



## PROVIDER POLICIES & PROCEDURES

### PATIENT LIFT SYSTEMS

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for patient lift systems. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

A patient lift is used to safely transfer an individual with physical limitations between bed, chair, wheelchair, commode, or shower/ bath chair and back, using electric, mechanical, or hydraulic power. Types of lift systems include a mobile floor lift, a sit-to-stand lift, a fixed overhead lift suspended from a ceiling mount or overhead track, and a portable lift suspended from overhead or wall track in which the motor is detaching and reattached between the various tracks. Patient lifts, incorporate a postural component for the person being lifted; i.e., straps, vests, slings, belts, body cradle. A patient lift with a sling and/ or other seated postural component is generally used for persons whose mobility is limited, who is unable to transfer independently using other durable medical equipment, transfer strategies, or assistance from a caretaker. A sit-to-stand lift is used for persons with some mobility but who lack strength or muscle control to rise to a standing position from a bed, wheeled mobility device, chair, or commode. These lifts use straps, vests, or belts to make this transition possible.

### CLINICAL GUIDELINE

Coverage guidelines for patient lift systems are made in accordance with the Department of Social Services (DSS) definition of Medical Necessity. The following criteria are guidelines only. Coverage determinations are based on an assessment of the individual and his or her unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

A patient lift may be medically necessary when the individual is unable to transfer with the assistance of one person, including being unable to use an assistive device or utilize non-mechanical methods. The specific type of lift requires a comprehensive analysis of the person's physical capacities and limitations, current transfer methods, safety issues, caretaker support, and environmental factors.

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**Hydraulic or mechanical patient lifts** are typically considered medically necessary or individuals with physical disabilities who meet the following criteria:

1. When transfers cannot be performed independently and require the assistance of more than one person and when the individual cannot be safely transferred without a mechanical lift due to the person's medical condition or caretaker limitations; and
2. When the individual would be bed confined without the use of a lift; and
3. When there is evidence that the equipment fits in areas/ rooms where it will be used.

**Other types of patient lifts** are typically considered medically necessary for individuals with physical disabilities when:

1. The above criteria are met; and
2. A hydraulic mechanical lift is proven ineffective for the individual's safety and medical condition; and
3. Other transfer methods have been demonstrated to be unsafe or not possible.

Requests for patient lifts not meeting the above criteria may be considered medically necessary based on an assessment of the individual and his or her unique clinical needs.

The following items typically do not meet the definition of durable medical equipment since they are not primarily medical in nature. However, these items may be considered medically necessary based on an assessment of the individual and his or her unique clinical needs

1. Van or car lifts (used to lift wheelchair into a vehicle).
2. Wheelchair lifts, platform lifts, porch lifts, elevators, or ramps addressing accessibility barriers.
3. Home modifications associated with installation of a lift or access within a home.

**Repairs, adjustments, or replacement of parts and accessories necessary for the normal and effective functioning of the patient lift equipment** are typically covered when the above criteria are met. Repairs, adjustments and replacement of parts and accessories not meeting the above criteria may be considered medically necessary based on an assessment of the individual and his or her unique needs.

NOTE: EPSDT Special Provision:

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set

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forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

## **PROCEDURE**

Prior authorization of patient lifts is required. Requests for coverage will be reviewed in accordance with procedures in place for reviewing requests for durable medical equipment. Coverage determinations will be based upon a review of requested and/ or submitted case-specific information.

### **Hydraulic/ Mechanical and Electric Patient Lifts (E0630, E0635)**

#### **Initial Authorization Requests**

A hydraulic or mechanical patient lift and an electric patient lift are generally rented before a purchase and require a prior authorization. These lifts are usually rented for 1 to 3 months.

