Vertical Platform (Wheelchair) Lift
Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Vertical Platform (Wheelchair) Lift		
MNG #: 094	☒**SCO** ☒**One Care** ☐ **MA Medicare Premier** ☐ **MA Medicare Value** ☐ **RI Medicare Preferred** ☐ **RI Medicare Value** ☐ **RI Medicare Maximum**	**Prior Authorization Needed?** ☒ **Yes (always required)** ☐ **Yes (only in certain situations. See this MNG for details)** ☐ **No**
Clinical: ☒	**Operational:** ☐	**Informational:** ☐
Benefit Type: ☐ **Medicare** ☐ **Medicaid**	**Approval Date:** 01/06/2022;	**Effective Date:** 5/07/2022;
Last Revised Date: 5/6/2022;	**Next Annual Review Date:** 01/22/2023; 5/6/2023;	**Retire Date:**

OVERVIEW:

A vertical platform lift, also known as a wheelchair lift, is a powered device that enables a member who requires a wheelchair for mobility to overcome a vertical barrier such as stairs. They can be vertical or inclined (travel along the grade of the stairway) and enable members to enter/exit their home in their wheelchair. They are supplied for members when a wheelchair ramp is unable to be used or when the cost of the platform lift is less than the ramp that would be required for the barrier.

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:

Vertical platform lifts can be provided to members who have a permanent or progressive condition and equipment will be required for long term use (greater than 6 months).

Determination of need:

Vertical platform lifts are considered medically necessary for members who meet **all of** the following criteria:

- Member uses a wheelchair for all mobility and is unable to transfer onto a less costly stair lift;
- Member is unable to leave the home without the use of an ambulance transport company stretcher by an l ambulance transport company;

- Vertical barrier is unable to be ramped or the cost of the required ramp is more than the cost of the platform lift; and
- Member owns property 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 Modification*s - *Acknowledgment and Agreement* from the owner(s), and
  b. proof of ownership of that residence.

LIMITATIONS/EXCLUSIONS:

- Member rents their home and is eligible for reasonable accommodations by their landlord.
- Home access is able to be resolved with a less costly alternative.
- Member has alternative funding available such as grants or the Massachusetts Home Modification Loan Program.
- Member already has equipment that serves the same purpose and is in good working order.
- Vertical platform 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:
  - The removal of any installed equipment or modifications if and when the member is no longer in need of it; or
  - The removal or remediation of existing modification or structures.

KEY CARE PLANNING CONSIDERATIONS:

- Member is motivated to utilize this system in order to leave their residence for community related daily activities and medical appointments.

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

Documentation Requirements: All of the follow documents are required to process vertical platform authorization.

1. Standard written Order (SWO);
2. Letter of Medical Necessity (LMN); and
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.

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. This MNG references the specific regulations, coverage, limitations, service conditions, and/or prior authorization requirements in the following:

This is not covered by Mass Health, but CCA applies its medically necessary guidelines to this equipment.

According to Mass Health a service is "medically necessary" if:

1. It is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and

   There is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorization request, to be available to the member through sources described in 130 CMR 450.317(C), 503.007, or 517.007.

Medically necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality.

RELATED REFERENCES:

Mass Health; 130 CMR 450.204: Medical Necessity; 130CMR 428.402
Definitions; 130CMR 409.402: Definitions**;** 130CMR 409.414 Non-covered services,
Commonwealth Care Alliance Decision Support Tool (DST); Home Modifications DST #160
Policy on Medically Necessary Home Modifications (P&P #49)
http://www.mass.gov/eohhs/consumer/disability-services/housing-disability/home-mod-loan/

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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.

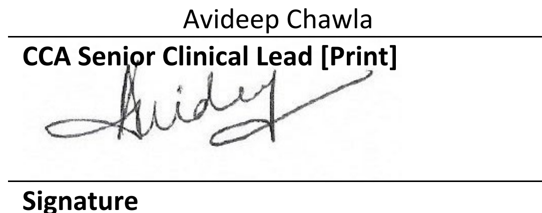
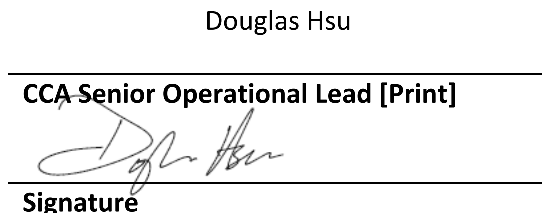
ATTACHMENTS:

EXHIBIT A	Acknowledgement and Agreement form
EXHIBIT B	Home Modifications DST #160
EXHIBIT C	Policy on Medically Necessary Home Modifications (P&P #49)

REVISION LOG:

REVISION DATE	DESCRIPTION
5/6/2022	Template update.

APPROVALS:

Avideep Chawla	Director, Utilization Management
CCA Senior Clinical Lead [Print]	**Title [Print]**
	05/06/2022
Signature	**Date**
Douglas Hsu	Vice President, Medical Policy & Utilization Review
CCA Senior Operational Lead [Print]	**Title [Print]**
	05/06/2022
Signature	**Date**
Lori Tishler	Senior Vice President, Medical Services

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CCA CMO or Designee [Print]	**Title [Print]**
[signature]	05/06/2022
Signature	**Date**