

# Bottom Line: Reimbursement for AAC Devices

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Reimbursement for treatment related to augmentative and alternative communication (AAC) devices, including speech-generating devices (SGDs) and non-SGDs, can be confusing. Many clinicians have questions about coverage, coding, non-dedicated devices, and other issues. Clinicians seeking reimbursement for AAC evaluation and treatment may find the following information helpful.

## **Q: Where can I find basic information regarding reimbursement for speech-language pathology services?**

The best place to start is with the [ASHA Coding and Reimbursement Modules](#), which provide an introduction to the language and terminology associated with payment policies. These PowerPoint presentations are available at no cost online.

## **Q: After I learn about reimbursement and coding and the associated terminology, where can I find more specific information about billing for AAC devices and related speech-language pathology services?**

Two websites provide a great deal of information. ASHA has information specific to [Medicare](#)—for example, a checklist to ensure the clinician completes the requirements for recommending an SGD for a Medicare patient. A comprehensive site, written and maintained by the AAC-Rehabilitation Engineering Research Center ([AAC-RERC](#)), looks at AAC from several perspectives, including Medicare reimbursement.

## **Q: Where can I find the correct codes under the Current Procedural Terminology (CPT; ©American Medical Association) and Healthcare Common Procedure Coding System (HCPCS) for reporting AAC evaluation, treatment, and devices?**

Both the ASHA and AAC-RERC websites include the CPT and HCPCS codes. At this time, however, Medicare covers only SGDs and services. ASHA expects to see new or revised CPT codes for non-SGDs in the near future. The current CPT codes are:

- **92605**, Evaluation for prescription of non-speech-generating augmentative and alternative communication device.
- **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.
- **92608**, Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; 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.

Medicare requires the use of 92506 for a non-SGD evaluation and 92507 for treatment related to the use of a non-SGD.

**Q: Can I bill for programming/modifying time for an AAC device that is not face-to-face?**

The patient should be with the SLP for programming or modification of the patient's SGD for the time to be considered part of the reported treatment session. Alternatively, it may be possible to bill 92609 with a modifier (-52) and a description of the reduced service, which would be used only if the whole service was non-face-to-face. Clinicians should contact the third-party payer to determine if this reduced service is covered as such.

**Q: Does Medicaid cover SGDs for children?**

Yes, two Medicaid regulations provide for SGDs for children.

SGDs are included in the Medicaid definition of the "services for individuals with speech, hearing, and language disorders" benefit. The Medicaid regulations at Title 42, *Code of Federal Regulations* §440.110, define these services as "...diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment."

In addition, Medicaid's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program, also found in Title 42 of the *Code of Federal Regulations* at §441.50, requires states to provide EPSDT services to "eligible Medicaid recipients under age 21 to ascertain physical and mental defects, and provide treatment to correct or ameliorate defects and chronic conditions found."

**Q: Is there reimbursement for non-dedicated devices?**

SLPs and consumers are increasingly looking to popular and readily available technology, such as apps for smartphones and tablet computers, as alternatives to traditional AAC devices and SGDs. These popular technologies meet the individual's communication needs; can be a good match for the person's visual, fine motor, and cognitive skills; and are readily accepted by patients. However, health plan reimbursement for such items is not available because they are not dedicated AAC devices. Clinicians note that traditional AAC devices are bigger, bulkier, and may have added unnecessary components. The costs are substantially different, with AAC devices running \$2,000–\$4,000 and up; an iPad, for example, costs about \$500, and an app around \$189.

Payers, such as Medicare, Medicaid, and private health plans, are justifiably concerned about the potential for abuse and fraud if non-dedicated communication devices readily available in the consumer market are included as reimbursable AAC/SGDs. Payers may worry about an increase

in utilization rates and the durability of computer tablets over traditional AAC devices. Outright fraud is a major problem for third-party payers.

Can new technologies be modified to be dedicated communication devices so that health plans may be more likely to reimburse? Does limiting a device's potential make sense just to obtain third-party reimbursement? These are questions that need exploring. ASHA is investigating the possibility of adding new and readily available technologies to the list of covered AAC and SGD devices.

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