

In addition to the specialty and subspecialty requirements outlined in this standard, all California Children's Services (CCS) Hypertonicity Special Care Centers (SCC) are required to comply with [CCS Chapter 3.37 "CCS Provider Core Standards."](#)

A. Hypertonicity SCCs – Definitions for CCS Eligibility

1. Hypertonicity is defined as increased resistance to externally imposed movement about a joint. Subtypes of hypertonicity include spasticity, rigidity, and dystonia or a combination of these findings.¹
2. An approved Hypertonicity SCC is a center in which a multidisciplinary team of specialists provides comprehensive, multispecialty care to CCS-eligible clients with brain or spinal cord lesions that result in clinically significant hypertonicity, including spasticity, rigidity, and/or dystonia. The core team includes a specialist in physical medicine and rehabilitation (PMR), an orthopedist, a neurologist, a coordinator, a nurse, a physical therapist (PT) and an occupational therapist (OT). Further description of core team members is in section C of this document.
3. Hypertonicity SCCs provide comprehensive spasticity management services including, but not limited to:
 - a. Intrathecal Baclofen Pump (ITB) implantation and management.
 - b. Oral antispasmodic medication management.
 - c. Chemo denervation and/or neurolysis procedures including botulinum toxin injections and phenol/alcohol blocks.
 - d. Tendon release surgery/tenotomy.
 - e. Osteotomy.
 - f. Selective Dorsal Rhizotomy (SDR) or coordination with a surgical implant team that provides SDR, when the client meets criteria defined in Numbered Letter 03-0120.²
 - g. Other procedures and services for clients with hypertonicity, including deep brain stimulation and targeted brain lesioning.
4. The Hypertonicity SCC may also conduct evaluations for ataxia, chorea, hyperkinetic dystonia, dyspraxia and balance disorders.
5. "CCS Special Hospital" is defined in the CCS Manual of Procedures, Section 3.3.4.³

B. CCS Program Requirements

1. The Hypertonicity SCC shall be located within a CCS-approved tertiary hospital with a CCS-approved Pediatric Intensive Care Unit (PICU) or within a CCS Special Hospital, and shall operate in conjunction with the teaching programs at the hospital. There shall be no satellite centers for the Hypertonicity SCC with equivalent expertise. The Hypertonicity SCC shall have a policy describing clinical criteria required for authorization of SDR.
2. The Hypertonicity SCC shall operate as an identifiable team and shall provide care in the inpatient and outpatient departments of the hospital. The Hypertonicity SCC shall collaborate with inpatient and outpatient rehabilitation centers affiliated with the hospital. The team shall be responsible for the coordination of all aspects of client's hypertonicity evaluation and management.
3. The Hypertonicity SCC core team members and designated consultants providing care to CCS clients shall be paneled according to the standards for panel participation established by the State CCS Program.⁴
4. CCS-eligible clients shall be referred to the Hypertonicity SCC by CCS-paneled specialists in physical medicine and rehabilitation, orthopedics, neurology, or other CCS-approved physician with expertise in the evaluation and management of children with Cerebral Palsy. Medical Therapy Program (MTP) clients must be referred by the Medical Therapy Conference (MTC) physician or CCS-paneled physician approved to case manage the MTP-eligible condition. Referrals for MTP clients not medically case managed by the MTC physician are subject to the review of the MTC physician. The SCC shall provide services to clients who meet the following conditions:
 - a. The client's musculoskeletal needs cannot be fully managed by interventions such as oral medications, orthotics, serial casting, botulinum toxin injection(s), routine orthopedic procedures, occupational therapy, or physical therapy and,
 - b. The client requires multidisciplinary evaluation for possible interventions including, but not limited to ongoing botulinum toxin treatments, placement of an ITB for spasticity, SDR, or other surgical intervention targeting improvement of hypertonicity.
 - c. Clients shall not receive services at a Hypertonicity SCC if their rehabilitation spasticity management needs can be fully met by a local county CCS MTC, CCS-paneled physician who is approved by the CCS Program to case manage the MTP-eligible condition (designee), or other CCS-paneled physician (for non-MTP children).

