Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200027 AUGUST 10, 2000

To: All Indiana Health Coverage Programs Durable Medical Equipment Providers, Home Health Care Providers, Hospitals, Medical Clinics, and Physicians

Subject: Standers

> *Note: The information in this bulletin is not directed to those providers rendering services in the risk-based managed care delivery system.*

Overview

This bulletin provides clarification that standers are covered by the Indiana Health Coverage Programs (IHCP) and are subject to prior authorization.

Standers refers to a mechanical standing device that provides support and positioning to aid in decreasing postural instability by targeting specific muscle groups with isokinetic exercises. The IHCP has established prior authorization criteria to be used for the evaluation of medical necessity. This criteria and the codes to be used for billing are being presented in this bulletin and are effective upon its issuance.

The IHCP has developed a medical clearance form to assist providers in supplying the necessary documentation required for evaluation of the medical information by prior authorization staff. The medical clearance form must be signed by the physician who orders the stander, and must be included with the prior authorization request. A copy of the new medical clearance form is included in this bulletin, and may be copied as needed.

Coverage Criteria for Standers

Standers require prior authorization. Initial requests for prior authorization must be accompanied by a medical clearance form signed by the physician and a copy of a physical or occupational therapy evaluation that was completed within the last two months. This evaluation should show the patient's functional and cognitive baseline and ability to progress within therapy. Subsequent requests for prior authorization will require ongoing documentation of progress toward goals up through the 15th month. The request for prior authorization must include documentation of medical necessity and a plan of care signed by the ordering physician that identifies measurable goals for therapy and training. The plan should identify the reasons the patient requires the stander as an adjunctive therapy. Examples of the reasons include, but are not limited to, the following:

- To aid in the prevention of atrophy in the trunk and leg muscles
- To improve circulation to the trunk and lower extremities
- To prevent formation of decubiti (pressure sores) with changeable positions
- To increase bone density and strength
- To improve circulation in the lower extremities
- To improve range of motion
- To decrease muscle spasms
- To strengthen the cardiovascular system and build endurance
- To improve strength to the trunk and lower extremities
- To prevent or decrease joint muscle contractures
- To lesson or prevent progressive scoliosis
- To aid normal skeletal development

Diagnoses that suggest medical necessity may include, but are not limited to, the following:

- 343.0 – Congenital diplegia
- 343.2 – Congenital quadriplegia
- 343.9 – Cerebral Palsy NOS
- 344.0 – Quadriplegia
- 742.4 – Brain anomaly NEC
- 355.20 – Amyotrophic Sclerosis

- 995.55 – Shaken Infant Syndrome
- 741.9 – Spina Bifida
- 348.3 – Encephalopathy NOS
- 783.4 – Lack of normal development
- 318.1 – Severe mental retardation
- 318.2 – Profound mental retardation

When a multi-positional stander is requested there must be documentation that supports the need for a multi-positional stander. Secondary complications that could justify the need for multi-positional standers include, but are not limited to, the following:

- A patient requires postural drainage
- A patient requires suctioning while in the stander related to excessive secretions
- A patient has a history of postural hypotension

Other documentation to support medical necessity would include:

- Specific muscle groups to be targeted and expected outcomes
- Training for the caregiver regarding specific orders and proper positioning of the recipient in the stander

Billing Instructions

Table 1.1 – Level III HCPCS Codes for Standers

Standers	
Code	**Description**
Z5104	Supine stander (includes all attachments and tray)
Z5105	Prone stander (includes all attachments and tray)
Z5106	Vertical stander (includes all attachments and tray)
Z5107	Multi positional stander (includes all attachments and tray)

Providers are to bill their usual and customary charge for the equipment and will be reimbursed the lesser of the submitted charges for the equipment or the maximum fee amount. The equipment is to be billed on a HCFA-1500 claim form using a DME provider number. Attachments and trays are included in the maximum fee and are not to be billed separately. The provider is obligated to provide repairs and maintenance for the first 15 months or until the item is purchased.

After 15 months, repairs and maintenance are billed using E1399 for replacement parts and E1340 for labor charges.

Further Information

Questions about this bulletin may be directed to the Health Care Excel (HCE) Medical Policy Department at (317) 347-4500. Questions about the billing procedures referenced in this bulletin may be directed to EDS Customer Service at (317) 655-3240 in the Indianapolis local area or 1-800 577-1278.

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MEDICAL CLEARANCE FORM

PHYSICAL ASSESSMENT FOR STANDING EQUIPMENT

Section A: Patient information			
Patient name _____ Recipient identification number _____			
Diagnosis _____			
Onset date of disability _____ Date of birth _____			
Current weight _____ Current height _____			
Section B: Physician Information			
Provider's name _____ Provider number _____			
Section C: General Physical Status **Please circle most appropriate answer. If abnormal or progress is circled, please explain in the space provided.*			
Cardiopulmonary status	Normal	Abnormal	Progress
Sensation/body awareness	Normal	Abnormal	Progress
Skin status	Normal	Abnormal	Progress
Sensation status	Normal	Abnormal	Progress
Muscle strength status (Specify upper and lower strength)	Normal	Abnormal	Progress
Muscle tone status	Normal	Abnormal	Progress
ROM status (Specify upper and lower ROM)	WFL (within functional limits)	Abnormal	Progress
Standing static and dynamic balance	Normal	Abnormal	Progress
Sitting static and dynamic balance	Normal	Abnormal	Progress

Section D: Requires Assistance With The Following ** Please circle most appropriate answer*				
Ambulation	Independent	Minimum	Maximum	Dependent
Transfers	Independent	Minimum	Maximum	Dependent
Propelling wheelchair	Independent	Minimum	Maximum	Dependent
Sitting	Independent	Minimum	Maximum	Dependent
Feeding	Independent	Minimum	Maximum	Dependent
Dressing	Independent	Minimum	Maximum	Dependent
Hygiene	Independent	Minimum	Maximum	Dependent

Section E: Rational For Use **Please circle yes or no*		
To maintain bone integrity and increase bone density	Yes	No
To improve circulation in the lower extremities	Yes	No
To improve range of motion	Yes	No
To decrease muscle spasms	Yes	No
To strengthen cardiovascular system and build endurance	Yes	No
To improve strength to the trunk and lower extremities	Yes	No
To prevent or decrease joint muscle contractures	Yes	No
To lessen or prevent progressive scoliosis	Yes	No
To aid normal skeletal development	Yes	No

Section F: Special Considerations
** Please circle the correct answer or fill in the blanks*

What is the height range and weight capacity of the stander requested?
Height range from_____ to _____ Weight capacity from _____ to _____
Additional Comments:

What are the position needs? Supine Vertical Prone Multi-positional
Additional Comments:

What is the cost of the stander?
Please individually list each requested accessory and its cost.

How long will the stander be required? Months _____ Years _____ Lifetime _____
Additional Comments:

Is the nonpaid primary caregiver willing and able to be trained to use the equipment safely?	Yes	No

Additional Comments:

Assessment Completed By:	**Date:**

Section G: Physician's Signature and Date

I certify the medical necessity of these items for this patient. I have examined the above-mentioned patient and to my knowledge there are no medical or surgical contraindications for the use of a stander.
Physician's signature: **Date:**