



“Creating A Better Tomorrow, Today”™

Medicare Funding Packet

**Our in-house funding team is
standing by to help you!**

Forbes Rehab Services, Inc.
49 South Illinois Avenue
Mansfield, Ohio 44905

(888) 884-2190 Toll Free
(419) 589-7688 Phone
(877) 884-9383 Fax
www.frs-solutions.com





“Creating A Better Tomorrow, Today”

RE: Medicare Funding

Dear Speech-Language Pathologist,

This cover letter will describe the steps to complete a successful funding package for Medicare. As you know, Medicare will now cover speech-generating devices (SGD) at the standard 80% coverage of the Medicare allowable. The documents described below are required by Medicare and must remain in our files. Also included is the Medicare Beneficiary and Family portion of the packet, which will need to be completed.

- Step #1 The process begins with your written evaluation. If you recommend one of the products sold by FRS, Inc., we will file the Medicare claim on the family’s behalf. Medicare requires very specific information and format in your report. We have enclosed a “Medicare Request for Speech – Generating Device (SGD) Funding Explanation & Elaboration” outline to help in completing your client’s evaluation. Notice there a several very specific statements that must be included in your evaluation. Be sure to sign the evaluation and list your credentials. (CCC’s are required.)

- Step #2 You must forward a copy of your evaluation to the patient’s physician.

- Step #3 The patient’s physician must complete the Order/Prescription Form.

- Step #4 Send your **original** signed evaluation and completed **original** Order/Prescription from the Physician to:
 Forbes Rehab Services, Inc.
 49 South Illinois Ave.
 Mansfield, OH 44905

- Step #5 Call our office if you prefer to help the family with their documentation. We will send the family funding package to you. You will be our only contact at that point.

It will be our responsibility to confirm supplemental insurance coverage and collect the co-pay. The equipment will be ordered, delivery confirmed thru UPS and the claim will be filed at that point. Call us if you have any questions. We look forward to working with you.

FRS Funding Department

“We Offer You More Choices”

49 South Illinois Ave. • Mansfield, Ohio 44905
Toll Free (888) 884-2190 • Fax (877) 884-9383



Medicare Request for Speech Generating Device (SGD) Funding Explanation & Elaboration

I. Demographic Information

- Patient Name (include middle initial)
- Patient Address (no P.O. Box)
- Date of Birth
- Medical Diagnosis
- Date of Onset

II. Current Communication Impairment

a. Impairment Type & Severity

- Indicate aphasia, apraxia, and/or dysarthria
- Describe impairment severity in appropriate terms
 - *Dysarthria* - % intelligible, speaking rate (Sentence Intelligibility Test/CAIDS)
 - *Aphasia* - scores on receptive and expressive language tests (e.g., BDAE, W AB tests/subtests)
 - *Apraxia* -motor planning/execution score on apraxia tests (Apraxia Battery for Adults, portions of aphasia tests)
 - *Anarthria*

This section should explicitly show how the medical condition results in a severe expressive speech disability. **STATE, "The patient's speaking needs cannot be met using natural communication methods or low-technology speaking aids."**

b. Anticipated Course of Impairment

- Indicate current staging of impairment (when available) and expected course. Examples include;

Amyotrophic Lateral Sclerosis:

- Stage 1: No detectable speech disorder
- Stage 2: Obvious speech disorder, intelligible
- Stage 3: Reduction in speech intelligibility
- Stage 4: Natural speech supplemented with SGDs
- Stage 5: No useful speech (SGD only)

Guillian- Barre Syndrome:

- Stage 1. Deterioration phase
- Stage 2. Loss of Speech
- Stage 3. Prolonged Speechlessness
- Stage 4. Spontaneous Recovery of Speech
- Stage 5. Long-term Residual Motor Speech Disorder

Brainstem CVA :

- Stage 1. No Useful Speech
- Stage 2. Reestablish Subsystem Control for Speech
- Stage 3. Independent Use of Natural Speech
- Stage 4. Maximize Speech Naturalness & Efficiency
- Stage 5. No Detectable Speech Disorder