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5. For clients eligible for the MTP:
 - a. The CCS MTC team or designee may refer the client to the Hypertonicity SCC following its determination that the spasticity management services available at the Hypertonicity SCC are medically necessary for the client in accordance with section B.4 above.
 - b. The county CCS Medical Consultant shall authorize services at the Hypertonicity SCC in conjunction with the MTC physician or designee.
 - c. The MTC physician or designee shall be a CCS-paneled provider with expertise in providing services to clients with chronic disabling conditions.
 - d. The MTC physician or designee shall review the Hypertonicity SCC plan of care as described in E.2.e.(10)(b) of this document, and advise the county CCS Program regarding the nature, frequency and duration of services by the Hypertonicity SCC.
 - e. The Hypertonicity SCC shall discuss all services and plan of care with the referring MTC physician or designee prior to and post-intervention. The MTC physician will determine when it is appropriate for the child to return to the MTC for medical case management based on these discussions.
 - f. The Hypertonicity SCC shall consult with Medical Therapy Unit (MTU) physical therapy and occupational therapy staff regarding initial and ongoing rehab care.
 - g. The county CCS Medical Consultant shall, when authorizing ongoing Hypertonicity SCC services, consult with the MTC physician or their designee to monitor progress towards goals and functional measures.
6. Services provided by health care professionals listed on the Hypertonicity SCC directory, as consultants, beyond the assessment recommended by the team conferences, require prior authorization. Requests for consultant services shall specify services needed, number of visits and duration, and include a medical justification. Extensions may be granted when indicated based on submitted medical justification.
7. The CCS Program shall only authorize SDR when a Hypertonicity SCC determines that SDR is medically necessary and submits a request for SDR to the CCS Program.
8. The Hypertonicity SCC shall complete a three-dimensional (3D) gait analysis prior to and following completion of each SDR procedure for ambulatory clients.

If the gait analysis is completed outside of the Hypertonicity SCC, then the SCC shall ensure that the gait analysis is completed and reviewed prior to the SDR.

C. Hypertonicity SCC Core Team Members and Specialty Consultants

1. The Hypertonicity SCC shall maintain a core team that includes:
 - a. A Hypertonicity SCC Medical Director, who shall be a CCS-paneled physician who is either a pediatric physiatrist certified by the American Board of Physical Medicine and Rehabilitation, or a Pediatric Neurologist with training and experience in hypertonicity and related disorders.
 - b. A physiatrist, neurologist or neurosurgeon, whichever specialty is not held by the Medical Director. This CCS-paneled physician will provide input, at minimum, on the treatment plans and use of standardized assessments to monitor progress towards treatment goals.
 - c. A CCS-paneled orthopedist with documented training and experience in hypertonicity and related disorders.
 - d. A Hypertonicity SCC Coordinator, nurse specialist, medical social worker (MSW) and registered dietitian (RD) as described in the SCC Core Standards with at least two years' experience working with clients with spasticity, and the following:
 - (1) The nurse specialist or other team member shall have completed specialized training in ITB analysis.
 - (2) The requirement for a RD may be waived for clients who are being followed by a Gastrointestinal (GI) SCC, and for clients who are found to have no impairment on the Eating and Drinking Ability Classification System (EDACS)⁵ or comparable assessment tool.
 - e. CCS-paneled PT and OT who are proficient in assessing spasticity/tone and have experience utilizing the Ashworth/Modified Ashworth scales.⁶
 - f. A CCS-paneled Speech Language Pathologist (SLP) shall be part of the core team or be available for consultation. The SLP shall be proficient in the EDACS.
2. Responsibilities of the Hypertonicity SCC core team members are as follows:
 - a. The Medical Director of the Hypertonicity SCC shall be subject to the core responsibilities described in the SCC Core Standards, C.3.a⁷ and additional responsibilities specific to the Hypertonicity SCC including:

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- (1) Oversight and participation in the evaluation and management of clients referred to and managed by the Hypertonicity SCC.
 - (2) Coordination with the CCS/MTP Program and other members of care team, including pre-and post-intervention documented communication.
 - (3) Ensure that team conference reports and other periodic evaluation and treatment are submitted to: the CCS/MTP Program, members of the child's care team including the client and/or family, the client's primary care provider, and the managed care plan case manager for clients in a Whole Child Model county.
 - (4) Ensure that multidisciplinary evaluations are comprehensive and include:
 - (a) Evaluation and recommendations from all core team members, and from all appropriate subspecialty consultants as described in C.3 of the SCC core standards.
 - (i) Updated functional goals for each client.
 - (ii) Documentation that client progress toward goals is evaluated using accepted functional measures.
 - (5) Referring clients to appropriate clinical trial(s) at the Hypertonicity SCC or another SCC offering this service.
 - (6) Referring clients to other Hypertonicity SCCs as needed to ensure that each client has access to appropriate subspecialty services (such as deep brain stimulation).
- b. The SCC Coordinator shall be subject to the responsibilities described in SCC Core Standards, C.3.b.1) – 3) as well as responsibilities specific to the Hypertonicity SCC listed below:
- (1) Ensuring coordination of services and communication with the MTP pre- and post-intervention, when appropriate;
 - (2) Ensuring coordination between the Hypertonicity SCC and the surgical team, pre- and post-intervention, regardless of whether the surgical team is onsite or located at a different facility; and
 - (3) Ensuring communication with the school and primary care provider, post-intervention.

