3) DEPARTMENT OF VERMONT HEALTH ACCESS
EVALUATION FOR AUGMENTATIVE COMMUNICATION DEVICE
Guidance for Application Completion

November 2016

OVERVIEW OF APPLICATION

The Medicaid evaluation for augmentative communication devices has 4 main parts. Each part is described briefly below.

Part 1 Beneficiary/ Request Information	
PROCEDURE CODES	The codes for the device and all requested components
DEMOGRAPHICS	Beneficiary's contact and identification
PRESCRIPTION CONTACTS	Medicaid information for physician, vendor, and Speech Language Pathologist (SLP)
INSURANCE	Other insurance, and documentation of denial.
Part 2: Beneficiary's Abilities and Needs	
MEDICAL NECESSITY	Details of beneficiary's diagnoses and conditions that impact their speech.
CURRENT STATUS	Relevant information about the beneficiary's abilities and needs.
Part 3: Device Consideration Process	
OVERVIEW	Brief description of how the device consideration process was conducted
RESULTS	Outcome of device consideration in form of access methods and requested device/app.
DEVICE AND APP PROFILE	Features of each device and app that was trailed.
PERFORMANCE PROFILE	Skills observed before and after trial of selected device/app.
Part 4: Next Steps:	
PLANNING	Treatment goals and plan.

Prescription	
Agreement	

Detailed Guide to Completing Form

Part 1: Beneficiary / Beneficiary Information	
Date of Application	Date application is completed and submitted to Medicaid
Requested Procedure Codes	Provide the proper procedure code for the device and all requested components. For iPad/iPod, the device and all components are bundled together under the single code E2510. Coding assistance is available from the vendor for traditional devices.
Beneficiary's Demographics	Provide requested information specific to the beneficiary's name, Medicaid ID, date of birth, and home address.
Prescription Contacts	Provide the name and provider numbers for the beneficiary's physician, the SLP who is prescribing this device, and the DME provider. For iPad/iPod, the DME provider is: Small Dog Electronics. Their provider # is 1019949.
Beneficiary's Insurance	If the beneficiary has any other insurance, you must provide the name of the insurance, the policy number, and you MUST obtain documentation from the insurer that states that the request for a speech device has been denied including an explanation of the reason for the denial.
Part 2: Beneficiary's Abilities and Needs	
Medical Necessity	The questions in this section are designed to establish that the AAC device is being requested due to medical necessity. Medical necessity is a requirement for all Medicaid coverage. Include information about the beneficiary's medical diagnoses that impact their speech and the specific communication diagnosis, with related ICD 10 diagnostic codes. Indicate if all the necessary elements of medical necessity are true for the client. If you cannot say "yes" to all the statements, document an explanation in the text space provided.
Beneficiary's Current Status	
hearing	Record the date of the most recent hearing testing and the results, or document if hearing is not a concern.

VISION	Record the date of the most recent visual acuity and cortical vision testing and the results, or document if visual acuity is not a concern.	
FINE MOTOR	Briefly describe the person's fine motor abilities and challenges specifically related to accessing and using a speech-generating device. Consider hand use, grading of movement, strength, accuracy of point, typing, etc. When appropriate, discuss alternate access methods (e.g. switch, alternate body part for direct access) and any necessary personnel supports, equipment, and adapted materials.	
GROSS MOTOR	Briefly describe the person's gross motor abilities and challenges related to seating, positioning, and mobility, including any necessary personnel supports, equipment, and adapted materials. Include information specifically related to accessing and using a speech-generating device such as the ability to transport and access the device from different positions.	
COGNITION	Briefly describe what is known about the person's cognitive abilities and challenges, such as memory, attention, and learning. Include any necessary personnel and material supports.	
LITERACY	Describe the beneficiary's current reading and writing skills. Include any technology or other supports the person uses.	
BEHAVIOR	Document any behavior issues that may affect the beneficiary's use of a speech generating device.	
NEUROLOGICAL	Document any neurological issues, such as tonal changes or seizure activity, that may affect the beneficiary's use of a speech generating device.	
MEDICATIONS	List the beneficiary's medications that may affect their ability to use a speech generating device.	
CARDIOVASCULAR/ PULMONARY	Document any cardiovascular or pulmonary issues that may affect the beneficiary's use of a speech generating device. For example, a cardiac condition that causes fatigue, or a pulmonary condition that affects breath support.	
COMMUNICATION	RECEPTIVE	Describe what the beneficiary comprehends, understands.
	EXPRESSIVE MODES	Describe the beneficiary's current modes of communication, such as unaided forms (e.g. actions, gestures, signs, speech) and aided forms (paper-based supports, high-tech supports). Do not include the use of the device being requested in this section.