Aphasia: This aphasia is (e.g., stable & chronic, progressive) in nature.

c. Language Skills

- Assessments completed and performance (BDAE, WAB, picture description)
- Competency or ability to develop functional language skills (addressing form, content, use)
- Symbols use by the individual. Do they require concrete picture symbols, letters, abstract?
- Describe the individual's linguistic capacity to formulate language/messages (whole vs. part level of independence)

d. Cognitive Ability

- Describe attention, memory, and problem-solving skills.
- Describe how these skills relate to the ability to enhance daily communication skills and/or develop functional communication skills with an SGD.
- Include cognitive levels for clients with TBI as appropriate (example from Rancho Los Amigos levels).
 1. No response
 2. Generalized response
 3. Localized response
 4. Confused –agitated
 5. Confused, inappropriate, non-agitated
 6. Confused-appropriate
 7. Automatic - appropriate
 8. Purposeful & appropriate

Example for Aphasia:

Mr. Smith's attention, memory, and nonverbal problem- solving skills are within functional limits. He sustained attention for a two-hour evaluation, recalled how to turn on and off a SGD (after initial instruction), and independently navigated between two pages on a SGD.

e. Vision Status

- Acuity
- Visual tracking
- Visual field
- Lighting needs
- Angle of view
- Size of symbols
- Size of symbols
- Contrast (color, detail)
- Spacing

f. Hearing Status

- Describe communicator's hearing relative to communicating with a SGD (may include communication partners status).
- Include (if related to SGD use/selection): acuity, localization, understanding of natural speech, understanding SGD speech.

III. Daily Communication Needs

a. Specific Daily Functional Communication Needs

- Document specific, daily functional communication needs in any of the three areas listed below. Supplement the categories by including daily, functional communication;
 - Situations
 - Communication environments
 - Communication partners
 - Messages
- Communication to participate in activities that promote psychosocial well - being.* Specific Examples: ability to communicate in emergency situations, attending and participating in support groups, participating in day treatment activities, directing behavior of caregivers, advocating for him/herself, communicating with family, friends or clergy using the telephone.
- Communication to fulfill family roles.* Specific Examples: communicating to participate in family decision making, communicating to participate in family leisure activities, communicating with extended family by telephone.
- Communication to participate in medical decision-making.* Specific Examples: reporting medical status and complaints, asking questions of medical providers, responding to medical provider's questions, discussing choices for end of life care, communicating with medical providers using the telephone.

b. Ability to fulfill these needs using low-tech strategies, natural speech and non-SGD treatment approaches:

- Share assessment results.
- Can the individual meet daily communication needs using natural modes of communication?
- Discuss success of speech therapy (to date and future prognosis) without SGD.
- Discuss why SGD is required as opposed to non-SGD treatment approaches.
- Discuss the individual's ability to use low-tech aids and natural modes of communication to meet their daily functional communication needs.
- Show explicitly that other forms of treatment have been considered and ruled out.

IV. Functional Communication Goals

- List communication goals and a timetable for completion of these goals.
- Goals should correspond to specific daily functional communication needs, and illustrate how the patient's speech disability will benefit from the acquisition and training of the SGD.

V. Cognitive and Physical Abilities to Use the Device

a. Cognitive

- Describe cognitive abilities to use the SGD (e.g., reading, comprehension, spelling, symbol skills, sequence recall, create complete messages with SGD, produce or formulate SGD communicative messages). Demonstrate that the patient possesses the cognitive abilities to effectively use the selected SGD and required accessories to communicate functionally.

b. Physical

- Describe pertinent considerations, (e.g., ambulatory status, position (when the individual will use the SGD), seating, description of how the person will access the SGD from a motor standpoint (direct selection, scanning), switch access requirements, and accommodations for access changes).
- Demonstrate that the patient possesses the physical abilities to effectively use the selected SGD and required accessories to communicate.

VI. Rationale for Device Selection

a. Describe the general features of the recommended SGD corresponding to individual needs and abilities.

