DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Giese	9-16-11

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-128	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____	[X] Prepare reply for appropriate signature DATE DUE 9-27-11
	[ ] FOIA DATE DUE _____
	[ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

DynaVox
Mayer-Johnson

September 14, 2011

Melanie Giese, RN
Deputy Director
Department of Health and Human Services (DHHS)
Division of Durable Medical Equipment
P.O. Box 8206
Columbia, SC 29202-8206

Dear Ms. Giese,

I am writing to request a review of your current covered HCPCS for Speech Generating Device.

The current fee schedule, published July 11, 2011 includes E2504 and E2510 as covered services within the speech generating device category; however E2506 and E2508 are not included as covered services. These HCPCS are covered by Medicare and were covered through South Carolina Medicaid prior to a revision in 2008.

We received a request for a South Carolina Medicaid beneficiary in need of a DynaWrite SGD, coded E2508. The request was submitted for prior authorization and denied, as the service is non-covered. I have attached this documentation for your review.

We would like to ask that you review the covered codes available for SGDs and re-open E2506 and E2508 as covered benefits.

Should you have any additional questions, you may reach me at 412-222-7824 or Alicia.Bundy@dynavoxtech.com. Thank you in advance for your attention to this matter.

Sincerely,

Alicia Bundy

Alicia Bundy
Reimbursement Manager
DynaVox Systems LLC
2100 Wharton Street, Suite 400
Pittsburgh, PA 15203

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Giese/Williams	9-16-11

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-128	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____	[X] Prepare reply for appropriate signature DATE DUE 9-27-11
	[ ] FOIA DATE DUE _____
	[ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. Colleen Williams	9-29-11		
2. BG Giese	10/3/11 OK		
3.			
4.			

South Carolina Department of Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

October 3, 2011

Ms. Alicia Bundy
Reimbursement Manager
DynaVox Systems, LLC
2100 Wharton Street, Suite 400
Pittsburgh, Pennsylvania 15203

Dear Ms. Bundy:

Thank you for your letter regarding coverage of DynaWrite Speech Generating Devices (SGD) Healthcare Common Procedure Coding System (HCPCS) code E2508. We welcome the opportunity to be of assistance.

Covered SGD categorized as E2510 are more advanced devices than the devices that are described in non-covered procedure codes, E2506 and E2508. The covered devices offer many years of usage and allows progressive utilization by the recipient. SCDHHS strives to ensure the most effective use of the SGD for the authorization period.

Our agency has reviewed the enclosed Prior Authorization (PA) request for the E2508 device. Based on the specific needs of this recipient, we will forward the documentation to our Speech Consultant, Ms. Emma Jean McKenzie, for further review of this PA packet. The request will be returned to DynaVox after it is reviewed with a determination of an approval or a denial for this device. Future requests for non-covered devices for recipients under the age of 21 will be reviewed case-by-case.

Thank you for bringing your concerns to our attention. If you have additional questions or concerns, you may contact your Program Representative, Ms. Evelyn Johnson in the Office of Physician, Pharmacy and Enhanced Care Services (803) 898-2655.

Sincerely,

Melanie "BZ" Giese, RN
Deputy Director

MG/wr

Medical and Managed Care Services
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-0178 Fax (803) 255-8235

Department of Enhanced Care Services
Post Office Box 8206
Columbia, South Carolina 29202-8206
Fax: (803) 255-8222

Date: 7-21-11 Provider ID#: DE2471

Recipient's Name: Andrew Campbell

The attached Prior Authorization (PA) request for equipment/supplies for the above Medicaid recipient is being returned. It cannot be processed because of the item(s) checked. **Before returning your request back to Medicaid, make sure all appropriate fields has been completed. Each time the request is returned it will delay the processing.**

( ) The Certificate of Medical Necessity (CMN) form was not attached to the prior authorization form.

( ) Please use the new Certificate Of Medical Necessity Form (DME001-dated 04/01/10)

( ) The CMN and/or support documentation does not medical justify the need for the equipment/supplies being requested.

( ) The CMN and/or support documentation submitted is not legible.

(✓) All fields were not completed on the PA and/or CMN. PA form: _____, _____, _____, _____, _____ and _____.
CMN form: 10, 13-Pt. Signature, _____, _____ and _____.

( ) Prior authorization form (214) is missing.

( ) Manufacturer pricing form missing.

(✓) Manufacturer pricing form must show the printed required NOC procedure codes on the form. Missing procedure code

( ) Medicaid number submitted is not valid. Please call Medicaid interactive voice response system at 1(888)-809-3040 for verification.

( ) Please call Medicaid Interactive Voice Response system at 1(888)-809-3040 for recipient insurance information before submitting to Medicaid.

( ) Recipient is in a HMO program: _____. Please contact them.

( ) Recipient is not eligible for Medicaid as of _____. ( ) Recipient has Medicare. Please bill them first.

( ) Recipient has other insurance. Please bill them first.

(✓) Other: Procedure code E2508 is non-covered. Missing the physician signature date and the prescription date must be written 60 days of the treating/ordering Physician signature date.

P.S. Please use the current CMN's listed in the DME manual.

