MEDICAL POLICY

Excellus
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Medical Policy Title	**Standing Devices and Gait Trainers**
Policy Number	**1.01.46**
Current Effective Date	February 20, 2025
Next Review Date	February 2026

Our medical policies are based on the assessment of evidence based, peer-reviewed literature, and professional guidelines. Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract. (Link to Product Disclaimer)

POLICY STATEMENT(S)

I. A standing device is considered **medically appropriate** when **BOTH** of the following criteria are met:

   A. There is documentation that the standing device is necessary for the patient to be independent in one or more of the following activities of daily living (ADLs) in the patient's home:

      1. Eating;
      2. Personal hygiene;
      3. Toileting;
      4. Dressing;
      5. Transfer; **and**

   B. The patient is unable to accomplish the activities identified in above with current durable medical equipment.

II. A standing device is considered **medically appropriate** for decubitus ulcer management when **BOTH** of the following criteria are met:

   A. There is documentation that off-loading of a decubitus ulcer cannot be accomplished by other means; **and**

   B. The patient has completed a one-month trial using the standing device and has shown meaningful improvement after the trial period. If there has been no documented trial period, but the patient meets criteria (refer to Policy Statement I or II.A), initial coverage is limited to one month only. Documentation from the referring provider that the patient has shown meaningful improvement during the trial period must be submitted, to be eligible for continued coverage.

III. A gait trainer is considered **medically appropriate** when **ALL** of the following criteria are met:

   A. There is documentation of the patient's mobility limitation, as described in Policy Guideline II;

   B. The patient has the potential for ambulation; **and**

   C. The patient is unable to accomplish the activities described in Policy Statement I.A above

with current durable medical equipment.

IV. DME Repair

A. Repair of a medically necessary [DME] or components not under warranty will be considered **medically appropriate** when the following criteria are met:

1. Physician documentation includes **ALL** the following:
   a. date of DME initiation;
   b. manufacturer warranty information, if applicable;
   c. attestation that the patient has been compliant with the use of the DME and will continue to benefit from the use of the DME;
2. The DME is no longer functioning adequately; and **BOTH** of the following criteria are met:
   a. inadequate function interferes with activities of daily living; **and**
   b. repair is expected to make the equipment fully functional (as defined by manufacturer).

B. Repair of equipment damaged due to patient neglect, theft, abuse, or when another available coverage source is an option (e.g., homeowners, rental, auto, liability insurance, etc.) is **ineligible for coverage**.

V. DME Replacement

A. Replacement of a medically necessary [DME] or components not under warranty will be considered **medically appropriate** when **EITHER** of the following criteria are met:

1. The DME is no longer functioning adequately and has been determined to be non-repairable or the cost of the repair is in excess of the replacement cost; **or**
2. There is documentation that a change in the patient's condition makes the present unit non-functional and improvement is expected with a replacement unit.
   a. The replacement of a properly functioning [DME], its components or accessories is considered not medically necessary. This includes, but is not limited to, replacement desired due to advanced technology or to make the DME more aesthetically pleasing;

B. The replacement of equipment damaged or lost due to patient neglect, theft, abuse, or when another available coverage source is an option (e.g., homeowners, rental, auto, liability insurance, etc.) is **ineligible for coverage**.

VI. Accessories or components for [DME] that are considered not medically necessary or investigational by peer-reviewed literature will also be considered as **not medically necessary or investigational** by the Health Plan.

RELATED POLICIES

Corporate Medical Policy

1.01.00 Durable Medical Equipment – Standard and Non-Standard

POLICY GUIDELINE(S)

I. Please contact the Customer Care (Member or Provider) Department, to determine benefits available under a member's subscriber contract.

II. Standing devices and gait trainers require individualized, patient-specific medical justification from the patient's orthopedic surgeon, neurologist, developmental pediatrician, or physiatrist, to determine medical necessity. Justification must be submitted for review, including the patient's diagnosis, a narrative description with functional criteria for the standing device or gait trainer, and any requested non-standard features, including wheels. At a minimum, such documentation must include **ALL** of the following:

   A. Diagnosis, prognosis, and severity of condition;

   B. A description of functional goals and current standing/gait training program;

   C. Re-evaluation of the member at the end of the trial period for the standing/gait training program (e.g., how long and how many times per day or week the standing device or gait trainer was used, and documented effectiveness of the standing/gait training trial program;

   D. History of standing and compliance when a standing device is requested; assessment of ability to ambulate or potential to ambulate when a gait trainer is requested;

   E. List of alternatives that were considered and rejected;

   F. If nonstandard features are requested (e.g., mobile [wheeled] or multi-positional standing device), an explanation as to why a standard device is inadequate for the particular activity or indication, and a statement that other standard devices have been trialed and found inadequate to meet the patient's needs;

   G. Other durable medical equipment that the patient currently uses; **and**

   H. Relevant medical records.

III. A person meeting medical necessity criteria for coverage of a stander will be eligible for such equipment should they be a "custodial" resident of a nursing facility or resident of an assisted living facility.

