Prior Authorization Review
Panel MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

<table>
<thead>
<tr>
<th>Plan: Aetna Better Health</th>
<th>Submission Date: 11/01/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Number: 0437</td>
<td>Effective Date:</td>
</tr>
<tr>
<td></td>
<td>Revision Date:</td>
</tr>
<tr>
<td>Policy Name: Speech Generating Devices</td>
<td></td>
</tr>
</tbody>
</table>

Type of Submission – Check all that apply:
- [ ] New Policy
- [x] Revised Policy*
- [ ] Annual Review – No Revisions

*All revisions to the policy must be highlighted using track changes throughout the document. Please provide any clarifying information for the policy below:

CPB 0437 Speech Generating Devices

Clinical content was last revised 07/17/2015. Additional non-clinical updates were made by Corporate since the last PARP submission, as documented below.

Revision and Update History since last PARP submission:
08/22/2018 - This CPB has been updated with additional background information and references.
04/25/2019 – Next tentative scheduled review date by Corporate.

Name of Authorized Individual (Please type or print):
Dr. Bernard Lewin, M.D.

Signature of Authorized Individual:

[Signature]

www.aetnabetterhealth.com/pennsylvania Updated 08/22/2018
Policy

I. Aetna considers speech generating devices (SGDs) as medically necessary durable medical equipment (DME) for members who meet all of the following criteria:

A. 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 formal, written evaluation must include, at a minimum, all of the following elements:

1. A description of the functional communication goals expected to be achieved and treatment options; and
2. A treatment plan that includes a training schedule for the selected device; and
3. An assessment of whether the individual's daily communication needs could be met using other natural modes of communication; and
4. Demonstration that the member possesses the cognitive and physical abilities to effectively use the selected device and any accessories to communicate; and

*Please see amendment for Pennsylvania Medicaid at the end of this CPB.
5. Evaluation of current communication impairment,
   including the type, severity, language skills,
   cognitive ability, and anticipated course of the
   impairment; and
6. For a subsequent upgrade to a previously issued
   SGD, information regarding the functional benefit to
   the member of the upgrade compared to the initially
   provided SGD; and
7. Rationale for selection of a specific device and
   accessories;
   and

B. A copy of the SLP's written evaluation and
   recommendation have been forwarded to the
   member's treating physician prior to ordering the
   device; and
C. Other forms of treatment have been considered and
   ruled out; and
D. The member's medical condition is one resulting in a
   permanent severe expressive speech disability,
   including, but not limited to, anarthria, aphasia,
   aphonia, apraxia or dysarthria; and
E. The member's speaking needs can not be met using
   natural communication methods; and
F. The member's speech disability will benefit from the
   device ordered; and
G. The SLP performing the evaluation of the member
   may not be an employee or have a financial
   relationship with the supplier of the SGD.

II. Aetna considers SGDs experimental and
    investigational when criteria are not met.

Accessories and upgrades for the SGD are considered
medically necessary if the basic medical necessity criteria are
met and the medical necessity for each accessory is clearly
documented in the formal evaluation by the SLP.
Other medically necessary features of the device include the capability to generate email, text, or phone messages to allow the member to “speak” or communicate remotely, as well as the capability to download updates to the covered features of the device from the manufacturer or supplier of the device.

Only 1 SGD or speech generating software program at a time is considered medically necessary per member.

Multi-lingual modules for SGDs are considered not medically necessary.

**Notes:**

As long as the speech-generating device is limited to use by a person with a severe speech impairment and is primarily used for the purpose of generating speech, it is not necessary for a speech-generating device to be dedicated only to speech generation to be considered DME. Desktop computers, laptop computers, pagers, personal digital assistants (PDAs), portable multi-media players (e.g., iPod), smart phones, and tablet devices (e.g., Galaxy, iPads, Kindle), or other devices that are not dedicated SGDs are not covered because they do not meet the definition of DME because they are useful in the absence of illness and injury. Please check benefit plan descriptions for details.

Software that enables a laptop computer, desktop computer, or PDA to function as a SGD is considered an SGD; however, installation of the program or technical support is not separately reimbursable.

