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Health Benefits Program Funding of Speech Generating Devices

Frequently asked follow-up questions from the December 2005 AAC-RERC webcast

Presenter: Lewis Golinker, Esq., Director, Assistive Technology Law Center, Ithaca, New York

SLP Report Obligations

Why Do Funding Reports Have to Say So Much?

The web-cast outlined the SLP role in SGD funding, including preparation of an assessment report and recommendation. Reports supporting SGDs funding requests to health based funding program are between 6-10 pages long. The web-cast implied the length of these reports has remained fairly consistent over time, and does not vary much from one health based funding program to another.

OK, fine. Even if all health based funding programs adopted a uniform reporting format, why must they be so long?

No one reason will answer this question. At least 4 reasons supply parts of the answer. Before listing them, I will concede that "reasons" or "explanations" may not suffice as "justifications." For some SLPs – perhaps many -- no reason or explanation is needed and no justification will suffice. To them, the reports are just too burdensome and any attempt to explain them, or worse, to justify current reporting requirements is an insult. What is necessary instead is a major effort to reduce the reporting demands, so they are less complex, shorter, and less time consuming to prepare.

I have only a partial answer to this demand, which I explain below.

The 4 most likely reasons to explain the SLP reporting requirement for SGD funding are:

- history;
- the absence of a definitive test for SGD need;
- the absence of any test of SLP expertise; and
- the absence of a competing model.

SLP reports are multi-topic, multi-page documents in part because that is how they always have been written. In the late 1970s and early 1980s, when AAC device funding began, SLPs wrote detailed reports covering many topics and filled many pages as a way of introduction. At that time, the task before those SLPs was extensive.

- SLPs had to explain who they were: at that time, SLPs were not professionals who submitted requests seeking prior authorization for durable medical equipment. Artificial larynxes were covered by health based funding programs, but they were a very rarely sought device. They also were covered most often as a prosthetic device, which may have been reviewed by different staff. Funding source staff responsible for DME items had no idea who SLPs were, or what or why or how they did their job. A long report was a way of promoting SLP credibility.

- SLPs also had to explain how the then-prevailing "wisdom" about people with severe communication disabilities was wrong: that these clients were not "beyond help," but instead could receive effective treatment through the use of an AAC device.
- SLPs had to introduce funding program staff to an entirely new class of devices. This introduction was necessary because the devices do not offer a cure, they do not treat underlying impairments, and they are expensive.
- SLPs had to explain how they determined a client was appropriate for one of these devices, a determination not based on any specific test result, but based on clinical judgment. And,
- SLPs had to explain how and why this class of equipment, which produced speech "for" a client, will serve a medical purpose and be medically necessary regardless what was being said, or to whom.

With so much to explain, it should not be surprising that these first letters were long and detailed.

OK, that was then. Why does history matter? Why must reports still be so long, 20 years or more after those first funding requests were submitted?

There have been many changes in the content of SLP reports over the years. Because "coverage" and "medical need" are no longer controversial issues among health based funding programs, the SLP report need not address these points expressly. Instead, the SLP report can focus on the description of the client evaluation and the SLP's conclusions. Also, reporting has become much more standardized: almost all programs now have SGD clinical criteria, and almost all of these criteria are consistent with or modeled after the SLP assessment stated in the Medicare RMRP for SGDs. That outline was designed by SLPs – it is not as if the funding sources are imposing onerous requirements based on their own imaginations.

Equally important: SLP reporting remains so similar to what always has been required because SGDs are such a low volume item and there is little incentive for funding program staff to devote much energy to change the status quo. There also are no competing models with origins in any AAC or SLP organization. SLPs may not like having to write long reports, but where is the proposed substitute?

If we have to live with the current reporting requirements, is there anything we can do or use to make their preparation less burdensome?

SLPs can affect their report writing burden in two ways: time and money. When surveyed, some SLPs report outrageous lengths of time needed to prepare their reports. While it is possible to spend hours and hours in report writing, it most certainly is not necessary. A complete report can be produced quickly and efficiently.