- State, "This individual requires a speech generating device to meet their functional communication goals."**

Selection Technique

1. Direct Selection

- Keyboard/Display: dynamic/static, number of keys/locations
- Activation Type: touch sensitive, pressure sensitive, adjustable,
- Optical pointer, eye gaze, other (specify)

2. Scanning

- Display: number of keys, dynamic/static
- Mode: visual, auditory
- Type of Scan: linear, row-column, group-row column, directed (joystick, track ball), adjustable speed
- Switch: type (pressure, feedback), position, mount

3. Encoding Type

- Position
- Category
- Semantic compaction
- Numeric
- Alphabetic
- Morse code
- Other (specify)

4. Type of symbols used to represent language

- Tactile
- Pictures: note quality, color vs. black & white
- Symbols: commercially available, individualized
- Words, phrases, letters
- Other (specify)

5. Message Storage Capacity

6. Vocabulary Expansion and Rate Enhancement Techniques

- Screens or levels
- Word prediction
- Other (specify)

7. Voice Output Parameters

- Digitized speech: Equal to or under 8 minutes or Over 8 minutes
- Synthesized speech: Age/gender specific, auditory scanning with alternate voice, etc.

8. Visual Display

- Type: LCD, Monochrome, Color
- Size: Number of Characters that display can accommodate, Size of Characters

9. Feedback options

- Auditory (voice, click, tone)
- Visual (e.g., increased size when selected)

10. Other Features

- Portability: Size & weight, transport/mount, case/carrier requirements
- Battery time required
- Manufacturer Warranty
- Platform (IBM vs. Mac)

b. Recommended Medicare Device Category

- Refer to accompanying chart to specify code (E2500- E2599) after determining the preceding parameters.
- State, "**The individual's ability to meet daily communication needs will benefit from acquisition and use of the (name the specific SGD).**"

c. Detailed description of equipment and procedures used for practice trials of the recommended SGD.

- Include evidence that the individual was present and actively participated in the evaluation and trial processes.
- Discuss trial outcomes in terms relating to described functional communication needs.
- Estimate prognosis that the patient's speech disability will benefit from the device ordered.

d. Other SGDs that were presented and the outcomes of the trials.

- List all equipment tried and outcome of each trial.

e. SGD and accessories recommended.

- List the specific SGD & include rationale for why this SGD will meet the patient's communication needs most effectively.
- Include rationale for peripheral accessories.

f. Patient/family support of SGD

- Discuss family/individual evaluation/trial participation, agreement and support of this equipment.

g. Physician involvement statement.

- State, " A copy of this report has been forwarded to (the patient's) treating physician (Name, license #) prior to ordering the (name SGD)."

VII. Intervention Schedule

- Frequency of Speech-Language Pathology Treatment
- Schedule for Goal Achievement
 - Operational competency achievement dates
 - Linguistic/functional communication competency achievement dates
- Type of Treatment (Individual vs. Group)
- Projected Frequency of Reassessment
- Follow-up Requirements for SGD
 - Individual(s) responsible for programming
 - Individual(s) responsible for troubleshooting
 - Include treatment plan that includes a training schedule and type of treatment for the selected device.

VIII. Functional Benefit of Upgrade

- To upgrade a previously issued SGD, provide information regarding the functional benefit to the patient compared to the initially provided SGD.
- Provide rationale for upgrade as related to daily functional communication needs.

IX. SLP Credentials & Signature

- Evaluating SLP name, ASHA #, License # & state.
- State, "The Speech-Language Pathologist performing this evaluation is not an employee of and does not have a financial relationship with the supplier of the SGD."**

