tobii dynavox

State-by-State Funding and Insurance Guide

Tobii Dynavox Funding Support

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The journey to **funding a speech generating device** begins with the right information and paperwork.

This guide provides information about funding a speech generating device through Medicare, Medicaid, or commercial health insurance, as well as state-specific funding and documentation requirements. Funding documentation and requirements are dependent on funding sources (i.e. which method of funding you're using) and state-specific requirements.

Use this guide to find information about requirements in your state, then work with your solutions consultant and visit the e-Funding Portal to complete the funding journey and start communicating.

Return to Table of Contents

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Table of Contents

Select the title of the section you'd like to visit to be taken to that page. You may find it helpful to review the information on General Funding Sources first, then navigate to specific states.

General Funding Sources 5
Alabama Funding 9
Alaska Funding 15
Arizona Funding 18
Arkansas Funding 21
California Funding 24
Colorado Funding 28
Connecticut Funding 32
Delaware Funding 35
District of Columbia Funding 38
Florida Funding 41
Georgia Funding 45
Hawaii Funding 48
Idaho Funding 51
Illinois Funding 55
Indiana Funding 59
Iowa Funding 62
Kansas Funding 65
Kentucky Funding 69
Louisiana Funding 72
Maine Funding 76
Maryland Funding 79
Massachusetts Funding 82
Michigan Funding 87
Minnesota Funding 90
Mississippi Funding 94
Missouri Funding 98
Montana Funding 102

Return to Table of Contents

Nebraska Funding 105
Nevada Funding 108
New Hampshire Funding 111
New Jersey Funding 114
New Mexico Funding 117
New York Funding 120
North Carolina Funding 125
North Dakota Funding 129
Ohio Funding 132
Oklahoma Funding 135
Oregon Funding 138
Pennsylvania Funding 141
Rhode Island Funding 145
South Carolina Funding 148
South Dakota Funding 151
Tennessee Funding 154
Texas Funding 159
Utah Funding 163
Vermont Funding 167
Virginia Funding 170
Washington Funding 174
West Virginia Funding 177
Wisconsin Funding 180
Wyoming Funding 185

Return to Table of Contents

General Funding Sources

Medicare

Medicare is a federal health insurance program for:

- People who are 65 years or older
- Certain younger people with disabilities
- People with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD)

Medicare Part B (medical insurance) covers certain doctors' services, outpatient care, medical supplies, and preventative services. Speech generating devices are covered under Medicare Part B.

Traditional Medicare

- No prior authorization requirement.
- Published criteria for obtaining a speech generating device – Local Coverage Determination (LCD), Policy Articles, Manuals.
- High rate of audit/medical record review.
- DME Medicare Contractors: Noridian Healthcare Solutions and CGS.
- For appeals, Medicare allows a seven-year lookback period.
- Place of service limitations – no coverage for Nursing Facility (NF), Skilled Nursing Facility (SNF), In-patient Hospitals (IPH), or hospice.
- Required documentation:
    - Evaluation Report
    - Detailed written order
    - Face-to-face visit record

Rx Required Information

- Order date
- Client name and date of birth.
- Items ordered
- Ordering provider's name, NPI, and signature

Face-to-Face Requirements

- Visit must have occurred within 6 months prior to prescription.
- Ordering physician must have a copy of Face-to-Face (F2F) chart notes.
- Must be treating, evaluating, or managing the medical condition that causes the need for the device.
- Information in F2F should not conflict with evaluation.

Return to Table of Contents

Requirements for Evaluation

- Full requirements included in the LCD and associated articles are available on the website.
- It is very important to document a "severe expressive speech impairment."
- Must include highly detailed information about cognitive ability and ability to use the device if client has a cognitive impairment of any kind.
- Access methods must be justified clearly. Medicare covers **only one** access method (e.g. they **will not** cover gaze for control and switch for click).

Medicaid

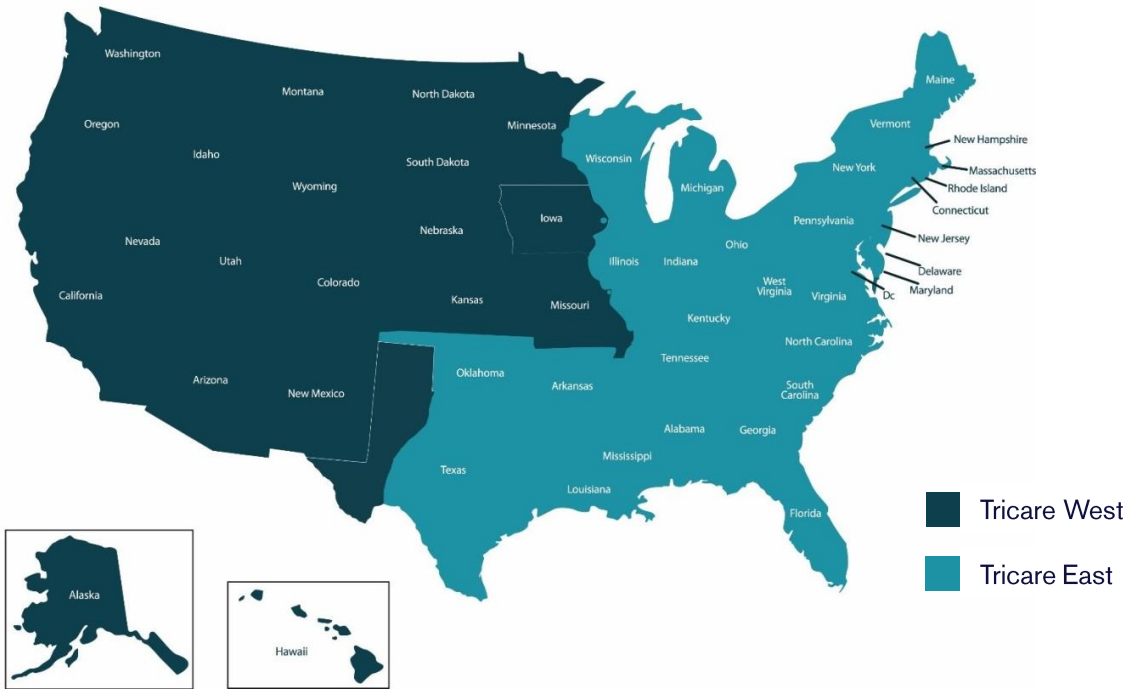
Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.

Medicaid Managed Care is a health care delivery system organized to manage cost, utilization, and quality. It provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and Managed Care Organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

Not every state Medicaid program contracts with MCOs. Check your specific state criteria for more information about participating Medicaid MCOs.

Tricare

Tricare is a government sponsored health insurance program for active duty, Reserves, retired military members, and eligible family members. TriCare is divided by regions:



Return to Table of Contents

Tricare East:

- Does not require authorization
- HMO/Prime plans require a Tricare referral (non HMO/Prime plans follow report requirements and are reviewed in house)
- Tobii Dynavox Funding Consultant submits referral request to Physician via Tricare Referral Request template in OMI
- Referral request must include:
    - Copy of Rx/CMN with the following information:
        - Beneficiary's name, date of birth, and diagnosis
        - Detailed description of items being ordered
        - Length of need
        - Physician name (PA and NP accepted), NPI, signature, and date (no stamps)
        - Order Date
    - Evaluation
    - Equipment Quote
    - Tricare Dedicated Letter (internal document provided by Tobii Dynavox to ensure the device is dedicated)

Tricare West:

- All plans require authorization
- No Tricare referral is required (if Tricare happens to deny for lack of referral, send request to doctor via Tricare Referral Request template in OMI)
- Tobii Dynavox Funding Consultant submits authorization online at https://www.tricare-west.com/idp/prov-login.fcc
- Submission must include:
    - Copy of Rx/CMN with the following information:
        - Beneficiary's name, date of birth, and diagnosis
        - Detailed description of items being ordered
        - Length of need
        - Physician name (PA and NP accepted), signature, and date (no stamps)
        - Order Date
    - Evaluation
    - Tricare Dedicated Letter (internal document provided by Tobii Dynavox to ensure the device is dedicated)
    - Equipment Quote

E2599 is listed as the covered code in the Tricare system for Tobii Dynavox. If the reviewer states the code is invalid/not specific, the Tobii Dynavox Funding Consultant may call Tricare and explain to the reviewer that there is an exception under code E2599 for our provider. There is no other specific code for this equipment.

Return to Table of Contents

Commercial Health Insurance

Commercial Health Insurance is health insurance provided and administered by non-governmental entities. It covers medical expenses and disability income for the insured. Employer, employer groups, and individuals can purchase commercial health insurance at an out-of-pocket expense.

Billing Information

SLP Therapy Services

- CPT codes 92607-92609 relate to speech-language pathology services for SGDs.
- CPT 92607 is used for coding the first hour of the evaluation for a SGD prescription.
- CPT 92608 allows the SLP to bill for each additional 30 minutes.
- Therapeutic services for the use of an SGD are reported using 92609

Speech Generating Device Codes

- E2510 - Speech-generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access
- E2512 - Accessory for speech-generating device, mounting system
- E2599 - Accessory for speech-generating device, not otherwise specified

Appeals

There are times when a health insurance company will either defer or deny the request for a speech generating device. Tobii Dynavox has an Appeals Department that is able to assist in written appeals, as well as provide guidance on scheduling peer-to-peer reviews.

Our Appeals Department can also provide support with the resources required by various payers, rather than calling out specific letters we don't use for most appeals. Please contact us directly to discuss how to process your appeal.

Please note: A client may have one or a combination of several of the insurance plans described in this guide. In most instances, all criteria for each plan an individual is enrolled in must be followed. If these requirements conflict, please reach out to the funding team for more information.

Return to Table of Contents

Alabama Funding

Quick Facts

Mounting

Are there mounting restrictions in Alabama?

- No.

Software

Is additional software covered?

- All software is covered.

Hardware

Does the funded device need to be dedicated?

- Closed for all devices unless direct bill or VA.

Trials

Does Medicaid require a trial? How long does it need to be?

- Yes. No specific length, just needs to have been trialed.

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- Yes.

State Specific Documentation Requirements

What state-specific forms or documentation is required for authorization?

- Referral form for clients 18 and under, CPPRS form, Team Qualifications, and special AL MCD Report form

Who can sign the Rx?

- MD/DO only

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- No

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- A trial is required but authorization is not.

Return to Table of Contents

Alabama Medicare Advantage

Each county of Alabama has between 5 and 28 Medicare Advantage Plans available. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare. Carriers include Aetna, Blue Cross Blue Shield of Alabama, Bright Health, Cigna, Humana, United Healthcare, Viva, and WellCare.

Alabama Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Alabama does not contract with MCOs.

Alabama Medicaid Durable Medical Equipment

As defined by Medicaid, DME is equipment:

- that can stand 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 appropriate for use in the home.

DME is necessary when it is expected to make a significant contribution to the treatment of the recipient's injury or illness or for the improvement of physical condition. The cost of the item must not be disproportional to the therapeutic benefits or more costly than a reasonable alternative. The item must not serve the same purpose as equipment already available to the recipient.

Medicaid covers the purchase of DME items for long term use. Long term use is defined as the use of DME which exceeds six months. Medicaid covers the rental of DME items for six months or less.

Augmentative Communication Devices (ACDs) are defined as portable electronic or non-electronic aids, devices, or systems for the purpose of assisting a Medicaid-eligible recipient to overcome or improve severe expressive speech-language impairments or limitations due to medical conditions in which speech is not expected to be restored. These devices also enable the recipient to communicate effectively.

These impairments include, but are not limited to, apraxia of speech, dysarthria, and cognitive communication disabilities. ACDs are reusable equipment items that must be a necessary part of the treatment plan consistent with the diagnosis, condition or injury, and not furnished with the convenience of the recipient or his family. Medicaid will not provide reimbursement for ACDs prescribed or intended primarily for vocational, social, or academic development and enhancement.

Alabama Medicaid Guidelines for Communication Device Purchase

An evaluation must be conducted within 90 days of the request for an ACD. Medicaid requires the following recipient information with the PA request: Providers should utilize the Augmentative Communication Device Evaluation Form on the website.

Return to Table of Contents

Topic	Information required for the PA
Identifying information	• Name • Medicaid recipient number • Date(s) of assessment • Medical diagnosis (primary, secondary, tertiary) • Relevant medical history
Sensory status (as observed by a physician)	• Vision • Hearing • Description of how vision, hearing, tactile, and/or receptive communication impairments affect expressive communication (e.g. sensory integration, visual discrimination)
Postural, mobility, and motor status	• Motor status • Optimal positioning • Integration of mobility with ACD • Recipient's access methods (and options) for ACD
Development status	• Information on the recipient's intellectual/cognitive/development status • Determination of learning style (e.g. behavior, activity level)
Family/caregiver and community support systems	• A detailed description identifying caregivers and support, the extent of their participation in assisting the recipient with use of the ACD, and their understanding of the use and their expectations.
Current speech, language, and expressive communication status	• Identification and description of the recipient's expressive or receptive (language comprehension) communication impairment diagnosis • Speech skills and prognosis • Communication behaviors and interaction skills (i.e. styles and patterns) • Description of current communication strategies, including use of an ACD, if any • Previous treatment of communication problems

Return to Table of Contents

Topic	Information required for the PA
Communication needs inventory	• Description of recipient's current and projected (e.g. within 5 years) speech-language needs • Communication partners and tasks, including partner's communication abilities and limitations, if any • Communication environments and constraints which affect ACD selection and/or features
Summary of recipient limitations	• Description of the communication limitations
ACD assessment components	• Justification for and use to be made of each component and accessory requested
Identification of the ACDs considered for recipient – must include at least three (3)	• Identification of the significant characteristics and features of the ACDs considered for the recipient • Identification of the cost of the ACDs considered for the recipient (including all required components, accessories, peripherals, and supplies, as appropriate) • Identification of manufacturer • Justification stating why a device is the least costly, equally effective alternative form of treatment for recipient • Medical justification of device preference, if any
Treatment plan and follow-up	• Description of short term and long term therapy goals • Assessment criteria to measure the recipient's progress toward achieving short and long term communication goals • Expected outcomes and description of how device will contribute to these outcomes • Training plan to maximize use of ACD
Additional documentation	• Documentation of recipient's trial use of equipment including amount of time, location, analysis of ability to use • Documentation of qualifications of speech language pathologists and other professionals submitting portions of evaluation. Physicians are exempt from this requirement • Signed statement that submitting professionals have no financial or other affiliation with manufacturer, vendor, or sales representative of ACDs. One statement signed by all professionals will suffice

Return to Table of Contents

Alabama Medicaid Criteria Requirements

Below are documents and requirements necessary to meet Alabama's Medicaid criteria:

- **Alabama Medicaid Agency Referral Form (Form 362)** must be completed for all clients with Alabama Medicaid for rental, purchase, or repair requests. It requires the signature of the same treating physician who signs and dates the prescription for the device (stamped or copied signatures will not be accepted). If possible, indicate the Medicaid number of the treating provider. The consultant's information is Tobii Dynavox.

  An EPSDT is required for clients under the age of 21. This requirement can be met with a separate screening or by the appropriate box being selected on the Form 362.
- **Augmentative Communication Team Evaluation Team Qualification** form must be signed by each member of the team. If other team members contribute their opinions for the ACD evaluation report, then their qualifications are required on this form.
- **Communication Prosthesis Payment Review Summary** form must be signed by the Speech Language Pathologist (SLP) and the treating physician for the patient. The facility information where the patient is treated by the SLP must be included. The manufacturer is Tobii Dynavox and is listed under *Device Information*. This form also includes a **Statement of Non-Affiliation** that the physician and SLP must sign.
- **Prescription from Physician** must include the physician's National Provider Identification (NPI) number and the Medicaid number. The prescription must be dated within 90 days of the date that the request is submitted to Tobii Dynavox and signed by the treating physician (either handwritten or through a viable electronic source; typed signatures are not accepted).

  Each device/accessory must be listed separately on the prescription form. For example, Tobii Dynavox E2510 I-13 device cannot be listed on the same line as E2599 Eye Gaze Accessory.
- **Speech Language Pathologist CEU** training certificates must be submitted for the treating SLP completing the evaluation for the patient. They must list the courses/workshops attended by the treating SLP within the last year.

Commercial Insurance in Alabama

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies. We will work with any insurance to obtain coverage for you or your client.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Blue Cross Blue Shield of Alabama*
- Tricare*

Return to Table of Contents

- Viva Healthcare

Alabama Schools

- Expenditures involving $15,000 or more are subject to competitive bidding.
- School boards can purchase goods or services through national or regional cooperative purchasing programs approved by the Alabama Department of Examiners of Public Accounts, to utilize GSA vendors, to define sole source, and to extend the maximum contract length to five years.
- Purchasing from a vendor without competitive bidding is allowable if a school board specifies that the vendor is a sole source of the goods and the documentation required by the competitive bid law is maintained.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Alaska Funding

Quick Facts

Mounting

Are there mounting restrictions in Alaska?

- No.

Software

Is additional software covered?

- When justified in report.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial?

- No.

State Specific Documentation Requirements

What state-specific forms or documentation is required for authorization?

- Rx, AK CMN (MD/DO completes page 1 and Tobii Dynavox Funding Consultant completes page 2).

Who can sign the Rx?

- MD/DO, PA, & NP can all sign the Rx.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx should be on the F2F notes; no preferred Dx's
- F2F must be within 6 months of start of services. Can be sick visit.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial is required.

Return to Table of Contents

Alaska Medicare Advantage

There are no individual Medicare Advantage plans available for sale in Alaska.

Alaska Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Alaska does not contract with MCOs.

Alaska Medicaid Requirements

Below are documents and requirements necessary to meet Alaska's Medicaid criteria.

- **Prescription, Certificate of Medical Necessity (CMN), and Speech Evaluation** must be included. The physician must document that the client was evaluated and/or treated for a condition that supports the speech generating device. This documentation (chart notes or office visit) must be provided along with the written order for the device.

  A prescription order for all durable medical equipment (DME), medical supplies, and related items and services must contain the following:
  - Recipient's name and date of birth
  - Item or service being prescribed
  - ICD diagnosis code
  - Quantity of item being prescribed
  - Directions or instructions for proper use of the item or service, including the frequency of use, if applicable
  - Duration or estimated length of need for the item ("lifetime", "99 months", etc.)
  - Enrolled prescribing provider's signature and signature date
  - Date of the face-to-face examination
  - A prescription order, or prescription order that is part of a CMN, will be accepted for no more than one year from the signature date forward.

- **Place of Service Requirements** covers DME when the client is at home only. Alaska Medicaid will not cover DME in a skilled nursing facility, hospital, rehab, etc.
- **The Face-to-Face (F2F) Encounter** must be related to the primary reason the member requires medical equipment and must occur no more than 6 months prior to the start of service.* The F2F encounter may be conducted by one of the following practitioners, in accordance with state law:
  - Physician
  - Nurse Practitioner or Clinical Nurse Specialist
  - Physician Assistant, under the supervision of a physician

  *Effective July 1, 2017, in accordance with 42 CFR 440.70

Return to Table of Contents

Commercial Insurance in Alaska

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies. We will work with any insurance to obtain coverage for you or your client.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Premera First Blue Shield
- Tricare*

Alaska Schools

- Any vendors wishing to supply goods and services to Alaska School Systems should complete the applicable purchasing interest forms with corresponding school districts.
- Tobii Dynavox does not have any direct school contracts, but we are always working to expand coverage.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Arizona Funding

Quick Facts

Mounting

Are there mounting restrictions in Arizona?

- No.

Software

Is additional software covered?

- Yes.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial?

- No.

State Specific Documentation Requirements

Who can sign the Rx?

- MD/DO, PA, & NP can all sign the Rx.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx should be on the F2F notes; no preferred Dx's
- F2F notes from prescribing physician must be within 6 months of Rx signature date.
- F2F visit from the evaluation for the equipment is different than F2F visit with the prescribing physician.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- An authorization is required.
- A trial is not required.

Return to Table of Contents

Arizona Medicare Advantage

Arizona has fair Medicare Advantage plan coverage. All counties have at least 3 plans available, some have over 25. Plan rules will vary by carrier, but will cover at least as much as Traditional Medicare.

Arizona Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Arizona is currently utilizing Managed Care plans. Arizona MCOs are listed below:

Participating:

- Mercy Care Arizona
- United Health Care Community Plan

In Process:

- Banner Health Plan
- University of Arizona Health Plan
- Health Net Access

Note: A speech evaluation and prescription are required for submission to AZ MCOs. Additionally, United Healthcare Community Plan requires face-to-face visit notes and will not cover for clients living in a skilled nursing facility.

Arizona Medicaid Requirements

Below are documents and requirements necessary to meet Arizona's Medicaid criteria.

- **Prescription, Speech Evaluation, and Quote** are all required to be submitted.
- **The Face-to-Face (F2F) Encounter** must be related to the primary reason the member requires medical equipment and must occur no more than 6 months prior to the start of services. The F2F encounter may be conducted by one of the following practitioners, in accordance with state law:
    - Physician
    - Nurse Practitioner or Clinical Nurse Specialist
    - Physician Assistant, under the supervision of a physician

Commercial Insurance in Arizona

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies. We will work with any insurance to obtain coverage for you or your client.

- Aetna*
- Cigna*

Return to Table of Contents

- Humana*
- United Healthcare*
- Arizona Blue Cross Blue Shield (**Note:** many AZ BCBS plans exclude SGDs)
- Tricare*

Arizona Schools

- Purchases of materials or services that exceed $100,000 must be procured using a formal solicitation, such as an invitation for bids, a request for proposals, or a request for qualifications.
- Sole Source Procurements: a contract may be awarded without competition if there is a determination that there is only one source for the required material. A vendor's self-serving declaration that it is sole source is not determinative. Sole source procurements are to be avoided expect when no reasonable alternative sources exist.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

All appeals must be filed within 60 days from date of denial on the letter. All denials should be forwarded to the Tobii Dynavox Appeals team upon receiving the official denial letter. A consent form is required to file appeal on member's behalf.

Return to Table of Contents

Arkansas Funding

Quick Facts

Mounting

Are there mounting restrictions in Arkansas?

- No.

Software

Is additional software covered?

- Based on medical necessity.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial?

- AR Medicaid does not require a formal trial, however Medicaid requests that at least three devices are trials with written documentation of each usage in the assessment.

State Specific Documentation Requirements

What state-specific forms or documentation is required for authorization?

- Arkansas Medicaid Certificate of Medical Necessity (in place of Rx). Tobii Dynavox obtains this form.

Who can sign the Rx?

- MD/DO only

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx should be on the F2F notes; no preferred Dx's
- F2F should mention the device
- No telehealth/sick visits

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- AR Medicaid only reviews if they are responsible for more than 50% of charges. A trial is not required.

Return to Table of Contents

Arkansas Medicare Advantage

Arkansas has fair Medicare Advantage plan coverage. All counties have at least 4 plans available, some have over 20. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

Arkansas Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Arkansas converted to managed care in September 2019. Arkansas Medicaid has moved to a program called Provider-Led Arkansas Shared Savings Entity (PASSE). PASSE's will cover Medicaid recipients with "complex behavioral health, developmental, or intellectual disabilities." There are 3 PASSE's:

- Arkansas Total Care: https://www.arkansastotalcare.com/
- Empower Health: https://getempowerhealth.com/
- Summit Community Care: https://www.summitcommunitycare.com/arkansas-passe/home.html
    - Requires multiple sessions for a trial
    - Though they do not specify, documentation of a 30-day trial would be helpful

Arkansas Medicaid Requirements

Below are documents and requirements necessary to meet Arkansas' Medicaid criteria.

- Prescription and Prior Authorization Request must be completed with the physician's information and the description of items that are requested in Section A of the form. Section B must be completed and signed by the physician. Signatures from a nurse practitioner or physician's assistant is not acceptable.
- **Certificate of Medical Necessity** is required for authorization.
- **Speech Language AAC Evaluation** must be completed by a licensed Speech Language Pathologist (SLP) with their CCC credentials. A licensed Occupational Therapist (OT) must co-sign the report or provide a separate addendum documenting agreement. A physical therapist may be added to the team if there is a need for assistance related to positioning and seating for use of the speech generating device. The evaluation must indicate that 3 devices were trialed.
- **Current Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Form** is required if the recipient is under the age of 21. This form or printed office visit notes can be obtained from the physician. The physician must write "Augmentative Communication Device needed" on the form or office visit notes, and it must be dated within 12 months of submission to the provider.
- **Lifetime Max Coverage** of $7500 for ages 21 and older. Additionally, Arkansas Medicaid Total Care Part B has a speech generating device exclusion.

