



MEDICAL POLICY STATEMENT

Georgia D-SNP

Policy Name & Number	Date Effective
Personal Emergency Response Systems-DSNP-MM-1426	09/01/2026
Policy Type	
MEDICAL	

Medical Policy Statements are developed from a review of the available evidence-based, clinical information based on and supported by clinical guidelines from medical specialties, peer-reviewed medical and scientific studies, nationally recognized utilization and technology assessment guidelines, and other medical management industry standards to aid in determining the medical necessity of a service. Medically necessary services are defined in the plan-specific Evidence of Coverage, Member Handbooks, Provider Manuals, Medical Policy Statements, and/or other plan policies and procedures.

Medical Policy Statements do not guarantee an authorization or payment of services. Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced in the Medical Policy Statement. Except as otherwise required by law, if there is a conflict between the Medical Policy Statement and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document. Reasonable discretion may be used in interpreting and applying this Policy Statement to services provided in a particular case, and the policy may be modified at any time. Medical Policy Statements may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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A. Subject

Personal Emergency Response System

B. Background

Personal Emergency Response Systems (PERS) are devices with an integrated service that can secure help in the event of an emergency. Older adults are at increased risk of recurrent falls, stroke, and other medical emergencies where a PERS could be lifesaving or help mitigate further injury. Currently available PERS allow for communication between the user and responders with additional services and alarms incorporated into the device depending on the sophistication of the device. Trained personnel at a remote monitoring station respond to an individual's alarm signal via the individual's PERS equipment. PERS can improve safety, medication adherence, and allow for independent living when part of the physician's prescribed plan of treatment.

C. Definitions

- **Personal Emergency Response System (PERS)** – Includes telecommunications equipment, a central monitoring station, and a medium for two-way, hands-free communication between the individual and the station. This does not include remote video monitoring of the individual in their home or systems that only connect to emergency service personnel.

D. Policy

- I. The use of a PERS in a member's home may be medically necessary when **ALL** the following criteria are met:
 - A. Documentation by the member's physician of the following:
 1. Specific clinical diagnoses and/or physical-functional limitations indicating a need for PERS.
 2. How PERS will improve member safety and facilitate continued residence at home.
 - B. The member retains an appropriate mobile or landline phone system that will support the PERS device.
 - C. To be eligible for PERS service, the member is assessed by CareSource case management to be:
 1. frail and functionally impaired
 2. living alone or with another functionally impaired person
 3. willing to arrange for private line telephone service, if private line is not currently in place OR willing to sign a form saying that they have accepted a wireless mobile device as an alternative
 4. mentally and physically able to use the equipment appropriately

E. Summary of Evidence

Casabona E et al. (2024) evaluated how using a PERS within a telemergency service helps identify risk profiles and assessment of any differences between non-fallers and fallers in community-dwelling older adults. In this sub-group analysis of a larger cross-

sectional study, fallers were divided into non-fallers (n=226), fallers (n=89), single fallers (n=66), and recurrent fallers (n=23). Recurrent fallers were less independent, had fewer comorbidities, and had more low-extremity disabilities. PERS use for medical issues was significantly associated with fall-risk reduction of 69% (adjusted OR=0.31, 95% CI, 0.16-0.61). Performing support calls showed a fall-risk reduction of 74% (adjusted OR=0.26, 95% CI, 0.14-0.49) in the non-fallers group

Andrew NE et al. (2021) performed a retrospective cohort study with a nested medical record audit to examine patterns of PERS use in 42,180 older adults. Falls (43%) and conditions coded as unwell (44%) were the most frequent reasons for alarm activations. Alarm attendance resulted in ambulance calls (57%), managed by the nominated contact (31%), and by the operator (12%). An ambulance was requested for 44% of the fall-related events and 81% of the events coded as unwell. Only 14% of hospital admissions resulted from a fall, with the other 86% following a patient feeling unwell. For those with a fall, 61% were admitted with the primary diagnosis of an injury, with the remaining 39% having a primary diagnosis of a medical condition. After 1-year follow-up, 78% of patients admitted to a hospital had readmissions with 24% of readmissions were primarily due to falls/injuries. Approximately 48% of the readmissions were classified as potentially preventable.

