BlueCross BlueShield of North Carolina

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Corporate Medical Policy

Patient Lifts

File Name:	patient_lifts
Origination:	6/2002
Last CAP Review:	9/2018
Next CAP Review:	9/2019
Last Review:	9/2018

Description of Procedure or Service

I. Patient Lifts

Patient lifts are assistive devices that enable the movement, transfer, and positioning of an immobilized patient to and from a sitting and/or lying position. The Hoyer lift is a manual device that uses hydraulics. The Saralift is motorized (electric) and portable.

II. Seat Lift Chair Mechanisms

A seat lift chair is a chair with a motorized seat mechanism which enables it to lift the body from a sitting to a standing position. The seat can also lower the body from a standing position to a sitting position. It is an assistive device for patients who are able to ambulate once they are in a standing position.

III. Ceiling Lifts

A ceiling lift is a device that incorporates a lift or walking sling that is mounted in tracks that are installed into the ceiling to allow for the transfer of a patient.

Related policies:
Durable Medical Equipment (DME)

******Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.***

Policy

BCBSNC will provide coverage for Hydraulic Patient Lifts when it is determined to be medically necessary because the medical criteria and guidelines shown below are met.

BCBSNC does not provide coverage for Electric Patient Lifts (e.g., Saralift). They are considered convenience items and therefore not covered.

Benefits Application

This medical policy relates only to the services or supplies described herein. Devices and equipment used for environmental accommodation such as, but not limited to, chair lifts, stair lifts, home elevators, standing frames, and ramps are specifically excluded under most health benefit plans. Durable medical equipment that serves no medical purpose or that is primarily for comfort or convenience is also excluded under most health benefit plans.

Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

See Other Services for Durable Medical Equipment. DME Suppliers must meet eligibility and/or credentialing requirements as defined by the Plan in order to be eligible for reimbursement.

Member eligibility requirements and any prior approval or preauthorization necessary for the rental/purchase of equipment should be verified.

DME benefits for rental versus purchase will be determined on an individual consideration basis. Refer to DME policy.

When Patient Lifts are covered

1. Hydraulic patient lifts may be considered medically necessary for disabled patients who meet the following criteria:

   a. When transfers cannot be performed independently and require the assistance of more than one person; **And**

   b. When the patient would be bed confined without the use of a lift; **And**

   c. When the patient's condition is such that periodic movement is necessary to improve the patient's medical condition or to arrest or retard deterioration of their condition.

2. Repair, adjustment, or replacement of parts and accessories necessary for the normal and effective functioning of the patient lift equipment is covered when the above criteria are met.

When Patient Lifts are not covered

1. When all the above criteria are not met.
2. For convenience of the caregiver(s).
3. For electrical or mechanical features which enhance basic equipment and which usually serve a convenience function.
4. When the patient resides in a facility or setting that would typically provide such equipment.

Policy Guidelines

The medical necessity of a patient lift is based on an analysis of the patient's needs and capabilities in relation to the following components of the definition of medical necessity:

- The lift is clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; **And**
- The lift is not primarily for the convenience of the patient, caregiver, physician or other healthcare provider; **And**
- The lift represents the least costly alternative that meets the patient's needs.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Note: This list of codes may not be all-inclusive.

Patient Lifts

Please refer to the member's benefit booklet for coverage information. Some plans may provide no benefits. If coverage is available for the specific item under the plan, the following are covered when medically necessary:

Applicable service codes:
E0621, E0630, E0640, E0641 E0642, E1035, E1036, E0172, E0625, E0627, E0629, E0635, E0636, E0637, E0638, E0639

An order for the patient lifts which is signed and dated by the ordering physician must be kept on file by the supplier.

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

Region D DMERC Supplier Manual. Chapter 9, PTLT-1, Published 8/1993, Reprinted 1/2001.

Medicare Coverage Issues Manual 60 - 9.

Specialty Matched Consultant Advisory Panel - 4/2003

Region C DMERC Policy Manual. Local Coverage Decision (LCD) L11562. Original determination effective 10/1993. Revision effective 01/01/2005.

Specialty Matched Consultant Advisory Panel review 12/2010.

Specialty Matched Consultant Advisory Panel review 9/2011

Specialty Matched Consultant Advisory Panel review 9/2012

Specialty Matched Consultant Advisory Panel review 9/2013

Specialty Matched Consultant Advisory Panel review 9/2014

Specialty Matched Consultant Advisory Panel review 9/2015

Medical Director review 9/2015

The Centers for Medicare and Medicaid, Local Coverage Determination LCD L33799 Patient Lifts, effective date 7/1/16, reviewed on August 23, 2016 from https://www.cms.gov/medicare-coverage-database

Specialty Matched Consultant Advisory Panel review 9/2016

Medical Director review 9/2016

The Centers for Medicare and Medicaid, Local Coverage Determination LCD L33799 Patient Lifts, effective date 1/1/17, reviewed on September 6, 2017 from https://www.cms.gov/medicare-coverage-database

Specialty Matched Consultant Advisory Panel review 9/2017

Medical Director review 9/2017

Specialty Matched Consultant Advisory Panel review 9/2018

Medical Director review 9/2018

Policy Implementation/Update Information

6/2002 Original policy issued.