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- c. The CCS-paneled nurse specialist in rehabilitation shall have responsibilities described in SCC Core Standards, C.3.c in addition to analysis of ITBs at each encounter.
 - d. The CCS-paneled MSW shall have responsibilities described in SCC Core Standards, C.3.d.
 - e. The CCS-paneled RD shall have responsibilities described in SCC Core Standards, C.3.e, and for nutritional assessment pre- and post-SDR.
 - f. The CCS-paneled PT shall be responsible for:
 - (1) The assessment of gross motor function, strength, range of motion, mobility, and equipment needs;
 - (2) Communication and coordination with the MTU PT regarding current therapy plan, past therapy history and potential goals of intervention;
 - (3) Communication and coordination with any private or school provided therapist involved in patient's care; and
 - (4) Completion of standardized assessments of tone and function, which may include Gross Motor Function Measure (GMFM)/ Pediatric Evaluation of Disability Inventory (PEDI), and Ashworth/Modified Ashworth scale, in collaboration with the OT.
 - g. The CCS-paneled OT shall be responsible for:
 - (1) The assessment of activities of daily living, fine motor skills, strength, tone, range of motion, motor control, sensory awareness, and equipment needs;
 - (2) Communication and coordination with the MTU OT regarding current therapy plan, past therapy history, and potential goals of intervention;
 - (3) Communication and coordination with any private or school provided therapist involved in patient's care; and
 - (4) Completion of standardized assessments including the PEDI/EADAC in collaboration with the SLP, as appropriate, and assessments of tone and function, described in F.1 of this document, in collaboration with the PT.
3. In addition to the required core team, there shall be a surgical implantation team (SIT) consisting of a neurosurgeon and a pediatric neurologist. The SIT shall be responsible for assessing and, as appropriate, providing interventional services

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to clients recommended by the core team as appropriate candidates for ITB. A pediatric anesthesiologist and a pediatric orthopedist shall be available for consultation and treatment.

4. For Hypertonicity SCCs that perform SDR, the SDR team shall be comprised of:
 - a. A pediatric neurosurgeon with SDR experience.
 - b. A pediatric anesthesiologist.
 - c. An electrophysiologist with experience in intra-operative monitoring.
 - d. An OT, a PT, an orthopedic surgeon and pediatric neurologist or PMR specialist, each with extensive experience in the management of hypertonicity/spasticity available for consultation.
5. The Hypertonicity SCC shall have direct access to the following pediatric subspecialties; pulmonology, cardiology, gastroenterology, urology, nephrology, genetics, otolaryngology, endocrinology, adolescent medicine. They shall be listed in the CCS SCC Directory and participate in Hypertonicity SCC activities when indicated.
6. The Hypertonicity SCC shall maintain allied health personnel that are regularly available for consultation, counseling and/or treatment. These allied health personnel shall be CCS-paneled as applicable, and shall include:

Respiratory care practitioners, SLP, if not part of core team, orthotists/prosthetists, genetic counselors, and pediatric dentists.
7. The Hypertonicity SCC shall ensure that the following services shall be provided, as necessary, by facility staff or by formal affiliation or consultation:
 - a. Psychological services, including neuropsychological evaluation by a CCS-paneled provider.
 - b. Audiology services by a CCS-paneled provider.
 - c. Durable medical equipment (DME) consultation.

D. Hypertonicity SCC Specialty Facilities and Equipment

1. In addition to SCC Core Standards C.1-9, the Hypertonicity SCC shall maintain the following facilities and equipment:

- a. Adequate clinic space for thorough assessment of gait by practitioners formally trained in the use of gait analysis and access to a computerized motion analysis laboratory with expertise in the treatment of children and young adults.
 - b. Standardized equipment, calibrated within the past year when appropriate, shall be available to provide anthropomorphic measurements appropriate for the ages and physical condition of the clients served. Therapeutic equipment standards are listed in CCS Information Notice (I.N.) 07-01.⁸
 - c. Electromyography, electrical stimulation, and/or ultrasound for ultrasound-guided botulinum toxin injections.
 - d. Access to high-resolution brain imaging for pre-surgical assessment and planning.
2. For Hypertonicity SCCs that provide SDR, the following additional equipment is required:
- a. Equipment to support 3D gait analysis, ability to refer for a 3D gait analysis or equipment to provide detailed objective assessment of client's mobility.
 - b. Rehabilitation facility and equipment to support acute inpatient rehabilitation and monitoring after SDR.

