07
Medicaid# 0780748581

Dr. Burton:

My granddaughter Sonya Morrison is a beautiful 2 year old who was diagnosed with cerebral palsy at age 1. SC Medicaid approved for Sonya to have a Selective Dorsal Rhizotomy on September 29, 2009 performed by T.S. Park, MD, Neurosurgeon-in-Chief at St. Louis Children's Hospital, St Louis, MO.

SC Medicaid recently limited physical therapy visits to 75 a year, which will not meet the required physical therapy protocol for post-op Selective Dorsal Rhizotomy. In order for Sonya to achieve maximum benefits from this surgery she will require 1 hour physical therapy sessions 4-5 times a week until her follow-up visit with Dr. Park on February 1, 2010. Physical therapy protocol then changes to 3-4 times per week. See enclosed Selective Dorsal Rhizotomy Post-op physical therapy protocol.

Enclosed are letters of medical necessity from Dr. Park and Sonya's physical therapist, Jennifer Frick, PT,MSRS.

Your prompt consideration is appreciated.



Debra Southerland
Guardian/Grandmother
Phone (803)944-7578

//3 enclosures



Center for Cerebral Palsy Spasticity
One Children's Place
St. Louis, Missouri 63110-1077

Phone 314.454.2813
Phone 800.416.9956

Date: December 4, 2009

Re: Sonya Morrison
DOB: 03-12-2007

To Whom It May Concern:

Sonya is a 2 year-old child with the diagnosis of spastic diplegic cerebral palsy who underwent selective dorsal rhizotomy on September 29, 2009. In order to reach the goals of that surgery, it is necessary that she continue to receive physical therapy to address range of motion, muscle strengthening, balance, coordination, gait training, functional and higher level gross motor skills, endurance, and patient and parent education. Sonya has consistently been meeting her physical therapy goals and continues to make progress.

It is our experience that children who continue to receive physical therapy benefit from the selective dorsal rhizotomy surgery. It is also observed that children who do not continue with the physical therapy, do not reach their maximum potential.

Continued physical therapy 4 times per week, 1 hour per session, is per our post rhizotomy protocol, is recommended for Sonya and is a medical necessity. If you have questions or concerns, please do not hesitate to contact me or a physical therapist at (314) 454-2813.

Sincerely,

A handwritten signature in black ink, appearing to read "T.S. Park".

T. S. Park, M.D.
Neurosurgeon-in-Chief
St. Louis Children's Hospital



Newberry Physical Therapy & Sports Medicine Clinic, Inc.



Date: December 7, 2009

Re: Sonya Morrison

DOB: 03-12-2007

To Whom It May Concern:

Sonya has been receiving physical therapy at Newberry Physical Therapy and Sports Medicine Clinic since 2009, following her selective dorsal rhizotomy on September 29, 2009. In order to receive the best benefit from the surgery she needs continued physical therapy 4 times a week, with each session lasting 1 hour. The goals of therapy are to help Sonya build up muscle strength, range of motion, coordination, and gait training to allow her to be the most functional.

Without continuing physical therapy sessions, Sonya will not be able to receive the maximum benefit from her surgery. She is making progress in therapy, but is not ready to be discharged.

Continued physical therapy is a medical necessity for Sonya. Thank you for your time and if you should have any questions, please feel free to give me a call at (803) 276-7370.

Sincerely,

Jennifer Frick, PT, MSRS
Jennifer Frick, PT, MSRS

**SELECTIVE DORSAL RHIZOTOMY
Post-operative Physical Therapy Protocol**

Center for Cerebral Palsy Spasticity
Department of Neurosurgery, Suite 4S-20
St. Louis Children's Hospital
One Children's Place
St. Louis, MO 63110
314-454-4166
800-416-9956, Ext. 1

Required frequency of physical therapy sessions:

- Hospital discharge to 6 months post-op: 4-5 times per week
- 6 to 12 months post-op: 3-4 times per week
- 12 to 36 months post-op: 2-4 times per week
- All PT sessions should be 60 minute sessions

Recommendations for changes in frequency of physical therapy will be given at the post-op visits at 4 and 16 months after surgery.

