Augmentative & Alternative Communication Device Evaluation

DATE OF EVALUATION:

EVALUATION SITE & REFERRING PHYSICIAN

Evaluation Site/Facility Name:

Evaluating Speech-Language Pathologist:

Referring Physician: NPI:

PATIENT INFORMATION

Patient Name:

Date of Birth: Age: Medicaid ID:

Home Address:

Medical Diagnoses:

Diagnosis	ICD-10 Code	Date of Onset

Communication Diagnoses:

Diagnosis	ICD-10 Code	Date of Onset	Severity*

PURPOSE AND SCOPE

The purpose of this augmentative and alternative communication (AAC) form is to provide a comprehensive guide that ensures a thorough and complete assessment of the patient's severe speech impairment and the medical condition that warrants the use of a device as described by the American Speech-Language-Hearing Association (ASHA) and Centers for Medicare & Medicaid Services (CMS). The checklist format provides a comprehensive structure to ensure the necessary areas of assessment are conducted, evaluated, and documented.

INSTRUCTIONS FOR USE

This form is intended to be completed by a Licensed Speech-Language Pathologist and/or multi-disciplinary team. Complete all sections of this template to ensure compliance with best practices and scope of benefit national coverage determination prescribed by ASHA and CMS.

I. CURRENT COMMUNICATION IMPAIRMENT

A. General Statements

Secondary to diagnosis of _____, patient presents with severe communication impairment characterized by _____. For this reason, patient was referred for this evaluation by the physician listed above.

B. Therapeutic History

The patient has participated in therapies for the following frequency, duration and across the listed settings:

- ☐ Speech therapy: _____in the _____ setting.
- ☐ Occupational therapy: _____ in the _____ setting.
- ☐ Physical therapy: _____in the _____setting.
- ☐ Other: _____.

Therapy has resulted in limited progress and the patient is unable to use their natural communication to meet their daily communication needs.

C. Current/Previous Speech-Generating Device

Does the patient currently own, or did the patient previously own, an Augmentative Communication Device?

- ☐ No
- ☐ Yes (provide information below)
  - Make and model of device: _____
  - Date of Purchase: _____
  - Funding Source: _____
  - Functional benefit of upgrade: _____

D. Comprehensive Assessment

a. Hearing

☐Hearing is within functional limits (WFL) with no modifications needed.

☐Patient presents with hearing loss but compensates in the following way: _____

☐Patient is aided with _____

☐Other: _____

With modifications listed above, the patient's hearing skills are functional for the purpose of AAC use at this time.

b. Vision

☐Visual acuity is WFL with no modifications needed.

☐Patient uses prescription glasses or contacts:

- ☐Single-focus lenses
- ☐Progressive lenses
- ☐Bifocals
- ☐Other_____

☐Patient presents with decreased visual acuity but compensates in the following way:

_____

☐Other: _____

With modifications listed above, the patient's visual skills are functional for the purpose of AAC use at this time.

c. Physical

This patient possesses the necessary physical abilities to effectively use a SGD and accessories to communicate and achieve functional goals (listed below).

Mobility

☐ Ambulates safely and independently.

☐ Uses a wheelchair

Make/Model_____

☐ Other mobility aids: _____

Neuromuscular

☐ Muscle tone WFL

☐ High muscle tone

☐ Low muscle tone

☐ Degenerative condition that indicates progressive change of tone over time

Fine Motor

☐ Patient demonstrates the ability to use direct access with SGD

☐ Patient requires access modifications (listed in the device rational section below)

d. Language and Cognition

This patient possesses the necessary cognitive/linguistic abilities to effectively use a speech-generating device and accessories to communicate and achieve functional goals (listed below).

Patient demonstrates the following language/cognitive skills:

☐ Consistent response to name

☐ Understands single words

☐ Attends when spoke to

☐ Comprehends yes/no, open-ended and choice questions

☐ Follows one-step directions

☐ Follows multiple-step directions

☐ Understands simple conversation

☐ Understands complex adult conversation

☐ Performs functions necessary to effectively trial SGDs

Patient demonstrates the following literacy skills:

☐ Pre-literate patient that recognizes photos and symbols to utilize a symbol-based system for expressive communication.

☐ Literate patient that is dependent on text-to-speech systems for expressive communication.

e. Oral Motor & Speech Intelligibility

☐ Non-verbal

☐ Decreased speaking rate of _____ WPM. Speaking rates < 95-110 WPM are often indicative of an imminent decline to nonverbal status.

☐ Decreased intelligibility, estimated at ___% to an unfamiliar listener.

☐ Oral motor control is impacted in the following ways: _____

_____

☐ Oral mechanism examination revealed the following: _____

_____

f. Social / Behavioral Observations

Patient demonstrates the following:

☐ Motivation to use a SGD to communicate wants and needs.

☐ Has a positive change in behavior with access to a SGD.

☐ Absence of a communication device results in the following negative behavior: _____

_____

g. Anticipated Course of Impairment (select one or more):

☐ Communication is unlikely to improve without use of the recommended SGD.

