BlueCross BlueShield of Illinois

Blue Cross and Blue Shield of Illinois Provider Manual

HMO Scope of Benefits Section

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Seat Lift

Benefit

A seat lift for home use is covered as durable medical equipment.

Interpretation

The seat lift must be considered medically necessary. Criteria for medical necessity may include:

- Device prescribed as part of a physician's course of treatment that is designed to show improvement or retard deterioration.
- Member has diagnosed condition that prohibits the member from assuming the upright position on his or her own effort.
- Member bed-ridden or chair-confined without device.
- Once in the standing position, member able to ambulate with an assistive device or stand-by assistance.

A basic non-recliner chair is covered and only the electrical components are considered as the medical device. Chair lifts (i.e., stairway elevator-like devices) and/or modifications to vehicles are not in benefit.

Paid by	**HMO**

Coverage Variation

Benefit Plan DIRPI: Excluded

Note All DME exception requests must be submitted prospectively to the CAU. See the instructions located on the Introduction page of this section of the Provider Manual. It is the intent of the CAU to respond to your requests within two business days.

Note: Effective July 1, 2011, for the State of Illinois members only, Durable Medical Equipment (DME) will be paid at 80% and the member will pay the remaining 20%. The employer group numbers affected are: H06800, H06801, H06802, H06803, B06800, B06801, B06802 and B06803.

Note: Blue Precision HMO℠ and BlueCare Direct℠ have a separate contracted provider list for Durable Medical Equipment (DME) and Orthotic and Prosthetic devices.

Note: Effective July 1, 2013, Medicare Primary members must use a Medicare Contracted Provider to ensure coverage by Medicare. If submitting the claim to the HMO for coordination of benefits and the provider is not an HMO contracted provider – stamp the claim group approved and indicate in writing “Medicare Contracted Billing.”