Precautions:

- No passive hip flexion past 90 degrees for 6 weeks after surgery. The patient can perform this activity to his/her tolerance.
- No passive trunk rotation/lateral flexion into extremes of range for 6 weeks after surgery. The patient can perform this activity to his/her tolerance.
- No vigorous hamstring stretching for 6 weeks after surgery. Hamstring stretching should be limited by **back pain** and not discomfort caused by the stretching of the hamstring muscles themselves.
- Because of increased weakness in the feet and ankles, any necessary splints should be worn during standing and ambulation activities.
- Expect some sensory changes in the lower extremities, especially some hypersensitivity on the plantar surfaces of the feet. This may be alleviated by handling feet firmly and wearing socks and shoes. This hypersensitivity usually resolves in the first 6-8 weeks.
- As the edema resolves around the site of the surgery, a bump may appear just above the scar. This is the spinous process of T-12 or L-1 and should not be a cause for concern.
- It is common for the child to tire more easily than normal. Changes in behavior such as irritability and frustration for no apparent reason are common as the child learns that movement feels different. Patients may not have the motor control and/or strength to produce the desired movement.
- Do not begin Aquatic therapy or swimming until two weeks after surgery
- Do not begin or resume electrical stimulation of any kind until 6 weeks after surgery
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- Please consult with Dr. Park's office before changing style of the child's orthotics. In the case of #3 DAFOs, it may be appropriate to use a removable pre-tibial strap for a brief time and wean from using it as soon as possible.
- Please call at any time if you feel that the orthotics are not appropriate for the child. A therapist will be happy to discuss the child's needs with you.

Recommended Post-operative Guidelines for Physical Therapy

- Please keep in mind that individual time frames will differ for each patient. This is intended to be a general guideline for the progression of the post-op physical therapy
- We expect that children will function at different levels and improve at different rates with different Physical Therapy goals. Please use this protocol as a guideline only.
- Please adapt and progress the child's home exercise program as indicated.

Step 1 -- Discharge through initial post-op period (about 6 weeks) Focus on strengthening

- A. Child should walk as much as possible as soon as they are able and walking causes no discomfort. Guarding assistance should be provided until child is safe in ambulation with or without an assistive device. Child should be encouraged to walk even if the pattern is not yet ideal.
- B. Posterior walkers such as the "Kaye Posture Walker" are recommended for post-rhizotomy patients. We recommend that all children using walkers have a posterior walker with swivel front wheels that can be locked in a non-swivel position. Other components that are frequently needed are pelvic stabilizer, hip extensor pad and sometimes a folding seat.
- C. Increase range of motion where limited through stretching and use of splinting such as knee immobilizers at night while sleeping. Most commonly shortened muscle groups are hamstrings, hip flexors (iliopsoas and rectus femoris) and gastrocnemius.
- D. Strengthening
Trunk, especially lower abdominals
Lower extremity musculature specifically in ranges now available to the child
Eccentric as well as concentric control of anti-gravity musculature
- E. Development or increase of weight bearing through lower extremities.
- F. Development of isolated movements in lower extremities
- G. Improvement of postural alignment in developmental positions, i.e. sitting, tall kneeling, $\frac{1}{2}$ kneeling, standing and ambulation if possible.
- H. Initiate movement in typical gross motor patterns.
- I. May begin partial weight bearing gait therapy if appropriate and if available

Step 2

- A. Children who are not yet walking independently with or without an assistive device, a stander may be indicated.
- B. May begin aquatic therapy one week after discharge from the hospital.
- C. Focus should be improving alignment, weight shift and step/stride length and control in ambulation.
- D. Development of balance and equilibrium reactions in static and dynamic sitting, kneeling, $\frac{1}{2}$ kneeling, and standing.
- E. Continue development of isolated movements in lower extremities
- F. Development of initiation and inhibition of movements throughout the range of motion of the lower extremities.
- G. Continue strengthening of antigravity musculature and development of concentric and eccentric control needed to hold a posture against gravity throughout the range of movement. Strengthening in CKC is recommended where possible. An activity based list of CKC strengthening activities is available. Please call if you would like a copy mailed, emailed or faxed to you.
- H. Work on isolated muscle strength and control throughout the available range of motion (i.e. Strengthen gastrocnemius, soleus, and hamstrings in the lengthened position).