IV. For a person who is inpatient in a skilled nursing facility (SNF), and maintains a skilled status, all durable medical equipment, including standing devices, are considered global to the SNF reimbursement.

DESCRIPTION

A standing device (sometimes called a stander) is a device that enables the user of a wheeled

mobility device (wheelchair or wheelchair and seated positioning system) to achieve a passive standing position. The devices are available by physician prescription only. There are three basic types of standing device: supine, prone, and upright. Supine standers (e.g., Rifton Supine Standers) support the back surface of the body and require the least amount of trunk and head control. Prone standers (e.g., Leckey Freestander,Rifton Prone Stander) support the front of the body while the user is supported in various angles. Upright standers are used primarily in the vertical position by individuals who have fair-to-good trunk and head control. Multi-positional standers (e.g., Easy Stand Bantum) combine features of all three types of standers into a single stander, to allow for a variety of positioning needs. They are equipped with cushions to secure the head, trunk, hip, knees, and feet. A foot-operated, pneumatic tilt permits the angle of the stander to be adjusted.

Standing devices have been proposed for patients who are wheelchair dependent including, but not limited to, patients with cerebral palsy, spinal cord injuries, muscular dystrophy, paraplegia, quadriplegia, and paralytic syndromes.

A gait trainer is an assistive device that enables a patient to be placed in an upright position to learn or relearn mobility skills safely and efficiently. Gait trainers are lightweight and may be equipped with armrests, seat. and chest support. which may be removed when no longer necessary.

Meaningful improvement after a one-month trial may include: improvement in the functional use of the arms, hands, or head, as well as trunk control, in the performance of ADLs; in digestive, respiratory, circulatory or excretory function; or in skin integrity, by off-loading weight through standing (e.g., relief of pressure sores not achievable by other means). Improvements in skin integrity may include lack of progression or signs of healing in the decubiti ulcer.

SUPPORTIVE LITERATURE

Though standing programs, as a therapeutic modality, have been part of the program of management of children with developmental disorders and children and adults with spinal cord injuries for many years, there is very limited evidence in the peer-reviewed literature of improvement in health outcomes attributable to standing.

Studies of very small groups of children suggest that weight-bearing activity may stimulate accrual of bone and reduction in muscle tone; however, no reports of fracture rates or other health outcomes, including bladder/bowel function, or incidence of contractures related to standing programs, were found in a search of the scientific literature. While no studies of skin integrity related to standing programs were found, off-weighting of pressure areas is essential to treatment of skin breakdown.

Logan et al. (2022) state that there is a paucity of evidence about how to implement early mobilization for people who have had a severe stroke. The authors assessed the feasibility of a randomized controlled trial to evaluate a functional standing frame program compared with usual physiotherapy for people with severe sub-acute stroke. Participants were 18 years or older with new diagnosis of severe sub-acute stroke (modified Rankin Scale (mRS) 4/5). Participants were randomized to receive either functional standing frame program (30 min. standing plus sit-to-stand repetitions) plus 15 min of usual physiotherapy daily (intervention) or usual physiotherapy (45 min) daily (control). Patient measures of motor impairment, activities/participation, and quality of life were

carried out by blinded assessors at baseline, 3, 15, 29, and 55 weeks post-randomization. Forty-five participants (51-96 years; 42% male, mRS 4 = 80% 5 = 20%) were randomized (n = 22 to intervention). Twenty-seven (60%) participants were followed-up at all time points. Twelve participants (27%) died during the trial; no deaths were related to the trial. Intervention group: mean standing time 13 min (SD 9); mean sit-to-stand repetitions/session 5 (SD 4). The authors concluded that the majority of progression criteria for this feasibility trial were met. However, adherence to the interventions was unacceptably low. This aspect of the trial design needs to be addressed prior to moving to a definitive RCT of this standing frame intervention in people with severe sub-acute stroke.

