2011 Durable Medical Equipment Criteria

Standing Frames: General (Custom) - UDOH(1, 2*MDR, 3, 4, 5, 6)

Created based on InterQual Subset: Standing Frames: General

Version: InterQual® 2011

Date Activated: 12-27-2011 Date Deactivated: - Date Printed: 12-27-2011

EQUIPMENT/INDICATIONS (choose one and see below)

☐ 100 Prone/supine/multi-position standing (E0641)
☐ 200 Dynamic standing frame (E0642)
☐ Indication Not Listed (Provide clinical justification below)

☐ 100 Prone/supine/multi-position standing (E0641) **[All]**(2*MDR, 5, 7, 8, 9, 10, 11, 12, 13)
- ☐ 110 Pre-ambulatory/nonambulatory **[One]**
  - ☐ 111 Developmental delay in ambulation and ≥ 2 yr of age(14)
  - ☐ 112 Documented neurological impairments and ≥ 2 yr of age(15)
- ☐ 120 Unable to tolerate upright standing position due to decreased motor control/abnormal tone(16)
- ☐ 130 Alert and responsive to stimuli
- ☐ 140 Required for long-term use ≥ 12 mos
- ☐ 150 Order by Physician for Home use of Standing Frame
- ☐ 160 Evaluation by PT/OT(11, 17)

☐ 200 Dynamic standing frame (E0642) **[All]**(2*MDR, 12, 18)
- ☐ 210 Pre-ambulatory/nonambulatory **[One]**
  - ☐ 211 Developmental delay in ambulation and ≥ 2 yr of age(14)
  - ☐ 212 Documented neurological impairments and ≥ 2 yr of age(10, 15)
- ☐ 220 Unable to tolerate upright standing position due to decreased motor control/abnormal tone(16)
- ☐ 230 Alert and responsive to stimuli **[One]**
  - ☐ 231 Shows ability to interact with peers and environment
- ☐ 240 Required for long-term use ≥ 12 mos
- ☐ 250 Order by Physician for Home use of Standing Frame(10)
- ☐ 260 Evaluation by PT/OT(17)

Notes

(1)

Alternate name(s) for this equipment include:

Stander

Standing Frame

(2)-MDR:

Standing frames are purchase only. Requests for standing frames for children under 2 years of age require secondary committee review.

(3)

The standing frame criteria apply to E0641 and E0642. They do not apply to standing frames with mobile capability or wheelchairs with standing features. Benefits of standing frames for the nonambulatory/pre-ambulatory patient include:

- Facilitate upright head and trunk control
- Promote elongation of the trunk and lower extremity musculature
- Decrease flexor spasticity, increase ROM, and reduce contractures
- Facilitate bone growth or decrease bone demineralization by requiring weight bearing through the extremities
- Improve bowel and bladder, circulatory, and respiratory function
- Promote skin integrity by off loading weight

(4)-POL:

Standing frames are a non-covered optional service under Utah Medicaid. Nevertheless, standing frames are a covered benefit for EPSDT eligible patients if the patient documentation meets the above criteria. Utah Medicaid covers three distinct categories of standers:

- Basic: Prior authorization is ***not*** required for E0637 or E0638.
- Multi-positional: Prior authorization required for code E0641.
- Dynamic stander: Prior authorization required for code E0642.

(5)

Pediatric standing frames are manufactured to allow for growth of the patient. The typical patient who requires a standing frame may have cerebral palsy or spastic quadriplegia. Weight and height are essential to provision of standing frames. Standing frames can come in various sizes with an array of positioning equipment and vary based on the manufacturer.

(6)-POL:

Medicaid pays for replacement equipment with documentation of why the equipment is needed. New equipment is available every five years according to Medicaid policy. See the Utah Medicaid Medical Supplies manual for more information. Consider the growth potential of the child when approving the standing frames. Girth, head, arm, hand control, accessories such as trays for activities at home and school, batteries, and how the stander is to be used should be considered.

(7)

The typical prone/supine standing frame may fit a child from 25 to 48 inches or 44 to 58 inches and has multiple adjustment features to allow for the child's growth.

(8)

Prone standing frames (*E0641)* require the user to have fair to good head control. They support the front of the body and can be used to improve head control, facilitate trunk extension, and encourage the user to use both hands. Supine standing frames support the back and are appropriate for users with limited trunk and head control. Both prone and supine standing frames can provide gradual adjustment to weight bearing by adjusting the angle.

(9)

Pediatric multi-positional standing frames (*E0641*), also known as three-way standing frames, can accommodate a user who requires upright, prone, and supine positions. Standing regimens may include both supine and prone positions and/or may progress from supine to prone to upright as head control improves.

(10)

Standing tolerance should be documented to indicate that the patient has had the opportunity to have a trial with the equipment and has been able to tolerate the upright position. (Trials of the equipment are not a requirement and only suggested. In some areas of the state equipment is not available for a trial.) In addition, the length of time the patient is able to tolerate standing should be documented. Studies suggest that the patient should be able to tolerate standing four days/week for at least 40 minutes.

(11)

The height and weight of a patient needs to be considered when determining the appropriate standing frame. Product specifications should be checked to assure that size requirements are met.

(12)-POL:
Accessories included

(13)
In a study conducted on the frequency of standing frame use within a spinal cord sample population, the average respondent stood once per day 4 days per week for a time period of 40 minutes (Eng et al., Phys Ther 2001; 81(8): 1392-1399).

(14)
Children begin walking typically between the ages of 10 and 18 months. Conditions such as congenital musculoskeletal or skeletal deformities can contribute to a developmental delay in ambulation. For example, in those children with arthrogryposis (a congenital anomaly involving multiple curved joints) who are unable to ambulate, standing therapy is used to promote stretching of the feet and leg muscles (Dunkley, Physiotherapy for children with arthrogryposis. 2007 [cited 2007 May]).

(15)
Children with spinal cord dysfunction can begin using standers by 1 year of age to enable them to participate in age appropriate activities that encourage exploration and development (Nelson, J Spinal Cord Med 2007; 30 Suppl 1: S172-177).

(16)
A prone/supine standing frame is appropriate for the pediatric patient who is developmentally delayed in crawling or standing. Typical diagnoses seen with this request include neuromuscular disorders or neurological disorders. This patient may have impaired head and trunk control and therefore may require postural supports to maintain proper postural alignment during use.

(17)
The functional impairments of the patient should be documented by a physician and PT/OT evaluation obtained. Evaluation must document: client's diagnosis; height; growth potential of the equipment; caregiver availabitlity to assist and supevise use; and environment of intended use.

(18)-DEF:
The dynamic stander (E0642) is also called a mobile stander. Dynamic standing frames are important for:
- improved bone density,
- allowing for stretch for tight muscles at hips, knees, and ankles
- improvements in pulmonary and digestive function,
- enables eye-level social interaction,
- creates access to activities and environment
- supports self-confidence and cognitive growth.