**Patient Information**

Stander Evaluation Date: 09/12/2017

Payor Information: MMMMMMMMMMMM

Insurance ID: xxxxxxxxxxxxxxxxxxxx

Patient Name: J T

Date of Birth: 11/01/2007

Gender: Male

Weight: 60 (pounds) Height: 50 (inches)

Summary of Medical Condition

Primary diagnosis: Cerebral Palsy, date of onset 11/01/2007

Secondary Diagnosis(s): Retinopathy of prematurity

Treatment Diagnosis(s): Spastic Quadriplegic, multiple hip surgeries for dislocation

**Prognosis:**

JT has been using a stander at home and school with very positive results until this past summer. At this time he has outgrown his home standing device. It is very evident when JT does not stand both at school and home- Example- this past summer when he outgrew his home stander and was not able to complete his home standing program. His teacher, family and I have noticed marked negative changes in his tone and ROM. Since starting back to school in September, his hip adductors have become very tight and require this therapist to restart his school standing program from the beginning- with very short bouts of standing 5-10 min, so that he can again tolerate the stretch on his lower extremities. This is a regression from last Spring when he was standing 2X's a day for 45-60 minutes. He is now presenting with L/E ROM deficits and increase adductor tone compared to last year end of school. It is of up most importance that JT receive a home standing device, with the ability to function in supine, upright and prone and to have an abduction component, to prevent changes to L/E tone, ROM and to help prevent further hip issues or surgeries.

**Co-morbid conditions:**

Retinopathy/ blindness, U/E and L/E spasticity/ increased muscle tone in his legs, L/E ROM deficits. JT also is prone to bouts of constipation. All issues appear to be exacerbated by lack of standing at home, due to JT outgrowing his home stander

**Chief complaints/presenting problems:**

JT was evaluated for a replacement for his outgrown home standing device. We used the Zing MPS TT size 2 stander. It was deemed most appropriate device due to JT's

need for hip stability and the ability of an abduction component on this stander. He has high adductor tone, has had 3 past hip procedures to stabilize his hips from dislocating. At his age we are very concerned about puberty and rapid growth which will put his hips at greater risk for further subluxation or dislocation.

JT was born at 24 weeks gestation. Diagnoses include: Retinopathy of prematurity resulting in detachment of his retina's causing blindness, Spastic Quadriplegic

Cerebral Palsy, presenting with high lower extremity tone and spasticity. 3 surgical procedures in the past 6 years between his right and left hips for hip dislocations.

**Clinician Expert Credentials**

Jane Doe, PT XXXX XXXXXXX School District

Areas of Practice: Adult & Pediatric, Birth to 21-years-old, School-age, Elementary, School-age, Middle School Out-patient rehabilitation

I have been a PT for the last 20 years, specializing in Adult ortho and for the past 10 years pediatrics. The last 10 years I have worked in the XXXX XXXXXXX school district

primarily with Elementary and Middle School students who have disabilities.

**Physical Assessment**

**Range of motion**

Currently JT is able to achieve - 9 degrees of full L/E ROM at the hips and knees, this is after 20 -30 minutes of mat stretches by PT. This is of concern since last June, he had full L/E ROM with 1-2 minutes of manual stretch. Another concern is growth, without a weight bearing/stander program, as he is has entered puberty-any growth will likely cause an increase in tightness to already tight L/E.

Implementing a home standing program with an abduction component should maintain his L/E ROM and with the abduction component we hope to decrease his

adductor tone/scissoring and help stabilize his hips to prevent further subluxation or dislocation

**Tone/Spasticity**

JT has high adductor and leg tone causing his legs to scissor putting him at great risk for further hip surgeries.

With JT's history of hip issues and surgeries, and the onset of puberty with growth spurts, we must look to all means to prevent further hip issues.

Research supports a standing program as means to decrease muscle tone (Tremblay 1990), as well as to maintain hip integrity (Hagglund 2005), when standing with hips in an abducted position.

**Functional Status**

**Communication**

With JT's body tone and blindness, touch communication via hand signals as well as switch access is extremely important. Controlling his body tone allows for best

access to caregiver’s hand signals and to switches which are JT's best communication method to date.

A stander that places JT in supported symmetrical alignment allows his U/E tone to decrease giving him access to switches placed on the tray of his stander.

