ACCI Funding Terminology

We have generated these term definitions because using the correct terminology throughout the funding process will expediate the success of your funding request. Please refer to these terms and definitions when reviewing and completing funding documentation.

Appeal

The process which occurs if the funding source denies a request for prior authorization or pre-determination, or if a claim is denied. The client advocate is responsible for initiating the appeal process. In most appeals, clarifying documentation is the key to success. There is usually a time limit in which an appeal can be filed. Many cases are funded by using the appeal process.

Claim

Claims are submitted by Augmentative Communication Consultants, Inc. (ACCI) to Medicaid, commercial and private insurance companies.

Client Information and Assignment of Benefits Form

A starting point for any funding packet that gathers client information required by the funding sources.

Diagnosis

The nature of the client's disability. Examples include cerebral palsy, developmental delay, spastic quadriplegia and Autism. (ICD 10 Codes)

Durable Medical Equipment (DME)

A categorical term used by various funding sources, often including augmentative communication device. This label usually means the equipment has the ability to withstand repeated use, is provided to correct or accommodate a physiological disorder or physical condition, and is suitable for use in the recipient's home.

Explanation of Benefits (EOB)

List the date of service, procedure codes along with deductibles, copays and payment. The EOB is used by the provider to bill the secondary insurance.

Funding Package Checklist

The final check prior to submittal of a funding request. Please make sure all of the required documents and information noted on the checklist are included with the submittal to ACCI.

Funding Packet

A collection of all of the documentation required by the funding source. A completed funding packet will include all of the standard forms listed in the funding downloads section.

ICD Codes

Codes from the international Classification of Disease. This includes codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.

Medical Necessity

A legal doctrine stating that the requested speech generating device must treat the identified condition of the communication disability. The equipment should be justified in terms of a goal to overcome and/or reduce the communication limitation.

Prior Authorization

The process in which the funding source, specifically Medicaid, reviews the required documentation gathered by the client advocate supporting the need for the requested speech generating device. Prior authorization may be approved, denied or deferred for more information based on specific regulations set by the funding source. Most funding sources focus on the medical necessity of the equipment requested. Prior authorization must be obtained before the requested DME can be supplied for the client.

Pre-Determination of Benefits

Essentially the same process as prior authorization, but is specific to commercial and private insurance companies and HMO's such as Blue Cross/Blue Shield, Aetna and Anthem.

Primary Insurance

The first funding source that must be used to secure funding. An insurance decision must be received prior to pursuing Medicaid funding for a speech generating device.

Secondary Insurance

The secondary coverage source when an authorization or claim is denied or only partial funding has been secured from the primary insurance.

Speech Generating Device (SGD)

A device which enables a client to overcome the disabling effects of communication impairment by representation of vocabulary or ideas and expression of messages.