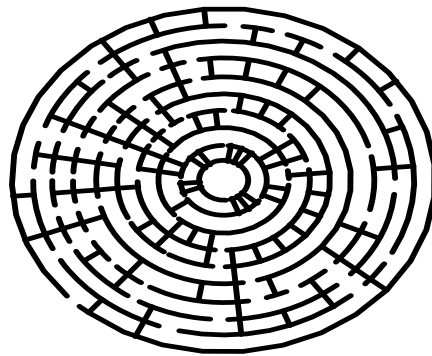


Insurance and Appeals

To download other “topics” or the entire Who Pays document go to:

<http://www.health.state.mn.us/mcysn>

Who Pays?



Taking the *MAZE* Out of Funding

Minnesota Children & Youth
with Special Health Needs



651-201-3650 OR 1-800-728-5420
www.health.state.mn.us/mcysn

Insurance & Appeals

Federal Health Care Reform – How it Will Affect Families

Minnesota Comprehensive Health Association (MCHA)

Sample Letter of Appeal

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Self Insured/Self Funded Health Plan Complaints

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SSI Appeals

SSI Overpayment



FAMILY VOICES STATEMENT ON THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Family Voices is an organization of families whose children have special health care needs. Its mission is to achieve family-centered care for all children and youth with special health care needs and/or disabilities.

Family Voices is very pleased that the *Patient Protection and Affordable Care Act* and the *Health Care and Education Affordability Reconciliation Act* will be the law of the land.

The new law makes a number of improvements in our nation's health care system for children and youth with special health care needs (CYSHCN) and disabilities. These include several benefits that would take effect within the next six months, including:

- **Elimination of lifetime benefit caps and a prohibition against rescinding coverage when someone get sick.**

Example 1: A premature baby is in hospital for many months and has been diagnosed with multiple health issues. Due to the length of stay in the hospital, the family is near reaching its lifetime maximum for the child. With the elimination of lifetime caps, the family will not have to worry whether child will be able to continue to receive medical treatment.

Example 2: A family has had coverage for several years. Their teenage child is injured and needs expensive rehabilitation. The insurance company suddenly rescinds the policy, claiming that the family had failed to disclose that the child had the pre-existing condition of acne, and therefore, the policy is invalid. The new law prohibits such cancellation of policies, absent intentional fraud on the part of the insured.

- **A prohibition against denying children coverage for treatment of pre-existing conditions. (By 2014, no one can be denied access to insurance or coverage for treatment related to a pre-existing condition; HHS intends to clarify by regulation that, six months from the bill's passage, children will have access to insurance regardless of pre-existing conditions.)**

Example 1: Sally, age 7, has cerebral palsy and is in need of a baclofen pump to assist with spasticity. Prior to the law's passage, the insurance company could have denied this due to her pre-existing condition of cerebral palsy. With passage of the law, this should no longer happen.

Example 2: A 6-month old is discovered to have a congenital heart defect. The insurance company refuses to cover necessary surgery because the defect is considered a pre-existing condition. This would be prohibited under the new law.

Example 3: Laurie has Down Syndrome. Once the regulations are issued to clarify that children cannot be denied insurance policies due to pre-existing conditions, Laurie's family will be able to add her to their plan.

Federal Health Care Reform – How it will affect families

- **The establishment of a national high-risk pool for those who have been uninsured due to pre-existing conditions (until 2014, when insurance can be purchased on “Exchanges”).**

Example: Christina, a self-employed young adult, age 28, has been unable to get insurance due to her Type 1 diabetes. If she has been uninsured for at least six months, she can get coverage through a high-risk pool that will be established within the 90 days from the signing of the bill.

- **A requirement that young adults be permitted to stay on their parents’ insurance policies until age 26, unless they have an offer of employer coverage.**

Example: Sam is a 23 year-year old with spina bifida, unable to find a job since he graduated from college, and unable to get insurance on his own because of his preexisting condition. Under the new law, Sam can stay on his parents’ insurance until he is 26 years old.

