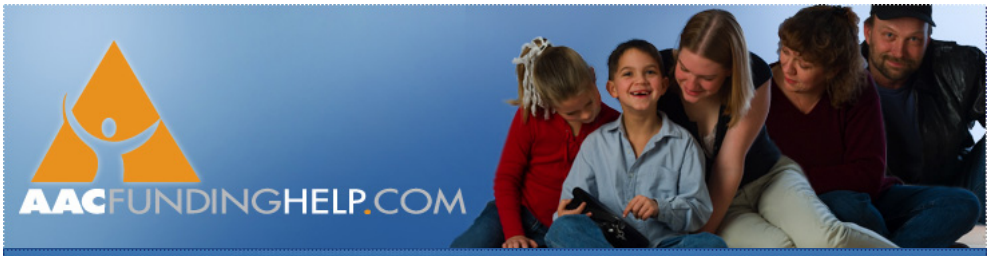
SGD Funding Solutions from Assistive Technology Law Center



SGD Funding Programs

Narrative descriptions of SGD funding programs will be added on an ongoing basis. Presently, narrative descriptions are posted for Medicare and Tricare. Also posted is information about insurers and health plans with SGD clinical criteria, and a database of insurers and plans that have approved SGDs.

2. Medicaid

Coming soon...

3. Insurance & Health Benefits Plan Coverage of Speech Generating Devices and Database

3.A. Insurance and Health Benefits Plan Coverage of Speech Generating Devices

Introduction

Speech Generating Devices (SGDs) are routinely covered by all health-benefits funding programs in the United States. This includes Medicare, all Medicaid programs, Tricare, the Veterans Administration, and more than 1,000 insurers and health benefits plans. This coverage exists even though SGDs (and as a general matter, other specific types of care or items of equipment) are only rarely identified by name by these programs. Instead, health benefits programs describe their scope of coverage by reference to broad categories of care, examples of which include in-patient hospital care; physicians' services; speech-language pathology services; durable medical equipment; and prosthetic devices.

To determine what specific types of care and equipment are subject to payment by these health-based funding programs, a four-question "test" is applied. This 4 question test was first described in Fred C. v. Texas Health & Hum. Serv. Comm'n, 988 F.Supp. 1032 (W.D.Tex. 1997), affirmed per curiam, 167 F.3d 537 (5th Cir. 1998)(applying test to Texas Medicaid); *prior decision,* 924 F.Supp. 724 (W.D.Tex. 1996), vacated and remanded per curiam, 117 F.3d 1416 (5th Cir. 1997); 68 Fed. Reg. 55,634,55,635, 2003 WL 22213011 (F.R.)(Sept. 26,2003)(discussing same in the context of Medicare). It asks:

1. Is the person a beneficiary, participant, or recipient of the benefits or funding program?
2. Does the type of care or item of equipment the recipient seeks "covered" within one or more of the benefits categories of the program?
3. Is the type of care or item of equipment the recipient seeks "medically necessary?" And
4. Is the type of care or item of equipment the recipient seeks subject to any limitations or exclusions?

An obligation to pay for requested care or equipment will arise if each of the first three of these questions is answered "yes," and the last question is answered "no."

SGDs have been covered by health insurers and health benefits plans since they were introduced for sale in the mid-to-late 1970s. Beukelman, Yorkston & Smith, "Third-Party Payer Response to Requests for Purchase of Communication Augmentation Systems: A study of Washington State," 1 AAC 5-10 (1985). SGDs have been "covered" [Question 2 above] most often as items of "durable medical equipment" (DME) or as "prosthetic devices," two health benefits categories that are commonly included in insurance policies and health benefits plans. The health benefits programs that cover SGDs and their SGD coverage designation are listed in Table 1

Speech Generating Devices ***are*** items of durable medical equipment because they "fit" all the typical characteristics of DME items and "meet" the most common definition of DME used by health-based funding sources.

Table 1: Health Benefits Funding Programs in the United States

Publicly Supported Health Benefits Programs	Basis for SGD Coverage	**Private Health Benefits Programs**	Basis for SGD Coverage
Medicare	DME	Insurers	Majority DME; some prosthetic devices

Medicaid	Majority DME; some prosthetic devices	Health Benefits Plans	Majority DME; some prosthetic devices
Tricare	Prosthetic devices		
Veterans Administration	Prosthetic devices		

Defining Durable Medical Equipment (DME)

There is no one source responsible to define or describe what constitutes an item of durable medical equipment. Instead, each program is free to write its own definition. In practice, however, the Medicare program provides the template for DME definitions used by both Medicaid programs and insurers.

Medicare defines DME as follows:

> Durable Medical Equipment is equipment … that:
>
> · Can withstand repeated use;
>
> · Is primarily and customarily used to serve a medical purpose;
>
> · Generally is not useful to a person in the absence of illness or injury; and
>
> · Is suitable for use in the home.

42 C.F.R. § 414.202

Medicare accepts that SGDs meet all of these criteria. Medicare SGD coverage criteria adopted in 2001 state SGDs are items of durable medical equipment. *See* Medicare National Coverage Decision for Speech Generating Devices, 2001, posted for review at this link; Medicare Local Coverage Decision for Speech Generating Devices, 2001 (formerly known as the Regional Medical Review Policy (RMRP)), posted for review at this link. This Medicare guidance was written following an 18 month investigation about SGDs by Medicare staff. A detailed description of that review process and the information presented to Medicare staff is posted for review at this link.

SGDs Can Withstand Repeated Use

The applicable benefits category is *Durable* Medical Equipment. According to Medicare, an item that is *durable* is one that can "withstand repeated use." Some insurers use different vocabulary to describe this characteristic of DME items: they state that items of DME are not "consumable or disposable." Regardless how it is phrased, this criterion is not a significant hurdle for SGDs to pass.

All augmentative and alternative communication devices, including both speech generating devices (SGDs) and aids that do not produce voice output, are *durable*; are *not disposable or consumable*; and *can withstand repeated use*. A communication board or book is an AAC aid that does not produce speech output. Typically, they are laminated pages that are intended for repeated use and are accessed by pointing. Communication boards or books are not "consumed" as an individual points to a word or picture. Nor is an SGD "consumed" or used up in any way as a person constructs messages and the device says them as speech. SGDs do run on batteries, but these are rechargeable and are designed to enable use day after day after day. SGDs are designed to be used on a daily basis for a period of years.

Nor can any of these aids and devices be described as "disposable." According to Webster's New Collegiate Dictionary, "disposable" is defined as "designed to be used once and then thrown away." This is not a characteristic of any type of AAC aid, either speech generating devices or non-speech generating devices. A communication book or board, just described, is the simplest form of AAC aid. They clearly are not single use items. To the contrary, laminating the pages is intended to protect them specifically to enable them to be used over and over, day after day.

