Home Accessibility Adaptations
Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Home Accessibility Adaptations		
MNG #: 097	☒ **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**
Benefit Type: ☐ **Medicare** ☒ **Medicaid**	**Approval Date:** 01/06/2022; 2/27/24	**Effective Date:** 5/07/2022; 2/27/24
Last Revised Date: 2/27/24	**Next Annual Review Date:** 01/06/2023; 2/27/25	**Retire Date:**

OVERVIEW:

Home accessibility adaptations are physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan and necessary to ensure the health, welfare and safety of the participant and/or to enable the participant to have in/out access to their home and function with greater independence within the home.

Such adaptations include, but are not limited to, the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant. Home accessibility adaptations may also include architectural services to develop drawings and narrative specifications for architectural adaptations, adaptive equipment installation, and related construction as well as subsequent site inspections to oversee the completion of adaptations and conformance to local and state building codes, acceptable building trade standards and bid specifications.

Home accessibility adaptations waiver services may be covered for eligible Commonwealth Care Alliance (SCO and One Care) members who are enrolled as participants under the Acquired Brain Injury (ABI)-N Waiver, Moving Forward Plan, (MFP)-RS Waiver or MFP-CL Waiver. Waiver programs ensure services follow an individualized and person-centered plan of care. Home accessibility adaptations may also be covered for participants who qualify for Transitional Assistance Services when adaptations are appropriate and necessary for the participant's discharge from a nursing facility or hospital and safe transition to the community. Services offered to Frail Elder Waiver (FEW) participants include Environmental Accessibility Adaptation. FEW participants age 65 and older are eligible to enroll in a Senior Care Options (SCO) plan. FEW participants who are enrolled in SCO have access to all waiver services and all services offered by the SCO plan in which they are enrolled.

In order to participate as a provider of home accessibility adaptations under an HCBS waiver, a provider must be qualified to perform environmental and minor home adaptations in accordance with applicable state and local building codes and comply with any applicable registration or licensure requirements. Providers must also be under contract with Massachusetts Rehabilitation Commission (MRC) in accordance with its standards, requirements, policies, and procedures for the provision of home accessibility adaptations.

Home accessibility adaptations may be minor in nature (e.g. installation of grab bars and railings, widening of a doorway which does not include alteration of load bearing walls) or more major (e.g. installation of ramp, stair glide/lift or vertical lift platform).

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DEFINITIONS:

1. **The Frail Elder Waiver (FEW):** A Home- and Community-Based Services (HCBS) waiver designed to make supports available to eligible frail elders aged 60 and older who meet the level of care for a nursing facility but prefer to remain in the community.
2. **Home/Environmental Accessibility Adaptations:** Physical modifications to the participant's home that are necessary to ensure the health, welfare, and safety of the participant or that enable the participant to function with greater independence in the home.
3. **Home and Community-based Services (HCBS) Waiver:** A federally approved program operated under § 1915(c) of the Social Security Act that authorizes the U.S. Secretary of Health and Human Services to grant waivers of certain Medicaid statutory requirements so that a state may furnish home- and community-based services to certain Medicaid beneficiaries who need a level of care that is provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID). For the purpose of 130 CMR 630.000, Home and Community-based Services Waiver refers to the two ABI waivers and the two MFP waivers.
4. **Massachusetts Rehabilitation Commission (MRC):** The state agency within the Executive Office of Health and Human Services that is organized pursuant to M.G.L. c. 6, §§ 74-84, to provide comprehensive services to individuals with disabilities, which maximize their quality of life and economic self-sufficiency. MRC accomplishes its work through multiple programs in its Community Living Division, the Disability Determination Service Division, and the Vocational Rehabilitation Division.
5. **Participant:** A MassHealth (SCO/One Care) member determined by the MassHealth agency (SCO/One Care) to be eligible for enrollment in one of the HCBS waivers, who chooses to receive HCBS waiver services, and for whom a service plan has been developed that includes one or more HCBS waiver services.
6. **Service Plan:** A written document that specifies the waiver and other services (regardless of funding source) along with any informal supports that are furnished to meet the participant's needs and goals, as assessed and identified through a person-centered planning process, and to assist a participant in remaining in the community. Service Plan is also known as the individual service plan and can include the waiver plan of care.
7. **Transitional Assistance:** Nonrecurring residential set-up expenses for participants who are transitioning from a nursing facility or hospital to a community living arrangement where the participant is directly responsible for their own set-up expenses. Allowable expenses are those that are necessary to enable a person to establish a basic household and do not constitute Room and Board.
8. **Waiver Provider:** A qualified individual or organization that meets the requirements of 130 CMR 630.000, provides waiver services to participants, and has signed a provider agreement with the MassHealth agency.
9. **Waiver Services:** Home and community-based services that are covered in accordance with the requirements of 130 CMR 630.000 for participants enrolled under an Acquired Brain Injury (ABI) waiver or Moving Forward Plan (MFP) waiver.

