Assistive Technology Appeals: Private Insurance

If You Have Private Insurance

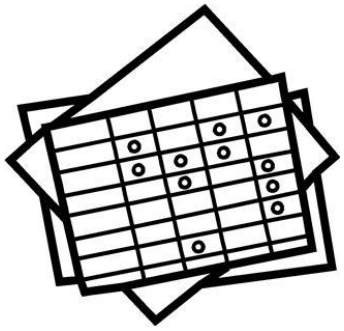
This fact sheet explains the steps you take when a private health insurance Plan denies coverage for assistive technology. Most private insurance plans use the term "durable medical equipment" or DME instead of assistive technology.

For information on appealing denials by Medical Assistance, see our fact sheet *Assistive Technology Appeals: Medical Assistance*.

Do private insurance plans cover DME?

Most plans cover some DME. Plans can use different definitions for what counts as DME but most include at least some coverage for things like wheelchairs, walkers, and other common medical equipment. Not all plans provide coverage for the same DME. For example, some plans cover speech generating devices while other plans don't.

How do I know what DME is covered under my Plan?



Before you sign up for a plan, read a description of what is covered. Many plans use a chart that describes the benefits. Look to see if your DME is covered. This helps you decide if the plan is a good plan for you.

Once you are signed up for the Plan, you should get a handbook that describes the Plan benefits in detail. If you don't get a handbook, ask for one. The benefits handbook has a lot of information you may need.

How do I know if my Plan denies coverage?

The DME provider (the place where you want to buy the item) submits a request to the Plan for your DME. Sometimes the request is submitted before you get the item. You should get a letter from the Plan telling you if the item is approved or denied. If you don't get a letter, call your provider to see if the Plan contacted them.

Sometimes the request is submitted after you already got the item and the provider wants to be paid. Once payment is sent to the provider, you get an Explanation of Benefits (EOB). This includes the item, what is covered, how much the Plan paid, and what the provider may bill you for.

What are some common reasons Plans won't pay for DME?

The denial might say:

- The device is not medically necessary
- A device that costs less can meet your medical needs
- The device is not covered or is excluded from coverage
- The device is experimental

Does my Plan pay the full cost of the DME?

Many Plans don't cover the full cost. You may be responsible for a co-payment, co-insurance, or a deductible. Your benefit handbook should tell you how much of the cost you have to pay.

What can I do if my Plan denies coverage for the DME I need?

Most Plans have an internal appeal process. This can also be called a complaint or grievance process. If you disagree with the Plan's decision, you may be able to submit an appeal or grievance. The appeal process can be different for each Plan. Check your benefits booklet or call the Plan for information about their appeal process.

How much time do I have to file an internal appeal with my Plan?

The amount of time you have to appeal is usually limited. Your benefit handbook should have a section on appeals, complaints, or grievances that tells you how many days you have to file an appeal. The denial letter you get from the Plan also may tell you the time limit. **File your appeal within these time limits or you may lose your right to appeal.**

What should I include in my appeal?

Carefully review your benefit handbook. There should be a section about DME. Review any letters from your Plan so you understand why the DME was denied. You also can ask your Plan to send you copies of your claim file and copies of any policies or standards the Plan used to deny the DME. This information should be free.

Get copies of your medical records, letters from your health care providers, like your doctor, physical therapist, or occupational therapist, and any other information that supports your appeal.

In your appeal, explain why you think the decision is wrong and why the Plan should approve your equipment. If the Plan denied the equipment saying it is not medically necessary, get a letter from your doctor. The letter should say why the equipment meets the Plan's definition of medical necessity and any other criteria. Criteria are the things the Plan looks at to see if the device is necessary.

Usually, the benefit handbook has a definition of medical necessity and the criteria for coverage of DME. Submit your appeal in writing and keep a copy for yourself. Your denial letter should tell you where and how to submit your appeal.

When do I get an answer on my appeal?

Most Plans issue a decision in 30 - 60 days. If you have an urgent medical need where your life or health is in jeopardy, ask for an expedited (fast) appeal. If the Plan agrees your appeal is urgent, you get a decision within 72 hours.

What if I disagree with the Plan's appeal decision?

You may be able to file a complaint with the agency that oversees the Plan or ask for an external review of the Plan's decision. You must file the complaint or external review request within 6 months of the date of your last denial. First, you need to find out what kind of Plan you have. This information should be in the benefit handbook.

In Minnesota, two state agencies regulate private health plans.

- The Department of Health regulates Health Maintenance Organizations (HMOs).
- The Department of Commerce regulates all other insurance plans except self-insured plans.

Call the agency to make sure they oversee your Plan.

Self-insured or self-funded employer plans are regulated by the U.S. Department of Labor. For more information on self-insured plans go to page 5.

Another option is to file a lawsuit. If you think you want to file a lawsuit, talk to a lawyer right away. There are time limits on when you can file lawsuits against insurance companies. If you do not file the lawsuit within the time limits, you may lose the right to sue.

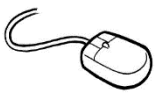
How do I file a complaint about the Plan's decision?

If you are in an HMO plan you file a complaint with the Minnesota Department of Health. You can file informally over the phone, or you can file a written complaint.

