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March 20, 2002

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RE: Tricare Coverage of AAC Devices

Dear Peter:

The enclosed materials supply information to aid Tricare's adoption of AAC device coverage criteria. The adoption of such criteria will allow the program to implement its recently granted statutory authority to offer AAC device coverage to all program enrollees, without limitation. As we discussed, the information stated below supports the proposal that Tricare adopt the Medicare AAC device coverage criteria for its own use.

Introduction

I write on behalf of the organizations listed at the conclusion of this letter. These organizations propose that Tricare implement its new authority to cover AAC devices as prosthetic devices[1] by adopting the Medicare AAC device coverage criteria. The Medicare AAC device guidelines are codified in the "Regional Medical Review Policy for Speech Generating Devices" (March 2001) and the "Medicare National Coverage Decision for Speech Generating Devices," Medicare Coverage Issues Manual, Section 60-23 (November 2000, effective, January 2001).[2]

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1 Pub.L.No. 107-107, Section 702(2) (2001).

2 These guidelines are attached as Exhibits 1A and 1B.

Tricare's adoption of the Medicare AAC device coverage criteria will yield a win-win result for Tricare enrollees, service providers, and policy and decision makers. Tricare enrollees will benefit because their needs for AAC devices will be determined by an assessment and reporting protocol recognized as incorporating "best practices" in AAC clinical assessment.

Adopting the Medicare coverage criteria also will enable speech-language pathologists (SLPs), the professionals with primary responsibility for identifying AAC device needs, making AAC device recommendations, and designing AAC device treatment plans, to take advantage of the wealth of supplemental training and support resources interpreting and explaining the Medicare coverage criteria. These supplemental materials have been developed (and continue to be developed) by the nation's leading AAC professionals. As a result, Tricare beneficiaries will have their AAC device needs determined in the most efficient and professionally sound manner, leading to the highest quality treatment recommendations and with the greatest potential for communicative benefit.

That these two federally supported programs will have consistent coverage criteria for the same benefit also will be of benefit to Tricare administrators. The Medicare AAC device coverage criteria represent a "turn-key" set of criteria which were developed following an 18 month policy review conducted jointly by Medicare staff physicians and the nation's leading AAC professionals, with input supplied by the nation's most respected and knowledgeable physicians and medical professional societies. The Medicare AAC device policy development process was the most extensive and inclusive effort undertaken by any third party funding program. And, Tricare staff and decision makers also can take personal advantage of the training and support resources developed for SLPs, so they too will better understand the funding requests that will be submitted.

Adopting the Medicare AAC device coverage criteria also will place Tricare in the same position as an increasing number of commercial insurers, and, it is hoped, the Department of Veterans Affairs. As more third party health care funding sources are becoming aware of the Medicare coverage criteria, they are adopting or deferring to these guidelines in the interpretation of their policies.[3] A proposal also has been presented to and is pending before the DVA for that agency to adopt and apply the Medicare AAC device coverage criteria.

In sum, Tricare's adoption of the Medicare AAC device coverage criteria represents the most efficient and effective way to implement the will of Congress when it authorized Tricare to cover AAC devices for all enrollees.

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[3] *See e.g.*, CareFirst Blue Cross, Blue Shield of Maryland, Medical Policy Reference Manual, Section 1.01.15A (2001), attached as Exhibit 2A; letter dated November 21, 2001 to Lewis Golinker, Esq. from Jane Murphy, M.S., C.C.C.-S.L.P., Coordinator, Assistive Technology Program, Oregon Health & Science University, attached as Exhibit 2B; Letter dated February 27, 2002 toMs.Pam V., from Health Net Oregon Grievance & Appeals, attached as Exhibit 2C.