Return to Table of Contents

Commercial Insurance in Arkansas

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies. We will work with any insurance to obtain coverage for you or your client.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Arkansas Blue Cross Blue Shield
- Tricare*

Arkansas Schools

- Contracts exceeding $75,000 will be awarded by competitive sealed bidding unless a determination is made in writing by the agency procurement official of the State Procurement Director that this method is not practicable and advantageous.
- Sole source procurements are available for contracts exceeding the $75,000 limit for commodities and technical services which, by virtue of the performance specification, are available from a single source.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

- Summit Community Care MCO denials must be appealed within 30 days from the denial letter date.
- Medicaid denials must be appealed within 35 days from denial letter date.
- All denials should be forwarded to Tobii Dynavox Appeals upon receiving the denial letter.
- SGD criteria can be found in section 212.202 of this document.

Return to Table of Contents

California Funding

Quick Facts

Mounting

Are there mounting restrictions in California?

- California Children Services (CCS) covers only 1 mount; no universals.
- Medicaid will only cover 1 mount per device.
- Other MCO's may not have mount restrictions; refer to your Funding Consultant for more information.

Software

Is additional software covered?

- If justified in report.

Hardware

Does the funded device need to be dedicated?

- Yes – provide sole source letter.

Trials

Does Medicaid require a trial? If so, how long?

- Straight Medicaid requires a trial. Minimum 30-day trial required – must show trial date span in evaluation.
- CCS & MCO's will require a trial.

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- Use recommended device throughout entire trial.

State Specific Documentation Requirements

Who can sign the Rx?

- MD/DO only

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- Medicare does not require a trial.
- Medicare/Medicaid does not require a trial or authorization.

Return to Table of Contents

California Medicare Advantage

California has good Medicare Advantage plan coverage. All counties have at least 2 plans available, some have over 40. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Contra Costa MCR
- Anthem of California MCR
- Kaiser Permanente MCR

California Medicaid Information

Medicaid Managed Care Organizations (MCOs)

California is currently utilizing managed care plans.

Participating:

- California Health and Wellness
- Cal Optima
- Contra Costa
- Gold Coast Health Plan
- Health Net of California
- Health Plan of San Mateo
- Inland Empire Health Plan
- LA Care
- Partnership Health Plan of CA (PHP)
- UHC Community Plan

In Process

- Cen Cal
- Anthem of CA Medicaid Plan
- Molina of California
- California Medical Groups
    - Loma Linda University
    - Network Medical/LaSalle Medical Group
    - Prime Care Medical

California Medicaid Requirements

Below are documents and requirements necessary to meet California's Medicaid criteria.

- **4-Week Speech Generating Device Trial** must be documented in the Speech Language AAC Evaluation.
- **Prescription, Speech Report, and Quote** must be submitted. Prescription must include the physician's state license number, National Provider Identification (NPI) number, and list the specific device and accessories being prescribed. MediCal requires that the client has a F2F examination with their physician no more than 6 months prior to the written order for the

Return to Table of Contents

speech generating device. The physician must document that the client was evaluated and/or treated for a condition that supports the speech generating device. This documentation must be provided upon request.

- **California Children Services (CCS)** requires an evaluation to be conducted by a licensed Speech Language Pathologist (SLP) for eligible clients. The SLP will work closely with the CCS case manager and/or the Occupational Therapist (OT). The prescribing physician must be CCS approved. Note: CCS number is the same as MediCal number.

  A trial period is required prior to purchase recommendation. The CCS OT is required to observe the client using the speech generating device. Please consult with the client's CCS Medical Therapy Unit for more detailed instructions on the submission process. For more information about the CCS program, visit https://www.dhcs.ca.gov/services/ccs/pages/default.aspx

California Medicaid Evaluation Criteria

Medicaid evaluation must include the following:

- Medical diagnosis and significant medical history
- Visual, hearing, tactile, and receptive communication impairments or disabilities, and their impact on the recipient's expressive communication, including speech and language skills and prognosis.
- Current communication abilities, behaviors and skills, and the limitations that interfere with meaningful participation in current and projected daily activities.
- Motor status, optimal positioning, and access methods and options, if any, for integration of mobility with the speech generating device (SGD).
- Current communication needs and projected communication needs within the next 2 years.
- Communication partners and tasks including any limitations in partner's communication abilities.
- Communication environments and constraints that impact SGD selection and features.
- Any previous treatment of communication problems, responses to treatment, and any previous use of communication devices.
- Treatment plan including the following:
  - Expected amount of time the device will be needed, and the amount, duration, and scope of any related services requested to enable the recipient to effectively use the device to meet basic communication needs.
  - Short-term and long-term communication goals.
  - Criteria to measure the recipient's progress towards meeting goals.
  - Identification of the services and providers (and their experience and expertise).
- Summary of SGD Rationale including the following:
  - Vocabulary requirements
  - Representational systems
  - Display organization and features
  - Rate enhancement techniques

Return to Table of Contents

- Message characteristics, speech synthesis, printed output, display characteristics, feedback, auditory visual output, programmability, input modes and their appropriateness for use by the specific recipient
- Access techniques and strategies
- Portability and durability, and adaptability to meet anticipated needs
- Identity, significant characteristics and features
- Manufacturer's catalog pages, including cost
- Any trial period when the recipient used the recommended device(s) in an appropriate home and community-based setting that demonstrated the recipient is able and willing to use the device effectively
- An explanation of why the requested device(s) and services are the most effective and least costly alternative available to treat the recipient's communication limitations

Commercial Insurance in California

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies. We will work with any insurance to obtain coverage for you or your client.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Anthem Blue Cross Blue Shield*
- Blue Shield of California
- Tricare*

California Schools

California only requires the competitive bidding process to be utilized for public works contracts.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

All denials should be forwarded to the Tobii Dynavox Appeals team upon receiving the official denial letter. A patient consent form is required for all insurance plans.

- Anthem denials must be appealed within 180 days from denial letter date.
- All MCO plans must be appealed within 60 days from initial denial date.
- SGD Criteria

Return to Table of Contents

Colorado Funding

Quick Facts

Mounting

Are there mounting restrictions in Colorado?

- CNCT-IT Mounts Only – no combos/universals.

Software

Is additional software covered?

- No.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial? If so, how long?

- Yes, but not a formal one month or extended trial. Must trial device at least once to show independent use.

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- Must be on recommended device.

Any other pertinent details about trial requirements?

- CO Medicaid requires 3 speech generating devices (SGD) to be trialed from at least 2 different manufacturers.
- If recommending eye gaze, all 3 trials must be with eye gaze devices.
- Devices cannot be ruled out based on size, weight, or durability.
- Devices cannot be considered and ruled out. Must be trialed and ruled out.
- Software and apps do not count as trials.

State Specific Documentation Requirements

Who can sign the Rx?

- MD/DO, PA, and NP can all sign Rx.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx should be on the F2F notes; no preferred Dx's.
- F2F should reflect that client is being treated for condition that warrants SGD

Return to Table of Contents

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- Medicare does not require a trial.
- Medicare/Medicaid does not require a trial or authorization.

Colorado Medicare Advantage

There are between 2 and 40 different Medicare Advantage plans available in each county of Colorado. Plans vary in coverage, but will cover at least as much as Traditional Medicare.

- Aetna
- Anthem
- Bright Health
- Cigna
- Clear Spring Health
- Denver Health Medical Plan
- Friday Health Plan
- Humana
- Kaiser
- Mutual of Omaha
- Rocky Mountain Health Plan
- United Healthcare

Colorado Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Colorado is currently operating through the use of a few managed care plans.

Participating:

- Rocky Mountain Health Plan

In Process:

- Northeast Health Partners
- Colorado Access
- Health Colorado, Inc.
- Colorado Community Health Alliance
- Denver Health Medical Plan

Colorado Medicaid Requirements

Below are documents and requirements necessary to meet Colorado's Medicaid criteria.

- **3 Device Trials** are requested from at least two different manufacturers; however these do not need to be official 30-day trials for each device.

Return to Table of Contents

- **Prescription** must be submitted. The physician must document that the client was evaluated and/or treated for a condition that supports the speech generating device (SGD). This documentation (chart notes or office visit notes) must be provided along with the written order for the SGD. The physician completing the Certificate of Medical Necessity (CMN) must be a Colorado Medicaid provider.
- **Face-to-Face Notes** must be submitted for a face-to-face examination that occurred no more than 6 months prior to the written order for the SGD.
- **Equipment Quote** must be submitted.
- **Place of Service Requirements** will not cover a device if client is in a skilled nursing facility, nursing home, hospital, rehab facility, or is receiving hospice services.
- **No diagnosis exclusions or age exclusions.**
- **Speech Evaluation and Assessment Documentation** that supports the recommendation must be submitted and signed by the SLP, with the following areas included in the report:
    - Medical diagnosis and description of current functional needs, communication skills/limitations, and prognosis for improvement or deterioration.
        - History of communication-related therapies.
        - Affirmation that alternative, natural communication methods, such as sign language, body language, written communication, etc. have been proven ineffective.
        - Evidence of cognitive and physical ability to operate the device and that client shows a potential to utilize recommended access methods (e.g. eye gaze, direct selection, etc.) as well as the AAC software.
        - Medical Justification for the AAC device, accessories, and software.
    - Description of trials, including how each device and AAC software met, or failed to meet, the client's cognitive and physical abilities and functional and expressive communication needs.
    - A statement that the recommended device is capable of – or can be modified to – meet the anticipated improvements in, or in deterioration of, cognitive and physical ability and functional and expressive communication over the next 5 years.
    - A statements that affirms that the device will be used as an AAC device, accessory, or software and that the client or client's caretaker/representative acknowledges and agrees with the usage requirement.
    - Description of expected improvement in the following:
        - Ability to communicate medical needs.
        - Ability to express basic needs.
        - Ability to provide feedback on treatment or therapy programs.
        - Prevention of secondary impairments.
        - Independence and personal safety.

Commercial Insurance in Colorado

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*

Return to Table of Contents

- Humana*
- United Healthcare*
- Anthem Blue Cross Blue Shield of Colorado*
- Kaiser Colorado
- Rocky Mountain Health
- Tricare*

Colorado Schools

- Purchases above the aggregate $250,000 threshold must be made with RFPs or bids.
- Non-competitive procurement can be used when an item is available only from a single source.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process. Colorado Medicaid SGD criteria can be found here.

Return to Table of Contents

Connecticut Funding

Quick Facts

Mounting

Are there mounting restrictions in Connecticut?

- Universal mounts are okay if you list it as one mount.
- Anthem CT only has an allowable amount of $456. If EU only has Anthem CT with no secondary insurance, universal mount is not allowed. Mount must be under $1500 or needs approval from manager.

Software

Is additional software covered?

- If justified in report.

Hardware

Does the funded device need to be dedicated?

- Yes – standard documentation is fine. No additional documents needed.

Trials

Does Medicaid require a trial? If so, how long?

- Yes. Medicaid and all MCOs require a 2-4 week trial (preferably 4 weeks, but experienced users may complete a 2 week trial).

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- Recommended device is recommended for trial, but if trial with software has taken place then we can try moving forward with that.

State Specific Documentation Requirements

Who can sign the Rx?

- MD/DO, PA, and NP can all sign Rx.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes?

- F2F notes should support the need for the device, but Dx being listed and no mention of device has been successful in the past.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No Medicaid authorization is needed, but would recommend a trial for at least 2 weeks.

Return to Table of Contents

Connecticut Medicare Advantage

Connecticut has good Medicare Advantage coverage. Each county ranges between 21-26 plans available. Each plan has its own rules, but will cover at least as much as Traditional Medicare.

- United Healthcare
- Aetna
- WellCare
- ConnectiCare
- Anthem
- CarePartners of CT

Connecticut Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Connecticut is not currently utilizing managed care plans.

Connecticut Medicaid Requirements

Below are documents and requirements necessary to meet Connecticut's Medicaid criteria.

- **Prescription and Certificate of Medical Necessity (CMN)** must be submitted. The physician must document that the client was evaluated and/or treated for a condition that supports the speech generating device (SGD). This documentation (chart notes or office visit notes) must be provided along with the written order for the SGD. The prescription must also have ICD-10 codes and physician's address listed.
- **The Equipment** must be consistent with generally accepted standards of medical practice.
    - Must be clinically appropriate in terms of type, frequency, timing, site, extent, and duration and considered effective for the individual's injury, illness, or disease.
    - Must not be primarily for the convenience of the individual or health care providers.
    - Must not be more costly than an alternative service or sequence of services at least as likely to product equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury, or disease.

  The device request must meet the definition of DME:
    - 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 an illness or injury.
    - Is non disposable.
    - The DME provider must submit a detailed product description and quotation including manufacturer, model-part number, product description, HCPC code, unit(s), quantity, Medicaid allowable price, actual acquisition cost, and manufacturer's suggested retail price.
- **Face-to-Face Notes** must be submitted for a face-to-face examination that occurred no more than 6 months prior to the written order for the SGD. Notes must include the durable medical equipment (DME) that is being recommended.

Return to Table of Contents

- **Speech Evaluation** must be submitted.
- **Clinical Documentation** must include an explanation why the requested DME is medically necessary for the client's specific situation. Needs to include:
    - The severity of the individual's condition.
    - The immediate and long-term need for the equipment.
    - The therapeutic benefits that the client is expected to realize from its use.
    - Proof of how the DME will restore or improve the client's bodily function.
- **Trial** is not officially required, but Medicaid likes to see at least 2-4 weeks of trial period.
- **Place of Service Requirements** specify that DME is only covered when the client is at home or in a group home only.
- No Medicaid authorization is required when the client has Medicare primary.
- CT Medicaid approvals take anywhere from 7-14 days.

Commercial Insurance in Connecticut

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Anthem Blue Cross Blue Shield of Connecticut*
- Tricare*

Connecticut Schools

- Purchases that exceed $50,000 must be based, when possible, on competitive bids or proposals obtained via a sealed bid process.
- Sole source purchasing is permissible if there is only one potential offer for an item and the compatibility of equipment, accessories, or replacement parts is the paramount consideration.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Delaware Funding

Quick Facts

Mounting

Are there mounting restrictions in Delaware?

- No.

Software

Is additional software covered?

- Unclear – not outlined in Delaware Medicaid Guidelines.

Hardware

Does the funded device need to be dedicated?

- No.

Trials

Does Medicaid require a trial? If so, how long?

- Trial requirement will be assessed based on the results of the evaluation, typically following Medicare guidelines. The results of the trial use period often helps determine the most appropriate AAC intervention, and thus are preferred.
- If the results of the assessment are clinically inconclusive, Medicaid may require a trial use period.

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- This is unclear and not tested. We recommend using the actual device.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- DME CMN is required, as well as PAR form.

Who can sign the Rx?

- MD/DO. NP can sign F2F notes.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Notes must be related to the primary reason the beneficiary requires DME.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

Return to Table of Contents

- No Medicaid authorization is needed. A trial is required for Medicare guidelines.

Delaware Medicare Advantage

Each county in Delaware has 17-19 plans available. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Humana
- Aetna
- Cigna
- United Healthcare

Delaware Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Delaware is currently utilizing managed care plans. Tobii Dynavox is contracted with the following:

- Highmark Health Options
- Amerihealth Caritas
- Keystone First
- United Healthcare Community Plan

Delaware Medicaid Requirements

Below are documents and requirements necessary to meet Delaware's Medicaid criteria.

- **Face-to-Face (F2F) Encounter Documentation** is required. May be conducted by one of the following practitioners:
    - The ordering or certifying physician;
    - An authorized non-physician practitioner such as nurse practitioners, clinical nurse specialists working in collaboration with the physician, a certified nurse-midwife, as authorized by state law or a physical assistant under the supervision of a physician;
    - An attending or post-acute physician for members admitted to home health services immediately after an acute or post-acute stay.

  The authorized non-physician practitioner performing the F2F encounter must communicate the clinical findings of the encounter to the ordering physician. Those findings must be incorporated into a written or electronic document in the beneficiary's medical record.

  To assure a clinical correlation between the F2F encounter and the associated ordering of DME supplies, the physician responsible for ordering the DME or supplies must document the F2F encounter related to the primary reason the patient requires the DME or supplies and must list the practitioner and date of the encounter. The F2F encounter may occur through telehealth, as implemented by DMAP.

Return to Table of Contents

- **Prescription and** Certificate of Medical Necessity (CMN) must be submitted. CMN must be completed by the physician and include the physician's 10-digit Medicaid provider number. For repairs, list the specific device to be repaired.
- **Equipment Quote** must be submitted.
- **Speech Evaluation** must be submitted.
- **Trial Use Period** is not required, but may be recommended by the speech language pathologist who conducts the AAC evaluation. The results of the trial use periods are often instructive in determining the most appropriate AAC intervention, and thus are preferred. If the results of the assessment are clinically inconclusive, Medicaid may require a trial use period.
- **Place of Service Requirements** specify that DME will not be covered if client is receiving hospice services.

Commercial Insurance in Delaware

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Coventry Healthcare*
- Independence Blue Cross Blue Shield*
- Tricare*

Delaware Schools

- Purchases that exceed $25,000 require a formal bidding process.
- A contract may be awarded without competition if the agency head determines in writing there is only one source for the required contract. Sole source procurement shall not be used unless there is sufficient evidence there is only one source for the required contract, and no other type of goods or services will satisfy the requirements of the agency.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

District of Columbia Funding

Quick Facts

Mounting

Are there mounting restrictions in the District of Columbia?

- $2000 max on mounts.

Software

Is additional software covered?

- No

Hardware

Does the funded device need to be dedicated?

- Yes

Trials

Does Medicaid require a trial? Does it need to take place with the recommended device, or is it OK to just trial the software?

- No specifications for trial are given, but typically one session is recommended with the requested device. Software-only trial has not been tested.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- 719A form is needed. D.C. Medicaid is very particular about this form and has denied if a box was not properly checked off.

Who can sign the Rx?

- MD/DO/NP - Must be enrolled with D.C. Medicaid

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Primary medical diagnosis preferred. Should support the need for an SGD.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required?

- No secondary authorization needed when Medicare is primary.

Return to Table of Contents

District of Columbia Medicare Advantage

There are 7 Medicare Advantage plans available in the District of Columbia. Coverage varies by plan, but all plans will cover at least as much as Traditional Medicare.

- Aetna
- Cigna
- Kaiser

District of Columbia Medicaid Information

Medicaid Managed Care Organizations (MCOs)

D.C. is currently operating through the use of managed care plans.

Participating:

- Health Services for Children with Special Needs

In Process:

- Amerigroup of District of Columbia
- Amerihealth of Caritas of District of Columbia
- MedStar Family Choice

District of Columbia Medicaid Requirements

Below are documents and requirements necessary to meet D.C.'s Medicaid criteria.

- **Letter of Medical Necessity, Plan of Treatment, and Face to Face Notes** must be submitted. Medicaid requires that the client have a face-to-face examination with their physician no more than 6 months prior to the written order for the speech generating device.
- **Equipment Quote** must be submitted.
- **Speech Evaluation** must be submitted. Include trial information, if applicable. The prescribing physician needs to sign the AAC evaluation.
- 719 A Prior Authorization Request Form needs to be completed and signed by the prescribing physician for D.C. Medicaid-only clients. This does not apply to clients who are eligible for MCOs.
- **Place of Service Requirements** specify that SGD will not be covered if client is living in a skilled nursing facility, nursing home, or receiving hospice services.
- **No Diagnosis or Age exclusions.**

Commercial Insurance in the District of Columbia

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*

Return to Table of Contents

- United Healthcare*
- 1199 SEIU Benefit & Pensions Funds*
- CareFirst Blue Cross Blue Shield*
- Johns Hopkins HealthCare
- Kaiser DC
- Tricare*

District of Columbia Schools

- Purchases over $100,000 are authorized via contracts and funded with POs.
- A sole source purchase is one where there is only one vendor capable of providing an item or service, and therefore it is not possible to obtain competitive bids.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Medicaid Criteria: prior authorization requests are reviewed by Qualis and they follow Interqual criteria.

Return to Table of Contents

Florida Funding

Quick Facts

Mounting

Are there mounting restrictions in Florida?

- $1200 mount limit with straight Florida Medicaid.

Software

Is additional software covered?

- Yes.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial?

- No.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- PT/OT Co-Signature on Evaluation for straight FL Medicaid only. Not required for MCOs.

Who can sign the Rx?

- MD/DO only. NP can sign if they have “autonomous practice license” (can be verified on FL license portal).

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx should be on F2F, but no preferred Dx’s.
- Sick visits are okay.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- Florida Medicaid secondary does not need authorization; if primary denies then submit to Florida Medicaid.
- No trial required.

Return to Table of Contents

Florida Medicare Advantage

Florida has good Medicare Advantage plan coverage. All counties have at least 6 plans available, some have over 40. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

Florida Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Florida currently utilizes several managed care plans across the state.

Participating:

- Coastal Care Services
- United Healthcare Florida MCO
- WellCare of Florida
- Sunshine State Health Plan
- Humana Florida
- Ambetter
- Children's Medical Services
- Molina Healthcare Florida (Falls under contract with Coastal Care Services)

In Process

- Simply Healthcare Florida

Florida Medicaid Requirements

Below are documents and requirements necessary to meet Florida's Medicaid criteria.

- **Individualized Action Plan or Plan of Care**, including documentation of medical necessity, must be submitted with the following information:
    - Explanation of any AAC device currently being used or owned by the recipient at home, work, or school and current use of the system, including limitations.
    - Appropriate long- and short-term therapy objectives.
    - Recommended AAC device (based on cost-effectiveness and recipient's needs).
    - Recommended length of trial period, if applicable.
    - Description of any AAC devices that the recipient has previously tried.
    - Specific benefits of the recommended AAC device over others.
    - Established plan for mounting, if necessary, repairing, and maintaining device.
    - Who is responsible to deliver and program the AAC device to operate at the level recommended by the interdisciplinary team.
    - Who will train the support staff, recipient, and primary caregiver in proper use and programming of AAC device.
- **Equipment Quote** must be submitted.
- **Face-to-Face (F2F) Notes** must be submitted. These are not required for any Sunshine Health insurance that we submit to them for. We do want to request them in case insurance requests additional information but not necessary for claims or submissions.

Return to Table of Contents

- **Prescription** from physician must be submitted. Include the physician's NPI . List the specific device and accessories that are being prescribed. Electronic signatures are accepted if it is legible and there is a time and date stamp with the signature.
- **Speech Evaluation** must be written within one year of purchase request. A 4-week trial of the device being requested must be documented with dates in the Speech Language AAC Evaluation prior to submitting for purchase (This is only for UHC PI insurances require trials, we do 90-day trials with UHC).

  The AAC evaluation must be completed by a licensed Speech Language Pathologist (SLP) with their CCC credentials. MCOs are good with only SAs, good to use for submitting but try to get CCC/ASHA added if possible before we release and ship the order and claims. The AAC evaluation must be dated within one year. If older than one year, provide an addendum stating current abilities and the reason for the delay.

  The SLP must document the following information in writing (the first 3 items are obtained from the recipient's medical record):
  - Significant medical diagnosis(es)
  - Significant treatment information and current medications
  - Medical prognosis
  - Motor skills (i.e. posture and positioning, wheelchair use)
  - Selection abilities, range and accuracy of movement, etc.
  - Cognitive skills (i.e. alertness, attention span, vigilance, etc.)
  - Sensory and perceptual abilities (i.e. hearing, vision, etc.)
  - Language comprehension and expressive language capabilities
  - Oral motor speech status
  - Use of communication and present communication abilities
  - Communication needs including the need to enhance conversation, writing, and signaling emergency, basic care, and related needs
  - Writing impairments, if any
  - Environment (i.e. home, work, etc. with a description of communication barriers)
  - AAC device recommendation, which may include symbol selection, encoding method, selection set (physical characteristics of display), type of display needed, selection technique, message output, literacy assessment, vocabulary selection, and participation patterns
  - Evaluator's printed name, title, copy of current professional license or Department of Education certification, phone number, and legible dated signature
- **Trial Use Period** is not required for MCOs, but a 90-day trial is required for UHC private insurances.
- **Place of Service Requirements** will not cover if client lives in a skilled nursing facility if the client is over 21 years old. If younger, FL Medicaid is the only insurance that will cover if client lives in a skilled nursing facility, but the client must be younger than 21 years old.

Commercial Insurance in Florida

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

Return to Table of Contents

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Florida Blue (CareCentrix handles all FL Blue and BCBS plans)
- Tricare*

Florida Schools

The competitive solicitation processes must be used for procurement of commodities or contractual services in excess of $35,000. Commodities or contractual services available only from a single source may be accepted from the competitive solicitation requirements.

Appeals

Medicaid denial reconsiderations must be submitted within 14 days from denial letter date. If the deadline is missed, a new request must be submitted.

- All MCO plans must be appealed within 60 days from initial denial date.
- All PI plans must be appealed within 180 days from initial denial date.
- All plans require patient consent form.

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Georgia Funding

Quick Facts

Mounting

Are there mounting restrictions in Georgia?

- Yes – Anthem BCBS GA don't allow Universal Mounts due to low reimbursement rates.

Software

Is additional software covered?

- Yes.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial?

