**Stander Evaluation Date**: 00/00/2000
**Payor Information**: XXXXXXXX of XX
**Insurance ID**: ZZZZZZZZZZZZZZZZZ
**Patient Name**: XXX XXXXX
**Date of Birth**: 00/00/0000
**Gender**: Male
**Weight**: 22 (pounds) **Height**: 30 (inches)

Summary of Medical Condition

**Primary diagnosis**: Cerebral Palsy, **date of onset** Birth
**Treatment Diagnosis(s)**: Gross motor delay, increased muscle tone
**Prognosis**:

XXX has increased muscle tone in his legs which puts him at risk of potential hip subluxation or dislocation if he does not maintain good hip integrity, he is getting tighter leg and hip muscles as he grows. In addition to his tone, he is also tube fed and takes anti-­‐seizure medication, which puts him at further risk of fracture according to research statistics

**Co-morbid conditions**:

Developmental Delay, increased muscle tone, decreased L/E range of motion

**Chief complaints/presenting problems**:

I am writing to request a stander on XXX XXX’s behalf. As described earlier, XXX has increased muscle tone in his legs which puts him at risk of potential hip subluxation or dislocation if he does not maintain good hip integrity, he is getting tighter leg and hip muscles as he grows. In addition to his tone, he is also tube fed and takes anti-­‐seizure medication, which puts him at further risk of fracture according to research statistics. Research supports standing as a means to maintain bone density which will prevent fracturing (Katz et al 2006), and research supports standing as a means to decrease muscle tone (Tremblay et al 1990), as well as maintain hip integrity (Hagglund et al 2005 & 2015, Macias 2015 & 2016), particularly when standing is done with hips in an abducted position. XXX is using a loaner stander from our school district and is tolerating standing in this stander for up to 60 minutes per day without difficulty, so we know his ability to tolerate standing will not be a barrier to use. Without the use of a standing device that allows abduction, XXX will likely follow with increased risk of fractures, or need for hip surgery.

XXX is significantly delayed in his gross motor mobility due to his increased muscle tone and diagnosis of cerebral palsy. He is more involved on his left side, and is able to use both hands, but prefers to use his right hand to initially grasp a toy. XXX has difficulty sitting independently because his trunk muscles are weaker and because his leg muscles will pull together and cause him to lose his balance when sitting against the couch and practicing sitting balance. He is able to belly crawl short distances on the floor and roll to move around his play area. He is not able to get into or out of sitting or standing without adult help, he needs constant adult help to stand at a support surface to be safe. Due to his muscle tone, XXX tends to scissor his legs when up standing and in other positions during his day (belly crawling, playing on the floor, or being held upright by foster mom in standing). He has recently been getting tighter in his legs despite standing on a regular basis and working on prolonged stretches with knee immobilizers. One area that is hard to maintain a prolonged stretch for is his hip adductors; he continues to pull his legs together whenever trying to move or being held in standing by the couch. Research shows that prolonged stretching is better for maintaining and improving range of motion (Gibson et al 2009).

Clinician Expert Credentials

ZZZZZZZ ZZZZZZZZZZZ, PT, DPT, ATP
Physical Therapist
**Areas of Practice**: Pediatric Birth to 21-years-old

I have over 30 years of experience as pediatric PT. I received my doctorate in physical therapy in 2000, and has been certified as an ATP since 2011. I am currently working with children and their families in birth to 3 yo but have worked with birth to 21 yo in BBBBB school district for 14 years.

Physical Assessment

**Range of motion**

XXX has high adductor and leg tone causing his legs to pull together/scissor decreasing his L/E ROM and putting him at risk for potential hip subluxation or dislocation.
Due to his increasing tone XXX doctor is scheduling Botox injections.

A stander with abduction will allow a prolonged stretching in an abducted position, XXX can use the stander to stretch his hip adductors, maintaining his range of motion and preventing the expense of repeated Botox to maintain ROM.

**Tone/Spasticity**

XXX has high adductor and leg tone causing his legs to pull together/scissor which puts him at risk for potential hip subluxation or dislocation.

Research supports a home standing program as a means to decrease muscle tone (Tremblay et al 1990), as well as maintain hip integrity (Hagglund et al 2005), particularly when standing is done with hips in an abducted position.
Research shows that standing can decrease tone for 35 minutes following standing, so using a stander that can reduce the tone in his leg hip adductor muscles will help XXX be able to build the muscles to stand in a more abducted position after a standing program, and build up to taking steps at home with his caregivers. XXX will also be more successful with developing the muscle control for sitting if his L/E tone is reduced and not causing him to pull his legs together and fall over. XXX is scheduled to have Botox to his hips due to the concern his physician has with his hip tone and recent tightening of his legs that puts him at greater risk of secondary complications with his hip. If XXX gets a stander that allows prolonged stretching in an
abducted position, he can use the stander to stretch his hip adductors, maintaining his range of motion and preventing the expense of surgery or repeated Botox to maintain ROM.

