MEDICAL POLICY

Medical Policy Title	**Augmentative and Alternative Communication Systems (e.g., Speech Generating Devices)**
Policy Number	**1.01.03**
Current Effective Date	August 21, 2025
Next Review Date	August 2026

Our medical policies are based on the assessment of evidence based, peer-reviewed literature, and professional guidelines. Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract. (Link to Product Disclaimer)

POLICY STATEMENT(S)

I. Augmentative and Alternative Communication Systems (AACs), including Speech Generating Devices (SGDs), are considered **medically appropriate** when **ALL** the following criteria are met:

A. The patient has had a formal evaluation of his/her ability to use the device effectively and of his/her language ability by a speech-language pathologist (SLP) with training and experience with a variety of different SGDs. The formal, written evaluation should include, at a minimum, the following elements:

1. a description of the current communication impairment, including type, severity, language skills, cognitive ability, and anticipated course of the communication impairment;
2. a technological assessment of whether the individual's basic daily communication needs could be met using other modes of communication which includes the use of the most basic technological device that is medically appropriate;
3. a description of the functional communication goals expected to be achieved, treatment options, and the rationale for selection of the specific device and accessories;
4. a treatment plan that includes a training schedule within the environment where the device will be used;
5. request for a minimum of a one-month trial of the device, to include the reevaluation of the member at the end of the trial period, and documented effectiveness of achieving expected goals of the AAC or SGD training/trial program; **and**
6. the formal evaluation documenting the history of AAC or SGD usage within all the environments that the device has been used;

B. Documentation by an appropriate health professional (e.g., occupational therapist, psychologist, developmental pediatrician) that the patient possesses the cognitive and physical abilities to effectively use the selected device and any accessories to communicate;

C. The patient's speech disability will benefit from the device ordered. Consideration of the device is based on which device is the most appropriate for the patient's current functional

level and can still be safely and efficiently used by the patient. If a high-tech device (please refer to Description Section for definition of high-tech device) is requested, documentation demonstrating that an alternative communication device or system has failed to meet the individual's basic communication needs must be included with the request;

D. The requested device has not been selected primarily for the convenience of the patient, the patient's family, the provider of services, or another provider.

II. AACs, including SGDs do not improve patient outcomes and are considered **not medically necessary** when basic communication needs (e.g., pain, hunger and toileting) of adults can be met by using natural communication methods (e.g., manual signing, writing).

III. Durable Medical Equipment (DME) Repair

A. Repair of medically necessary AACs/SGDs or components not under warranty will be considered **medically appropriate** when the following criteria are met:

1. Physician documentation includes **ALL** the following:

a. date of AACs/SGDs initiation;

b. manufacturer warranty information, if applicable;

c. attestation that the patient has been compliant with the use of the AAC/SGD and will continue to benefit from the use of the AAC/SGD;

2. The AAC/SGD is no longer functioning adequately; and **BOTH** of the following criteria are met:

a. inadequate function interferes with activities of daily living; **and**

b. repair is expected to make the equipment fully functional (as defined by manufacturer).

B. Repair of equipment damaged due to patient neglect, theft, abuse, or when another available coverage source is an option (e.g., homeowners, rental, auto, liability insurance, etc.) is **ineligible for coverage**.

IV. DME Replacement

A. Replacement of medically necessary AACs/SGDs or components not under warranty will be considered **medically appropriate** when **EITHER** of the following criteria are met:

1. The AAC/SGD is no longer functioning adequately and has been determined to be non-repairable, or the cost of the repair is in excess of the replacement cost;

2. There is documentation that a change in the patient's condition makes the present unit non-functional and improvement is expected with a replacement unit.

B. The replacement of properly functioning AACs/SGDs, its components or accessories is considered **not medically necessary**. This includes, but is not limited to, replacement desired due to advanced technology or to make the DME more aesthetically pleasing;

C. The replacement of equipment damaged or lost due to patient neglect, theft, abuse, or when another available coverage source is an option (e.g., homeowners, rental, auto, liability insurance, etc.) is **ineligible for coverage**.

