Anthem

# Clinical UM Guideline

**Subject:** Lifting Devices for Use in the Home
**Guideline #:** CG-DME-23
**Status:** Reviewed
**Publish Date:** 09/27/2023
**Last Review Date:** 08/10/2023

## Description

This document addresses lifting devices for use in the home, including a multi-positional transfer system to assist a caregiver(s) in transferring an individual to and from a bed to a chair (or other locations) when the individual is unable to assist with the transfer.

**Note:** Please see the following related documents for additional information:

- CG-DME-10 Durable Medical Equipment
- CG-DME-25 Seat Lift Mechanisms

## Clinical Indications

**Medically Necessary:**

A. A hydraulic or mechanical lift is considered **medically necessary** for an individual when **all** of the following criteria are met:
   1. When it is used for the transfer of the individual between a bed and a chair, wheelchair, commode, or shower/bath chair; **and**
   2. When transfers cannot be performed independently and require the assistance of more than one person; **and**
   3. When the individual would be bed confined without the use of a lift; **and**
   4. When the individual's condition is such that periodic movement is necessary to improve his/her condition or to arrest or retard deterioration of their condition.

B. A canvas or nylon sling or seat for a hydraulic or mechanical lift is considered **medically necessary** as an accessory when ordered as a replacement for the original equipment item and the criteria listed above are met.

C. A multi-positional transfer system is considered **medically necessary** in lieu of any of the following mobility assistive equipment, including but not limited to canes, crutches, walkers, rollabout chairs, transfer chairs, manual wheelchairs, power-operated vehicles, or power wheelchairs, when **both** of the following criteria are met:
   1. The criteria for a hydraulic or mechanical lift are met; **and**
   2. The individual requires supine positioning for transfers.

**Not Medically Necessary:**

A. A hydraulic or mechanical lift or multi-positional transfer system is considered **not medically necessary** when the criteria listed above are not met.

B. An electric lift mechanism is considered **not medically necessary.**

## Coding

*The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.*

**When services may be Medically Necessary or Reconstructive when criteria are met:**

| **HCPCS** | |
|---|---|
| E0621 | Sling or seat, patient lift, canvas or nylon |
| E0625 | Patient lift, bathroom or toilet, not otherwise classified |
| E0630 | Patient lift; hydraulic or mechanical, includes any seat, sling strap(s) or pad(s) |
| E0636 | Multipositional patient support system, with integrated lift, patient accessible controls |
| E0637 | Combination sit to stand frame/table system, any size including pediatric, with seat lift feature, with or without wheels [when used as a lift or transfer system] |
| E0639 | Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories |
| E0640 | Patient lift, fixed system, includes all components/accessories |
| E1035 | Multi-positional patient transfer system, with integrated seat, operated by care giver, patient weight capacity up to and including 300 lbs |
| E1036 | Multi-positional patient transfer system, extra-wide, with integrated seat, operated by care giver, patient weight capacity greater than 300 lbs |

| **ICD-10 Diagnosis** | |
|---|---|
| | All diagnoses |

**When services are Not Medically Necessary:**
For the procedure codes listed above when criteria are not met or for situations designated in the Clinical Indications section as not medically necessary.

**When services are also Not Medically Necessary:**
For the following procedure codes; or when the code describes a procedure designated in the Clinical Indications section as not medically necessary.

| **HCPCS** | |
|---|---|
| E0635 | Patient lift; electric, with seat or sling |

**ICD-10 Diagnosis**

All diagnoses

## Discussion/General Information

A lift device is used within the home or place of residence to assist the caregiver(s) in transferring an individual between a bed and a chair, wheelchair, commode, or shower/bath chair and back when the individual is unable to assist with the transfer. A multi-positional transfer system is used to assist the caregiver(s) in transferring an individual who requires the use of a lift along with supine positioning for transfer. Multi-positional transfer systems (for example, AryCare Home1000 Patient Lifts, AryLift, Inc., Shallotte, NC; Barton™ Medical *Convertible*® H-250 Chair Solutions I-400, I-700 & I-1000, Barton Positioning and Transfer System (PTS™), Barton™ Medical Corporation, Austin TX) are intended to facilitate an independent and safe transfer for the caregiver and individuals that have medical conditions that precludes the use of a standard transfer device (that is, a hydraulic or mechanical lift).

The medical necessity of a lift for use in the home setting is based on an evaluation of the individual's needs and capabilities in relation to the following components of the definition of medical necessity:

1. Provides therapeutic benefits or enables the individual to perform certain tasks that he or she is unable to undertake otherwise due to certain medical conditions or illnesses; and
2. Can withstand repeated use; and
3. Is primarily and customarily used to serve a medical purpose; and
4. Generally is not useful to a person in the absence of an illness or injury.