- No.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- Certificate of Medical Necessity (CMN), IEP for school age children (MCOs do not require CMN or IEP, just Rx and clinical notes). Letter of Medical Necessity for Anthem BCBS GA.

Who can sign the Rx?

- MD/DO only. Physician must be GA Medicaid certified.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx should be stated on F2F but no preferred Dx. Medicare requires documentation of Dx.
- F2F should be within 6 months of date services provided.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- Medicare/Medicaid does not require a trial. Authorization is only required when eye gaze is being recommended.

Return to Table of Contents

Georgia Medicare Advantage

Each county of Georgia has between 5 and 41 Medicare Advantage plans available. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- All Well
- Anthem BCBS
- Cigna
- Clear Spring Health
- Clover Health
- Humana
- Kaiser
- United Healthcare
- WellCare

Georgia Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Georgia has a few managed care programs. Tobii Dynavox is in-network with the following:

- UHC Community Plan of Georgia
- Amerigroup
- CareSource
- PeachState

Georgia Medicaid Requirements

Below are documents and requirements necessary to meet Georgia's Medicaid criteria.

- **Prescription and/or** Certificate of Medical Necessity (CMN) dated fewer than 90 days prior to the date of service on the request must be submitted. CMN must include date of client's last office visit (which must be within the last 6 months), the diagnosis description and ICD-10 codes. Required form must include the physician's Medicaid provider and NPI numbers. Must be physically or electronically signed and dated by physician (signature stamps are not accepted).
- **Individualized Education Plan (IEP)** is required for clients under the age of 21.
- Speech Language AAC Evaluation must be submitted. The Speech Language Pathologist (SLP) must include their GA license number and ASHA number on the evaluation.
- **DME/Supplies Face-to-Face (F2F) Encounter Certification** needs to be completed and included in the funding request. The form can be completed either by the prescribing physician or the client's SLP.
- **F2F Notes** from the last 6 months must be submitted.
- **Results of any previous trial periods** of the requested equipment must be included.

Return to Table of Contents

- **A Durable Medical Equipment (DME) Evaluation** prepared by a Georgia licensed professional (occupational therapist, physical therapist, speech language pathologist) giving a comprehensive clinical assessment including the history, current and projected capabilities and limitations as it pertains to the equipment being requested must be submitted.

  Include member's medical diagnosis or condition requiring the use of the equipment, the member's specific physical limitations, and a complete description of the medical equipment and/or supplies requested including the model number and manufacturer's name and address, and the length of need for the items requested. If the length of need for equipment exceeds 10 months, then providers may request the purchase of equipment where policy permits.
- **Place of Service Requirements** specify that SGD will not be covered if client is in a skilled nursing facility, nursing facility, or in-patient hospital.

Commercial Insurance in Georgia

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Anthem BCBS of Georgia*
- Coventry*
- Kaiser Permanente*
- Tricare*

Georgia Schools

- Purchases exceeding $25,000 requires a formal solicitation (RFP or RFQ).
- Sole source purchasing is available if only one vendor can provide the required goods or services.
- Single source purchasing is available when the goods are obtained for compatibility, standardization, or an academic or professional learning priority based on proprietary technology, copyright, or a supplier's unique capability.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Medicaid criteria for AAC devices, policy 1101, can be found here under the Durable Medical Equipment tab.

Return to Table of Contents

Hawaii Funding

Quick Facts

Mounting

Are there mounting restrictions in Hawaii?

- Hawaii Medicaid down not allow combos or universals for CNCT-IT mounts. MCOs may differ.

Software

Is additional software covered?

- No.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial?

- No.

State Specific Documentation Requirements

Who can sign the Rx?

- MD/DO, PA, and NP can all sign Rx. only.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx should be stated on F2F but no preferred Dx.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial is required.

Return to Table of Contents

Hawaii Medicare Advantage

There are 3 to 14 Medicare Advantage plans on each island of Hawaii. Coverage varies by plan, but all plans cover at least as much as Traditional Medicare.

- HMSA
- Humana
- Kaiser
- United Healthcare
- WellCare

Hawaii Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Hawaii is currently operating through the use of managed care plans.

Participating:

- Ohana Health Plan
- United Healthcare of Hawaii
- HMSA
- Aloha Care

Hawaii Medicaid Requirements

Below are documents and requirements necessary to meet Hawaii's Medicaid criteria.

- **Prescription** from a Hawaii licensed physician must be submitted.
- **Face-to-Face (F2F) Notes** from the last 6 months must be submitted.
- **Speech Evaluation and Equipment Quote** must be submitted.
- **Place of Service Requirements** specify that SGD will not be covered if client is living in a skilled nursing facility, nursing home, in-patient hospital, or receiving hospice services.
- **No diagnosis or age exclusions.**

Commercial Insurance in Hawaii

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Kaiser

Return to Table of Contents

Hawaii Schools

- Expenditures of $25,000 or more normally require formal competition and public advertisement of the purchase. The law prohibits parceling of expenditures to avoid this legal requirement.
- Sole source purchasing is available when there is only one source for the good, service, or construction.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Medicaid criteria can be found here.

Return to Table of Contents

Idaho Funding

Quick Facts

Mounting

Are there mounting restrictions in Idaho?

- No combination/universal mounts.

Software

Is additional software covered?

- No.

Hardware

Does the funded device need to be dedicated?

- Yes, should include dedicated device letter.

Trials

Does Medicaid require a trial? If so, how long?

- Yes, a 1-week minimum trial per device is required, but it does not have to be a formal trial.

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- Trials can be completed on an iPad with communication software.
- Need to rule out a minimum of 3 speech generating devices (SGD) with at least 2 different vendors.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- Idaho Medicaid Durable Medical Equipment (DME) Request Form. Must be signed by both the SLP and the physician.

Who can sign the Rx?

- MD/DO, PA, and NP can all sign Rx.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx should be stated on F2F but no preferred Dx.
- F2F needs to mention need for device.
- F2F should be within 6 months of date Rx is signed and date of when services are provided.

Return to Table of Contents

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial is required.

Idaho Medicare Advantage

There are between 2 and 51 Medicare Advantage plans available in 39 of Idaho's 44 counties. Coverage varies by plan, but all plans cover at least as much as Traditional Medicare.

- Aetna
- Blue Cross Blue Shield
- Humana
- United Healthcare

Idaho Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Idaho is currently operating through the use of managed care plans.

Participating:

- Regence Blue Cross Blue Shield
- Select Health Idaho
- Altius Health Plans
- Blue Cross Blue Shield of Idaho

In Process:

- Molina Idaho

Idaho Medicaid Requirements

Below are documents and requirements necessary to meet Idaho's Medicaid criteria.

- **Speech Evaluation** must be conducted by the Speech Language Pathologist (SLP) prior to the delivery of the SGD. The formal, written evaluation must include, at minimum, the following elements:
    - Current communication impairment, including the type, severity, language skills, cognitive ability, and anticipated course of the impairment.
    - As assessment of whether the participant's daily communication needs could be met using other natural modes of communication.
    - A description of the functional communication goals expected to be achieved and treatment options.
    - Rationale for selection of a specific device and any accessories.
    - Demonstration that the participant possesses a treatment plan that includes a training schedule for the selected device.

Return to Table of Contents

  - The cognitive and physical abilities to effectively use the selected device and any accessories to communicate.
  - For a subsequent upgrade to a previously issued SGD, information regarding the functional benefit to the participant of the upgrade compared to the initially provided SGD.
  - The participant's medical condition is one resulting in a severe expressive speech impairment that will benefit from the device ordered.
  - The participant's speaking needs cannot be met using natural communication methods.
  - Other forms of treatment have been considered and ruled out.
  - A formal training plan that has been constructed for the individual participant once requested service is ready to be utilized.

  A copy of the SLP's written evaluation and recommendation need to be forwarded to the participant's treating physician prior to ordering the device. The SLP performing the evaluation may not be an employee of or have a financial relationship with the supplier of the SGD.
- **Trial Data** must be submitted on supplemental form. A minimum of 3 speech generating devices (SGDs) from at least 2 different vendors must be trialed. Trial length of 1 week to 1 month for each device that may meet the participant's communication needs. The length of time the participant used the device each week must be reported. Documentation that the parents and participant have tried the device in the participant's home must be shown.
- **Durable Medical Equipment (DME) Prior Authorization Form** and Speech Generating Device (SGD) Supplemental Form must be completed and submitted.
- **Prescription** must be signed and dated by a physician, nurse practitioner, or physician assistant. Must include order date.
- **Equipment Quote** must be submitted.
- **Place of Service Requirements** specify that SGD will not be covered if client is living in a skilled nursing facility or if client is on hospice services.

Commercial Insurance in Idaho

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Idaho Blue Cross Blue Shield

Idaho Schools

- Purchases above the Small Purchase Threshold ($50,000) are subject to a 2-tiered purchasing process:

Return to Table of Contents

    - Semi-Formal Bidding ($50,000 - $99,999) – Issue written requests for bids describing goods or services desired to at least 3 vendors.
    - Formal Bidding ($100,000+) – Publish publicly available formal bid which is awarded by choosing the lowest priced bid who conforms to all material terms and conditions.
- Sole Source Purchasing – the governing board may declare that there is only one vendor for the following situations:
    - Where the compatibility of equipment, components, accessories, computer software, replacement parts, or service is the paramount consideration;
    - Where the competitive solicitation is impractical, disadvantageous, or unreasonable under the circumstances.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

- Anthem SGD Medicaid criteria can be found here.
- Select Health requires a 3 month trial with the recommended or similar device in a home setting; a plan for a doctor visit within 6 months from receiving the device is also required.
- Both plans must be appealed within 180 days from initial denial date.
- Patient consent form is needed for both plans.

Return to Table of Contents

Illinois Funding

Quick Facts

Mounting

Are there mounting restrictions in Illinois?

- Blue Cross Blue Shield Illinois has an $800 limit.
    - No SP Mounts.
    - Connect-It only unless with approval.
- Meridian MCO requires strong justification for any universal mounting system. Justification should provide reasons why a single mounting system would not be appropriate.

Software

Is additional software covered?

- No.

Hardware

Does the funded device need to be dedicated?

- Yes, but no documentation is needed to show the device is dedicated.

Trials

Does Medicaid require a trial? If so, how long?

- Yes, Medicaid requires a 30-day trial.

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- Trial must be completed on recommended device.
- Prefer trial data to be included on a separate Trial Summary form.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- Certificate of Medical Necessity (CMN) from physician is required for Medicaid and MCOs. Trial summary form is generally needed for Medicaid and MCOs unless previous device user.

Who can sign the Rx?

- MD/DO, PA, and NP can all sign Rx.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx should be stated on F2F but no preferred Dx.

Return to Table of Contents

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial is required.

Illinois Medicare Advantage

There are between 3 and 46 plans available in each county of Illinois. Plan coverages vary, but each plan will cover at least as much as Traditional Medicare.

- Aetna
- Ascension Complete
- Blue Cross Blue Shield of Illinois
- Bright Health
- Cigna
- Clear Spring Health
- Community Care Alliance
- Essence Healthcare
- Health Alliance
- Health Partners
- Humana
- iCare
- Senior Preferred
- Sunrise Advantage
- United Healthcare
- WellCare
- Zing Health

Illinois Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Illinois is currently operating through the use of a few managed care plans.

Illinois Medicaid Requirements

The determination of medical necessity for a speech generating device (SGD) is based on the participant's ability to communicate with multiple individuals in multiple settings while conveying varying message types in a manner sufficient to determine the participant's care and treatment needs. Below are documents and requirements necessary to meet Illinois' Medicaid criteria.

- **Prescription and Certificate of Medical Necessity (CMN)** from the participant's practitioner must be submitted.

Return to Table of Contents

- **Speech Evaluation** must be submitted. Medicaid requires clear indication that the client was evaluated for AAC candidacy prior to the initiation of the 30-day trial. This can be reflected in the evaluation date at the top of the report, or indicated in the body of the report.
- **Trial Assessment Form** or documentation of a trial in the evaluation must be submitted. We highly recommend using Tobii Dynavox's trial assessment form.
    - Molina MCO requires six 30-minute trial sessions completed with the recommended device and this length/frequency of trial should be documented in the report.
- **Equipment Quote** must be submitted.
- A prior approval request for a SGD must include the **HFS 1409 Prior Approval Request Form** and, at a minimum, the following four elements:
    - A **prescription** and **Certificate of Medical Necessity (CMN)** from the participant's practitioner;
    - A formal, **written evaluation completed by a Speech Language Pathologist (SLP)** that is completed within 3 months preceding the date of submission of the prior approval request;
    - A descriptive, narrative **report of successful trial use** of the requested SGD and any necessary components needed for utilization;
    - And individual **treatment and implementation plan**.
- **Face-to-Face (F2F) Encounter,** which is related to the primary reason the patient requires medical equipment, supplies or appliances, must occur no more than 6 months prior to the start of services. A F2F encounter may also occur through telehealth, as defined in 89 1Il Admin. Code Section 140.403. An order for Durable Medical Equipment (DME) and supplies is valid for one year. A new F2F encounter will be required if a new order is written for DME and supplies. The F2F encounter must be performed by one of the following:
    - The certifying physician;
    - A nurse practitioner or clinical nurse specialist who is working in collaboration with the physician in accordance with state law;
    - A physician assistant under the supervision of the physician;
    - For patients admitted to home health immediately after an acute or post-acute stay, the physician who cared for the patient in an acute or post-acute facility.

  The documentation must indicate the practitioner who conducted the encounter and the date of the encounter. If the certifying physician does not perform the F2F encounter personally, the practitioner who did perform the encounter must communicate the clinical findings of the F2F patient encounter to the certifying physician. The clinical findings must be incorporated into a written or electronic document in the patient's medical record.
- **Place of Service Requirements** specify that SGD will not be covered if client is living in a skilled nursing facility, nursing home, hospital, intermediate care facility, or receiving hospice services.
- **No diagnosis or age exclusions.**

Commercial Insurance in Illinois

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*

Return to Table of Contents

- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Aetna Better Health*
- Blue Cross Blue Shield of Illinois
- Health Alliance Medical Plans
- Molina Healthcare*

Illinois Schools

- All purchases in excess of $25,000 must be competitively bid and awarded to the lowest responsible bidder. (The $25,000 level refers to aggregate purchases on an annual basis).
- Illinois allows contracts to be awarded without using a competitive method of source selection when there is only one economically feasible source for an item. Sole source contracts require heightened scrutiny and may include a public hearing before they are awarded.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process. Illinois Medicaid criteria can be found here.

Return to Table of Contents

Indiana Funding

Quick Facts

Mounting

Are there mounting restrictions in Indiana?

- Anthem Blue Cross Blue Shield Indiana does not approve universal mounts.

Software

Is additional software covered?

- No.

Hardware

Does the funded device need to be dedicated?

- Yes. Standard documentation is fine, no additional documentation needed.

Trials

Does Medicaid require a trial?

- No.

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- Best if with recommended device. iPads with communication apps need to be ruled out for Medicaid.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- Medicaid requires prior authorization.
- No trial required.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- Indiana AAC Selection Form. SLP fills out client demographics and Section B. Physician fills out Section A and signs both pages. Must be the same physician that signs Rx.

Who can sign the Rx?

- MD/DO only.

Return to Table of Contents

Indiana Medicare Advantage

Each county of Indiana has between 9 and 28 Medicare Advantage Plans. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- AllWell
- Anthem
- Health Alliance
- Humana
- Indiana University
- United Healthcare
- WellCare

Indiana Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Indiana is currently operating through the use of managed care plans.

Indiana Medicaid Requirements

Below are documents and requirements necessary to meet Indiana's Medicaid criteria.

- Augmentative Communication System Selection Form must be completed and signed by Speech Language Pathologist (SLP) and physician.
- Prior Authorization Request Form must be signed and dated by the physician for all clients with Indiana Medicaid as well as any MCO.
- **Prescription** from client's physician (cannot be a NP or PA) must be submitted. Signing physician must be an Indiana Medicaid provider. Must include Indiana Medicaid provider ID number and must list out client's medical and speech diagnosis.
- **Speech Evaluation** must be submitted. Indiana Health Coverage Programs (IHCP) only grant authorization for a speech generating device (SGD) when the documentation shows the all of the following:
    - The member has demonstrated sufficient mental and physical abilities to benefit from the use of the device.
    - In the absence of the device, the member cannot effectively make him or herself understood by others.
    - The provider reasonably expects that the member's medical condition will necessitate use of the device for at least 2 years.
    - The device will be used to compensate for the loss or impairment of communication function.
    - The recommendation is for the least expensive communication device.

- **Trial is not required** but Medicaid may defer a request for a trial if they feel it is warranted. This is on a client-to-client basis. E2506 and iPad with communication apps must be ruled out.

Return to Table of Contents

- **Equipment Quote** must be submitted.
- **Face-to-Face (F2F) Notes** must be submitted.
- **If the client resides in a skilled nursing facility** (SNF), SLP must specifically state in the report that client needs to go outside SNF for treatment and will need device.
- **No diagnosis or age exclusions.**

Commercial Insurance in Indiana

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Anthem Blue Cross Blue Shield Indiana

Indiana Schools

Purchases above $150,000 require a bid or RFP. Sole source purchasing is available when there is only one good or service that can reasonably meet the need and there is only one vendor who can provide the good or service.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process. Indiana Medicaid criteria can be found here.

Return to Table of Contents

Iowa Funding

Quick Facts

Mounting

Are there mounting restrictions in Iowa?

- Wellmark Blue Cross Blue Shield and Amerigroup have a lower allowable on mounts and are restricted to one ConnectIt mount.

Software

Is additional software covered?

- Based on necessity. Justify in report.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial?

- Iowa Medicaid and all MCOs require a 30-day trial.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- Iowa Medicaid AAC Selection Form is required for Medicaid, but MCOs do not require this form.

Who can sign the Rx?

- MD/DO, PA, and NP can all sign Rx.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Medical Dx should be on F2F notes, but no preferred Dx's.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial is required.

Return to Table of Contents

Iowa Medicare Advantage

There are between 3 and 20 plans available in each county of Iowa. Coverage varies, but all plans will cover at least what Traditional Medicare covers.

- Aetna
- HealthPartners
- Humana
- Medica
- Medical Associates
- Senior Preferred
- United Healthcare

Iowa Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Iowa is currently operating through the use of managed care plans.

Iowa Medicaid Requirements

Below are documents and requirements necessary to meet Iowa's Medicaid criteria.

- Augmentative Communication System Selection Form is required for clients who have coverage with Traditional Medicaid, but MCOs do not require it.
- **Speech Evaluation** conducted by a Speech Language Pathologist (SLP) must be submitted. Information pertaining to the trial period with the requested device needs to be provided. Please include length of trial and client's success with the requested device. Evaluation should also contain current functional abilities in the following areas:
    - Communication skills
    - Motor status
    - Sensory status
    - Cognitive status
    - Social and emotional status
    - Language status
    - Educational ability and needs
    - Vocational potential
    - Anticipated duration of need
    - Prognosis regarding oral communication skills
    - Prognosis with a particular device
    - Recommendations
- **Prescription** must be submitted.
- **30-day Trial** with requested device is required. Must show that the client had daily access to the device and has used it across all environments.
- **Equipment Quote** must be submitted.
- **No diagnosis, age, or place of service exclusions.**

Return to Table of Contents

Commercial Insurance in Iowa

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Sanford Health Plan
- Wellmark Blue Cross Blue Shield

Iowa Schools

- The Formal Procurement Method must be used when the dollar amount of the procurement event has an estimated value equal to or greater than the federal small purchase threshold (Simplified Acquisition Threshold), which is currently at $250,000.
- Sole source procurement is available when “necessary and justifiable.”

Appeals

We recommend following each payer’s criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process. Iowa Medicaid criteria can be found here.

Return to Table of Contents

Kansas Funding

Quick Facts

Mounting

Are there mounting restrictions in Kansas?

- No.

Software

Is additional software covered?

- Yes.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial?

- No.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- Authorization is required but no trial requirement.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- Letter of Medical Necessity (LMN).

Who can sign the Rx?

- MD/DO only

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Medical Dx should be on F2F notes, but no preferred Dx's.
- F2F visit between physician and client is different from F2F between SLP and client. Need physician/client visit within 6 months of services being provided.

Return to Table of Contents

Kansas Medicare Advantage

There are between 4 and 32 plans available in each county of Kansas. Coverage varies, but all plans will cover at least what Traditional Medicare covers.

- Aetna
- Allwell
- Ascension Complete
- Blue Cross Blue Shield of Kansas
- Cigna
- Humana
- UHC

Kansas Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Kansas is currently operating through the use of a few managed care plans.

Participating:

- Aetna Better Health Kansas
- United Healthcare Kansas

In Process:

- Sunflower Health Plan

Kansas Medicaid Requirements

Below are documents and requirements necessary to meet Kansas' Medicaid criteria.

- **Speech Evaluation** conducted by a Kansas licensed Speech Language Pathologist (SLP) must be submitted. The evaluation must contain the evaluating SLP's phone number, as well as the client's name, address, date of birth, and KMAP identification number. The following criteria must be included in the evaluation:
    - Medical diagnosis relation to communication dysfunction leading to the device need.
    - Current communication status and limitations.
    - Prognosis for speech and/or written communication.
    - Cognitive readiness for use of an augmentative communication device (ACD) or speech generating device (SGD) and beneficiary's motivation to communicate via the use of an ACD/SGD.
    - Interactional/behavioral and social abilities (both verbal and nonverbal).
    - Cognitive, postural, mobility, and sensory (visual and auditory) capabilities and medical status.
    - Current limitations of communication abilities without an ACD/SGD.
    - Residential, vocational, educational, and other situational needs requiring communication.
    - Ability to meet projected communication needs.

Return to Table of Contents

  - Anticipated changes and modifications for up to two years.
  - Complete training program and plans for continued support.
  - Statement as to why prescribed ACD/SGD is the most appropriate and cost-effective way to meet beneficiary's needs.
  - Comparison of the advantages, limitations, and cost of alternative systems evaluated.
  - Description of ACD/SGD prescribed, including all accessories or modifications.

The requested device must meet the following criteria:

  - The requested device must be consistent with the diagnosis, condition, or injury and not furnished for the convenience of the beneficiary or family. It must be the most appropriate and cost-effective device available to meet the communication needs of the beneficiary.
  - Devices and accessories are not covered for vocational or academic reasons.
  - The beneficiary must be able to physically use the requested device.
  - The device must be prescribed by the beneficiary's primary care physician and a Kansas licensed SLP who meets KMAP requirements.
  - At least 3 different devices from two different manufacturers must be attempted and documentation must show why the recommended device is more appropriate than other devices.
  - The beneficiary must be evaluated by a team of professionals meeting KMAP standards prior to the request being submitted.

- **Prescription and Letter of Medical Necessity (LMN)** from Kansas licensed provider must be submitted. 10-digit Medicaid provider number is required. Example LMN can be found here.
- **Equipment Quote** must be submitted.
- **Place of Service Requirements** will not cover if a client is in a skilled nursing facility.
- **No diagnosis or age exclusions.**

Commercial Insurance in Kansas

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Blue Cross Blue Shield of Kansas

Kansas Schools

- Purchases greater than $20,000 must be made with sealed proposals to the lowest bidder except in the case of educational materials directly related to curriculum and secured by copyright.

Return to Table of Contents

- Sole Source Purchasing is available for an item for which competition is precluded due to the existence of a patent, copyright, secret process, or monopoly.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Kentucky Funding

Quick Facts

Mounting

Are there mounting restrictions in Kentucky?

- Anthem Blue Cross Blue Shield will not cover universal mounts.

Software

Is additional software covered?

- Look to Learn.

Hardware

Does the funded device need to be dedicated?

- Yes. The quote must show as “closed” and letter must be submitted with Prior Authorization.

Trials

Does Medicaid require a trial?

- No.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- F2F and Rx must be within 60 days.

Who can sign the Rx?

- MD/DO, APRN, and NP can all sign Rx and CMN.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- No preferred medical Dx but primary and communication diagnosis are helpful to be on the F2F if the appointment isn’t a well check or specifically for a speech generating device.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No prior authorization is required for Medicare/Medicaid cases.
- No trial is required, the AAC Report under trials section is sufficient.

Return to Table of Contents

Kentucky Medicare Advantage

There are between 7 and 29 plans available in each county of Kentucky. Coverage varies, but all plans will cover at least what Traditional Medicare covers.

Prior Authorization required for KY MCD with Medicare Advantage Plans

- Aetna
- Anthem
- Humana
- United Healthcare
- WellCare

Kentucky Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Kentucky is currently operating through the use of managed care plans, which have different requirements than Kentucky Medicaid plans. Tobii Dynavox is contracted with the following:

- Aetna Better Health Kentucky
- Anthem Kentucky
- Humana Kentucky
- Passport Health Plan by Molina Kentucky
- United Healthcare Community Plan Kentucky
- Wellcare Kentucky: Please note, Wellcare KY MCO does not require Face-to-Face Notes before submitting Prior Authorization.

