

**COMMUNICATION PROSTHESIS  
PAYMENT REVIEW SUMMARY**

DEVELOPED BY  
SPECIALIZED PRODUCT/EQUIPMENT COUNCIL (SPEC)  
1988

# COMMUNICATION PROSTHESIS PAYMENT REVIEW SUMMARY

|  |   |                          |                          |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
|--|---|--------------------------|--------------------------|---------------|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--|--------------------------|--------------------------|-----------|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|---------------|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|---|
| <p><b>1. PATIENT INFORMATION</b></p> <p>Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Birthdate _____ Health Ins. # _____</p> <p>Medical Diagnosis _____</p> <p>Speech-Language Diagnosis _____</p>   | <p><b>5. COGNITIVE PREREQUISITES</b><br/>(Check Appropriate Square)</p> <table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;">Present</td> <td style="text-align: center;">Absent</td> </tr> <tr> <td>a. Attempts to communicate with consistent response mode</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. Functional Yes/No</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. Understands that communication will cause an action to occur</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>d. Understands that symbols (i.e. words, pictures, Bliss, sign) stand for verbal communication</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;">Guarded</td> <td style="text-align: center;">Poor</td> <td style="text-align: center;">Absent</td> </tr> <tr> <td>e. Prognosis to develop intelligible speech</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;">Present</td> <td style="text-align: center;">Absent</td> <td style="text-align: center;">Unknown</td> </tr> <tr> <td>f. Demonstrates memory retention of verbal instruction</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p>g. Names of standardized tests and scores (if applicable)</p> <p>Spelling _____</p> <p>Reading _____</p> <p>Cognition _____</p> |                          | Present                  | Absent        | a. Attempts to communicate with consistent response mode | <input type="checkbox"/> | <input type="checkbox"/> | b. Functional Yes/No     | <input type="checkbox"/> | <input type="checkbox"/> | c. Understands that communication will cause an action to occur | <input type="checkbox"/> | <input type="checkbox"/> | d. Understands that symbols (i.e. words, pictures, Bliss, sign) stand for verbal communication | <input type="checkbox"/> | <input type="checkbox"/> |           | Guarded                  | Poor                     | Absent                   | e. Prognosis to develop intelligible speech | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                    | Present                  | Absent                   | Unknown                  | f. Demonstrates memory retention of verbal instruction | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
|  | Present   | Absent                   |                          |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
| a. Attempts to communicate with consistent response mode   | <input type="checkbox"/>  | <input type="checkbox"/> |                          |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
| b. Functional Yes/No   | <input type="checkbox"/>  | <input type="checkbox"/> |                          |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
| c. Understands that communication will cause an action to occur  | <input type="checkbox"/>  | <input type="checkbox"/> |                          |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
| d. Understands that symbols (i.e. words, pictures, Bliss, sign) stand for verbal communication   | <input type="checkbox"/>  | <input type="checkbox"/> |                          |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
|  | Guarded   | Poor                     | Absent                   |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
| e. Prognosis to develop intelligible speech  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
|  | Present   | Absent                   | Unknown                  |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
| f. Demonstrates memory retention of verbal instruction   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
| <p><b>2. FACILITY INFORMATION</b></p> <p>Facility _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Telephone _____</p> <p>Physician _____</p> <p>Specialty _____</p> <p>Speech-Language Pathologist _____</p>   | <p><b>6. SELECTION OF DEVICE</b></p> <p>a. Patient's current means of communication: _____</p> <p>_____</p> <p>b. Other devices considered and rationale for elimination:</p> <p>_____</p> <p>_____</p> <p>c. Rationale for selection of specific devices: _____</p> <p>_____</p> <p>d. Indicators for success with recommended devices:</p> <p>_____</p> <p>_____</p>  |                          |                          |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
| <p><b>3. DEVICE INFORMATION</b></p> <p>Item Description _____</p> <p>_____</p> <p>Manufacturer _____</p> <p>Distributor/Dealer _____</p>   | <p><b>7. PROGNOSIS</b></p> <p>a. Communication ability: _____</p> <p>_____</p> <p>b. Independence within environment: _____</p> <p>_____</p> <p>c. Placement in least restrictive environment: _____</p> <p>_____</p> <p>d. Academic ability: _____</p> <p>_____</p> <p>e. Vocational training/retraining: _____</p> <p>_____</p>   |                          |                          |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
| <p><b>4. PHYSICAL STATUS PER DOCUMENTATION</b><br/>(Check Appropriate Square)</p> <table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;">Adequate</td> <td style="text-align: center;">Inadequate</td> <td style="text-align: center;">Non-essential</td> </tr> <tr> <td>a. General Medical Status</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. Respiratory</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. Hearing</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>d. Vision</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>e. Head Control</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>f. Trunk Stability</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>g. Arm Movement</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>h. Ambulation</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>i. Seating/Positioning for use of device</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>j. Ability to access the device (switches, etc.)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p>Summary _____</p> <p>_____</p> <p>_____</p> <p>_____</p> |   | Adequate                 | Inadequate               | Non-essential | a. General Medical Status                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | b. Respiratory           | <input type="checkbox"/> | <input type="checkbox"/>  | <input type="checkbox"/> | c. Hearing               | <input type="checkbox"/>   | <input type="checkbox"/> | <input type="checkbox"/> | d. Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | e. Head Control                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | f. Trunk Stability | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | g. Arm Movement  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | h. Ambulation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | i. Seating/Positioning for use of device | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | j. Ability to access the device (switches, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <p>Physician _____</p> <p style="text-align: center;">(Signature/Date)</p> <p style="text-align: right;">Speech-Language Pathologist _____</p> <p style="text-align: right;">(Signature/Date)</p> |
|  | Adequate  | Inadequate               | Non-essential            |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
| a. General Medical Status  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
| b. Respiratory   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
| c. Hearing   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
| d. Vision  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
| e. Head Control  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
| f. Trunk Stability   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
| g. Arm Movement  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
| h. Ambulation  | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
| i. Seating/Positioning for use of device   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |
| j. Ability to access the device (switches, etc.)   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |               |  |                          |                          |                          |                          |                          |   |                          |                          |  |                          |                          |           |                          |                          |                          |   |                          |                          |                          |                    |                          |                          |                          |  |                          |                          |                          |               |                          |                          |                          |  |                          |                          |                          |  |                          |                          |                          |   |



