

State of Vermont

Agency of Human Services

Department of Vermont Health Access

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DEPARTMENT OF VERMONT HEALTH ACCESS
EVALUATION FOR A SPEECH GENERATING DEVICE

This communication device evaluation should do the following:

- Establish a current picture of the beneficiary from a medical perspective
- Promote collaboration between individual service providers, family members, and medical personnel
- Promote high expectations for the person's capacity to learn and use a communication device
- Encourage a thoughtful process of selecting the most appropriate hardware and software
- Model appropriate AAC program practices that will continue after procurement of the device
- Firmly establish the medical necessity of the speech generating device for the beneficiary

PART 1: COVER LETTER

Please complete the following information to include the relevant participants and codes related to this application.

Date of Application

Name of Prescribing SLP

Role / Title

Relationship to Beneficiary

AAC Consultant (if applicable)

Contributing Team Members

Identify individuals involved in device trial and/or documentation. Because this is a medically-based application, the OT and PT are expected to be involved. If not, please explain why:

Beneficiary

Name

Medicaid Unique ID

Date of Birth

Home Address

Primary MD

Name

Medicaid Provider #

DME Provider

Name

Medicaid Provider#

Procedure Code

E2510

E2511

E2512

E2599

Insurance

Other Insurance

Does the beneficiary have insurance other than Medicaid?

no - skip to next section

yes - complete the items below

Insurance Name

Policy #:

Denial

REQUIRED denial documentation attached

PART 2: BENEFICIARY

BENEFICIARY DEMOGRAPHICS

For the purposes of this application, the term “Beneficiary” refers to the person with augmentative communication needs unless otherwise noted.

Medical Diagnoses (include ICD10 diagnosis code)

Communication Diagnosis (include ICD10 diagnosis code)

Medical Necessity

Check all statements below that are true and demonstrate medical necessity:

- Beneficiary requires speech-language pathology treatment
- Beneficiary is unable to meet their daily communication needs using natural communication methods
- Speech-generating device is recognized in current, peer reviewed medical literature as an appropriate treatment for beneficiary’s communication impairment diagnosis.
- Beneficiary’s receptive language is or appears higher than their expressive language
- Beneficiary’s ability to report medical needs, including but not limited to activities of daily living, communicate with medical personnel, share important personal information, is impacted by a speech impairment.

BENEFICIARY PROFILE

This section provides a quick look at the health, medical and personal issues that may have a significant impact on the beneficiary’s functioning. Indicate with an ‘X’ if the area listed significantly impacts the beneficiary. These areas may affect the device selection process and should be referenced when considering hardware and software, to ensure that appropriate items are selected.

<input type="checkbox"/>	PERSONAL	<input type="checkbox"/>	Literacy
<input type="checkbox"/>	home language	<input type="checkbox"/>	reading
<input type="checkbox"/>	mental health	<input type="checkbox"/>	writing
<input type="checkbox"/>	Medical	<input type="checkbox"/>	Motor
<input type="checkbox"/>	chronic condition(s) / illnesses	<input type="checkbox"/>	mobility – standing, walking, stability
<input type="checkbox"/>	seizures	<input type="checkbox"/>	positioning – sitting, lying down
<input type="checkbox"/>	medication	<input type="checkbox"/>	manual access – reach, point, touch
<input type="checkbox"/>	Sensory	<input type="checkbox"/>	Daily Living Activities
<input type="checkbox"/>	vision	<input type="checkbox"/>	feeding / eating
<input type="checkbox"/>	hearing	<input type="checkbox"/>	bathing /grooming / dressing
			toileting
<input type="checkbox"/>	Cognition and Behavior	<input type="checkbox"/>	Communication

- | | |
|--|---|
| <input type="checkbox"/> organization | <input type="checkbox"/> speech |
| <input type="checkbox"/> attention / focus | <input type="checkbox"/> auditory comprehension |
| <input type="checkbox"/> memory | <input type="checkbox"/> language |
| <input type="checkbox"/> problem-solving | <input type="checkbox"/> communication |
| <input type="checkbox"/> initiation | <input type="checkbox"/> social skills |
| <input type="checkbox"/> self-regulation | <input type="checkbox"/> joint attention |
| <input type="checkbox"/> behavior | |

In the spaces provided below, please provide a comprehensive view of the beneficiary from a medical, physical, sensory, cognitive and communication perspective. If you have identified areas of significant impact above, please explain those in more detail below.

