Priority Health	BILLING POLICY No. 162
Patient Lift	
Date of origin: Sept 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

Reimbursement specifics

What reimbursement guidelines are included in this policy
A multi-positional patient transfer system (E0636) is covered if both of the following criteria 1 and 2 have been met:

1. The basic coverage criteria for a lift are met; and
2. The beneficiary requires supine positioning for transfers

If either criteria, 1 or 2 are not met, code E0636, will be denied as not reasonable and necessary.

The only products that may be billed with codes E0636, E0639, E0640, E1035, are those which have received a written Coding Verification Review from the Pricing, Data Analysis, and Coding (PDAC) contractor and that are listed in the Product Classification List on the PDAC web site.

Heavy duty and bariatric lifts are also included in the codes for patient lifts, E0630, E0635, E0636, E0639, E0640.

A Column II code is included in the allowance for the corresponding Column I code when provided at the same time.

Column 1	Column 2
E0625	E0621
E0630	E0621

E0635	E0621
E0636	E0621
E0639	E0621
E0640	E0621

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 - Multipositional 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

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

EY - No physician or other licensed health care provider order for this item or service
GA - Waiver of liability statement issued as required by payer policy, individual case
GK - Reasonable and necessary item/service associated with a GA or GZ modifier
GL - Medically unnecessary upgrade provided instead of nonupgraded item, no charge, no advance beneficiary notice (ABN)
GZ - Item or service expected to be denied as not reasonable and necessary
KX - Requirements specified in the medical policy have been met

When an upgrade is provided, the GA, GK, GL, and/or GZ modifiers must be used to indicate the upgrade.

Suppliers must add a KX modifier to codes E0636, only if all the coverage criteria has been met

If all the criteria has not been met, the GA or GZ modifier must be added to the code

Claims lines billed with codes without a KX, GA or GZ modifier will be rejected as missing information.

Place of Service
Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

REFERENCES
Article - Patient Lifts - Policy Article (A52516)

DISCLAIMER
Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Sept 2025	New policy – effective Oct 16, 2025