The following information is needed to review requests for the rental of a hydraulic or mechanical patient lift or an electric patient lift:

1. Fully completed Outpatient Prior Authorization Request Form or fully completed authorization request via on-line web portal;
2. A prescription written within the past three (3) months from a licensed physician (MD or DO), Advanced Practice Registered Nurse (APRN), or Physician's Assistant (PA) enrolled in the Connecticut Medical Assistance Program (CMAP);
3. A signed letter of medical necessity describing the individual's medical condition as it relates to the need for a specific patient lift system. The information should typically include:
  - a. individual's height and weight;
  - b. medical evaluation by the individual's physician, which may be either a specific evaluation for a patient lift, signed discharge orders from a hospital or nursing facility, or other evaluation, such as the most recent history and physical examination and subsequent progress notes;
  - c. anticipated length of time that the individual will need a patient lift; and
  - d. List of all current durable medical equipment; i.e., wheeled mobility device, stander, walker, hygiene equipment, orthotics, and prosthetics; including manufacturer, model number (when available), and special features; date of purchase, and individuals ability to independently utilize.

#### **Re-authorization Requests**

Reauthorization beyond the initial rental period is required. The rental period of a hydraulic or mechanical patient lift and an electric patient lift are used to evaluate the effectiveness of the specific

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patient lift for the individual. This information obtained during the rental period is used to determine if a patient lift is needed beyond the rental period, if the type of lift used during the rental period is appropriate, or if a different type of patient lift is needed.

The following information is needed to review requests for the reauthorization of a hydraulic, mechanical or electric patient lift:

1. Fully completed Outpatient Prior Authorization Request Form or fully completed authorization request via on-line web portal; including updated documents used for the initial authorization request if the individual's medical condition and anticipated length of need has changed;
2. Documentation describing a home evaluation with recommendations from a Connecticut licensed occupational therapist, physical therapist, or registered nurse, performed within three (3) months prior to submission of the prior authorization request, which meets the criteria in the above Clinical Guideline. The clinical documentation should include the following:
  - a. Individual's medical condition and functional status that requires the specific kind of lift requested;
  - b. Description of this person's ambulation, mobility, and transfer method(s), including independence, safety, amount and type of assistance from others, and reason this method does not meet the recipient's needs; such as postural/ motor control, muscle strength, tone, coordination/ balance, range of motion, cardiopulmonary status;
  - c. Individual's weight and height, and general strength/ health and age of primary caretaker;
  - d. Description of type and amount of caretaker support;
  - e. Other functional strategies or DME evaluated or considered and reason for ineffectiveness;
  - f. List of all current durable medical equipment; i.e., wheeled mobility device, stander, walker, hygiene equipment, orthotics, and prosthetics; including manufacturer, model, and special features; date of purchase, and individual's ability to independently utilize;
  - g. Documented evidence that the requested patient lift addresses the individual's current medical condition and associated functional needs, plans for anticipated medical change; and
  - h. If the provider is requesting authorization for an electric lift after rental of a hydraulic or mechanical lift, documentation regarding why the hydraulic or mechanical lift did not meet the individual's needs. In these instances the electric lift is typically rented prior to purchase.
3. A detailed product description including manufacturer, model/ part number, product description, HCPC code, unit(s), and Medicaid allowable (purchase only).

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## **Bathroom and Other Patient Lifts (E0625, E0636, E0639, E0640, E1035, E1036)**

When a hydraulic or mechanical patient lift or an electric patient lift is found not to address the individual's medical needs, a different type of lift may be needed.

### **The following information is needed to review requests for bathroom and other patient lifts:**

1. Fully completed Outpatient Prior Authorization Request Form or fully completed authorization request via on-line web portal;
2. A prescription from a licensed practitioner enrolled in the Connecticut Medical Assistance Program (CMAP);
3. A signed letter of medical necessity describing the individual's medical condition as it relates to the need for a specific patient lift system, including the following:
  - a. Individual's height and weight;
  - b. Medical evaluation by the individual's primary care provider, which may be either a specific evaluation for a patient lift, signed discharge orders from a hospital or nursing facility, or other evaluation, such as the most recent history and physical examination and subsequent progress notes; and
  - c. Anticipated length of time that the individual will need a patient lift.
4. A home evaluation with recommendations from a Connecticut licensed occupational therapist, physical therapist, or registered nurse, performed within the three (3) months prior to the submission of the prior authorization request, which meets the criteria in the above Clinical Guideline. The clinical documentation should include the following:
  - a. Individual's medical condition and functional status that requires the specific kind of lift requested;
  - b. Description of this person's ambulation, mobility, and transfer method(s), including independence, safety, amount and type of assistance from others, and reason this method does not meet the recipient's needs; such as postural/ motor control, muscle strength, tone, coordination/ balance, range of motion, cardiopulmonary status;
  - c. General strength/ health and age of primary caretaker;
  - d. Description of type and amount of caretaker support;
  - e. Other functional strategies or DME evaluated or considered and reason for ineffectiveness;
  - f. List of all current durable medical equipment; i.e., current patient lift, wheeled mobility device, stander, walker, hygiene equipment, orthotics, and prosthetics; including manufacturer, model (when available), and special features; date of purchase, and the individual's ability independently utilize;
  - g. Documented evidence of a comparative evaluation of various patient lifts that explains the rationale for the requested patient lifts to address the individual's

