

Ohio Department of Medicaid
**CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
 SPEECH GENERATING DEVICE (SGD)
 INITIAL CERTIFICATION**

Name of Provider _____
Provider NPI # _____
Medicaid Legacy # _____

Instructions: The Certificate of Medical Necessity (CMN) must be used for speech generating devices under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of Consumer	Billing Number
<input type="checkbox"/> Trial/Rental period	<input type="checkbox"/> Purchase
Date of Birth	

Section A - Must be completed by Prescriber

Diagnosis (ICD-9 Code and Description)	Consumer's Diagnosis/Prognosis
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Include consumer's name on all attachments.

Section B - OT/PT Assessment of consumer

Explain if OT/PT Assessment NOT warranted.

Motor function (range of motion, tone, active motion).

Postural/positioning.

Mobility status.

Integration of mobility and positioning with the SGD.

OT/PT Signature (<i>No stamps</i>)	Date	License #
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Section C - Cognitive status assessment

Explain if Cognitive status assessment is not warranted.

Estimate of developmental and intellectual age or range.

Describe method of assessing cognitive status.

Document consumer's most recent cognitive assessment (*done by speech-language pathologist*).

Section D - Sensory Status (Describe assessment methods)

Explain if Sensory Status is not warranted.

Visual abilities.

Auditory abilities.

Section E - Speech, language, and communication status

Specific description of communications disability, including speech diagnosis.

Speech skills and prognosis.

Language skills: expressive and receptive.

Description of communication behaviors and interaction skills.

Description of consumer's use of current SGD, if applicable. *(Include date current SGD acquired by consumer).*

Emotional status as it relates to communication.

State why current communication behaviors prevent the consumer from communicating basic needs.

Identify primary communication partners (family members, caregivers, etc.) and any associated limitations and needs.

Message needs (pragmatics).

Vocabulary (*semantics*).

Communication environments. *(Include description of vocational and education status).*

Section F - SGD Assessment

A. Assessment of consumer's needs

1. Representational systems (*symbol system*)

2. Vocabulary encoding (*i.e., minkspeak, levels plus location, traditional orthography, etc.*).

3. Vocabulary expandability and message generation (*i.e., pre-programmed, fully programmable, combination of pre-programmed and programmable, additional memory, messages stored as letters, words, phrases, sentences, etc.*).

4. Rate enhancement techniques (*i.e., simple symbol selection, symbol sequencing, key linking, dynamic displays, abbreviation-expansion, word lists, word prediction, icon prediction, minsets, macros, etc.*).

5. Access techniques and strategies.

6. Overlay or keyboard organization and features (*i.e., key size, keys per overlay, spacing between keys, overlay size, keyguard, multiple location overlay, etc.*).

7. Device output modes (*i.e., speech synthesis, printed output, display characteristics, auditory and visual prompting, auditory and visual feedback, etc.*).

8. Portability concerns.

(Attach product description information, as needed.)

B. Comparison of SGD specifications

1. List specifications for the SGD that most effectively and efficiently meets the consumer's basic communication needs.
2. Document why nonrequested comparable SGDs were considered to be inappropriate to meet the consumer's basic communication needs and capabilities.

3. If a higher tech SGD requested, document why a lower tech SGD is inadequate.

Section G - Treatment plan and follow-up

Short and long-term communication goals.

Individual speech-language pathologist and/or organization/facility responsible for SGD training.

Necessary modification of SGD to suit the individual consumer's access needs.

Schedule for evaluating the outcome of the trial use period. (Must be used when requesting authorization for rental during a trial use period).

Section H - Prescription for SGD

Name of Requested SGD

List all required components, accessories, peripheral devices, supplies.

Device vendor(s)

Signatures/Dates

Equipment Vendor <i>(Print)</i>	Vendor Signature/Date
Name/title of Speech-Language Pathologist <i>(Print)</i>	Signature/Date
Date of Assessment	License #

Prescriber Attestation and Signature/Date

Prescriber's Name *(Printed)*

I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber Signature <i>(No stamps)</i>	Date	Ohio Medicaid Prescriber #
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