- **No-cost preventive care for children in new insurance plans (excluding ERISA plans), based on the “Bright Futures” recommendations of the Maternal and Child Health Bureau and the American Academy of Pediatrics.**

Example: Children will be able to receive comprehensive preventive care, including developmental screenings, at no cost.

Other important provisions, to take effect in 2014, include:

- Expansion of the Medicaid program to *all* individuals with incomes up to 133% of the federal poverty level. (Currently, states cannot receive federal Medicaid funds for covering childless adults.)
- Elimination of all pre-existing condition exclusions (i.e., guaranteed issue of insurance), and a prohibition on charging higher premiums for people with pre-existing conditions.
- Elimination of annual benefit caps.

Example: Jack has required extensive hospitalization for multiple heart surgeries in his first year of life, exceeding the annual limit his insurance company will pay on his behalf. Under the new law, there will be no arbitrary annual limits, so Jack’s family will not have to pay out-of-pocket for the balance of his expenses that year.

- A loan repayment program aimed at reducing shortages of pediatric subspecialists, including non-physician providers of mental and behavioral health care and substance abuse prevention and treatment services.
- Incentives for more community-based, long-term care in Medicaid and establishment of a voluntary, public long-term care insurance program (the CLASS Act).
- Support for establishment of medical home models.
- Significant increases in funding for prevention and wellness efforts and the development of the public health infrastructure.
- Authorization of a new program to support school-based health centers and provision of \$200 million for immediate construction of such centers.
- Provisions to improve the oral health of children. (Inclusion of oral health care among the benefits required of insurance plans offered through state “Exchanges” with no charge for preventive pediatric oral health services.)

NOTE: This is a preliminary summary. The new law is over 2,400 pages long, and there will be many regulations issued to implement it. We will provide further analysis and information as it becomes available.

MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION (MCHA)

Since becoming operational in 1977, MCHA has served as an insurance safety net for Minnesotans who have been turned down for individual health insurance due to pre-existing conditions. There are many different circumstances that cause Minnesotans to turn to MCHA such as:

- Self –employed individuals who want insurance but are rejected due to pre-existing conditions
- Individuals who exhaust COBRA benefits
- HIPAA eligible persons (generally, persons leaving employer group coverage)
- Spouses & dependents of employees whose employer doesn't offer dependent health coverage
- Individuals eligible under the Trade Adjustment Assistance (TAA), alternative TAA, or Pension Benefit Guaranty Corporation (PBGC)
- Changes in self-insured employer or union plans (changes in/cancellation of benefits)
- Persons reaching lifetime maximums in their insurance policies
- Persons reaching lifetime maximums in their employer's self-insured plans
- Individuals working for employers who do not offer health insurance benefits
- Individuals laid off/terminated by self-insured employers who don't offer conversion policy
- People waiting for employer coverage while fulfilling probationary employment period
- People who had individual health coverage or group coverage that was cancelled by their insurance company
- Former employees of bankrupt companies
- Former insured's of HMOs or insurance companies that become insolvent
- Some recipients of Ryan White funding

Eligibility - MCHA's eligibility criteria are set in Minnesota Statute 62E.14. The following eligibility requirements are meant to serve as general information only. You are eligible for MCHA if you:

Are a Minnesota resident on the date of application for MCHA coverage and

- have lost group coverage. You must be an "eligible individual" under Health Insurance Portability and Accountability Act (HIPPA); or
- are also eligible for the Health Coverage Tax Credit (HCTC) program. You must be eligible for Trade Adjustment Assistance (TAA), Alternative Trade Act Adjustment Assistance (ATAA), or between ages 55-64 and receive pension payments from the Pension Benefit Guaranty Corporation (PBGC); or

Have been a Minnesota resident for the six months immediately prior to the date of application for MCHA coverage and

- have reached age 65 or over and are not eligible for the health insurance benefits of the Federal Medicare Program; or
- within the past six months have been rejected for individual health coverage from a Minnesota based insurance carrier or have received a rejection of coverage from a health insurance agent due to health related reason(s); or
- have been treated within the last three years for one of the special "Presumptive Conditions" listed in the "MCHA Instructions and Application for Individual Coverage" document..