Clinical documentation should include the details of the individual's condition and clearly support the need for the lift device.

An electric lift mechanism is considered not medically necessary as an alternative lift mechanism, as a hydraulic or mechanical lift or multi-positional transfer system is at least as likely to produce equivalent therapeutic results for the treatment of an individual's illness, injury, or disease.

The following types of lifts and accessories are considered self-help or convenience items and do not meet the definition of durable medical equipment:

- van or car lifts (used to lift wheelchair into a truck or van);
- wheelchair lifts or ramps (for example, Wheel-O-Vator lift, National Wheel-O-Vator Co., Inc., Roanoke, IL [ThyssenKrupp Access, Grandview, MO]) (provides vertical lift access to stairways or platform ramps for cars/ trunks);
- ceiling lifts, platform lifts, porch lifts, stair lifts, stairway elevators, and other lifts (electric/motorized or non-motorized), addressing accessibility limitations of a home;
- home modifications associated with installation of a lift or access within a home.

## References

**Government Agency, Medical Society, and Other Authoritative Publications:**


1. Centers for Medicare and Medicaid Services (CMS). National Coverage Determination for Durable Medical Equipment Reference List. NCD #280.1. Effective May 5, 2005. Available at: http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Accessed on July 10, 2023.


## Index

AryCare Patient Lifts
Barton *Convertible* H-250 Chair
Hoyer Lift
Lift-Aid Chamber Lift
Multi-positional Transfer System
Trans-Aid Lift

**The use of specific product names is illustrative only. It is not intended to be a ecommendation of one product over another, and is not intended to represent a complete listing of all products available.**

## History

| Status | Date | Action |
|---|---|---|
| Reviewed | 08/10/2023 | Medical Policy & Technology Assessment Committee (MPTAC) review. Updated References section. |
| Reviewed | 08/11/2022 | MPTAC review. Updated References section. |
| Reviewed | 08/12/2021 | MPTAC review. Updated References section. |
| Reviewed | 08/13/2020 | MPTAC review. Updated Discussion and References sections. Reformatted Coding section. |
| Reviewed | 08/22/2019 | MPTAC review. Updated References section. |
| Reviewed | 09/13/2018 | MPTAC review. Updated References section. |
| Reviewed | 11/02/2017 | MPTAC review. The document header wording updated from "Current Effective Date" to "Publish Date." Updated Discussion, References, and Index sections. |
| Reviewed | 11/03/2016 | MPTAC review. Updated formatting in Clinical Indications section. Updated References section. |
| Reviewed | 11/05/2015 | MPTAC review. Updated Discussion and References sections. Removed ICD-9 codes from Coding section. |
| Revised | 11/13/2014 | MPTAC review. Clarifications to the medically necessary and not medically necessary statements. Updated Description, Discussion, and References sections. |
| Reviewed | 11/14/2013 | MPTAC review. Minor format changes to Discussion and Coding sections. Updated Reference section. |
| Reviewed | 11/08/2012 | MPTAC review. Updated Discussion, Coding, and References. |
| Reviewed | 11/17/2011 | MPTAC review. Updated Discussion and References. |

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| Reviewed | 11/18/2010 | MPTAC review. Revised title: Lifting Devices for Use in the Home. Updated references. |
| Reviewed | 11/19/2009 | MPTAC review. Clarified Clinical Indication for lifts, adding “mechanical” to hydraulic lift statements. Removed Place of Service and Case Management sections, addressing in the Discussion section. Further updates to Discussion and References sections. Updated Coding section to include 01/01/2010 HCPCS changes. |
| Revised | 11/20/2008 | MPTAC review. Addition of a medically necessary criteria and not medically necessary indications for a multi-positional transfer system. Description, Case Management, Discussion, References, Coding and Index updated. |
| Reviewed | 11/29/2007 | MPTAC review. Clinical Indications, not medically necessary statement clarified. References and Index updated. Updated Coding section with 01/01/2008 HCPCS changes. |
| Reviewed | 12/07/2006 | MPTAC review. References updated. |
| New | 12/01/2005 | MPTAC initial document development. |

| Pre-Merger Organizations | Last Review Date | Document Number | Title |
|---|---|---|---|
| Anthem, Inc. | | | No Document |
| Anthem CO/NV | 10/29/2004 | DME.210 | Patient Lifts |
| Anthem CT | 10/01/2004 | DME Coverage Criteria Document, Section E | Patient Lifts and Accessories |
| WellPoint Health Networks, Inc. | | | No Document |

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