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- current medical condition and associated functional needs, plans for anticipated medical change;
  - h. Documented evidence, in the presence and collaboration with the individual's caretaker and evaluating health care clinician, of satisfactory use of the recommended lift and specific sling or other type of body support, including safety, comfort, and function;
  - i. Description of how a patient lift is currently used or will be used in essential areas within the home that address the person's medical needs such transfers between the wheeled mobility device, bed, and/ or hygiene location;
  - j. Documented anticipated changes in the individual's environment;
  - k. Documentation that the lift will fit in all identified essential areas of the home for activities of daily living;
  - l. Documentation regarding the less costly alternatives considered and why they were rejected; and
  - m. For prior authorization for a ceiling or wall mounted lifts, a schematic drawing by the evaluating DME Provider for the pathway of the patient lift; written permission from the individual's landlord is required, if applicable.
5. A detailed product description including manufacturer, model/ part number, product description, HCPC code, unit(s), and Medicaid allowable price, and proof of manufacturer's suggested retail price (purchase only).

**Sling or Seat, Patient Lift, Canvas or Nylon (E0621)**

Slings and seats for patient lifts have a quantity limit of two (2) per year.

**Note:** An updated evaluation may be requested by Community Health Network if it is determined that the person's medical condition or typical activities of daily tasks have changed since receiving the current patient lift.

**EFFECTIVE DATE**

This policy is effective for prior authorization requests for patient lift systems for individuals covered under the HUSKY Health Program beginning April 1, 2015.

**LIMITATIONS**

N/A

**CODES**

Code	Description
E0621	Sling or seat, patient lift, canvas or nylon

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E0625	Patient lift, bathroom or toilet, not otherwise classified
E0630	Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s) or pad(s)
E0635	Patient lift, electric with seat or sling
E0636	Multi-positional patient support system, with integrated lift, patient accessible controls
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 caregiver, patient weight capacity greater than 300 lbs.

## DEFINITIONS

1. **Medically Necessary or Medical Necessity:** (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition
2. **Prior Authorization:** A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary

## ADDITIONAL RESOURCES AND REFERENCES:

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- Medicare National Coverage Determinations Manual, Centers for Medicare and Medicaid Services (CMS), Publication 100-03, Chapter 1, Part 4, Section 280.1. [www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1\\_part4.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_part4.pdf) .
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## PUBLICATION HISTORY

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Original Publication	March 2015	Approved by DSS on March 13, 2015
Reviewed	March 2015	Approved at the March 16, 2015 Clinical Quality Subcommittee Meeting.
Updated	March 2016	Updates to language in introductory paragraph pertaining to purpose of policy. Updates to Clinical Guideline and Information Required for Review sections pertaining to definition of Medical Necessity and documentation requirements. Updates throughout policy to reflect importance of person-centeredness when reviewing requests for these items. Changes to section titled <u>"Sling or Seat, Patient Lift, Canvas or Nylon (E0621)"</u> . All changes approved by Clinical Quality Subcommittee on April 12, 2016. Changes approved by DSS on April 21, 2016.
Updated	November 2016	Format changes to Clinical Guideline section. Changes approved at the Medical Policy Review Meeting on October 26, 2016. Changes approved at the December 20, 2016 Clinical Quality Subcommittee meeting. Approved by DSS on January 3, 2017.

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