PROFILE AREA	DESCRIPTIVE INFORMATION
PERSONAL	<i>Relevant home factors, such as language and cultural differences; mental health issues; family factors</i>
Medical	<i>Medications; cardiovascular/pulmonary; psychosocial; chronic conditions; neurological; orthopedic; seizures</i>
Sensory	<i>Vision status; eye control; hearing status; hearing aids; tactile status</i>
Motor	<i>Manual access – reach, point, touch; typing abilities; hand dominance; hand functioning Mobility – standing, walking, stability; Positioning – sitting, lying down; Posture and movement: head control, trunk control, posture; tone</i>
Daily Living Activities	<i>Feeding/eating; bathing; dressing; grooming; toileting Assistance level: Independent, minimal, moderate, or maximum</i>
Cognition and Behavior	<i>Attention; memory; problem solving; understand cause/effect; learning Self-regulation; aggression; impulse control</i>
Literacy	<i>Reading and writing abilities</i>
Communication	<i>Auditory comprehension/listening; language; MLU; speech characteristics (e.g. intelligibility, comprehensibility); modes: natural speech, sign, facial expression, point, eye gaze, gesture, other; history related to communication such as previous SLP treatment; previous technology and why it is no longer appropriate</i>

PART 3 - COMMUNICATION DEVICE EVALUATION

The information in this section reflects the device trial process, outcomes, and plan for next steps. Please enter the information requested by referencing your own trial planning and data documents.

Summary of Trial

DEVICE TRIAL OVERVIEW

time The device trial began _____ and continued through _____
(must be at least one month and must include home use):

materials The following items were trialed: _____

decision As a result of this trial, the team has identified the following device and application as the most appropriate, medically necessary equipment:

Technology Selection

As a result of the device consideration process, the team has determined:

- that a Mobile Communication Device - commercially available technology, such as iPad - is appropriate for the individual. [MOVE TO THE NEXT SECTION]
- that a Specialized Communication Device – a device specifically designed for augmentative communication and available through specialized vendors, such as a traditional speech generating device - is required for the individual.

Specialized Device Evidence

Consideration of assistive technology requires identification of the most cost-effective tool to meet the individual's needs. Please provide specific, compelling evidence that demonstrates that the individual could not use a Mobile Communication Device and instead requires a Specialized Communication Device. Address motor/physical access, sensory access, and durability issues as appropriate:

DEVICE SELECTION PROCESS – Overview of the trial of selected device/program

Name of **device** and specific **program** or app selected: _____

Necessary/ important device and program **settings**, including specific page set or **version** of the program or app:

Team members who are part of the trial, including implementation, data collection, and device application input (must include family): _____

Contexts, locations, activities, places where the trial took place (must include home):

PERFORMANCE NOTES - Summary of the information gathered during the trial.

Beneficiary's method of **accessing** the device: _____

Beneficiary's response to the device in terms of their interest, **engagement**:

Beneficiary's level of **independence** with the device, including **initiation** (spontaneous, independent production):

Functions of language that were observed during the trial, including examples taken from the trial when possible: _____

ANALYSIS - Team's conclusions from the trial process.

Reflections of trial process and outcomes from team members: _____

Information about all **other devices or applications** that were considered during the trial but were not selected:

Anticipated application of the device for **medical necessities**: _____

IMPLEMENTATION PLAN - Team's plan for what to do once the prescribed equipment is received.

Person who will **coordinate** the device implementation and other **team** members who will be actively involved:

Training required and plan for meeting them (must include family): _____

Plan to ensure the device is transported, used, and stored **safely** and receive necessary **maintenance**:

BASELINE / ENDLINE PERFORMANCE CHART

Beneficiary Name:						
Rating Scale	0	never, rarely	1	sometimes, inconsistently	2	consistently
Device/Application						

Start Date:						End Date:		
Start Trial			Observable Behavior	End Trial				
0	1	2		0	1	2		
			Device Awareness / Acceptance					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	permits device in personal space	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	permits partner to use device in personal space	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	looks towards device	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	attends to partner using device	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	attends to device display	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
			Early – Emergent Independent Access					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reaches for display	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	explores targets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	explores targets intentionally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	activates targets following model (imitation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reaches for display at appropriate time in interaction (accuracy not considered)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	reaches for/towards specific target	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	navigates to word not on current screen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	remembers navigation to familiar message (in same session)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	remembers navigation to familiar message (not in same session)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Uses single word for a variety of communicative functions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Uses a variety of vocabulary / parts of speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Advanced Independent Access			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sequences icons to produce single word/message (no navigation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sequences icons to produce multi-word (2 or more words) phrase/sentence (no navigation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	locates word within categories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	produces 2-word phrase	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	produces 3-word phrase	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	produces 4 / 4+ word phrases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	repairs errors in navigation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	uses word endings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			App Operations			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	activates message window to speak message	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	uses "clear" (display) function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	uses "delete" (letter, word) function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	uses "home" button to return to main screen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shows ownership of device	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Text-Based Skills			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	uses app keyboard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	uses keyboard word prediction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART 4 - PRESCRIPTION

This form is a prescription for speech generating devices and accessories. Provide specific information about beneficiary, providers (doctor, SLP, vendor) and their contact information, and prescribed items. Signatures from the beneficiary (or legal guardian) medical doctor, and SLP are required.