**Other Physical Issues**

Bone density maintenance: XXX is tube fed and takes anti-­‐seizure medication, which puts him at further risk of fracture according to research statistics ( Presedo et al 2007)

Research supports standing as a means to maintain bone density which will prevent fracturing (Katz et al 2006)

Functional Status

**Balance**

XXX must be physically supported in the seated or standing position or his extreme leg tone will interfere with balance and he tips over.

Standing will help to decrease XXX lower extremity tone (Tremblay et al 1990) enabling him to work on balance skills out of the stander.

**ADLs/IADLs**

XXX is more involved on his left side, and is able to use both hands, but prefers to use his right hand to initially grasp a toy. Play or ADLs must be done in a physically supported position as XXX lower extremity tone does not allow for independent sitting or standing.

Use of a stander will give XXX the body support he needs to increase his fine motor skills while standing; including play and ADL's while working on decreasing his leg tone working towards independent sitting and hopefully standing with use of a walker in the future.

Documentation of Other Standing Devices Considered

**One Position Stander**

XXX is currently using the XXXXXXXXXX upright stander; while this is working ok for him, it does not allow him to stand with his hips in an abducted position to stretch out his hip adductors which are becoming tighter as he grows. This stander does not allow him to work toward his goals, as well as the size of this stander, it will not grow with him and will only last through age 3-­‐4 at best guess.

A prone stander was considered but again, did not allow for a hip abducted position, and XXX can also fatigue if placed in a prone position for longer periods, he will lean forward with rounded shoulder posture and be unable to use his hands and arms for playing and learning while standing. He needs to have the option of supine to allow for rest periods when working prone.

**Sit to stand Stander**

A sit to stand style stander was considered but again does not allow for XXX to stand with his hips in an abducted position for stretching and working toward his goals. So this device was ruled out.

Documentation of Trialed Devices and Outcomes

05/19/2016
PA5520 Zing MPS Size 1 Multi-position stander

The Easy Stand Zing MPS size 1 stander was tried with XXX to see how he would respond to standing in hip abduction that this stander allows. XXX was able to be up in the stander for 30 minutes with his hips in a range of 10 degrees to 20 degrees of hip abduction. He played with toys on the tray and was able to tolerate 15 degrees of hip abduction without complaining of discomfort, when moved to more abduction (20 degrees) he would make faces and try to shift his weight; once moved back to about 15 degrees he demonstrated he was comfortable by resuming his play and smiling again. XXX did well in a fully upright position to slight prone position, he could also play for 10 minutes in a 20 degrees of prone, and was able to indicate he was tired by resting on his arms and leaning forward more in his back when he needed to be back upright or supine to rest. Once XXX got out of the Zing stander, he was held by the trunk to see if he would take steps to get to the couch and stand to play. For the first time ever, XXX was able to take 10-­‐12 steps without any leg scissoring; he could lift his leg and take steps without scissoring the entire way to the couch, he was able to stand at the couch to play with a toy, again without trying to bring his legs together. Research shows that standing can decrease tone for 35 minutes following a standing program, so using a stander that can reduce the tone in his leg hip adductor muscles will help XXX be able to build the muscles to stand in a more abducted position after standing, and build up to taking steps at home with his caregivers. XXX will also be more successful with developing the muscle control for sitting if his L/E tone is reduced and not causing him to pull his legs together and fall over. XXX is scheduled to have botox to his hips due to the concern his physician has with his hip tone and recent tightening of hips that puts him at greater risk of secondary complications with his hip. If he gets a stander that allows prolonged stretching in an
abducted position, he can use the stander to stretch his hip adductors, maintaining his range of motion and preventing the expense of repeated botox to maintain ROM. The goals for XXX with standing, are not to simply stand and prevent fractures and hip dislocation; the goals are to promote strength and help him to build better motor skills. There are no other standers that could fit the needs for XXX when it comes to addressing the tone in his hips unless special modifications were made to a product. No other standers available will allow a child to stand with true hip abduction up to 30 degrees and have the capability of supine, prone or upright. While you can try to move a foot plate out, a child with increased tone, cannot handle the plate being outward if not supported well at the knee too; the Zing MPS stander allows the hip to move outward into abduction as a unit, supporting the hip, knee, and foot plate (the entire lower leg) as it moves outward together.