History

The Medicare AAC device coverage criteria, attached as Exhibit 1, were adopted following an 18 month policy review initiated directly by the then-HCFA (now CMS) Administrator, Nancy Ann Min DeParle. In June 1999, Administrator DeParle directed her disability policy assistant, Henry Claypool, to contact the Assistive Technology Law Center. There were two reasons for this contact. First, Claypool reported that HCFA had decided to conduct a policy review of AAC devices. Second, he requested, on behalf of the Administrator, that the Assistive Technology Law Center assemble a work-group of AAC professionals to prepare and submit a written analysis of the medical professional literature related to AAC interventions.

This HCFA decision represented the culmination of approximately one year's preliminary inquiries about Medicare's coverage of AAC devices. For more than a decade, Medicare had guidance in the form of a "National Coverage Decision," that stated AAC devices were *not* covered, describing them as "convenience items," as "not primarily medical in nature," and therefore, not "durable medical equipment."[4] However, when asked the basis for this guidance, none could be found: it simply existed, but HCFA could not state precisely when it had been issued, what had been reviewed, or who had made this decision.[5]

A complicating factor was that prior to April 1999, Medicare had no procedures for the re-review of "National Coverage Decisions" ("NCDs"). At that time, however, Medicare published procedural guidance on NCD development and re-review.[6]

Once the foundation was laid for Medicare to re-review its coverage policy toward AAC devices, the focus shifted to presentation of information explaining whether AAC devices could be covered, and if so, to what extent. HCFA staff requested information regarding the medical treatment basis for AAC intervention, the relationship of AAC assessment to speech-language pathology assessment, the characteristics of AAC devices, how AAC devices "fit" within the Medicare program's menu of benefits, and finally, proposed, inclusive Medicare AAC device coverage criteria. It was for these tasks that the Assistive Technology Law Center was asked to provide assistance.

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[4] Medicare National Coverage Decision for Augmentative Communication Devices, codified in Medicare Coverage Issues Manual, Section 60-9. The full text of this guidance stated:

Augmentative Communication Device	see Communicator
Communicator	Deny -- convenience item, not primarily medical in nature (§ 1861(n) of the Act).

[5] *See* Letter dated July 8, 1999 to Elizabeth Carder, Esq., from Phillip Brown, Director, HCFA Division of Freedom of Information and Privacy, attached as Exhibit 3.

[6] 64 Fed. Reg. 22,619-22,625 (April 27, 1999).

From mid-June through the end of December 1999, a work group of the nation's pre-eminent AAC professionals prepared *The Formal Request for National Coverage Decision for Augmentative and Alternative Communication Devices*, the document that addressed all the points about which HCFA had sought information.[7]

The *Formal Request* was submitted to HCFA on December 30, 1999. It was submitted by the Assistive Technology Law Center on behalf of a coalition of 13 organizations representing all the diverse interests related to AAC device coverage policy reform. Included in the coalition were organizations representing people with disabilities, assessment and treatment professionals, device manufacturers, and advocates.[8] The *Formal Request* was then sent for review and comment to the American Medical Association, and to the two specialty medical professional societies whose members are most often responsible for the care and treatment of patients with AAC device needs: the American Academy of Neurology and the American Academy of Physical Medicine and Rehabilitation. The *Formal Request* also was sent for review to Stephen Hawking, the physicist who is perhaps the world's best known AAC device user.[9]

All of these sources responded. Dr. Hawking wrote to President Clinton stating, in part:

> I gather that the Medicare programme is currently evaluating its policy on providing augmentative communication devices. I urge you to use your influence to ensure those in need, like I was, can be given such devices.[10]

The American Medical Association wrote:

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

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7 The work-group consisted of 14 AAC professionals who wrote and edited the *Formal Request's* six substantive chapters. They are identified in Exhibit 4. The *Formal Request* is attached as Exhibit 5.

8 The coalition's members included: The American Speech-Language-Hearing Association; Amyotrophic Lateral Sclerosis Association; Brain Injury Association; Center on Disability and Health; Communication Aid Manufacturers Association; Communication Independence for the Neurologically Impaired; International Society for Augmentative and Alternative Communication; National Association of Protection & Advocacy Systems; National Multiple Sclerosis Society; RESNA; Sunrise Medical; United Cerebral Palsy Associations; and the United States Society for Augmentative and Alternative Communication.