Please contact me at (803) 898-2573 if you have questions regarding this action.

Evelyn Johnson
Program Coordinator I
School Base Service

Revised 12/10

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM
FOR POWER/MANUAL WHEELCHAIRS AND/OR ACCESSORIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name: _____ Medicaid # (10 digits) _____

(2) DOB ___/___/___; Sex: ___ HT: _____(in); WT: _____ Date of Service: _____

(3) Provider's name: _____ Provider's DME # _____ NPI#: _____

(4) Street address: _____ City: _____ State: _____ Zip: _____ Local telephone #: _____

(5) Provider's signature: _____ Date: _____

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN ON: _____

_____

_____

PLEASE NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

I ATTEST THAT THE PT/OT THERAPIST AND/OR THE TREATING /ORDERING PHYSICIAN HAS NO FINANCIAL RELATIONSHIP WITH MY COMPANY.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD-9): _____ Diagnosis(s): _____

_____ _____

(8) Indicate the patient's mobility limitation & explain how it interferes with the performance of activities of daily living (ADLs):

_____

_____

- Explain why a cane or walker is not sufficient to meet the patient's mobility needs in the home:

_____

- Explain why a manual wheelchair is not sufficient to meet the patient's mobility needs in the home:

_____

- How long has the condition been present and what is the patient's clinical progression:

_____

_____

- Indicate any related diagnosis and all other interventions tried and the results:

_____

_____

- Has the patient ever used a walker, manual or power wheelchair and what were the results?

_____

_____

(9) Please indicate the date that the patient was seen for the equipment/supplies prescribed: _____

(10) Prescription Date: _____

(11) Duration of need (Maximum of 12 months): _____

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(12) PRINT PHYSICIAN'S NAME: _____ NPI # _____

PHYSICIAN'S SIGNATURE: _____ DATE ___/___/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR POWER/MANUAL WHEELCHAIRS AND/OR ACCESSORIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND MEDICAID #:	**Indicate the patient's name and his/her Medicaid # (10 digits).**
PATIENT DOB, SEX, HEIGHT, WEIGHT:	**Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds.**
DATE OF SERVICE:	**Indicate the date of service (DOS). The date of service must be the same as the delivery date.**
PROVIDER'S NAME, DME # AND NPI#:	**Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.**
PROVIDER'S PHYSICAL ADDRESS AND TELEPHONE NUMBER:	**Indicate the provider's physical address (provider's location) and telephone number.**
PROVIDER SIGNATURE AND DATE:	**Signature of DME provider representative and date.**
HCPCS CODES:	**List all HCPCS procedure codes for items ordered by the treating/ordering physician. Note: For all procedure codes that are covered, but do not have an established price, you must include manufacturer price list.**

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES:	**In the first field, list the ICD-9 diagnosis code(s) that represent(s) the primary reason(s) for ordering this item. In the second field, list the description(s) for each ICD-9 diagnosis code(s).**
QUESTION SECTION:	**This information is used to gather clinical information to help Medicaid determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered.**
DATE PATIENT WAS SEEN FOR EQUIPMENT/SUPPLIES PRESCRIBED:	**Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 60 days before prescribing equipment and/or supplies.**
PRESCRIPTION DATE:	**Indicate the prescription date. The prescription date must be within 60 days of the date of treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame will be returned (if submitted with a PA) or rejected (if attached to a claim) and the MCMN will be deemed invalid.**
EST. LENGTH OF NEED:	**Indicate the estimated length of need (the length of time the physician expects the patient to require use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the equipment/supplies prescribed.**
PHYSICIAN ATTESTATION:	**The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B; (2) answers in Section B are correct and the self-identifying information in Section A is correct.**
PHYSICIAN SIGNATURE AND DATE:	**After completion and/or review by the physician of Sections A and B the physician's must sign and date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's signature also certifies the item(s) order is medically necessary for this patient.**

SECTION 4 DURABLE MEDICAL EQUIPMENT FEE SCHEDULE

HCPCS Code	Description	Modifier	Payment Rate	MCMN Required	Prior Auth Required
E2397	PWR W-CHR ACC,LITHIUM-BASED BATTERY, EA.	LL	$37.97		
E2397	PWR W-CHR ACC,LITHIUM-BASED BATTERY, EA.	NU	$379.62		
E2397	PWR W-CHR ACC,LITHIUM-BASED BATTERY, EA.	UE	$284.70		
E2402	NEGATIVE PRESUR WOUND THER ELECTRIC PUMP	RR	$1356.12		X
E2500	SPEECH GENERAT DEV,DIGIT PRE-REC <=8 MIN	LL	$38.76		X
E2500	SPEECH GENERAT DEV,DIGIT PRE-REC <=8 MIN	NU	$358.46		X
E2500	SPEECH GENERAT DEV,DIGIT PRE-REC <=8 MIN	UE	$268.85		X
E2502	SPCH GENERAT DEV,DIG PRE-REC >8 <=20 MIN	LL	$109.61		X
E2502	SPCH GENERAT DEV,DIG PRE-REC >8 <=20 MIN	NU	$1096.13		X
E2502	SPCH GENERAT DEV,DIG PRE-REC >8 <=20 MIN	UE	$822.10		X
E2504	SPCH GEN DEV,DIG PRE-REC MSG,>20MIN,<=40	LL	$144.60		X
E2504	SPCH GEN DEV,DIG PRE-REC MSG,>20MIN,<=40	NU	$1445.94		X
E2504	SPCH GEN DEV,DIG PRE-REC MSG,>20MIN,<=40	UE	$1084.44		X
E2510	SPCH GEN DEV,SYN SPCH,MULTI METH MSG/ACC	LL	$620.41		X
E2510	SPCH GEN DEV,SYN SPCH,MULTI METH MSG/ACC	NU	$6204.11		X
E2510	SPCH GEN DEV,SYN SPCH,MULTI METH MSG/ACC	UE	$4653.08		X
E2512	ASS. FOR SPEECH GEN. DEVICE	NU	M		X

