

Patient Lifts (for Tennessee Only)

Policy Number: CS185TN.F
Effective Date: July 1, 2024

[➔ Instructions for Use](#)

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Related Policy

- [Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements \(for Tennessee Only\)](#)

Application

This Medical Policy only applies to Medicaid and CoverKids in the state of Tennessee.

Coverage Rationale

Patient Lifts are proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Durable Medical Equipment, Patient Lift System.

[Click here to view the InterQual® criteria.](#)

For coverage limitations and exclusions, refer to the [TennCare Medicaid, Chapter 1200-13-13-.10: Exclusions](#).

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

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

References

TennCare Medicaid, Chapter 1200-13-13-.10 Exclusions. <https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-13.20230101.pdf>. Accessed February 19, 2024.

Policy History/Revision Information

Date	Summary of Changes
07/01/2024	<ul style="list-style-type: none"><li data-bbox="337 365 972 394">• Routine review; no change to coverage guidelines<li data-bbox="337 394 914 424">• Archived previous policy version CS185TN.E

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state, or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state, or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state, or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state, or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual[®] criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.