9 Dr. Hawking requires an AAC device due to anarthria secondary to Amyotrphic Lateral Sclerosis.

10 Letter dated February 24, 2000 to President Bill Clinton, from Stephen Hawking, Lucasian Professor of Mathematics, University of Cambridge, attached as Exhibit 6.

> In the Formal Request . . ., Section 3: Clinical Aspects of AAC Devices, there is an excellent summary of the strong clinical evidence for the efficacy and effectiveness of AAC devices for the treatment of dysarthria, apraxia and aphasia. The clinical decision making process is appropriately outlined in this Section and is consistent with the proposed coverage criteria in Section 6.
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> * * * * *
>
> The AMA considers these devices as medically necessary and appropriate for carefully selected patients and we support the formal request for coverage.[11]

The American Academy of Neurology, in the first of 3 letters in support of the *Formal Request*, wrote:

> In general, the American Academy of Neurology supports a policy that includes [AAC] devices to be covered as Medicare or Medicaid durable medical equipment when incorporated into a speech language pathology or neurological treatment plan. The treatment plan which authorizes this coverage should include a thorough speech-language pathology assessment or neurological assessment that concludes the individual is unable to meet communication needs arising in the course of daily activities using natural communication techniques.
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> * * * * *
>
> In summary, the AAN believes that [AAC] devices are a form of durable medical equipment which can be of great help to selected individuals with neurological disorders unable to communicate during hte course of daily activities. They are safe, effective and definitely not experimental. They can be a successful form of treatment as part of a speech-language therapy plan in carefully selected and evaluated individuals.[12]

The American Academy of Physical Medicine and Rehabilitation provided further support for the *Formal Request*:

> The Academy lends its full support for Medicare coverage of these devices for patients with severe communication impairments, such as dysarthria, apraxia and

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[11] Letter dated March 21, 2000 to Hugh Hill, M.D., Acting Director, HCFA Coverage and Analysis Group, from E. Ratcliffe Anderson, Jr., M.D., Executive Vice President, American Medical Association. Attached as Exhibit 7.

[12] Letter dated March 22, 2000 to Hugh Hill, M.D., Acting Director, HCFA Coverage and Analysis Group, from Francis I. Kittredge, Jr., M.D., President, American Academy of Neurology, attached as Exhibit 8A. The AAN submitted 2 additional letters in support of the *Formal Request*. These are attached as Exhibits 8B and 8C.

aphasia, regardless of the motor or neurological impairment that gives rise to the communication impairment.

> The Academy strongly believes that [AAC] devices are medically necessary aids for communication. Clearly, there are no suitable substitutes for these devices for individuals with disabilities who require them. . . . The Academy believes AAC devices are reasonable and necessary to treat these patients. They are necessary to meet the communication needs arising in daily activities.[13]

Approximately two dozen individual physicians who treat individuals who use AAC devices also wrote to HCFA in support of the *Formal Request,* as did the American Speech-Language-Hearing Association, and the United Cerebral Palsy Research and Educational Foundation. ASHA's letter supported the *Formal Request's* explanation of AAC interventions as part of a comprehensive speech-language pathology assessment. ASHA also supported the appropriateness of adopting coverage criteria for AAC devices that are consistent with the existing Medicare coverage criteria for SLP services, as was proposed in the *Formal Request.*[14]

On April 26, 2000, HCFA announced its decision on its AAC device policy review. Its decision was based on the information stated in the *Formal Request,* the supplemental letters discussed above, and two, half-day in-service presentations provided to the HCFA staff by members of the work group that produced the *Formal Request.* The agency reached 3 conclusions: 1) it will withdraw the "convenience item" guidance; 2) it will cover AAC devices as Medicare items of durable medical equipment, effective January 1, 2001; and 3) it will continue working on developing new coverage criteria to guide decision making for AAC device funding requests.[15]

In the six month period following this announcement, the Assistive Technology Law Center and the AAC professionals that produced the *Formal Request* continued to provide information to assist HCFA staff develop Medicare AAC device coverage criteria. These efforts included conducting a full-day in-service presentation to each of the Medicare DME Regional Carrier (DMERC) medical directors, and a full-day in-service presentation to HCFA staff at the August 2000 biennial conference of the International Society for Augmentative & Alternative Communication, which was held in Washington, D.C.