E. Hypertonicity SCC Patient Care

1. Authorization
 - a. CCS Clients referred to the Hypertonicity SCC may be authorized to the Hypertonicity SCC for:
 - (1) One-time consultation/evaluation;
 - (2) A specified intervention; and/or
 - (3) Ongoing management.
 - b. The Hypertonicity SCC will check CCS/MTP status when receiving referrals from sources other than CCS when the client is potentially CCS/MTP eligible.
 - c. The CCS authorization shall specify whether referral to the Hypertonicity SCC is for consultation, evaluation, specific intervention, and/or ongoing management.

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- d. If authorization is for intervention or ongoing management, the Hypertonicity SCC responsibilities include: coordination of all aspects of the client's hypertonicity evaluation and care, including coordination between the inpatient and outpatient departments of the hospital and with the local CCS/MTP for MTP eligible clients as outlined in section B.5.a – g. above. MTU staff shall be included in all pre- and post-evaluation coordination and discharge planning for MTP-eligible clients.
- e. For individuals with cerebral palsy or at risk of hip displacement, hip surveillance shall be complete at least annually.

2. Patient care

- a. For those clients whose care will be ongoing, the Hypertonicity SCC shall conduct an evaluation and team conference at least annually.
- b. MTP-eligible clients receiving ongoing management by the Hypertonicity SCC shall receive occupational therapy and/or physical therapy from the local MTP unless there are insufficient staff or capacity at the MTU, or the MTU is not equipped to provide the specialized modalities that the client requires. In these cases, upon approval by the local county CCS Program, the client may receive therapy at the Hypertonicity SCC or through a local county-paneled physical therapy or occupational therapy provider.
- c. For clients whose care will be ongoing and who are receiving occupational therapy and/or physical therapy treatment services at a frequency of one time or more per week, the Hypertonicity SCC shall provide a core team evaluation and new therapy orders at least every six months. Clients receiving periodic physical therapy and/or occupational therapy (a frequency less than one time per week) shall receive a core team examination and new therapy orders at least every 12 months.
- d. For individuals with CP at risk of hip displacement, hip surveillance shall be completed at least annually
- e. For initial encounter, annual review or consultation, the Hypertonicity SCC shall generate a composite team conference report consisting of:
 - (1) The physical findings including a description of the muscle groups and severity affected by hypertonicity.
 - (2) The functional skills of the client related to mobility and activities of daily living.

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- (3) Interventions attempted in the recent past and related outcomes.
- (4) Documentation of all relevant intervention(s) considered and the rationale for the choice of recommended treatment and anticipated goals.
- (5) Documentation of family or caregiver understanding and support for the recommended treatment.
- (6) A list of concomitant medical conditions that could impact the provision of care to the client.
- (7) Input from the MTU PT and/or OT if they are providing services.
- (8) Summary medical evaluation by the Hypertonicity SCC Medical Director or physician designee.
- (9) The individual core team member assessments and recommendations.
- (10) The goals of Hypertonicity SCC services, to be discussed with the family, which must include one or more of the following:
 - (a) Improved physical function such as, but not limited to, increased mobility, increased motor control, improved speed, improved posture, or enhanced ability to perform activities of daily living.
 - (i) Increased ability or independence in hygiene care.
 - (ii) Increased ability or independence as the result of being able to utilize medically necessary positioning device(s), e.g., braces, or splints.
 - (iii) Relief of pain.
 - (iv) Avoidance or postponement of surgical intervention, e.g. through hip surveillance.
 - (b) The Hypertonicity SCC shall create a plan of care for the client that shall be approved by the Medical Director, that includes:
 - (i) Anticipated treatment for the next six to twelve months including recommendations and prescriptions as appropriate for adjunctive and follow-up needs including physical therapy and/or occupational therapy, positioning, bracing, DME or surgery.

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- (ii) Documentation of the client and family's involvement in the care plan.
- (iii) Submission of both individual and composite reports, following each comprehensive evaluation, to the Independent county CCS program, or to the CCS Special Populations Unit for those clients who reside in a CCS Dependent county.
- (iv) Services that separate CCS authorizations including, but not limited to occupational therapy and physical therapy services, DME needs, orthotics, specialty consultations, local provider services, hospitalizations, outpatient procedures/surgeries, and
- (v) Magnetic Resonance Imaging scans.