There should be no separate billing of any software, interfaces, cables, adapters, interconnects, and switches necessary for the accessory to interface with the SGD.
Internet or phone services or any modification to a member's home to allow use of the speech generating device are not covered because such services or modifications could be used for non-medical equipment such as standard phones or personal computers. In addition, specific features of a speech generating device that are not used by the individual who has a severe speech impairment to meet his or her functional speaking needs are not considered medically necessary. This would include any computing hardware or software not necessary to allow for generation of audible/verbal speech, email, text or phone messages, such as hardware or software used to create documents and spreadsheets or play games or music, and any other function a computer can perform that is not directly related to meeting the functional speaking communication needs of the patient, including video communications or conferencing.

Note:

SGDs, as described above, are considered medically necessary regardless of whether the plan has an exclusion for "communication aids." Communication aids that are not SGDs are not covered under plans that exclude communication aids. Please check benefit plan descriptions for details.

Note:

This CPB does not apply to electronic speech aids that are used by laryngectomized persons and persons with a permanently inoperative larynx. These are considered prosthetics. There are 2 types of electronic speech aids. One operates by placing a vibrating head against the throat. The other amplifies sound waves through a tube which is inserted into the user's mouth. A person who has had radical neck surgery and/or extensive radiation to the anterior part of the neck would generally be able to use only the "oral tube" model or one of the sensitive and more expensive "throat contact" devices.
Background

This policy is based on Medicare DME MAC criteria for speech generating devices (SGDs). Speech generating devices (SGDs), also known as augmentative or alternative communication devices, are utilized to help individuals who have severe speech impairments such as aphasia, apraxia or dysarthria, to be able to meet their functional speaking needs. The individuals may also have impairments that interfere with writing.

SGDs may utilize either digitized or synthesized speech. Digitized SGDs are those that deliver "whole message" speech output. These devices deliver words or phrases that have been prerecorded by an individual other than the user of the speech generating device, who can play it back on demand.

Synthesized SGDs are those that translate the user's input into device-generated speech using algorithms representing linguistic rules. Users are not limited to prerecorded messages but can create messages independently according to their communication needs. These devices may also be called text to speech systems.

Speech generating devices are defined as durable medical equipment that provides an individual who has a severe speech impairment with the ability to meet his or her functional, speaking needs. Speech generating devices are speech aids consisting of devices or software that generate speech and are used solely by the individual who has a severe speech impairment. The speech is generated using one of the following methods:

- Digitized audible/verbal speech output, using prerecorded messages;
- Synthesized audible/verbal speech output which requires message formulation by spelling and device
access by physical contact with the device-direct selection techniques;
• Synthesized audible/verbal speech output which permits multiple methods of message formulation and multiple methods of device access; or
• Software that allows a computer or other electronic device to generate audible/verbal speech.

Other covered features of the device include the capability to generate email, text, or phone messages to allow the patient to “speak” or communicate remotely, as well as the capability to download updates to the covered features of the device from the manufacturer or supplier of the device.

As long as the speech-generating device is limited to use by a patient with a severe speech impairment and is primarily used for the purpose of generating speech, it is not necessary for a speech-generating device to be dedicated only to speech generation to be considered DME. Computers and tablets in general are not considered DME because they are useful in the absence of an illness or injury.

Internet or phone services or any modification to a patient’s home to allow use of the speech generating device are not covered because such services or modifications could be used for non-medical equipment such as standard phones or personal computers. In addition, specific features of a speech generating device that are not used by the individual who has a severe speech impairment to meet his or her functional speaking needs are not covered. This would include any computing hardware or software not necessary to allow for generation of audible/verbal speech, email, text or phone messages, such as hardware or software used to create documents and spreadsheets or play games or music, and any other function a computer can perform that is not directly
related to meeting the functional speaking communication needs of the patient, including video communications or conferencing.

Synthesized speech, unlike pre-recorded messages of digitized speech, is a technology that translates a user’s input into device-generated speech using algorithms representing linguistic rules. Users of synthesized speech SGDs are not limited to pre-recorded messages but rather can independently create messages as their communication needs dictate. Some SGDs require message formulation by spelling and access by physical contact with a keyboard, touch screen, or other display containing letters. Speech generating software programs enable a laptop computer, desktop computer or personal digital assistant (PDA) to function as an SGD. Within this policy, the term SGD also describes these speech generating software programs. Speech generating devices may permit multiple methods of message formulation and multiple methods of device access. For purposes of this policy, a SGD with multiple methods of message formulation should include message selection by 2 or more of the following methods: letters, words, pictures, and symbols. A SGD with multiple methods of access should include the capability to access the device by 2 or more of the following: direct physical contact with a keyboard or touch screen, indirect selection techniques and a specialized access device such as a joystick, head mouse, optical head pointer, light pointer, infrared pointer, scanning device, or Morse code.

