May 5, 2026

Krista Hoglund
President, Jefferson Health Plans
1101 Market Street, Suite 3000
Philadelphia, PA 19107

RE: Six-Month Delay for Approving Medically Necessary Speech-Generating Augmentative and Alternative Communication (AAC) Devices

Dear President Hoglund:

On behalf of the American Speech-Language-Hearing Association (ASHA), we write to express concern regarding Jefferson Health/Health Partners Plans “Speech Generating Devices” medical policy (MN.025.A). The policy requires patients to complete at least six months of speech therapy without improvement and to demonstrate lack of benefit from alternative communication methods before coverage for a medically necessary speech-generating device (SGD) is considered.[1]

ASHA is the national professional, scientific, and credentialing association for 247,000 members, certificate holders, and affiliates who are audiologists; speech-language pathologists (SLPs); speech, language, and hearing scientists; audiology and speech-language pathology assistants; and students. Over 210,000 ASHA members are certified SLPs.

ASHA is particularly concerned with the following provisions:

- “The member has participated in a trial of speech therapy without benefit (Documentation must show at least 6 months of treatment provided).”
- “The member has tried alternative methods of treatment without benefit, including but not limited to manual signs through gestures or sign language, visual interaction using books or boards, and communication through writing or drawing.”

These requirements create an inappropriate and potentially harmful barrier to timely access to medically necessary augmentative and alternative communication (AAC) technology. Coverage determinations for SGDs should be based on the individual’s diagnosis, functional communication needs, prognosis, and the findings of a comprehensive clinical evaluation—not on a fixed waiting period or a mandatory trial-and-failure sequence.

Healthcare.gov defines medically necessary services as “health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.”[2] A policy that requires every individual to undergo six months of alternative treatment methods without progress before access to an SGD can be considered—despite a qualified clinician’s determination that the device is the most appropriate intervention—does not meet accepted standards for AAC assessment and intervention.

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For many individuals with significant communication impairments, delayed access to an SGD has real and meaningful consequences. Postponing use of a clinically indicated device can compromise functional communication; limit participation in health care, education, employment, and community; and reduce the likelihood of successful device training and long-term adoption.

Best practice is clear that AAC should be considered as early as possible to support timely adoption of an SGD when it is clinically indicated.[3,4,5,6]

SLPs conduct AAC evaluations to determine the most appropriate communication supports for each individual. That process is individualized, evidence-based, and clinically rigorous. The initial evaluations often include a speech and language evaluation followed by an AAC evaluation. The evaluation process includes determining whether communication needs can be met through natural speech, low-tech communication supports, other AAC strategies, or an SGD. Clinicians recommend an SGD only when they determine that the device is medically necessary and represents the most clinically appropriate communication option for the patient.[7]

Importantly, there is a critical distinction between **considering** alternative communication methods during an evaluation and **requiring** every individual to fail those methods over time before SGD coverage is an option. Some individuals are not able to communicate effectively through gestures, sign language, communication books or boards, writing, or drawing. Requiring them to demonstrate failure with those approaches needlessly delays appropriate care and overrides individualized clinical judgment.

This distinction is clearly reflected in the Medicare local coverage determination for SGDs (LCD L33739) cited in your policy, which relies on the evaluation report and recommendations from the evaluating clinician to determine candidacy. The LCD policy indicates that the evaluation must assess whether communication needs can be met through other modes of communication. It requires that other forms of treatment have been considered but does not impose a blanket requirement that clinicians engage in treatment using these alternative modes of communication before prescribing an SGD. [8]

Clinicians must provide clinical justification for their determination to prescribe an SGD in the evaluation report. However, SLPs are not required to override their clinical judgement by providing six months of therapy they do not in order to attain approval for the device and services the evaluation indicates is medically necessary.

Therefore, ASHA urges you to revise the “Speech Generating Devices” policy to:

- Remove the requirement that an individual complete six months of therapy without improvement before SGD coverage will be considered;
- Remove the requirement that an individual demonstrate unsuccessful treatment with other communication methods as a universal prerequisite to SGD coverage; and
- Base SGD coverage determinations on individualized medical necessity, including the clinical judgment of qualified providers and the findings of a comprehensive AAC evaluation.

A coverage policy grounded in individualized medical necessity review aligns with accepted standards of care, current AAC clinical practice, and Medicare's coverage policy. This approach avoids arbitrary requirements, ensures timely and clinically appropriate access to care, and supports optimal patient outcomes.

If you have questions or would like additional information, please contact:

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Submitted on behalf of the
American Speech-Language-Hearing Association

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[1] Jefferson Health Plans. (2025). *MN.025.A Speech Generating Devices*. https://www.healthpartnersplans.com/content/dam/jeffersonhealthplans/documents/providers/tools-and-resources/policy-bulletins/medical-necessity-policy-bulletins/mn025a-speech-generating-devices-05162025.pdf
[2] HealthCare.gov. (n.d.). *Medically necessary*. https://www.healthcare.gov/glossary/medically-necessary/
[3] Speech-Language & Audiology Canada. (March 2015). *SAC Position Paper on the Role of Speech-Language Pathologists with Respect to Augmentative and Alternative Communication (AAC)*. https://www.sac-oac.ca/wp-content/uploads/2023/02/aac_position-paper_en.pdf
[4] Avagyan, A., Mkrtchyan, H., Shafa, F. A., Mathew, J. A., & Petrosyan, T. (2021). Effectiveness and Determinant Variables of Augmentative and Alternative Communication Interventions in Cerebral Palsy Patients with Communication Deficit: a Systematic Review. *CoDAS*. https://www.scielo.br/j/codas/a/syBhwBKMqhxngsQCMkSjzHj/?lang=en
[5] Geytenbeek, J. Prevalence of speech and communication disorders in children with CP. *Developmental Medicine & Child Neurology*. https://onlinelibrary.wiley.com/doi/10.1111/j.1469-8749.2010.03803.x
[6] Ciarmoli, D. & Stasolla, F. (2023). The Use of Alternative Augmentative Communication in Children and Adolescents With Neurodevelopmental Disorders: A Critical Review. *Current Developmental Disorders Reports*. https://link.springer.com/article/10.1007/s40474-023-00273-9
[7] American Speech-Language-Hearing Association. (n.d.). *Augmentative and Alternative Communication (AAC)*. https://www.asha.org/practice-portal/professional-issues/augmentative-and-alternative-communication/
[8] Centers for Medicare & Medicaid Services. (n.d.). *Speech Generating Devices (SGD)*. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33739