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Medicare Considerations for SGD Reports

General

- Medicare will only fund a device based on the user's needs RIGHT NOW, not down the road. They don't care that someone with ALS has, for example, "increased weakness" in his/her hands; you will need to document why that person cannot use his/her hands to operate a device at this point in time. Avoid talking about future needs as a reason why the client needs an SGD now.
- When writing the report, less is more. Try to be clear and concise; Medicare reviewers go through reports with a checklist.
- Focus on what the person CANNOT do because of the communication impairment, not what they CAN do, since Medicare wants to know why they should purchase this equipment, and Medicare's perspective is functional, everyday communication in the home.
- Speed of communication cannot be used as a reason why an access method or alternative treatment option is ruled out; Medicare does not care how long it takes to communicate.

Impairment Type/Severity

- Medicare will only fund a device if the user has a SEVERE speech disability. Sometimes a combination of things, like moderate dysarthria and extremely low volume/compromised breath support can result in a severe communication problem, so try to document it that way. If they don't see SEVERE in the report, they won't pay for it.

Cognitive Status

- It is a red flag for Medicare if you describe the client as having severe or profound cognitive impairment; instead, give observations of positive things the client can do.

Physical Status

- Medicare is picky about "fatigue", and reviewers want to see that it comes on quickly and causes the user to be unable to continue the activity, like writing or holding the arm up to point on a screen. General statements that say the user can't do something "due to fatigue" are not enough.
- Medicare will only fund an eyegaze accessory if all other (less expensive) access methods have been ruled out, including direct-select with touch, use of switches for scanning, and use of a Headmouse. These all need to be addressed in the report in order for Medicare to fund eyegaze.
- If you are requesting eyegaze access and the client has a motorized wheelchair and uses a joystick, the report must state why he/she cannot use a joystick to access an SGD.

Specific Daily Functional Communication Needs

- Medicare is only concerned with use of the SGD in the HOME, not out in the community.

Ability to Meet Communication Needs with Non-SGD Treatment

- Medicare will only fund a device if the user cannot make use of low-tech options, so specific use of paper communication systems like communication books and boards must be ruled out, as well as sign language and the use of writing as a functional communication mode. [Note: If a person was functioning WNL prior to change in medical condition, it is not necessary to rule out sign language. However, if condition present since birth, Medicare will look for rule out of sign language.]

Input Features/Selection Technique

- Medicare will only fund ONE access method – they will not fund a keyguard and an eyegaze accessory, for example.

Description of Equipment Used and/or Considered During the Evaluation

- Describe use of the recommended device, especially with clients who have low-cognitive functioning. Give specific examples of what the client was able to do with the device.
- Medicare looks for independent use of the device.
- Medicare reviews for reasonable and necessary. To help support an E2510 device category, the report should include rule out for devices in less-expensive categories. This includes devices in the E2506 (recorded-speech like a GoTalk) category, and E2508, which includes typing devices that require direct contact with a keyboard.

SGD and Accessories Recommended

- For devices with eyegaze, the gaze accessory must be listed separately – Medicare will not reimburse if it is referred to as "I-12+ with eyegaze". List it as I-12+ SGD, and Eyegaze Accessory.
- Each piece of equipment should have a justification for medical necessity.
- Medicare will only fund ONE type of mounting system every 5 years, and it can be a universal mount, but it must be for use in the home, not out in the community. Mount must be listed as universal mount in the report. Report must not mention multiple mounts; i.e., Client will require a universal mount (wheelchair mount and rolling mount) to access their SGD
- Medicare will not fund a universal mount consisting of a Floorstand and a desk mount; it is considered redundant.
- Carry cases are included with every device and do not need to be listed.