V. Accessories or components for AACs/SGDs that are considered not medically necessary or investigational by peer-reviewed literature will also be considered as **not medically necessary or investigational** by the Health Plan

VI. Altered auditory feedback devices (delayed or frequency are classified as communication aids for the treatment of stuttering (e.g., SpeechEasy, SmallTalk, Fluency Enhancer). The use of altered auditory feedback devices is considered **investigational.**

VII. A laptop computer, desktop computer, personal digital assistant (PDA) or other devices that is not a dedicated AAC (including SGD) is **ineligible for coverage** because it does not meet the definition of durable medical equipment (DME).

VIII. Software that enables a laptop computer, desktop computer or PDA to function as an SGD is **eligible for coverage** as a SGD. Installation of the program or technical support is not separately reimbursable.

IX. Accessories are **eligible for coverage**, if the coverage criteria for the base device are met and the medical necessity of each accessory is clearly documented in the formal evaluation for the SGD.

X. For New York State Managed Medicaid members, coverage for Augmentative and Alternative Communication Devices will be reviewed by the Health Plan for medical necessity per the eMedNY DME provider manual: https://www.emedny.org/ProviderManuals/DME/PDFS/DME_Procedure_Codes.pdf [accessed 25 Jul 03]

RELATED POLICIES

Corporate Medical Policy

1.01.00 Durable Medical Equipment – Standard and Non-Standard

1.01.18 External Prosthetic Devices

11.01.15 Medically Necessary Services

11.01.03 Experimental or Investigational Services

Coverage for artificial larynx or tracheo-esophageal voice prosthetics is not addressed in this policy. Refer to Corporate Medical Policy #1.01.18 External Prosthetic Devices

POLICY GUIDELINE(S)

I. Pursuant to New York State law, an AAC (including an SGD) is considered a component of a comprehensive treatment plan for an individual with autism spectrum disorder and will be covered if the individual meets the criteria identified in this policy.

II. Prior to submission of a request to the Health Plan for coverage of an AAC (including an SGD) for a pre-school or school-age child:

   A. An Individualized Educational Plan (IEP) should be completed through the school district before a request for coverage is submitted to the Health Plan, as a school district is obligated to provide a device to a child when it is stipulated in the child's IEP.

   B. If a child is home-schooled, an assessment by the school district should be completed. Requests for home-schooled children outside New York State will be reviewed on an individual basis, in accordance with regulations of the state in which the member resides.

   C. Devices not stipulated in a child's IEP or denied by the school district for the child will be reviewed by the Health Plan for medical necessity in accordance with the member's subscriber contract.

III. The individual must complete at least a one-month trial using the AAC device and have shown meaningful improvement after the trial period. If there has been no documented trial period and the patient meets criteria (please refer to Policy Statement I), initial coverage is limited to one month only. Documentation from the referring provider that the patient has shown meaningful improvement during the trial period must be submitted for continuation of coverage.

IV. There are many types of AACs/SGDs. When a device with high-tech features is requested, coverage will be determined for the medically necessary device that is adequate to meet the patient's needs.

V. Coverage of all DME, including communication aids, is contract dependent, unless mandated under federal or state law.

VI. The SLP who performs the evaluation must not have a financial relationship with or be an employee of the supplier of the device.

VII. The device should be rented or loaned for a maximum one-month trial period before purchase, to allow for demonstration of the patient's ability to use the device and for measurement of communication goals.

DESCRIPTION

Traditional AAC methods are designed to assist users communicate via alternatives to natural speech. These can be low- or high-tech solutions and range from letter boards to button-activated voicing to eye tracking. Aided communication requires external tools or aids to supplement or replace speech. Low-tech AAC includes basic tools like communication boards, paper-based systems, and symbol

books. They are often cost-effective and easy to implement. High-tech AAC encompasses advanced options like tablet apps, dedicated communication devices, specialized digital hardware, speech generating devices (SGD), and computer software. These often offer greater versatility and can sometimes be customized to suit an individual's unique needs.

SGDs are electronic devices that produce speech based on user input. They are often used by individuals with more complex communication needs, including ataxia. These devices may use text-to-speech technology, pre-programmed messages, and predictive text options. Some SGDs can be controlled through physical movements, such as head movements or eye gaze, making them accessible to individuals with severe motor impairment.

SGDs are considered durable medical equipment that use high technology computer-based programs to provide individuals with severe speech impairment the ability to meet their functional speaking needs. These devices generate digitized or synthesized speech for word-by-word, phrase, or sentence production.