	FUNCTIONS	Indicate which communicative functions the beneficiary currently expresses, in any form (not including the AAC device being trialed).
	MEAN LENGTH OF UTTERANCE (MLU)	Average number of words per utterance (any combination of forms) as determined by language sample.
	INTELLIGIBILITY	Percent of speech that is understood by partners. Include familiar and unfamiliar partners, familiar and unfamiliar content.
PERSONAL	Include any information about the beneficiary – their personality, preferences, etc. – that is important to consider in the device process.	
PAST HISTORY	Document the past history of SLP treatment.	
OTHER MEDICAL EQUIPMENT	Document the equipment used by the beneficiary that may impact their use of the speech generating device. For example, a person using a wheelchair may need a mounting system.	
INVOLVEMENT OF OT/PT	Document the other therapy disciplines that assisted in the evaluation process. For example, an OT may have been involved in determining the precise location for the most efficient use of a wheelchair-mounted device.	
POSITIONING NEEDS	Document if specific positioning needs are required to ensure that the device will work for the beneficiary. For example, a person using a wheelchair, with limited motor endurance, may need a particular arm support to use the speech generating device.	
TRANSPORTATION	Document the modes of transportation used by the beneficiary. For example, a school bus or public transportation.	
ADL STATUS	Document the amount of assistance needed to perform activities of daily living such as feeding, grooming, dressing, and hygiene.	
TECHNOLOGY	Document all previous types of technology related to speech generation that have been used by this beneficiary, when it was used, and why it is no longer appropriate.	
CURRENTLY AVAILABLE TECHNOLOGY	Specify what is currently available to the beneficiary. For example, an ipad may be available at school, and has been used successfully, but is not available for home/community use.	
PSYCHOSOCIAL	Provide information related to the beneficiary's life that may impact the use of the speech generating device. For	

	example, if the person needs to walk for long distances, a carry case with a strap may be needed.
PART 3: DEVICE CONSIDERATION PROCESS	
CONSIDERATION	The term "consideration" is used to refer to the larger process of identifying an appropriate AAC device.
TRIAL	The term "trial" is used to refer to the more specific process of using an AAC device with the client and recoding the results.
Overview	
START/END DATES	Identify when the device consideration process began and when it ended. Also document when the trial of the requested device started and when it ended. A successful one month trial inclusive of both the home and community settings is required.
TEAM ROLES	Identify all team members who were involved in the device consideration process. Document if an external AAC specialist participated in the process.
LOCATIONS	Document the contexts used as part of the device trial process. Note that the home MUST be included as one of the contexts.
DEVICES AND APPS	List the names of the devices and applications (apps) or programs, if non-iPad devices were considered that were considered in this process.
PROCESS	Briefly describe the sequence of activities conducted as part of the device consideration process.
RESULTS	• Identify the specific device and app that was selected as a result of the consideration process. • Indicate and describe the access method that was identified as the most appropriate.
DEVICE AND APP PROFILE	
A device/app profile should be completed for <u>each</u> device/app that was used in a trial with the client. Devices/apps that were considered (but not actually tried) do not need to a profile.	
DEVICE/APP	Indicate the name of the device/app. Also, indicate which page set or vocabulary you have selected.
TARGETS	Specify the number of messages per page (indicate range if it varies) and the number of messages in the overall app. It is helpful to include a screen shot of the main page to help the reviewer know what the display looks like.