Upgrades of a SGD are subsequent versions of a SGD’s software program or memory modules that may include enhanced features or other improvements. Mounting switches are devices necessary to place the SGD, switches, and other access devices within the reach of the patient.

Accessories for SGDs include, but are not limited to, access devices that enable selection of letters, words, or symbols via direct or indirect selection techniques. Examples of access
devices include, but are not limited to, optical head pointers, joysticks, and SGD scanning devices. The assessment of need for an SGD should be performed by a qualified speech-language pathologist (SLP). For purposes of this policy, SLPs are licensed health professionals trained in the diagnosis and treatment of speech and language disorders. The SLP should hold a Certificate of Clinical Competence from the American Speech and Hearing Association.

Communication aids that do not generate speech or writing are not covered under most Aetna benefit plans, as most plans have a specific contractual exclusion of communication aids. Please check benefit plan descriptions for details. In addition, communication aids that are not SGDs are not considered prosthetics for speech, as they do not replace internal or external body parts lost or impaired by disease or injury. Picture books and flashcards are examples of non-covered communication aids.

In addition, these communication aids that are not SGDs do not meet the definition of covered durable medical or surgical equipment under Aetna’s benefit plans. Aetna’s DME benefit covers medical or surgical equipment for treatment of disease or injury; or for the purpose of improving body function lost or impaired by disease or injury; or to enable the patient to perform essential activities of daily living related to the patient's health and hygiene, within or outside the home, with minimal or no assistance from others. Aetna does not consider communication to be a bodily function. Although communication may be considered an activity of daily living, it is an activity that is not related to the patient's health and hygiene. Examples of functions and essential activities of daily living for which Aetna covers DME include bathing; feeding; toileting; walking; and transferring from bed to chair, wheelchair or walker. Aetna does not consider communication to be an activity of this type. Furthermore, patients requiring a
communication aid are usually unable to perform any of these functions without assistance from others, with or without a communication aid.

The literature for some communication aids emphasize their value in expanding vocabulary skills, for use in business and for report preparation, and their ability to be connected to a personal computer. This goes beyond what is considered to be an essential medical device. For similar reasons, Aetna does not cover visual alert systems for the deaf or special controls on cars for people who need them to drive.

Speech may gradually improve after head trauma or stroke. For these acquired disorders, SGDs are used as a last option. Therefore, use of an SGD is not usually initiated less than 4 to 6 months after trauma or stroke.

Medicare classifies SGDs as DME. To be eligible for an SGD, Medicare requires that the beneficiary is enrolled in Medicare Part B; the beneficiary lives in his/her family home, or an assisted living facility (but not in a hospital, skilled nursing facility, or hospice); the beneficiary is determined, following an assessment by a SLP, to require an SGD to meet daily functional communication needs; and the beneficiary's physician prescribes the SGD.

Rispoli and colleagues (2010) reviewed communication interventions that involved the use of SGD for individuals with developmental disabilities. Systematic searches of electronic databases, journals and reference lists identified 35 studies meeting the inclusion criteria. These studies were evaluated in terms of (i) participants, (ii) SGD function, (iii) SGD characteristics, (iv) intervention procedures, (v) intervention results and (vi) certainty of evidence. Across these studies, intervention was provided to a total of 86 subjects aged 1 to 42 years. Communication skills targeted included requesting, social or conversational skills, labeling items and receptive
language. Intervention approaches were categorized as using Discrete Trial Training, Milieu teaching or a combined instructional approach. Positive outcomes were reported in 86% of the studies with 54% of studies categorized as providing conclusive evidence. The authors concluded that this literature base is considered promising due to the large number of conclusive studies and the replication of intervention approaches.