Important Information on Pre-existing Conditions:

For all MCHA policies, no benefits are payable during the first six months of coverage for expenses for any preexisting condition, injury, illness or other physical or mental condition that was diagnosed, treated or evaluated during the 90 days preceding the effective date of coverage. However, Minnesota State law does provide some exceptions to the preexisting condition limitation. To determine if you may be eligible for a waiver, you must request a waiver of the preexisting condition limitation by completing the applicable section of the MCHA application.

**Minnesota Comprehensive Health Association, Customer Service, Mail Route CP555,
401 Carlson Parkway Minnetonka, MN 55305 1-866-894-8053 www.mchamn.com**

Sample Appeals Letter

Use these guidelines to organize your letter:

- State your purpose for writing
- Explain your child's diagnosis and how it affects the child
- Give specific reasons why your child needs the service or equipment
- Mention the supporting documentation you are including
- Close by focusing on action

Here is a sample letter that follows these guidelines

<i>Child's name & policy number</i>	January 1, 2XXX ABC Insurance Company 1234 Insurance Lane Anytown, MN 12345 RE: John Smith Policy Number: 123456
<i>Purpose for Writing</i>	Dear Insurance Company Representative: I am writing to appeal your recent decision denying a wheelchair for my son John Smith. I understand from your letter dated January 1, 2XXX, that you will only pay for a wheelchair if John is unable to walk without it.
<i>Diagnosis explained</i>	My son John is a six year old, in kindergarten who was diagnosed with XYZ syndrome at the age of six months. XYZ syndrome causes John to have weak muscles in his legs and so he has difficulty walking long distances. John has great difficulty walking through the grocery store, and cannot walk during trips to the zoo or other similar family outings.
<i>Reasons child needs service or equipment</i>	In order for John to be able to participate in family and school activities with his siblings and friends, John needs a wheelchair. John is too old for a stroller and resents the implications of being a baby, especially at school. A wheelchair would allow John to maneuver independently from adults, which is important for his psycho-social development.
<i>Supporting documentation</i>	I have attached letters from John's pediatrician and neurologist who both feel John needs a wheelchair, and have outlined their medical opinions. I have also attached a letter from John's physical therapist explaining the type of wheelchair he needs and why. Also attached you will find a bid for the cost of the wheelchair John needs from two equipment companies that have contracts with your company.
<i>Action</i>	We understand from your appeal process that you have 60 days to respond to our appeal, and we will await your written reply. Sincerely, George and Kathy Smith 9876 Consumer Avenue Anytown, MN 12345 (123) 456-7890
<i>People who will receive a copy of your appeal</i>	cc: Dr. Mary Jones Pediatrician Address



Reasons for appeal

If you have applied for or are getting financial help, Medical Assistance, Food Support, or social services through the county or state agency, and:

- The county agency does not act quickly enough and you think it has gone beyond the legal time limit to act, you can appeal.
- The county agency decides you can not get help, you can appeal.
- The county agency providing you with assistance or services reduces or stops them, you can appeal.
- The state agency denies you a specific medical service, you can appeal.
- The county or state agency thinks you maltreated a child or a vulnerable adult, you can appeal.

When you disagree with any county or state agency action, you have the right to appeal. You must ask for a fair hearing by the state.

Time limits

Your request for a hearing must be received within 30 days after you get a written notice about the county's or state's decision. If you show "good cause" for not appealing within this time limit, you may appeal up to 90 days after you get the notice. "Good cause" is when you have a good reason for not appealing on time. The human services office will decide if your

reason is a good cause reason. With Food Support you may appeal up to 90 days after you get a notice of the county's decision and **do not** have to show good cause.

After the state gets your request, it will set a date for a hearing. The state will tell you the exact date, time, and place.

Preparation for a hearing

Get all the information about your case.

- Bring a letter from a doctor if a medical question is involved.
- Bring any other papers you want the hearing officer or appeals referee to see.
- Ask others who know about your case to come to the hearing.

It is a good idea to make a list ahead of time of the points you want to make and bring it with you to the hearing.

Hearings

A Human Services judge, who has not been involved in the decision you are appealing, will look at the facts in your case. He or she will look at the evidence and hear arguments by you and the county or state agency. Every effort is made to get all information needed to arrive at a fair decision based on the law. Your hearing may be conducted by telephone unless you object.