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[13] Letter dated March 23, 2000 to Hugh Hill, M.D., Acting Director HCFA Coverage and Analysis Group, from Ronald Henrichs, Executive Director, American Academy of Physical Medicine and Rehabilitation, attached as Exhibit 9.

[14] *See* Letter dated March 20, 2000 to Hugh Hill, M.D., Acting Director, HCFA Coverage and Analysis Group, from Jeri A. Logemann, Ph.D., President, American Speech-Language-Hearing Association, attached as Exhibit 10 A; Letter dated February 24, 2000 to Hugh Hill, M.D., Acting Director, HCFA Coverage and Analysis Group, from Murray Goldstein, D.O., Medical Director, UCP Research and Educational Foundation, attached as Exhibit 10 B.

[15] Decision Memorandum from Hugh F. Hill, III, M.D., Acting Director, HCFA Coverage and Analysis Group, re: CAG-00055, Augmentative and Alternative Communication Devices, April 26, 2000.

On October 24, 2000, the development process for this guidance concluded. On that date, the four Medicare DMERC Medical Directors jointly published the "Regional Medical Review Policy (RMRP) on Speech Generating Devices." This guidance states the scope of Medicare coverage of AAC devices as well as the SLP assessment and report required to establish individual medical need. The RMRP was released for public notice and comment; after only minor changes, it became final guidance in March 2001.[16] In addition, in late-November 2000, HCFA issued National Coverage Decision 60-23, which formally replaces the "convenience item" national non-coverage decision. This NCD states the scope of Medicare AAC device coverage; it defers to the RMRP regarding the determination of medical need.[17]

Review of Medicare AAC Device Coverage Criteria

The RMRP and NCD are notable for 3 reasons. First, they provide for Medicare coverage of AAC devices without limitation. The full range of AAC devices, as well as AAC software, mounts and accessories are covered. The RMRP and NCD also reflect the recognition by HCFA staff that severe communication disabilities arise from a wide range of neurological conditions, and thus, it is inappropriate to limit coverage to specific underlying neurological conditions.[18] And, the RMRP recognizes the limited role of the treating physician in the AAC intervention determination process. The physician's role is characterized by identification of key symptoms of communication impairment, and referral for an SLP assessment for determination of the type and severity of the impairment, and for preparation of an SLP plan of treatment.[19]

Second, the RMRP properly identifies the speech-language pathologist as the key professional responsible for determining AAC device need, based on a comprehensive AAC assessment and report. This guidance is unique because it represents the only Medicare covered benefit for which

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16 *See* Exhibit 1A.

17 *See* Exhibit 1B.

18 *See* Letter dated March 23, 2000 to Hugh Hill, M.D., Acting Director, HCFA Coverage and Analysis Group, from Ronald Henrichs, Executive Director, American Academy of Physical Medicine and Rehabilitation, attached as Exhibit 9 ("The Academy lends its full support for Medicare coverage of these devices for patients with dysarthria, apraxia and aphasia, ***regardless of the motor or neurological condition that gives rise to the communication impairment.***"); *see also,* Letter dated April 25, 2000 to Hugh Hill, M.D., Acting Director, HCFA Coverage and Analysis Group, from Francis I. Kittredge, Jr., M.D., President, American Academy of Neurology, attached as Exhibit 8 B; Letter dated October 23, 2000 to Hugh Hill, M.D., Acting Director, HCFA Coverage and Analysis Group, from Francis I. Kittredge, Jr., M.D., President, American Academy of Neurology, attached as Exhibit 8 C.