Kentucky Medicaid Requirements

Below are documents and requirements necessary to meet Kentucky's Medicaid criteria.

- **Speech Evaluation** must be submitted. The evaluation must contain the following information:
    - Name, date of birth, and date of evaluation;
    - Medical and speech diagnosis;
    - Onset of impairment;
    - Vision/hearing status and status of physical abilities;
    - Language skills and cognitive ability to use recommended device;
    - Must explain if the client has reliable gross and fine motor skills and documentation as to the need for extensive fringe vocabulary;
    - Description of daily communication needs and desirable communication goals;
    - Description of how the recommended device will grow with the client;
    - Description of why the client's needs cannot be met using other modes of communication and other treatments ruled out (e.g. sign language, writing, communication boards, etc.);
    - Rationale for selection of device and accessories (all accessories must have a specific rationale);
    - Trials/Assessments ruling out other devices;

Return to Table of Contents

    - Treatment plan and schedule;
    - Statement showing that the evaluation was sent to the physician for prescription after the evaluation was completed;
    - Conflict of interest statement from Speech Language Pathologist (SLP);
    - Replacement requests must describe benefit to upgrading to a new device as compared to initial device.
- **Prescription** must be submitted. For repairs, list the specific device to be repaired.
- **Equipment Quote** must be submitted.
- **Face to Face Notes** must be within 60 days of prescription date.
- **Place of Service Requirements** will not cover if a client is in a skilled nursing facility, hospital, rehabilitation hospital, or nursing home.
- **Will not cover for clients with Developmental Delay diagnosis.**
- **No age exclusions.**

Commercial Insurance in Kentucky

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Anthem Blue Cross Blue Shield

Kentucky Schools

- Purchases greater than $20,000 require competitive bidding.
- A procurement is exempt from competitive bidding if there is only one known capable supplier of a commodity due to the unique nature of the requirement, supplies, or market condition.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process. Kentucky Medicaid criteria can be found here.

Return to Table of Contents

Louisiana Funding

Quick Facts

Mounting

Are there mounting restrictions in Louisiana?

- No.

Software

Is additional software covered?

- All software is covered.

Hardware

Does the funded device need to be dedicated?

- Closed for all devices unless direct bill or VA.

Trials

Does Medicaid require a trial?

- No.

State Specific Documentation Requirements

Who can sign the Rx?

- MD/DO only.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- No.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No trial or authorization is required.

Return to Table of Contents

Louisiana Medicare Advantage

Each county of Louisiana has between 12 and 24 Medicare Advantage plans available. Plan rules vary by carrier, but all plans will cover at least what Traditional Medicare covers.

- Aetna
- Allwell
- Blue Cross Blue Shield of Louisiana
- Humana
- People's Health
- Vantage Health
- WellCare

Louisiana Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Louisiana is currently operating through the use of managed care plans.

- Louisiana Healthcare Connections uses InterQual Criteria. When submitting online, the criteria review must be completed for each code being submitted.

Louisiana Medicaid Criteria for AAC Device Reimbursement

Consideration will be given for Medicaid reimbursement of AAC devices for beneficiaries of all ages if the device is considered medically necessary, the beneficiary can physically and mentally use a device and its accessories, and if criteria are met as listed below:

- The beneficiary has a diagnosis of a significant expressive or receptive communication impairment or disability;
- The impairment or disability either temporarily or permanently causes communication limitations that preclude or interfere with the beneficiary's meaningful participation in current and projected daily activities;
- The beneficiary works with a Speech Language Pathologist (SLP) who:
    - Performed an assessment and submitted a report pursuant to the criteria set forth in Assessment/Evaluation;
    - Recommends speech language pathology treatment in the form of AAC devices and services;
    - Documented the mental and physical abilities of the beneficiary to use, or learn to use, a recommended AAC device and accessories for effective and efficient communication;
    - Prepared a speech language pathology treatment plan that describes the specific components of the AAC devices and the required amount, duration, and scope of the AAC services that will overcome or ameliorate communication limitations as earlier described;

Return to Table of Contents

- Requested AAC devices that constitute the least costly, equally effective form of treatment that will overcome or ameliorate communication limitations as earlier described. You can find more information about these requirements in the Louisiana Department of Health Durable Medical Equipment Provider Manual here.

Louisiana Medicaid Requirements

Below are documents and requirements necessary to meet Louisiana's Medicaid criteria.

- **Speech/AAC Evaluation** must be submitted. Must include the following information about the beneficiary:
  - Identifying information: name, Medicaid ID number, date of assessment, medical and neurological diagnosis (primary, secondary, tertiary), significant medical history, mental or cognitive status, and educational level and goals.
  - Sensory status: vision and hearing screening (no more than 1 year prior to evaluation), and a description of how vision, hearing, tactile, and/or receptive communication impairments or disabilities affect expressive communication. If vision or hearing screening is failed, a complete vision or hearing evaluation is required.
  - Postural, mobility, and motor status: gross motor assessment, fine motor assessment, optimal positioning, integration of mobility with AAC devices, and beneficiary's access methods (and options) for AAC devices.
  - Current speech, language, and expressive communication status: identification and description of the beneficiary's expressive or receptive communication impairment diagnosis, speech skills and prognosis, language skills and prognosis, communication behaviors and interaction skills (i.e. styles and patterns), functional communication assessment including ecological inventory, indication of past treatment (if any), and description of communication strategies, including use of an AAC device (if any).
- **Prescription Form** must be submitted.
- **Equipment Quote** must be submitted.
- **CCR Referral** from physician is required for clients that have Community Care eligibility.
- **Place of Service Requirements** will not cover if a client is in a skilled nursing facility, nursing home, or intermediate care facility.
- **No diagnosis or age exclusions.**

Commercial Insurance in Lousiana

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Blue Cross Blue Shield LA* (Note: Local plans have AAC devices listed as an exclusion)

Return to Table of Contents

Louisiana Schools

- Sealed bids or competitive proposals must be utilized for purchases exceeding $25,000.
- Noncompetitive proposals (sole source purchases) are appropriate only when available from a single source.

Appeals

Tobii Dynavox has not had many appeals in Louisiana for several years, but we recommend following each payer's criteria to avoid denials. Louisiana Medicaid criteria can be found here.

If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Maine Funding

Quick Facts

Mounting

Are there mounting restrictions in Maine?

- Anthem ME only has an allowable amount of $456 for E2512.
- If client only has Anthem ME with no secondary insurance, a universal mount will not be approved.
- Mounts must be under $1500 or needs approval from manager.

Software

Is additional software covered?

- If justified in report.

Hardware

Does the funded device need to be dedicated?

- Yes. Standard documentation is fine; no additional documents needed.

Trials

Does Medicaid require a trial? If so, how long does it need to be?

- Yes, a trial is required.
- For Medicaid and all MCOs, a 30-day minimum trial is required. Experienced users may be allowed to do a shorter trial, but we recommend consulting with your Tobii Dynavox Funding Consultant first.

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- We recommend trialing with the recommended device, but we can try moving forward with a software-only trial.

State Specific Documentation Requirements

What state-specific forms or documentation is required for authorization?

- InterQual form, Letter of Medical Necessity (LMN), comprehensive Plan of Care and Training Plan must be included in the evaluation.

Who can sign the Rx?

- MD/DO, PA, and NP.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- F2F should support the need for device, but specific Dx's have not been an issue.

Return to Table of Contents

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- For plans where Medicare is primary (straight Medicare and Medicare Advantage), Prior Authorization (PA) is not required for out of state providers, as long as it shows as QMB enrolled on online eligibility.
- No PA is needed for Medicare copay/deductible, however if Medicare does not cover, Medicaid may require a trial – but only if we have a PA on file.

Maine Medicare Advantage

Maine has good Medicare Advantage plan coverage. All counties have at least 18 plans available, some have over 90. Plan rules vary by carrier, but all plans will cover at least as much as Traditional Medicare.

Maine Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Maine utilizes a few managed care plans.

Participating:

- Geisinger Health Plan
- Harvard Pilgrim Health Care

In Progress:

- Health Options Maine

Maine Medicaid Requirements

Below are documents and requirements necessary to meet Maine's Medicaid criteria.

- **Augmentative Communication and Speech Evaluation** must be submitted. Evaluation should follow Medicare criteria/format and specifically include a description of the following:
    - Client's medical and speech diagnosis, severity, and prognosis.
    - Client's past treatment history and ability to use a speech generating device.
    - Client's physical ability to access the device.
    - 3-5 speech generating devices that have been considered and the reasons why they were ruled out for the client. Must include the manufacturer's name and price of these devices. (These may include low tech options, including communication books, PECs, etc.). Must rule out alternative methods of communication, i.e. writing and sign language.
    - For replacement devices, Speech Language Pathologist (SLP) must include details about the prior device and why it no longer meets the needs of the client. Justify the need for replacement.
- **Supplemental DME Prior Authorization Form (MA56)** must be submitted.

Return to Table of Contents

- **Prescription and Letter of Medical Necessity (LMN)** from the physician is required. Medicaid prefers a Rx listing the recommended equipment and a separate LMN indicating the physician's agreement of the recommendations. Must indicate date last seen by the physician that is dated within 6 months of submission to MainCare.
- InterQual Criteria Sheet for AAC device must be completed and signed by the referring physician. The SLP can complete the necessary sections for the client and forward to the physician for signature.
- **4-week Trial** is required.
- **Plan of Care and Training Plan** must include the name and qualifications of the person responsible for programming the device, the estimated length of time for the programming to be completed (i.e. when will the device be fully operational for the client), the type of training that will be provided, and the anticipated length of training.
- **Face-to-Face (F2F) Notes** from the last 6 months are required.
- **Equipment Quote** must be submitted.
- **No diagnosis, place of service, or age exclusions.**

Commercial Insurance in Maine

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Anthem Blue Cross Blue Shield

Maine Schools

- Procurement requirements are organized into 3 tiers based on price:
    - $5,000 or less: competitive process/sole source justification is not required.
    - $5,001 - $10,000: must be determined by administrator at your organization.
    - $10,001 and above: subject to Request for Proposal rules. Must either competitively bid (RFP) or be approved as sole source.
- Sole Source approval is for items that qualify under the Uniqueness Justification – the supplies or services required are unique to a specific contractor.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Maryland Funding

Quick Facts

Mounting

Are there mounting restrictions in Maryland?

- No, but low reimbursement rate.

Software

Is additional software covered?

- No.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial? If so, how long does it need to be?

- No specific trial length required, but should be able to show examples of independent use. One session with the device/software is all that is needed, with an emphasis on what the user was able to say/select.

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- Trials on iPads with communication software are acceptable.

State Specific Documentation Requirements

What state-specific forms or documentation is required for authorization?

- Medicaid Certificate of Medical Necessity (CMN).

Who can sign the Rx?

- MD/DO/NP/PA. All physicians must include the Maryland Medicaid ID on both the RX and CMN.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx should be on F2F, but no preferred Dx's.
- F2F visit must be within 6 months of Rx. Sick visits are okay.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

Return to Table of Contents

- No authorization is required from Medicare Medicaid Secondary.
- Medicare Replacement Plans should still submit to Medicaid Secondary for authorization.
- Should meet Medicare trial standards.

Maryland Medicare Advantage

Each county of Maryland has between 1 and 16 Medicare Advantage plans available. Plan rules vary by carrier, but all plans will cover at least as much as Traditional Medicare.

- Aetna
- Cigna
- Humana
- Johns Hopkins Healthcare
- Kaiser
- United Healthcare
- Carefirst

Maryland Medicaid Information

Medicaid Managed Care Organizations (MCOs)

We do not directly work with any MCOs in Maryland. All funding goes directly to Maryland Medicaid, regardless of MCO enrollment. **Maryland Medicaid Requirements**

Below are documents and requirements necessary to meet Maryland's Medicaid criteria.

- **Preauthorization Request for Durable Medical Equipment (DHMH-4527)** is required for clients who have Maryland Medicaid and must be signed by physician. The physician's notes from an office visit with the client documenting a speech generating device must be included with the document and signed by the physician. The date of the physician's notes and the "Last Seen Date" on this form must match and must be within 6 months.
- **Prescription &** Certificate of Medical Necessity (CMN) from the physician is required. Both of these documents MUST have the prescribing physician's Maryland Medicaid ID, or the claim will deny.
- **Speech Evaluation** must follow Medicare guidelines.
- **Face-to-Face (F2F) Notes** within 6 months of prescription signature date is required. The prescriber must be a physician, physician's assistant, clinical nurse specialist, or nurse practitioner licensed in the state in which the prescriber's practice is maintained who has examined the participant.
- **Equipment Quote** is required.
- **Trial** is required, but there is no set timeframe for this. They want to see that the client could use the device and examples of what they could create independently. A single session with device or software is acceptable.
- **Place of Service Requirements** will cover in a SNF, group home, nursing home. Will cover hospice for patients 16 and under.

Return to Table of Contents

- No diagnosis or age exclusions.

Commercial Insurance in Maryland

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- 1199 SEIU Benefits & Pension Funds*
- CareFirst Blue Cross Blue Shield*
- Johns Hopkins HealthCare*
- Kaiser*

Maryland Schools

- Competitive bids are required for purchases above $10,000 unless available through a statewide contract.
- Whenever the procurement officer determines that there is only one available source for the subject of a procurement contract, the procurement officer may award the procurement contract without competition to that source.

Appeals

Tobii Dynavox has not had many appeals in Maryland for several years, but we recommend following each payer's criteria to avoid denials. Maryland's Medicaid criteria can be found here.

If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Massachusetts Funding

Quick Facts

Mounting

Are there mounting restrictions in Massachusetts?

- Medicaid will allow universal mounts as long as it is listed as one mount. “Universal Mount” or “Mounting System” should be stated on Certificate of Medical Necessity. Evals should not reference the two mounts which make up the universal, as it confuses them.
- Masshealth CCM members need to have trialed both mounts in order for CCM to approve a universal mount. If both mounts have not been trialed, detailed information must be well documented, including rule out of other mounts and consultation with Solutions Consultant verifying equipment will fit in all environments.
- Blue Cross Blue Shield (BCBS) Massachusetts only has an allowable amount of $778 for E2512. If the end user only has BCBS with no secondary insurance, universal mount is not allowed. Mount must be under $1500 or needs approval from manager.

Software

Is additional software covered?

- Yes, Tobii Dynavox PODD is covered.

Hardware

Does the funded device need to be dedicated?

- Yes. Standard documentation is fine; no additional documents needed.

Trials

Does Medicaid require a trial? If so, how long does it need to be?

- Yes.
- For Medicaid and MCOs, a 30-day minimum or 4-week trial is required.
    - If only standard Massachusetts Medicaid and not an MCO, raw data sheets are required from the trial.
    - If it is an experienced user, the trial requirement time limit is more relaxed, but they still want to see raw data sheets.

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- We recommend trialing with the recommended device, but if trial with software only has already taken place we can try moving forward.

State Specific Documentation Requirements

What state-specific forms or documentation is required for authorization?

- Certificate of Medical Necessity (CMN) is the prescription.

Return to Table of Contents

Who can sign the Rx?

- MD/DO, PA, and NP are acceptable.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- No. F2F is needed for claim and will be needed before shipping.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- Standard Medicare does not require authorization or a trial.
- Managed Care requires authorization and a trial.

Massachusetts Medicare Advantage

There are 110 Medicare Advantage plans available in Massachusetts. Plan rules vary by carrier, but all plans will cover at least as much as Traditional Medicare.

- Aetna
- Blue Cross Blue Shield of MA
- Commonwealth Care Alliance
- eternalHealth
- Fallon Health
- Health New England
- Humana
- Mass Advantage
- Mass General Brigham
- Molina Healthcare (Senior Whole Health)
- Tufts Health Plan
- United Healthcare
- Wellcare

Massachusetts Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Massachusetts utilizes several managed care plans.

Participating:

- Blue Cross Blue Shield of Massachusetts
- Harvard Pilgrim Health Care
- Health New England/Northwood
- All Ways Health Plan
- Northwood

Return to Table of Contents

- Tufts Health Plan
- UHC Community Plan
- 1199 SEIU
- Health New England
- Mass General Brigham Health Plan

In Progress:

- Fallon Community Health Plan

Massachusetts Medicaid Criteria for AAC Devices

- The member has a severe expressive communication impairment related to a medical condition or developmental disability that severely limits daily functional communication.
- The member cannot meet daily functional communication needs by using unaided strategies.
- The member has the cognitive, visual, language, and physical abilities to effectively use an AAC device.
- The recommended device, system, or software is the least costly, medically appropriate alternative eligible for federal matching funds.
- The multidisciplinary team recommends the device or software. The team must include a licensed, certified Speech Language Pathologist (SLP) who meets nationally accepted knowledge and skill qualifications for AAC communication service delivery. A licensed physician, nurse practitioner, or physician's assistant must prescribe the device or software. Other professionals may be included as needed for determining motor or other needs, such a physical access to the device.
- The recommended device or software matches the cognitive and physical capabilities for the member.
- Device recommendations include the consideration of the impact of the presence of significant behaviors, if appliable, such as physical aggression and property destruction.
- The member has demonstrated the ability to learn to effectively use the recommended device and any necessary accessories functionally for communication.
- For subsequent upgrade of a previously provided AAC device or software, the determination of medical necessity will also be based on additional clinical data including, but not limited to, clinical data-driven information that demonstrates why the initially covered AAC device or software is no longer clinically effective in meeting the member's medical need and that supports the functional medical benefit of the upgrade to the member in comparison to the initially provided AAC device or software.

Massachusetts Medicaid Requirements

Below are documents and requirements necessary to meet Massachusetts' Medicaid criteria:

- MassHealth Durable Medical Equipment and Medical Supplies General Prescription and Medical Necessity Review Form must be completed within 90 days of request.
- **Treatment Plan and Schedule** must contain short- and long-term communication goals for device, and treatment options including support to meet goals.

Return to Table of Contents

- **4-Week Trial Period Report** must include the following:
  - Length of trial period.
  - Data collected during the trial.
  - Environment in which the SGD or software trial took place (e.g. home, school, community).
  - Manner in which the device or software was accessed (e.g. eye gaze, direct selection, scanning).
  - Client's ability to learn to use the device functionally for communication.
  - Sampling of messages communicated, including frequency, level of cuing, and communication partner.
  - Number of messages expressed in a time period and level of cuing required for expression of such messages.
  - Degree to which the member could move beyond the exploratory phase and use the device or software to communicate intentionally; whether such progress occurred in both structured and unstructured settings, and with what level of proficiency progress beyond the exploratory phase occurred.
  - Communicative intents expressed.
- **Recommended Device with Accessories** must include a detailed description of the recommended device, including a comparison to other devices trialed/considered. If replacement, document the cost to repair and cost to recommend new.
- **Speech Evaluation and Report** must contain the following information:
  - Impairment type and severity.
  - Cognitive level: developmental testing characterizing cognitive learning abilities and levels of function. Formal testing results preferred (name of test, development levels, date performed).
  - Sensory functioning: vision and hearing status.
  - Motor/physical abilities:
    - Gross motor abilities (ambulatory, or walks with crutches/walker, or uses wheelchair; seating and positioning/posture; head control and trunk mobility).
    - Fine motor and upper extremity abilities and function (ability to point, type, write, access a device via direct selection).
    - Ability to access via eye gaze, head mouse, single switch or multiple switch scanning, or other alternative access methods.
  - Communication abilities and levels of function:
    - Speech (articulation/intelligibility, oral-motor function, respiratory insufficiency, and other relevant information).
    - Expressive and receptive language.
    - Use of nonverbal communication strategies (signs, eye pointing, gestures, or other nonverbal communication strategies).
    - Other language skills (reading, writing, telephone, and computer).
    - Current and previous history using AAC devices, including dates utilized and, if applicable, the reason the currently used device no longer meets communication needs.
    - Projected course of speech progress and needs.
  - Behavioral and learning abilities observed, evaluated, or gathered from records of evaluations:
    - Executive functioning, including attention span;
    - Memory;

Return to Table of Contents

    - Problem-solving skills;
    - Ability to understand cause and effect;
    - Presence of significant behaviors, such as physical aggression and property destruction.
- **Place of Service Requirements** will not cover if client is in inpatient hospital or receiving hospice care.
- **Equipment Quote** is required.
- **No diagnosis or age exclusions.**

Commercial Insurance in Massachusetts

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Massachusetts Blue Cross Blue Shield
- Mass General Brigham*
- Harvard Pilgrim*

Massachusetts Schools

- For purchases over $35,000 sealed bids or proposals are required.
- State law allows for sole source procurement for purchases not to exceed $50,000 when only one practicable source for the required supply exists.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

- Medicaid defers for additional information until an approval is received and, therefore, we do not file appeals for Medicaid.
- All private insurance plans must be appealed within 180 days from initial denial date.
- Patient consent form is required for all plans.

Return to Table of Contents

Michigan Funding

Quick Facts

Mounting

Are there mounting restrictions in Michigan?

- No.

Software

Is additional software covered?

- Yes.

Hardware

Does the funded device need to be dedicated?

- Yes. Need dedicated device letter and PDAC letter.

Trials

Does Medicaid require a trial? If so, how long does it need to be?

- Yes. A 30-day minimum trial is required.
- SLP must show trial date span and the environments the trial took place in (e.g. home, school, community).

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- Needs to be with recommended device.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial is required unless the client lives in a skilled nursing facility.

State Specific Documentation Requirements

Who can sign the Rx?

- MD/DO or PA. NP is not able to sign.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Diagnosis should be on F2F, but no preferred diagnosis.

Return to Table of Contents

Michigan Medicare Advantage

Michigan has at least 26 Medicare Advantage plans available statewide, with more than 70 in some counties. Plan rules vary by carrier, but all plans will cover at least as much as Traditional Medicare.

- Michigan Medicare Advantage
- Blue Cross Blue Shield Michigan (authorization through Northwood)
- Humana
- Priority Health
- Meridian (may be dual Medicare/Medicaid plan)
- Health Alliance Plan (Tobii Dynavox is out-of-network)
- Aetna

Michigan Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Michigan utilizes several managed care plans.

Participating:

- Blue Cross Complete of Michigan (authorization through Northwood)
- Meridian Health Plan MI Medicaid
- McLaren Health Plan MI Medicaid
- Priority Health Plan MI Medicaid
- Upper Peninsula Health Plan

In Process:

- Molina Health Plan MI Medicaid
- United Healthcare Community Plan MI

Michigan Medicaid Requirements

Below are documents and requirements necessary to meet Michigan's Medicaid criteria. Please note, Michigan Medicaid can be known to defer request for additional information.

- **AAC Evaluation** must be within 6 months. Must include language/cognitive ability, physical status, and vision/hearing status. Speech diagnosis must be severe, and course of impairment must be poor. An SGD must be an integral part of the client's care. Low-tech options (PECS, sign language, and writing) must be ruled out. Must also contain a treatment plan and SLP non-conflict statement.
- **4-Week Trial** with recommended device is required. Must be trialed in the home, community, and school (if applicable). SLP must list exact dates of the trial and where the trial took place. At least 1 other brand SGD must be ruled out.
- **PT or OT Report** from within 6 months is required, regardless of the device being requested. Must show that the patient can ambulate device safely and successfully.

Return to Table of Contents

- **Prescription with Face-to-Face Visit Notes** from physician is required and must be from within 6 months. Needs to contain a description of the client's current medical status and history.
- **Individualized Education Plan (IEP)** is required for school-aged children.
- **Vision/Hearing Report** is needed if the client has any documented hearing/vision diagnoses.
- Medicaid will not cover if client is enrolled in hospice.
- If Medicare is primary, Medicaid will not review unless the client resides in the a skilled nursing facility.

Commercial Insurance in Michigan

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Health Alliance Plan (HAP)
- Blue Cross Blue Shield of Michigan* (authorization is sometimes required through Northwood)
- Priority Health* (all PPO/HMO plans have an exclusion for SGDs)

Michigan Schools

Competitive bidding is required for purchases greater than $20,959. Sole source procurement is also permissible with a sole source letter.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Minnesota Funding

Quick Facts

Mounting

Are there mounting restrictions in Minnesota?

- Blue Cross Blue Shield Minnesota: single mounts only, no combos/universal mounts.

Software

Is additional software covered?

- Yes.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial? If so, how long does it need to be?

- Yes, up to a 30-day trial.
- Blue Cross Blue Shield Minnesota MCO requires 30-day trial (Blue Plus). Date span should be included in evaluation.
- UCare MCO requires a trial, but it can be as short as one day.

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- Software is okay.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization required, but trial is required.

State Specific Documentation Requirements

Who can sign the Rx?

- MD/DO, PA, and NP are all acceptable.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx should be on F2F notes, but no preferred Dx.