Lawyer or friend can speak for you

You may have a lawyer or another person speak for you at the hearing. However, the state or county agency can not get a lawyer for you or pay for one. Contact the legal services office in your area if you want a lawyer.

The county may pay for some of the costs of your appeal. These costs may be for transportation and child care expenses.

Decision

You usually will be told of the judge's final decision within 60 days of your Food Support appeal or 90 days of all other appeals.

How to Appeal

Request a hearing. This is easy to do. Your request for a hearing must be in writing. You or someone who represents you must sign the request. With Food Support appeals you may make a verbal request for a hearing. Send or make the request to the county agency or to:

Minnesota Department of Human Services
Appeals Office
PO Box 64941
St. Paul, MN 55164-0941
Metro: (651) 431-3600 (Voice)
Outstate: (800) 657-3510
TTY: (800) 627-3529
Fax: (651) 431-7523

Attention. If you want free help translating this information, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية في ترجمة هذه المعلومات، فاسأل مساعدك في مكتب الخدمة الاجتماعية أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ បើអ្នកចង់បានជំនួយបកប្រែព័ត៌មាននេះដោយមិនគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿងរបស់អ្នក ឬ ទូរស័ព្ទទៅលេខ 1-888-468-3787 ។

Pažnja. Ako vam je potrebna besplatna pomoć za prevod ove informacije, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Ceeb toom. Yog koj xav tau kev pab txhais cov xov no rau koj dawb, nug koj tus neeg lis dej num (worker) lossis hu 1-888-486-8377.

ໂປຼດຊາບ. ຖ້າທ່ານກຳລັງຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປຂໍ້ຄວາມດັ່ງກ່າວນີ້ພໍລິ, ຈົ່ງຖາມນຳພັນກຳລັງຊ່ວຍວຽກຂອງທ່ານຫຼືໂທໂທຕາມເລກໂທ 1-888-487-8251.

Hubaddhu. Yoo akka odeeffannoon kun sii hiikamu gargaarsa tolaa feeta ta'e, hojjataa kee gaafaddhu ykn lakkoofsa kana bilbili 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в переводе этой информации, обратитесь к своему социальному работнику или позвоните по следующему телефону: 1-888-562-5877.

Ogow. Haddii aad dooneyso in laga kaalmeeyo tarjamadda macluumaadkani oo lacag la' aan ah, weydii hawl-wadeenkaaga ama wac lambarkan 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para traducir esta información, consulte a su trabajador o llame al 1-888-428-3438.

Chú Ý. Nếu quý vị cần dịch thông tin này miễn phí, xin gọi nhân-viên xã-hội của quý vị hoặc gọi số 1-888-554-8759.

LB2-0004 (10-09)

ADA3 (5-09)

This information is available in alternative formats to individuals with disabilities by calling (651) 431-3600 or (800) 657-3510. TTY users can call through Minnesota Relay at (800) 627-3529. For Speech-to-Speech, call (877) 627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.

**FREQUENTLY ASKED QUESTIONS ON
PERSONAL CARE ASSISTANCE (PCA) CHANGES & APPEALS
2009 & 2010 LEGISLATIVE SESSIONS**

**Updated August 4, 2010
MN Disability Law Center
www.mylegalaid.org/mdlc**

NOTE: At the web address directly below, you will find many resources & documents discussing PCA changes from the 2009 Legislative Session and a document summarizing the 2010 Legislative Session changes to the PCA Program. You can, also, access THIS very document online, which when it is online, is able to link you directly to specific websites and the actual current DHS documents used for the PCA Program.

<http://www.mylegalaid.org/mdlc/current-projects/pca-changes>

1. What are the changes which will affect current Personal Care Assistance (PCA) recipients?

1) Eligibility for PCA services has been tightened. (DHS calls this “Access to PCA Services”)

*****Until July 1, 2011, a person must have either: A dependency in an Activity of Daily Living (ADL), OR Qualify as having Level I Behavior.**

***** After July 1, 2011, the eligibility criteria will be further tightened to require a dependency in at least 2 ADLs. Persons with Level I behavior will no longer qualify for PCA services.** (See #1.6) on next page for more information on the July 2011 changes).