1. Digitized speech utilizes words or phrases that have been recorded for playback upon command by the SGD user.
2. Synthesized speech, unlike the prerecorded messages of digitized speech, translates a user's input into device-generated speech using algorithms representing linguistic rules. Users of SGDs that produce synthesized speech are not limited to pre-recorded messages, but, rather, can independently create messages as their communication needs dictate.

Examples of high-tech devices include but are not limited to, the Tobii Dynavox series, the Accent Series, PRiO (Prentke-Romich), and QuickTalker (AbleNet,).

Pursuant to New York State law, effective November 1, 2012, every contract providing physician services, or providing medical, major medical, or similar comprehensive-type coverage must provide coverage for the screening, diagnosis, and treatment of autism spectrum disorders when prescribed or ordered by a licensed physician or a licensed psychologist for medically necessary services. Treatment includes services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, and social worker when the policy generally provides such coverage. Therapeutic treatment must include care that is deemed habilitative or non-restorative. The law prohibits the imposition of limitations that are solely applied to the treatment of ASD. However, as long as the visit limit is not imposed solely on services required to treat an ASD, a visit limit continues to be permissible, as long as such visit limit also passes the testing requirements under the Mental Health Parity Addiction and Equity Act of 2008.

SUPPORTIVE LITERATURE

This policy is based upon Health Plan contract benefits and is intended to clarify those benefits.

Barton-Hulsey et al (2017) reported the findings of three children aged three years and six months to five years and three months with developmental and language delays who were provided experience

with a traditional grid-based display and a contextually organized visual scene display on the 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, five days a week for three weeks. Symbol comprehension and use was assessed pre- and post-three weeks of experience. Comprehension of symbol vocabulary on both displays increased after three weeks of experience. 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. 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.

Thiemann-Bourque et al (2018) examined the effects of incorporating a peer-mediated approach into an SGD intervention on communication of 45 non-verbal and minimally verbal preschoolers with autism spectrum disorder (ASD) and 95 peers without disabilities. The SGD was an iPad 2 (Apple) with a voice output application. Effects were evaluated using a multi-variate randomized controlled trial (RCT) design with repeated measures for four cohorts across baseline, intervention, generalization, and maintenance phases. Children were randomly assigned to an experimental treatment that trained peers on use of the SGD or a business-as-usual comparison condition with untrained peers. Communication outcomes were measured for both children with ASD and peers. Children receiving the treatment demonstrated significant increases in rates of communication and more balanced responses and initiations (a measure of reciprocity) than children in the comparison group. They were able to generalize improvements and maintain communication gains. The authors concluded that the findings of this study supported positive effects on communication of teaching young children with ASD and peers without disabilities to use the same SGD system in typical preschool activities. These researchers stated that SGD interventions that utilize peer-mediated approaches may improve core deficits in communication and reciprocity and allow for greater classroom social participation and interactions with peers.

PROFESSIONAL GUIDELINE(S)

According to the American Speech-Language-Hearing Association (ASHA), augmentative and alternative communication (AAC) is used by people who, for some or all the time, cannot rely on their speech. AAC describes multiple ways to communicate that can supplement or compensate for an impairment or disability patterns for individuals with severe expressive communication disorders. Augmentative means to add to someone's speech. Alternative means to be used instead of speech. People of all ages can use AAC, and choosing an aided AAC system (e.g., communication board or speech generating devices) requires careful consideration of an individual's current skills, strengths, and needs.

According to the United States Society for Augmentative and Alternative Communication (USSAAC), augmentative aids (e.g., picture and symbol communication boards and electronic devices) are available to help people express themselves. AACs are typically divided into two categories:

1. Unaided: These “no-tech” methods of communication include examples such as body language, facial expressions, finger spelling, gestures, manual signs, vocalizations, and verbalizations.
2. Aided: These methods of communication require the use of an external tool, either electronic or nonelectronic. Low-tech communication aids are defined as those that do not need batteries, electricity, or electronics to meet the user’s communication needs (e.g., picture/symbol boards, visual schedules, writing). High-tech aids are electronic devices that permit the storage and retrieval of messages, many allowing the use of speech output. Such devices can also be referred to as Speech Generating Devices (SGDs) or Voice Output Communication Aids (VOCAs).