Speech generating devices will, by definition, produce speech output. They are battery powered, electronic devices with the capacity to produce speech. They are intended to be used for years – not used once and then thrown away. Nothing could be farther from an accurate description of their intended use. That they range in price up to more than $ 7,000 should be sufficient rebuttal to any suggestion that SGDs are "disposable."

In addition to a dictionary definition of "disposable," Medicare expressly distinguishes items that are "durable" from items that are "disposable."

> An item is considered durable if it can withstand repeated use, i.e., the type of item which could normally be rented.

Medicare Hospital Manual, § 235.1A, posted for review at this link.

Medicare's coverage of SGDs makes clear that it concludes SGDs are "durable" and not "disposable." Its SGD coverage criteria state plainly that SGDs are an item of durable medical equipment. Medicare will pay for SGDs both as items to be purchased, as well as items that are rented. *See* Medicare SGD coverage criteria; *see also* Medicare fee schedule for purchase and rental of SGDs, posted for review at this link.

Medicare guidance also states:

> Medical supplies of an expendable nature such as incontinent pads, lamb wool pads, catheters, ace bandages, elastic stockings, surgical face masks, irrigating kits, sheets and pads are not considered "durable" within the meaning of the definition [of durable medical equipment].…

Medicare Hospital Manual, § 235.1A, posted for review at this link.

Like the dictionary definition of "disposable," Medicare recognizes that disposable items are intended for one time or short time use, and durable items are intended for repeated use over a long period of time. SGDs are recognized by Medicare – and by all other systems of benefits – as examples of durable items.

SGDs are "durable" because they are designed and built to last many years of daily use. As a class, all SGDs have been designed as sturdy, durable communication devices. Their cases are designed and manufactured to withstand the often rough handling they typically are subjected to when carried or when mounted to a wheelchair, as well as when they are used. One SGD manufacturer calls one of its models the "Toughbook." They are so-named for good reason: they are housed in "ruggedized" cases that are used in military and industrial applications. In general, our devices are used for the life of the patient.

Letter dated March 13, 2002 to Lewis Golinker from Ronald F. Creeley, Vice President, Marketing, Words Plus, Inc., posted for review at this link.

Another SGD manufacturer estimated the useful life of its products is 3-5 years. Letter dated January 23, 2002 to Lewis Golinker from Gregory Lesher, Ph.D., President, Enkidu Research, posted for review at this link.

Prentke Romich, one of the first SGD manufacturers, described one of its earlier devices, the Delta Talker, as follows:

> One of our most successful devices is the Delta Talker, which was introduced in the summer of 1995. . . . This device is very durable. Before the device was shipped to the public, it went through a series of durability tests, such as: dropping it from several locations, throwing it down a flight of stairs, and standing on the device. Occasionally, we have seen a cracked outer case on the Delta Talker, however, this does not affect the operation of the device.

> . . . We estimate the expected life span of this device to be 7-10 years.

Letter dated December 4, 2001 to Lewis Golinker from Angie Neveadomi, Funding Coordinator, Prentke Romich Company, posted for review at this link.

The same report is available from Dynavox Technologies, the leading manufacturer of SGDs and from Tobii, another of the largest SGD manufacturers. Dynavox reported:

> To serve the needs of our clients, Dynavox SGDs are built to be extremely durable. Durability – to be able to withstand the often rough handling given to them by their users – and longevity – to be able to remain in use for years – are both absolutely necessary. Our products must be able to meet our clients' needs day in and day out, for years: whenever and wherever their communication needs arise. The durability of our products also can be demonstrated by the fact that many of the original Dynavox models are still are in use, in some cases, for the past 10 years. In general the life expectancy for Dynavox devices tends to be 5-8 years.

Letter January 17, 2002 to Lewis Golinker from Michele Rimmel, Funding Supervisor, Dynavox Systems; *see also* Letter dated April 23, 2010 to Lewis Golinker from Deb Jennings, Director of Funding, Tobii, ATI, posted for review at this link.

These SGD manufacturers are providing essentially the same message. All of their SGDs are durable; they are all able to withstand repeated use.

Benefits and funding program decisions have addressed this question and concluded SGDs are durable and able to withstand repeated use. For example, a Medicare ALJ noted that the beneficiary's former SGD, a VOIS 130 (which is no longer made), had been in continuous use for 8 years before it ceased to function, leading to a request to Medicare that it be replaced. *In re: Kim D.*, Slip Op. at 4, No. 000-19-3751 (Social Security Admin. Office of Hearings & Appeals July 28, 2000, posted for review at this link. . In another Medicare ALJ decision, the judge noted that a Delta Talker was durable because it ran on rechargeable batteries and was not a disposable supply. *In re: Martin B.*, Slip op. at 3, No. 999-07-9279 (Social Security Admin. Office of Hearings & Appeals November 29, 2001), posted for review at this link.

Typically, that SGDs are "not disposable," "not consumable," and are "durable," because they can "withstand repeated use," is not a matter of controversy.

SGDs Are Primarily and Customarily Used to Serve a Medical Purpose

The second Medicare DME criterion states that DME items are "primarily and customarily used to serve a medical purpose." As wit h the "durability" criterion, the text used to describe this DME characteristic may vary among benefits and funding programls. Som e state that DME items must serve as "treatment" or a "therapeutic" purpose instead of a "medical purpose." These words all share a common meaning.

> We, however, must give the word "medical" its ordinary sense, as referring more usually and broadly to the treatment, cure, or alleviation of any health condition, including disability….

Blue v. Bonta, 99 Cal App.4th 980, 989, 121 Cal.Rptr.2d 483 (First District 2002).

Just as the concepts of "treatment" and "medical" are synonyms, so too is "therapeutic." According to the Stedman's Medical Dictionary, the term "therapeutic" means "related to treatment of disease," which also is the definition of "therapy."

Specifically, all SGDs are recommended, prescribed, and used to implement a program of speech-language pathology (SLP) treatment for severe communication impairment. The generally accepted principle – established by both professional medical literature and adopted as the coverage standard by systems of health benefits – is that SGDs are medically necessary and appropriate treatment when an SLP determines an individual cannot meet daily communication needs using natural communication methods, such as oral speech or writing.