- I. Direct attention to strengthening lower extremity musculature at the **end of available passive range of motion**. In particular, the gastroc, soleus and hamstrings are typically weak at the mid and end range and especially at the lengthened position of the muscle. E-Stim may be continued throughout protocol.

- J. May begin Hippotherapy.

- K. May begin NMES if indicated and available. NMES protocol and suggestions for type of unit and use are available. Please call if you would like a copy mailed, faxed or e-mailed to you.

- L. Treadmill walking for improving gait pattern and endurance

Step 3

- A. Continue strengthening of trunk muscles, specifically internal and external obliques, thoracic and lumbar extensors, while attempting to incorporate strengthening exercises into functional activities in CKC.

- B. Direct attention to strengthening lower extremity musculature. Functional activities in the home, school, community such as playground should be regularly practiced.

- C. Continue development of typical gait pattern with attention to alignment, step/stride length and weight shift.

- D. Continue development of concentric and eccentric muscle control in major muscle groups of the lower extremities.

- E. Begin to place greater emphasis on speed of movement in functional transitions and in a variety of patterns of movement.

- F. Family should be encouraged to take child to playground, climbing walls, and long walks. Child should walk around the home even if help is required.

- G. Crawling/creeping in home should be discouraged

- H. All toys in the home should be placed on a surface at which the child needs to tall kneel or stand based on the functional level of the child. Floor play should be discouraged.

Step 4

- A. Strengthening of specific muscles needed for functional movement patterns, especially in the CKC.

- B. Assess symmetry of strength in calves, ankles and feet. Most children will be somewhat asymmetrical in strength, range of motion and motor control. More work may need to be directed to the more involved extremity.

- C. Refinement of balance and equilibrium reactions in sitting, kneeling, $\frac{1}{2}$ kneeling and standing on stable and dynamic surfaces.

- D. Increase speed and control of reciprocal movements of the lower extremities.

- E. Address individual components of gait (step and stride length, hip extension, terminal knee extension and propulsion) to improve smoothness, coordination, and level of independence in ambulation. Weakness in calf muscles is almost always a problem for children with CP. Weakness in the gastroc and soleus can cause crouch gait and toe walking.

- F. Improvement of endurance in daily activities.

Step 5

- A. Continue development of strength, balance, coordination, speed and endurance with the addition of sports, dance and recreational activities.

- B. Continue refinement of gait pattern by assessing the individual components of gait and addressing range of motion and strength deficits.

- C. Continue strengthening in areas of persistent weakness in CKC, concentric and eccentric activities. Muscles below are listed in priority of greatest weakness and need for strengthening.

- Gastroc and soleus in the mid and end range
- Glut max and glut med in mid and shortened ranges
- Hamstrings in the lengthened range
- Quads in the shortened range
- Anterior tibialis in the shortened and mid range

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December 21, 2009

Ms. Debra Southerland
1262 Wheeland School Road
Little Mountain, SC 29075

Dear Ms. Southerland:

Thank you for your letter concerning Sonya. I have reviewed the clinical records that you forwarded, including the post-operative physical therapy protocol. I concur that additional physical therapy visits certainly seem to be clinically appropriate in this situation. I will communicate this with my colleagues at the SC Department of Health and Human Services to see what additional support we can provide. Someone from our agency will be contacting regarding this matter in the near future. Meanwhile if you have any concerns you have to address with me by phone please call me at 803-255-3400 or 803-898-2580. Thank you again for corresponding with us.

Sincerely,

O. Marion Burton, MD
Medical Director

log # 266

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Per Sheila Platt,
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Out.
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

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TO <i>Myers</i>	DATE <i>12-11-09</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <div style="text-align: center; font-size: 1.2em;"><i>.J011266</i></div>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <div style="text-align: center; font-size: 2em; color: green;">✓</div>	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>12-23-09</i> <input type="checkbox"/> FOIA DATE DUE _____ <input type="checkbox"/> Necessary Action