Device Reference

	SGD	SGD	SGD	SGD	SGD Software	Mounts	Accessory
Code	E2500	E2502	E2508	E2510	E2511	E2512	E2599
Speech Output	Digitized	Digitized	Synthesized	Synthesized	Synthesized	N/A	N/A
Message Type	Prerecorded Messages	Prerecorded Messages	Message formulation	Message formulation	Message formulation	N/A	N/A
Recording Time	< 8 minutes	> 8 minutes	N/A	N/A	N/A	N/A	N/A
Access Method	Multiple	Multiple	Direct physical contact with SGD	Multiple	Multiple	N/A	N/A
Message Formulation Technique	N/A	N/A	Spelling	Spelling and other methods	Spelling and other methods	N/A	N/A
FRS Products				FRS Comlink ST+ ComLink LT ChatPC-D4+ ChatPC Silk-D ChatBox 40-XT Alt Chat-D		Mount	Switches, Case, Optical head pointer, Joystick, W/C integration devices, SGD scanning devices, Replacement battery & or battery charger

**SAMPLE
SPEECH GENERATING DEVICE EVALUATION
FOR MEDICARE**

I. DEMOGRAPHIC INFORMATION

Name: _____ History Number: _____
Date of Birth: _____ Account Number: _____
Medical Diagnosis: _____
Medicare: _____ Date: _____
Date of Onset: _____
Mailing Address: _____

II. CURRENT COMMUNICATION IMPAIRMENT

Circle: Aphasia Apraxia Dysarthria Anarthria

(This is a sample of what Medicare wants in the evaluation. The following blank lines are for patient's name).

A. Severity

This patient's needs cannot be met using natural communication methods or low-technology speaking aids. _____ has no useable speech. _____ is unable to produce intelligible utterances.

B. Anticipated Course of Impairment

Circle:

- Stage 1: No detectable speech disorder
- Stage 2: Obvious speech disorder, intelligible
- Stage 3: Reduction in speech intelligibility
- Stage 4: Natural speech supplemented with Speech Generating Device (SGD)
- Stage 5: No useful speech (Speech Generating Device only)

Patient is currently at stage 5 and will remain at this level due to the degenerative nature of the disease.

C. Language Skills

_____ has the ability to formulate messages and converse using augmentative communication systems. _____ demonstrates good use of semantics and syntax.

D. Cognitive Ability

_____ attention, memory and nonverbal problem-solving skills are within functional limits. _____ sustained attention for a two-hour evaluation; recalled how to turn on and off the device and how to do simple short cuts to navigate between two screens.

_____ has also demonstrated some programming with a loaner FRS Comlink ST.

E. Vision Status

_____ demonstrated good visual skills on the FRS Comlink ST and because he/she is active and ambulatory the small size makes it easy to take into the community. Visual tracking was 100% on the assessment portion of the FRS Comlink ST.

F. Hearing Status

Hearing was functional for communication in one on one and in-group settings and for the synthesized voice of the FRS Comlink ST.

III. DAILY COMMUNICATION NEEDS

A. Specific Daily Functional Communication Needs

Using the speech-generating device (SGD), _____ will have the ability:

1. To participate in activities that promote psychosocial well-being such as emergency situation, support groups and community activities.
2. To fulfill family roles such as participating in family decision making, family leisure activities and communication with extended family by phone.
3. To participate in medical decision making such as reporting medical status, complaints, asking questions of medical providers and discussing choices for end of life care and communicating with medical providers by phone.

B. Ability to Use Low-Tech Strategies

Attempts to use low-tech aids revealed difficulty with use of letter board since _____ does not spell. He/she had difficulty with recall of letters indicated to spell words and phrases.

The use of a SGD could be used over the telephone and without the burden of communication on the listener. Other forms of treatment for improved speech are not indicated due to the progressive nature of his diagnosis.

IV. FUNCTIONAL COMMUNICATION GOALS

Pt. has already demonstrated use of the device without cues in various community settings using a loaner. Pt. will program two pages without cues with 95% accuracy to communicate needs to caregiver within the first 3 weeks.

Pt. will demonstrate communication of information to spouse with 95% accuracy using the SGD within the first 3 weeks.

Pt. and caregiver will complete a 6-hour training class for programming and use of the SGD in the community.

V. USE OF THE DEVICE

1. Cognitive

The patient demonstrates the ability to read, comprehend, spell, recall instructions and sequences and create complete messages with the SGD. He/she demonstrates the ability to use the SGD selected as well as the required accessories to communicate functionally.