The American Speech-Language-Hearing Association (ASHA) has for approximately 3 decades formally recognized AAC intervention, including use of an SGD, as a SLP treatment methodology and within the scope of practice of speech-language pathologists. ASHA, "Position Statement on Non-Speech Communication," 23 *Asha* 577-581 (August 1981). This position has been renewed and updated and it remains ASHA's current and official position. Am. Speech-Lang.-Hearing Assoc., Scope of Practice in Speech-Language Pathology, at p. 7 (2007); Am. Speech-Lang.-Hearing Assoc., Preferred Practice Patterns for the Profession of Speech-Language Pathology: § 26 Augmentative and Alternative Communication Assessment;" "§ 27 Augmentative and Alternative Communication Intervention; §28 Prosthetic/Adaptive Device Assessment; §29 Prosthetic/Adaptive Device Intervention, at pp. 75-88 (2004); Am. Speech-Lang.-Hearing Assoc., Roles and Responsibilities of Speech-Language Pathologists with Respect to Augmentative and Alternative Communication: Technical Report (2004); Am. Speech-Lang.-Hearing Assoc., Augmentative and Alternative Communication: Knowledge and Skills for Service Delivery, (2002); Am. Speech-Lang.-Hearing Assoc., Scope of Practice in Speech-Language Pathology, at pp. I- 28, 30 (2001); Am. Speech-Lang.-Hearing Assoc., Preferred Practice Patterns for the Profession of Speech-Language Pathology, at § 12.3 Augmentative and Alternative Communication Assessment, § 15.2 Augmentative and Alternative Communication System and/or Device Treatment/Orientation, at pp. I -141-42; 165-166 (1997); Am. Speech-Lang.-Hearing Assoc., Preferred Practice Patterns for Speech-Language Pathology, § 30.3 Augmentative and Alternative Communication Assessment,; § 31.1 Augmentative and Alternative Communication System Fitting/Orientation," at pp. 61-62; 87-88 (1992); Am. Speech-Lang.-Hearing Assoc., Augmentative and Alternative Communication: Position Statement, 33 Asha (Suppl. 5), 8 (1991); Am. Speech-Lang.-Hearing Assoc., Competencies for Speech-Language-Pathologists Providing Services in Augmentative Communication, 31 Asha 107-110 (1989).

AAC treatment methodologies include unaided strategies, which rely on a person's residual speech ability, gesture or sign language; and aided strategies, which include non-voice output aids, such as writing, communication boards, or notebooks; and voice output aids, i.e., SGDs. In short, SGDs are one form of AAC treatment.

The treatment role of SGDs, in general, is well documented in the professional medical literature and in professional policy guidance written by the American Speech-Language-Hearing Association. There are more than 40 years of professional literature and practice related to augmentative communication interventions, including SGDs, as treatment for severe expressive communication disabilities and to prevent the adverse effects associated with an inability to speak or otherwise expressively communicate. Zangari, Lloyd & Vicker, "Augmentative and Alternative Communication: An Historic Perspective," 10 *AAC* 27-59 (1994); G. Vanderheiden and D. Yoder, "Overview," in S. Blackstone, Ph.D., Ed. Augmentative & Alternative Communication: An Introduction 10-13 (1986); *see also* Hourcade, Pilotte, West and Parette, "A History of Augmentative and Alternative Communication for Individuals with Severe and Profound Disabilities, 19 *Focus on Autism and Other Developmental Disabilities* 235-244 (2004).

The common goal of all treatment involving AAC interventions including SGDs is to overcome or ameliorate the communication limitations that preclude or interfere with the person's meaningful participation in dairy activities. Beukelman & Mirenda, Augmentative and Alternative Communication 104 (1992). *See also* Beukelman, Garrett & Yorkston, Augmentative Communication Strategies for Adults with Acute or Chronic Medical Conditions 4 (Baltimore: Brookes Publ. 2007)("The general definition for AAC used in most legal, educational and funding activities is similar to the following: AAC is needed by individuals with such complex communication limitations that they are unable to meet their daily communication needs through natural speech (and/or language)."); Medicare RMRP (now LCD) for Speech Generating Devices (2001), posted for review at this link.; Myers v. State of Mississippi, No. 3:94- CIV- 185 LN (S.D. Miss. June 23, 1995) (SGDs are "electronic and non-electronic devices that allow individuals to overcome, to the maximum extent possible, communication limitations that interfere with their dairy activities."). Meaningful participation means effective and efficient communication of messages in any form the person chooses. National Joint Committee for the Communicative Needs of Persons with Severe Disabilities, "Guidelines for Meeting the Communication Needs of Persons with Severe Disabilities," 34 *Asha* (Supp. 7) at 2-3 (1992).

The American Medical Association, American Academy of Neurology, American Academy of Physical Medicine and Rehabilitation, and American Academy of Pediatrics, all recognize the role of SGDs as medical treatment for a range of severe communication impairments. The American Academy of Neurology stated:

> In general, the American Academy of Neurology supports a policy that includes Augmentative and Alternative Communication (AAC) devices to be covered … when incorporated into a speech language pathology treatment plan. The treatment plan which authorizes this coverage should … conclude[] the individual is unable to meet communication needs arising in the course of daily activities using natural communication methods.

* * * * *

The AAN believes that augmentative and alternative communication devices are a form of durable medical equipment which can be of great help to selected individuals with neurological disorders unable to communicate during the course of daily activities. They can be a successful form of treatment as part of a speech language therapy plan in carefully selected and evaluated individuals.

Letter dated March 22, 2000 to Hugh Hill, M.D., from Francis I. Kittredge, Jr., M.D., President, American Academy of Neurology, posted for review at this link.

AMA stated:

> The AMA agrees with the American Academy of Neurology that these devices are medically necessary for severely speech-impaired patients to meet the communication needs arising in the course of their daily activities…

Letter dated March 21, 2000 to Hugh Hill, M.D., from J. Ratcliffe Anderson, Jr., M.D., Executive Vice President, American Medical Association posted for review at this link.

The AAPMR stated:

> the Academy strongly believes that augmentative and alternative communication (AAC) devices are medically necessary aids for communication....
>
> * * * * *
>
> The Academy lends its full support for Medicare coverage of these devices for patients with severe communication impairments, such as dysarthria, apraxia and aphasia, regardless of the motor or neurological condition that gives rise to the communication impairment.
>
> * * * * *
>
> They are necessary to meet the communication needs arising in daily activities.

Letter dated March 23, 2000 to Hugh Hill, M.D., from Ronald Henrichs, Executive Director, American Academy of Physical Medicine and Rehabilitation posted for review at this link.

Most recently, the American Academy of Pediatrics stated:

> Many children and youth with special health care needs can improve day-to-day functioning with the aid of assistive technology, including alternative and augmentative technology."

L. Desch, D. Gaebler-Spira, and Council on Children with Disabilities, *Special Report*: *Prescribing Assistive-Technology Systems: Focus on Children with Impaired Communication*, 121 Pediatrics, 1271-1280 (June 2008). This documents is posted for review at this link.

