Clinical Policy: Assistive Communication Device

Reference Number: TX.CP.MP.551 Coding Implications
Last Review Date: 09/23 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy provides guidelines to determine medical necessity of Assistive Communication Devices (ACDs), as well as related software and accessories for STAR, STAR+PLUS, STAR Health, STAR Kids, and CHIP members.

Augmentative and alternative communication (AAC) devices, also known as ACDs, are durable medical equipment tools that allow individuals with severe expressive speech/language deficits to attain functional expressive communication. Those who do not have the ability to communicate verbally or through the use of speech alternatives, such as writing or sign language, may have the ability to use an ACD, which can produce sound output comparable to verbalizations.

ACDs vary widely in terms of the features which they offer, the methods employed by the user to operate them, the types of voice output they produce, and the complexity of operation. They also vary as to durability, portability, and cost. Some of the factors that influence the selection of a particular device for any individual user include:

- Mobility, seating, and postural considerations
- Sensory-perceptual skills
- Behavioral and environmental needs
- Vocabulary requirements
- Cognitive skills
- Language abilities
- Executive level functioning
- Literacy level

Most commonly, ACDs are classified into two main categories of devices based on the type of voice output they produce – digitized or synthesized. Digitized ACDs use words or phrases that have been pre-recorded for playback upon command. Synthesized ACDs use specialized technology that translates the user's input into novel sounds, words, or phrases that are device-generated, rather than relying upon pre-recorded messages.

Method of access is also a key feature in the use of an ACD as this feature corresponds to the way the individual user will make selections in order to produce the desired voice output. One common type of access method involves physical selection via the use of a keyboard or touch screen. Some devices offer only this method of access, while others also allow one or more indirect selection methods, such as selection via joystick, head mouse, light pointer, infrared pointer, or scanning device.

Depending upon the type of ACD selected, other items may be required for use in conjunction with the device. Those may include items that are typically included with the purchase of an ACD, such as batteries, battery chargers, power cables, and mounting devices, or they may include separate accessories such as additional access devices, wheelchair-specific mounting systems, or carrying cases.

As an alternative to traditional ACDs, which are devices designed solely for the purpose of facilitating expressive communication, manufacturers also make available specialized software programs which are intended for use on a laptop computer or other personal electronic device, effectively adding ACD functionality to the existing device. For some individuals, this option is selected as preferable to the use of a traditional ACD, for reasons that may include portability, efficiency, versatility, social considerations, and/or cost effectiveness.

Note: *This policy does not apply to the type of electronic speech aids that are commonly used by individuals who have undergone laryngectomy, such as an electrolarynx or other artificial larynx device. Those devices are considered prosthetics.*

Policy/Criteria

I. It is the policy of Superior HealthPlan that ACDs are **medically necessary** when all the following criteria are met:

A. A completed assistive/augmentative communication evaluation has been performed by a licensed speech-language pathologist (SLP). If the signed evaluation is greater than one year old when requesting the purchase of a device, justification for the delay should be provided.

B. The evaluation must be signed and dated by the ordering physician or allowed practitioner.
Note: The licensed SLP completing the evaluation must not be employed by or similarly affiliated with the device manufacturer or vendor.
The evaluation must include:

1. Diagnosis or condition causing the impairment of speech.
2. Medical and treatment history, to include:
   a. Documentation verifying that there is no reasonable expectation the member can develop functional verbal communication or that the member's capacity for functional verbal communication falls significantly below his or her expressive capacity.
   b. A description of prior therapies provided to the member, with outcomes.
   c. Documentation of the diagnostic and/or treatment interventions which have been utilized in determining the member's potential for developing functional expressive language without the use of a communication device.
3. Member specific objective data establishing the member's functional status in the following areas:
   a. Cognitive skills (including, but not limited to, attention, memory, and problem solving)

b. Language abilities (including, but not limited to, following directions, sequencing, coding, symbol recognition, expressive language skills, ~~and~~ pragmatic language skills, and receptive language skills)
c. Sensory-perceptual skills (including, but not limited to, sensorimotor, visual acuity, hearing acuity, and tactile sensation)
d. Literacy level, if non-reader, include description of emergent literacy or pre-literacy skills.

4. Documentation the member's communication needs cannot be met verbally or through the use of speech alternatives.
5. Member specific objective documentation of the member's functional communications needs, encompassing anticipated expressive language capacity and specifying his/her level of vocabulary requirements (core vs. fringe vocabulary needs).
6. The rationale for selection of the requested device, to include objective documentation regarding any other devices which were considered and rejected, with evidence of the insufficiency of the non-selected devices.
7. Member specific objective documentation demonstrating the member's capacity to use the features available on the requested device, to include detailed objective documentation of the outcome of the member's trial period with the device.
8. Identification of the member's educational/training needs relating to use of the device, as well as those of any applicable caregivers, with a treatment plan to include SMART (specific, measurable, attainable, realistic and time based) goals and documenting the intervention required to meet those needs.
9. Documentation of any mobility limitations which would impact the member's ability to access the features of the device.
10. Recommendations as to the most appropriate access method or methods for the member.
11. The member and the member's primary communication partner are willing to learn and use the device for daily communication.
12. Documentation must support the recommended device is the least costly and most appropriate method of communication for the member.