2. Physical

The patient is ambulatory and can access the communication device by using direct selection.

_____ was able to demonstrate use of the device to communicate needs during the evaluation.

He/she has used the device during clinic to communicate to physicians and therapists without difficulty.

VI. RECOMMENDATION AND RATIONAL FOR DEVICE SELECTION

The patient requires use of the FRS Comlink ST+ to meet functional daily communication needs. He/she was able to demonstrate use with limited error productions. _____ also attempted to use an eyegaze board, a laptop with onscreen keyboard, Allora and Tellus 3+. The FRS Comlink ST+ was selected because of _____ ability to use touch, the portability of the device and the ability to create multiple pages to communicate at home, church and in the community where _____ remains active. Use of the other devices did not provide the speed, accuracy and ability to communicate novel utterances in addition to preset icons/words. Use of the keyboard in alphabetical order was helpful, as _____ was not familiar with a standard QWERTY keyboard prior to his disability. Due to the degenerative nature of the disease _____ will require the use of the plate switch for access.

Based on SGD trials, the patient would benefit from acquiring & using a SGD from the:
(E2510) FRS Comlink ST+ - to improve functional communication.
(E2512) Wheelchair Mount – needed to secure the SGD onto the wheelchair, to help maintain proper position of the device for use.

These items are available from:
Forbes Rehab Services, Inc.
49 S. Illinois Ave.
Mansfield, OH 44905
1-888-884-2190

VI. PATIENT AND FAMILY EDUCATION

The patient, _____ and caregiver were educated on use of the FRS Comlink ST+ and basic information was reviewed with the patient demonstrating comprehension. The patient and the family selected the ST+ and related accessories and agreed to support the use of this equipment at home and in the community.

VII. INTERVENTION SCHEDULE

_____ has completed a 1-hour individual training with a loaner FRS Comlink ST+ and is using it on a consistent basis. Training will include a 6-hour group class for use of this SGD and individual follow-up every 3 months in Neuromuscular/ALS clinic.

VIII. FUNCTIONAL BENEFIT OF UPGRADE (if this is first device see second paragraph)

The patient has relied on her/his Original DynaVox to augment her/his speech. However, it is malfunctioning and we have been advised that parts are no longer available for repair. Combined with the higher quality technology that is now available, the length of time of ownership of the current SGD (over 7 years), and the significant nature of the current SGD, a new FRS Comlink ST+ is warranted.

If this is the patient's first device put in statement - The patient has not previously owned a speech generating device; this is her/his first request to purchase one.

(Name of SLP) MA CCC-SLP

Speech Language Pathologist, (Name of Facility)

"I am not an employee of and do not have a financial relationship with the supplier of the SGD recommended."

(Doctors name), PhD, MD

Medical Director, (Name of Facility)

"I agree with the above recommendations and acknowledge receipt of this evaluation prior to the equipment order."



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PHYSICIAN ORDER / PRESCRIPTION

Patient Information:

Patient Name: _____

Patient Address: _____

Medicare No. (HICN): _____

Clinical Information

Prescribed Date: _____ Length of Need: _____

Diagnosis & ICD-9 Codes: _____

MR Diagnosis: No Yes, if yes, provide Diagnosis Code: _____

Prognosis: _____

Equipment Prescribed (Must be item specific, list all items)

_____	_____
_____	_____
_____	_____
_____	_____

Please indicate if you have received a copy of the Speech-Language Pathologist's completed Augmentative Communication Evaluation for the subject patient. (Required by Medicare)

Yes No

Physician's Information

Physician's Name: _____ NPI#: _____

UPIN# _____ Phone # (____) _____

Address: _____

Physicians Signature: _____ Date: _____





“Creating A Better Tomorrow, Today”

Dear Medicare Beneficiary and Family,

Your Physician and Speech Therapist recommended a Speech Generating Device during a recent evaluation. This equipment is covered by Medicare part B at the standard 80% coverage of the allowable cost. Our company, Forbes Rehab Services, Inc., is the sole-source provider for this equipment. We will be responsible for filing the claims on your behalf with Medicare, your private supplemental insurance carrier (if applicable) or Medicaid (if applicable). If your secondary funding is Medicaid, no monies will be due from you. However, for all other secondary funding sources, we must collect the 20% co-pay before we can deliver the equipment. Our company must gather some information and documents from you to begin this process. The steps below will give you detailed instructions regarding what we require from you.

