Power Seat Lift Chairs
Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Power Seat Lift Chairs		
MNG #: 102	☒**SCO** ☒**One Care** ☐ **MA Medicare Premier** ☐ **MA Medicare Value** ☐ **RI Medicare Preferred** ☐ **RI Medicare Value** ☐ **RI Medicare Maximum**	**Prior Authorization Needed?** ☐**Yes** ☐**No**
Clinical: ☒	**Operational:** ☐	**Informational:** ☐
Medicare Benefit: ☐**Yes** ☒**No**	**Approval Date:** 03/03/2022;	**Effective Date:** 8/23/2022;
Last Revised Date: 9/1/2022; 1/18/2023;	**Next Annual Review Date:** 3/3/2023; 9/1/2023; 1/18/2024;	**Retire Date:**

OVERVIEW:

Powered reclining/lift chairs are provided to members who require hands on assistance to safely transition from sit to stand and/or elevation of lower extremities to support therapy of poorly controlled lower extremity edema with prescribed application of compression garments. Using a wired hand control and powered lifting mechanism, the powered recliner/lift chair pushes the entire chair up from its base and assists the user from a seated position to an almost standing position.

DECISION GUIDELINES:

Clinical Eligibility:

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations, contractual requirements, and uses InterQual Smart Sheets, when available, to review prior authorization requests for medical necessity. This MNG applies to all CCA Members unless a more expansive and applicable CMS National Coverage Determination (NCD), Local Coverage Determination (LCD), or state-specific medical necessity guideline exists.

CCA may cover a power seat lift chair for one of the following:

A. Member is unable to safely transition from a seated position to a standing position safely with or without an assistive device and/or hands on caregiver assistance due to irreversible physical limitations, including but not limited to:
   - Severe arthritis of the hip or knee joint range of motion that affects transfers.
   - Functionally debilitating neuromuscular disease.
   - Irreversible mobility impairment.
   - Lower extremity weakness without potential to improve.
   - Balance impairment.

   A physical or occupational therapist in-home or virtual video assessment to determine functional mobility is required. The therapist written evaluation must document all of the following criteria:

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1. Member is unable to safely transition from sit to stand using a regular armchair or any chair inside his/her home; and
2. Member cannot safely transition from sit to stand with the use of appropriate DME; and
3. When standing, Member is able to ambulate with or without an assistive device; and
4. Member must be able to independently and safely use the hand control functions of the chair to safely and independently transition from sit to stand.

B. Member has chronic venous insufficiency or chronic venous disease, and all of the following criteria are met:

- Lower extremity elevation to at least heart level for 30 minutes three to four times per day is not otherwise possible without the use of a power seat lift chair; and
- Member has tried and failed or has a contraindication to compression therapy; and
- Letter of Medical Necessity from the Member's treating/ordering provider (physician, nurse practitioner, or physician's assistant) that documents all of the following:
    - Diagnosis of chronic venous insufficiency or chronic venous disease; and
    - Factors that make leg elevation otherwise not possible; and
    - Reason for failure or contraindication to compression therapy.

LIMITATIONS/EXCLUSIONS:

CCA does not consider a power seat lift chair to be medically necessary under certain circumstances:

- The member has other equipment that serves the same purpose as Durable Medical Equipment already in use by the member, can meet their needs and is in good working order.
- The member's needs could be met with a less costly alternative.
- The equipment cannot reasonably be expected to make a meaningful contribution to the treatment of a member's illness or injury.
- The member's environment will not accommodate the size of the equipment, including space necessary to fully recline the powered reclining/lift chair.
- Heat and massage features are not considered medically necessary.
- Dual motor power seat lift chairs are only covered for bariatric needs.
- Power Seat Lift Chairs are covered only for purposes as described in the Clinical Eligibility section.

Authorization:

CCA requires all of the following to be included with a request for a power seat lift chair:

- Standard Prior Authorization Request Form; and
- Standard Written Order (SWO); and
- Physical or Occupational Therapist assessment or requesting provider LMN as noted in the Clinical Eligibility section in this MNG.
- Manufacturer's quote.

REGULATORY NOTES:

Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage decisions are made. CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. If at any time an applicable CMS LCD or NCD or state-specific MNG is more expansive than the criteria set forth

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herein, the NCD, LCD, or state-specific MNG criteria shall supersede these criteria. This MNG references the specific regulations, coverage, limitations, service conditions, and/or prior authorization requirements in the following:

1. Medicare Local Coverage Determination (LCD): Seat Lift Mechanisms LCD 33801
2. MassHealth Code of Massachusetts Regulations; 130 CMR 450.204: Medical Necessity; 130 CMR 409.402: Definitions**;** 130 CMR 409.414 Non-covered services.
3. https://www.mass.gov/doc/130-cmr-450-administrative-and-billing-regulations/download
4. https://www.mass.gov/doc/130-cmr-409-durable-medical-equipment-services/download

Disclaimer:
This MNG guide is not a rigid rule. As with all CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity (supporting literature (full text preferred) should be attached to the request), or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another service which would otherwise be covered. Note that not infrequently both supporting science and a description of the member's unique clinical circumstances will be required.

ATTACHMENTS:

EXHIBIT A:	N/A
EXHIBIT B	

Exhibit A: Title

N/A

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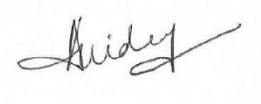
REVISION LOG:

REVISION DATE	DESCRIPTION
9/1/2022	Updated template and formatting.
1/17/2023	Limitations/Exclusions: criteria removed - "Use of power seat lift chair to be used primarily for sleeping in lieu of a bed", criteria added - "Power Seat Lift Chairs are covered only for purposes as described in the Clinical Eligibility section.", criteria modified- The member has other equipment that "serves the same purpose as Durable Medical Equipment already in use by the member," can meet their needs and is in good working order.". Clinical Eligibility: The term less restrictive removed and more expansive added. Formatting updates and grammatical errors corrected.

APPROVALS:

Avideep Chawla	Director, Utilization Management
CCA Senior Clinical Lead [Print]	**Title [Print]**
	2/9/2023
Signature	**Date**
Debra Poskanzer, MD	Utilization Review Medical Director
CCA Senior Operational Lead [Print]	**Title [Print]**
	2/9/2023
Signature	**Date**
Nazlim Hagmann, MD	SVP, Associate Chief Medical Officer
CCA CMO or Designee [Print]	**Title [Print]**
	2/9/2023
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