DECISION GUIDELINES

Clinical Coverage Criteria:

Commonwealth Care Alliance (CCA) may cover home accessibility adaptations when all the following criteria are met:

1. Proof of home ownership (see documentation requirements below); and
2. Home accessibility adaptation services are included in member's individualized plan of care; and
3. Member participant would be unable to access and/or reside in their home without the adaptations; or
   The accessibility adaptations enable the participant to function with greater independence within the participant's home; or
   The accessibility adaptations eliminate or decrease the need for direct human assistance (e.g. personal care services); and
4. Adaptations are reasonable and necessary and least costly alternative (e.g. use of home and community-based services, raised toilet seat vs. installation of comfort height toilet, relocation from second floor bedroom to first floor

bedroom, installation of ramp vs. vertical lift) to enable the member participant to function safely and with greater independence within their home.

LIMITATIONS/EXCLUSIONS:

Commonwealth Care Alliance does not cover the following:

1. Adaptations to bring a substandard dwelling up to minimum standards or to make improvements to a residence that are of general utility, and are not of direct medical or remedial benefit to the participant including, but not limited to:
    a. new carpeting
    b. roof repairs
    c. installation/updates to central air conditioning or heating systems
    d. pave driveways or walkways
    e. deck, fence installation
    f. repair or replacement of pre-existing structure or condition
    g. remediation of any pre-existing condition (e.g. asbestos, lead, or mold)
2. Adaptations that add to the total square footage of the home except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair)
3. Adaptations which are required by law to be made by a landlord or other third-party
4. Adaptation requests for which there is a less costly alternative to meet member's needs (e.g. raised toilet seat vs. installation of comfort height toilet, ramp vs. vertical platform)
5. Transitional Services that are not necessary for the participant's safe transition to the community
6. Home accessibility adaptations to a residential habilitation site, group home, or other provider-owned and -operated residential setting
7. The cost of maintenance, upkeep, or an improvement to a participant's place of residence
8. Home accessibility adaptations considered unsafe, unreasonable, or unnecessary for participant (e.g. installation of swimming pool, hot tub, whirlpool, steam bath or sauna for either indoor or outdoor use, renovate or build rooms for the use of physical therapy equipment)
9. Services furnished prior to the development of the individual service plan or not included in a participant's individual service plan
10. Services requested for the benefit of an individual other than the member participant who is eligible to receive such services and for whom such services are approved in the individual service plan
11. The removal and/or remediation of existing home accessibility adaptations and/or any installed equipment if and when member is no longer in need of it
12. Accessibility adaptations NOT included in authorized Home Modification Plan
13. Purchase of extended service and/or maintenance contract(s)

CODING:

When applicable, a list(s) of codes requiring prior authorization is provided. This list is for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment.

CPT/HCPCS CODE	CODE DESCRIPTION
S5165	Home modifications, per service

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DOCUMENTATION REQUIREMENTS:

Provider must submit all the following documentation:

1. Standard Written Order (SWO) or Prescription for home accessibility adaptation(s) requested; and
2. A signed Letter of Medical Necessity (LMN) from member's prescribing provider indicating how requested home accessibility adaptation will contribute to the member's goals for functional independence and safe management in their home; and

3. A signed LMN or environmental assessment note, completed by the assessing Physical Therapist (PT) or Occupational Therapist (OT). An Outpatient PT or OT, a Home Health PT or OT, or a CCA internal rehabilitation team member may be utilized; and
4. A detailed Home Accessibility Adaptation/Modification Plan, including:
    a. Detailed drawing of the Home Accessibility Adaptation/Modification; and
    b. The service provider's quote regarding the cost of the of Home Accessibility Adaptation/Modification, including:
        i. a labor detail sheet; and
        ii. the manufacturer's invoice for any products used under the HCPCS Code S5165 code; and
5. **Home Accessibility Adaptation/Modifications - Acknowledgment and Agreement** signed by homeowner(s); and
6. Proof of home ownership **(deed or tax bill)**

Note: CCA reserves the right to require an in-home accessibility assessment as part of the request process.

REFERENCES:

130 CMR 630.000: Home – and Community-Based Services waiver Services, 2022. https://www.mass.gov/doc/home-and-community-based-services-waivers-regulations/download

Disclaimer

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses evidence based InterQual© criteria, 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. 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.

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. 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).

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.

REVISION LOG:

REVISION DATE	DESCRIPTION
2/27/24	MNG title change. Template update. Updated criteria to align with MassHealth scope of home accessibility adaptation service

APPROVALS:

David Mello	Senior Medical Director, Utilization Review and Medical Policy
CCA Senior Clinical Lead [Print]	**Title [Print]**
	2/27/24
Signature	**Date**
Signature	**Date**
Nazlim Hagmann	Chief Medical Officer
CCA CMO or Designee [Print]	**Title [Print]**
	2/27/24
Signature	**Date**