

Pediatric Gait Trainers and Standing Systems

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[Instructions for Use](#)

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| Related Commercial Policy |
|---|
| <ul style="list-style-type: none"> Durable Medical Equipment, Orthotics, Medical Supplies and Repairs/Replacements |
| Community Plan Policy |
| <ul style="list-style-type: none"> Pediatric Gait Trainers, Standing Systems, and Walkers |

Coverage Rationale

[See Benefit Considerations](#)

Pediatric Gait Trainers

Gait Trainers for [Functional Ambulation](#) are proven and medically necessary when the following criteria are met:

- The individual is 18 years of age or younger; and
- The individual has the potential for Functional Ambulation; and
- The individual uses the Gait Trainer when documentation shows assistive devices have not been effective.

Gait Trainers for therapeutic ambulation are proven and medically necessary for treating non-ambulatory individuals when the following criteria are met:

- The individual is 18 years of age or younger; and
- The individual is capable of utilizing and tolerating the equipment safely; and
- The individual requires moderate to maximum support for ambulation (i.e., handheld ambulation assist devices are not feasible); and
- The individual has an acquired injury (e.g., spinal cord or traumatic brain injury) or a chronic physical limitation that affects the ability to ambulate (e.g., cerebral palsy, neuromuscular disease, or spina bifida); and
- The individual has a physician directed written treatment plan (including frequency and duration).

Standing Systems

Stationary, mobile and active Standing Systems are proven and medically necessary for treating non-ambulatory individuals when all of the following criteria are met:

- There is a goal of prevention of one or more of the following medical complications:
 - Decubitus ulcer: Where there is a need for off-loading of a decubitus ulcer which cannot be accomplished by other means;
 - Osteoporosis: Where improvement or stabilization of bone density cannot be achieved with other treatment or activities;

- Contracture development: High potential for progressive contracture formation including but not limited to post-operative release of contractures;
- Compromised bowel/bladder function: Where there has been demonstration of incomplete emptying of bladder or constipation refractory to other medical treatment;
- Pulmonary complications: Where there has been demonstration of recurrent infections and poor clearance of pulmonary secretions despite the use of other medical treatment;
- Hip dislocation: Where hip subluxation/dislocation is worsening and alternate treatments have not been successful; and
- The individual is unable to accomplish the above goals with his/her current medical device/equipment or alternate medical treatment; and
- The individual has been evaluated in physical therapy with a trial using the standing device and has shown compliance, tolerance and demonstrated potential for clinical benefit, as determined by the evaluator; and
- There is a written plan of care

Definitions

Functional Ambulation: The ability to walk, with or without the aid of appropriate assistive devices (such as prostheses, orthoses, canes or walkers), safely and sufficiently to carry out mobility-related activities of daily living (Lam et al., 2008).

Gait Trainer: A gait trainer (sometimes referred to as a rollator) is a term used to describe certain devices that are used to support a member during ambulation.

Standing System: A standing frame, also known as a standing aid or stander, is specifically designed for wheelchair users. These devices allow the individual to achieve a standing position and then support the person in the standing position.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

| HCPCS 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., 3-way stander), any size including pediatric, with or without wheels |
| E0642 | Standing frame/table system, mobile (dynamic stander), any size including pediatric |
| 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 |

Description of Services

Gait Trainers are supportive walking devices that take the weight of the body through a solid or fabric 'seat', stabilize the trunk, and support the pelvis (Paleg and Livingstone, 2016).

Supported standing devices such as standers or tilt-tables allow the user to attain and maintain a standing or partial-standing position and commonly stabilize hips, knees and ankles through posterior heel, anterior knee and posterior hip supports and/or straps (Paleg and Livingstone, 2015).

Benefit Considerations

Convenience features, such as powered standing systems, standers attached to a wheelchair, or electric lift mechanisms, are excluded from coverage. Refer to the Coverage Determination Guideline titled [Durable Medical Equipment, Orthotics, Medical Supplies and Repairs/Replacements](#).