CONTENT	Indicate the types of messages that are available within the device/app. The client does not need to be using all of these at this time – these categories represent robust system elements that would be there as a potential for use.
FEATURES	Indicate the features, settings, or options that are available within this device/app. Again, they do not need to be used by the beneficiary, but it is important that the team know what is possible. A screen shot may be included if that is helpful.
TRAINING	Indicate how the team obtained information about this device/app and its features to be able to make an informed decision about its potential. Include AAC specialist training, webinars, vendor support etc.
TRIAL	Describe the device trial process. Information should include: contexts, activities, frequency of trials/data collection, partners, instruction, and client performance. Data sheets may be attached if they clearly display the necessary information.
OUTCOME	Identify what was decided as a result of the trial of the device/app – whether it was selected as the appropriate device/app and if not, why.
BASELINE AND ENDLINE PERFORMANCE PROFILE	
This form should be completed for <u>each</u> device/app trialed. Devices/apps that were considered (but not actually tried) do not need to a profile.	
RATING SCALE	Indicate how well/often the beneficiary demonstrates the target behavior: 0 = never 1 = sometimes or inconsistently demonstrates the behavior 2 = consistently, usually, often demonstrates the behavior
OBSERVABLE BEHAVIORS	Use this list of behaviors to help identify appropriate device trial outcomes. Consider which behaviors are demonstrated consistently (current level of functioning), which are inconsistent (aim to become more consistent) and which are not observed (provide opportunities for learning and showing these behaviors). This list is NOT a list of prerequisites or a hierarchy – it is one way of recording trial outcomes.
PLANNING	
SHORT TERM OUTCOMES	Identify goals that appear to be attainable within the next year.
LONG TERM OUTCOMES	Identify goals that appear to be attainable with multiple years of instruction and use.

TRAINING SUPPORT	Identify the plan to educate and support communication partners, particularly home partners.
RESPONSIBLE PARTIES	Indicate who – at home and other primary context (e.g. school, work) - will assume responsibility for keeping the device safe from damage, theft, or loss and device maintenance. Provide contact information.

PRESCRIPTION
Choose the correct prescription form and complete it entirely. Do not leave blank spaces or the request may be delayed or denied.

REQUESTED DEVICE AND PERIPHERALS
Identify the device and app that was selected as a result of the consideration and trial process. Also indicate all of the peripherals/equipment necessary to access and use the device across contexts.

AGREEMENT
The Ownership, Operation, and Maintenance form must be signed by all responsible parties and included in every request to Vermont Medicaid.

4) DEPARTMENT OF VERMONT HEALTH ACCESS

EVALUATION FOR AUGMENTATIVE COMMUNICATION DEVICE

This form must be completed in its entirety to enable review.

January 2017

PART 1: BENEFICIARY/REQUEST INFORMATION

Date of Application: Month: _____ Day: _____ Year: _____

Requested Procedure Codes:
☐E2500 ☐E2502 ☐E2504 ☐E2506 ☐E2508 ☐E2510 ☐E2511 ☐E2512 ☐E2599

BENEFICIARY'S DEMOGRAPHICS

Name: _____ Medicaid Unique ID: _____

Date of Birth: month: _____ day: _____ year: _____

Home Address: house /apt # _____

street: _____

city/town: _____

state: VT zip: _____

PRESCRIPTION CONTACTS

Primary MD Name: _____ MD Medicaid Provider #: _____

Prescribing SLP Name _____ SLP Medicaid Provider #: _____

DME Provider Name: (if an ipad/ipod: Small Dog Electronics _____ DME Medicaid Provider#: (if an ipad/ipod: 1019949) _____

BENEFICIARY'S INSURANCE

Does the beneficiary have any insurance other than Medicaid?

☐ no - skip to next section ☐ yes - complete this section

Insurance Name _____ Insurance Policy #: _____

☐ Attach the denial letter or denial policy from the Primary Insurance: REQUIRED

PART 2: BENEFICIARY'S ABILITIES AND NEEDS

MEDICAL NECESSITY

Beneficiary's medical diagnoses and conditions that contribute or relate to their communication impairment (include icd-10 diagnosis codes and dates of onset):Click or tap here to enter text.