5/03 Specialty Matched Consultant Advisory Panel review. No change to policy. Reaffirm.

5/04 Benefits Application and Billing/Coding sections updated for consistency.

1/6/05 First Quarter 2005 HCPCS codes E0639 and E0640 added to the Billing/Coding section of policy.

4/7/05 Specialty Matched Consultant Advisory Panel [MPAG] review on 3/10/2005. No changes made to policy criteria. MPOC review and discussion on 2/14/05. Description section broadened to clarify different types of lift devices. Policy section rewritten to include that BCBSNC does not provide coverage for Electric Patient Lifts, Seat Lift Mechanisms or Ceiling Lifts because they are considered convenience items and therefore not medically necessary. When Patient Lifts are Covered section revised to indicate that repair, adjustment, or replacement of parts and accessories necessary for the normal and effective functioning of the patient lift equipment is covered if all the above criteria is met. When Patient Lifts are Not Covered section revised to clarify noncoverage for: 1) equipment that serves as a comfort or convenience item, 2) electrical or mechanical features which enhance basic equipment which usually serve a convenience function, or 3) repair, adjustment, or replacement of parts and accessories for Seat Lift Mechanisms or Ceiling Lifts. Also included for noncoverage are Stairglides, Van Lifts, and Wheel-O-Vators. Billing/Coding section updated to include E codes: E0621, E0625, E0627, E0628, E0629, E0636, E0637, and E0638. Medical terms expanded to include Hydraulic lifts, Ceiling lifts, Seat Lift Mechanism, Electric lift, DME0215. Reference added. Notification 4/7/2005. Effective 6/16/2005.

4/9/07 Routine biennial review. Statements regarding physicians' orders was moved from the Policy Guidelines section to the Billing/Coding/Physician Documentation section. Statement regarding patients residing in facilities or settings that typically provide patient lift equipment moved from Policy Guidelines section to the Not Covered section. The following information was added to the Policy Guidelines section: "The medical necessity of a patient lift is based on an analysis of the patient's needs and capabilities in relation to the following components of the definition of medical necessity: The lift is clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and the lift is not primarily for the convenience of the patient, caregiver, physician or other healthcare provider; and the lift represents the least costly alternative that meets the patient's needs." Specialty Matched Consultant Advisory Panel review meeting 3/15/07. (adn)

8/27/07 HCPCS Codes E0641 and E0642 added to Billing/Coding section. (adn)

7/28/08 Guidelines in the When Covered and When Not Covered sections reformatted into numbered lists. Specialty Matched Consultant Advisory Panel review meeting 6/19/08. No change to policy statement. (adn)

6/22/10 Policy Number(s) removed (amw)

3/1/11 Specialty Matched Consultant Advisory Panel review meeting 12/16/2010. No change to policy statement. (lpr).

10/11/11 Specialty Matched Consultant Advisory Panel review 9/28/2011. Under "Benefits Application" section added: "Devices and equipment used for environmental accommodation such as, but not limited to, chair lifts, stair lifts, home elevators, standing frames, and ramps are specifically excluded under most health benefit plans." Also added "Durable medical equipment that serves no medical purpose or that is primarily for comfort or convenience is also excluded under most health benefit plans." Removed references to items excluded by benefit under "Policy and When Not Covered". (lpr)

11/13/12 Specialty Matched Consultant Advisory Panel review 9/21/12. No change to policy statement. (lpr)

10/15/13 Specialty matched consultant advisory panel review 9/18/2013. (lpr)

10/14/14 Specialty matched consultant advisory panel review 9/2014. No change to policy statement. (lpr)

10/30/15 Billing/Coding section updated to add codes: E1035, E1036, and E0172 and codes reformatted for clarity. References updated. Specialty Matched Consultant Advisory Panel review 9/30/2015. Medical Director review 9/2015. Policy noticed October 30, 2015 for effective date December 30, 2015. (td)

10/25/16 References updated. Specialty Matched Consultant Advisory Panel review 9/2016. Medical Director review 9/2016 (jd)

12/30/16 Updated code section, removed E0628 as it is deleted effective 1/1/17. (jd)

10/13/17 References updated. Specialty Matched Consultant Advisory Panel review 9/2017. Medical Director review 9/2017. (jd)

10/12/18 Specialty Matched Consultant Advisory Panel review 9/2018. Medical Director review 9/2018. (jd)