3. Hypertonicity SCC collaboration with MTU

- a. The Hypertonicity SCC shall offer copies of team reports, plans of care, and other relevant information as applicable to the client's family or caregiver.
- b. The Hypertonicity SCC shall work with CCS to arrange medical transport of client between the client's home and the Hypertonicity SCC when necessary, particularly clients who have a tracheostomy or are ventilator dependent, or who must be accompanied by trained personnel such as a registered nurse.
- c. The Hypertonicity SCC will provide communication, coordination and referral services (when necessary) to the client including inpatient, outpatient and MTP based rehabilitation.
- d. The inpatient rehabilitation unit shall be at either the same institution or at an outside inpatient rehabilitation unit when there is collaborative agreement between the institute offering Hypertonicity SCC services and the institution providing the inpatient rehabilitation.
- e. For MTP eligible clients, the Hypertonicity SCC shall ensure that medically necessary outpatient rehabilitation is arranged, prior to discharge from inpatient rehabilitation, as needed to achieve the recommended recovery before transfer to outpatient physical/occupational therapy services at the CCS/MTP. When the client has achieved the short-term in-patient rehab goals, the client will resume ongoing therapy at the CCS/MTP.
- f. The Hypertonicity SCC shall have written agreements with any outpatient rehabilitation facilities identified for provision of medium length rehabilitation services for those clients not followed in the MTP.

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- g. The Hypertonicity SCC shall have provisions for the timely transcription and dissemination of medical records.
- h. For MTP eligible clients, the Hypertonicity SCC shall communicate with MTU staff regarding pre and post-op assessment, treatment and discharge planning including any needed DME.
- i. While the Client is under the management of a Hypertonicity SCC, the Hypertonicity SCC will request services as described in the above section A.3. The CCS/MTP Program will manage medically necessary rehabilitative services not covered by the Hypertonicity SCC while the client is under the care of the Hypertonicity SCC.
- j. Clients shall be referred to the State Department of Rehabilitation as appropriate.

F. Quality Assurance and Quality Improvement

1. Quality assurance shall include routine assessment of tone reduction and improvement in function, pain, and/or quality of life, using standardized tools to assess mobility, tone, and quality of life. Standardized tools shall include, but are not limited to, Ashworth or Modified Ashworth scale, PEDI, GMFM-66, GMFM-88, and EADAC. Alternate assessment tools that provide specific, objective information on mobility, tone, function and eating ability may be used when appropriate.
2. The Hypertonicity SCC shall make available to Integrated Systems of Care Division (ISCD) all annual reports on Hypertonicity SCC quality improvement projects.
3. The Hypertonicity SCC shall offer a formal mechanism for family input into the policies and practices of the Hypertonicity SCC. This should include the use of satisfaction surveys.

¹ Sanger TD, Delgado MR, Gaebler-Spira D, Hallett M, Mink JW; Task Force on Childhood Motor Disorders. Classification and definition of disorders causing hypertonia in childhood. *Pediatrics*. 2003;111(1):e89-e97. doi:10.1542/peds.111.1.e89.

² CCS Numbered Letters

<https://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx>

³ CCS Manual of Procedures, Section 3.3.4

<https://www.dhcs.ca.gov/services/ccs/Documents/Special.pdf>

⁴ Program Participation Requirements by Provider Type

<https://cmsprovider.cahwnet.gov/PANEL/provider-paneling-standards.jsp>

⁵ The Eating and Drinking Ability Classification System for cerebral palsy Sellers D, Bryant E, Hunter A, Campbell V, Morris C. The Eating and Drinking Ability Classification System for cerebral palsy: A study of reliability and stability over time. *J Pediatr Rehabil Med*. 2019;12(2):123-131. doi:10.3233/PRM-180581

<https://www.ncbi.nlm.nih.gov/pubmed/31227668>

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⁶ The interrater and intrarater reliability of the Modified Ashworth Scale in the assessment of muscle spasticity: limb and muscle group effect. Ansari NN, Naghdi S, Arab TK, Jalaie S. The interrater and intrarater reliability of the Modified Ashworth Scale in the assessment of muscle spasticity: limb and muscle group effect

<https://www.ncbi.nlm.nih.gov/pubmed/18560139>

⁷ 3.37.1 Special Care Centers (SCCs)

<https://www.dhcs.ca.gov/services/ccs/Documents/Chapter-3.37-CSS.Core.Standards.pdf>

⁸ CCS I.N. 07-01

<https://www.dhcs.ca.gov/services/ccs/Documents/ccsin0701.pdf>