**Autism Spectrum Disorder**

van der Meer and Rispoli (2010) reviewed communication intervention studies that involved the use of SGD for children with autism. A total of 23 studies were identified that met the inclusion criteria following systematic searches of electronic databases, journals and reference lists. Studies were evaluated in terms of: (i) participants, (ii) setting, (iii) mode of communication, (iv) communication skill(s) taught to the participant, (v) intervention procedures, (vi) outcomes, (vii) follow-up and generalization, (viii) reliability and treatment integrity and (ix) design and certainty of evidence. Intervention, most commonly targeting requesting skills, was provided to a total of 51 children aged 3 to 16 years. Intervention strategies followed 2 approaches: (i) operant/behavioral techniques and (ii) naturalistic teaching procedures. Positive outcomes were reported for 86% of the studies and 78% of the studies were categorized as providing conclusive evidence. The authors concluded that the literature base suggests that SGDs are viable communication options for children with autism. However, they stated that several areas warrant future research.

Lorah et al (2015) stated that powerful, portable, off-the-shelf handheld devices, such as tablet based computers (i.e., iPad; Galaxy) or portable multi-media players (i.e., iPod), can be adapted to function as SGDs for individuals with autism spectrum disorders or related developmental disabilities. These investigators reviewed the research in this new and
rapidly growing area and delineated an agenda for future investigations. In general, participants using these devices acquired verbal repertoires quickly. Studies comparing these devices to picture exchange or manual sign language found that acquisition was often quicker when using a tablet computer and that the vast majority of participants preferred using the device to picture exchange or manual sign language. The authors concluded that future research in interface design, user experience, and extended verbal repertoires is recommended.

Gevarter et al (2016) taught individuals with autism spectrum disorder (ASD) and limited vocal speech to emit target vocalizations while using a SGD. Of the 4 participants, 3 began emitting vocal word approximations with SGD responses after vocal instructional methods (delays, differential reinforcement, prompting) were introduced; 2 participants met mastery criterion with a reinforcer delay and differential reinforcement, and 1 met criterion after fading an echoic model and prompt delay. For these participants, vocalizations initiated before speech outputs were shown to increase, and vocalizations generalized to a context in which the SGD was absent. The 4th participant showed high vocalization rates only when prompted. The authors concluded that these results suggested that adding vocal instruction to an SGD-based intervention can increase vocalizations emitted along with SGD responses for some individuals with ASD. These preliminary findings need to be validated by well-designed studies.

Almirall et al (2016) noted that there are limited data on the effects of adaptive social communication interventions with a SGD in autism. These researchers compared growth in communications outcomes among 3 adaptive interventions in school-age children with ASD who are minimally verbal. A total of 61 children, aged 5 to 8 years, participated in a sequential, multiple-assignment randomized trial (SMART). All children received a developmental behavioral communication
intervention: joint attention, symbolic play, engagement and regulation (JASP) with enhanced milieu teaching (EMT). The SMART included 3 2-stage, 24-week adaptive interventions with different provisions of a SGD in the context of JASP+EMT. The first adaptive intervention, with no SGD, initially assigned JASP+EMT alone, then intensified JASP+EMT for slow responders. In the second adaptive intervention, slow responders to JASP+EMT were assigned JASP+EMT+SGD. The third adaptive intervention initially assigned JASP+EMT+SGD; then intensified JASP+EMT+SGD for slow responders. Analyses examined between-group differences in change in outcomes from baseline to week 36. Verbal outcomes included spontaneous communicative utterances and novel words. Non-linguistic communication outcomes included initiating joint attention and behavior regulation, and play. The adaptive intervention beginning with JASP+EMT+SGD was estimated as superior. There were significant (p < 0.05) between-group differences in change in spontaneous communicative utterances and initiating joint attention. The author concluded that school-age children with ASD who are minimally verbal made significant gains in communication outcomes with an adaptive intervention beginning with JASP+EMT+SGD. They stated that future research should explore mediators and moderators of the adaptive intervention effects and second-stage intervention options that further capitalize on early gains in treatment. These findings were also confounded by the use of multiple modalities.