Return to Table of Contents

Minnesota Medicare Advantage

Each county of Minnesota has between 9 and 35 Medicare Advantage plans available. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- Blue Cross Blue Shield
- Health Partners
- Humana
- Medica
- Network Health
- Senior Preferred
- Ucare
- United Healthcare

Minnesota Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Minnesota utilizes a few managed care programs. Tobii Dynavox is in network with the following plans:

- UCare
- Hennephin Health Plan
- Homelink/GEHA
- Medica
- Prime West Health Plan MN MCD
- South Central Health Alliance
- United Healthcare Community Plan
- Blue Cross Blue Shield Minnesota, Blue Plus
- Surest

Minnesota Medicaid Speech Generating Device (SGD) Policy

The following criteria must be met for authorization of a SGD to be funded by Minnesota Medicaid:

- A description of the recipient's current medical status and history.
- An assessment of the verbal and physical capabilities in relation to need and use of an AAC device.
- Speech diagnosis and course of impairment.
- Detailed description of the therapeutic history in the areas of physical and occupational therapy and speech language pathology including the nature, frequency, and duration of total therapeutic history provided to the recipient. Speech language treatment approaches in relation to the need and use of an AAC device must be detailed.
- Explicit evaluation of each AAC device or method of communication tried by the recipient and information on the effectiveness of each device.

Return to Table of Contents

- Detailed description of the recipient's ability to use the requested device, including speech and accuracy.
- Description of the level of communication initiation with the selected device and whether or not the equipment is used accurately and spontaneously.
- Trial period should show device use in multiple environments with various partners. Rule out low tech options such as writing, sign language, or PECs.
- Detailed treatment plan for recipient moving forward with device.

Minnesota Medicaid Requirements

Below are documents and requirements necessary to meet Minnesota's Medicaid criteria.

- **Prescription Form** must document that the client was evaluated and/or treated for a condition that supports the SGD. This documentation (chart notes or office visit notes) must be provided along with the written order for the SGD. Medicaid requires that the client have a face-to-face examination with their physician no more than 6 months prior to the written order for the SGD.
- **Equipment Quote** is required.
- **Speech Evaluation** is required.
- **Trial** with the recommended device and/or software must be documented with examples of independent use in all environments included.
- **No diagnosis, age, or place of service exclusions.**

Commercial Insurance in Minnesota

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- South Country Health Alliance*
- Sandford Medical Plan*
- Health Partners/Homelink*
- Ucare*
- Medica*
- MMSI of MN*
- Coventry*
- Blue Cross Blue Shield of MN*

Minnesota Schools

- Any services and/or materials that are expected to cost $100,000 or more must undergo a formal notice and bidding process.

Return to Table of Contents

- The state may waive bidding process requirements when it is determined there is only one legitimate or practical source for such materials or services and that grantee has established a fair and reasonable price.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

- Medicaid criteria can be found here.
- Blue Cross Blue Shield Minnesota requires that patient completes a 30-day trial and receives the least costly device meeting communication needs. BCBS MN AAC device policy can be found here.

Return to Table of Contents

Mississippi Funding

Quick Facts

Mounting

Are there mounting restrictions in Mississippi?

- No.

Software

Is additional software covered?

- All software is covered.

Hardware

Does the funded device need to be dedicated?

- Closed for devices unless direct bill or VA.

Trials

Does Medicaid require a trial?

- No.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- Certificate of Medical Necessity (CMN) form for Mississippi Medicaid.

Who can sign the Rx?

- MD/DO only.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes?

- No.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No prior authorization required.
- Trial is required.

Return to Table of Contents

Mississippi Medicare Advantage

Each county of Mississippi has between 4 and 19 Medicare Advantage plans available. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- Allwell
- Cigna
- Humana
- United Healthcare
- WellCare

Mississippi Medicaid Information

For recipients with Mississippi Medicaid or Medicaid Managed Care (MCO), all paperwork must be dated within 6 months of the date it's submitted for approval. A SGD will be covered when the following apply:

- The patient's ability to communicate using speech and/or writing is insufficient for communication purposes.
- Documentation clearly supports that the patient is mentally, emotionally, and physically capable of operating/using an Augmentative Communication Device (ACD).
- Evaluation and recommendation by a licensed Speech Language Pathologist (SLP) is completed (see evaluation requirements below).
- The prescription includes specification for ACD, component accessories, and all necessary therapies and/or training, which is also documented in the speech evaluation report (see prescription requirements below).

Medicaid Managed Care Organizations (MCOs)

Mississippi is currently operating through the use of managed care plans. Tobii Dynavox is participating with the below plans:

- Magnolia Health
- United Healthcare Community Plan

Mississippi Medicaid Requirements

Below are documents and requirements necessary to meet Mississippi's Medicaid criteria. Please note, the below requirements do not apply to clients who are eligible for United Healthcare Community Plan.

- **Plan of Care Form** is required.
- **Equipment Quote** is required.
- **Place of Service Requirements** will not cover if the client is in a skilled nursing facility, nursing facility, or inpatient hospital.
- **No diagnosis or age exclusions.**

Return to Table of Contents

- **Prescription and Certificate of Medical Necessity (CMN)** must be completed and signed by the physician. Physician must be a pediatrician, neurologist, or a physician specializing in rehabilitation and who has documented training in assessment for the prescription of a speech generating device (SGD). This form cannot be signed by a nurse practitioner or physician assistant, as indicated on the form. The form is valid for 90 days from the physician's signature. The following information must be included in the CMN:
    - The SGD and accessories must be listed, and the physician must prescribe "Speech Therapy" as well as frequency of the speech therapy.
    - Date the client was last seen by the physician (must be within the last year).
    - Physician's Medicaid provider number or state license number.
    - Client's height and weight.
    - The box for "Other" needs to be selected and "Occupational Therapy (OT)" needs to be written in the provided space.
- **Speech Language AAC Evaluation** and recommendations must be performed by a team of licensed, qualified professionals including (but not limited to) a SLP, a licensed psychologist with expertise in administering nonverbal tests for intelligence, and a physical therapist or occupational therapist. The evaluation is valid for 90 days. A written copy of the evaluation must be submitted with the request for approval. The evaluation must include the following:
    - Communication status and limitations, abilities to meet communication needs through other means such as sign language, manual communication, etc.
    - Current speech and language skills, including motivation to communicate.
    - Prognosis for speech and/or written communication.
    - Cognitive readiness, interactional/behavioral, and social abilities.
    - Capabilities and needs including intellectual (educational), postural, physical, sensory (visual and auditory), motor, and cognitive.
    - Environmental assessment (residential, vocational, and educational).
    - Current seating or positioning equipment and any modifications that would be required secondary to the ACD.
    - Integration of communication with other behavior.
    - Alternative ACD(s) considered with comparison of capabilities.
    - Other communication methods/devices tried.
    - Ability of recommended ACD to be implemented/integrated into environments.
    - Ability to meet projected communication needs (growth potential), projected length of time the patient will be able to use the proposed system.
    - Anticipated changes, modifications, or upgrades with projected time frames (short and long term).
    - Training plan including who, what, when, and where training will take place. Include names, addresses, and capabilities of available caregivers.
    - Statement of other funding resources that have been explored.

Commercial Insurance in Mississippi

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

Return to Table of Contents

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Magnolia Health*

Mississippi Schools

- Purchases over $5,000 and less than $50,000 may be made by receiving 2 competitive bids without public advertisement.
- Purchases over $50,000 must be made with published bid advertisements.
- Sole source purchasing is an option when there is only one source for the required commodity.

Appeals

We recommend following each payer's criteria to avoid denials. Mississippi Medicaid criteria for AAC devices can be found here.

If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Missouri Funding

Quick Facts

Mounting

Are there mounting restrictions in Missouri?

- No.

Software

Is additional software covered?

- Yes.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial?

- No.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- Evaluation needs 3 signatures. If only 1 signature is provided, it will be sent back for others.
- MO Health Net only accepts approved evaluators.

Who can sign the Rx?

- MD/DO only.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx should be on F2F notes, but no preferred Dx.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No prior authorization or trial required for Medicare/Medicaid cases.

Return to Table of Contents

Missouri Medicare Advantage

Missouri has between 8 and 33 plans available by county. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- Allwell
- Anthem
- Essence Healthcare
- Humana
- Medica
- United Healthcare
- WellCare

Missouri Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Missouri utilizes a few managed care programs. Tobii Dynavox is in network with the following plans:

- Healthy Blue MO
- Molina Health Care of Missouri
- Aetna Better Health of Missouri
- Missouri Care
- Home State Health Plan
- United Healthcare

Missouri Medicaid Requirements

Below are documents and requirements necessary to meet Missouri's Medicaid criteria.

- **Speech Language AAC Evaluation** must be completed by a Speech Language Pathologist (SLP) at an approved Medicaid evaluation site. A list of sites can be found on the Missouri Assistive Technology website. All of the following must be met before an ACD can be considered for approval. The communication device must be:
    - Medically necessary; consistent with the diagnosis, condition, or injury and not furnished for the convenience of the participant or family.
    - Necessary and consistent with generally accepted professional medical standards of care (i.e. not experimental or investigational).
    - Established as safe and effective for the participant's treatment protocol.
    - The most appropriate and least expensive device that meets the communication needs of the participant and Is not intended for vocational or academic reason.
    - Supported by the client/family.

    The evaluation must be completed by a licensed SLP and three members of the team must sign the last page of the document. The evaluation must contain the following information:

Return to Table of Contents

  - Participant's name, address, date of birth and MO HealthNet/MO HealthNet Managed Health Care plan ID number.
  - Medical diagnosis related to communication dysfunction leading to the need for an ACD.
  - Speech and language skills, which must include a prognosis for speech and/or written communication.
  - Cognitive readiness for use of an ACD.
  - Interactional/behavioral and social abilities (both verbal and nonverbal).
  - Cognitive, postural, mobility, sensory (visual and auditory) capabilities and medical status.
  - Current communication status and limitations (include limitations of participant's current communication abilities without an ACD. If device is currently in use, a description of the limitation of this device).
  - Motivation to communicate with an ACD.
  - Residential, vocational, educational, and other situations requiring communication.
  - ACD's ability to meet projected communication needs (e.g. ACD growth potential, how long it will meet needs).
  - Anticipated changes, modifications, or upgrades for up to 2 years.
  - Training plans, including plans for parental/caregiver training and support.
  - Statement as to why the prescribed ACD is the most appropriate and cost effective device. Include comparison of the advantages, limitations, and cost of alternative systems evaluated with the participant.
  - Complete description of ACD prescribed including all medically necessary accessories or modifications.

  For ACD team/sites currently enrolled as a Speech Language Pathologist, rehabilitation center, or outpatient hospital but not previously approved by the Bureau of Special Health Care Needs (BSHCN) that wish to be considered as a MO HealthNet ACD evaluation team/site, contact the Provider Enrollment Unit via email at providerenrollment@dss.mo.gov. Providers should state if they are currently enrolled as a MO HealthNet provider. Approval is given to SLPs, rehabilitation centers, or outpatient hospitals that meet the following criteria:

  - The ACD team/site leader must be a Missouri licensed SLP who has a certificate of clinical competency from the American Speech-Language Hearing Association.
  - The SLP must possess at a minimum 2 years' experience in the evaluation and selection of ACDs.
- **Prescription Form** is required. Medicaid requires that the client have a face-to-face examination with their physician no more than 6 months prior to the written order for the device. The physician must document that the client was evaluated and/or treated for a condition that supports the device. This documentation (chart notes or office visit notes) must be provided along with the written order for the device.
- **Equipment Quote** is required.
- **Trial** with the recommended device must be completed and documented within the ACD evaluation report.
- **No diagnosis, age, or place of service exclusions.**

Return to Table of Contents

Commercial Insurance in Missouri

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Anthem Blue Cross Blue Shield*

Missouri Schools

- Purchases above the small purchases threshold ($250,000) require formal procedures for purchases such as publicly published bids/RFPs.
- Single/sole source purchasing is available when supplies are proprietary and only available from the manufacturer or a single distributor.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Montana Funding

Quick Facts

Mounting

Are there mounting restrictions in Montana?

- No.

Software

Is additional software covered?

- Based on medical necessity.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial?

- No.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- Montana Medicaid Certificate of Medical Necessity (CMN).

Who can sign the Rx?

- MD/DO, PA, and NP can all sign Rx.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx should be on F2F notes, but no preferred Dx.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial required.

Return to Table of Contents

Montana Medicare Advantage

Each county of Montana has between 1 and 8 Medicare Advantage Plans. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Blue Cross Blue Shield of Montana
- Humana
- PacificSource
- United Healthcare

Montana Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Montana is not currently utilizing managed care.

Montana Medicaid Requirements

Below are documents and requirements necessary to meet Montana's Medicaid criteria.

- **Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Prior Authorization and Certificate of Medical Necessity Form** is required for all clients under the age of 21.
- **Prior Authorization Request (PAR) Form** must be completed and submitted.
- **Prescription and** Certificate of Medical Necessity (CMN) must be signed by physician.
- **Face-to-Face Notes** from physician are required.
- **Equipment Quote** is required.
- **Speech Evaluation** must follow Medicare guidelines.
- **No Formal Trial** is required, but Montana Medicaid will want to see that the device was used/trialed in some capacity.
- **No diagnosis, place of service, or age exclusions.**

Commercial Insurance in Montana

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Blue Cross Blue Shield Montana
- PacificSource

Montana Schools

For purchases greater than the small purchase threshold ($80,000), follow the formal procurement process, using either request for proposals (RFP) or invitation for bid (IFB). Sole source procurement is permissible under the following circumstances:

Return to Table of Contents

- The compatibility of current services or equipment, accessories, or replacement parts is the paramount consideration.
- There is no existing equivalent product.
- The only one source is acceptable or suitable for the supply or service item.

Appeals

We recommend following each payer's criteria to avoid denials. Montana Medicaid criteria can be found here.

If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Nebraska Funding

Quick Facts

Mounting

Are there mounting restrictions in Nebraska?

- No.

Software

Is additional software covered?

- No.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial?

- Regular Medicaid does not require a trial.
- NE Total Care Medicaid MCO requires a 30-day trial or 30 days' worth of device/software use data.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- MS78 Selection Form (Certificate of Medical Necessity) for all Nebraska MCOs.

Who can sign the Rx?

- MD/DO/NP/APRN are all acceptable signatures for Medicaid and PPO providers with in NE.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx should be on F2F notes, but no preferred Dx.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial required.

Return to Table of Contents

Nebraska Medicare Advantage

Nebraska has low Medicare Advantage plan coverage. All counties have at least 1 plan available, some have over 10. No county has more than 30% of Medicare beneficiaries enrolled in a Medicare Advantage plan. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

Nebraska Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Nebraska currently utilizes several managed care plans.

- Nebraska Total Care
- United Healthcare Community Plan
- Molina Nebraska MCO

Nebraska Medicaid Requirements

Below are documents and requirements necessary to meet Nebraska's Medicaid criteria.

- **Prescription** from physician is required. Nebraska Medicaid will not accept prescriptions from physician assistants or nurse practitioners.
- MS78 Selection Form must be completed and signed by the speech therapist and physician.
- **Equipment Quote** is required.
- **Speech Evaluation** must address the client's medical diagnosis, speech language diagnosis, physical status, communication abilities, vision and hearing acuity, cognitive, neuromotor, language and other skills required for use of the specific device selected. The specific device recommended along with all accessories required for use of the device must be identified and selection justified. Devices will only be covered for clients who meet the following criteria:
    - Client is unable to use natural oral speech as a primary means of communication.
    - Client has severe expressive communication disorder.
    - The specific device requested must be appropriate for use by the client and the client must demonstrate the abilities or potential abilities to use the device selected. Client/family/environment must support the use of the device.
    - An evaluation of the client's communication needs by a qualified professional speech pathologist is required. A background and experience in augmentative communication is recommended.
- **Place of Service Requirements** will not cover in a skilled nursing facility.
- **No age or diagnosis exclusions.**
- **No trial requirement.**

Commercial Insurance in Nebraska

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

Return to Table of Contents

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Blue Cross Blue Shield Nebraska

Nebraska Schools

Purchases greater than $10,000 must be informally bid. Sole source purchases are used for the procurement of commodities/goods available from only one source due to the unique nature of the requirement, compatibility, its supplier, proprietary product, or market conditions.

Appeals

We recommend following each payer's criteria to avoid denials. Nebraska Medicaid criteria can be found here.

- Total Care MCO must be appealed within 60 days from initial denial date. Consent form is required. A Peer to Peer (P2P) can be initiated by SLP with Total Care Medical Reviewer by calling 844-385-2192.
- Blue Cross Blue Shield Nebraska must be appealed within 180 days from initial denial date. MD is required to set up P2P. Blue Cross Blue Shield Nebraska Speech Generating Device criteria can be found here.

If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Nevada Funding

Quick Facts

Mounting

Are there mounting restrictions in Nevada?

- No.

Software

Is additional software covered?

- No.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial?

- A trial period is not required for all requests, but a trial period of 3 months may be required if there is not sufficient documentation of the use of the device.

State Specific Documentation Requirements

Who can sign the Rx?

- MD/DO, PA, and NP can all sign Rx.

Does the medical diagnosis need to be stated on the Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx should be on F2F, but no preferred Dx.
- F2F encounter should be no earlier than 6 months prior to submitting a prior authorization request and the provider's written order shall include the date of the encounter and the primary clinical reason the recipient needs the item(s).
- Telehealth/Telemed F2F encounters are acceptable as long as they include both video and audio notes.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial is required.

Return to Table of Contents

Nevada Medicare Advantage

Each county of Nevada has between 1 and 26 Medicare Advantage plans available. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- Allwell
- Anthem
- Humana
- Prominence Health Plan
- SelectHealth
- Senior Care Plus
- United Healthcare
- Viva
- WellCare

Nevada Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Nevada is currently operating through the use of a few managed care plans.

- Anthem of NV MCO: **Must rule out PRC devices** or Anthem will deny as they are in-network with PRC and we are out of network.

Nevada Medicaid Requirements

Below are documents and requirements necessary to meet Nevada's Medicaid criteria.

- **Attestation Form FA-1E** must be submitted with all prior authorization requests. This form must be signed by the family and the physician.
- **Speech Evaluation** is required. Must show a long term (lasting more than one year) disability and a severe speech impairment.
- **Face-to-Face (F2F) Notes** from the treating physician are required. F2F encounter with the physician must occur no more than 6 months from the date the prescription is signed. F2F notes are specific to the need for the device. F2F encounter should be a clinical assessment from the client's physician that include their name, diagnosis, date of birth, and recommends the speech device for the client. Telehealth/Telemed F2F encounters are acceptable as long as they include both video and audio notes.
- **Order Forms** are required for eye gaze devices and mounts.
- **Equipment Quote** is required.
- **Trial** is not required for all requests, but a trial period of 3 months may be required if there is not sufficient documentation of the use of the device. We recommend completing a trial period with the device and documenting in the SLP Speech Evaluation.
- **Place of Service Requirements** will not cover if the client is in a skilled nursing facility. If the client is in hospice, a Hospice Non-Coverage Letter is required by the facility providing care.
- **No diagnosis or age exclusions.**

Return to Table of Contents

Note: be sure to pay attention to authorization dates. They will provide approval before the actual authorization start date.

Commercial Insurance in Nevada

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Anthem Blue Cross Blue Shield of Nevada

Nevada Schools

Purchases over $25,000 require the sealed formal bid or proposal process. The Purchasing Division may authorize direct procurement when it is determined that the service or commodity is not adapted to competitive solicitation or is a single source.

Appeals

We recommend following each payer's criteria to avoid denials. Nevada's Medicaid criteria can be found here.

If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Note: Nevada Medicaid tends to approve within a couple days, but they only allow 5 days to submit additional information. Be sure to check the portal 2 to 3 days after prior authorization is submitted.

Return to Table of Contents

New Hampshire Funding

Quick Facts

Mounting

Are there mounting restrictions in New Hampshire?

- Anthem New Hampshire only has an allowable amount of $456 for E2512. If client only has Anthem New Hampshire with no secondary insurance, universal mount is not allowed. Mount must be under $1500 or needs approval from manager.
- New Hampshire Healthy Families (NHHF) MCO only has an allowable amount of $652. If the client only has NHHF with no secondary insurance, universal mount is not allowed. Mount must be under $1500 or needs approval from manager.

Software

Is additional software covered?

- If justified in report.

Hardware

Does the funded device need to be dedicated?

- Yes. Standard documentation is fine. No additional documents needed.

Trials

Does Medicaid require a trial? If so, how long?

- Yes. Medicaid and MCOs require a 30-day minimum trial.

Does the trial need to take place with the recommended device or is it OK to just trial the software?

- We recommend using the recommended device for the trial, but if software-only trial has already taken place we can try moving forward.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- AAC 288F – AAC Information
- AAC 288SG – AAC Safe Guarding Plan
- AAC 288T – AAC Trial Summary

Who can sign the Rx?

- MD/DO, PA, and NP acceptable.

Return to Table of Contents

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial required.

New Hampshire Medicare Advantage

New Hampshire has 40 Medicare Advantage plans available. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Humana
- Anthem
- Aetna
- Cigna
- Harvard Pilgrim Healthcare
- United Healthcare
- WellCare
- Martin's Point

New Hampshire Medicaid Information

Medicaid Managed Care Organizations (MCOs)

New Hampshire currently utilizes several managed care plans. Tobii Dynavox is in network with the following:

- MVP Health Plan
- New Hampshire Healthy Families
- WellSense
- Amerihealth Caritas

New Hampshire Medicaid Requirements

Below are documents and requirements necessary to meet New Hampshire's Medicaid criteria.

- New Hampshire Medicaid AAC Form (288F) is required.
- New Hampshire Medicaid AAC Trial Summary Form (288T) is required.
- New Hampshire Medicaid AAC Safeguarding Plan (288SG) is required.
- **AAC Quote Form** is required.
- **Prescription Form** is required.
- **Speech Evaluation** is required.
- **Equipment Quote** is required.
- **Trial Requirements** specify a 30-day minimum trial for Medicaid and all MCOs.
- **Place of Service Requirements** will not cover if the client is receiving hospice services.
- **No age or diagnosis exclusions.**

Return to Table of Contents

Commercial Insurance in New Hampshire

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Anthem Blue Cross Blue Shield New Hampshire*
- MVP Health Plan*

New Hampshire Schools

Sealed bidding or proposals are required for purchases above $250,000. Purchases above $250,000 where the item is available from a single source can be made with a noncompetitive proposal.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

New Jersey Funding

Quick Facts

Mounting

Are there mounting restrictions in New Jersey?

- No.

Software

Is additional software covered?

- All software is covered.

Hardware

Does the funded device need to be dedicated?

- Closed for all devices unless direct bill or VA.

Trials

Does Medicaid require a trial? If so, how long?

- No.

State Specific Documentation Requirements

Who can sign the Rx?

- MD/DO only.

Does the medical diagnosis need to be stated on the Face-to-Face (F2F) notes?

- No.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- Yes, both trial and authorization are required.

Return to Table of Contents

New Jersey Medicare Advantage

Each county of New Jersey has between 8 and 32 plans available. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Humana
- Aetna
- Cigna
- United Healthcare
- Amerivantage
- Clover Health Choice
- Horizon Blue Cross Blue Shield
- WellCare
- Erickson Advantage

New Jersey Medicaid Information

Medicaid Managed Care Organizations (MCOs)

New Jersey currently utilizes several managed care plans. Tobii Dynavox is in network with the following:

- UHC Community Plan of New Jersey
- 1199 SEIU
- Geisinger Health Plan
- Horizon New Jersey Health Plan
- Amerihealth Health Plan
- Wellcare of NJ

New Jersey Medicaid Requirements

Below are documents and requirements necessary to meet New Jersey's Medicaid criteria.

- **Prescription Form** is required.
- **Evaluation** is required.
- **Equipment Quote** is required.
- **Trial** is recommended but not required.
- **Place of Services Requirements** will not cover if client is living in a skilled nursing facility.
- **No age or diagnosis exclusions.**

Commercial Insurance in New Jersey

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*

Return to Table of Contents

- United Healthcare*
- Tricare*
- 1199 SEIU*
- Geisinger Health Plan*
- Horizon New Jersey Health Plan*
- Keystone 65*

New Jersey Schools

Orders over $40,000 require formal bidding and school board approval. Sole source purchasing is available if the item is available from one vendor only, the item is one-of-a-kind, and the manufacturer is the sole distributor.

Appeals

Managed care plans follow New Jersey Medicaid guidelines for AAC devices. Private insurance plans have their own guidelines. We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

New Mexico Funding

Quick Facts

Mounting

Are there mounting restrictions in New Mexico?

- No.

Software

Is additional software covered?

- No.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial? If so, how long?

- Yes. Medicaid requires a 30-day minimum trial.

Does the trial need to take place with the recommended device or is it OK to just trial the software?

- Can be with software or recommended device.

State Specific Documentation Requirements

Who can sign the Rx?

- MD/DO, PA, and NP can all sign Rx.

Does the medical diagnosis need to be stated on the Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx should be on F2F, but no preferred Dx.
- F2F should be within 6 months of Rx signature date.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial is required.

