Medical Policy

Blue Care Network of Michigan

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BCN Policy Effective Date: 3/17/25
(See policy history boxes for previous effective dates)

Title: Patient Lifts (Hoyer Lift, Electric Lift)

Description/Background

A patient lift is an assistive device that enables the movement, transfer, and positioning of an immobilized patient to and from a sitting and/or lying position. . A seat or sling is placed under the patient who is then hydraulically or electrically lifted out of the bed or chair. Lifts may be portable or fixed. 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.

Medical Policy Statement

The safety and effectiveness of specified patient lifts have been established. They may be useful therapeutic options when indicated.

Inclusionary and Exclusionary Guidelines

Inclusions:

- A patient lift is covered if transfer between bed and a chair, wheelchair or commode is required **and**
  - Cannot be performed independently and require the assistance of more than one person, **and**
  - When the patient would be bed confined without the use of a lift; **and**
  - 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.
- Hydraulic and electric patient lifts described by codes E0630, E0635, E0639 or E0640 are covered if the basic coverage criteria are met. If the coverage criteria are not met, the lift will be denied as not medically necessary.

- A multi-positional patient support/transfer system (E0636, E1035, E1036) is covered if both of the following criteria (1 and 2) are met:
  1. The basic coverage criteria for a lift are met; and
  2. The patient requires supine positioning for transfers.

  If criterion 1 is not met, codes E0636, E1035 and E1036 will be denied as not medically necessary. If criterion 1 is met but criterion 2 is not met, the least costly medically appropriate alternative, E0630, will be covered.

If coverage is provided for code E1035 or E1036, payment will be discontinued for any other mobility assistive equipment, including but not limited to: canes, crutches, walkers, rollabout chairs, transfer chairs, manual wheelchairs, power-operated vehicles or power wheelchairs. Code E0621 is covered as an accessory when ordered as a replacement for a covered patient lift.

Code E0640 describes a device in which the lift mechanism is attached to permanent ceiling tracks or a wall mounting system and which is used in a room other than the bathroom. The lift/transport mechanisms may be mechanical or electric. No separate payment is made for installation. All costs associated with installation are included in the payment for the device.

Exclusions:
- Patient lifts incorporated into motor vehicles or bathroom facilities are considered home and motor vehicle modifications and are not considered durable medical equipment
- Equipment that duplicates the function of existing home equipment is considered not medically necessary
- "Standing frame" systems
- *Installation* costs of ceiling or wall mounted patient lift systems
- Equipment that serves as a comfort or convenience item (e.g., Stair glides, van lifts and Wheel-O-Vators) are considered convenience items and are not covered

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CPT/HCPCS Level II Codes (*Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure)*

Established codes:

E0621 E0630 E0635 E0639 E0640 E1035 E1036

Other codes (investigational, not medically necessary, not a benefit, etc.):

E0625 E0636 E0637 E0638 E0641 E0642

Rationale

Standard and hydraulic patient lifts are helpful in moving bed-bound patients from a bed to a chair and vice-versa. This aids in preventing bedsores and helps the caregiver assist the patient in moving.

Government Regulations
National:
No national coverage determination (NCD) on this topic.

Local:
National Government Services, Inc., LCD L33799 “Patient Lifts”
https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33799&ver=6&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=Michigan&KeyWord=patient+lift&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAACAAAAAAAA%3d%3d&. Effective on or after 01/01/2020

Indications and Limitations of Coverage and/or Medical Necessity
For any item to be covered by Medicare, it must:
- Be eligible for a defined Medicare benefit category
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
- Meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity.

For an item to be covered by Medicare, a written signed and dated order must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not medically necessary.
- A patient lift is covered if transfer between bed and a chair, wheelchair or commode is required and, without the use of a lift, the patient would be bed confined.
- A patient lift described by codes E0630, E0635, E0639 or E0640 is covered if the basic coverage criteria are met. If the coverage criteria are not met, the lift will be denied as not medically necessary.
- A multi-positional patient support/transfer system (E0636, E1035, E1036) is covered if both of the following criteria (1 and 2) are met:
  1. The basic coverage criteria for a lift are met; and
  2. The patient requires supine positioning for transfers

  If either criterion 1or 2 is not met, codes E0636, E1035 and E1036 will be denied as not medically necessary. If criterion 1 is met but criterion 2 is not met, payment will be made for the least costly medically appropriate alternative, E0630.

If coverage is provided for code E1035 or E1036, payment will be discontinued for any other mobility assistive equipment, including but not limited to: canes, crutches, walkers, rollabout chairs, transfer chairs, manual wheelchairs, power-operated vehicles or power wheelchairs.

Code E0621 is covered as an accessory when ordered as a replacement for a covered patient lift.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated

and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

N/A

References

1. National Government Services, Local Coverage Decision (LCD) for Patient Lifts, L33799, < https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33799&ver=6&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=Michigan&KeyWord=patient+lift&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAACAAAAAAAA%3d%3d& > (accessed February 2025).
2. National Government Services. Article for Patient Lifts (A52516). < https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52516&ver=5&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=Michigan&KeyWord=patient+lift&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAACAAAAAAAA%3d%3d&> (accessed February 2025).
3.

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through February 2025, the date the research was completed.

BCN Medical Policy History

Date	Rationale
5/13/91	BCN policy established
1/16/01	Policy maintenance
2/6/06	Policy updated
02/18/07	Routine maintenance
5/21/08	Routine maintenance
2/17/10	Clarified Medicaid coverage
2/18/11	CMS information updated, Clarified policy to reflect coverage for fixed or movable (with assembly and disassembly) patient lifts, excluding the cost of installation.
8/15/12	Routine review; remains consistent with Medicare.
2/19/14	Routine maintenance
4/15/15	Routine maintenance
4/20/16	Routine maintenance, updated CMS materials.
4/19/17	Routine maintenance.
3/21/18	Routine maintenance. No change in policy status.
3/20/19	Routine policy maintenance. No change in policy status.
3/12/20	Routine policy maintenance. No change in policy status.
3/11/21	Routine policy maintenance. No change in policy status.
3/10/22	Routine policy maintenance. No change in policy status.
3/9/23	Routine policy maintenance, no change in policy status. Removed “and preauthorization decisions” from Inclusion/Exclusion section.
3/14/24	Deleted Medicaid provider reference, routine policy maintenance, no change in status. Vendor managed: Northwood (ds)
3/17/25	Routine policy maintenance, no change in status. Vendor managed: Northwood (ds)

Next Review: 1st Qtr. 2026

MEDICAL POLICY TITLE: PATIENT LIFTS
BCN BENEFIT ADMINISTRATION

I. Coverage Determination

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered; criteria apply. Standing frames are not covered.
BCNA (Medicare Advantage)	See government section
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines

- The member's contract must be active at the time the service is rendered.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate benefits and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.
- Duplicate (back-up) equipment is not a covered benefit.