Please contact our office with any questions you may have.

- Step #1 Complete the Funding Questionnaire. All required documents are noted at the bottom of the form; send everything back to FRS, Inc.

- Step #2 Sign the Medicare Release and Assignment of Benefits Form. This form allows the funding sources to pay us directly and gives us permission to have your sensitive medical information. (This will be sent later)

- Step #3 Make copies of your Medicare, Medicaid and supplemental insurance Cards, front and back.

- Step #4 If you owe the 20% co-payment, send a check made payable to FRS, Inc. If you have not met the \$135.00 calendar 2009 deductible for Medicare, include that in your co-pay amount or send a check for \$135.00 payable to FRS, Inc.

We thank you for your interest in a Speech Generating Device and pledge we will provide the equipment to you as soon as possible.



"Creating A Better Tomorrow, Today"

Funding Questionnaire

Beneficiary Information (The beneficiary is the recipient of the funding. No PO Box please for shipping reasons).

First Name _____ MI _____ Last Name _____
Address _____ Phone #(_____) _____
City _____ Date of Birth _____
State _____ Zip _____ SSN# _____
Sex: Male Female
Place of Residence? Home Group Home Nursing Home Long Term Care Facility
 Other _____ Facility Fax #(_____) _____
Have you applied for or currently on Hospice? No Yes

Have you ever owned a Speech-generating Device?
 No Yes, attach invoice from old device.

Beneficiary Contact Information (Who could answer any questions we may have by phone?)

First Name _____ Last Name _____
Address if Different than above _____
Home Phone # (_____) _____ Work Phone # (_____) _____
Fax # (_____) _____ Email address: _____
Relation to Beneficiary: Spouse Parent Guardian Other: _____

Who Is Your Speech Therapist?

First Name _____ Last Name _____
Facility Name _____
Address _____
City _____ State _____ Zip _____
Phone # (_____) _____ Fax # (_____) _____
Email address: _____

Required Documents

This is your checklist; we need all of the following documents sent to FRS, Inc.

- Completed Funding Questionnaire (this form)
- Clear and current copies of both sides of all insurance cards (Medicare, Medicaid, Private Ins. CHAMPUS)
- Signed Medicare Release and Assignment of Benefits Form
- Payment of Co-Pay and/or Deductible enclosed, (if applicable)





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Place of Service Billing Code

Forbes Rehab Services, Inc. is putting together a funding request for a repair/replacement or new Speech Generating Device for _____. Medicare requires that we identify the exact “Place of Service” before billing Medicare. If the beneficiary lives in a private residence then mark code 12 and have signed by the beneficiary, parent/guardian or POA. For a facility, indicate the licensing category for the wing the beneficiary resides in and have signed by a member of the facility’s management.

Please indicate below, what licensing category the above named beneficiary resides in, the name of the facility (if applicable), phone number and the full address:

- _____ Code 12 – Private Residence
- _____ Code 31 – Skilled Nursing Facility (SNF)
- _____ Code 32 – Nursing Facility
- _____ Code 33 – Custodial Care Facility
- _____ Code 54 – Intermediate Care Facility/ Mentally Retarded

Facility name (if applicable): _____ Phone # (____) _____

Full address: _____
City State Zip Code

Signature & Title of person completing this form _____ Date _____

When completed, please FAX to **1-877-884-9383** or mail this form to FRS, Inc.

PLEASE INCLUDE CURRENT COPY OF THE CLIENT’S MEDICAID/MEDICARE CARD WITH THE RETURN OF THIS FORM.

Thank you for your help.

Forbes Rehab Services, Inc.
Funding Department
49 South Illinois Avenue
Mansfield, OH 44905