C. The member has completed a trial period greater than or equal to 30 days with the selected device, and the device has been shown to meet the member's communication needs. Member specific objective documentation must be provided to validate the member's ability to utilize the requested device for functional communication. Dates of service during which the trial occurred should be reported.

II. Documentation Requirements

A. A completed order, signed and dated by a physician or allowed practitioner (advanced practice registered nurse who is licensed as a certified nurse practitioner (CNP), physician assistant (PA), or clinical nurse specialist (CNS) is acceptable) familiar with the member, including diagnosis that the member has a permanent and/or progressive condition that results in severe expressive communication disability.

1. A current signature and date is valid for no more than 90 days prior to the date of the requested prior authorization or the initiation of service.

B. The date of last visit seen by the ordering practitioner must be within the past 6 months.
C. The ACD evaluation must be signed and dated by the ordering practitioner and the evaluating SLP.
D. A copy of the manufacturer's specifications for the requested ACD system, including all component accessories necessary for use.

III. It is the policy of Superior HealthPlan that approval of a **rental for trial purposes** does not guarantee authorization for purchase if all required documentation noted in *Section I and II* is not submitted with the purchase request.

IV. It is the policy of Superior HealthPlan that approval requests for **purchase** must include all required documentation in *Section I and II*, regardless of previously approved trial rental.

V. Items included in the reimbursement for an ACD system and not reimbursed separately include, but are not limited to, the following:

A. Basic, essential software (except for software purchased specifically to enable a client-owned computer or personal electronic device to function as an ACD)
B. Batteries
C. Battery charger
D. Power supplies
E. Interface cables
F. Interconnects
G. Sensors
H. Moisture guard
I. Alternating current (A/C) or other adapters
J. Adequate memory to allow for system expansion within a three-year timeframe
K. Access device, when necessary
L. Mounting device, when necessary
M. All basic operational training necessary to instruct the client and family/caregivers in the use of the ACD system
N. Manufacturer's warranty

VI. It is the policy of Superior HealthPlan that requests for **accessories** to ACDs must be accompanied by specific objective documentation of medical necessity for those accessories. If accessories are requested separately and at a later date from the original ACD request, supporting documentation for medical necessity must be provided. Accessories will be considered **medically necessary** if one or more of the following criteria are met:

A. The member will be unable to access the ACDs in the absence of the requested accessory.
B. Absence of the requested accessory renders one or more key features of the device ineffective or inaccessible due to the member's unique communication or mobility needs;

C. The requested accessory is required to ensure the security and maintenance of the requested device due to the member's unique communication, mobility, or environmental needs.

VII. Software programs which add ACD functionality to a member's computer or other personal electronic device will be considered **medically necessary** when all of the applicable criteria set forth above for ACDs have been met **and** the use of the software is more cost effective than a traditional ACD. Purchase of a computer or other personal electronic device to be used with speech generating software is not a covered benefit under this policy.

VIII. A request for **repairs** to member-owned equipment may be for prior authorization, as needed, with documentation of **medical necessity** from the attending physician or allowed practitioner (advanced practice registered nurse who is licensed as a certified nurse practitioner (CNP) , physician assistant (PA), or clinical nurse specialist (CNS) is acceptable) substantiating that the medical appliance or equipment continues to serve a specific medical purpose and an itemized estimated cost list from the DME provider of the repairs. A repair will be considered, based on the age of the item and cost to repair it. Documentation must include the date of purchase and serial number of the current equipment.

- The Clinical reviewer can **approve** repair requests if documentation of medical necessity is submitted including the manufacturer's explanation why the repair is not covered by the warranty.

IX. Replacement to member-owned equipment may be considered for prior authorization, as needed, with documentation of **medical necessity.**

A. The Clinical reviewer can **approve** replacement requests if objective documentation of medical necessity is submitted and it is **within the benefit limitation(s).**
B. A trial period is not required when replacing an existing ACD system.
C. When the members' needs have changed and an alternate ACD system or access method is being considered, a trial of the requested device with supporting objective documentation must be included.
D. Equipment replacement is considered medically necessary when **one** of the following occurs:
   1. There has been a significant change in the client's condition such that the current device no longer meets the member's communication needs; and/or
   2. The ACD is no longer functional and either cannot be repaired or it is not cost effective to repair; and/or
   3. Three years have passed and the equipment is no longer repairable.