Return to Table of Contents

New Mexico Medicare Advantage

There are between 4 and 32 plans available in New Mexico depending on county. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- Allwell
- Amerigroup
- Blue Cross Blue Shield
- CHRISTUS
- Cigna
- Humana
- Imperial Insurance
- Molina
- Presbyterian
- United Healthcare

New Mexico Medicaid Information

Medicaid Managed Care Organizations (MCOs)

New Mexico is currently operating through the use of some managed care plans including:

- Presbyterian Salud
- Lovelace Salud
- Blue Salud
- Cimarron Salud
- Molina of New Mexico
- Amerigroup Community Care
- Blue Cross Blue Shield of New Mexico.

New Mexico Medicaid Requirements

Below are documents and requirements necessary to meet New Mexico's Medicaid criteria.

- **Prescription Form** from recipient's primary care physician is required.
- **Speech Evaluation** must be completed by a Speech Language Pathologist (SLP). The SLP may not be a vendor of the augmentative communication system nor have a financial relationship with the vendor.
- **Trial Requirement** of 30 days is required before purchase. At the end of the trial rental period, if purchase of the device is recommended, documentation of the recipient's ability to use the communication device must be provided showing that the recipient's ability to use the device is improving and that the recipient is motivated to continue using the device.
- **Equipment Quote** is required.
- **Additional documentation** including a physical therapy assessment, psychological evaluation, occupational therapy evaluation, and summary of trial are not required but may be helpful.

Return to Table of Contents

- **Place of Service Requirements** will not cover the equipment if the client is living in a hospital, nursing home, skilled nursing facility, intermediate care facility for individuals with intellectual disabilities, or a rehabilitation facility.
- Medicaid does not pay for supplies for ACD, such as paper, printer ribbons, and computer discs.
- A provider or medical supplier that routinely supplies an item to the recipient must document that the order for additional supplies was requested by the recipient or his/her authorized representative and the provider or supplier must confirm that the recipient does not have in excess of a 15-calendar day supply of the item before releasing the next supply order to the recipient. A provider must keep documentation in his or her files available for audit that show compliance with this requirement.

Commercial Insurance in New Mexico

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Blue Cross Blue Shield of New Mexico

New Mexico Schools

Competitive bids are utilized when the small purchasing limit of $20,000 is exceeded. A sole source contract may be awarded without competitive bidding when the determination is made that only one manufacturer or vendor can meet the requirements or specifications.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

New York Funding

Quick Facts

Mounting

Are there mounting restrictions in New York?

- Medicaid and all MCOs will only fund one mount (no universals).
- Plane like Empire, GHI/Emblem, Molina, NYS Medical Indemnity Fund, and VNSNY will only fund one mount and may have more specific mounting requirements.

Software

Is additional software covered?

- Most insurances may cover other software if they are justified in the report.
- Medicaid and all MCOs will not cover additional software.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial? If so, how long?

- Yes. Medicaid and all MCOs require a 30-day minimum trial.

Does the trial need to take place with the recommended device or is it OK to just trial the software?

- Recommended device for all eye gaze devices. A Switch Kit must be included in the equipment during the 30-day trial. As switches must be trialed and ruled out using the Switch Template created for NY Medicaid.
- SC Tablet/I-110 may be trialed for one week with recommended equipment, and the remaining trial can be completed using iPad and software being recommended.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- New York Medicaid requires a NY State Prescription Pad be used for the prescription. Generated prescriptions may not be used. (MCR or MCR/MCD does not require this.)

Who can sign the Rx?

- MD/DO, and PA.
- NP only if in collaborative agreement for one or more elements of NP Practice.

Does the medical diagnosis need to be stated on the Face-to-Face (F2F) notes?

- No, but recommended.

Return to Table of Contents

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- Medicare does not require a trial.
- No authorization or trial is required for Medicare/Medicaid cases.

New York Medicare Advantage

New York has good Medicare Advantage plan coverage. All counties have at least 18 plans available, some have over 90. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- United Healthcare/AARP
- Blue Cross Blue Shield
- Fidelis
- Emblem

New York Medicaid Information

Medicaid Managed Care Organizations (MCOs)

New York has a wide range of managed care plans for members to select.

Participating:

- UHC Community Plan
- YourCare Health Plan New York
    - YourCare Option MCO
    - Child Health Plus
    - YourCare Essential Plan
- Affinity Health Plan
    - Child Health Plus
    - Family Health Plus
    - MCO
- Capital District Physicians Health Plan, Inc. (CDPHP)
    - Child Health Plus
    - Family Health Plus
    - MCO
- Excellus Blue Cross Blue Shield of New York
    - Child Health Plus
    - Family Health Plus
    - MCO
- Fidelis
- Partners Health Plan

Return to Table of Contents

In Process:

- WellCare
- Amerigroup
- Molina

New York Medicaid Requirements

Below are documents and requirements necessary to meet New Mexico's Medicaid criteria.

- **Prescription** on physician's official prescription pad is required. The following information must be included:
    - Specific equipment
    - Client's Medicaid ID
    - Physician's Medicaid ID
    - Date of last face-to-face visit (must be within 6 months of purchase request)
    - Diagnosis ICD-10 codes
    - Lifetime needed
    - Signature and date
- **Detailed Speech Evaluation** must document the following information:
    - Recipient must have a severe expressive communication impairment.
    - Recipient's ability to communicate using speech or writing is insufficient to meet daily needs.
    - Recipient has the cognitive, auditory, visual, language, and physical abilities to use the device.
    - The speech generating device (SGD) and related accessories are the adequate, less expensive alternative to enable the member to meet daily functional communication needs. There must be a clear explanation of why other alternatives were ruled out.
    - The SGD and related accessories must allow recipient to improve their communication to a functional level not achievable without a SGD or less costly device.
- **Individualized Education Plan (IEP)** must be submitted for all school aged clients.
- **Trial Period** of one month is required by Medicaid before purchase. Recipient must demonstrate the ability to use the recommended device and accessories or software for functional communication as evidenced by a data driven trial showing that skills can be demonstrated repeatedly over time, beyond a single occurrence or evaluation session. Report should include the following information:
    - Length and dates of trial, and amount of time device was used during the trial.
    - Time framed measurable goals for functional communication set for trial and criteria for measurement.
    - Empirical data including baseline performance and results of trial period goals.
    - Description of environments in which device was trialed such as, but not limited to, home, school, and community.
    - Did communication occur in both structured and unstructured settings?
    - How was the device accessed? (e.g. direct selection, eye gaze, switch, etc.)
    - Description of member's ability to use the SGD for functional communication.

Return to Table of Contents

    - Sampling of messages communicated including the frequency, type, and level of cuing required.
    - Number of messages expressed in a time period including type and level of cuing required.
    - Communicative intents and functions expressed.
    - If recommending eye gaze, the recipient's endurance to maintain gaze, ability to calibrate or obstacles to calibration.
- **Eye Gaze Accessory Regulations** require that scanning and head pointing systems must be tried repeatedly over time and ruled out as not appropriate. The recipient must demonstrate the ability to use eye gaze technology beyond cause and effect activation, simple eye tracking activities, and learning tool. The recipient must also have the physical ability to activate the system and demonstrate meaningful use of the device without being caregiver dependent. A physical therapist and/or occupational therapist with assistive technology experience must show that the recipient's positioning needs and head control abilities are adequate for eye gaze. Documentation must show that other eye gaze access devices from multiple manufacturers have also been considered. A vision assessment may also be required.
- **Place of Service Requirements** will not cover if client is in a skilled nursing facility, hospital, rehabilitation hospital, or nursing home.
- **No diagnosis or age exclusions.**

Commercial Insurance in New York

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Blue Cross Blue Shield of Western New York
- Excellus Blue Cross Blue Shield
- Anthem Blue Cross Blue Shield
- Blue Cross Blue Shield of Northeastern New York

New York Schools

All school districts' purchases involving an individual item or commodity group which will necessitate the expenditure of $20,000 or greater in any given fiscal year is required to be advertised and awarded based on formal bids.

A sole source procurement is one in which only one vendor can supply the commodities or services required by an agency. The agency must document why the proposed vendor is the only viable source for the commodities and/or services needed by the agency.

Return to Table of Contents

New York City Department of Education (NYCDOE)

NYCDOE allows for purchase of goods through sole source procurement when there is only one source for goods and when no other product is available that meets the same or substantially similar requirements of form, function, and utility. Tobii Dynavox has a sole source procurement contract with NYCDOE.

The FAMIS portal allows user sot make purchases from DOE contracted vendors. Tobii Dynavox's Contracting Department maintains an up-to-date list of items for purchase through its portal.

Boards of Cooperative Educational Services (BOCES)

Purchasing rules for New York school districts and BOCES vary from local governments but many practices and procedures are the same. Competitive bidding is a statutory requirements in New York state and a standard method of procurement when purchases are expected to exceed $20,000. The sole source requirement is an exception to bidding for BOCES.

Appeals

We recommend following each payer's criteria to avoid denials. Medicaid defers for additional information until an approval is received and, therefore, we do not file appeals for Medicaid.

- All MCO plans must be appealed within 60 or 90 days from initial denial date.
- Patient consent form is required for all plans.

If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

North Carolina Funding

Quick Facts

Mounting

Are there mounting restrictions in North Carolina?

- No.

Software

Is additional software covered?

- Yes.

Hardware

Does the funded device need to be dedicated?

- Yes, covered on Certificate of Medical Necessity (CMN).

Trials

Does Medicaid require a trial? If so, how long?

- Yes. Medicaid requires a 30-day minimum trial. Evaluation must include a trial date range specified (e.g. 01/01/2024 – 01/31/2024).

Does the trial need to take place with the recommended device or is it OK to just trial the software?

- It's okay to trial software on a different device, but include an explanation in the evaluation as to why the recommended device meets the client's needs and the trial device does not.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- Certificate of Medical Necessity.

Who can sign the Rx?

- MD/DO, PA, and NP can all sign.

Does the medical diagnosis need to be stated on the Face-to-Face (F2F) notes?

- Dx should be on F2F notes, but no specific Dx's preferred.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization required. Trial not required unless Medicare won't cover.

Return to Table of Contents

North Carolina Medicare Advantage

Each county of North Carolina has between 3 and 26 Medicare Advantage plans available. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- Blue Cross Blue Shield North Carolina
- Cigna
- HealthTeam
- Humana
- United Healthcare
- Teal Premier
- WellCare
- ApexAscend
- FirstMedicare
- Troy Medicare
- Experience Health
- Clear Spring
- ApexHealth

North Carolina Medicaid Information

Medicaid Managed Care Organizations (MCOs)

North Carolina has a few MCO plans available. Tobii Dynavox is in network with Amerihealth Caritas North Carolina.

North Carolina Medicaid Requirements

Augmentative and alternative communication (AAC) devices, software, and related accessories are covered by North Carolina Medicaid when all of the following conditions are met:

- The device is determined to be medically necessary.
- The device is a dedicated communication device.
- It is solely used by the beneficiary.
- The beneficiary has a long-term severe communication impairment.

Below are documents and requirements necessary to meet North Carolina's Medicaid criteria.

- North Carolina Medicaid Request for Prior Approval CMN/PA must be signed by both the physician and Tobii Dynavox. The following documentation must be included:
    - A physician's report with a description of the beneficiary's current medical status and history.
    - A physician's order for the AAC device, including an itemization of the components (switches, special mounting devices, etc.) required by the beneficiary.

Return to Table of Contents

    - An AAC device evaluation performed by a licensed Speech Language Pathologist (SLP) who fulfills either requirements 1 and 3 or requirements 2 and 3 below:
        1. Has a valid license issued by the North Carolina Speech and Language Pathologists and Audiologists Board of Examiners, and has Certificate of Clinical Competence (CCC) from the American Speech-Language-Hearing Association (ASHA).
        2. Has either completed the equivalent educational requirements and work experience necessary for the CCC, or has completed the academic program and is acquiring supervised work experience to qualify for the CCC.
        3. Has the education and experience in augmentative communication necessary to assess an individual and prescribe an AAC aid, system, or device that will maximize the individual's effective and functional communication.
- **Prescription** from the physician is required in addition to the Prior Approval CMN/PA form. Client must have a face-to-face examination with their physician no more than 6 months prior to the written order for the speech generating device (SGD). The physician must document that the client was evaluated and/or treated for a condition that supports the SGD. This documentation (chart notes or office visit notes) must be provided along with the written order for the SGD.
- **Equipment Quote** is required.
- **Speech Language AAC Evaluation** must be performed by an SLP who does not have a financial relationship with Tobii Dynavox. The evaluation must include all of the following information:
    - The language skills, oral and motor speech status, and type/severity of current communication impairment(s) that affect the beneficiary's abilities to communicate with and without the AAC device.
    - A detailed description of the therapeutic history in the areas of speech language pathology, occupational therapy, and physical therapy including the nature, frequency, and duration of treatment and the specific speech language therapy approaches that have been tried in relation to the need for and use of an AAC device.
    - A detailed description of related impairments, including audio visual, perceptual, cognitive, and memory deficits that would limit the beneficiary's ability to use a device, or that would require the use of a particular AAC device.
    - A detailed description of each communication device or method of communication tried by the beneficiary in the past and information on the effectiveness of each.
    - Specific information about the requested device, including the manufacturer's name, catalog number, product description, and list of accessories requested; justification for and use to be made of the device and accessories; and documentation of the manufacturer's price quote.
    - An explanation of the medical necessity of the AAC device, including how the device will be used in the home or other settings and a statement that the device will be required for 12 months or longer.

Return to Table of Contents

    - Demonstration that the beneficiary possesses a treatment plan that includes a training schedule for the selected device (technical assistance from the AAC vendor must include training on the use of the AAC device).
    - A statement that the SLP performing the device evaluation is neither an employee of nor has a financial relationship with the vendor of the AAC device.
    - A sole use and financial statement: "The [device name] is for sole use of [client name]."
    - A 4-week trial of the device being requested is required by NC Medicaid and must be documented in an exact date format (mm/dd/yyyy to mm/dd/yyyy) in the evaluation prior to submitting for purchase.
- **Place of Service Requirements** will not cover durable medical equipment if the client is in a skilled nursing facility, inpatient hospital, or receiving hospice services.
- **No diagnosis or age exclusions.**

Commercial Insurance in North Carolina

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- CareFirst Blue Cross Blue Shield*

North Carolina Schools

Formal bids are issued for procurements over $10,000. Competition may be waived where a needed product is available from only one source of supply or the amount of the purchase is too small to justify competition.

Appeals

We recommend following each payer's criteria to avoid denials. North Carolina Medicaid criteria for AAC devices can be found here.

If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

North Dakota Funding

Quick Facts

Mounting

Are there mounting restrictions in North Dakota?

- Universal mounts are okay.

Software

Is additional software covered?

- No.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial?

- No.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- Individualized Education Plan (IEP) for school aged children.
- Face-to-Face required to submit to insurance.
- Rx must include a description of use.

Who can sign the Rx?

- MD/DO, PA, and NP can all sign.

Does the medical diagnosis need to be stated on the Face-to-Face (F2F) notes?

- Dx should be on F2F notes, but no specific Dx's preferred.
- F2F should be within 90 days of requested start date/date Rx is signed.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial required.

Return to Table of Contents

North Dakota Medicare Advantage

There are between 2 and 28 plans available in North Dakota depending on county. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- HealthPartners
- Humana
- Medica
- NextBlue
- United Healthcare

North Dakota Medicaid Information

Medicaid Managed Care Organizations (MCOs)

North Dakota is not currently utilizing Manage Care plans, but this may change in the future.

North Dakota Medicaid Requirements

North Dakota Medicaid will cover SGDs if a severe expressive speech disability is present and, prior to the delivery of the SGD, the member has had a formal evaluation of their cognitive and language abilities by a Speech Language Pathologist (SLP). The equipment must:

- Be medically necessary;
- Be appropriate and effective to the medical needs of the member;
- Be timely, considering the nature and present state of the member's medical condition;
- Be furnished by a DME POS provider with appropriate credentials;
- Be the least expensive appropriate alternative health service available;
- Represent an effective and appropriate use of program funds.

North Dakota Medicaid will only replace a device and/or mount every 10 years. Below are documents and requirements necessary to meet North Dakota's Medicaid criteria.

- **Prescription** is required. The client is required to have an examination with their physician no more than 90 days prior to the written order for the speech generating device (SGD). The prescription must include directions for use (e.g. "Direction of Use: Device to be used for patient to communicate their medical needs.") The physician must document that the client was evaluated and/or treated for a condition that supports the SGD. This documentation must be provided along with the prescription for the SGD.
- **Face-to-Face Visit Notes** from the physician are required. Face to Face visit date needs to be prior to the prescription date and within 90 days of the start date on the authorization/date the pre-authorization request is submitted.
- **Speech Evaluation** from within 6 months prior to the submission is required. SLP needs to rule out at least two other similar (direct touch or eye gaze) devices, and at least one of the ruled-out devices must be from a different manufacturer.
- **Individualized Education Plan (IEP)** is required for school aged children.
- **Trial Period** is not required before purchase.

Return to Table of Contents

- **Place of Service Requirements** will not cover equipment if the client is living in a skilled nursing facility.
- **No diagnosis or age exclusions.**

Commercial Insurance in North Dakota

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Blue Cross Blue Shield North Dakota*

North Dakota Schools

If the purchase is greater than $25,000, it must be awarded on a bid basis. Purchases are exempt from this requirement if items are so distinctive that only one source exists. There is also an exemption for purchases of items to match those already in use.

Appeals

We recommend following each payer's criteria to avoid denials. North Dakota Medicaid criteria for AAC devices can be found here.

If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Ohio Funding

Quick Facts

Mounting

Are there mounting restrictions in Ohio?

- Yes, no universal mounts for Ohio Medicaid/MCOs or Anthem of Ohio.

Software

Is additional software covered?

- Gateway if justified in the evaluation.

Hardware

Does the funded device need to be dedicated?

- Yes. No additional documentation required. The quote showing “closed” is sufficient.

Trials

Does Medicaid require a trial?

- No.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- Ohio Medicaid Certificate of Medical Necessity (CMN) is required for traditional Medicaid and must include the provider’s OH Medicaid ID#.

Who can sign the Rx?

- MD/DO, PA, and NP can all sign. Traditional Medicare requires MD/DO only.

Does the medical diagnosis need to be stated on the Face-to-Face (F2F) notes?

- No.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial required.

Return to Table of Contents

Ohio Medicare Advantage

Each county of Ohio has between 19 and 62 Medicare Advantage plans available. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- Allwell
- Anthem Blue Cross Blue Shield
- Buckeye
- Devoted Health
- Humana
- Medical Mutual of Ohio
- MediGold
- Mutual of Omaha
- Paramount
- PrimeTime
- SummaCare
- The Health Plan
- United Healthcare
- WellCare
- Valor Health

Ohio Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Ohio is currently utilizing MCO plans and Tobii Dynavox is in network with the following:

- Aetna Better Health of Ohio
- Amerihealth Caritas of Ohio
- Buckeye Health Plan
- CareSource
- Molina of Ohio
- UHC Community Plan

Ohio Medicaid Requirements

Below are documents and requirements necessary to meet Ohio's Medicaid criteria.

- Ohio Repair of Durable Medical Equipment Form is required when a repair is needed to a client's SGD. The client information may be completed and sent to Tobii Dynavox for the form to be completed. A separate letter from a licensed SLP and prescription from the physician must accompany this form.
- Certificate of Medical Necessity (CMN) is required and must be signed by the physician and include the physician's OH Medicaid ID#. The client is required to have an examination with their physician no more than 60 days prior to the written order for the speech generating device (SGD). The physician must document that the client was evaluated and/or

Return to Table of Contents

treated for a condition that supports the SGD. This documentation must be provided along with the CMN for the SGD.
- **Prescription** must be signed by the physician and submitted.
- **Evaluation by SLP** is required.
- **Face-to-Face Notes** from the past 6 months are required.
- **Equipment Quote** is required.
- **No trial required.**
- **Place of Service Requirements** will not cover durable medical equipment (DME) if the client is receiving hospice services.
- **No age or diagnosis exclusions.**

Commercial Insurance in Ohio

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Anthem Blue Cross Blue Shield of Ohio*
- Kaiser Permanente*
- Molina*
- BCMH (typically secondary insurance for children. We will need a letter from the school district to submit the request and it could take up to 6 months to receive a determination).

Ohio Schools

Through direct purchasing authority, agencies can spend up to $50,000 with a vendor/year without going through a formal competitive process (i.e. ITB or RFP). Schools must follow internal agency procurement guidelines. Ohio also allows for sole source purchasing.

Appeals

We recommend following each payer's criteria to avoid denials. Ohio Medicaid criteria for AAC devices can be found here.

If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Oklahoma Funding

Quick Facts

Mounting

Are there mounting restrictions in Oklahoma?

- No universal mounts.

Software

Is additional software covered?

- Based on medical necessity.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial?

- No.

State Specific Documentation Requirements

Who can sign the Rx?

- MD/DO, PA, and NP can all sign.

Does the medical diagnosis need to be stated on the Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx should be on F2F, but no preferred Dx's.
- F2F should be within 6 months of Rx signature.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial required.

Return to Table of Contents

Oklahoma Medicare Advantage

All counties in Oklahoma have at least 2 plans available, some have over 20. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

Oklahoma Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Oklahoma is currently utilizing a few managed care plans.

Participating:

- Aetna Better Health
- Humana Healthy Horizons

In Process:

- Oklahoma Complete Health

Oklahoma Medicaid Requirements

Below are documents and requirements necessary to meet Oklahoma's Medicaid criteria.

- **Prescription** is required.
- **Equipment Quote** is required.
- **Evaluation by Speech Language Pathologist (SLP)** is required. Evaluation should discuss member's strengths/deficits relevant to speech/language abilities and factors that affect communication and justify the need for an AAC device, such as:
    - History of speech therapy with minimal improvement and speech production.
    - Diagnoses affecting current or potential speech/language skills such as cerebral palsy, muscular dystrophy, TBI, etc.
    - Poor speech intelligibility in most situations.
    - Discussion of specific devices/systems trialed and ruled out with an explanation of why these did not meet the member's needs (at least 3 different systems). Needs to address at least 3 different software programs. Software does not necessarily need to be trialed formally, but must consider and rule out other software programs.
    - Full descriptions of the type of AAC device that best meets the member's needs and justification for this decision, including data from device trials that document use of device and how abilities changed over time.
- **Video Media** showing member functionally using the device is required. Should include clear views of both the member and device and views of the communication partners who may be prompting or assisting. Assure the lighting and volume is adequate for viewing. The video media in its entirety should not exceed 15 minutes.
- **Place of Service Requirements** will not cover speech generating devices (SGDs) for clients in a skilled nursing facility.

Return to Table of Contents

Commercial Insurance in Oklahoma

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Oklahoma Blue Cross Blue Shield

Oklahoma School Information

Purchases of $5,000 or more should be based on 3 competitive price quotes. Purchases less than $5,000 may be made without documented price quotes.

Items that are unique to a single vendor are exempt from the quotation requirements. A “Sole Source” affidavit must be submitted and approved by the Oklahoma Department of Education Finance Office.

Oklahoma State Purchasing Requirements

Oklahoma state purchasing requirements can be found here.

Appeals

We recommend following each payer’s criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Oregon Funding

Quick Facts

Mounting

Are there mounting restrictions in Oregon?

- No mounting restrictions

Software

Is additional software covered?

- OR Medicaid will sometimes cover additional software if the SLP indicates the need for it.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial?

- No formal trial is needed.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- Physician Statement/Letter of Medical Necessity (LMN).
- DMAP 3047 – SLP Evaluation Form.
- All Oregon Medicaid MCOs will need a LMN, DMAP, and F2F notes.

Who can sign the Rx?

- MD/DO, PA, and NP can all sign.
- Rx must include ICD-10 codes of primary Dx and length of need.

Does the medical diagnosis need to be stated on the Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Medical Dx should be stated on F2F.
- An in-person F2F encounter related to obtaining the speech generating device must occur no more than 6 months prior to the start of services.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial required.

Return to Table of Contents

Oregon Medicare Advantage

There are between 2 and 35 plans available in Oregon depending on county. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- AllCare
- Atrio
- Health Net
- Humana
- Kaiser
- Moda Health
- PacificSource
- Providence
- Regence
- Samaritan Advantage
- United Healthcare

Oregon Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Oregon is currently operating through the use of a few managed care plans including:

- Trillium: Please note, the evaluation **must rule out PRC devices** or Trillium will deny.
- Allcare
- CareOregon
- UMPQUA
- EOCCO
- Willamette Valley Health
- Kaiser
- Providence

Oregon Medicaid Requirements

Below are documents and requirements necessary to meet Oregon's Medicaid criteria.

