usersFIRST™ MobilityMap

Finding Funding:
Dealing with an Insurance Denial

The Steps for Dealing with a Denial

- First, use your wheelchair team. The clinician and the supplier are usually working hard to get the best chair for you.
- Get the Denial in Writing
- Figure out why you were denied. Non-covered benefit? Least costly alternative? Not considered medically necessary? Discrimination?
- Review the details about your policy to find errors or issues with the denial decision.
- File an appeal.
- Reach out for extra help. Talk to consumer organizations, an attorney, your clinician and therapist, and/or your supplier for help and feedback.

1) Get the Denial in Writing

Get the Denial in Writing to see what the reasoning is for denying the equipment. Many times, funding sources will contact your supplier's office on the phone to say that they are denying your equipment request. This is an unacceptable form of notifying you and the supplier of the denial. It is your right to get any denial for your equipment *in writing*.

If you do not have the actual denial in writing, it will be difficult, if not impossible, to proceed through the appeals process. This is especially important if your claim ends up going to a fair hearing.

2) Figure out why you were denied

1. Non-Covered Benefit
2. Least Costly Alternative
3. Not Medically Necessary
4. Other Discriminatory Reasons

Non-Covered Benefit

It is worth *at least* one level of appeal if you get a denial based on an item that's "non-covered." Know your policy well! If you can prove the item qualifies as DME under the policy definition or qualifies under the definition of 'medical necessity' for your specific needs – then it should NOT be considered excluded.

Private Insurance Companies

May have excluded items because they fall outside of their:

- Definition of Durable Medical Equipment (DME)
- Definition of Medical Necessity, or
- Definition of Excluded Items – typically this states, "anything not determined to be medically necessary, for example . . ."

Non-Covered Benefit Cont.

Medicare

Policies may exclude some items such as:

- Group 4 power wheelchairs,
- Seat elevation (E2300) Note: this is a Medicare code. Medicare attaches a code to every product and procedure. , and
- Wheelchair standers (E2301/E2230)

Medicaid

May not deny any item because it's 'not covered.' All decisions in Medicaid must be made based on individual medical necessity.

Least Costly Alternative

If your receive a denial that offers you instead a 'least costly alternative' to the equipment requested, you should take the following into account when filing your appeal:

- To be a true alternative – the item must be EQUALLY EFFECTIVE!
- Know how the recommended product differs from other products in the same category. Contact the manufacturer's representative for help with comparing similar products from other manufacturers.
- 'Least costly' doesn't necessarily mean 'cheapest' – Consider your holistic needs of equipment and cost savings across the entire medical spectrum.
- For example – the feature on your wheelchair might allow you to reduce the amount of paid caregiver time, medications required, or other interventions that cost money.
- Is there a true alternative? There may not be if the alternative is not equally effective.

Not Medically Necessary

If your receive a denial stating that the equipment requested is 'not medically necessary,' you should take the following into account when filing your appeal:

- Know your insurer's definition of medical necessity in your individual policy
- You should be able to show how the equipment meets the definition of medical necessity *in your individual case* and *use research* if it is available.
- Work with the manufacturer of the equipment being requested to provide additional support during this appeal process.

Each insurance company has its own definition of medical necessity. It is imperative for you to know how *your* insurance company defines medical necessity and what criterion you need to meet in order to qualify for a wheelchair.

There are many ways to find your insurer's definition of medical necessity:

- Check your insurance handbook,
- Search the insurer's website, or
- Call your member services.

Discrimination

If you receive a denial for reasons such as age, diagnosis, or life expectancy, then your appeal will cite federal law pertaining to discrimination.

Contact UsersFirst at http://www.usersfirst.org/submit-your-story

3) Review the details about your policy

It is very important you review your insurance handbook for details to combat the denial in an appeal. If you do not have your handbook anymore, you can go to your insurer's website for information or call customer service to request a new handbook.

4) File an appeal

There are many different policies for each insurance company. The best way to find out the appeal policy for your particular insurance plan is to check your member handbook. Look under appeals or grievances for more information or contact your insurance company. Listed below are some general appeals processes for each company listed.

- Anthem BlueCross BlueShield
- Aetna (PDF)
- Cigna
- United Healthcare
- Medicare

If you do not see your insurer listed above, go to your insurer's website or call their customer service line to learn the process for appeal.

5) Reach out for help

Contact UsersFirst or other organizations listed here (www.usersfirst.org).