☐ High probability of continued decline in verbal speech

☐ Other: _____

II. DAILY COMMUNICATION NEEDS

A. Patient's specific daily communication needs include (select all that apply):

☐ Expressing needs in emergency situations

☐ Expressing physical wants and needs (e.g., hunger; thirst; pain; toileting)

☐ Expressing informed consent regarding medical decisions

☐ Gaining a listener's attention (e.g., "help!")

☐ Requesting object/action (e.g., "drink!")

☐ Refusal (e.g., saying "I don't want that")

☐ Sharing information (e.g., providing name and address in case of emergency)

☐ Commenting (e.g., "yum, that's good!")

☐ Labeling (e.g., "that's a cup.")

☐ Asking questions (e.g., "Did I take my medicine?")

☐ Asking for repetition (e.g., "I didn't understand. Can you say that again?")

☐ Answering yes/no questions

☐ Answering open ended questions (e.g., providing an appropriate answer to "What's up with you?")

☐ Other: _____

B. Ability to Meet Communication Needs with Natural, Non-SGD Treatment

This patient's daily communication needs cannot be met by natural speech. Natural, non-SGD approaches, such as sign-language, picture exchange and manual communication boards, are insufficient to meet the patient's needs. These approaches limit access to a robust vocabulary and do not provide auditory feedback required to check for accuracy of message selection and gain attention in an emergency. To express their wants, needs and concerns with the highest level of independence and specificity, the patient requires a dynamic SGD.

Writing messages was considered; this is an insufficient method of communication for the patient. The patient cannot use writing as a reliable communication method because pen and paper are not always available. In addition, this requires the patient's communication partners to be literate.

Sign language is not a feasible option for communication. The patient's caregivers/teachers/peer do not use sign language to communicate. Sign language is not English. The patient's primary language is English and their communication partners speak English.

☐ The patient lacks the fine motor skills to use writing and/or sign-language as a mode of communication.

☐ The patient lacks the literacy skills to use writing as a mode of communication.

☐ Patient is unable to consistently meet these functional daily communication needs using low-tech strategies, natural speech or non-SGD treatment approaches.

☐ Therapy to improve natural speech production is no longer indicated or appropriate.

III. RATIONALE FOR DEVICE SELECTION

A. General Features of Recommended SGD and Accessories

Based on the comprehensive assessment documented above, it has been determined that patient requires a Speech-Generating Device to meet their functional communication goals. Other forms of treatment have been considered and ruled out. This SGD must allow the following:

☐ Keyguards –

SGDs can be fit with keyguards to allow SGD users to activate buttons most accurately on the screen. The keyguards can be customized to meet each user's unique fine and gross motor needs by allowing for buttons to be circle or square, small or large. The thick design prevents accidental activations maximizing a user's efficiency in their communication, but the soft to touch edges allows for safe interaction with the keyguard. They are designed specifically to prevent accidental pull-off of the keyguard making it great for users who have spasticity and inadvertently pull of their keyguards.

☐ Screens can be adjusted for different cell layouts – allowing for flexible programming

☐ Screens are backlit – easy to see in a variety of environments

☐ Cells can be color-coded for easier visual access

☐ Built-in camera – needed for personalizing vocabulary with photographs of familiar people, places, and items

☐ Built-in realistic symbol set – needed for visual representation of nouns, verbs, and other vocabulary because the patient cannot read.

☐ Dynamic display – providing access to many messages with automatic navigation and allowing the patient to be independent in getting to their vocabulary selections.

☐ Voice output – needed to self-monitor his selections and to communicate with adults and peers who are not in close proximity

☐ Mount – needed for positioning when seated in his wheelchair

☐ Dedicated device – a communication system that serves no purpose other than to provide PATIENT NAME with speech/language treatment for the communication impairment (Medicare members ony)

B. Trials with SGDs:

Listed below are specific details regarding the devices trialled or considered. This must include comparison of the advantages, limitations and cost alternative systems evaluated. Devices must be from members choice of manufacturer(s). The trials will consist of 3 categories these are low, mid and high technology devices. 2 of the 3 categories must be trialed

AAC Devices considered and ruled out:

AAC Trials/Considerations	Selection Method	Procedures / Outcome
_____ (Manufacturer) _____ (Vocabulary)	☐ Direct Selection Modification(s) required:_____ ☐ Eye Gaze Accessories used: _____ ☐ Scanning Accessories used: _____ ☐ Mouse Emulation Accessories used: _____ ☐ Integration with Power Wheelchair Controls ☐ Head Pointing Accessories used: _____ ☐ Other: _____	This product was ruled out as it is not medically appropriate as this patient's means of communication, due to the following.
_____ (Manufacturer) _____ (Vocabulary)	☐ Direct Selection Modification(s) required:_____ ☐ Eye Gaze Accessories used: _____ ☐ Scanning Accessories used: _____ ☐ Mouse Emulation Accessories used: _____ ☐ Integration with Power Wheelchair Controls ☐ Head Pointing Accessories used: _____ ☐ Other: _____	This product was ruled out as it is not medically appropriate as this patient's means of communication, due to the following.

