| KAISER PERMANENTE® Mid-Atlantic States | **Electric Patient Lift Medical Coverage Policy** |
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**Utilization *ALERT***

- Prior to use of this MCP for evaluation of medical necessity, benefit coverage MUST be verified in the member's EOC or benefit document.
- An electric patient lift is eligible for coverage based on availability of benefit and if the medical necessity criteria are met.
- Please refer to the member's benefit plan for availability and limitations of benefit.
- For Medicare members, please refer to CMS guidelines through Medicare Coverage Database requirements.
- Note: After searching the Medicare Coverage Database, if no NCD/LCD/LCA is found, then use the policy referenced above for coverage guidelines

**I.** Procedure or Service: **Electric Patient Lift**

**II.** Specialty: **Durable Medical Equipment**

**III. Referral**

A. **Clinical Indications**

A patient lift is medically necessary when ALL the following criteria are present:

1. An underlying condition that results in immobility (such as spinal cord disorder, paralysis, or neuromuscular disease).
2. Requires periodic movement to achieve improvement in condition or to arrest or retard the deterioration of condition;
3. Unable to independently ambulate or perform the needed transfer between bed and chair, wheelchair, commode, or shower/bath chair without the assistance of more than one person and without the use of a patient lift will be bed confined.
4. The intent for the lift is to transfer from one resting surface to another. The equipment is NOT meant to be a transport device.
5. Mental state:
   - ***a.*** Member is calm and if alert can understand and follow instructions while being lifted.
   - ***b.*** A member with disabilities who cannot cooperate, agitated, resistant, or combative while being lifted does not meet the required criteria as this can result in a fall, severe injury or death;
6. Capable to assume supine or medically appropriate position for safe transfer; *and*
7. Has one or more caregiver(s) who are capable of receiving education and training from a qualified medical professional on the proper operation of the equipment and safe handling of the patient.

## IV. Limitations/ Exclusions

### A. Limitations

1. A patient lift and related accessories such as sling, sling bar and type of clips, fasteners/latches or loop attachments for the sling bar are medically necessary and eligible for coverage when:
   a. Ordered by the reviewing or treating practitioner; and
   b. Appropriate, correctly sized, and specifically designed for the ordered lift based on patient's measurements, weight limit and manufacturer's equipment specification and recommendation;
   c. When ordered as a replacement for the original covered item due to reasonable wear and tear of equipment or accessory parts.
2. A patient lift is subject to review every *6 months* or if the member's underlying clinical condition changes to ensure it is still medically indicated and assure proper/safe operation of equipment.
3. Other types of lift equipment such as ceiling lifts, seat lift mechanisms, standing devices, bathroom or toilet patient lifts, platform lifts, stair gliders, stair lifts/stairway chairs, stairway elevators, van lifts, wheelchair lifts nor ramps are not addressed in this policy. Please refer to member's benefit for availability of coverage.

### B. Exclusions:

1. Electric lifts are not considered medically necessary unless the patient's documented (within the past 1 month) weight exceeds the current hydraulic lift weight capacity of the available lifts provided from KP-MAS contracted vendors.

**References**

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## Approval History

Effective June 01, 2016, state filing is no longer required per Maryland House Bill HB 798 – Health Insurance – Reporting

| Date approved by RUMC | Date of Implementation |
|---|---|
| 05/14/2020 | 05/14/2020 |
| 05/04/2021 | 05/04/2021 |
| 05/25/2022 | 05/25/2022 |
| 05/29/2023 | 05/29/2023 |
| 05/23/2024 | 05/23/2024 |

*The Regional Utilization Management Committee received delegated authority in 2011 to review and approve designated Utilization Management and Medical Coverage Policies by the Regional Quality Improvement Committee.

Note: Kaiser Permanente Mid-Atlantic States (KPMAS) include referral and authorization criteria to support primary care and specialty care practitioners, as appropriate, in caring for members with selected conditions. Medical Coverage Policies are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by a practitioner in any particular set of circumstances for an individual member.