19 *See* Letter dated October 23, 2000 to Hugh Hill, M.D., Acting Director, HCFA Coverage and Analysis Group, from Francis I. Kittredge, Jr., M.D., President, American Academy of Neurology, attached as Exhibit 8 C.("***[N]eurologists typically do not conduct specific tests prior to making referral for a speech-language pathology and/or AAC evaluation.***")

a non-physician is authorized to make a determination of medical need. This policy conclusion reflects the high degree of trust HCFA staff and the DMERC medical directors placed on the skill, professionalism and ethics of the speech-language pathologists with whom they worked to reverse the "convenience item" NCD, and to develop the new AAC device coverage criteria.

Third, the RMRP is notable because the required SLP assessment and report it describes reflects "best practices" in AAC assessment. The required assessment and reporting elements comprise a comprehensive inquiry into the nature and extent of communication impairment, and of the range of possible treatment alternatives that may be implemented. The RMRP also recognizes the proper scope of treatment: to enable the patient to meet daily communication needs[20] and the importance of a written treatment plan stating "functional communication goals."

Implementation of the New Medicare AAC Device Coverage Guidance

Medicare coverage of AAC devices began on January 1, 2001. This policy change is estimated in the *Formal Request* to be of direct benefit to approximately 50,000 current Medicare beneficiaries with AAC device needs.

Before Medicare beneficiaries will be able to take advantage of these policy changes, however, an additional barrier must be overcome: the extensive shortage of SLPs, particularly SLPs with AAC experience, who work with adults. Historically, SLPs with AAC experience faced strong disincentives to holding positions which served significant percentages of Medicare beneficiaries. Medicare refused to cover the devices, and their costs precluded private purchases. Thus, there was no effective way to implement AAC device recommendations and treatment plans.

In addition, because Medicare is the nation's largest health care benefits program, its coverage policy is often used as a guide to commercial insurers. If Medicare did not cover AAC devices, insurers refused to do so as well. And, until the late 1990's, many Medicaid programs had refused to cover AAC devices for adult beneficiaries. Thus, there were extensive barriers to adult access to AAC devices across a wide range of third party funding programs.

The acute shortage of SLPs able to provide AAC assessment to Medicare beneficiaries is reflected in the exceedingly low number of Medicare funding requests for AAC devices that were submitted in 2001. In total, fewer than 100 AAC devices were requested for Medicare beneficiaries throughout the country and throughout that calendar year.

To address this shortage of assessment personnel, both for Medicare beneficiaries and for adults in general, the AAC professionals who worked on the Medicare policy reform effort formed a "Medicare Implementation Team." The mission of the MIT, as it has come to be known, is to develop training and education materials for SLPs to learn about the new Medicare coverage policy, and how to properly and completely complete the required AAC assessment and report. Throughout 2001, the MIT developed an extensive written outline of each element of the RMRP, including the nature of the inquiry, the the types of data to be reported, and the inquiry methods

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[20] *Compare* Exhibit 1A, Coverage and Payment Rules, at paragraph 1b, *with* the AMA, AAN and AAPMR letters, attached as Exhibits 7, 8 and 9.

that will yield the required data. Sample reports, based on individuals with specific conditions, also have been developed. This information was then presented at national, regional and state conferences held throughout the year, and all of this information has been posted for SLP review and use at the web site www.aac-rerc.com.

These continuing professional education efforts are ongoing. Most recently, a new technology: "web-casts," has been added as a mechanism to deliver these training presentations. Web-casts allow SLPs to participate in live, inter-active continuing professional education presentations without leaving their offices. These web-casts also are archived at www.kornreich.com, which allows SLPs to review them at their desks, and whenever it is convenient to do so.

The goal of these continuing professional education efforts is to use the Medicare coverage criteria as the template to expand the capability of SLPs to conduct quality assessments of AAC device needs, and to enable SLPs to develop AAC treatment plans that will lead to the greatest possible benefit to individuals with severe communication disabilities for whom AAC device use is necessary.

