MEDICAL POLICY STATEMENT
Michigan Coordinated Health

Policy Name & Number	Date Effective
Personal Emergency Response Systems-MI Coordinated Health-MM-1816	01/01/2026
Policy Type	
MEDICAL	

Medical Policy Statements are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Medical Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) 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, then the plan contract will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject
Personal Emergency Response Systems

B. Background
Personal Emergency Response Systems (PERS) are devices with an integrated service that can secure help in the event of an emergency. Currently available PERS allow for communication between the user and responders with additional services and alarms incorporated into the devices depending on the sophistication of the device. Trained personnel at a remote monitoring station respond to a member's alarm signal via the individual's PERS equipment. PERS can provide safety, assist in 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 may include a portable help button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once the button is activated. Trained personnel at the station respond to an individual's alarm signal via the individual's PERS equipment.

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 provider of all the following:
      1. specific clinical diagnoses and/or physical-functional limitations, which serve as an indication for a PERS
      2. how PERS specifically will improve member safety and facilitate continued residence in the home setting
   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 HAP 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 the member has accepted a wireless mobile device as an alternative.
      4. mentally and physically able to use the equipment appropriately
   D. The PERS meets applicable standards of manufacture, design, and installation. The Federal Communication Commission (FCC) must approve the equipment used for the response system. The equipment must meet UL® safety standards 1637 specifications for Home Health Signaling Equipment.

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E. There is documentation that the best value in warranty coverage was obtained for the item at the time of purchase.

F. The PERS provider must ensure at least monthly testing of each PERS unit to maintain proper functioning.

II. PERS coverage does not include monthly telephone charges associated with use of the device.

III. The provider must staff the response center with trained personnel 24 hours per day, 365 days per year. The response center is responsible for all the following:
   A. provide accommodations for persons with limited English proficiency
   B. maintain the monitoring capacity to respond to all incoming emergency signals
   C. ability to accept multiple signals simultaneously
   D. must not disconnect calls for a return call or put on a first call, first serve basis
   E. provide written instructions and appropriate training for staff

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 divived 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

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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 30-days, 34.4% for 90-days, and 42.2% for 180-days. During the 5-year study duration, 90- (p=.3) and 180-day (p=0.04) readmission rates increased significantly. In addition, 21% of all admission 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 users' perspective, indicating what is important for different actors in regard to accepting and using the technology in community care services. In this integrative review included 33 studies that focused on the end users' 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

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negative experiences that shows 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	07/30/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	01/01/2026	
Date Archived		

I. References

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