AAC Device considered and chosen:

______________________ (Manufacturer) ______________________ (Vocabulary)	☐ Direct Selection Modification(s) required:_________________ ☐ Eye Gaze Accessories used: ______________________ ☐ Scanning Accessories used: ______________________ ☐ Mouse Emulation Accessories used: ______________________ ☐ Integration with Power Wheelchair Controls ☐ Head Pointing Accessories used: ______________________ ☐ Other: ____________________________________	This product is recommended as it meet the medical necessity for this patient's means of communication, due to the following.

C. Recommended Equipment & HCPCS Codes

Based on comprehensive assessment and SGD trials, it was determined that the equipment below is feature-matched to meet the patient's stated communication needs.

Name of device or accessory	HCPCS Code	Justification
	☐ E2510 (SGD) ☐ E2512 (Mount or mount plate) ☐ E2599 (Accessory)	☐ Medically necessary to meet functional communication goals ☐ Medically necessary to allow access to SGD ☐ Other:
	☐ E2510 (SGD) ☐ E2512 (Mount or mount plate) ☐ E2599 (Accessory)	☐ Medically necessary to meet functional communication goals ☐ Medically necessary to allow access to SGD ☐ Other:
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	☐ E2510 (SGD) ☐ E2512 (Mount or mount plate) ☐ E2599 (Accessory)	☐ Medically necessary to meet functional communication goals ☐ Medically necessary to allow access to SGD ☐ Other:

The patient's ability to meet daily communication needs will benefit from the acquisition and use of the SGD _________________ device and _________________________ accessories, billing codes _____________.
(name of device) (accessories such as eye gaze, switches, batteries) (E2510, E2599)

D. Anticipated Modifications

The device and accessories listed above are the most appropriate and least expensive feature-matched options for this patient. It is anticipated to meet the patient's communication needs over the next 2-5 years. Anticipated changes and modifications during this time include:

- ☐ No Modifications anticipated at this time
- ☐ Addition or Change in Mount _____
- ☐ Access Method Change anticipated _____

E. Patient and Family Support of SGD

The patient's immediate family and/or primary caregiver was present at this evaluation. All individuals present were supportive of patient using the stated SGD, and agreed to the necessity of the SGD for meeting the patient's communicative needs.

IV. TREATMENT PLAN & FUNCTIONAL COMMUNICATION GOALS

A. Treatment Options:

- ☐ Self-study (patient and caregiver(s)
- ☐ Onsite training at assessment facility
- ☐ Formal training from manufacturer representative
- ☐ Ongoing technical support from manufacturer
- ☐ Other: _____

B. Treatment Plan & Training Schedule:

Upon receipt of SGD, it is recommended that the patient receive _____ (duration) of _____ (type of treatment) every _____ (frequency). This intervention will address the functional communication goals listed below.

C. Functional Communication Goals:

Upon receipt of the recommended equipment, patient will achieve the following:

✓	Functional Communication Goal	Time Frame
☐		☐ Within 1 - 3 weeks ☐ Within 3 - 5 weeks ☐ Within 6 - 8 weeks ☐ Other: _____
☐		☐ Within 1 - 3weeks ☐ Within 3 - 5 weeks ☐ Within 6 - 8 weeks ☐ Other: _____
☐		☐ Within 1 - 3 weeks ☐ Within 3 - 5 weeks ☐ Within 6 - 8 weeks ☐ Other: _____
☐		☐ Within 1 - 3 weeks ☐ Within 3 - 5 weeks ☐ Within 6 - 8 weeks ☐ Other: _____
☐		☐ Within 1 - 3 weeks ☐ Within 3 - 5 weeks ☐ Within 6 - 8 weeks ☐ Other: _____

☐		☐ Within 1 - 3 weeks ☐ Within 3 - 5 weeks ☐ Within 6 - 8 weeks ☐ Other: _____
☐		☐ Within 1 - 3 weeks ☐ Within 3 - 5 weeks ☐ Within 6 - 8 weeks ☐ Other: _____
☐		☐ Within 2 weeks ☐ Within 2 - 6 weeks ☐ Within 6 - 8 weeks ☐ Other: _____
☐		☐ Within 2 weeks ☐ Within 2 - 6 weeks ☐ Within 6 - 8 weeks ☐ Other: _____
☐		☐ Within 2 weeks ☐ Within 2 - 6 weeks ☐ Within 6 - 8 weeks ☐ Other:

D. **Expected Goal Achievement:** It is anticipated that the functional communication goals listed above are reasonable and achievable within the time frame stated.

V. PHYSICIAN INVOLVEMENT

A copy of this report, including equipment recommendations, has been forwarded to the patient's treating physician, Dr. _____, on _____ (date) for review and prescription.

VI. SIGNATURES / SLP ASSURANCE OF FINANCIAL INDEPENDENCE

The Speech-Language Pathologist performing this evaluation is not an employee of, and does not have a financial relationship with, the supplier of the recommended SGD.

Signed,

_____

Name, M.S., CCC-SLP
Speech-Language Pathologist
Phone #:

ASHA #: _____ NPI #: _____
License #: _____ State of License: _____