# Stair Lift
# Medical Necessity Guideline

| Medical Necessity Guideline (MNG) Title: Stair Lift | | |
|---|---|---|
| **MNG #: 079** | **☒SCO ☒One Care**<br>**☐ MA Medicare Premier**<br>**☐ MA Medicare Value**<br>**☐ RI Medicare Preferred**<br>**☐ RI Medicare Value**<br>**☐ RI Medicare Maximum** | **Prior Authorization Needed?**<br>**☒ Yes (always required)**<br>**☐ Yes (only in certain situations. See this MNG for details)**<br>**☐ No** |
| **Clinical: ☒** | **Operational: ☐** | **Informational: ☐** |
| **Benefit Type:**<br>**☐ Medicare**<br>**☐ Medicaid** | **Approval Date:**<br>7/1/2021; | **Effective Date:**<br>9/28/2021; |
| **Last Revised Date:**<br>5/30/2022; | **Next Annual Review Date:**<br>7/1/2022; 5/30/2023; | **Retire Date:** |

**OVERVIEW:**

A stair lift is a mechanical device with a seat that transports members up and down stairs. It enables members with mobility impairments who are unable to safely climb stairs access to their home.

**DECISION GUIDELINES:**

**Clinical Coverage Criteria:**

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses InterQual Smart Sheets, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists.

**Clinical Eligibility:** Member has mobility impairments that prevent safe stair use such as weakness or balance deficits resulting from permanent injury or medical condition.

**Determination of need:**

A stair lift is considered medically necessary for members who meet **all** of the following criteria:

1. Member needs assistance to safely ascend or descend stairs due to a physical illness; and
2. Member must access other levels of their home for ADL's; and
3. Member is unable to modify present home to enable access to ADLs without the use of a stair lift (i.e., relocate bedroom to same level as bathroom/kitchen, enter home through an alternate entry); and
4. For an external stair lift to be considered the member can only exit their home by ambulance transport and the ability of a ramp for the member to exit the home must be ruled out; and
5. Member/family owns residence where the lift is to be installed.
   *Note:* In accordance with CCA's *Policy on Medically Necessary Home Modifications* (P&P # 49), CCA must receive:
   a. a written *Home Modifications - Acknowledgment and Agreement* from the owner(s), and

b. proof of ownership of that residence, such as a copy of the deed or the tax bill.

**LIMITATIONS/EXCLUSIONS:**

1. Member cannot safely transfer onto/off the seat of the stair lift.
2. Member cannot independently maintain their seated balance when using the stair lift.
3. Member cannot independently operate the controls of the stair lift safely.
4. Member rents their residence and is eligible for reasonable accommodations from landlord.
5. Other less costly alternatives must have been considered (as part of the assessment process),
6. Community resources and alternative funding sources must have been exhausted, including but not limited to grants and the Massachusetts Home Modification Loan Program.
7. Stair Lift installation does not include the cost, if any, of restoring a site to its previous configuration or condition, this includes but is not limited to:
    a. The removal of any installed equipment or modifications if and when the member is no longer in the need of it; or
    b. The removal or remediation of existing modification or structures.

**KEY CARE PLANNING CONSIDERATIONS:**

Member is motivated to use this system in order to access other levels of their residence. A stair lift will improve the member's life by allowing them to complete their ADLs more efficiently. Member has explored alternative funding sources such as grants or Massachusetts Home Modification Loan Program.

**AUTHORIZATION:**

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not signify 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. This Medical Necessity Guideline is subject to all applicable Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider's agreement with the Plan (including complying with Plan's Provider Manual specifications).

**HCPCS code S5165 is to be used for Stair Lift authorization requests.**

**Documentation Requirements:**

1. Standard written Order (SWO)
2. Letter of Medical Necessity (LMN)
    a) Clinical evaluation notes from a physical or occupational therapist that states the medical necessity.
3. Detailed Home Modification Plan, including:
    a) *Home Modification*s - *Acknowledgment and Agreement* from the owner(s), as applicable,
    b) Detailed drawing of the Home Modification, and
    c) The service provider's quote regarding the cost of the of Home Modification, including:
        1) a labor detail sheet, and
        2) the manufacturer's invoice for any products used under the HCPCS Code S5165 code.

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**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 herein, the NCD, LCD, or state-specific MNG criteria shall supersede these criteria.

**RELATED REFERENCES:**

Commonwealth Care Alliance: Home Modification Decision Support Tool (DST) # 160

Mass Health; 130 CMR 450.204: Medical Necessity; 130CMR 428.402

Definitions; 130CMR 409.402: Definitions**;** 130CMR 409.414 Non-covered services,

http://www.mass.gov/eohhs/consumer/disability-services/housing-disability/home-mod-loan/

**Disclaimer**

This Medical Necessity Guideline is not a rigid rule. As with all of 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 both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

**ATTACHMENTS:**

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| **EXHIBIT A** | Acknowledgement and Agreement Form |
| **EXHIBIT B** | |

**REVISION LOG:**

| REVISION DATE | DESCRIPTION |
|---|---|
| 5/30/2022 | Template changed. Overview and format updated with numbering. |

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**APPROVALS:**

| | |
|---|---|
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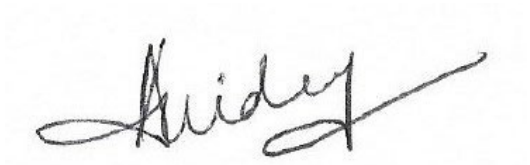
|  | 7/1/2021 |
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