Chen and associates (2016) analyzed the effectiveness of the interface design of SGDs on t3 non-verbal adolescents with ASD, in hopes of improving their on-campus communication and cognitive disability. The intervention program was created based on their social and communication needs in school. Two operating interfaces were designed and compared: (i) the Hierarchical Relating Menu, and (ii) the Pie Abbreviation-Expansion Menu. The experiment used the
ABCACB multiple-treatment reversal design. The test items included: (i) accuracy of operating identification; (ii) interface operation in response to questions; and (iii) degree of independent completion. Each of these 3 items improved with both intervention interfaces. The children were able to operate the interfaces skillfully and respond to questions accurately, which evidenced the effectiveness of the interfaces. The authors concluded that both interfaces were effective enough to help non-verbal children with ASD at different levels.

This study had 2 major drawbacks: (i) because of the small pool of non-verbal adolescents with ASD in Taiwan, only 3 highly heterogeneous participants were recruited, and (ii) Mirenda and Erickson hypothesized that the development of communication and adolescent mental function are strongly related, and the present study did not stratify the participants in IQ-level groups (which would have been statistically meaningless because there were only 3 participants); thus, those IQs might have affected the results.

Gevarter and colleagues (2017) reported the findings of 5 children with ASD who were taught to request preferred items using four different augmentative and alternative communication (AAC) displays on an iPad-based SGD. Acquisition was compared using multi-element designs. Displays included a symbol-based grid, a photo image with embedded hotspots, a hybrid (photo image with embedded hotspots and symbols), and a pop-up symbol grid. Three participants mastered requesting items from a field of 4 with at least 3 displays, and 1 mastered requesting items in a field of 2. The 5th participant did not acquire requests in a field of preferred items. Individualized display effects were present, and the photo image appeared to have provided the most consistent advantages for 3 participants. Some errors were more or less common with specific displays and/or
participants. The authors concluded that the results have important implications for AAC assessment and implementation protocols.

Thiemann-Bourque et al (2017) examined the effects of a peer-mediated intervention that provided training on the use of a SGD for preschoolers with severe ASD and peer partners. Effects were examined using a multiple probe design across 3 children with ASD and limited to no verbal skills; 3 peers without disabilities were taught to Stay, Play, and Talk using a GoTalk 4+ (Attainment Company) and were then paired-up with a classmate with ASD in classroom social activities. Measures included rates of communication acts, communication mode and function, reciprocity, and engagement with peers. Following peer training, intervention effects were replicated across 3 peers, who all demonstrated an increased level and upward trend in communication acts to their classmates with ASD. Outcomes also revealed moderate intervention effects and increased levels of peer-directed communication for 3 children with ASD in classroom centers. Additional analyses revealed higher rates of communication in the added context of preferred toys and snack. The children with ASD also demonstrated improved communication reciprocity and peer engagement. The authors concluded that these findings provided preliminary evidence on the benefits of combining peer-mediated and SGD interventions to improve children’s communication. Furthermore, it appeared that preferred contexts were likely to facilitate greater communication and social engagement with peers.

Furthermore, an UpToDate review on “Autism spectrum disorder in children and adolescents: Overview of management” (Weissman and Bridgemohan, 2018) does not mention SGDs as management tools.

Children with Developmental and Language Delays
Barton-Hulsey and colleagues (2017) reported the findings of 3 children aged 3 years and 6 months to 5 years and 3 months with developmental and language delays who were provided experience with a traditional grid-based display and a contextually organized visual scene display on a SGD to illustrate considerations for practice and future research in AAC assessment and intervention. Twelve symbols were taught in a grid display and visual scene display using aided input during dramatic play routines. Teaching sessions were 30 minutes a day, 5 days a week for 3 weeks. Symbol comprehension and use was assessed pre- and post-3 weeks of experience. Comprehension of symbol vocabulary on both displays increased after 3 weeks of experience. Subjects 1 and 2 used both displays largely for initiation; subject 3 had limited expressive use of either display. The authors concluded that the methods used in this study demonstrated one way to inform individual differences in learning and preference for SGD displays when making clinical decisions regarding AAC supports for a child and their family. They stated that future research should systematically examine the role of extant comprehension, symbol experience, functional communication needs, and the role of vocabulary type in the learning and use of grid displays versus visual scene displays.

