

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. 1Cxxxxxxxx)

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: If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a

ANSWERING SECTION B physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title
QUESTIONS: 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 Supplier gives (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs;
DESCRIPTION OF (2) the supplier's charge for each item(s), options, accessories, supplies and drugs; and (3) the Medicare fee schedule
EQUIPMENT & COST: allowance for each item(s), options, accessories, supplies and drugs, if applicable.

SECTION D: (To be completed by the physician)

PHYSICIAN The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the
ATTESTATION: answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE After completion and/or review by the physician of Sections A, B and C, the physician's must sign and date the CMN in
AND DATE: Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered
are medically necessary for this patient.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0679. The time required to complete this information collection is estimated to average 12 minutes per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Blvd. Baltimore, Maryland 21244.

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

SAMPLE

**CERTIFICATE OF MEDICAL NECESSITY
CMS-849 — SEAT LIFT MECHANISMS**

DME 07.03A

A.
B.
C.
D.
E.
F.
G.
H.
I.
J.

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

PATIENT NAME, ADDRESS, TELEPHONE and HICN <u>B</u> HICN _____		SUPPLIER NAME, ADDRESS, TELEPHONE and NSC or NPI # <u>C</u> NSC or NPI # _____	
PLACE OF SERVICE <u>D</u>	Supply Item/Service Procedure Code(s): _____	PT DOB _____	SEX (M/F) _____ Ht. (in) _____ Wt. _____
NAME and ADDRESS of FACILITY if applicable (see reverse) <u>F</u>		PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN or NPI # <u>G</u> 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): H 1-99 (39=LIFETIME) | DIAGNOSIS CODES: I

ANSWERS	ANSWER QUESTIONS 1-5 FOR SEAT LIFT MECHANISM (Check Y for Yes, N for No, or D for Does Not Apply)
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> D	1. Does the patient have severe arthritis of the hip or knee?
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> D	2. Does the patient have a severe neuromuscular disease?
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> D	3. Is the patient completely incapable of standing up from a regular armchair or any chair in his/her home?
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> D	4. Once standing, does the patient have the ability to ambulate?
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 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)

K

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 L DATE ___ / ___ / ___

Signature and Date Stamps Are Not Acceptable.

L.

CERTIFICATE OF MEDICAL NECESSITY CMS-849 — SEAT LIFT MECHANISMS

Physician (MD, NP or PA) Instructions: Please complete the following on the enclosed blank CMN form as well as an Rx and supportive office notes order to justify the need for a lift mechanism. If any one item is skipped or **not completed by you personally**, this paperwork will not meet the medical criteria for this item. Note: (parts of the required paperwork cannot be completed by anyone other than the ordering MD)

Boxes to be completed:

- a. Date of exam
- b. Full patient name, address, phone AND insurance ID number
- c. The provider info (Southern Mobility and Medical, 1829 Capital Blvd, Raleigh NC 27604, 1-800-681-8831, NPI # 1922035567
- d. 12
- e. Patient DOB, sex, height and weight
- f. E0627
- g. MD information including your NPI#
- h. Length of need in months
- i. Relevant ICD-10 codes
- j. Answers to 1-5
- k. E0627 Seat Lift Mechanism \$265
- l. Your signature and date

These are general instructions for your MD to complete the Insurance CMN form. The completion of this form does not guarantee coverage, approval or payment for a lift mechanism. Other documentation such as an Rx and appropriate supporting medical notes are also required.