MAIL TO: DEPT. OF HEALTH AND HUMAN SERVICES, P. O. BOX 8206, COLUMBIA, S. C. 29202-8206

PRIOR AUTHORIZATION

1 CLAIM CONTROL NUMBER (DO NOT WRITE IN THIS SPACE)

TYPEWRITER ALIGNMENT
USE CAPITAL LETTERS ONLY

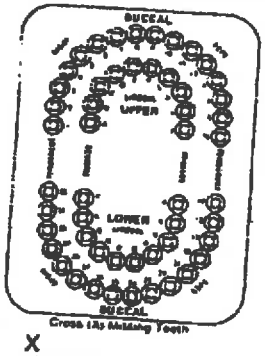
PROVIDER INFORMATION

2 PROVIDERS NAME: DYNAVOX SYSTEMS
3 PROVIDER ID NUMBER: DE2471
4 OWN REFERANCE #
5 DATE SUBMITTED: 7/19/11
6 STREET ADDRESS: 2100 WHARTON ST, #400
7 CITY/STATE/ZIP: PITTSBURGH, PA 15203
8 NAME AND DEGREE OF MEDICAL PROVIDER
9 PRIOR AUTHORIZATION #

RECIPIENT INFORMATION

10 RECIPIENT NAME (FIRST, MIDDLE INITIAL, LAST): ANDREW CAMPBELL
11 RECIPIENT ID NUMBER: 27806780 54
12 SEX: M
13 BIRTH DATE: 9/1/92

14 SERVICE INDICATOR	15 SERVICE CODE	16 MODIFIER	17 TYPE OF SALE	18 REQUESTED # BILLINGS	19 EPSDT REFERRAL	20 PROPOSED CHARGE	21 AUTHORIZED	22 ALLOWED # BILLINGS	23 DELETE	24 SERVICE NAME	25 TOOTH #	26 TOOTH SURFACES	27 AUTHORIZED CHARGE	28 EXPIRATION DATE
5	E2508	NU	3			4995.00				DYNAWRITE				
29	30	31	32	33	34	35	36	37	38	39	40	41	42	43
44	45	46	47	48	49	50	51	52	53	54	55	56	57	58
59	60	61	62	63	64	65	66	67	68	69	70	71	72	73
74	75	76	77	78	79	80	81	82	83	84	85	86	87	88



89 DOCUMENTATION ATTACHED
90 TOTAL UNITS BILLED
91 TOTAL PROPOSED CHARGES
92 TOTAL AUTHORIZED CHARGES

EXPLAIN MEDICAL NECESSITY FOR EACH PROCEDURE BELOW

X

93 REVIEWED BY (FOR DEPARTMENT USE ONLY)

X DAVID DUGHAN 7-19-11

94 PROVIDERS SIGNATURE

DHHS FORM 214 (4/97) Replaces DSS Form 3204 (1-79) which may be used until exhausted.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM FOR EQUIPMENT/SUPPLIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name: Andrew Campbell Medicaid # (10 digits): 2780678054

(2) DOB: 09/01/1992; Sex: M HT: ______ (in); WT: ______ Date of Service: / / Upon Approval

(3) Provider's name: DynaVox Provider's DME # DE2471 NPI# 1831263110

(4) Street address: 2100 Wharton St. City: Pittsburgh State: PA Zip: 15203 Local telephone #: 800-344-1778

(5) Provider's signature: [signature] Date: 6/27/11

(6) LIST ALL PROCEDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR EQUIPMENT/SUPPLIES:
E2508

NOTE: FOR ALL PROCEDURE CODES THAT ARE COVERED, BUT DO NOT HAVE AN ESTABLISHED PRICE, YOU MUST INCLUDE MANUFACTURER PRICE LIST.

SECTION B: ALL FIELDS IF APPLICABLE MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

(7) Diagnosis codes (ICD-9) 313.23 Description(s): Mutism

(8) Indicate patient's ambulatory status while performing activities of daily living: ___ Non-ambulatory ✓ Ambulatory, without assistance ___ Ambulatory with the aid of a walker or cane, ___ Ambulatory, with other assistance as described

Does the patient have decubitus ulcers? ___ Yes ✓ No. If yes, circle stage(s): I, II, III, or IV. Indicate the wound size(s): ______

Please describe how this equipment / supply is medically necessary, the benefits to the recipient and how long will it take for the benefit to be evident:

(9) For supplies, please indicate the dressing change required per day, week, month, etc.