The general acceptance that SGDs serve a medical, therapeutic, or treatment purpose or role also extends to other federal agencies. For example, the United States Food and Drug Administration (FDA) is a regulatory, not a funding agency. The FDA is the federal agency responsible for classification of medical devices. It reached the conclusion that SGDs serve a medical purpose ***in 1983.*** At that time, the FDA created a classification called "powered communication systems," which it defined as:

> An AC- or battery-powered device ***intended for medical purposes*** that is used to transmit or receive information. It is used by persons unable to use normal communication methods because of physical impairment. . . .

48 Fed. Reg. 53049 (November 23, 1983), codifying 21 C.F.R. § 890.3710(emphasis added).

Another example is supplied by Medicare and Medicaid. Not only are SGDs classified as items of DME by both programs, both Medicare and Medicaid are *required* to offer covered services consistent with "accepted *medical* practice." Congress expressly prohibits Medicare from providing reimbursement for any item or service that is "not reasonable and necessary for the diagnosis *or treatment* of illness or injury or to improve the functioning of a malformed body member." 42 U.S.C. § 1395y(a)(1)(A). Medicare guidance expressly states the concept of "reasonable and necessary" limits coverage only to "services or supplies that are needed for the diagnosis *or treatment* of your medical condition and meet accepted standards of *medical* practice." Medicare & You, 2011, at p. 129, posted for review at this link.

Medicaid programs are required to make determinations about coverage of items or services consistent with accepted standards of *medical* practice. Detsel v. Sullivan, 895 F.2d 58, 64 (2nd Cir. 1990).

As to the conclusion that SGDs serve a medical, therapeutic or treatment purpose, there is no evidence to the contrary, from any source.

A closer examination of the "*medical* purpose" served by SGDs: treatment for severe communication impairment, reveals that it is the same as the medical purpose served by all other speech-language pathology treatment methodologies. All SLP services treat severe communication impairments by improving the individual's ability to meet daily communication needs. Peggy Locke, the former president of the Communication Aid Manufacturers Association stated:

> *The medical purposes served by the AAC devices and related products manufactured by CAMA member companies offer treatment to persons with severe expressive communication disabilities. The people who use and benefit from AAC devices have historically been those whose communication disabilities are so severe that improved expressive communication was believed to be impossible. But with AAC devices, they are able to get their needs met, live successfully in the community, lead active lifestyles, and be employed.*

Letter dated October 23, 1999 to Lewis Golinker from Peggy Locke, President, Communication Aid Manufacturers Association. This letter was submitted to Medicare staff as part of that program's development of its current SGD coverage criteria, and is posted for review at this link.

Stated most simply, a person with no severe communication impairment that precludes accomplishment of daily communication needs using natural communication methods will never be assessed for, never be appropriate for, never be recommended for, and never need or use an SGD. That an SGD is needed for no purpose other than as treatment for severe communication impairment – a medical purpose – is a conclusion easy to test:

> ***but for (solely because of)*** _____ the person would be able to meet his or her daily communication needs using natural communication methods, such as oral speech.

Only one reason or "purpose" can fill the blank in the preceding statement and make it true. It is ***only*** because the person has **a severe communication impairment** that an SLP assessment will be conducted, that consideration will be given to various methods of SLP treatment, and that the ultimate recommendation will be of an SGD as the most appropriate treatment method.

These general statements about SGDs serving a "medical," "therapeutic," or "treatment" role or purpose are supplemented by a large volume of professional literature that is addressed to specific speech and language impairments, such as dysarthria, apraxia, aphasia, and aphonia, *see e.g.,* L. Golinker, Esq., Ed., *Formal Request for National Coverage Decision for Augmentative and*

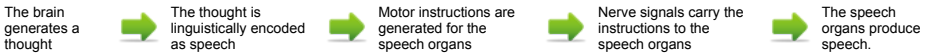
Alternative Communication Devices, Chapter 3 (1999)(describing the professional literature related to SGD use as effective treatment for dysarthria, apraxia and aphasia). The *Formal Request* was prepared by the nation's leading AAC and SGD clinicians, educators and researchers and was submitted to Medicare staff to aid their development of Medicare SGD coverage criteria. The AMA described this section of the *Formal Request* "an excellent summary of the strong clinical evidence for the efficacy and effectiveness of AAC devices for the treatment of dysarthria, apraxia and aphasia." Letter dated March 21, 2000 to Hugh Hill, M.D., from E. Ratcliffe Anderson, Jr., M.D., Executive Vice President and CEO, American Medical Association, posted for review at this link. Medicare staff were the first to acknowledge the ability of SGDs to be effective for people with aphonia. This observation subsequently was confirmed by ASHA. *See* Memorandum dated June 27, 2000 to Lewis Golinker from Steven White, Ph.D., American Speech-Language-Hearing Association, posted for review at this link.

There also is professional literature describing the effectiveness of SGDs as treatment for specific conditions, such as ALS and autism. SGD use is recognized by the American Academy of Neurology as the standard of care for treatment of the communication impairments associated with ALS. *See* 48 Amyotrophic Lateral Sclerosis Standard of Care Consensus Conference, 48 J. Neurology Supp. 4 (1997). SGD use also is recognized as effective by evidence based peer reviewed professional literature as effective treatment to improve the functional communication of people with autism. *See generally,* Letter dated June 15, 2011 to Lewis Golinker from Pamela Mathy, Ph.D., Kennedy Krieger Institute, posted for review at this link; *see also* Ganz, et al, "A Meta Analysis of Single Case Research Studies on Aided Augmentative and Alternative Communication Systems with Individuals with Autism Spectrum Disorders," J. Autism & Developmental Disorders (Published on-line March 5, 2011); van der Meer & Rispoli, "Communication Intervention Involving Speech-Generating Devices for Children with Autism: A Review of the Literature," 13 Developmental Neurorehabilitation, 294-306 (2010).

Yet another way to look at the medical purpose served by SGDs is to review the items to which SGDs have been compared. The most common comparison is between SGDs and power wheelchairs. The U.S. Food and Drug Administration, which is responsible for classification of medical devices, places SGDs and power wheelchairs in the same category of medical devices. *See* 21 C.F.R. § 890.3710. The FDA recognized that both devices provide their benefits through the same mechanism: both permit an individual to accomplish a specific functional intent, *i.e.*, to move from place to place, or to speak, by *by-passing* the body parts necessary for the normal accomplishment of that intent, but which are not working due to disability. For mobility, the brain generates an intent to move from point A to point B; it then generates motor instructions for the muscles of the legs to accomplish that intent; and it sends those instructions along the nerves to the muscles to implement that intent. If, due to disability, those instructions cannot be carried out in the normal fashion, the brain can *by-pass* the non-functioning body parts and re-direct the instructions to the arms and hands, which can propel a manual wheelchair or control a power wheelchair through a joystick. Thus, by *by- passing* the non-functional body parts **and** with the aid of an item of durable medical equipment, the original intent can be accomplished.