Beneficiary Prescription Information

Beneficiary Name:

Beneficiary Address:

Beneficiary Email: (for mobile communication devices only)

Beneficiary Unique Medicaid ID:

Beneficiary Apple ID: (for mobile communication devices only)

Beneficiary Apple iTunes password: (for mobile communication devices only)

Diagnosis Code:

Procedure Code

E2510 E2511 E2512 E2599

PRESCRIBED MOBILE DEVICE, APPLICATION, AND PERIPHERALS

Item	Need?	Specific Name	Vendor	Medical necessity rationale	Procedure Code
iPad	<input type="checkbox"/>				
application	<input type="checkbox"/>				
carry/protective case	<input type="checkbox"/>				
stand	<input type="checkbox"/>				
speakers	<input type="checkbox"/>				
switch	<input type="checkbox"/>				
switch	<input type="checkbox"/>				
keyguard	<input type="checkbox"/>				
mounting system	<input type="checkbox"/>				

- mounting system
- stylus
- other

I acknowledge that this device is medically necessary and is provided for use as the sole dedicated speech-generating device for this beneficiary. The purpose of the device provided is for communication that originates from the beneficiary and not a facilitator or support person, and the device must be used as determined by the prescribing speech language pathologist to ensure the safety and maximum benefit of the beneficiary. All parties signed below deem this prescription accurate and medically appropriate:

Beneficiary or legal guardian Printed Name
 Signature
 Date
 Contact Information

Primary care physician Printed Name
 Signature
 Date
 Contact Information

Speech Language Pathologist Printed Name
 Signature
 Date
 Contact Information

PART 5 - DURABLE MEDICAL EQUIPMENT OWNERSHIP, OPERATION, AND MAINTENANCE AGREEMENT

Revision: November 6, 2020, January 2, 2019, May 8, 2014, June 25, 2013 Original: April 23, 2012

Provider and beneficiary/legal guardian must sign this sheet during the prescription/authorization/delivery process and provide it to the beneficiary for signature during that time. The provider must keep this form on file and provide a copy to the beneficiary for their records. If Vermont Medicaid is providing primary coverage for the device, a Vermont Medicaid sticker must be affixed to the device upon delivery of the equipment. Do not apply a sticker or sign this form if the device will be covered by a primary insurance.

Your checkmark or initials, and your signature at the bottom of the form indicate agreement with each statement.

Provider Acknowledgement: *Please check each statement*

- I have researched, and have not found, any less costly devices that would be appropriate to the beneficiary's medical needs at this time. Any components from the individual's current equipment that can be utilized will be placed on the new device.
- I have instructed the beneficiary/caregivers on the safe use of the device.
- I have explained to the beneficiary/caregivers that, should the device no longer meet the medical need or be needed by the beneficiary, it is the property of Vermont Medicaid and should be returned to Vermont Medicaid; please call the number on the sticker placed on the equipment by the provider.
- I have explained to the beneficiary/caregivers that the expectation is that this device will last for at least 5 years and should be treated so that it will last for this amount of time. If there is a change in the beneficiary's condition, consideration will be given to replacing the device/accessories.
- I have explained to the beneficiary/caregivers that, should any defects in the device develop, the beneficiary should report the defects to the vendor.
- I have explained to the beneficiary/caregivers that, should the device be lost or stolen, a police report must be submitted with any request for replacement of the device.

Beneficiary / Legal Guardian Acknowledgement: *Please check each statement*

- I accept the specific device and/or components that have been requested on my behalf by the prescribing medical professional.
- I have had an opportunity to try the device or a simulation so that I know it will work for me/my child.
- I understand how to properly care for and maintain the device so that it can last for 5 years.
- I understand how to properly operate the device.
- I understand that to return the device, I should call the number on the sticker that has been placed on the device.
- I understand that if the device is lost or stolen, a police report must be submitted with any request for a replacement of this device

Provider's signature

Date

Beneficiary / legal guardian signature

Date