2) Dependency definition has been changed.

The 2009 stricter definition of “Dependency” requires that the person has a need on a daily basis for hands-on physical assistance or constant cuing and supervision. During the 2010 Legislative session, the definition was changed so that those who are dependent, but do not need or choose to accomplish the task daily, still qualify as dependent.

The **2010 definition of dependency:** requires that the person has a need on a daily basis or on the days during the week the task is completed for hands-on physical assistance to complete the task **or** cuing & constant supervision to complete the task.

NOTE: The old criteria for dependency included: “Help of another - Person able to participate.” Prompting to begin or accomplish tasks no longer qualifies as a dependency.

Activities of Daily Living (ADLs) Include: (1) Grooming; (2) Dressing; (3) Bathing; (4) Transferring; (5) Mobility; (6) Positioning; (7) Eating; (8) Toileting.

3) Requirements for Level I Behavior: (1) Physical aggression towards self; **or** (2) Physical aggression towards others; **or** (3) Destruction of property **and** (4) requires the immediate response of another person.

(For discussion of changes in the behavior documentation requirements, see pages 8-10 of the **PCA Assessment and Service Plan Instructions and Guidelines (DHS-3244A, 5-10)**. You can link to these DHS forms on the MNDLC website. **www.mylegalaid.org/mdlc/current-projects/pca-changes**
More information on the New Assessment Formula next page #2)

NOTE: To qualify for Level I behavior, one of the behaviors must have occurred within the past 12 months. (DHS trainer stated the 12-month standard during the Assessor trainings given across the state in the Fall 2009.)

NOTE: Nearly 1,000 persons under 65 and perhaps 150 seniors have been terminated from PCA services entirely as of July 2010, because they are not dependent under the new definition in an ADL or do not qualify as having Level I behavior.

4) PCA time (authorized hours) reduced.

Hours of PCA service will be reduced for thousands by instituting a new assessment with a specific formula to determine hours of care. See the three-step authorization chart and new decision tree with the 10 new home care ratings (HCR) and time allotted for each HCR. The document is on the MNDLC website entitled: **DHS Colored Assessment Chart [10-09] and Decision Tree with Base Amount of Hours [1-1-10]**.

www.mylegalaid.org/mdlc/current-projects/pca-changes

NOTE: It is estimated that between 6,000 and 7,000 current PCA recipients out of over 16,000 recipients under age 65 and nearly 2,000 seniors will have their hours of service cut by some amount. It is expected that some may receive an increase in hours.

5) Hours a PCA can be paid limited to 275 hours per month.

The Legislature limited the hours a PCA could work to 310 hours per month in 2009. The Governor reduced the PCA monthly work hours further to 275 hours through unallotment in June, 2009. The 2010 Legislature ratified the Governor's unallotment, so that 275 hour monthly PCA work limit is now in statute.

6) Stricter PCA eligibility criteria becomes effective July 1, 2011.

As of July 1, 2011, persons will need to qualify as dependent (see #1.2 on first page) in at least 2 activities of daily living (ADLs). Level One behavior will no longer qualify a person for PCA services. DHS is required to develop recommendations for alternatives for those with mental health conditions or behavioral problems who are terminated from PCA services. The recommendations are due in a report to the Legislature by January 15, 2011. About \$4 million dollars per year for two years was set aside to match federal Medicaid funds for the alternative PCA services.

DHS data on the PCA assessments show that in addition to the over 1,000 persons whose PCA services were terminated by July 1, 2010, another 2,000 will lose PCA services by July 2011.

QUESTIONS ON NEW ASSESSMENT FORMULA

2. Where can I get information about the new assessment?

The new assessment document is called the **Personal Care Assistance (PCA) Assessment and Service Plan (DHS-3244, 5-10)**. There is a companion instruction document called the **PCA Assessment and Service Plan Instructions and Guidelines (DHS-3244A, 5-10)**. You can link to these forms on the MN DLC website or these forms can, also, be found on the DHS website www.dhs.state.mn.us. You can access the forms by going to the blue horizontal bar and click on Forms-eDocs and then type in the form number.