The same *by-pass* exists for SGDs. Ordinarily, speech is the outcome of a series of linked physiological steps. The "communication chain," a metaphor for how the body produces expressive communication (and extends to the steps related to hearing and receptive communication), was coined by Crystal & Varley, in their text *Introduction to Language Pathology*, now in its fourth edition. This metaphor is almost 100 years old. (The origin of the communication chain metaphor can be traced to F. deSaussure Course in General Linguistics (1916). It also is used in C. Shannon & W. Weaver, The Mathematical Theory of Communication (1949); P. Denes and E. Pinson, The Speech Chain: the Physics and Biology of Spoken Language (1963) and most recently D. Crystal & R. Varley, Introduction to Language Pathology (4th Ed.)(Baltimore: Brookes Publ. Co.1999)).

The "communication chain" states that expressive communication results from a series of 5 linked steps that must work properly to be successful. These steps include: the brain generates a thought; it is then linguistically encoded into speech; motor instructions are generated for the speech organs; the nerves then carry those instructions to the speech organs; and the speech organs execute the motor instructions. Viewed graphically, the communication chain can be represented as follows:



Disability can affect any of these "links" or steps in the communication chain. ALS, for example, directly interferes with the fourth link of the chain: it causes the loss of the motor neurons that carry instructions from the brain to the speech organs. And, because those body parts are no longer receiving motor instructions, they cease to function and atrophy, making them unable to function.

When there is a break in the communication chain, items of durable medical equipment, such as an SGD, are available to provide a by-pass around the non-functioning body part or link and enable the person to perform the speech task. For example, a person with ALS who still has the use of her hands will by-pass the non-functioning motor neurons to the speech organs and instead re-direct the motor instructions for speech to the hands, which will direct an SGD to create and speak a message.

Peggy Locke, the former President of the Communication Aid Manufacturers Association, explained this to Medicare staff as follows:

> AAC devices allow their users to achieve [their communication] goals by providing a functional substitute for body organs and structures that are necessary for the production of speech but which are non-functioning or mal-functioning due to illness, injury, disease or condition. Another way to describe the purpose of AAC devices is as a functional by-pass of these non- or mal-functioning body structures, *i.e.*, they allow the AAC device user to express a thought (message) as speech, by by-passing the nerves, muscles, and organs of speech which, due to impairment, make natural speech ineffective. The AAC device is the by-pass. Viewed in this way, AAC devices provide the same benefits and serve the same functional purposes as power wheelchairs. . . .

Letter dated October 23, 1999 to Lewis Golinker from Peggy Locke, President, Communication Aid Manufacturers Association. (This letter was submitted to Medicare as part of the *Formal Request*), posted for review at this link.

This "functional equivalence" between wheelchairs and SGDs has long been recognized by decision makers for health benefits and funding programs. For example, this fact was acknowledged in decisions by Medicaid programs in the late 1970s and 1980s and in Medicare decisions in the 1990s. *See In re: Donald S.*, Slip Op. at 3-4, No. 000-89-3072 (Social Security Admin. Office of Hrgs & Appeals October 1, 1999); *In re: Anonymous-I* (Minn. Dept. Of Human Services April 30, 1984); *In re: Anonymous-II* (Minn. Dept. Of Human Services April 30, 1984); *In re: John P.*, No. 7454-82 (NJ Office of Admin. Law Dec. 8, 1982); *In re: Kevin K.*, No. 2938-81 (NJ Office of Admin. Law Sept 1, 1981); *In re: Anthony M.*, No. 1360-79 (NJ Office of Admin. Law July 17, 1979).

All of the foregoing supports the conclusion that SGDs are used for "medical," "therapeutic" or "treatment" purposes and are medically appropriate and effective treatment for individuals with severe communication impairments. No evidence exists to question the role or effectiveness of SGDs as treatment for severe communication impairment.

SGDs Generally Are Not Useful To A Person In The Absence Of Illness Or Injury

The third Medicare DME criterion states that a DME item "generally is not useful to a person in the absence of illness or injury."

That SGDs are not useful to and are not used by people whose natural speech is sufficient to engage in functional communication already has been discussed. No person who is able to speak using his or her natural voice will have any reason to consider an SGD. Among the obvious reasons for this conclusion is that the rate at which people can produce speech is far faster and more flexible than the rate at which they can produce a message by any other means. *See* D. Beukelman and P. Mirenda, Augmentative and Alternative Communication 73 (2nd Ed. 1998)(discussing rate of speech production in natural speech and with SGDs). Even to the extent a person has a communication impairment, consideration of SGD needs will occur in the course of an SLP evaluation only after it is determined that no other SLP intervention or treatment will be sufficient to enable the person to meet daily communication needs. *See Formal Request* at Chapter 3, posted for review at this link (scroll to bottom of the page).

In addition, for more than a decade, SGD manufacturers have been producing devices that are "Medicare-compliant," *i.e.*, that conform to the Medicare SGD coverage guidance and therefore will be covered and reimbursed by Medicare. Medicare guidance states that only devices that are "dedicated speech generating devices, used solely by the individual who has a severe speech impairment," will be covered. Medicare National Coverage Decision for Speech Generating Devices, (2001), posted for review at this link. Medicare recognizes and accepts that some SGDs will be computer based or PDA-based, but will cover and provide reimbursement only for those devices that "have been modified to run only AAC software." Letter dated May 4, 2001 to Lewis Golinker from Thomas Hoyer, Health Care Financing Administration, posted for review at this link.

Dedicated SGDs, whether purpose built or computer based, will be of no interest to and of no use to anyone who does not have a severe communication impairment, which is exactly why Medicare imposed these limitations.

SGDs Are Suitable For Use In The Home

The fourth and final characteristic of an item of DME as stated in the Medicare definition is that it is "suitable for use in the home." Another phrasing for this criterion states that DME items must be "designed for outpatient use."

All SGDs meet this criterion. SGDs clearly are suitable for use in the home, as well as anywhere else the person with a severe communication impairment happens to be. SGDs are intended to provide a "voice" to people who are unable to meet daily communication needs using speech, or other natural means of communication, such as sign language or writing. For this reason, SGDs are intended to come and go with the person and be used wherever and whenever a communication need arises. This includes the person's home and everywhere else in the community the person goes and wants to speak.