Beneficiary's precise communication diagnosis (e.g. apraxia, dysarthria):
Click or tap here to enter text.

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

☐

☐ 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 the beneficiary's communication impairment diagnosis.

☐ Beneficiary's receptive language appears to be at a higher level than their expressive language abilities.

☐ Beneficiary's ability to report medical needs including but not limited to activities of daily living, communicate with medical personnel, and share important personal health information is impacted by speech impairment.

BENEFICIARY'S CURRENT STATUS

Sensory	Hearing: Click or tap here to enter text. Vision: Click or tap here to enter text. Eye Control:Click or tap here to enter text.
Motor	Fine motor: Click or tap here to enter text. Ability to point:Click or tap here to enter text. Ability to type:Click or tap here to enter text. Hand Dominance:Click or tap here to enter text. Gross motor: Click or tap here to enter text. Mobility status:Click or tap here to enter text. Trunk control:Click or tap here to enter text. Head Control:Click or tap here to enter text. Posture:Click or tap here to enter text.
Cognition and Literacy	Cognition:Click or tap here to enter text. Attention: Click or tap here to enter text.

Behavior	Memory: Click or tap here to enter text. Problem Solving:Click or tap here to enter text. Understanding of cause/effect: Click or tap here to enter text. Learning:Click or tap here to enter text. Literacy: Click or tap here to enter text. Click or tap here to enter text.
Neurological	Seizure activity:Click or tap here to enter text. Tone: Click or tap here to enter text.
Medications	Click or tap here to enter text.
Cardiovascular /Pulmonary	Click or tap here to enter text.
Communica-tion	Receptive: Click or tap here to enter text. Expressive:Click or tap here to enter text. Method of Expression: (check all that apply) ☐Natural Speech ☐Sign ☐Facial expression ☐Point ☐Eye gaze ☐Gesture ☐Other Functions: ☐request items/ action ☐request assistance ☐comment, describe ☐interject / social ☐direct others ☐ask questions / request info ☐affirm / agree ☐social etiquette Mean Length of Utterance: Click or tap here to enter text. % Intelligibility: Click or tap here to enter text.
Personal:	Click or tap here to enter text. History related to communication including previous SLP treatment:

Past History:	Click or tap here to enter text.
Other medical equipment:	(example: Wheelchair, hearing aid, visual assistance device):Click or tap here to enter text.
Involvement of OT/PT (if applicable:	Click or tap here to enter text.
Positioning needs	Click or tap here to enter text.
Transportation	Click or tap here to enter text.
ADL status:	☐Independent ☐Requires minimal assistance ☐Requires moderate assistance ☐Require maximal assistance
Previously used technology and reason why the previous technology is no longer appropriate:	Click or tap here to enter text.
Currently available technology: Home:	Click or tap here to enter text.
School:	Click or tap here to enter text.
Psychosocial:	Click or tap here to enter text.

PART 3: DEVICE CONSIDERATION PROCESS

OVERVIEW	
Start/ end dates	Device consideration dates: Click or tap here to enter text. Trial dates: (Must be at least 1 full month including home trials): Click or tap here to enter text.
Team roles	Click or tap here to enter text.
Locations	Click or tap here to enter text.
Devices and Apps	Click or tap here to enter text.
Process	Click or tap here to enter text.

RESULTS			
Device/App	Selected device_____ Selected Hardware_____	Selected App _____	
Access	Access Method	☐ direct select	☐ scanning
	Describe_____		

iDEVICE VERSUS DEDICATED OR OPEN SPEECH GENERATING DEVICE				
Consideration of assistive technology requires identification of the most cost-effective tool to meet the individual's needs. The information below must be provided if the team has, as a result of the device consideration process, determined that a speech generating device other than an iDevice is required for the individual.				
Rationale	☐	motor/physical access	☐	sensory (vision, hearing) access
	☐	durability	☐	other
Explanation	Please provide specific, compelling evidence that demonstrates that the individual could not use an iDevice and instead requires an alternate speech-generating device.			