- **OHP Augmentative Communication Device Support Summary Form** is required to completed by the Speech Language Pathologist (SLP).
- **Speech Evaluation** must be completed following Medicare guidelines. Evaluation must show that a trial period has been completed with the requested device/equipment.
- **Prescription Form** must document that the client was evaluated/treated for a condition that supports the speech generating device (SGD). This documentation (chart notes or office visit notes) must be provided along with the written order for the SGD.
- **Face-to-Face Visit Notes** from a face-to-face examination with the physician no more than 6 months prior to the written order for the SGD are required.

Return to Table of Contents

- **Physician Statement/Letter of Medical Necessity** is required. Please contact your Tobii Dynavox funding consultant if you have any questions regarding this form.
- **Equipment Quote** is required.
- **Place of Service Requirements** will not cover if client is living in a skilled nursing facility, nursing home, or inpatient hospital.
- If client has Medicare as their primary insurance, no authorization is needed through Medicaid.

Commercial Insurance in Oregon

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Regence Blue Cross Blue Shield*

Oregon School Information

Purchases greater than $150,000 must utilize competitive sealed bidding. For purchases in the range of $10,000 to $150,000, the school must seek 3 competitive price quotes.

Sole source procurements are available if it is determined that only one known source exists or that only one single supplier can fulfill the requirements.

Appeals

We recommend following each payer's criteria to avoid denials. Oregon Medicaid criteria can be found here. Oregon MCOs follow Medicaid criteria for SGDs.

If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Pennsylvania Funding

Quick Facts

Mounting

Are there mounting restrictions in Pennsylvania?

- No.

Software

Is additional software covered?

- UPMC MCO does not allow for added software.
- Amerihealth Caritas MCO and Keystone First MCO will not cover specific features that are not related to functional speech, such as hardware or software used to create documents or play games.

Hardware

Does the funded device need to be dedicated?

- Yes. The quote must show as “closed” and letter must be submitted with Prior Authorization.

Trials

Does Medicaid require a trial? If so, how long?

- Traditional Pennsylvania Medicaid requires trial of recommended device and device from a competitor in the same device category (rule out) and trial (rule out) of least costly device. No specific trial time frame, just needs to be mentioned in evaluation.
- UPMC MCO requires a trial of the device being recommended. No specific trial time frame, just needs to be mentioned in the evaluation.
- Highmark Wholecare MCO requires a trial of the recommended device. There is a 30-day trial period requirement. Speech generating devices (SGDs) are not approved unless the patient has used the requested SGD for a trial period in their everyday speaking environment for at least 30 days. During this time, the patient should have access to the device daily and use it in a variety of communication situations.

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- Software-only trial is okay but need to mention a rule out of least costly device.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- Geisinger MCO requires Tomorrow Health Referral form and Rx before submitting for prior authorization.
- Traditional Medicaid requires MA97 form (one for device and one for accessories if applicable). Needs to be signed by family and MD.

Return to Table of Contents

Who can sign the Rx?

- MD/DO, PA, and NP can all sign.
- Traditional Medicaid requires MD's Pennsylvania license number on Rx and Rx filled out completely.

Does the medical diagnosis need to be stated on the Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Medical Dx should be stated on F2F notes.
- Traditional Medicaid prefers a formal medical diagnosis (e.g. Autism/apraxia over developmental delay).

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- Authorization is usually required.
- Trial needs to be mentioned in evaluation if traditional Medicaid.

Pennsylvania Medicare Advantage

There are between 20 and 62 plans available in each county of Pennsylvania. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- Capital BC
- Cigna
- Clover Health
- Independence BC
- Highmark BS
- Geisinger
- Humana
- UPMC
- Vibra Health Plan
- United Healthcare
- Allwell
- Health Partners
- Sunrise Advantage

Pennsylvania Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Pennsylvania is currently utilizing managed care plans. Tobii Dynavox will manage prior authorization requests for Community Health Choice plans where client resides in a Skilled Nursing Facility. Tobii Dynavox is in network with the following:

Return to Table of Contents

- Keystone First
- Amerihealth Caritas
- UHC Community Plan
- Aetna Better Health

- UPMC for You
- PA Health and Wellness
- Geisinger
- Gateway
- Highmark Wholecare (formerly Gateway): Please note, for any I-110 requests through Highmark Wholecare MCO, we recommend that the SLP completes the Highmark Wholecare Addendum sample. This addendum needs to include rule out of other devices including our least costly devices and devices from other vendors. 30-day trial dates along with trial information that shows successful use of recommended device should also be included. Since we have seen requests for I-110 denied, we highly recommend the addendum along with evaluation be completed. All other Highmark Wholecare MCO requests will need to mention rule out of Ablenet device and rule out of least costly device in the evaluation.

The Tobii Dynavox Funding Department will manage all prior authorization requests for Medicaid MCO Community Health Choice plans where the client resides in a Skilled Nursing Facility (SNF).

Pennsylvania Medicaid Requirements

Below are documents and requirements necessary to meet Pennsylvania's Medicaid criteria.

- **Prescription Form** is required. Medicaid requires that the client have a face-to-face examination with their physician no more than 6 months prior to the written order for the speech generating device (SGD). The physician must document that the client was evaluated and/or treated for a condition that supports the SGD. This documentation (chart notes or office visit notes) must be provided along with the written order for the SGD. The notes must document a history and physical examination that includes a recent neurologic and developmental exam along with an appropriate examination of the ears.
- **Speech Evaluation** is required.
- Prior Authorization Form (MA-97) needs to be completed. Complete one form for the main device and a second form if accessories and/or a wheelchair mount/table stand/floor stand is being recommended. If the client is eligible for a MCO, this form is not needed.
- **Trial** of recommended device needs to be included in evaluation, but no specific time frame is required. Trial information also needs to include trial of a device from a different vendor and rule out of least costly device.
- Traditional Medicaid prefers a formal medical diagnosis (e.g. Autism/apraxia preferred over developmental delay).
- If the client is in a skilled nursing facility, nursing facility, intermediate care facility, or custodial care facility and Medicare or Medicaid is paying a per diem cost for the client to be cared for, they will not cover the device. The facility can use a **MA97LTC Form** under the DME

Return to Table of Contents

Grant Program to file for coverage of the device. The facility must file the request for Prior Authorization on the MA97LTC, and once they receive authorization they will provide Tobii Dynavox with a letter of intent, PO, or check to pay for the device. Orders must go through prior authorization and not direct bill since the facility will send payment with PA Medicaid rates. Facility can submit to PA Medicaid via fax at (717) 213-3780.

- Will not cover if client is receiving hospice services.

Commercial Insurance in Pennsylvania

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Highmark Blue Cross Blue Shield*
- Gateway*
- Johns Hopkins Health Care*
- Keystone First*
- UMPC*
- Capital Blue Cross*
- Geisinger Health Plan*

Pennsylvania School Information

Public bidding is required for purchases of $10,000 or more. A contract may be awarded for a supply without competition if the contracting officer first determines in writing that only a single contractor can provide the supply. Bidding is not required for software purchases.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Rhode Island Funding

Quick Facts

Mounting

Are there mounting restrictions in Rhode Island?

- Medicaid will allow a universal mount as long as it's listed as one mount.
- NHP of Rhode Island (Integra) only has an allowable amount of $472.50. If the client only has NHP of RI with no other insurance, universal is not allowed. Mount must be under $1,500 or needs approval from manager.

Software

Is additional software covered?

- If justified in report.

Hardware

Does the funded device need to be dedicated?

- Yes. Standard documentation is fine. No additional documents needed.

Trials

Does Medicaid require a trial? If so, how long?

- Yes. Medicaid and all MCOs require a 30-day minimum trial.

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- We recommend trialing with the recommended device, but if software-only trial has already taken place we can try moving forward.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- Certificate of Medical Necessity (CMN)
- Request for Prior Authorization for Durable Medical Equipment Form (children only)
- Face-to-Face Encounter Form
- Most current Individualized Education Plan (IEP) for school aged children

Who can sign the Rx?

- MD/DO, PA, and NP can all sign.

Does the medical diagnosis need to be stated on the Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx will need to be listed on F2F Encounter Form, but not on F2F notes directly

Return to Table of Contents

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- For those beneficiaries dually enrolled in the RI Medicaid Program and Medicare, including Medicare Part C, prior authorization is not required for Medicare covered DME services. When prior authorization is required for a service, and the recipient falls in the following categories, then RI Medicaid will require a prior authorization:
    - Client has RI Medicaid as their primary plan
    - Client has dually enrolled in Medicare or Medicare Part C
    - Client has other insurance or third party liability
- No trial is needed.

Rhode Island Medicare Advantage

There are 16 plans available in Rhode Island. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- Blue Cross Blue Shield of Rhode Island
- United Healthcare

Rhode Island Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Rhode Island is currently utilizing managed care plans including:

- Neighborhood Health Plan
- United Healthcare Community Plan

Rhode Island Medicaid Requirements

Below are documents and requirements necessary to meet Rhode Island's Medicaid criteria.

- Request for Prior Authorization for Durable Medical Equipment Form is required for children who are Medicaid recipients and must be signed by the physician, parent/guardian, school therapist, and the ordering/recommending clinician (SLP, OT, PT).
- **Prescription Form** must be signed by the physician (MD/DO, NP, or PA). Prescribing physician must be enrolled in Rhode Island Medicaid.
- Face-to-Face Encounter Form must be completed and signed by the physician. Medicaid requires that the client have a face-to-face examination with their physician no more than 6 months prior to the written order for the speech generating device (SGD). The physician must document that the client was evaluated and/or treated for a condition that supports the SGD. This documentation (chart notes or office visit notes) must be provided in addition to the Face-to-Face Encounter Form, along with the written order for the SGD.
- Certificate of Medical Necessity (CMN) Form is required.
- **Individualized Education Plan (IEP)** is required for all children under the age of 21.
- **Speech Evaluation** is required.

Return to Table of Contents

- If a trial period is not completed, an explanation must be given on the Children's DME Form. Reviewer may request additional trial information.
- **Place of Service Requirements** will not cover if client lives in a skilled nursing facility, hospital, or intermediate care facility. They also will not cover if client is receiving hospice services.
- **No diagnosis or age exclusions.**

Commercial Insurance in Rhode Island

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Blue Cross Blue Shield of Rhode Island

Rhode Island School Information

Purchases over $5,000 require the bidding process unless it is determined that a sole vendor can supply the item.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

South Carolina Funding

Quick Facts

Mounting

Are there mounting restrictions in South Carolina?

- Blue Cross Blue Shield SC doesn't cover combo/universals. $525.00 maximum allowable.

Software

Is additional software covered?

- Yes.

Hardware

Does the funded device need to be dedicated?

- Yes. Documentation covered in Certificate of Medical Necessity.

Trials

Does Medicaid require a trial? If so, how long?

- Yes. A 30-day minimum trial is required.

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- It's okay to trial on software/a different device, but include explanation of why the recommended device meets the client's needs and the trial device did not.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- Certificate of Medical Necessity (CMN) is required, unless Medi-Medi.

Who can sign the Rx?

- MD/DO, NP, or PA can sign.

Does the medical diagnosis need to be stated on the Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx will needs to be listed, but no specific Dx preferred.
- F2F notes must be within 90 days or less before Rx and CMN date.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization required. No trial required unless Medicare won't cover.

Return to Table of Contents

South Carolina Medicare Advantage

Each county of South Carolina has between 13 and 43 Medicare Advantage plans available. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- Allwell
- ApexHealth
- Blue Cross Blue Shield South Carolina
- Bright Health
- Cigna
- Clear Spring Health
- Clover Health
- Humana
- United Healthcare
- WellCare

South Carolina Medicaid Information

Medicaid Managed Care Organizations (MCOs)

South Carolina is currently utilizing managed care plans. Tobii Dynavox is in network with the following:

- United Healthcare Community Plan
- WellCare of South Carolina
- Absolute Total Care

Bluechoice Healthplan is a popular MCO, but Tobii Dynavox is not in-network.

South Carolina Medicaid Requirements

Below are documents and requirements necessary to meet South Carolina's Medicaid criteria.

- **Prescription Form** is required.
- Certificate of Medical Necessity (CMN) must be completed by the physician and include the physician's NPI number. The CMN must have all the specific equipment that is being prescribed in field number 6. For repairs, list the specific device to be repaired.
- **Speech Language AAC Evaluation** is required. A 4-week trial of the device being requested is required and must be documented in the Speech Language AAC Evaluation prior to submitting for purchase. The AAC evaluation report must also list 3 devices that were tried and reasons as to why they were ruled out.
- **Face-to-Face Notes** within 90 days or less before Rx and CMN are required to be submitted.
- **Equipment Quote** is required.
- **Place of Service Requirements** will not cover if client lives in a skilled nursing facility or receives hospice services.
- **No diagnosis or age exclusions.**

Return to Table of Contents

Commercial Insurance in South Carolina

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Blue Cross Blue Shield of South Carolina*

South Carolina School Information

Contracts greater than $50,000 must be awarded by competitive sealed bidding. A contract may be awarded for a supply without competition if it is determined in writing that there is only one source for the required supply.

Appeals

We recommend following each payer's criteria to avoid denials. South Carolina Medicaid criteria for AAC devices can be found here.

If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

South Dakota Funding

Quick Facts

Mounting

Are there mounting restrictions in South Dakota?

- No.

Software

Is additional software covered?

- Based on medical necessity.

Hardware

Does the funded device need to be dedicated?

- Yes. Need a dedicated device letter.

Trials

Does Medicaid require a trial?

- No.

State Specific Documentation Requirements

Who can sign the Rx?

- MD/DO, PA, and NP can all sign Rx as long as they have a NPI.

Does the medical diagnosis need to be stated on the Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx will needs to be listed, but no specific Dx preferred.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial required.

Return to Table of Contents

South Dakota Medicare Advantage

There are between 7 and 20 plans available in South Dakota depending on county. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- HealthPartners
- Humana
- Medica
- United Healthcare

South Dakota Medicaid Information

Medicaid Managed Care Organizations (MCOs)

South Dakota is not currently utilizing managed care plans.

South Dakota Medicaid Requirements

Below are documents and requirements necessary to meet South Dakota's Medicaid criteria.

- **Prior Authorization Request Form** is required.
- **Speech Evaluation** must be completed by a licensed Speech Language Pathologist (SLP) and co-signed by the ordering physician that signs the prescription.
- **Prescription Form** must be signed by the physician and include Face-to-Face visit notes.
- **Face-to-Face Visit Notes** are required.
- **Equipment Quote** is required.
- **No trial required.**
- **Place of Service Requirements** will not cover durable medical equipment if client is living in an inpatient hospital or receiving hospice services.
- **No age or diagnosis exclusions.**
- South Dakota Medicaid **will not cover device carrying cases** (transportation bags).

Commercial Insurance in South Dakota

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Wellmark Blue Cross Blue Shield of South Dakota*

Return to Table of Contents

South Dakota School Information

Bids are required for purchases over $25,000. Sole source procurement can be used when only one source is available.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Tennessee Funding

Quick Facts

Mounting

Are there mounting restrictions in Tennessee?

- No universal mounts for Amerigroup.

Software

Is additional software covered?

- Yes, justify in report.

Hardware

Does the funded device need to be dedicated?

- Yes. TennCare (also known as Bluecare) requires this to be stated in report for all devices.

Trials

Does Medicaid require a trial?

- Tennessee does not have straight Medicaid, everything is an MCO. Trial requirements differ by MCO.

State Specific Documentation Requirements

Who can sign the Rx?

- MD/DO only.

Does the medical diagnosis need to be stated on the Face-to-Face (F2F) notes?

- No.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- All 3 TN MCOs require prior authorization.
- Trial requirements depend on MCO.

Return to Table of Contents

Tennessee Medicare Advantage

There are between 13 and 35 plans available in Tennessee depending on county. Plan rules vary by carrier but will cover at least as much as Traditional Medicare.

- Aetna
- Amerigroup
- American Health Advantage
- Apex Health
- Blue Cross Blue Shield of Tennessee
- Bright Health
- Cigna
- Clover Health
- Humana
- United Healthcare
- WellCare

Tennessee Medicaid Information

Tennessee does not have any straight Medicaid; it exclusively operates through Managed Care Organizations MCOs. Each MCO has its own specific requirements. Below are documents and requirements necessary to meet each organization's criteria:

Tenncare Select/Bluecare

- **Prescription** from physician is required.
- **Face-to-Face Visit Notes** are required.
- **Equipment Quote** is required.
- **No formal trial is required** before purchase, but 3 devices need to be ruled out.
- **AAC Evaluation** by Speech Language Pathologist (SLP) must include the following information:
    - Billable ICD-10 medical and speech diagnosis with dates of onset;
    - Severity and expected course of impairment;
    - Vision and hearing abilities;
    - Language skills and cognitive skills that describe and are functional for use of an SGD;
    - Communication needs and goals;
    - Rule out of ability to use gestures, writing, and non-electronic options to meet daily communication needs and goals;
    - Family/caregiver support for use of device;
    - Ability to reliably respond to yes/no questions (can be via head nods or gestures);
    - A training plan and schedule which includes frequency and duration;
    - Medical justification for accessories;
    - Statement about readiness and ability to communicate via pictures and words;
    - Statement that the device is going to be a **closed dedicated device** for use by the client only;

Return to Table of Contents

- SLP CCC credentials and ASHA number listed (if CF, must have CF supervisor signature and ASHA number).

Amerigroup

- **Prescription** from physician is required.
- **Face-to-Face Visit Notes** are required.
- **Equipment Quote** is required.
- **Trial with recommended device is required** and must include all of the following information:
  - Assessment trial outcome with recommended SGD demonstrating ability to use;
  - Duration of device trial, number of trials, length of sessions, and total duration in days is **required** for selected device;
  - Communication tasks evaluated during trials (initiation of communication, responding to questions, making requests);
  - Language function evaluated during trials (responding to greetings, expressing feelings, asking questions);
  - Type and number of symbols/words used in **each** device trial.
- **AAC Evaluation** by Speech Language Pathologist (SLP) must include the following information:
  - Billable ICD-10 medical and speech diagnosis with dates of onset;
  - Physiological description of the underlying disorder with description of functional limitations;
  - Severity and expected course of impairment;
  - Vision and hearing abilities;
  - Physical abilities described are suitable for an SGD;
  - History of any physical, occupational, and/or speech therapy;
  - Language ability to use selected device (including any formal or informal assessments);
  - Documentation of cognitive ability to use selected device, including a standardized assessment (if appropriate);
  - Daily specific communication needs, including number of words at baseline;
  - Expected functional communication goals with the device;
  - Rule out of ability to use gestures, speech, or writing;
  - Documentation that a non-electronic device will not meet communication needs;
  - Trial of recommended device must be included. See above for specific trial information that needs to be included;
  - Extent to which the client can independently navigate the device and date of anticipated independence;
  - Medical justification of accessories;
  - Treatment plan to coordinate with goals and a training schedule with frequency and duration;
  - Plan of care must include programming and training with family/caregiver and re-evaluation/re-assessment to determine continued needs of client;
  - Statement that the device is going to be a **closed dedicated device** for use by the client only;

Return to Table of Contents

  - A statement that the device is capable of modification to meet learning potential is required for pre-literate clients;
  - SLP CCC credentials and ASHA number listed (if CF, must have CF supervisor signature and ASHA number).
  - If patient had a previous device, must explain the functional benefit of an upgrade, including name of device with manufacturer, year it was purchase,d an dwho funded it.

United Healthcare (Medicaid managed and commercial)

- **Prescription** from physician is required.
- **Face-to-Face Visit Notes** are required.
- **Equipment Quote** is required.
- **AAC Evaluation** by Speech Language Pathologist (SLP) must include the following information:
  - Billable ICD-10 medical diagnosis;
  - Severity and expected course of impairment;
  - Vision and hearing abilities;
  - Physical abilities;
  - Language skills and cognitive abilities;
  - Detailed description of why client's needs cannot be met using no-tech or low-tech modes of communication/treatment;
  - Rule out of natural modes of communication;
  - Rational for selection of device;
  - Assessment trial outcome with recommended SGD demonstrating ability to use (including number of trials, types of trials, and length of trials);
  - Least costly SGDs ruled out;
  - Rationale for accessories;
  - Rule out standard input for alternate input devices (e.g. eye gaze);
  - Treatment plan and training schedule that coordinates with goals;
  - Statement that speech impairment will benefit from use of selected device;
  - SLP CCC credentials and ASHA number listed (if CF, must have CF supervisor signature and ASHA number).
  - If the device is a replacement or upgrade, must include information about previous device (name, manufacturer, date of purchase, who funded it) and statement that it is not functional.
- **Trial** is not required for Medicaid MCO, but a 3-month trial is required for commercial insurance.

Commercial Insurance in Tennessee

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*

Return to Table of Contents

- Humana*
- United Healthcare*
- Tricare*
- Blue Cross Blue Shield Tennessee/TennCare*

Tennessee School Information

Bids are required for contracts for goods greater than $10,000. Sole source purchasing can be utilized when only one vendor possesses the unique and singularly available capability to meet the requirement of a solicitation.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

- **Katie Beckett Waiver**: can be used to pay for copays or the entire device.

Return to Table of Contents

Texas Funding

Quick Facts

Mounting

Are there mounting restrictions in Texas?

- It depends on the MCO. Not a rate reimbursement as far as Texas, but TMHP guidelines specifically state that End User can do a wheelchair or desk mount, but not a floor mount (in their criteria). Some MCOs follow this criteria exactly.
- For United Healthcare, you must do a universal mount if you want a floor mount. They will deny your mount as not covered. You could also do a wheelchair and floor mount or desk and floor mount.
- Wellpoint only covers E2512 every 2 years. Texas also has the criteria that the first mounting system is included in the funding of the device.
- TX Blue Cross Blue Shield does not allow universal mounts

Software

Is additional software covered?

- No.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial? If so, how long?

- Yes. Medicaid requires a 90 day trial, but can be cancelled after 30 days of a successful trial.
- The 90-day trial requirement can be waived if the SLP fills out a TX Medicaid Trial Addendum.

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- Except for Community First Health Plan of TX, all other MCOs must trial with the recommended device or a similar device. Trial is not required for previous device users.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- For MCO plans, a Title 19 form is required to be filled out by the physician/practitioner.

Who can sign the Rx?

- MD/DO and PA can sign.

Return to Table of Contents

- NP needs to have prescription rights to sign Rx.

Does the medical diagnosis need to be stated on the Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx should be on F2F, but no preferred Dx's.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial required.

Texas Medicare Advantage

Texas has good Medicare Advantage plan coverage. All counties have at least 5 plans, some have over 30. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

Texas Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Texas has several managed care plans throughout the state.

Participating:

- Aetna Better Health of Texas
- Wellpoint
- Children's Medical Center Health Plan (CMCHP)
- Cook Children's Health Plan
- FirstCare Health Plan
- Parkland Community Health Plan
- Superior Health Plan of Texas
- Texas Children's Health Plan
- United Healthcare Community Plan
- El Paso Health Plan

In Process:

- WellCare of Texas
- Dell Children's Health Plan
- CHRISTUS Health Plan
- Sendero Health Plan
- Seton Healthcare Family

Texas Medicaid Requirements

Below are documents and requirements necessary to meet Texas' Medicaid criteria.

- **Face-to-Face Clinicals** are required for device funding.
- **Equipment Quote** is required.

Return to Table of Contents

- Title XIX DME/Medical Supplier Physician Order Form must be completed, signed, and dated by the physician. Form must list the prescribed augmentative communication device (ACD) system, access device, and accessories (such as mounting device). This form must be completed for clients with Texas Medicaid Managed Care Organizations (MCOs) except Children with Special Health Care Needs (CSHCN).
- **Prescription** must be signed by the physician and list the specific speech generating device (SGD) and accessories being prescribed. A prescription is required in addition to the signed Prior Authorization form. Note: the copy cannot have a Void or illegal watermark appearing on it when we receive it.
- **AAC Evaluation/Re-evaluation** must document the comparison of 3 SGDs. A 3-month trial is required of the recommended SGD prior to purchase (see additional details below). Include a training plan for the recommended SGD in the AAC Evaluation. If a wheelchair mount is being requested, include the make, model, and original purchase date of the wheelchair in the evaluation. Note: If physician signs the evaluation, Texas Medicaid and MCOs do not require a separate prescription, just the Title XIX DME Form and signed evaluation.
- **3-Month Trial Period** that includes experience with the requested system is required to authorize SGD for purchase. This trial period may be cancelled after 1 month if the client shows that they can functionally use the device. The SLP can write a short addendum showing that it is their clinical judgement that the client has demonstrated functional abilities and they support the direct purchase of the device after 1 month of trial. A trial period is not required when replacing an existing SGD, unless the clients needs have changed and another system is being considered.
- **Place of Service Requirements** will not cover if client is living in a nursing facility, hospital, or intermediate care facility.
- **No diagnosis or age exclusions.**
- CSHCN Services Program Prior Authorization Request for ACDs Form F00052 is required for clients with CSHCN insurance. The Title XIX forms are not needed for this MCO.
- ACD systems, equipment, and accessories that have been purchased are anticipated to last a minimum of 3 years.
- **The Specialized Telecommunications Assistance Program (STAP)** is a voucher program that provides financial assistance to Texans with disabilities that interfere with access to the telephone networks for the purchase of specialized assistive equipment or services. The type of devices available under the STAP program are listed on their website under “Vouchers and Values.” The STAP Application is also available on their website. Please check with your Tobii Dynavox consultant for specific communication devices that qualify for this program.

