Physician instructions for Lift Chairs

Dear Physician,

In order for a patient to qualify for a Seat Lift Mechanism, they must:

- meet the medical coverage criteria established by Medicare (see A. below) and
- specific documentation requirements must be completed by the Physician (see B. below)

Just FYI, if all medical criteria are documented correctly, an Rx and CMN are completed and all delivery paperwork is compliant, the patient MAY receive reimbursement in the range of $210-$275. They are still financially responsible for the remainder of the chair which is typically $450-$1500. A courtesy claim to Medicare will be submitted but there is no guaranty of payment.

A. For a Seat Lift Mechanism to be covered under insurance policy, all of the following medical criteria must be met:

1. The patient must have severe arthritis of the hip or knee or have a severe neuromuscular disease.

2. The seat lift mechanism must be part of the physician's course of treatment and be prescribed to effect improvement, or arrest or retard deterioration in the patient's condition.

3. The patient must be completely incapable of standing up from a regular armchair or any chair in their home. (The fact that a patient has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all patients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms.)

4. Once standing, the patient must have the ability to ambulate. Coverage of seat lift mechanisms is limited to those types which operate smoothly, can be controlled by the patient, and effectively assist a patient in standing up and sitting down without other assistance.

5. The physician ordering the seat lift mechanism must be the treating physician or a consulting physician for the disease or condition resulting in the need for a seat lift. The physician's record

must document that all appropriate therapeutic modalities (e.g., medication, physical therapy) have been tried and failed to enable the patient to transfer from a chair to a standing position.

B. Documentation Needed for a Seat Lift Mechanism: Insurance requires the following:

• Documented Face to Face Visit in regards to the need for a Seat Lift Mechanism, including the above criteria listed in A.

• Written Order Prior to Delivery (WOPD)

• Certificate of Medical Necessity (CMN) for a Seat Lift Mechanism • A copy of the treating physician's records indicating all therapeutic modalities (e.g., physical therapy, medications…) have been tried and failed.

-The treating physician must have an in-person examination with the beneficiary within the six (6) months prior to the date of the WOPD. This examination must document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered.

The WOPD (Rx) must have the following information: • Beneficiary's full name • Physician's Name • Date if the order and the start date, if start date is different from the date of the order. • Detailed description of the item needed. May be narrative description or brand name/model number. • The physician's signature and signature date. Signature and date stamps are not allowed. To ensure that an item is still medically necessary, the delivery date/date of service must be within three months from the "Initial Date" of the CMN or three months from the date of the physician's signature. Patient medical records may include but are not limited to the physician' office records, hospital records, nursing home records, test reports, physical therapy progress notes or records from other healthcare professionals. These records should describe the patient's functional capabilities and limitations, the therapeutic modalities that were tried and failed and the physician's plan of treatment.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0679

DME 07.03A

CERTIFICATE OF MEDICAL NECESSITY
CMS-849 — SEAT LIFT MECHANISMS

SECTION A: Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HICN	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI #
(__ __ __) __ __ __ - __ __ __ __ HICN _____	(__ __ __) __ __ __ - __ __ __ __ NSC or NPI #_____
PLACE OF SERVICE _____ Supply Item/Service Procedure Code(s):	PT DOB ____/____/____ Sex ____ (M/F) Ht. ____(in) Wt ____
NAME and ADDRESS of FACILITY *if applicable (see reverse)*	_____ _____ _____ _____
	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NPI #
	(__ __ __) __ __ __ - __ __ __ __ UPIN or NPI #_____

SECTION B: Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 *(99=LIFETIME)* | DIAGNOSIS CODES: _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1-5 FOR SEAT LIFT MECHANISM (Check Y for Yes, N for No, or D for Does Not Apply)
❑ Y ❑ N ❑ D	1. Does the patient have severe arthritis of the hip or knee?
❑ Y ❑ N ❑ D	2. Does the patient have a severe neuromuscular disease?
❑ Y ❑ N ❑ D	3. Is the patient completely incapable of standing up from a regular armchair or any chair in his/her home?
❑ Y ❑ N ❑ D	4. Once standing, does the patient have the ability to ambulate?
❑ Y ❑ N ❑ D	5. Have all appropriate therapeutic modalities to enable the patient to transfer from a chair to a standing position (e.g., medication, physical therapy) been tried and failed? If YES, this is documented in the patient's medical records.

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER:_____

SECTION C: Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. (see instructions on back)

SECTION D: PHYSICIAN Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE_____ DATE _____/_____/_____

Signature and Date Stamps Are Not Acceptable.

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY FOR SEAT LIFT MECHANISMS (CMS-849)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space TYPE/ marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1C followed by the 10-digit number. (For example. 1Cxxxxxxxxxx)
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
SUPPLY ITEM/SERVICE PROCEDURE CODE(S):	List all procedure codes for items ordered. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the PHYSICIAN'S name and complete mailing address.
PHYSICIAN INFORMATION:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicate this by using the qualifier XX followed by the 10-digit number. If using UPIN number, use the qualifier 1G followed by the 6-digit number. (For example. 1Gxxxxxx)
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a Physician employee, it must be reviewed, and the CMN signed (in Section D) by the treating practitioner.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the patient will require the item for the duration of his/her life, then enter "99".
DIAGNOSIS CODES:	In the first space, list the diagnosis code that represents the primary reason for ordering this item. List any additional diagnosis codes that would further describe the medical need for the item (up to 4 codes).
QUESTION SECTION:	This section is used to gather clinical information to help Medicare determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, checking "Y" for yes, "N" for no, or "D" for does not apply.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item(s), options, accessories, supplies and drugs; and (3) the Medicare fee schedule allowance for each item(s), options, accessories, supplies and drugs, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician's must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see http://www.medicare.gov/ for information on claim filing.