The MIT's efforts to develop these education and training resources, based on the Medicare AAC device coverage criteria, also include a self-evaluation component. A committee of AAC professionals has been formed to conduct a qualitative review of the SLP reports submitted during the first year of Medicare AAC device coverage. This committee will operate under the auspices of the American Speech-Language-Hearing Association, the professional society responsible for certification of all SLPs in the United States, and for the certification of all education programs. This committee is to determine whether those reports are in any way deficient. If so, the MIT will be directed to revise existing education and training resources to address those weaknesses.[21]

In addition to providing this vehicle for SLP education and training, the Medicare coverage criteria for AAC devices have had a substantive effect on other third party programs. A significant number of insurers report that they follow Medicare DME coverage criteria in the interpretation of their own policies, and as a result, they are now covering AAC devices. Some, have gone so far as to adopt the Medicare guidance and incorporate it into their internal decision making reference manuals.[22]

In sum, the Medicare AAC device coverage criteria are being used for 3 purposes. First, they are the instrument SLPs must use to prepare a complete funding request to Medicare. Second, they are being used as the template for increasing AAC assessment skills among practicing speech-

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[21] *See* Letter dated October 31, 2001 to Sarah Blackstone, Ph.D., from Larry Higdgon, Vice President for Governmental and Social Policies, American Speech-Language-Hearing Association, attached as Exhibit 11 A. *See also*, memorandum dated November 5, 2001 to Sarah Blackstone, Ph.D., from Walter Smolski, Ph.D., Chair, Health Care Economics Committee, American Speech-Language-Hearing Association, attached as Exhibit 11 B.

[22] *See* Exhibit 2.

language pathologists, generally. And third, they are being used to expand AAC device coverage and to establish consistent coverage criteria among multiple third party funding programs.

Tricare Coverage of AAC Devices

Tricare has long covered AAC devices for one sub-group of its beneficiary population. Specifically, AAC devices have been covered for individuals enrolled in the Tricare "program for people with disabilities." This program is available to the dependents of active duty military personnel. By contrast, AAC devices were not covered for dependents of military retirees, who were not eligible for the program for people with disabilities.

This coverage distinction arose because Tricare's definition of "durable medical equipment," 32 C.F.R. Section 199.2, has an express exclusion for "other communication devices," which has been interpreted to include AAC devices. ("Durable Medical Equipment," sub-paragraph 6). However, the Tricare regulations also contained an exception: a separate definition exists for "durable equipment," which is

> A device or apparatus which does not qualify as durable medical equipment (as defined in this section), and which is essential to the efficient arrest or reduction of functional loss resulting from a qualifying condition, as provided by Section 199.5.

32 C.F.R. Section 199.2 (definition of "durable equipment").

The reference to section 199.5 is to the regulations governing the "program for persons with disabilities." AAC devices were thus available to individuals enrolled in the program for persons with disabilities under the definition of "durable equipment."

A search was conducted for the basis of this distinction; more specifically, for the basis of the express communication device exclusion in the Tricare DME definition. The exclusion was not commanded by Congress. However, a search of relevant Federal Register filings from 1977 and 1986 did not provide any explanation.

What is known is that this regulatory exclusion persisted in spite of the more than 20 year trend of general acceptance of AAC devices as items of durable medical equipment or as prosthetic devices by every other health-based funding program in the United States. The Veterans Administration has covered and provided AAC devices since the late 1970's. So too have insurers and Medicaid programs.[23] Presently, hundreds if not thousands of insurers cover and provide AAC devices, as do all state Medicaid programs. In addition, in 1983, the Food and Drug Administration adopted regulations classifying AAC devices as medical devices. The FDA placed AAC devices in a category known as "physical medicine prosthetic devices." Other devices in this

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[23] D. Beukelman, K. Yorkston & K. Smith, "Third Party Payer Response to Requests for Purchase of Communication Augmentation Systems: A Study of Washington State," 1 *AAC* 5 (1985).

same classification include power wheelchairs.[24] And, as described above, in 2000-2001, Medicare reversed its longstanding exclusion of AAC devices, and began to cover them, without limitation.