## INSTRUCTIONS

1. **PATIENT INFORMATION**
  - > Name - Patient's complete name
  - > Address - Patient's home address
  - > Birthdate - Month/Day/Year
  - > Health Insurance Number - Appropriate number for coverage
  - > Medical Diagnosis - Document medical diagnosis (ICD-9-CM) for the patient
  - > Speech-Language Diagnosis - Document speech-language diagnosis (ASHACS) for patient
2. **FACILITY INFORMATION**
  - > Facility - Where the patient is receiving treatment
  - > Address/Phone Number - Facility address and phone (with area code)
  - > Physician/Specialty - Physician in charge of this case
  - > Speech-Language Pathologist - SLP working with patient
3. **DEVICE INFORMATION**
  - > Item Description - General description of device being recommended
  - > Manufacturer - Maker of the device
  - > Distributor/Dealer - Local source of supply, including service and training
4. **PATIENT'S PHYSICAL STATUS**
  - > Check the square which characterizes the patient's current physical condition per medical/clinical documentation or personal observation.
  - > Adequate/Inadequate ratings related to physical parameters only as they apply to the use of the specific communication device selected.
  - > Non-essential indicates status is not related to the use of the device for this patient.
5. **PATIENT'S COGNITIVE PREREQUISITES**
  - > Check the appropriate square which best describes the patient's current status.
  - > If applicable, provide the name of the testing instrument and the scores obtained.
6. **SELECTION OF AUGMENTATIVE COMMUNICATION DEVICE**
  - a. Current Means - Describe how this patient currently communicates and why it is not the best method of choice.
  - b. Other Devices - List other devices considered for this patient and why they would not be applicable.
  - c. Rationale - What characteristics of this device influence the determination that this was the best choice, e.g., portability, size, symbols, service or training
  - d. Indicators - Has the patient had an opportunity to use the device? How long? Rental? What was observed, e.g., increased initiations or ADL's
7. **PROGNOSIS**
  - a. Communication ability - Will the patient's ability to communicate their basic needs, such as health and safety information, improve?
  - b. Independence - Will the patient's independence increase with the use of the device?
  - c. Placement - Will the community placement be affected? Example: group home vs nursing home.
  - d. Academic ability - Will the patient's ability to learn and retain new information change?
  - e. Vocational training - Will the patient's ability to advance in vocational rehabilitation improve?
8. **COMMENTS** - Give any comments unique to this device or what it will offer for this individual that would help in determining payment. Use space provided on the reverse side of the summary form.

PLEASE HAVE THE SUMMARY SIGNED AND DATED BY THE PHYSICIAN AND THE SPEECH-LANGUAGE PATHOLOGIST.

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**The Specialized Product/Equipment Council (SPEC) is a broad based consortium, comprised of third party payers, clinical professionals and specialized equipment suppliers. The Council was formed in 1986 to develop guidelines for uniform submission of product and clinical information to facilitate consistent reimbursement decisions for specialized equipment.**

**Specialized equipment is defined as any product or system that is "specifically built/modified for an individual user." Claims for specialized equipment represent a small percentage of total claims for home medical equipment. Yet, payment for specialized equipment can be disproportionately problematic, for all parties concerned. Delivery of such equipment is typically very service-intensive, since the equipment must be carefully tailored for use by a person with special needs. This makes it essential for sufficient information to be given to the third party payer, explaining the need for the specialized level of intervention. Without this information, it is difficult for the payer to make the appropriate payment decision nor to justify the generally higher costs of specialized equipment claims.**

**Recognizing this fundamental need for exchange of information, SPEC has tapped the expertise of its members to develop payment forms that are useful and readily recognizable by claims personnel, and which are designed to ensure that appropriate information is provided by clinicians and equipment providers. As these forms gain acceptance and use by providers and become integrated into the various third party payment systems, they will guide the exchange of appropriate information, thereby reducing the payment delays caused by payers returning claims for additional information.**