Is additional information attached on separate sheet? ___ Yes ✓ No (If "yes," enter recipient's name & I.D. Medicaid number on attachment

(10) Please indicate the date that the patient was seen for the equipment/supplies prescribed: ______

★ (11) Please indicate the prescription date: 11-13-09

(12) Duration of need (maximum of 12 months): 12 months
(Please indicate duration by months, not to exceed 12).

I certify that I am the treating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission or concealment of material fact may subject me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.

(13) PHYSICIAN'S NAME: Joe B. Castles, III M.D PHYSICIAN'S NPI #: 1508961442

★ PHYSICIAN'S SIGNATURE: [signature] DATE / / (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

DME 881 - Dated 04/01/10

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY

SECTION A:

LINES 1 THRU 10 TO BE COMPLETED BY ENROLLED DME PROVIDER:

Line 1 - Enter recipient's full name, height and weight.
Line 2 - Enter recipient's Medicaid 10-digit number, sex and date of birth.
Line 3 - Enter the date of telephone/written/fax order and date of service.
Line 4 - Print provider's name and provider's DME number.
Line 5 - Provider's signature and date.
Line 6 - Enter provider's street address and city.
Line 7 - Enter provider's state, zip code and local telephone number.
Line 8 - Enter diagnosis code(s) and description.
Line 9 - Print treating/ordering physician's name and enter License Number
Line 10 – List all procedure codes for Equipment/Supplies

SECTION B:

LINES 11 THRU 14 TO BE COMPLETED BY TREATING/ORDERING PHYSICIAN

Line 11 -This medical information is used to determine medical necessity.
(If applicable, enter the appropriate oxygen/saturation levels)
Line 12 - Date last seen or evaluated by treating/ordering physician.
Line 13 - Enter duration of need.
Line 14 - Physician must sign and date the MCMN.

Please list all procedure codes that will be utilized on the following lines:

E2508, 1 UNIT, DYNAWRITE $4,995.00

PHYSICIAN PRESCRIPTION

Patient Information

Patient Name: Andrew Campbell

Patient DOB: 09/01/1992

Patient Medicare Number (if applicable): N/A

Patient Address: 109 Vineyard Crossing Ct.
Columbia, SC 29229

Clinical Information

Medical Diagnosis (please do not list ICD-9 code): Selective Mutism

Communication Diagnosis (please do not list ICD-9 code):

Prognosis: Good Length of Need: Lifetime

Equipment Prescribed:

Device: DynaVox Dynawrite

Accessories:

Mounting System: Yes or No (circle one)

Physician Information

I have reviewed a copy and agree with the Speech-Language Pathologist's completed Augmentative Communication Evaluation for the subject patient (required by Medicare).

The prescribed Speech generating Device and accessories are necessary to achieve the functional communication goals stated for this patient in the Speech-Language Pathologist's treatment plan.

Physician's Name (print): Joe B. Castles, III

NPI #: 1508961442 Phone #: 803-799-9044

Medicaid Provider #: GP2802 License #: 22534

Address: 14 Medical Park Ste. 480
Columbia, SC 29203

Physician's Signature:

Date: 6/27/11

UNIVERSITY OF SOUTH CAROLINA

JUN 13 2011

DEPARTMENT OF COMMUNICATION SCIENCE AND DISORDERS
ARNOLD SCHOOL OF PUBLIC HEALTH

Augmentative Communication Evaluation Report

Client's Name:	Andrew Campbell	**Evaluation Date:**	2/28/11
DOB/Age:	09/01/1992; 18;5	**SSN:**	590-27-4301
Address:	109 Vineyards Crossing Ct Columbia, SC 29229	**Phone Number:**	(803)699-3294
Primary Contact Person:	Mr. Anthony Campbell	**Relationship:**	Father
Address:	same as above	**Phone Number:**	same as above
Medical Dx:	Self Imposed Mutism (per parent)	**Date of Diagnosis:**	unknown
Speech-Language Dx:	315.31/784.5	**Referred by:**	Vocational Rehabilitation
Date of Request:	11/08/10	**Phone Number:**	803- 691-8284
Speech-Language Pathologist:	Sarah C. Scarborough	**Phone Number:**	803-777-2622

Background Information

Mr. Campbell was referred to The USC Speech and Hearing Research Center by Vocational Rehabilitation services, for an evaluation regarding assessment of a communication problem which may indicate a need for an augmentative communication device. According to Mr. Campbell's father, Anthony has been previously diagnosed with self- imposed mutism by his school. Mr. Campbell was accompanied to this evaluation by his father, who was present throughout the evaluation. According to parental report, changes in Mr. Campbell's communication skills were first noticed when he was a toddler. He has received speech therapy since five years of age. Most recently he was seen for speech therapy at the University of Central Florida.