There are **three steps** to the new assessment:

(Step 1) Determine eligibility for PCA service (dependency in an ADL and/or Level I behavior); and

(Step 2) Determine the home care rating based on the number of activities of daily living (ADL), behavioral issues and complex health needs; and

(Step 3) Add:

- (a) Time for critical ADLS's (eating, transferring, mobility, toileting);
- (b) Behaviors-if these occur four times a week:
 - (1) Increased vulnerability due to cognitive deficits or socially-inappropriate behavior;
 - (2) Resistive to care, verbally aggressive; or
 - (3) Physical aggression toward self, others or property destruction; and

NOTE: The maximum time for all behavior criteria allowed is 90 minutes per day in addition to the basic home care rating number of hours in step 2

- (c) Complex health conditions, such as catheters, bowel program, wound care or other interventions, which are listed, can add 30 minutes per complex health procedure.

3. Are those using the CONSUMER SUPPORT GRANT (CSG) affected by the PCA changes to eligibility, PCA hours limits and the assessment?

YES. See the new CSG Monthly Budget Chart for the new limits. The chart is available on the MN DLC Website. Because CSG is based on the PCA program, CSG participants are also being terminated and reduced due to the tightened PCA criteria and hours formula.

4. What should I do to prepare for the assessment?

- a. If you have medical documentation of your disability and need for assistance, it is important to have copies of that for the assessment.
- b. If you have Level I behavior, it is important to have documentation of those problems from your physician, mental health provider or psychologist, school, day care provider, or anyone else in the community aware of the issues.
- c. If you have complex health procedure needs which have been ordered by your doctor such as tube feeding, wound care, bowel program, seizures, and so on, it is important to have the doctors' orders for the assessment. If you have been getting PCA service help with those needs, use the documentation of those needs from your current PCA provider. The new law says that to get PCA time for complex health procedures, they must be ordered by a doctor. You are not required to show the assessor the doctor's orders, but if you can do that, you will avoid problems and reduce the need to appeal.
- d. Read the **PCA Assessment and Service Plan Instructions and Guidelines (DHS-3244A-ENG 5-10)** to find out what the process is like.
- e. The guidelines have been updated since some assessors were trained, so be sure they follow the online instructions. (For instance, the draft Guidelines defined "constant supervision" as 100% visibility, eyes on the person, but the updated Guidelines on p. 10 define constant supervision as "continued interaction and/or visibility to ensure person's safety and task completion.")

TERMINATION OF PCA SERVICES

5. What if I am terminated from PCA services?

If you are cut off of PCA services and think that the assessor did not fairly consider your need for physical help or cuing and constant supervision or your behavioral issues which meet the Level I criteria, you have the right to appeal.

You will get two mailings about changes in your PCA services: 1) your completed "Assessment and Service Plan" from the county or health plan nurse and 2) a computer generated notice from the Minnesota Department of Human Services that your PCA services have been terminated and information about your appeal rights.

In thinking about the fairness of your assessment, it will be helpful to review your completed assessment and the **PCA Assessment and Service Plan Instructions and Guidelines. (Form DHS 3244A)-ENG 5-10**. It is

important to review your assessment so that you can be specific at your appeal about where mistakes were made or you disagree with the assessment.

If you decide to appeal, it is very important that you ask for the **appeal in writing within 30 days of the date on the notice. Also, if you need your PCA services to continue during the appeal, you must ask for continued services when you request an appeal.** DHS is required to authorize PCA hours to continue during the appeal period at the level you were getting before the new assessment. PCA hours used during the appeal period should not be subtracted from the PCA hours authorized after the appeal.

If you need the PCA services to continue at the current level and you lose your appeal, it is important to understand that the commissioner of DHS may bring a claim against you for the PCA payments made pending appeal. However, the Disability Law Center is not aware of any case involving medical assistance where this has been done by DHS since the law was passed in 1991.