Golas SB et al. (2021) conducted a randomized controlled trial (RCT) to evaluate the impact of the Stepped-Care approach (predictive analytics and tailored nurse-driven interventions) on healthcare utilization among 370 older adult patients enrolled in a homecare management program and using PERS. The control group received care as usual and the intervention group received Stepped-Care during a 180-day intervention period. The primary outcome of a decrease in emergency encounters was not statistically significant (15%, p=0.291). There were significant reductions in total 90-day readmissions (68%, p=0.007), 90-day readmissions (76%, p=0.011), total 180-day readmissions (53%, p=0.020), and emergency medical service (EMS) encounters (49%, p=0.006). Lachal F et al. (2016) conducted a prospective cohort study to evaluate the effectiveness of light paths coupled with PERS on the functional decline in an elderly population living at home. There were 190 older adults assessed for functional status using the Functional Autonomy Measurement System (SMAF) scale at baseline and followed for 1 year. The exposed group were equipped with PERS and light paths, while the control group did not receive any additional technological assistance. Both groups had a similar percentage of stable autonomy. In the 1-year follow-up, 16% of the exposed group presented a functional decline compared with 43% of the unexposed group. In addition, 31% of the exposed group presented with functional improvement compared with 2% of the unexposed group.

Agboola S et al. (2017) conducted a retrospective, longitudinal analysis of healthcare and PERS utilization records in 4,290 older adults from 2011-2015. The primary outcome was healthcare utilization of PERS patients for 30-, 90-, and 180-day readmission rates, frequency of principal admitting diagnoses, and prevalence of conditions leading to potentially avoidable admissions. The overall readmission rate was

14.2% for 30days, 34.4% for 90days, and 42.2% for 180days. During the 5-year study duration, 90- (p=.0.3) and 180-day (p=0.04) readmission rates increased significantly. In addition, 21% of all admissions were due to potentially avoidable conditions. The PERS help button was mainly used to access help for acute or chronic condition-related symptoms and fall-related events, with significantly more symptom-related events (70%) leading to emergency room transport compared with fall-related events (29%).

Lachal F et al (2016) conducted a prospective cohort study to evaluate the effectiveness of light paths coupled with PERS on the functional decline in an elderly population living at home. There were 190 older adults assessed for functional status using the Functional Autonomy Measurement System (SMAF) scale at baseline and followed for 1 year. The exposed group were equipped with PERS and light paths, while the control group did not receive any additional technological assistance. Both groups had a similar percentage of stable autonomy. In the 1-year follow-up, 16% of the exposed group presented a functional decline compared with 43% of the unexposed group. In addition, 31% of the exposed group presented with functional improvement compared with 2% of the unexposed group.

Stokke R (2016) examined how research literature describes the use of PERS from the user perspective, indicating what is important for different actors in regard to accepting and using the technology in community care services. This integrative review included 33 studies that focused on the end user' experiences and consequences of having and using a PERS and how PERS changes caring practices and interactions between the actors. PERS contributes to safety and independent living for users by providing help and safety when needed. Use of PERS is accompanied by a range of positive and negative experiences that show that the technology is often used in unforeseen and different ways than intended (eg, older women using the PERS to scare away unwanted intruders). Having a PERS reduced hospital days and medical complications and the sense of well-being and sense of security; however, PERS did not reduce anxiety or directly improve quality of life.

F. Conditions of Coverage
NA

G. Related Policies/Rules
NA

H. Review/Revision History

DATE		ACTION
Date Issued	02/01/2023	New Policy
Date Revised	01/31/2024	Annual review: minor adjustment to background and definitions, added state-specific information, and updated the references. IN no longer covered. Approved at Committee.

The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.

	12/18/2024	Annual review: updated case management eligibility and references. Approved at Committee.
	08/13/2025	Annual review: added Summary of Evidence and updated references. Approved at Committee.
	05/20/2026	Updated references. Approved at Committee.
Date Effective	09/01/2026	
Date Archived		

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11. *Part II – Chapter 16: Policies and Procedures for EDWP (CCSP and Source) Emergency Response System Services*. Georgia Dept of Community Health; 2024. Accessed April 20, 2026. www.mmis.georgia.gov

The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.

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