Mr. Campbell is currently attending a post-graduate life skills program at Blythewood High School. He graduated from Blythewood High School in 2010. He has held restaurant jobs in the past but is currently unemployed. He currently volunteers at a farm grooming horses. He lives with his mother, father and brother where his father reported that he occasionally uses spoken language. He enjoys watching the news and CSI, playing video games and shopping on the internet as well as reading science and space articles. He attends church with his mother and his father is teaching him to cook.

Mr. Campbell's father reported Andrew uses limited verbal output and does not currently have an alternative augmentative communication device (AAC). Andrew is reported to be using a loaned AAC device in high school and became proficient using a keyboard style device. He would like to see Andrew have any means of communication to be able to join the work force.

Speech and Language Status

Speech and language status was determined by: report, informal assessment, and formal testing. For any expressive communication beyond pointing, Mr. Campbell responded through the use of a Dynawrite Text-to-speech device.

The *Peabody Picture Vocabulary Test, 4th Edition, PPVT,* was administered to assess receptive language. Mr. Campbell received a standard score of 84, which is considered to be a moderately low score.
The *Western Aphasia Battery-Revised (WAB-R)* picture description subtest was administered to get an overview of Mr. Campbell's expressive abilities. Mr. Campbell correctly described at least 10 people and their actions. Mr. Campbell answered using complete, grammatically correct sentences. While describing the picture, however, the sentences' grammatical structure was extremely simplistic and was without the use of adjectives or adverbs. The sequential commands' task of the WAB-R was also administered. Mr. Campbell scored 78 out of 80 possible points missing only one of the single-step commands ['shut your eyes'] and correctly following several more complicated commands [e.g., 'put the comb on the other side of the pen and turn over the book']. On the *Mini-Mental State Exam* (MMSE), Mr. Campbell scores 23 out of 30 possible points. For the *MMSE*, earning 24 points or above indicate no deficits; therefore, Mr. Campbell did not pass this screen.

Receptive Language

Formal and in formal results of this evaluation show that Mr. Campbell comprehends the following:

- ☑ single words
- ☑ phrases
- ☑ sentences
- ☑ conversation
- ☑ one-step directions
- ☑ two-step directions
- ☑ multiple-step directions
- ☑ Yes/no questions
- ☑ choice questions
- ☑ wh-questions (*most*)

Mr. Campbell has only mild discernable deficits in comprehension.

Expressive Language

Mr. Campbell communicates using the following modalities:

- ☐ facial expression
- ☑ pointing
- ☐ formal signs
- ☐ gestures
- ☐ eye gaze
- ☑ vocalizations (by report, limited to yes/no, only to his closest family)
- ☐ speech at the word level

☐ objects/pictures/symbols/printed words

☑ voice output communication device

Mr. Campbell produced no speech during this evaluation.

Written Language

During the evaluation Mr. Campbell produced words and sentences by writing. Using a Dynawrite, he typed in sentences and acclimated quickly to the word finding options. No discernable deficits were observed in written (typed) language when using the device. Typing is slow as he only uses one hand to type and the positioning of his hands while typing was unusual. He maintained one thumb on the table and used his fingers to reach for letter keys. Mr. Campbell initially used his right hand for typing but, approximately ¾ of the way through this evaluation, he switched to his left hand to continue typing.

Reading

Reading was not formally assessed during this evaluation secondary to time constraints. However, the *Scanning/Visual Field/ Print Size/Attention Screening Task*, Mr. Campbell's found the targeted word on 34 of 35 trials. His only error was in the second row on the extreme left of the page with 16 point type. He correctly scanned both closely and widely spaced 12 point type without error.

Cognition

Mr. Campbell's memory for tasks presented today was

☐ within functional limits

☑ partially limited

☐ severely limited.

His attention to the tasks presented today was

☐ within functional limits

☑ partially limited

☐ severely limited.

Mr. Campbell possesses the cognitive abilities to use an augmentative communication device to achieve functional communication goals.

Results of the *MiniMental State Exam (MMSE)* showed orientation to date are correct. However, Mr. Campbell was neither oriented to the county nor the season. Written responses to all other questions were correct. The *MMSE* showed that Mr. Campbell's calculation skills are impaired and that his attention was partially limited.

Speech

Oral Peripheral examination showed Mr. Campbell to have a symmetrical structure that he demonstrated appropriate movement of his tongue for non-speech acts (elevation, lateralization, protrusion, retraction). At rest, Mr. Campbell maintains an open mouth posture. His upper incisors were judged too far anterior to his lower incisors (over bite). He had a gap between his central incisors and had a chip on one of the central incisors. He was missing his right upper first molar. No difficulty with eating was reported. His favorite food is reported to be cheese pizza.

Throughout this assessment, Mr. Campbell did not produce voice or make any visible attempts to produce voicing. Per his father's report, Mr. Campbell only verbally responds to his parents and only with an inaudible yes/no response.

Summary of Speech and Language Status

In summary, Mr. Campbell demonstrates speech and language skills consistent with an Independent/Creative communicator. Characteristics of an Independent/Creative communicator include the ability to:

- independently combine a variety of message components to create new messages
- utilize several steps to produce a single message (e.g., symbol sequences, word prediction, spell a series of letters)
- combine single words, spelling, and phrases together to create novel and flexible messages about a variety of subjects.