The Minnesota Department of Health investigates your complaint and decides if the HMO followed the law and the terms of your plan. There is no cost to file a complaint, and you can file a complaint at the same time you are appealing the denial with the Plan. For more information, or to file a complaint, contact the Minnesota Department of Health at:

(651) 201-5100 (telephone)
(800) 657-3916 (toll-free)

There is more information about the Department of Health's Complaint Process, including a complaint form on their website. Go to: www.health.state.mn.us and follow the steps below.



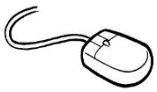
→ Click on "Health Care, Facilities, Providers & Insurance"
→ Click on "Insurance"
→ Under "Managed Care Systems" click on "Enrollee Complaint and Appeal Options"

If you are on a plan that the Department of Commerce oversees, contact the Consumer Response Team to ask questions or file a complaint.

The Consumer Response Team decides if the Plan followed their policies and followed Minnesota law and rules of business practice. For more information, or to file a complaint, contact the Minnesota Department of Commerce Consumer Response Team:

(651) 539-1600 (telephone)
1-800-657-3602 (toll free)

There is more information about the written complaint process, including a complaint form, on the Department of Commerce website. Go to the website, https://mn.gov/commerce, and follow the steps below:



→ Click on "Consumers" on the top menu
→ Click on "File a complaint" from the dropdown

Fill out the information and file your complaint online.

What is an external review?

An external review is an appeal to an independent organization. The independent organization is contracted by the State of Minnesota. The external review organization looks at the Plan's decision and makes a decision about whether the DME should be approved or denied.

How much does an external review cost?

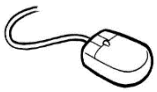
There is a $25 fee for the review, but you can ask to have the fee waived if it is a financial hardship. You need to show why paying the fee would be a financial hardship. For example, the fee might be waived if you are low income, have high medical bills, or if you lost your job. You need to show documents proving it.

How can I ask for an external review of the appeal decision?

If your Plan is an HMO, you ask for an external review through the Department of Health. If you have other insurance, you can ask for an external review with the Department of Commerce so long as it is not a self-insured Plan. You must ask for external review within 6 months of the date of the last denial.

How do I ask for an external review with the Department of Health?

To start the external review process, fill out an external review form. You can get a copy of the form on the Department of Health's website. Go to: www.health.state.mn.us and follow the steps below.



→ Click on "Health Care, Facilities, Providers & Insurance"
→ Click on "Insurance"
→ Under "Managed Care Systems" click on "Enrollee Complaint and Appeal Options"
→ Scroll down and click on "Apply for an External Review"

You can also call to get a copy of the form:
(651) 201-5100
(800) 657-3916 (toll-free)

How do I ask for an external review with the Department of Commerce?

If your insurance Plan is not an HMO and it is not self-insured, you may be able to ask for an external review with the Department of Commerce. To start the process, fill out an external review form within 6 months from the day of your last claim. You can get a copy of the form on the Department of Commerce's website: https://mn.gov/commerce. Click on "Consumer Help" then click on "Insurance Tips" and then "Health Insurance." There is a link to the external appeal form at the bottom of the page. You can also call the Department of Commerce at:

(651) 539-1600
(800) 657-3602 (toll-free)

Should I send any documents with the external review form?

Complete **all** sections of the external review form. Include copies of your medical records, letters from your doctor or other health care providers, such as a physical or occupational therapist. Send any information that supports your appeal.

How long does the review process take?

Usually, you get a decision within 40-45 days after the case is sent to the independent review organization.

What is a self-insured health Plan?

In a self-funded or self-insured Plan, your employer sets up the Plan and pays all of the health claims instead of buying insurance through an insurance company. It can be hard to tell if your Plan is self-insured because sometimes the employer hires an insurance company to run the Plan. That company decides what should be covered or denied. Since it looks like you are getting your coverage from the private Plan, you may not know your employer is self-insured.

If you work for a large company or government, your Plan may be self-insured. If you do not know what kind of Plan you have, ask your employer or Plan administrator.

Who investigates complaints about self-insured employer Plans?

Most self-insured Plans fall under the Employee Retirement Income Security Act (ERISA). The U.S. Department of Labor enforces ERISA. If you have a Self-Insured Plan, you can contact the Department of Labor for help. Contact them at:

Employee Benefits Security Administration
Kansas City Regional Office
2300 Main St., Suite 11093
Kansas City, MO 64108

(816) 285-1800 (telephone)
(816) 285-1888 (fax)
(866) 444-3272 (toll-free)

www.dol.gov/ebsa/

But the Department of Labor does not regulate Plans through school districts, other municipalities, or churches. If you have this type of Plan, file a complaint with the Plan or file a case in court.

How can I contact the Minnesota Disability Law Center?

The Minnesota Disability Law Center provides free legal help to people with disabilities in Minnesota.

To apply for help, call:
Metro: (612) 334-5970
Toll Free: 1-800-292-4150

For all other calls: 612-332-1441

Minnesota Disability Law Center
111 North 5th Street, Suite 100
Minneapolis, MN 55403

https://mylegalaid.org/disability-law-center/

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