Commercial Insurance in Texas

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*

Return to Table of Contents

- United Healthcare*
- Tricare*
- Blue Cross Blue Shield of Texas

Texas School Information

All school district contracts valued at $50,000 or more for each 12-month period must use one of the following methods:

- Competitive proposal
- Request for proposal
- Interlocal contract

For something to qualify as sole source under the Texas Education Code, there must be no other like items available for purchase that would serve the same purpose or function. Under this code, Tobii Dynavox products do not meet the Texas sole source requirements.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

- All MCO plans must be appealed within 60 days from initial denial date.
- BCBS Texas and other private insurance companies must be appealed within 180 days from initial denial date.
- Patient consent form is required for all plans.

Return to Table of Contents

Utah Funding

Quick Facts

Mounting

Are there mounting restrictions in Utah?

- Universal mounts are okay.

Software

Is additional software covered?

- If justified in report.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial? If so, how long?

- Yes. 30-day/1-month trial minimum.

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- Needs to be with recommended device.

State Specific Documentation Requirements

Who can sign the Rx?

- MD/DO and PA can sign.
- NP only when in a collaborative agreement for one or more elements of NP Practice. The limit on independent practice only applies to NPs who have been in practice less than 3 years or 2,000 hours working as an NP, or who are working in a pain management clinic. If a NP has transitioned to solo practice, they can prescribe DME.

Does the medical diagnosis need to be stated on the Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- Dx should be on F2F, but no preferred Dx's. Should state primary reason client needs SGD.
- F2F should fall within 6 months of date Rx signed/date services start and should state.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial required.

Return to Table of Contents

Utah Medicare Advantage

There are between 1 and 19 plans available in Utah depending on county. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- Humana
- Molina
- Regence
- SelectHealth
- United Healthcare

Utah Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Utah is currently operating through the use of managed care plans, including:

- SelectHealth
- Molina of Utah
- Healthy U

Utah Medicaid Requirements

Below are documents and requirements necessary to meet Utah's Medicaid criteria.

- **Prior Authorization Request** is required and must include a treatment plan that states the following:
    - The expected duration of need for the device, and the amount, duration, and scope of any related services requested, how the device will enable the client to effectively meet his/her medical and basic functional communication needs;
    - Short and long term communication goals;
    - Criteria to be used to measure the client's progress towards meeting both short and long term goals;
    - Which service providers will be used and their expertise and experience in rendering services.

  The request must also include professional orders and assessments including:
    - A written order from a licensed physician documenting the device is medically necessary to correct an expressive communication disability.
    - A written assessment completed by a Utah licensed speech language pathologist (SLP). The assessment may be in conjunction with other licensed practitioners of the healing arts acting within their scope of practice, including physical and occupational therapists, if the client has physical limitations which may impact his/her ability to use the device.
- **Prescription** from treating physician is required.
- **Equipment Quote** is required.
- **30-day/1-month Trial Period** with recommended device is required.

Return to Table of Contents

- **Speech Evaluation** must follow Medicare guidelines and include written documentation of the client's medical diagnosis and significant medical history, including:
    - Previous treatment(s) of damaged, malfunctioning, or absent speech controlling mechanisms;
    - Visual, hearing, tactile, and receptive communication impairments or disabilities including prognosis, and the impact of the client's expressive communication, including speech and language skills and prognosis with and without the device;
    - Current communication abilities, behaviors and skills, and the limitations interfering with meaningful communication of medical and basic functional needs in current and projected daily activities;
    - Motor status, optimal positioning, and access methods and options (if any) for integration of mobility with the device.
    - Current and projected communication needs within the next 2 years.
    - Communication environments and constraints which impact device selection and features.

  The evaluation must also include a summary of the device proposed for the client, which describes:
    - Vocabulary requirements;
    - Representational systems;
    - Display organization and features;
    - Rate enhancement techniques;
    - Message characteristics, speech synthesis, printed output, display characteristics, feedback auditory and visual output;
    - Access techniques and strategies;
    - Portability and durability;
    - Type and significant characteristics and features of the device
    - Cost
- **Place of Service Requirements** may not cover some clients if they are living in a skilled nursing facility.
- **No diagnosis or age exclusions.**

Commercial Insurance in Utah

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Premera First Blue Shield*

Return to Table of Contents

Utah School Information

Bids are used when the cost is the most determinative factor in contracts exceeding $50,000. Sole source purchasing is available when there is only one source for the procurement item.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Vermont Funding

Quick Facts

Mounting

Are there mounting restrictions in Vermont?

- Universal mounts are okay.

Software

Is additional software covered?

- If justified in report.

Hardware

Does the funded device need to be dedicated?

- Yes. Standard documentation is fine. No additional documents needed.

Trials

Does Medicaid require a trial? If so, how long?

- Yes. Medicaid and all MCOs require a 4-week trial.

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- Recommended device is recommended for trial, but if software-only trial has already taken place, we can try moving forward.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial required.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- Vermont Evaluation Form (they will not accept E-Funding Reports).
- Medical Necessity Form.
- Ownership Agreement Form.
- Vermont Medicaid Prescription.

Who can sign the Rx?

- MD/DO, PA, and NP acceptable.

Return to Table of Contents

Vermont Medicare Advantage

There are between 11 and 13 plans available in each county of Vermont. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- United Healthcare
- MVP

Vermont Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Vermont utilizes a few MCO plans. Tobii Dynavox is in network with MVP Health Plan.

Vermont Medicaid Requirements

Below are documents and requirements necessary to meet Vermont's Medicaid criteria.

- **Durable Medical Equipment (DME) Ownership Form** is required.
- **Prior Acknowledgement Form** is required.
- Vermont Medicaid Prescription Form is required.
- Vermont Medical Necessity Form is required.
- Vermont Speech Evaluation Form is required. Vermont Medicaid will not accept E-Funding Reports.
- **Equipment Quote** is required.
- **4-Week Trial** is required.
- **Place of Service Requirements** will not cover speech generating devices if client is in a skilled nursing facility, hospital, or is receiving hospice services.
- **No diagnosis or age exclusions.**

Commercial Insurance in Vermont

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- MVP Health Plan*
- Blue Cross Blue Shield Vermont: **All BCBS VT plans have exclusions for SGDs.**

Vermont School Information

When the cost exceeds $15,000, bids are required for the purchase or lease of any item or items required for supply, equipment, maintenance, repair, or transportation of students. Vermont has a sole source exception when only one vendor can supply an item.

Return to Table of Contents

Appeals

We recommend following each payer's criteria to avoid denials. Vermont Medicaid criteria for speech devices can be found here.

If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Virginia Funding

Quick Facts

Mounting

Are there mounting restrictions in Virginia?

- Anthem Medicare or Commercial do not allow for universal mount. Anthem MCO does.

Software

Is additional software covered?

- Nothing specific mentions software in DMAS criteria. Only mention is 'Speech generating software program, for personal computer or personal digital assistant' (Must be for medically necessary communication device) would be covered.

Hardware

Does the funded device need to be dedicated?

- Yes

Trials

Does Medicaid require a trial? If so, how long?

- Yes. Medicaid states a 30-60 day trial is to be considered. Many MCOs adhere to a 30-day trial requirement. Trial date span needs to be included with sufficient trial data.

Does the trial need to take place with the recommended device, or is it OK to just trial the software?

- Virginia Medicaid allows a software trial on a similar device. Many MCOs require the trial to be on the recommended device.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- Virginia Department of Medical Assistance Services Certificate of Medical Necessity for DME and Supplies is required, unless Medicare is primary.

Who can sign the Rx?

- MD/DO, PA, and NP acceptable.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes?

- Primary medical diagnosis should be mentioned on F2F notes.

Return to Table of Contents

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization required, Medicaid follows primary MCR auth. Trial is recommended.

Virginia Medicare Advantage

All counties in Virginia have at least 2 plans available, some have over 20. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

Virginia Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Virginia has a wide range of managed care plans to choose from.

Participating:

- Aetna Better Health Virgnia
- Anthem
- In Total Health (a UHC plan)
- United Healthcare Community Plan
- Sentara Health PlanCoventry Health Plan

In Process:

- Molina Health Care of Virginia – No LOA required if accepting 100% of VA MCD fee schedule. No separate prior authorization needed if they are secondary.
- Sentara Healthcare

Virginia Medicaid Requirements

Below are documents and requirements necessary to meet Virginia's Medicaid criteria.

- Certificate of Medical Necessity (CMN) Form is required.
- **Speech/Language Evaluation** is required.
- **Prescription Form** is required. Medicaid requires that the client have a face-to-face examination with their physician no more than 6 months prior to the written order for the speech generating device (SGD). The physician must document that the client was evaluated and/or treated for a condition that supports the SGD. This documentation (chart notes or office visit notes) must be provided along with the written order for the SGD.
- **Equipment Quote** is required.
- **30-Day Trial** is required. DMAS criteria states this trial must be CONSIDERED, and arguments have been made for ALS clients to try and avoid the 30-day trial.
- **Place of Service Requirements** will not cover speech generating devices if client is living in a skilled nursing facility.

Return to Table of Contents

- No diagnosis or age exclusions.

The CMN, speech/language evaluation, and/or other verifiable supporting documentation must include all of the following:

- The complete practitioner's prescription for the augmentative communication device (ACD), including an itemization of the components (i.e. special switches, special mounting devices, etc.) required by the individual.
- Documentation describing the individual's medical condition/diagnosis, including a description of the individual's disease, general prognosis, and prognosis for intelligible speech.
- Documentation if the condition is permanent, temporary, or changing.
- Documentation to demonstrate if the medical condition will result in an increased or decreased need for a device in the future.
- A description of how the individual communicates medical needs now and how communication needs are currently met/unmet.
- Is the individual cognitively/physically able and motivated to use an ACD? Documentation must include an assessment of the individual's gross and fine motor skills (e.g. hand use skill, including finger dexterity).
- A description of related impairments including audio/visual, perceptual, and/or memory, that would limit the client's ability to use a device ,or that would require the use of a specific ACD.
- A description of the plan to provide ongoing speech language therapy and support in the use of the communication device in the individual's home and community; a list of other devices that have been tried by the individual (describe success/failure); a description of how the requested device better meets the individual's medical needs than more cost-effective devices available.
- A description of the extent to which the individual and/or family/caregivers are able to properly program and utilize the device.
- Specific information about the device including: the manufacturer's name, catalog number, product description, a photo (if available), and documentation of the provider's cost, less any discounts available.
- The speech language pathology documentation must show that the individual's ability to use the device is improving and that the individual is motivated to continue to use the device.
- If the communication device(s) supplied for the required 2-month rental period is new upon delivery, DMAS will consider paying the full purchase price listed in the DME Listing in addition to the initial 2-month rental period for these items.

Commercial Insurance in Virginia

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*

Return to Table of Contents

- United Healthcare*
- Tricare*
- Anthem Blue Cross Blue Shield/ Anthem Healthkeepers
- Virginia birth related neurological injury compensation program – a specific coverage, separate from Medicaid. Requires their own prior authorization but typically pay in full if they are the only insurance.

Virginia School Information

Formal bids or RFPs are required when the estimated cost is over $100,000. Sole source procurement is available upon determination that there is only one source practicably available, a contract may be negotiated and awarded to that source without competitive sealed bidding or competitive negotiation.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

- All MCO plans must be appealed within 60 days from initial denial date.
- Patient consent form is required.

Return to Table of Contents

Washington Funding

Quick Facts

Mounting

Are there mounting restrictions in Washington?

- No universal mounts; reimbursement rate low.
- Molina and Community Health Plan (OON LOA/SCA needed) can usually provide universal mounts.

Software

Is additional software covered?

- No restrictions.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial?

- No trial required, but evaluation should show that the client can use the device independently and show success during use.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- DSHS Form
- State specific prescription – evaluation prescription and device prescription (chronological order and within 30 days of eval order and eval report).

Who can sign the Rx?

- MD/DO, PA, and NP can all sign Rx.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- F2F on file only.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

Return to Table of Contents

- Medicaid does not require authorization when secondary to traditional Medicare and some Medicare replacements, like UHC. Medicaid does require authorization when secondary to Medicare HMOs like Humana, AARP, BCBS, Premera, Regence, etc.
- No trial required.

Washington Medicare Advantage

There are between 1 and 43 plans available in Washington depending on county. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- Amerigroup
- Asuris
- Community Health Plan
- Health Alliance
- Health Net
- Humana
- Kaiser
- PacificSource
- Premera
- Providence
- Regence
- United Healthcare
- WellCare

Washington Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Washington is currently operating through the use of some managed care plans, including:

- United Healthcare
- Coordinated Care
- Community Health Plan of Washington
- Amerigroup of Washington
- Molina of Washington

Washington Medicaid Requirements

Below are documents and requirements necessary to meet Washington's Medicaid criteria.

- **Prescription for Speech Language AAC Evaluation** must be written using form DSHS 13-794 or other written order from physician. Must be dated before the evaluation is started.
- Health and Recovery Services Administration Prescription Form (DSHS 13-794) must be completed on Washington Medicaid prescription form. Prescription should list the specific device and accessories. It should include the length of time the speech generating device is needed. (Note: Washington Medicaid will not accept "lifetime" as a proper length of time. "5+ years" would be an acceptable length of time.

Return to Table of Contents

- Speech Language Pathologist (SLP) Evaluation for Speech Generating Devices (DSHS 15-310) is required to be completed and signed by a licensed SLP. This form must be dated within 90 days of the prescription for the Speech Language AAC Evaluation and less than 60 days from the date Tobii Dynavox submits to Washington Medicaid. If a wheelchair mount is requested, the SLP must include the make, model, and serial number of the wheelchair in the Speech Language AAC Evaluation.
- **Face-to-Face Visit Notes** are required.
- **Equipment Quote** is required.
- **A trial is not required** before purchase with regular Washington Medicaid. Evaluation still needs to show that the client can use the device independently and show success during use.
- **Place of Service Requirements** will not cover if client is receiving hospice services.
- **No diagnosis or age exclusions.**

Commercial Insurance in Washington

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Premera First and Regence Blue Shield*

Washington School Information

Bids are required for procurements greater than $50,000. Sole source purchasing is an option when only one supplier is capable of delivering the required products.

Appeals

We recommend following each payer's criteria to avoid denials. Washington Medicaid criteria can be found here. Most managed care organizations follow Medicaid criteria for SGDs.

If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

West Virginia Funding

Quick Facts

Mounting

Are there mounting restrictions in West Virginia?

- No.

Software

Is additional software covered?

- Accessories for the speech generating device (e.g., operating system, Word core software, battery charger, mounting plate, built-in stand, vocabulary software, USB cable, 1 battery pack, and a standard 1-year warranty) are included with the initial placement of the device and cannot be billed separately. Accessories not included in initial placement (e.g., cables, battery pack, carrying case, and picture communication symbols) are billed separately.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial?

- No trial required, but a single session with the recommended device or software is suggested. WV Medicaid finds a software trial on an iPad acceptable.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- The West Virginia Certificate of Medical Necessity (CMN) is needed, and occasionally a cost calculation form for prior authorization.

Who can sign the Rx?

- MD/DO, and certified PAs and NPs are allowed to sign.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- No preferred diagnosis, F2F notes are always preferred to mention primary medical diagnosis at least.

Return to Table of Contents

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial is required.

West Virginia Medicare Advantage

There are between 13 and 23 plans available in West Virginia depending on county. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- Highmark
- Humana
- The Health Plan
- United Healthcare

West Virginia Medicaid Information

Medicaid Managed Care Organizations (MCOs)

West Virginia is currently operating through the use of managed care plans.

West Virginia Medicaid Requirements

Below are documents and requirements necessary to meet West Virginia's Medicaid criteria.

- **Prescription Form and** West Virginia Certificate of Medical Necessity (CMN) are required to be completed by the physician and include the physician's Medicaid provider number. Medicaid requires that the client have a face-to-face examination with their physician no more than 6 months prior to the written order for the speech generating device (SGD). The physician must document that the client was evaluated and/or treated for a condition that supports the SGD. This documentation (chart notes or visit notes) must be provided along with the written order for the SGD.
- **Speech Evaluation** must be completed by a licensed Speech Language Pathologist (SLP) following Medicare guidelines.
- **Equipment Quote** is required.
- **No trial is required**, but a single session with the recommended device or software is suggested. WV Medicaid finds a software trial on an iPad acceptable.
- **Cost Calculation** may be requested.
- **Place of Service Requirements** will not cover if client is in a skilled nursing facility.
- **No diagnosis or age exclusions.**

Commercial Insurance in West Virginia

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

Return to Table of Contents

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Highmark Blue Cross Blue Shield*

West Virginia School Information

Purchases greater than $10,000 will require the formal bidding process. Sole source purchasing is available when a commodity is available from only one source.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Wisconsin Funding

Quick Facts

Mounting

Are there mounting restrictions in Wisconsin?

- Universal mounts are okay, except under Anthem Plans.

Software

Is additional software covered?

- If justified in report.

Hardware

Does the funded device need to be dedicated?

- Yes.

Trials

Does Medicaid require a trial? If so, how long does the trial need to be?

- Yes. A 30-day minimum trial is required.

Does the trial need to take place with the recommended device or is it OK to just trial the software?

- It's okay to be trialed with software.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization is required, but a trial is.

State Specific Documentation Requirements

Are there any state-specific forms or documentation required for authorization?

- Certificate of Medical Necessity (CMN).
- Individualized Education Plan (IEP) for school aged children.

Who can sign the Rx?

- MD/DO, NP, or PA can all sign.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes?

- No diagnosis needs to be included, but F2F needs to state the need for a speech generating device. If the F2F does not include this information, Tobii Dynavox will request a detailed Letter of Medical Necessity (LMN) from the physician.

Return to Table of Contents

Wisconsin Medicare Advantage

Each county of Wisconsin has between 9 and 35 Medicare Advantage plans available. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- Anthem Blue Cross Blue Shield
- Dean Advantage
- Health Partners
- Humana
- Medica
- Network Health
- Security Health Plan
- Senior Preferred
- Ucare
- United Healthcare

Wisconsin Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Wisconsin currently utilizes MCO programs. Tobii Dynavox is in network with the following:

- Inclusa
- Dean Health Plan
- My Choice Family Care
- Network Health
- SouthWest Family Care Alliance
- UHC Community Plan
- Wisconsin Physician Services
- Anthem Blue Cross Blue Shield of Wisconsin
- Lakeland Care District
- Care Wisconsin First
- Community Care of Wisconsin
- Community Health Partner

Wisconsin Medicaid Requirements

Below are documents and requirements necessary to meet Wisconsin's Medicaid criteria.

- **Prescription Form** is required. Medicaid requires that the client have a face-to-face examination with their physician no more than 6 months prior to the written order for the speech generating device (SGD). The physician must document that the client was evaluated and/or treated for a condition that supports the SGD. This documentation (chart notes or office visit notes) must be provided along with the written order for the SGD. The documentation of the visit must be a clearly titled, separate and distinct section of, or a clearly titled addendum to the prescription. The notes must contain:

Return to Table of Contents

  - Date of the face-to-face examination;
  - Name and credentials of the physician or NPP who conducted the face-to-face examination for the SGD;
  - Clinical findings that support the client's need for the SGD. **Must specifically state that the patient needs an SGD**. If not, Tobii Dynavox will request a detailed Letter of Medical Necessity from the physician;
  - Signature of prescribing physician or NPP that conducted the face-to-face examination.
- **Letter of Medical Necessity (LMN)** will be required if Face-to-Face (F2F) notes are not sufficient. Physician will need to sign the LMN.
- **Speech Evaluation** with trial data is required. Evaluation should include the following information:
  - The medical status and medical diagnosis underlying the client's expressive speech language disorder.
  - Current expressive speech language disorder, including the type, severity, anticipated course of the disorder, and present language skills.
  - Functional receptive language abilities and functional expressive language with an attention to task of 5 minutes. How do you predict this will impact the ability to use the device? A description of the client's current aided and unaided modes of communication. How does the client express the intent to communicate?
  - The alternate forms of therapy/intervention that have been considered and ruled out.
  - The rationale for the recommended ACD system and each accessory, including a statement as to why the recommended device is the most appropriate, least costly alternative for the client and how the recommended system will benefit the client.
  - Documentation that the client possesses the cognitive and physical abilities to use the recommended system. The client's cognitive age should be listed in the SLP evaluation. This can be the receptive language age.
  - A comprehensive description of how the ACD system will be integrated into the client's everyday life, including home, school, or work.
  - A treatment plan that includes training in the basic operation of the recommended ACD system necessary to ensure optimal use by the client and, if appropriate, the client's caregiver, and a therapy schedule for the client to gain proficiency in using the ACD system.
  - A description of the client's speech language goals and how the recommended ACD system will assist the client in achieving these goals.
  - The augmentative communication evaluation should list the least costly alternatives with an explanation of why the requested device is the most effective and economical alternative to meet the beneficiary's communication needs. Requests that do not indicate the reason why a less costly device is not appropriate will likely be denied.
  - Identification of the assistance/support needed by, and available to, the client to use and maintain the ACD system.
  - A statement that the SLP is financially independent of the ACD system manufacturer/vendor.

Return to Table of Contents

- **PA/DMEA Form** is required. Tobii Dynavox will complete this form.
- **Individualized Education Plan (IEP)** is required for school aged children.
- **Equipment Quote** is required.
- **No diagnosis, age, or place of service exclusions.**
- **4-Week Trial** is recommended. Trial data should include the following information:
    - How long the trial period was.
    - Specific examples across environments of when and how the device was used by the client.
    - Level of client motivation and appeal of reinforcement. How did this affect the use of the device during the trial period?
    - How many hours per day was the device used during the trial period? How did the client demonstrate communicative intent with the device? At school? At home? In the community?
    - What kind of support is required? Describe the primary caregiver's ability to use this specific device in the home and community environment. How much training will be required for the parent/caregiver to maintain and upkeep the device?
    - Provide specific examples of how the device was used in various environments and what the client was able to communicate.
    - If the client is a child, does the use of the device improve communication with peers and/or siblings? Did the parents or staff notice any communication barriers improving? Is the school staff supportive and will they be integrating the device into daily activities for the child? Are the parents encouraging the child to use the device to communicate at home? Does the IEP also show support of the device? If the IEP reports significant motor planning needs, such as hand-over-hand assistance, how would this affect independent use of the device? Will IEP goals change based on the use of the device?

Commercial Insurance in Wisconsin

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*
- Anthem Blue Cross Blue Shield of Wisconsin*
- Dean Health Plan*
- Health Partners*
- Homelink/GEHA*

Wisconsin School Information

Purchases above $100,000 must be obtained with publicly solicited bids. Sole source purchasing is available when an item is available only from a single source.

Return to Table of Contents

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents

Wyoming Funding

Quick Facts

Mounting

Are there mounting restrictions in Wyoming?

- No.

Software

Is additional software covered?

- Based on medical necessity.

Hardware

Does the funded device need to be dedicated?

- No.

Trials

Does Medicaid require a trial?

- No.

Medicare/Medicaid Cases

In cases where the customer has Medicare and Medicaid coverage, is an authorization from Medicaid required? A trial?

- No authorization or trial is required.

State Specific Documentation Requirements

Who can sign the Rx?

- MD/DO, PA, and NP can all sign Rx.

Does the medical diagnosis need to be stated on Face-to-Face (F2F) notes? Are there preferred medical diagnoses that should be used?

- F2F needs to be within 6 months of Rx signature and service date.

Return to Table of Contents

Wyoming Medicare Advantage

There are between 1 and 3 Medicare Advantage plans available in each county of Wyoming. Plan rules vary by carrier, but will cover at least as much as Traditional Medicare.

- Aetna
- United Healthcare

Wyoming Medicaid Information

Medicaid Managed Care Organizations (MCOs)

Wyoming is not currently utilizing managed care plans.

Wyoming Medicaid Requirements

Below are documents and requirements necessary to meet Wyoming's Medicaid criteria.

- **Speech Evaluation** is required.
- **Prescription** is required.
- **Face-to-Face Notes** are required.
- **No place of service exclusions.**

Commercial Insurance in Wyoming

Tobii Dynavox is contracted with all payers noted with a *. We are continually working to expand our network of insurance companies.

- Aetna*
- Cigna*
- Humana*
- United Healthcare*
- Tricare*

Wyoming School Information

Districts must get competitive bids for purchases between $10,000 and $25,000 and RFPs for purchases above $25,000. Sole source procurement occurs only when the goods or services are available from only one manufacturer through only one distributor or supplier.

Appeals

We recommend following each payer's criteria to avoid denials. If you encounter a denial, we have a dedicated team that will walk you through the appeals process.

Return to Table of Contents