Common among SGDs is that they were expressly designed to be portable, either to be carried by the person or to be mounted to a wheelchair.

The phrase "designed for outpatient use" is intended to distinguish (and exclude) equipment that is most often used by individuals who are in a hospital or residents of some form of long-term care facility or institution. Although SGDs *can* and *are* used by individuals in these settings, these uses just prove the prior point that SGDs are intended to be used and are suitable for use in any setting in which the person has something to say. There is nothing about SGDs that reflect "design" for use in these settings, and hospitals or long-term care facilities and institutions are not common funding sources for SGDs.

Rather, SGDs are most commonly provided to individuals who reside in their own homes or their family homes. There is no basis to conclude that SGDs are hospital-based or institutional equipment. That Medicare covers SGDs as DME provides strong evidence to support this conclusion. DME is an element of Medicare Part B; hospital benefits are provided through Medicare Part A. Moreover, Medicare does not provide DME items for residents of institutions. 42 U.S.C. § 1395x(n)(Medicare items of DME are not covered for individuals who reside in hospitals or nursing facilities.)

Regardless where their users reside, SGDs have been designed to enable their users to meet daily communication needs in all settings in which those needs will arise. They are intended to be used in any and every place where the user has the desire to speak. Overwhelmingly, they are provided to individuals who live in their own home or in their family's home, as compared to an institution.

Conclusion

More than 10 years ago, the American Academy of Physical Medicine & Rehabilitation stated: "Clearly there is no substitute for these devices [SGDs] for individuals with disabilities who require them…." Letter dated March 23, 2000 to Hugh Hill, M.D., from Ronald Henrichs, Executive Director, American Academy of Physical Medicine and Rehabilitation, posted for review at this link. Because of their unique role and importance: "Language is the principal skill distinguishing human beings from other animals. The inability to speak can be the single most devastating aspect of any handicap, Fred C. v. Texas Health & Hum. Serv. Comm'n, 988 F.Supp. 1032, 1034 (W.D.Tex. 1997), *affirmed per curiam*, 167 F.3d 537 (5th Cir. 1998), it is essential that SGDs are recognized by all systems of health benefits as routinely covered items of equipment.

As explained above, SGDs "meet" or "fit within" the definitions of Durable Medical Equipment stated most frequently health benefits and funding programs. The Medicare DME definition is the most common definition used by these programs which includes the majority of Medicaid programs, and most insurers and health plans. United Healthcare, for example, one of the nation's largest insurers and a frequent claims and appeals fiduciary for employer sponsored health benefits plans, approved dozens if not hundreds of SGDs because they met the plans' DME definitions which were substantively identical to the Medicare DME definition.

As to all of the information presented here, there is no objective basis whatsoever to support a conclusion to the contrary.

3.B. Insurance and Health Benefits Plans Database

In 2003, the ATLC asked 5 SGD manufacturers [Assistive Technology; Dynavox; Enkidu; Prenke Romich; Words Plus] to produce a list of the insurance companies and health benefits plans that had approved and paid for their products. The manufacturers were asked to generate this list any way available to them, e.g., through computerized customer records or hand review of their files – whatever procedure they were willing to follow.

Each of the companies responded with some information. Assistive Technology and PRC also have been sending updated reports, but the other companies have not.

The Insurance and Health Benefits Plans Data Base contains the information reported. The data base states the names of more than 1100 insurers and health benefits plans that have approved SGDs. In addition, the data base lists how many times the manufacturers reported each insurer and health plan approved a device.

This data base is admittedly incomplete. Data was not sought from every SGD manufacturer. The data provided by the companies spans only a few years, from the mid-to-late 1990s to 2003, but insurance funding for SGDs extends back to the late 1970s. Also, insurance and health plan funding for SGDs extends to the present, and in general, it is expanding in scope, but only 2 companies are reporting their ongoing approval data. Finally, no effort was made to control the completeness of the various searches.

Admitting these limitations in no way detracts from the value of the data base. It always was intended as an advocacy tool, not as scientific research. And, as an advocacy tool, the data base is extremely valuable.

That the data base is incomplete is itself of value: it supports the conclusion that both the total number of insurers and health benefits plans that approved SGDs and the total number of approved devices is larger, perhaps substantially larger.

In addition, as a practical matter, the presence of an insurer or plan on this list is more valuable than the total number of companies or devices listed. Specifically, insurers and health plans on the list will have obligations that must be honored before any SGD funding request can be decided. Failing to honor these obligations will have procedural and may have substantive consequences. Procedurally, failing to honor these obligations will preclude the denial of an SGD funding request. Substantively, the information generated by fulfilling these obligations may make it impossible for the insurer or plan to deny the SGD funding request.

General Importance of the Extent of Insurance SGD Funding

Knowledge about the extent of insurer and health plan funding for SGDs can have many uses. These data support conclusions that SGD coverage by insurers and health plans is extensive; that SGD funding by insurers and plans is appropriately viewed as "the rule;" and that non-coverage is "the exception" and most often, is not justified. These conclusions support an expectation that an SLP's SGD recommendation will lead to device access. They also are important as general information to insurers and health plans that are considering SGD funding requests for the first time.

This knowledge already has paid dividends. In the 1990s, PRC maintained a list of insurance coverage of its SGDs. The total number of insurers from that list was cited routinely in court pleadings filed to force expansion of Medicaid program SGD coverage. In addition to data about the extent of SGD coverage by other Medicaid programs, the insurer total was offered to show that there was widespread acceptance of SGDs by other funding programs as well. In *Myers v. State of Mississippi, 3:94 CV 185 LN (S.D.Miss. 1995)*, the District Court expressly referred to these data when it rejected Mississippi Medicaid's refusal to cover SGDs – based on its claim that SGDs were not 'medically necessary.'

> Though this fact is certainly not controlling, the court does find it instructive that forty other Medicaid programs do pay for AAC devices, i.e., finds them medically necessary [reference omitted]... Moreover, over 200 health insurance providers pay for AAC devices. [reference omitted].

Slip Op. at 12.

Importance of the Extent of Insurance SGD Funding to Individual SGD Funding Requests & Appeals

Knowledge of past insurer and plan SGD approvals also is a valuable asset in individual funding requests and appeals. It becomes one of the four pillars supporting current SGD funding requests and appeals. The other three are:

- the legal duty of insurers and health plans to investigate the facts of funding claims;

  Both insurers and health plans have legal duties to investigate the facts and the proper interpretation of key criteria related to a claim for benefits. For policies, the duty to investigate will arise under state common-law, state statute or regulation, or it may be an express provision of the policy. See 14 Couch on Insurance (3d Ed) § 198:27 (2005). For health benefits plans, the duty to investigate is a central element of a plan administrator's fiduciary duty to act as would a "prudent person" under the circumstances. 29 U.S.C. § 1104(a)(1)(B). A leading treatise on health benefits plans describes this duty as follows: Prudence focuses on the process that the fiduciary undertakes in reaching a decision. That is, prudence is a test of conduct and procedure, not results. . . . [A] fiduciary's duty to investigate is a key facet of prudence . . . . Jorden, Phlepsen, & Goldberg, ERISA Litigation (2d Ed.) § 3.03[A], at p. 3-58-59 (2004).