Clinical Evidence

Pediatric Gait Trainers

Paleg and Livingstone (2015a) conducted a systematic review regarding use of gait trainers at home or school with children who are unable to walk independently or with hand-held walkers. Included studies involved at least one child with a mobility limitation and measured an outcome related to gait trainer use. Seventeen studies involving 182 children were included. Evidence from one small randomized controlled trial suggested a non-significant trend toward increased walking distance while another evidence level II study (concurrent multiple baseline design) reported increased number of steps. Two level III studies (non-randomized) reported statistically significant impact on mobility level with one finding significant impact on bowel function and an association between increased intervention time and bone mineral density. Remaining descriptive level evidence provided support for positive impact on a range of activity outcomes, with some studies reporting impact on affect, motivation and participation with others. The authors concluded that evidence supporting outcomes for children using gait trainers is primarily descriptive and, while mainly positive, is insufficient to draw firm conclusions.

Gharib et al. (2011) conducted a randomized controlled trial to assess the effects of additional gait trainer assisted walking exercises on walking performance in children with hemiparetic cerebral palsy. Thirty children with spastic hemiparetic cerebral palsy were included in the study. Children were randomly assigned into two equal groups; experimental and control. Participants in both groups received a traditional physical therapy exercise program. Those in the experimental group received additional gait trainer based walking exercises which aimed to improve walking performance. Treatment was provided three times per week for three successive months. Children received baseline and post-treatment assessments to evaluate gait parameters including average step length, walking speed, time on each foot and ambulation index. The ambulation index was 75.53 ± 7.36 (11.93 ± 2.89 change score) for the experimental group and 66.06 ± 5.48 (2.13 ± 4.43 change score) for the control group. Time of support for the affected side was 42.4 ± 3.37 (7 ± 2.20 change score) for the experimental group and 38.06 ± 4.63 (3.33 ± 6.25 change score) for the control group. Also, there was a significant improvement in step length and walking speed in both groups. The authors concluded that gait trainer walking exercises combined with traditional physical therapy increase the chance of improving gait performance in children with spastic hemiparetic cerebral palsy.

Standing Systems

Farrarello et al. (2015) conducted a randomized controlled trial evaluating standing frames as an adjunct rehabilitation intervention in individuals with severe disability due to stroke. After baseline assessment, 75 participants with severe disability due to stroke, all receiving conventional physical therapy (PT), were randomly assigned to adjunctive 20 (n = 24) or 40 (n = 31) minutes of supported standing practice (SSP) or PT only (n = 20). Motor function, autonomy, and mobility were assessed before and after training, and three months later. Most outcome measures improved from baseline through the end of treatment, and at follow-up, in all groups. The extent of change was comparable across the three groups. The authors concluded that SSP did not provide any sizeable adjunctive benefit, above and beyond PT, in this patient population.

In a systematic review, Paleg and Livingstone (2015b) evaluated the evidence for all outcomes potentially impacted by a supported standing program in adults with chronic neurological conditions. The primary goal was effectiveness, and the secondary goal was to identify evidence-based dosage recommendations for home-based programs. A standing intervention was defined as being positioned above 60° (from horizontal) for at least 10 min for a minimum of five sessions within a 2-week period. Thirty-six articles met the inclusion criteria (studies published in English, peer-reviewed journals, with clear information on standing dosage). The results of the review showed that moderate to high quality evidence supports the positive impact of standing on range of motion (ROM) and activity for adults with neurological conditions. The strongest evidence, resulting from

level II moderate or high quality studies, supports impact on ROM for adults with stroke and spinal cord injury. Strong evidence from a high quality randomized study, and other lower quality studies, also support the benefit of supported standing on activity outcomes such as standing symmetry and ability to maintain a stable standing position for the sub-acute and chronic stroke population. Strong evidence also supports the addition of task-specific training to tilt-table standing for improvement in gait, functional activity and muscle strength in the sub-acute stroke population. Evidence for other outcomes is weak or very weak. Dosage data suggests that use of a standing device should occur for 30 min 5 times a week for positive impact on most outcomes such as self-care and standing balance, ROM, cardio-respiratory, strength, spasticity, pain, skin and bladder and bowel function while 60 min 4–6 times a week may be required for positive impact on bone mineral density (BMD) and mental function.