Rapson et al. (2022) assessed the feasibility of a randomized controlled trial (RCT) to evaluate the effect of different doses of standing time on hip migration rate in children with cerebral palsy (CP). Twenty-five children aged 1-12 years with CP GMFCS levels III-V were recruited and randomized to either doubling or continuing with their usual time in their standing frame. Caregivers kept a standing time diary. The primary outcome measure was Reimers hip migration percentage, measured at baseline, 12 and 24 months. A blinded assessor measured secondary clinical outcomes at baseline, 6 and 12 months. Feasibility results were reported following CONSORT guidelines. Of the 25 children recruited, 19 were randomized and 10 completed the 12-month intervention. The mean daily standing time in the intervention group was 49 minutes (SD 39.1) (Monday-Sunday) and 58.1 (SD 44.1) minutes during weekdays. In children remaining in the trial, primary and secondary clinical outcome measures were available in 54% and 90% of children respectively. The authors concluded that it may be feasible to conduct an RCT to assess the effect of duration of standing on hip migration in children with CP with an altered protocol. The suggested target dose is 60-minutes five times per week compared to a control group standing for 30-minutes three times per week, over twelve months.

PROFESSIONAL GUIDELINE(S)

Not Applicable

REGULATORY STATUS

The Rifton Prone Stander (Rifton Equipment for the Handicapped) received United States Food and Drug Administration (FDA) 510K premarket approval in 1992.

The Leckey Freestander (James Leckey Design) received FDA 510K premarket approval in 1994.

The Easy Stand Bantum (Altimate Medical, Inc.) received FDA 510K premarket approval in 2013.

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
No code(s)	

HCPCS Codes

Code	Description
E0637	Combination sit-to-stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels
E0638	Standing frame/table system, one position (e.g., upright, supine or prone stander), any size including pediatric, with or without wheels
E0641	Standing frame/table system, multi-position (e.g., three-way stander), any size including pediatric, with or without wheels
E0642	Standing frame/table system, mobile (dynamic stander), any size including pediatric
E2230	Manual wheelchair accessory, manual standing system
E2301	Wheelchair accessory, power standing system, any type
E8000	Gait trainer, pediatric size, posterior support, includes all accessories and components
E8001	Gait trainer, pediatric size, upright support, includes all accessories and components
E8002	Gait trainer, pediatric size, anterior support, includes all accessories and components

ICD10 Codes

Code	Description
Numerous	

REFERENCES

Chiu HC, et al. Mechanically assisted walking training for walking, participation, and quality of life in children with cerebral palsy. Cochrane Database Syst Rev. 2020 Nov 18;11(11):CD013114.

Eng JJ, et al. Use of prolonged standing for individuals with spinal cord injuries. Phys Ther. 2001 Aug;81(8):1392-9.

Freeman J, et al. Assessment of a home-based standing frame programme in people with progressive multiple sclerosis (SUMS): a pragmatic, multi-centre, randomised, controlled trial and cost-effectiveness analysis. Lancet Neurol. 2019 Aug;18(8):736-747.

Logan A, et al. Functional standing frame programme early after severe sub-acute stroke (SPIRES): a randomised controlled feasibility trial. Pilot Feasibility Stud. 2022;8(1):50.

Rapson R, et al. Effect of different durations of using a standing frame on the rate of hip migration in children with moderate to severe cerebral palsy: a feasibility study for a randomised controlled trial. Physiotherapy. 2022;116:42-49.

SEARCH TERMS

Jenx Monkey, Tumbleform 2 Tristander, Easy Stand Magician-ei, Tumbleform Tristander 45/58

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

There is currently no National (NCD) or Local Coverage Determination (LCD) for standing frames/tables or gait trainers. Standing frames/tables with the following HCPCS codes (E0638, E0641, E0642) are considered non-covered.

Durable Medical Equipment Reference List (NCD 280.1) [accessed 2024 Jan 10]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION

Committee Approval Dates

02/23/06, 02/22/07, 02/28/08, 04/23/09, 08/27/09, 02/25/10, 02/24/11, 02/27/12, 02/28/13, 02/27/14, 02/26/15, 02/25/16, 02/23/17, 02/22/18, 02/28/19, 02/27/20, 02/25/21, 02/17/22,

02/16/23, 02/22/24, 02/20/25	
Date	**Summary of Changes**
02/20/25	• Annual update, no changes to policy intent.
01/01/25	• Summary of changes tracking implemented.
01/20/05	• Original effective date