In the Defense Reauthorization Act of 2001, Public Law 107-107, signed by President Bush on December 28, 2001, Congress brought Tricare into the mainstream of funding programs regarding AAC device coverage. That law authorized Tricare to cover AAC devices as prosthetic devices. Section 702(2). The effect of this classification will be to eliminate the exclusion of AAC device coverage for dependents of military retirees: the Tricare prosthetic device benefit is available to all enrollees. Thus, the coverage limitation or distinction created by the former AAC device exclusion under DME and its coverage as durable equipment becomes moot.

What is now needed is for Tricare to adopt coverage criteria that will allow for the implementation of this new statutory authority. AAC devices, although an exceedingly low incidence need, are nonetheless invaluable to those individuals who need it. As Tricare itself recognized by its coverage of AAC devices as "durable equipment:" AAC devices are "*essential* to the efficient arrest or reduction of functional loss resulting from a qualifying condition." 32 C.F.R. Section 199.2(emphasis supplied).

Conclusion

Severe communication impairments have been described as "not a loss of life, but a loss of access to life."[25] They preclude individuals from effectively expressing their needs, their wants, and to otherwise exchange information. They interfere with or preclude living independently in the community, being left alone, obtaining adequate health care, acquiring or maintaining employment, acquiring an education, and maintaining one's social role within the family and community.[26]

As Medicare and all other health based funding programs, and most recently the Congress have recognized, AAC devices are a tool that will enable individuals with severe communication impairments to have that "access to life" restored. AAC devices have the ability to enable such

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[24] 44 Fed Reg. 50,458, 50,489-90 (August 1979)(proposed rule); 48 Fed.Reg. 53,032 (Nov. 1983), codifying 21 C.F.R. Section 890.3710.

[25] D. Beukelman & K. Garrett, "Augmentative Communication for Adults with Acquired Severe Communication Disorders," 4 *AAC* 104 (1988).

[26] J. Light, "'Communication is the Essence of Human Life;' Reflections on Communicative Competence," 13 *AAC* 61-70 (1997); L. Fox & M. Sohlberg, "Meaningful Communication Roles," in D. Beukelman, K. Yorkston, & J. Reichle, Augmentative and Alternative Communcation for Adults with Acquired Neurologic Disorders 1 (Baltimore: Brookes 2000).

individuals to meet the communication needs arising in their daily lives, and to engage in what is universally recognized as a vitally important basic human functional ability.[27]

The adoption of Tricare AAC device coverage criteria will determine the scope of communication opportunities by program enrollees: children and adults with severe communication impairments. On behalf of the organizations listed below, it is requested that Tricare adopt, at its earliest opportunity, the coverage criteria for AAC devices that currently are being used by the Medicare program.

If any additional information is needed, please contact the undersigned.

Thank you.

Sincerely,

Lewis Golinker, Esq.
Director

Organizations Supporting this proposal:

American Speech-Language-Hearing Association
Amyotrophic Lateral Sclerosis Association
Brain Injury Association
Communication Independence for the Neurologically Impaired
Center on Disability and Health
RESNA
Sunrise Medical
United States Society for Augmentative and Alternative Communication