Mr. Campbell possesses the abilities to use an augmentative communication device to achieve functional communication goals. With his reported diagnosis of Self Imposed Mutism, Mr. Campbell does not produce speech but demonstrated throughout this evaluation the ability to proficiently use an AAC device.

Current Communication Needs

Environments

Mr. Campbell needs to communicate in the following environments:

- ☑ Home/Residence
- ☑ School
- ☑ Work
- ☑ Medical Facility
- ☑ Community Support Group
- ☑ Face-to-face
- ☑ Telephone
- ☑ Other (Travel)

Partners

Mr. Campbell needs to communicate with the following communication partners:

- ☑ Immediate family
- ☑ Extended family
- ☑ Friends
- ☑ Peers
- ☑ Co-workers
- ☑ Teachers
- ☐ Residential staff
- ☑ Medical professionals
- ☐ Home health assistants/caregivers
- ☑ Individuals in the community

Topics/Functions

Mr. Campbell needs to communicate about the following topics:

- ☑ Activities of Daily Living (ADLs)
- ☑ Medical needs
- ☑ Medical/Personal/Legal decision making
- ☑ Emergency needs/information
- ☑ Personal needs
- ☑ Personal information

He must communicate to meet the following functions:

- ☑ Ask questions
- ☑ Respond to questions
- ☑ Social interaction (family and community)
- ☑ Resolve/prevent communication breakdowns

Summary and Prognosis

For Mr. Campbell to be the most functional and efficient communicator possible he must be able to communicate about a variety of topics with a variety of partners in a variety of environments. He must also express messages that meet a variety of communicative functions as well.

Mr. Campbell's daily functional communication needs cannot be met using natural speech or low-tech/no-tech augmentative communication techniques. Given Mr. Campbell's current communication needs and skills, his prognosis for functional use of an augmentative communication system is good.

He will rely on an augmentative communication system device as his primary mode of communication. The device will be used in all settings of daily living.

Sensory and Motor

Vision/Hearing

Mr. Campbell's visual acuity was reported to be corrected (glasses); functional for effective use of an augmentative communication system.

The Scanning/Visual Field/Print Size/Attention Screening Task was assessed to determine appropriate font size for a potential device. Mr. Campbell scored 34 out of 35 possible points indicating he would be able to attend to fonts as low as 12 pt.

Mr. Campbell failed a hearing screening at 1000 Hz bilaterally at 20dB. He was referred for a full audiological evaluation.

Motor

Mr. Campbell ambulatory without the use of an assistive device He demonstrated functional use of his upper extremities. Mr. Campbell demonstrates awkward fine motor movement when typing. He may benefit from training to refine that skill. In addition, an occupational therapy evaluation may be in order to determine long term effects of his current style of typing on the use of his hands in the future as well as to assist in determinations of which type of keyboard would prove to be most effective and appropriate for Mr. Campbell.

Required Features

Based on Mr. Campbell's current speech, language, and motor status, the following features were identified as being required in an augmentative communication device. Without these features, it is unlikely he would be able to meet his functional daily communication needs as stated previously.

Language

- Word, character, and phrase prediction to increase rate of communication and/or decrease effort when spelling.
- A Qwerty key board similar to the one on a computer seemed easier for Mr. Campbell today.

Access

- Carrying case for protection while device is being transported and used
- Keyboard to allow for spelling of novel messages
- Accessible via direct selection

Device Characteristics

- Portability for use in multiple environments
- Durability to withstand daily use
- Battery power to allow for use throughout the day
- Voice output sufficient for communication in all environments
- Natural sounding synthesized speech for production of novel messages
- Flexible font size and color for clearest visual presentation
- Ability to save, retrieve, and edit longer files for use during story telling, speeches, and caregiver direction

Connections to the World

- Telephone access to allow for communication of emergency information.
- If needed for employment, computer access control may be important

Note: Without any of these required features, intervention using the augmentative communication device would be minimally effective at best and completely inappropriate at worst. These required features have been determined based on an assessment of Mr. Campbell's skills and needs today and for continued use into the future. Failure to meet these needs with the most appropriate communication device is inappropriate and, likely, wasted money.

Assessment of Specific Equipment and Techniques

During the evaluation Mr. Campbell proficiently used the Dynawrite, and acclimated quickly to the word finding options.

When a smaller device, the iPod Touch with Assistive Chat [a text to speech 'app'] was presented, Mr. Campbell was much slower to respond to questions. A larger iPad may be appropriate to try since size was the most obviously salient difficulty with the iPod touch. An Occupational Therapist assessment of Mr. Campbell's keyboard technique would be best to determine the long term effects (if any) of the various types and sizes of keyboards for access to text to speech devices.

The speech language pathologist has contacted the SC Assistive Technology Center to discuss different device choices to determine the best equipment to meet Mr. Campbell's needs. After many discussions, as well as research into options available, it was determined that providing Mr. Campbell and his family and Vocational Rehabilitation counselors with a list of available appropriate devices and how to reach the manufacturer to ask about trials.

