PROVIDER POLICIES & PROCEDURES

STAIR LIFT SYSTEMS

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for stair lift systems. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

A stair lift system is a device used to transfer an individual with physical limitations to another floor level or living area within their home environment, with a chair or lift seat on tracks. Types of stair lift systems include a stairway chair, stair lift, or stair glider. They can be used on straight, curved, or spiral stairs to aid with the individual's mobility throughout the home. Many of these types of devices are used to facilitate transportation within the home and/or facilitate transportation in and out of the home and are considered for the convenience of the individual. These type of devices can also be considered home modifications and may not meet the definition of durable medical equipment (DME) in all instances.

CLINICAL GUIDELINE

Coverage guidelines for stair lift systems are made in accordance with the Department of Social Services (DSS) definition of Medical Necessity. The following criteria are guidelines *only*. Coverage determinations are based on an assessment of the individual and his or her unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

A stair lift system may be medically necessary when the individual is unable to transfer or mobilize to another floor level or living area in their home to perform activities of daily living (ADLs) independently; with use of an assistive device or with use of other non-mechanical methods; or with the assistance of a caregiver. A stair lift system requires a comprehensive analysis of the individual's physical capacities and limitations, current transfer methods, safety issues, caretaker support, and environmental factors.

A stair lift system is typically considered medically necessary for individuals with physical disabilities or limitations who meet the following criteria:

1. When the individual cannot transfer or mobilize to another floor or living area within their home independently, with use of an assistive device, with use of other non-mechanical methods, or with the assistance of a caregiver due to the person's medical condition or caretaker limitations and when the individual would be confined to one floor without the ability to perform ADLs; and
2. When there is evidence the individual is unable to transfer, mobilize, or perform ADLs in their home without the use of a stair lift system.

Requests for stair lift systems not meeting the above criteria may be considered medically necessary based on an assessment of the individual and his or her unique clinical needs.

Repair, Adjustment, and Replacement of Parts and Accessories

Repairs, adjustments, and replacement of parts and accessories necessary for the normal and effective functioning of the stair lift system are typically covered when the above criteria are met. Repairs, adjustments, and replacement of parts and accessories not meeting the above criteria may be considered medically necessary based on an assessment of the individual and his or her unique needs. An updated evaluation may be requested if it is determined that the individual's medical condition or their ability to perform ADLs has changed since receiving the current equipment.

EPSDT Special Provision

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE

Prior authorization of a stair lift system is required. Requests for coverage will be reviewed in accordance with procedures in place for reviewing requests for durable medical equipment. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for a stair lift system:

1. Fully completed Outpatient Prior Authorization Request Form or fully completed authorization request via on-line web portal;
2. A signed prescription, written within the past 12 months, from the ordering physician, advanced practice registered nurse (APRN), or physician assistant (PA) enrolled in the Connecticut Medical Assistance Program (CMAP);
3. Clinical documentation from the ordering provider that includes the following:
    a. Individual's height and weight;
    b. Medical evaluation documenting the member's medical need for the stair lift system. Evaluation must be within the last twelve (12) months of this request; and
    c. Anticipated length of time that the individual will need a stair lift system;
4. A home evaluation with recommendations from a Connecticut licensed occupational therapist or physical therapist, performed within three (3) months prior to the submission of the prior authorization request, which meets the criteria in the above Clinical Guideline. The clinical documentation should include the following:
    a. Individual's medical condition and functional status (including a description of the individual's ambulation and transfer status along with the level of assistance needed) that requires the stair lift system requested;
    b. Description of type and amount of caretaker support for completing ADLs;
    c. Other functional strategies or DME evaluated or considered, and reason for ineffectiveness related to the individual's posture, motor control, muscle strength, tone, balance, range of motion and/or cardiopulmonary status;

d. List of all current durable medical equipment; i.e., current patient lift, wheeled mobility device, stander, walker, hygiene equipment, orthotics, and prosthetics; including manufacturer, model (when available), and special features; date of purchase, and the individual's ability to independently utilize;
e. Documented evidence, in the presence and collaboration with the individual's caretaker and evaluating physical or occupational therapist, of the satisfactory use of the recommended stair lift system including the individual's safety, comfort, and level of assistance needed for sit-to-stand transfers and/or stand-to-pivot transfers. (Documentation of a Trial Simulation performed);
f. Description of how a stair lift system is currently used or will be used in essential areas within the home that address the person's medical needs such transfers and mobility to another level with a kitchen, bed, and/or hygiene location;
g. Documentation of the anticipated changes in the individual's environment;
h. Documentation that the stair lift system will fit in all identified essential areas of the home for ADLs; and

5. A detailed product description including manufacturer, model/part number, product description, HCPCS code and unit(s). Actual Acquisition Cost (AAC) and Manufacturer's Suggested Retail Pricing (MSRP) for code E1399, including documentation disclosing any and all discounts per *DSS Pricing Policy for MEDS Items*.

EFFECTIVE DATE

This Policy is effective for prior authorization requests for stair lift systems for individuals covered under the HUSKY Health Program beginning February 01, 2024.

LIMITATIONS

N/A

CODES

Code	Description
E1399	Durable medical equipment, miscellaneous

DEFINITIONS

1. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).

5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B)recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.
8. **Prior Authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

ADDITIONAL RESOURCES AND REFERENCES:

- Tural E, Lu D, Cole DA. Factors predicting older Adults' attitudes toward and intentions to use stair mobility assistive designs at home. Prev Med Rep. 2020 Mar 16;18:101082. doi: 10.1016/j.pmedr.2020.101082. PMID: 32257778; PMCID: PMC7113478.
- DSS Pricing Policy for Medical Equipment, Device, and Supplies (MEDS) Items. Available at: https://www.huskyhealthct.org/provider/policies_procedures.html

PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	December 2023	Approved at the December 13, 2023 Medical Reviewer meeting. Approved at the CHNCT Clinical Quality Subcommittee on December 18, 2023. Approved by DSS on January 03, 2024.
Updated	December 2024	Procedure updated to reflect the need for a signed prescription within 12 months. Clarified the documentation requirements for a trial simulation. Changes approved at the December 11, 2024 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on December 16, 2024. Approved by DSS on December 27, 2024.