- the legal rule that policy or plan vocabulary must be given *reasonable* or *non-arbitrary and capricious* interpretations;

  A general rule of insurance interpretation is that when terms are subject to multiple possible interpretations, i.e., they are "ambiguous." See generally B. Ostrager & T. Newman, Handbook of Insurance Coverage Disputes, § 1.02 at p. 9 (9th Ed 1998)("An ambiguity exists when a word or phrase is reasonably susceptible to more than one construction."). A second general rule of insurance policy interpretation is that any reasonable interpretation of the policy language that supports coverage will be controlling of the outcome. The leading treatise on insurance law states: The words, "the contract is to be construed against the insurer" comprise the most familiar expression in the reports of insurance cases. It purports to be an application of the rule contra proferentem.[footnote omitted] If an insurer uses language that is uncertain, any reasonable doubt will be resolved against it; if the doubt relates to extent or fact of coverage, whether as to peril insured against, the amount of liability, or the person or persons protected, the language will be understood in its most inclusive sense, for the insured's benefit.2 Couch on Insurance (3d Ed.), § 22:14

- the legal conclusion that different interpretations of the same facts at different times is "capricious."

  If no objective basis for the difference in conclusion exists, the decision on a current request will represent merely an arbitrary or capricious decision, based on personal opinion of the decision makers. In general, this is a paradigm of capricious action. See Lefrak Forest Hills Corp. v. Galvin, 40 A.D.2d 211, 388 N.Y.S.2d 932,937 (2d Dept. 1972) affirmed, 32 N.Y.2d 796, 345 N.Y.S.2d 547, cert. denied, 414 U.S. 1004 (1973); Mayer v. Wing, 922 F.Supp. 902, 911(S.D.N.Y. 1996).

Knowledge of past SGD approvals, plus these legal rules help current SGD funding requests in the following way:

- Whenever a funding request is received, the insurer and plan has a duty to investigate to see if it should be approved. A *complete* investigation must be done to honor this obligation. Specifically, the insurer or plan should be searching to see if an SGD "fits" within the language of this policy or plan. This determination should be based on how the policy or plan terms have been interpreted before, if this is knowable, and not just on the basis of personal opinion of the insurer or plan reviewer.

- Where to look? Why not start with the earlier decisions approving SGDs made by the same insurer or plan? If the terms are the same, then the result should be the same: approve the device.

- For insurers, its own interpretation of the same terms will constitute a "reasonable interpretation" of those terms, and as a matter of law, a reasonable interpretation supporting coverage must control. For a plan, looking at the same terms on two separate days and reaching opposite conclusions is the definition of arbitrary and capricious action.

In other words, the data base supplies a starting point for an insurer or plan to investigate current SGD funding requests. In particular, to justify a denial, the decision maker should be required to explain how *each* earlier favorable decision is based on a scope of coverage different from the current policy or plan. Moreover, the decision maker should be required to explain not only that there is some difference in scope of coverage, but that the difference is so significant as to justify a "yes" to the earlier request, but that a "no" is appropriate now.

Procedurally, insurers and plans are unlikely to engage in this type of factual investigation when they make their initial determination. For this reason, *every* denial issued by an insurer or plan listed in the data base should be appealed, and specific reference to the existence of earlier SGD approvals should be noted.

If the insurer or plan issues a new decision and again fails to explain how these earlier approvals are based on substantially different coverage criteria, this denial should be appealed again, and again, until it is set aside. In short, if the insurer or plan is listed on the data base, absent specific reference to and explanation of past decision making, a denial decision is fatally flawed.

No insurer or plan can say these earlier decisions are not important. They may point to their freedom to use unique language in every policy or plan. That it true, but what matters is what these policy or plan documents *did* say, not what they *could* say. Only by looking at past policies and plan documents can it be determined whether the same or different language was used. And, to the extent the language used is the same, how will insurers or plans argue that their own prior interpretations are not reasonable, or that contradicting them now is not arbitrary?

Together, facts about earlier SGD approvals and these legal rules create a presumption that a current SGD funding request or appeal should be approved. The insurer or plan can rebut this presumption, but only by producing information to show there is a significant difference between the way the benefits were described in the current policy or plan and those earlier cases. Also, the greater the number of earlier SGD approvals, the stronger the presumption applicable to the current claim. The greater the number of earlier approvals, the greater the likelihood that one or more were based on the same coverage vocabulary as is used in the current claim. Because the insurer or plan already interpreted that vocabulary to support coverage, to not do so again, is not reasonable and instead, is arbitrary and capricious. Armed with these data, ***what is past, is prologue.***

The Insurance & Health Plan SGD Approval Database

The database is a table with two columns. One lists the names of insurers and health plans; the other identifies the number of SGD approvals reported by the manufacturers.

How to Use the Insurance & Health Plan SGD Approvals Database

SLPs, families, funding staff of SGD manufacturers and suppliers, funding staff at government programs such as Medicaid, and advocates all should examine the data base. Whenever a client has insurance or a health benefits plan as the primary funding source, the presence of an insurer's or plan's name on the data base means it has paid for an SGD before, and a presumption should be created that it should approve the current request. If the insurer or plan already has said no to funding request, its presence on the data base provides grounds for appeal.

Insurers and health benefits plans are listed alphabetically. The names of the insurers are printed as they were reported by the manufacturers. Search to match the current insurer or plan against the database list. Care should be taken to consider all common spelling variations, and common variations on the names of the insurers.

NOTE: Insurers often act as plan administrators. Whenever an insurer has this role, the Database should be searched for the insurer as well as for the plan.

If a match is found, the next step is to note how many SGD approvals are reported.

For any one listing, this task is easy: the number printed to the right of the insurer or plan name represents the number of approvals reported. However, some companies are listed multiple times, which may only reflect differences in the way the manufacturers reported the names to the ATLC. For example, there is little doubt that "Aetna," "Aetna Insurance," and "Aetna US Healthcare" are the same insurer, or that "Cigna" and "Cigna Health Care" are the same insurer. It is recommended, therefore, that all the policies and plans listed for a particular company be included in the total.