XXX maintained medical stability during the standing device trail. The only changes experienced were when abduction was increased from 15 to 20 degrees. Then XXX started to shift weight and make faces. Once the abduction was moved back to 15 degrees each leg he went back to smiling and playing with toys on his tray.

The trial was conducted in XXX foster home, which easily accommodated the stander.
The Zing MPS size 1 Frame Footprint =Maximum Dimensions 21.5″x 29.5″

See the appendix for documentation.

Standing Program Goals

The goal of a standing program for XXX are to maintain his range of motion, decrease the muscle tone in his hip adductor muscles to allow improved hip abduction range of motion, maintain bone density to prevent secondary fractures, promote strength to help him get stronger for moving on the floor independently, and walking along the couch or walking in a walker in his house to explore and learn.

**Recommended Standing Program:**

XXX will be using his stander on a daily basis, beginning with 30 minutes, 2x/day at 10 degrees of abduction; increasing to 20 degrees of hip abduction, a minimum of 2x/day for 30 minutes. XXX is currently in foster care and the carryover with standing program is excellent with 60-­‐90 minutes of standing a day. The stander will fit into his home without issue, and I would expect it would fit into any future home should he be adopted in the future.

Justification of the Selected Device

Make/Model/Size of Device Selected: PA5520 Zing MPS Size 1
Transfer Considerations:

n/a client is a one person lift at this time

Evidence patient ability to use device:

See above trial.

Growth Considerations:

XXX is 30" tall and 22 lbs. The Zing MPS size 1= Size 1 fits: children from infancy up to 44” and up to 70 lbs. So plenty of growth for the next years.

Necessary support or positioning components:

**PA5520 EasyStand Zing MPS Size 1 Base**

**Frame color:** Orange
**Mast:** PA5532 Mast with Leg Abduction
to allow abduction position is standing for decrease tone, improved range of motion, prevention of hip dislocation, development of strength in hip abductors for improved gross motor skills.

**PA5614 Gas Spring Lift Lockout**
to prevent XXX from accidentally being moved from supine, prone or upright by a child standing on the rear release mechanism, he is in foster care and will eventually be moved to another foster situation closer to his biological mother, in the event that there are other children near the stander this would be a necessary safety feature.

**Foot Plates:** PA5624 Multi-Adjustable Foot Plate 6"Lx3"W
these are needed because XXX wears orthotics which changes the alignment of his feet on the foot plate, he is currently in SMO's but may need to use AFO's in the future as he does push into plantar flexion with standing.

**PA5548 Foot Straps - extra small**
foot straps are needed to keep XXX feet in proper alignment for a standing program.

**PA5558 Multi-Adjustable Knee Pad - small**
XXX needs both the anterior (knee pad) and posterior (calf pad) support around his knees to be able to stand in an abducted hip position without compromising his knee joint.

**PA5560 Multi-Adjustable Calf Pad 3.5"**
XXX needs both the anterior (knee pad) and posterior (calf pad) support around his knees to be able to stand in an abducted hip position without compromising his knee joint.

**PA5562 Planar Pad 5"H x 7"W**
The posterior pelvic support pad is necessary for support and alignment of XXX pelvis.

**PA5574 Hip Supports**
Adjustable and rotating hip supports (works with abduction mast), keeps the pelvis centered and supported for correct pelvic and hip postural alignment. XXX needs this support as he has more tone and involvement on his left side which can often cause him to shift his weight and lean. Symmetrical alignment is very important when standing.

**PA5610 Padded Positioning Strap**
This strap has padding to increase and support the anterior surface area of the pelvis and to give added symmetrical alignment to the pelvis.

**PA5562 Planar Pad 5"H x 7"W**
Provides posterior upper body support, necessary for upper body support and alignment. XXX needs the back, lateral supports and a upper body positioning support strap to help maintain trunk symmetry while standing. XXX has more tone on and involvement on his left side which can often cause him to lean when standing.

**PA5576 Lateral Supports**
the lateral supports are necessary for upper body/trunk support and alignment.

**PA5610 Padded Positioning Strap**
XXX needs the Padded Positioning strap that has a Velcro® and D-ring adjustment to give additional anterior and some lateral support of the trunk.

**PY5626 Head Support - Extra Small (pad 5"H X 8"W)**
a head support is necessary for supine loading of client. Posterior support for xxx for fatigue rests after using in prone.

**PA5596 Black Molded Tray**
A Swing-away tray is accessible in all positions and provides anterior support as XXX moves from supine to upright and prone positions. Adjustable in depth, height and tray angle.

**PA5604 Forearm Wings-Black Molded Tray**
The forearm wings give additional area to support forearms for functional tasks when in standing position.

Signed:

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Appendix