Background

Definitions:

- **Clinical Reviewer**: includes Specialty Therapist (OT, PT, and SLP) or Prior Authorization Nurse.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2021, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
E2351	Power wheelchair accessory, electronic interface to operate speech generation device using power wheelchair control interface
E2502	ACDs, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time
E2504	ACDs, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time
E2506	ACDs, digitized speech, using pre-recorded messages, greater than 40 minutes recording time
E2508	ACDs, synthesized speech, requiring message formulation by spelling and access by physical contact with the device
E2510	ACDs, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access
E2512	Accessory for ACDs, not otherwise classified
E2599	Accessory for speech generating device, not otherwise classified

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
Deleted E2500, E2511, and E2512 from the applicable codes table on page 3 since these codes are not listed on the most recent ARQ list. Added repairs	08/14	08/14

Reviews, Revisions, and Approvals	Date	Approval Date
and replacement criteria. Added authorization protocol which included the verbal order protocol. Updated work process to include both non-clinical and clinical work process. Updated references and signatories.		
Removed work process and imbedded in attachment section. Added policy to reference list.	02/15	02/15
Added mounting device to the list of bundled equipment.	11/15	11/15
Removed work process imbedded in attachment section. Grammatical edits. Document name changes to Prior Authorization of Assistive Communication Device. Speech generating device changed to assistive communication device. Updated signatories.	01/16	01/16
Removed product region references. Added Star Kids to product type. Added E2512, found on updated ARQ 2017. Updated references. Updated signatories. Grammatical edits.	01/17	01/17
Updated review date, references and signatories. Deleted revision history prior to 2014.	01/18	01/18
Annual review. Updated reference and signatories. Removed authorization protocol work process information.	01/19	01/19
Updated to new template from TX.UM.10.51 (TX.CP.MP.551 nomenclature implementation 10/1/19). Added requirements for rental of trial period. Removed Authorization protocol section as it was duplicative in nature and work process information.	10/19	10/19
Added clarifying statement to Section V: "If accessories are requested separately and at a later date from the original ACD request, supporting documentation for medical necessity must be provided." Annual Review. References Updated.	09/20	09/20
Annual Review. Removed order specification from section I. Removed in II B *In lieu of having the treatment plan signed, the provider may submit a signed and dated prescription/order.* Reformatted to groups I *Evaluation* and II *Documentation Requirements*. Added "member focused" to section I:A3, A5, A7. Added to section I: A8 "*to include SMART (specific, measurable, attainable, realistic and time based) goals".* References Updated. Technical edits.	09/21	9/21
Annual Review. References Updated.	09/22	09/22
Ad hoc review to complete changes made throughout document to align "physician" to allowed practitioners per amendments of 1 Texas Administrative Code rules 354.1031, 354.1035, 354.1037, 354.1039, 354.1040, and 354.1043 and are in alignment with 42 Code of Federal Regulations §440.70	03/23	03/23
Annual Review. References Updated. Section I B regarding evaluation be signed by practitioner. Clarifying language added to Section I B 1 of "*or*	09/23	9/23

Reviews, Revisions, and Approvals	Date	Approval Date
condition causing the impairment of speech" in I B 1 c "*and receptive language skills*" and I B 1 d "if non-reader, include description of emergent literacy or pre-literacy skills". Removed from section I B 10 regarding least costly device and new 12 created "*Documentation must support the recommended device is the least costly and most appropriate method of communication for the member*". Section II A 1 added "*A current signature and date is valid for no more than 90 days prior to the date of the requested prior authorization or the initiation of service*". Clarified Section II B regarding date last seen by practitioner must be within last 6 months. Added XI B per TMPPM "*A trial period is not required when replacing an existing ACD system*" and XI C. "*When the members' needs have changed and alternate ACD system or access method is being considered, a trial of the requested device with supporting objective documentation must be included*".		

References

1. Texas Medical Provider Procedures Manual, Durable Medical Equipment, Medical Supplies and Nutritional Products Handbook, Volume 2, Section 2.2.5, Augmentative Communication Device (ACD) System, August 2022.
2. American Speech-Language-Hearing Association. (2004). Roles and responsibilities of speech-language pathologists with respect to augmentative and alternative communication: technical report [Technical Report]. Available from www.asha.org/policy.
3. American Speech-Language-Hearing Association. (2002). Augmentative and alternative communication: knowledge and skills for service delivery [Knowledge and Skills]. Available from www.asha.org/policy.
4. American Speech-Language-Hearing Association. (2005). Roles and responsibilities of speech-language pathologists with respect to augmentative and alternative communication: position statement [Position Statement]. Available from www.asha.org/policy.
5. National Joint Committee for the Communication Needs of Persons with Severe Disabilities. (2003). Position statement on access to communication services and supports: Concerns regarding the application of restrictive "eligibility" policies [Position Statement]. Available from www.asha.org/policy or www.asha.org/njc.
6. National Joint Committee for the Communicative Needs of Persons with Severe Disabilities. (1992). Guidelines for meeting the communication needs of persons with severe disabilities. ASHA, 34(Suppl. 7), 2 www.asha.org/NJC/bill_of_rights.html.
7. TX.UM.05 Timeliness of UM Decisions and Notifications.
8. TX.UM.10.35 Physician Peer to Peer Policy.
9. TX.UM.26 Electronic and Verbal Signature Policy.
10. Texas Medical Provider Procedures Manual, Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook, Volume 2, Section 4 Therapy Services Overview, August 2021

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed

herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.