Example: Aetna has 19 distinct listings in the database, but it is reasonable to assume all these policies were issued by the same parent company, and as a result all the approvals for these 19 listings can be added together (214). This total represents the number of earlier decisions Aetna must distinguish from the current policy or plan in order to justify a denial. (If Aetna wishes to claim that not all of these approvals are appropriate for consideration, it is free to do so as part of a response. Also, because the number of earlier approvals is so large, the likelihood the scope of benefits in the current policy or plan will match none of these

earlier policies or plans is very small. Thus, when Aetna is the insurer for a current client, the family, SLP and advocates should hold a strong presumption that an SGD funding request will be approved.)

NOTE: whenever earlier approvals are reported, the number should be described in correspondence as "at least ___ SGD approvals have been issued," based on the incomplete nature of the database.

Once a match is found, the insurer or plan should be put on notice, in writing, that this information is known, and that to justify denial of the current SGD funding request, the insurer or plan will have to investigate and explain the difference between the current request and *every* previous SGD approval.

One way to insist that this investigation be conducted is to request the documents from those earlier decisions. Producing these documents will permit an independent review. Individuals who are insured, or who are health plan participants, should demand ***in writing*** that the insurer or plan produce all records related to earlier SGD approvals. In addition, these requests should seek production of the description of the scope of benefits, including the definition or characteristics of durable medical equipment in the policy or plan.

Sample request for records from individual insured by policy:

"Produce all records describing the scope of benefits, including the definition of, or characteristics of durable medical equipment, in all policies issued by _____[name of insurer] and for all health benefits plans administered by _____ [name of insurer] in which an SGD has been approved. Information in the Insurer & Health Plan SGD Approvals Database, posted at www.aacfundinghelp.com reveals that at least ___ earlier SGD approvals have been issued by _____ [name of insurer].

As part of your duty to conduct a good faith investigation of the facts surrounding my claim for SGD funding, please produce these data within 30 days of the date of this letter. If you fail to produce the requested information, you must explain in writing the steps taken to conduct a reasonable search. You are on notice that the SGD manufacturers who supplied data to the Database can identify each individual for whom an earlier SGD approval was issued, and from that information, all relevant policy and plan terms can be located. Once located, they can be compared against the comparable terms of my policy. If the vocabulary used to describe the scope of benefits is the same, the result must be the same – the approval of my requested SGD. Insurers are obligated to accept any reasonable interpretation supporting coverage. Certainly your own earlier interpretations of the same terms or phrases will be deemed reasonable.

If you claim the vocabulary describing the scope of benefits is different, your written report should explain why the differences are so significant that a different outcome is justified.

In lieu of conducting the search and analysis stated above, or producing the records to permit independent analysis of the relevant terms, you may approve the requested SGD."

Sample paragraph for participant in a health benefits plan or where an insurance company serves as plan administrator:

"Pursuant to 29 USC § 1104, and 29 CFR §§ 2560.503-1(b)(5); (j)(3); & (m)(8), within 30 calendar days of the date of this letter, produce, without charge, all records describing the scope of benefits, including the definition of, or characteristics of durable medical equipment, in all policies issued by _____[name of plan or of insurer acting as plan administrator] and for all health benefits plans administered by _____ [name of plan or of insurer acting as plan administrator] in which an SGD has been approved. Information in the Insurer & Health Plan SGD Approvals Database, posted at www.aacfundinghelp.com reveals that at least ___ earlier SGD approvals have been issued by _____ [name of plan or of insurer acting as plan administrator].

As part of your fiduciary duty, you must conduct a complete investigation of the facts surrounding my claim for SGD funding. You are on notice that the SGD manufacturers who supplied data to the Database can identify each individual for whom an earlier SGD approval was issued, and from that information, all relevant policy and plan terms can be located. Once located, they can be compared against the comparable terms of my plan. If the vocabulary is the same, the result must be the same – the approval of my requested SGD. Different interpretations of the same terms on different days is arbitrary and a violation of ERISA. Even if the vocabulary is different, you must explain why the differences are so significant that a different outcome is justified.

In lieu of conducting the search and analysis stated above, or producing the records to permit independent analysis of the relevant terms, you may approve the requested SGD."

Go to Insurer and Health Plan SGD Database

How to use the Insurer & Health Plan SGD Approvals Database

4. Federal Employee Health Benefits Plan

Coming soon...

5. Department of Veterans Affairs

Coming soon...

6. Tricare

Tricare Coverage of AAC Devices

The Tricare program, formerly known as CHAMPUS, is a publicly funded health benefits program established for dependents of act ive duty military personnel and military retirees and their dependents.

The Tricare program has covered AAC devices for many years. Until the end of 2001, however, Tricare/CHAMPUS AAC device cov erage had been limited to the dependents of active duty military personnel. The military retirees and their dependents were not abl e to get Tricare/CHAMPUS funded AAC devices.

This coverage limitation has now been eliminated. On December 28, 2001, President Bush signed the FY 2002 military reauthoriza tion bill, which includes Tricare reforms. In one of those reform provisions, Congress authorizes Tricare to cover AAC devices as a prosthetic device.

Prosthetic devices are a Tricare benefit that is available to all enrollees. Specifically, Pub. L. No. 107-107, Section 702(2) (2001), a mends the Tricare scope of prosthetic device coverage. 10 U.S.C. Section 1077(a)(15). The statutory amendment states, simply an d clearly:

An augmentative communication device may be provided as a voice prosthesis under subsection (a)(15).

After this statutory change was enacted, advocates sought to persuade Tricare administrators to adopt SGD coverage criteria as s oon as possible. Letter dated March 20, 2002 to Peter Thomas, Esq., from Lewis Golinker (describing proposal to Tricare to adopt Medicare SGD Coverage Criteria); Letter dated April 17, 2003 to Ms. Ann Fazzini; Letter dated June 13, 2003 to Tricare Manageme nt Authority.

Tricare's SGD coverage criteria mirror the Medicare national coverage decision for SGDs. These criteria became effective on April 1, 2005. Tricare Policy Manual Table of Contents (TPO2) and SGD Coverage Policy (TP02 Chapter 7); Tricare Policy Manual, Cha pter 7, Section 23.1.

For an unknown reason, Tricare suspended these criteria during the summer of 2005 and then made them effective again on Septe mber 1, 2005. Change 26 (June 13, 2005) from Office of the Assistant Secretary of Defense, Health Affairs. These criteria were not changed in any way and they remain in effect today.

7. Special Education

Coming soon...

8. Early Intervention

Coming soon...

9. Vocational Rehabilitation

Coming soon...

10. Telecommunication Equipment Distribution Programs

Coming soon...

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