

Ohio Department of Job and Family Services
CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
Speech Generating Device (SGD)
INITIAL CERTIFICATION

Instructions: The Certificate of Medical Necessity (CMN) must be used for speech generating devices under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of consumer		Billing Number	
<input type="checkbox"/> Trial/Rental period	<input type="checkbox"/> Purchase	Date of Birth	

Section A—Must be completed by Prescriber

Diagnosis (ICD-9 Code and Description)	Consumer's diagnosis/prognosis
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Include consumer's name on all attachments.

Section B— OT/PT Assessment of consumer

Explain if OT/PT Assessment NOT warranted

Motor function (range of motion, tone, active motion)

Postural/positioning

Mobility status

Integration of mobility and positioning with the SGD

OT/PT signature(<i>No stamps</i>)	Date	License #
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Section C—Cognitive status assessment

Explain if Cognitive status assessment is not warranted

Estimate of developmental and intellectual age or range

Describe method of assessing cognitive status

Document consumer's most recent cognitive assessment (done by speech-language pathologist)

Section D—Sensory Status (Describe assessment methods)

Explain if Sensory Status is not warranted

Visual abilities

Auditory abilities

Section E—Speech, language, and communication status
Specific description of communications disability, including speech diagnosis
Speech skills and prognosis
Language skills: expressive and receptive
Description of communication behaviors and interaction skills
Description of consumer's use of current SGD, if applicable. (Include date current SGD acquired by consumer)
Emotional status as it relates to communication
State why current communication behaviors prevent the consumer from communicating basic needs.
Identify primary communication partners (family members, caregivers, etc.) and any associated limitations and needs
Message needs (pragmatics)
Vocabulary (semantics)
Communication environments. (Include description of vocational and education status)

Section F—SGD Assessment**A. Assessment of consumer's needs**

1. Representational systems (symbol system)
2. Vocabulary encoding (i.e., minkspeak, levels plus location, traditional orthography, etc.)
3. Vocabulary expandability and message generation (i.e., pre-programmed, fully programmable, combination of pre-programmed and programmable, additional memory, messages stored as letters, words, phrases, sentences, etc.)
4. Rate enhancement techniques (i.e., simple symbol selection, symbol sequencing, key linking, dynamic displays, abbreviation-expansion, word lists, word prediction, icon prediction, minsets, macros, etc.)
5. Access techniques and strategies
6. Overlay or keyboard organization and features (i.e., key size, keys per overlay, spacing between keys, overlay size, keyguard, multiple location overlay, etc.)
7. Device output modes (i.e., speech synthesis, printed output, display characteristics, auditory and visual prompting, auditory and visual feedback, etc.)
8. Portability concerns

(Attach product description information, as needed.)

B. Comparison of SGD specifications

1. List specifications for the SGD that most effectively and efficiently meets the consumer's basic communication needs.
2. Document why nonrequested comparable SGDs were considered to be inappropriate to meet the consumer's basic communication needs and capabilities.
3. If a higher tech SGD requested, document why a lower tech SGD is inadequate.

Section G—Treatment plan and follow-up		
Short and long-term communication goals		
Individual speech-language pathologist and/or organization/facility responsible for SGD training.		
Necessary modification of SGD to suit the individual consumer's access needs.		
Schedule for evaluating the outcome of the trial use period. (Must be used when requesting authorization for rental during a trial use period).		
Section H—Prescription for SGD		
Name of requested SGD		
List all required components, accessories, peripheral devices, supplies.		
Device vendor(s)		
Signatures/Dates		
Equipment Vendor (<i>Print</i>)	Vendor signature/Date	
Name/title of Speech-Language Pathologist (<i>Print</i>)	Signature/Date	
Date of Assessment	License #	
Prescriber Attestation and Signature/Date		
Prescriber's name (<i>Printed</i>)		
<i>I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.</i>		
Prescriber signature (<i>No stamps</i>)	Date	Ohio Medicaid Prescriber #