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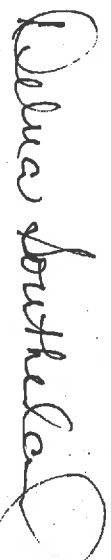
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Department of Neurosurgery, Suite 4S-20
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- C. Increase range of motion where limited through stretching and use of splinting such as knee immobilizers at night while sleeping. Most commonly shortened muscle groups are hamstrings, hip flexors (iliopsoas and rectus femoris) and gastrocnemius.
- D. Strengthening
 - Trunk, especially lower abdominals
 - Lower extremity musculature specifically in ranges now available to the child
 - Eccentric as well as concentric control of anti-gravity musculature
- E. Development or increase of weight bearing through lower extremities.
- F. Development of isolated movements in lower extremities
- G. Improvement of postural alignment in developmental positions, i.e. sitting, tall kneeling, ½ kneeling, standing and ambulation if possible.
- H. Initiate movement in typical gross motor patterns.
- I. May begin partial weight bearing gait therapy if appropriate and if available

Step 2

- A. Children who are not yet walking independently with or without an assistive device, a stander may be indicated.
- B. May begin aquatic therapy one week after discharge from the hospital.
- C. Focus should be improving alignment, weight shift and step/stride length and control in ambulation.
- D. Development of balance and equilibrium reactions in static and dynamic sitting, kneeling, ½ kneeling, and standing.
- E. Continue development of isolated movements in lower extremities
- F. Development of initiation and inhibition of movements throughout the range of motion of the lower extremities.
- G. Continue strengthening of antigravity musculature and development of concentric and eccentric control needed to hold a posture against gravity throughout the range of movement. Strengthening in CKC is recommended where possible. An activity based list of CKC strengthening activities is available. Please call if you would like a copy mailed, e-mailed or faxed to you.
- H. Work on isolated muscle strength and control throughout the available range of motion (i.e. Strengthen gastrocnemius, soleus, and hamstrings in the lengthened position).

- I. Direct attention to strengthening lower extremity musculature at the **end of available passive range of motion**. In particular, the gastroc, soleus and hamstrings are typically weak at the mid and end range and especially at the lengthened position of the muscle. E-Stim may be continued throughout protocol.
- J. May begin Hippotherapy.
- K. May begin NMES if indicated and available. NMES protocol and suggestions for type of unit and use are available. Please call if you would like a copy mailed, faxed or e-mailed to you.

L. Treadmill walking for improving gait pattern and endurance

Step 3

- A. Continue strengthening of trunk muscles, specifically internal and external obliques, thoracic and lumbar extensors, while attempting to incorporate strengthening exercises into functional activities in CKC.
- B. Direct attention to strengthening lower extremity musculature. Functional activities in the home, school, community such as playground should be regularly practiced.
- C. Continue development of typical gait pattern with attention to alignment, step/stride length and weight shift.
- D. Continue development of concentric and eccentric muscle control in major muscle groups of the lower extremities.
- E. Begin to place greater emphasis on speed of movement in functional transitions and in a variety of patterns of movement.
- F. Family should be encouraged to take child to playground, climbing walls, and long walks.
- G. Crawling/creeping in home should be discouraged
- H. All toys in the home should be placed on a surface at which the child needs to tall kneel or stand based on the functional level of the child. Floor play should be discouraged.

Step 4

- A. Strengthening of specific muscles needed for functional movement patterns, especially in the CKC.
- B. Assess symmetry of strength in calves, ankles and feet. Most children will be somewhat asymmetrical in strength, range of motion and motor control. More work may need to be directed to the more involved extremity.
- C. Refinement of balance and equilibrium reactions in sitting, kneeling, $\frac{1}{2}$ kneeling and standing on stable and dynamic surfaces.
- D. Increase speed and control of reciprocal movements of the lower extremities.
- E. Address individual components of gait (step and stride length, hip extension, terminal knee extension and propulsion) to improve smoothness, coordination, and level of independence in ambulation. Weakness in calf muscles is almost always a problem for children with CP. Weakness in the gastroc and soleus can cause crouch gait and toe walking.
- F. Improvement of endurance in daily activities.

Step 5

- A. Continue development of strength, balance, coordination, speed and endurance with the addition of sports, dance and recreational activities.
- B. Continue refinement of gait pattern by assessing the individual components of gait and addressing range of motion and strength deficits.
- C. Continue strengthening in areas of persistent weakness in CKC, concentric and eccentric activities. Muscles below are listed in priority of greatest weakness and need for strengthening.

- Gastroc and soleus in the mid and end range
- Glut max and glut med in mid and shortened ranges
- Hamstrings in the lengthened range
- Quads in the shortened range
- Anterior tibialis in the shortened and mid range

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