Summary and Recommendations

Mr. Campbell presents as a 18; 5 year old male with a reported diagnosis of self imposed mutism. His daily functional communication needs cannot be met using his natural speech. It is recommended that a Mr. Campbell plan a trial period with several devices [on the attached list] to determine the most appropriate device for his communication needs.

Treatment Plan and Follow-Up

Once an appropriate device is selected short term speech therapy is recommended for training in the use, care, and programming of the device.

Topics to be covered in the training sessions include:

1. Ways to encourage use of the device during daily activities
2. Programming of messages/abbreviations-expansions that will be used often
3. Care of the device (e.g., cleaning, battery charging)

Following these initial treatment sessions, Mr. Campbell will be reevaluated as needed (at the request of the patient, physician, or family) to determine the need for updates/modifications to the augmentative communication device.

Upon receipt of the augmentative communication device, the following goals will be targeted:

Operational:

1. Mr. Campbell will demonstrate comprehension of basic maintenance and operations (charging, on-off, adjusting volume, etc) of the device with 80%% accuracy.

Basic Communication:

1. Mr. Campbell will communicate basic/medical needs and feelings to family/caregivers independently with 80% accuracy.
2. Mr. Campbell will greet and initiate conversation independently with 80% accuracy.
3. Mr. Campbell will ask questions, respond to questions, and express opinions independently with 80% accuracy.

Language learning:

1. Mr. Campbell will use word prediction and saved phrases to increase use of reference to describe previous day activities and or future plans with 80% accuracy (within 2 weeks).

Communication in the community:

1. Mr. Campbell will describe physical symptoms and ask questions while interacting with a physician or other health care provider independently with 80% accuracy.

Signatures

Mr. Campbell's family/caregivers are supportive of the use of an augmentative communication device. It was a pleasure to evaluate Mr. Campbell today. If there are any questions regarding this report or if we can be of any further assistance to Mr. Campbell or others involved, please contact USC Speech and Hearing Research Center at 803-777-2614.

A copy of this report will be forwarded to Mr. Campbell's parents. At the request of Mr. Campbell's father he has been placed on our Center's waiting list. In the event they wish to pursue therapy at another facility, a referral list has been enclosed.

If you have any questions or comments regarding this report, please contact the USC Speech and Hearing Center at 803-777-2622.

Erla Hafsteinsdottir and Lauren Burke
Graduate clinicians

Sarah C Scarborough M.A., CCC-SLP
Speech-Language Pathologist
Senior Clinical Instructor
ASHA # 01042913 SC # 2289

Note: The speech-language pathologist conducting this evaluation has no financial relationship with nor will receive any financial gain from the supplier of this device.

Cc:
Mr. Anthony Campbell
109 Vineyards Crossing Ct
Columbia, SC 29229

Mr. Andric J McNeil
201 Corporate Park Boulevard
Columbia, SC 29223

<Enc> Referral list/AAC choices

Text to Speech Devices (or Software) available for consideration for Mr. Campbell:

Product Name	Weight	Voice	Manufacturer	Phone Number	Address	Cost
Allora	2.2.lbs	RealSpeak™	**ZYGO Industries, Inc** www.zygo-usa.com	**(800) 234-6006**	PO Box 1008 Portland, OR 97207-1008 U.S.A.	$4,295.
*** DynaWrite**	2 lbs 2 oz.	DECtalk or VeriVox	DynaVox Mayer-Johnson www.dynavoxtech.com	**1-866-396-2869**	2100 Wharton St. Suite 400 Pittsburgh, PA 15203	~not on website
LightWriter SL40	1.9 lbs.	Acapela HQ Speech	TobiiATI www.tobiiATI.com ****this is available at the SCATP***	**800-793-9227**	333 Elm Street Dedham, MA 02026	$ 4 943,00
SpeakOut	2.2 lbs.	Acapela HQ Speech	Saltillo Coproration http://www.saltillo.com	**1-800-382-8622**	2143 Township Road #112 Millersburg, OH 44654-9410 USA	$3900.00
AAC software on Laptop Computer formats						
Freedom LITE *with* E Z Keys™	Just Under 5 lbs	DECtalk™ or AT&T Voice	**Words+, Inc. http://www.words-plus.com** "we'll even loan you one to try out" from website	**800-869-8521**	42505 10th Street West • Lancaster, CA 93534-7059	**$8295.00**
Polyana—JT with Persona	1.8 lbs.	Neo speech synthesizer	**ZYGO Industries, Inc** www.zygo-usa.com You may request a **Persona** demonstration CD to try the software on a Windows PC ****a precursor to this is available at the SCATP***	**(800) 234-6006**	PO Box 1008 Portland, OR 97207-1008 U.S.A.	**$1,495.00**
Also for use on computers at home or at school; there is a free text to speech software program available for download to PCs: http://www.naturalreaders.com/download.htm . It uses the voices already present on computers (pretty robotic sounding).						
For iPads there are also several different products [apps] that allow text- to- speech:						
***Assistive Chat** produced by **assistive apps** . Cost is $24.99				**"Verbally"** produced by company of same name. **FREE!**		

* Device used during this evaluation.