In a systematic review, Glickman et al. (2010) investigated the available evidence underlying supported standing use for individuals of all ages, with a neuromuscular diagnosis, based on the Center for Evidence-Based Medicine (CEBM) Levels of Evidence framework. Of 112 unique studies, 39 met the inclusion criteria, 29 with adult and 10 with pediatric participants. In each group of studies were user and therapist survey responses in addition to results of clinical interventions. The data were moderately strong for the use of supported standing for BMD increase, showed some support for decreasing hypertonicity (including spasticity) and improving ROM, and were inconclusive for other benefits of using supported standers for children and adults with neuromuscular disorders. The addition of whole body vibration (WBV) to supported standing activities appeared a promising trend but empirical data were inconclusive. The survey data from physical therapists (PTs) and participant users attributed numerous improved outcomes to supported standing: ROM, bowel/bladder, psychological, hypertonicity and pressure relief/bedsores. BMD was not a reported benefit according to the user group. The authors recommend empirical mechanistic evidence to guide clinical supported standing programs across practice settings and with various-aged participants, particularly when considering a life-span approach to practice.

In a one-group quasi-experimental study, Gibson et al. (2009) studied whether static weight-bearing in a standing frame affected hamstring length and ease of activities of daily living (ADLs) in non-ambulant children with CP. Five children were recruited (age range 6-9 years, mean age 7 years 2 months, SD 1 year 4 months). Participants stood in a standing frame for 1 hour, 5 days per week, for 6 weeks, followed by 6 weeks of not using a standing frame; each phase was repeated. Popliteal angle measurements were made at baseline and weekly throughout the study period. High compliance with the standing regime was achieved (85% of intended sessions completed). Repeated-measures analysis of variance and t-tests showed hamstrings significantly lengthened during standing phases (mean improvement 18.1 degrees, SD 5.5, $P < 0.01$ for first standing phase; mean improvement 12.1 degrees, SD 7.7, $P = 0.03$ for second standing phase). A trend for hamstrings to shorten during nonstanding phases was observed (mean change -14.0 degrees, SD 4.2, $P = 0.02$ for first nonstanding phase; mean change -7.3 degrees, SD 6.5, $P = 0.20$ for second nonstanding phase). Preliminary evidence that 6 weeks of standing frame use leads to significant improvements in hamstring length in non-ambulant children with CP, and may increase ease of performance of ADLs was found.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Gait trainers are classified as Class I devices in product category INN and are exempt from 510(k) marketing requirements.

Standing systems may be classified in product categories ION (exerciser, non-measuring), INW (table, mechanical) and IPL (stand-up wheelchair). Devices in product categories ION and INW are Class I devices and are exempt from 510(k) marketing requirements. For additional information on product category IPL, refer to the following website: <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>. Accessed February 9, 2022.

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Paleg GS, Smith BA, Glickman LB. Systematic review and evidence-based clinical recommendations for dosing of pediatric supported standing programs. *Pediatr Phys Ther*. 2013 Fall;25(3):232-47.

Policy History/Revision Information

| Date | Summary of Changes |
|------------|--|
| 11/01/2022 | <p>Title Change</p> <ul style="list-style-type: none"> Previously titled <i>Pediatric Gait Trainers, Standing Systems and Walkers</i> <p>Template Update</p> <ul style="list-style-type: none"> Changed policy type classification from “Coverage Determination Guideline” to “Medical Policy” <p>Coverage Rationale</p> <ul style="list-style-type: none"> Removed coverage guidelines for walkers; refer to the Medical Policy titled <i>Walkers</i> <p><i>Pediatric Gait Trainers</i></p> <ul style="list-style-type: none"> Revised coverage criteria for Gait Trainers for Functional Ambulation; replaced criterion requiring “the individual uses the <i>pediatric</i> gait trainer when documentation shows assistive devices have not been effective” with “the individual uses the gait trainer when documentation shows assistive devices have not been effective” <p><i>Standing Systems</i></p> <ul style="list-style-type: none"> Removed language indicating powered standing systems, standers attached to a wheelchair, or electric lift mechanisms are not medically necessary because they are a convenience feature; refer to the <i>Benefit Considerations</i> section of the policy <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>Benefit Considerations, Clinical Evidence, FDA, and References</i> sections to reflect the most current information Archived previous policy version CDG.038.03 |

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual[®] criteria, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.