REGULATORY STATUS

Various Augmentative and Alternative Communication Systems have been cleared for marketing by the FDA for specified indications. FDA device approval status can be determined using the following link: https://www.accessdata.fda.gov/scripts/cdrh/devicesatfda/index.cfm [Accessed 2025 Jul 10]

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech
92605	Evaluation for prescription of non-speech–generating augmentative and alternative communication device, face-to-face with the patient; first hour
92618	each additional 30 minutes (list separately in addition to code for primary procedure)
92606	Therapeutic service(s) for the use of non-speech-generating-device, including programming and modification
92607	Evaluation for prescription for speech-generating-augmentative and alternative communication device, face-to-face with the patient; first hour

Code	Description
92608	each additional 30 minutes (list separately in addition to code for primary procedure)
92609	Therapeutic services for the use of speech-generating device, including programming and modification

HCPCS Codes

Code	Description
E1902	Communication board, nonelectronic augmentative or alternative communication device
E2351	Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface
E2500	Speech generating device, digitized speech, using pre-recorded messages, less than or equal to eight minutes recording time
E2502	Speech generating device, digitized speech, using pre-recorded messages, greater than eight minutes but less than or equal to 20 minutes recording time
E2504	Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time
E2506	Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time
E2508	Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device
E2510	Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access
E2511	Speech generating software program, for personal computer or personal digital assistant
E2512	Accessory for speech generating device, mounting system
E2599	Accessory for speech generating device, not otherwise classified

Code	Description
E3000 Effective 01/01/24	Speech volume modulation system, any type, including all components and accessories (Effective 01/01/24) (Replacing code K1009)
K1009 Termed 12/31/23	Speech volume modulation system, any type, including all components and accessories

ICD10 Codes

Code	Description
Several	Codes with resulting communication impairments

REFERENCES

American Speech-Language-Hearing Association (ASHA) [Internet]. Augmentative and alternative communication (AAC) [accessed 2025 Jul 7] Available from: https://www.asha.org/public/speech/disorders/aac/

Barton-Hulsey A, et al. Comparing the effects of speech-generating device display organization on symbol comprehension and use by three children with developmental delays. Am J Speech Lang Pathol. 2014 May; 26(2):227-240.

Muharib R, et al. Effects of interventions involving tablet based speech generating devices for individuals with ASD: A meta-analysis. Journal of Autism and Developmental Disorders. 2023 published online https://doi.org/10.1007/s10803-023-06173-6.

New York Insurance Law [Internet]. Assembly Bill A8512: Relates to coverage for the screening, diagnosis and treatment of autism spectrum disorder. 2012 Nov 1. [accessed 2025 Jul 7] Available from: https://www.nysenate.gov/legislation/bills/2011/a8512

Thiemann-Bourque K, et al. Incorporating a peer-mediated approach into speech-generating device intervention: effects on communication of preschoolers with autism spectrum disorder. J Speech Lang Hear Res. 2018 Aug 8;61(8):2045-2061.

United States Society for Augmentative and Alternative Communication (USSAAC) [Internet]. AAC devices. [accessed 2025 July 7]. Available from: https://ussaac.org/aac-info/aac-devices/

Vogel, et al. Optimizing communication in ataxia: a multifaceted approach to alternative and augmentative communication (AAC). Cerebellum. 2024 Oct;23(5):2142-2151.

SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

NCD - Speech Generating Devices (50.1) [accessed 25 Jul 03]

LCD - Speech Generating Devices (SGD) (L33739) [accessed 25 Jul 03]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION

Committee Approval Dates

02/21/02, 02/27/03, 02/26/04, 12/02/04, 10/27/05, 10/26/06, 10/24/07, 12/11/08, 12/10/09, 12/09/10, 06/24/11, 04/26/12, 10/24/13, 10/23/14, 12/10/15, 12/08/16, 12/14/17, 12/13/18, 12/12/19, 12/10/20, 12/16/21, 06/23/22, 07/20/23, 08/22/24, 08/21/25

Date	Summary of Changes
08/21/25	• Annual review; updated DME canned repair/replacement policy statements
01/01/25	• Summary of changes tracking implemented.
02/21/02	• Original effective date