UNIVERSITY OF SOUTH CAROLINA

Department of Communication
Science and Disorders
Arnold School of Public Health

Andrew

Addendum to ~~Anthony~~ Campbell's AAC Evaluation of 2-28-11 5-20-2011

To Whom It May Concern:

I completed a speech language /alternative-augmentative communication assessment for Andrew Campbell on 2-28-11. My recommendations at that time were that his daily functional needs could not be met using his natural speech. His communication needs could best be met using some sort of text -to- speech device. However, at the time of the evaluation, I could not determine which of many different text to speech devices would be most functional for Andrew.

I had several questions that needed to be answered before I could recommend a particular device:

- An Occupational Therapy assessment was needed to determine if Andrew's unusual mode of typing with his preferred device (a DynaWrite) would end up causing harm to his hands, arms, etc. with long term use of the device.
- I, furthermore, needed information about vocational plans for Andrew since this would dictate the features for the chosen device.
- Another concern related to his preferred device was that the manufacturer of this device was planning to discontinue the device (and would provide repairs/assistance as needed.

Today I spoke with Andrew's Vocational Rehabilitation Engineer, Jonathan Cruce, and he reports the OT assessment has been completed with the recommendation made that after training, which either the school or Vocational Rehabilitation will provide, Andrew will be able to use the DynaWrite safely. Mr. Cruce also reported the DynaWrite would satisfy all of Andrew's vocational communication needs. He said he had consulted with DynaVox [maker of the DynaWrite] DynaVox representative assured him that they will not be discontinuing this device anytime soon.

With all of my questions about devices answered, I do recommend that the DynaWrite be purchased for Anthony Campbell. Short term therapy to assist Mr. Campbell with choosing appropriate phrases that will be used over and over and, which should therefore be saved to the

device to increase speed of communication is recommended. Here are the goals for speech therapy as outlined in the initial evaluation.

Behavioral Objectives:
Upon receipt of the augmentative communication device, the following goals will be targeted:

Operational:

1. Mr. Campbell will demonstrate comprehension of basic maintenance and operations (charging, on-off, adjusting volume, etc.) of the device with 80%% accuracy.

Basic Communication:

1. Mr. Campbell will communicate basic/medical needs and feelings to family/caregivers independently with 80% accuracy.
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3. Mr. Campbell will ask questions, respond to questions, and express opinions independently with 80% accuracy.

Language learning:

1. Mr. Campbell will use word prediction and saved phrases to increase use of reference to describe previous day activities and or future plans with 80% accuracy (within two weeks).

Communication in the community:

1. Mr. Campbell will describe physical symptoms and ask questions while interacting with a physician or other health care provider independently with 80% accuracy.

Signatures
A copy of this addendum will be forwarded to Mr. Campbell's parents. If you have any questions or comments regarding this report, please contact the USC Speech and Hearing Center at 803-777-2622.

Sarah C Scarborough M.A., CCC-SLP
Speech-Language Pathologist
Senior Clinical Instructor
ASHA # 01042913 SC # 2289

Note: The speech-language pathologist conducting this evaluation has no financial relationship with nor will receive any financial gain from the supplier of this device.

cc: Mr. Anthony Campbell
109 Vineyards Crossing Ct
Columbia, SC 29229

Mr. Andric J McNeil
201 Corporate Park Boulevard
Columbia, SC 29223

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TECHNOLOGIES
Technology for human expression.

Fax Cover Sheet

DYNAVOX TECHNOLOGIES
2100 WHARTON STREET
PITTSBURGH, PA 15203
Phone: 1-800-344-1778
Fax: 1-866-513-9261
Website: www.dynavoxtech.com

Date:	7/19/11
Send To:	SC DHS ATTN: DIANE MCLEOD
From :	David Dugan
RE:	PRE AUTH REQUEST A. CAMPBELL ID# 2780678054
Fax Number:	803-255-8222

☐ URGENT ☐ REPLY ASAP ☐ PLEASE COMMENT ☒ PLEASE REVIEW ☐ FOR YOUR INFORMATION

TOTAL PAGES, INCLUDING COVER: 17

Comments:

Please see the attached documents for pre auth review request.

Thank you

team.six@dynavoxtech.com

Price Quotation

Dynavox Systems LLC
2100 Wharton Street
Suite 400
Pittsburgh, PA 15203
1-800-344-1778
Fax: 412-381-5241

Quote	00000000006
Date	07/19/
Page	

To:

CAMPBELL ANDREW
109 VINEYARDS CROSSING CT
COLUMBIA, SC 29229
803/699-3294

Purchase Order No.	Customer ID	Salesperson ID	Shipping Method	Payment Terms	Req Ship Date
	000000000053094 / 000000000060347	HAWTHORNE	UPS GROUND		

Quantity	Item Number	HCPC	Description	UOM	Unit Price	Ext. Price
1.00	750313		DYNAWRITE 2.0,ENG,DEVICE ONLY	EACH	4,995.00	4,995.00
1.00	800218		DYNAWRITE 2,DEVICE,CONFIG,ALL VOICE,USA	EACH	0.00	0.00

Instructions

Subtotal	4,995.00
Tax	0.00
Total	4,995.00

Please include a copy of the quote or the quote number when placing an order.