There are at least 2 "tools" that SLPs can use to reduce the time needed to prepare their reports. One is called the AAC Report Coach, which was designed by Pam Mathy, Ph.D., SLP clinical director at Arizona State University. It is an on-line report template that allows the SLP to prepare a complete, personalized narrative report without extensive writing. For facts that have a narrow range of choices, such as the description of the client's communication impairment diagnosis, the AAC Report Coach allows the SLP to choose from pull-down menus. For other client-specific facts, the SLP is instructed where to fill in blanks with facts gathered during the assessment process. When complete, the AAC Report Coach will generate a report that will satisfy the Medicare funding process. The AAC Report Coach is

available without charge, from lgolinker@aol.com. Shortly, it will be posted and available to all at www.aacfundinghelp.com. Another similar tool, also available for free, is called the Funding Manager, which is available at www.dynavoxsys.com.

Another reason to rely on a template for report writing is their ability to help reduce if not eliminate one of the most common factors causing funding delays and SLP frustration: communication from the manufacturer's funding staff, or the funding program's staff that something is missing and additional information is required. By using a template, SLPs can have greater assurance that everything that needs to be reported is reported – the first time.

A second way SLPs can reduce the time required to get a client a device is to avoid trial periods unless they are absolutely necessary. Trial period multiply the amount of time the SLP has to assess the client and often requires multiple client visits, multiple reports, multiple requests for prescriptions, and follow up reporting. And, what's the point: in almost every cases, the device used during the trial is then recommended for purchase. That suggests the *initial* recommendation could just as well have been for purchase, avoiding the trial all together. SLPs should be much more vigorous in opposing funding program demands for trial periods, and should voluntarily engage in trial periods only when they are absolutely necessary.

Regarding money, SLPs complain that the time required to prepare a report is unpaid, and therefore, report writing competes with other job related obligations and for employers, it competes with other revenue generating activities. But this is not a requirement of the funding programs. One way to approach this question is to ask whether the time spent in report writing can become paid time? The answer is yes.

For Medicare, for example, SGD assessment is a timed activity. If the SLP prepared the report during the clinical assessment – as s/he went along – then this time could be reimbursed. For Medicare, after the first hour, each additional 30 minute period is reimbursed poorly, but it is reimbursed. No one is going to get rich on these fees, but isn't something for one's time better than nothing?

To make this work, the SLP must rely on a template that can be filled in as the assessment progresses. Many doctors' offices now have computers in client examination rooms where clinical notes are typed while the patient is present. SLPs can do the same thing.

Can time and money also be saved by avoiding common reporting mistakes?

Yes. The most common SLP reporting mistake is a failure to explain sufficiently the SLP's consideration of device alternatives. First, every SLP report must state a recommendation of a specific model of SGD, not just the HCPCS code, which describes certain device characteristics. Funding programs are not authorized to choose the model –the SLP's job is to make a recommendation and the doctor's job is to prescribe a specific model – something that can then be ordered. Because there are multiple models in every code, which have different features, and different functional characteristics among common features, the SLP errs if the report does not produce a model-specific recommendation.

In addition, the SLP errs when insufficient attention is paid to consideration of alternatives. Alternatives can be approached 2 ways. First, the SLP can report how specific codes are ruled out. For example, if a client is able to formulate his or her own messages independently, rather than just make selections of pre-stored, complete messages, then all the digitized devices – all 4 codes – can be ruled out. No identification or discussion of any specific model in any of these codes is required. Then, by stating the client is not most efficient at spelling and typing, or the client will not access the device by direct selection, the type-writer or

keyboard based devices (HCPCS E 2508) also have been ruled out. This leaves only one code, E 2510, and here, comparisons of specific models is appropriate. These devices should be compared on the basis of operating software, which differs significantly among the models, hardware features and functioning, support, and cost.

A reference that can aid in this process is found in the *Formal Request* submitted to Medicare in late 1999. The proposed key clinical indicators stated in that document provide one sentence ways to rule out the various codes. The *Formal Request* is posted for review at www.augcominc.com/funding.htm.