**Documentation of Other Standing Devices Considered**

**One Position Stander**

We considered a supine only stander, but determined that it would not allow enough change of position to challenge JT's head control. Yet, a prone only stander would not allow for rest periods when fatigue sets in. It was determined that a one position stander would not function for JT.

**Sit to stand Stander**

JT's previous stander was a sit to stand which worked well until the last two years during growth and with more tone issues. Unfortunately, this device does not come with a prone component. neither does it come with an abduction component which this PT feels is of upmost importance in hip health for JT.

**Documentation of Trialed Devices and Outcomes**

PB5500 Zing MPS Size 2 TT

JT has had a week trial with this standing device and we found it to work very well for him, his family and caregivers. Loading and unloading were done at about 45 degrees of supine allowing some gravity to assist with leg positioning.

JT maintained good medical stability throughout the week of Zing MPS TT size 2 trial. We started slow (10 minutes the first day, increasing 10 minutes up each day, ending

at 50 min a day. JT interacted and communicated with his family and showed no signs of distress, which his family is very good at determining. No redness was noted on the ankles or feet from AFO's post standing.

JT's house is small, but with each of the components requested, the standing device worked well in their house.

See the appendix for documentation.

**Standing Program Goals**

The goal of JT's home standing program is to gain back L/E ROM, and to decrease adductor tone so as to allow JT to function as he was last May with full L/E ROM and decreased L/E tone.

**Recommended Standing Program:**

JT will begin his home standing program with 10 min upright 2 times a day, increasing as tolerated 10 min more each day up to 60 minutes at home. He will concurrently stand up to 60 min at school.

When JT isn't able to be in school, due to illness, school break, or other, the family will stand him 2 times a day up to 60 min. each time.

**Justification of the Selected Device**

Make/Model/Size of Device Selected: PB5500 Zing MPS Size 2

**Transfer Considerations:**

The family prefers to do a one or two-person transfer at this time. Dad can transfer JT by himself. Mom and Aunt utilize a two-person lift transfer. A patient lift was discussed but the family would prefer to not use one at this time. A patient lift was used at school with this standing device and we know it will work when the family is ready.

**Evidence patient ability to use device**:

demonstrated in his trail at home

**Growth Considerations:**

JT's current height is 50" and weight 60 lbs. The Zing MPS TT size 2 has a range of: 40-60 " and 154 lbs. allowing 10" of height growth and 90 lbs of weight increase.

**Necessary support or positioning components:**

PB5562 Zing MPS TT size 2 Gas Spring Lift

Frame color: Orange

Mast: PB5514 Mast with Leg Abduction

JT needs the abduction mast due to a long history of hip subluxation/dislocation issues. Research has shown standing in abduction can improve musculoskeletal development, specifically the development of the acetabulum for children who are unable to functionally bear weight through the long bones of the legs. -Increasing L/E Rom, decrease L/E tone, reduce or prevent hip dislocation, improve abductor strength.

PA5614 Gas Spring Lift Lockout

JT's house includes younger sibling who like to tinker with his equipment. Gas Spring Lift lockout can prevent inadvertent position changes in environments where other children may be present.

Foot Plates: PB5522 Multi-Adjustable Foot Plate 9.75"Lx4"W

The multi - adjustable footplates provide proper individual leg and foot support and alignment especially for the client who uses AFO such as JT does, and needs to adjust foot angle to accommodate orthotic for proper aligned weight bearing.

PT50080 Foot Straps-10"L

JT needs D-ring adjustable foot straps to hold his feet (diagonal angle near the ankle) in symmetrical alignment for proper foot positioning and safety.

Leg Support: PB5572 Planar Pads-12"Hx7.5"W(pair)

JT needs posterior support pads for proper posterior knee support and alignment, specifically related to his current decrease in L/E ROM.

PB5578 Knee Strap for Planar Pad PB5572

The planar pad strap will keep JT’s knees positioned in symmetrical alignment vs, internal rotation which is where his legs like to drift.

PB3015 Planar Pad 22"Hx16"W

-JT needs an adjustable posterior pelvic pad and lateral hip support to keep pelvis in symmetrical alignment when weight bearing

**Conclusion & Clinician’s Signatures:**

The above items have been determined to be medically necessary for JT, and are in no

way for his, or the family’s convenience. Thank you in advance for your review of this

much needed item for JT. Please feel free to contact me if you have any questions.

Sincerely,

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Physical Therapist

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Physician