Jayhawk Pharmacy Services

Patient Supply
2620 SW 6th Ave.
Suite "E"
Topeka, KS 66606
785-235-9700`
785-235-9703 Fax
NPI: 1033397716

Pharmacy & Patient Supply
2860 SW Mission Woods Drive
Topeka, KS 66614
785-228-9700
785-228-1375 Fax
NPI: 1104852672

Custom Prescription Center
6730 SW 29th
Topeka, KS 66614
785-228-9740
800-338-9700

Medicare Requirements for Seat Lift Mechanism

A seat lift mechanism is covered if all of the following criteria are met:

1. The beneficiary must have severe arthritis of the hip or knee or have severe neuromuscular disease.
2. The seat lift mechanism must be a part of the physician's course of treatment and be prescribed to effect improvement, or arrest or retard deterioration in the beneficiary's condition.
3. The beneficiary must be completely incapable of standing up from a regular armchair or any chair in their home. (The fact that a beneficiary 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 beneficiaries 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 beneficiary must have the ability to ambulate.

- ❖ Coverage of seat lift mechanisms is limited to those types which operate smoothly, can be controlled by the beneficiary, and effectively assist a beneficiary in standing up and sitting down without other assistance.
- ❖ Excluded from coverage is the type of lift which operates by spring release mechanism with a sudden, catapult-like motion and jolts the beneficiary from a seated to a standing position.
- ❖ Coverage is limited to the seat lift mechanism, even if it is incorporated into a chair (E0627). The supplier may bill the seat lift mechanism using E0627 and A9270 for the chair.
- ❖ 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.

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

Form Approved OMB
No. 0938-0679
Expires 02/2020

CERTIFICATE OF MEDICAL NECESSITY
CMS-849 — SEAT LIFT MECHANISMS

DME 07.03A

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

PATIENT NAME, ADDRESS, TELEPHONE and MEDICARE ID		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI # BT-CMN
(__ __ __) __ __ __ - __ __ __ __ Medicare ID _____		(__ __ __) __ __ __ - __ __ __ __ 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)

$0.00 $0.00 /

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.