	_____

DEVICE AND APP PROFILE

Device 1 profile:	_____	
App 1 profile:	Name _____	
	Page Set _____	
Targets	Per page _____	
	Total _____	
Content	☐ individual words	☐ phrases, sentences
	☐ alphabet/keyboard	☐ social terms, interjections
	☐ regulatory/control vocabulary	☐ verbs/actions
	☐ question words	☐ adjectives, adverbs
	☐ pronouns/people	☐ nouns
Features	display _____	
	buttons _____	
	speech _____	
	message window _____	
	rate enhancement _____	
	other _____	
Training	_____	
Trial	_____	
Outcome	_____	

Device 2 profile (if applicable):	n/a: ☐ _____
App 2 profile (if applicable):	n/a: ☐ Name _____
	Page Set _____
Targets	Per page _____
	Total _____

Content	☐ individual words	☐ phrases, sentences
	☐ alphabet/keyboard	☐ social terms, interjections
	☐ regulatory/control vocabulary	☐ verbs/actions
	☐ question words	☐ adjectives, adverbs
	☐ pronouns/people	☐ nouns
Features	display _____	
	buttons _____	
	speech _____	
	message window _____	
	rate enhancement _____	
	other _____	
Training	_____	
Trial	_____	
Outcome	_____	

BASELINE AND END LINE PERFORMANCE PROFILE

Rating Scale:
0 = never
1 = sometimes, inconsistently
2 = consistently

Start Trial			Observable Behavior	End Trial		
0	1	2	Device Awareness / Acceptance	0	1	2
☐	☐	☐	allow device in personal space	☐	☐	☐
☐	☐	☐	looks towards device	☐	☐	☐
☐	☐	☐	attends to partner using device	☐	☐	☐
☐	☐	☐	attends to device display	☐	☐	☐
0	1	2	Early – Emergent Independent Access	0	1	2
☐	☐	☐	reaches for display	☐	☐	☐
☐	☐	☐	explores display	☐	☐	☐
☐	☐	☐	reaches for display at appropriate time in interaction	☐	☐	☐
☐	☐	☐	reaches for/towards specific target	☐	☐	☐

☐	☐	☐	navigates to word not on current screen	☐	☐	☐
☐	☐	☐	remembers navigation to familiar message (not in same session)	☐	☐	☐
0	1	2	Advance Independent Access	0	1	2
☐	☐	☐	sequence targets to produce word (same page)	☐	☐	☐
☐	☐	☐	sequence targets to produce phrase/sentence (same page)	☐	☐	☐
☐	☐	☐	locates word within categories	☐	☐	☐
☐	☐	☐	produces 2 word phrase	☐	☐	☐
☐	☐	☐	produces 3 word phrase	☐	☐	☐
☐	☐	☐	produces 4/4+ word phrases	☐	☐	☐
☐	☐	☐	repairs errors in navigation	☐	☐	☐
☐	☐	☐	uses word endings	☐	☐	☐
0	1	2	App Operations	0	1	2
☐	☐	☐	activates message window	☐	☐	☐
☐	☐	☐	uses navigation buttons such as "home", "back"	☐	☐	☐
☐	☐	☐	uses "clear" (display, word) function	☐	☐	☐
0	1	2	Text-Based Skills	0	1	2
☐	☐	☐	types using keyboard	☐	☐	☐
☐	☐	☐	uses word prediction	☐	☐	☐

PLANNING

TRIAL OUTCOMES	_____
EXPECTED SHORT TERM OUTCOMES	_____
EXPECTED LONG TERM OUTCOMES	_____
TRAINING SUPPORT	Must include robust assistance for home/community users: Click or tap here to enter text. Plan to keep device safe from damage, theft or loss: Click or tap here to enter text.

PARTIES RESPONSIBLE FOR DEVICE SECURITY AND MAINTENANCE	home	name	_____	contact	_____
	school	name	_____	contact	_____
	work	name	_____	contact	_____

If the request is for a replacement device due to loss or theft, attach police report