CPT Codes / HCPCS Codes / ICD-10 Codes

Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by "+":

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92521</td>
<td>Evaluation of speech fluency (eg, stuttering, cluttering)</td>
</tr>
<tr>
<td>Code</td>
<td>Code Description</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>92522</td>
<td>Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)</td>
</tr>
<tr>
<td>92523</td>
<td>Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)</td>
</tr>
<tr>
<td>92524</td>
<td>Behavioral and qualitative analysis of voice and resonance</td>
</tr>
<tr>
<td>92607</td>
<td>Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour</td>
</tr>
<tr>
<td>+ 92608</td>
<td>each additional 30 minutes (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>92609</td>
<td>Therapeutic services for the use of speech-generating device, including programming and modification</td>
</tr>
</tbody>
</table>

HCPCS codes covered if selection criteria are met:

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E2500</td>
<td>Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time</td>
</tr>
<tr>
<td>E2502</td>
<td>Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time</td>
</tr>
<tr>
<td>E2504</td>
<td>Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time</td>
</tr>
<tr>
<td>Code</td>
<td>Code Description</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>E2506</td>
<td>Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time</td>
</tr>
<tr>
<td>E2508</td>
<td>Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device</td>
</tr>
<tr>
<td>E2510</td>
<td>Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access</td>
</tr>
<tr>
<td>E2511</td>
<td>Speech generating software program, for personal computer or personal digital assistant</td>
</tr>
<tr>
<td>E2512</td>
<td>Accessory for speech generating device, mounting system</td>
</tr>
<tr>
<td>E2599</td>
<td>Accessory for speech generating device, not otherwise classified [not covered if used as a modification to home internet or phone services.]</td>
</tr>
<tr>
<td>G0153</td>
<td>Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes</td>
</tr>
<tr>
<td>V5336</td>
<td>Repair/modification of augmentative communicative system or device (excludes adaptive hearing aid)</td>
</tr>
<tr>
<td>V5362</td>
<td>Speech screening</td>
</tr>
<tr>
<td>V5363</td>
<td>Language screening</td>
</tr>
</tbody>
</table>

HCPCS codes not covered for indications listed in the CPB:

<p>| E1902  | Communication board, nonelectronic augmentative or alternative communication device |</p>
<table>
<thead>
<tr>
<th>Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Other HCPCS codes related to the CPB:</td>
</tr>
<tr>
<td>L8500</td>
<td>Artificial larynx, any type</td>
</tr>
<tr>
<td>L8505</td>
<td>Artificial larynx replacement battery/accessory, any type</td>
</tr>
<tr>
<td></td>
<td>ICD-10 codes covered if selection criteria are met:</td>
</tr>
<tr>
<td>F80.0 - F80.9</td>
<td>Specific developmental disorders of speech and language</td>
</tr>
<tr>
<td>I69.020 - I69.028</td>
<td>Speech and language deficits following cerebrovascular disease</td>
</tr>
<tr>
<td>I69.120 - I69.128</td>
<td></td>
</tr>
<tr>
<td>I69.220 - I69.228</td>
<td></td>
</tr>
<tr>
<td>I69.320 - I69.328</td>
<td></td>
</tr>
<tr>
<td>I69.820 - I69.828</td>
<td></td>
</tr>
<tr>
<td>I69.920 - I69.928</td>
<td></td>
</tr>
<tr>
<td>R47.01 - R47.9</td>
<td>Speech disturbances, not elsewhere classified</td>
</tr>
</tbody>
</table>

The above policy is based on the following references:

2. NHIC, Corp. Speech generating devices. Medicare Local Coverage Determination (LCD). Durable Medical


34. Weissman L, Bridgemohan C. Autism spectrum disorder in children and adolescents: Overview of management. UpToDate [online serial], Waltham, MA: UpToDate; reviewed February 2018.
Copyright Aetna Inc. All rights reserved. Clinical Policy Bulletins are developed by Aetna to assist in administering plan benefits and constitute neither offers of coverage nor medical advice. This Clinical Policy Bulletin contains only a partial, general description of plan or program benefits and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee any results or outcomes. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Treating providers are solely responsible for medical advice and treatment of members. This Clinical Policy Bulletin may be updated and therefore is subject to change.
Amendment to
Aetna Clinical Policy Bulletin Number:
0437 Speech Generating Devices

There are no amendments for Medicaid.

www.aetnabetterhealth.com/pennsylvania  Updated 08/22/2018