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[27] The "vital" importance of expressive communication is generally recognized by the judiciary, scientific community, and the public at large. *See See Fred C. v. Texas Health & Human Services Comm'n,* 988 F.Supp. 1032, 1036 (W.D.Tex. 1997), *affirmed per curiam,* 167 F.3d 537 (5th Cir. 1998)(Table)[*Fred C-II*]; 924 F.Supp. 788, 792 (W.D.Tex. 1996), *vacated and remanded on other grounds*, 117 F.3d 1416 (5th Cir. 1997)(Table)[*Fred C.-I*]; *Hunter v. Chiles*, 944 F.Supp. 920 (S.D.Fl. 1996)(These cases mandated AAC device coverage by Texas and Florida Medicaid.) Expressive communication also has long been recognized as a functional ability that distinguishes human beings from all other species. D. Bickerton, Language and Human Behavior (1995); S. Pinker, The Language Instinct (1994); M. Batshaw & Y. Perrett, Children with Handicaps: A Medical Primer (2d Ed 1986); M. Fisher, Ed., Illustrated Medical & Health Encyclopedia (1956); J. Wilford, "Ancestral Humans Could Speak, Anthropologists' Finding Suggests," N.Y. *Times*, April 28, 1998, at A:1. *See also* the American Speech-Language-Hearing Association (ASHA) and the United States Society for Augmentative and Alternative Communication (USSAAC) have both asserted, as a matter of organizational policy, that "communication is the essence of human life." ASHA, "Report: Augmentative & Alternative Communication," 33 *Asha* 9 (Suppl. 5) (1991); USSAAC, By-laws, Article II, § 1.

Exhibits List

1. A. Regional Medical Review Policy for Speech Generating Devices (Final) (March 2001

   B. Medicare National Coverage Decision for Speech Generating Devices, Medicare Coverage Issues Manual, Section 60-23 (November 2000, effective January 1, 2001).

2. A. Care First Blue Cross Blue Shield of Maryland, Medical Policy Reference Manual, Section 1.01.15A (2001)

   B. Letter dated November 21, 2001 to Lewis Golinker, Esq., from Jane Murphy, M.S., C.C.C.-S.L.P., Coordinator, Assistive Technology Program, Oregon Health & Sciences University

   C. Letter dated February 27, 2002 to Ms. Pam V., from Health Net Oregon Grievance and Appeals.

3. Letter dated July 8, 1999 to Elizabeth Carder, Esq., from Phillip Brown, Director, HCFA Division of Freedom of Information and Privacy.

4. List of 14 AAC professionals who wrote and edited the *Formal Request for National Coverage Decision for Augmentative and Alternative Communication Devices.*

5. *Formal Request for National Coverage Decision for Augmentative and Alternative Communication Devices.*

6. Letter dated February 24, 2000 to President Bill Clinton, from Stephen Hawking, Lucasian Professor of Mathematics, University of Cambridge.

7. Letter dated March 21, 2000 to Hugh Hill, M.D., Acting Director, HCFA Coverage and Analysis Group, from E. Ratcliffe Anderson, Jr., M.D., Executive Vice President, American Medical Association.

8. A. Letter dated March 22, 2000 to Hugh Hill, M.D., Acting Director, HCFA Coverage and Analysis Group, from Francis I. Kittredge, Jr. M.D., President, American Academy of Neurology

   B. Letter dated April 25, 2000 to Hugh Hill, M.D., Acting Director, HCFA Coverage and Analysis Group, from Francis I. Kittredge, Jr. M.D., President, American Academy of Neurology

C. Letter dated October 23, 2000 to Hugh Hill, M.D., Acting Director, HCFA Coverage and Analysis Group, from Francis I. Kittredge, Jr. M.D., President, American Academy of Neurology

9. Letter dated March 23, 2000 to Hugh Hill, M.D., Acting Director, HCFA Coverage and Analysis Group, from Ronald Henrichs, Executive Director, American Academy of Physical Medicine and Rehabilitation

10. A. Letter dated March 20, 2000 to Hugh Hill, M.D., Acting Director, HCFA Coverage and Analysis Group, from Jeri A. Logemann, Ph.D., President, American Speech-Language-Hearing Association

B. Letter dated February 24, 2000 to Hugh Hill, M.D., Acting Director, HCFA Coverage and Analysis Group, from Murray Goldstein, D.O., Medical Director, UCP Research and Educational Foundation

11. A. Letter dated October 31, 2001 to Sarah Blackstone, Ph.D., from Lawrence Higdon, Vice President for Governmental and Social Policies, American Speech-Language-Hearing Association

B. Memorandum dated November 5, 2001 to Sarah Blackstone, Ph.D., from Walter Smolski, Ph.D., Chair, Health Care Economics Committee, American Speech-Language-Hearing Association