It is most important to consider the circumstances of the person who has lost services and wants to appeal, including whether the assessor may have made mistakes or didn't consider necessary information about the person's condition. Continuing services during an appeal is often necessary to be able to stabilize people, keep them in their homes and keep their trained care givers. During an appeal, if vulnerable children or adults are unsafe in their homes, get injured or lose trained caregivers, they will suffer serious harm even though they might win their appeals. That is why the law provides for services pending appeal.

If you need an interpreter to be at the hearing, you should call or write the human services judge as soon as possible. Tell the human services judge what help you need. The human services judge will make sure that an interpreter is at the hearing. These services are available to you at no charge. Your request for an appeal and for your PCA services to continue during the appeal process must be sent or faxed, within 30 days of the notice, to:

**MN Dept. of Human Services--Appeals Office
P.O. Box 64941, St. Paul, MN 55164-0941**

**Phone: 651-431-3600 or Toll Free 1-800-657-3510
TTY: (800) 627-3529, FAX: 651-431-7523**

DHS has a lot of information about appeals on their website www.dhs.state.mn.us . Go to left column and click on **A-Z Topics**, scroll down **A Listings** and click on **Appeals**.

Use the **Fair Hearings Decision Database** to search human services appeals decisions. The database contains a comprehensive collection of decisions, with private data and county identifying data removed, dating back to July 2001. The archive includes a keyword search function, and is available to members of the public interested in seeing how the appeals function has addressed particular issues.

The **Frequently Asked Questions About State Appeal Hearings** page has information about how to request a hearing. The form **Information about State Appeal Hearings (DHS-2811)** is, also, available in DHS **eDocs (eForms) library**, along with the form **Instructions for Requesting an Appeal (DHS-0033)**.

However, if you think the assessment was accurate and you no longer qualify for PCA services because of the changes, then it is most important to try to find other services as soon as possible. The Assessor nurse is required to provide you with a list of other possible services. **See questions farther below on Referrals to Other Services.**

REDUCTION IN HOURS OF PCA SERVICE

6. What if my hours of service are reduced and I want to appeal?

If you have your PCA hours reduced and think that the assessor did not fairly consider your need for physical help or cuing and constant supervision, your behavioral issues or your complex health procedures, you have the right to appeal.

You will get two mailings about changes in your PCA services: 1) your completed Assessment and Service Plan from the county or health plan nurse required to be sent to you within 10 working days of your assessment; and 2) A notice that your PCA units (15 minute per unit) have been reduced and information on how to appeal.

In thinking about the fairness of your assessment, it will be helpful to review your completed assessment and the DHS “Instructions and Guidelines” for Assessors. It is important to review your assessment so that you can be specific at your appeal hearing about where mistakes were made or where you disagree with the assessment.

Did the assessor note down all the areas (ADLs, qualifying behaviors and complex health procedures) with which you said you needed help? If there are activities of daily living, behaviors or complex health needs that you need help with that are not written on the assessment, those are the areas to gather information on for your appeal.

Remember, the amount of time you need for each activity is no longer important because the PCA time now is figured according to a formula for everyone.

The only way to get more PCA time is to qualify as dependent in more activities of daily living or having the listed behaviors or complex health procedures for which PCA time is allowed.

PLEASE NOTE: The following recommendations for “persons whose PCA services were reduced” are the same recommendations as those for “persons whose PCA services were terminated”.

If you want to appeal, it is very important that you ask for your **appeal in writing within 30 days of the date on the notice**. Also, **if you need your PCA services to continue while you appeal, you must ask for continued PCA services during the appeal process**. DHS is required to authorize PCA hours during the appeal period at the level you were getting before the new assessment. PCA hours used during the appeal period should not be subtracted from the PCA hours authorized after the appeal.

If you need the PCA services to continue at the current level and you lose your appeal, it is important to understand that the commissioner of DHS may bring a claim against you for the PCA payments made pending appeal. However, the Disability Law Center is not aware of any case involving medical assistance where this has been done by DHS since the law was passed in 1991.

It is most important to consider the circumstances of the person who has lost services and wants to appeal, including whether the assessor may have made mistakes or didn’t consider necessary information about the person’s condition. Continuing services during an appeal is often necessary to assure safety, keep people in their homes and keep their trained care givers. During an appeal, if vulnerable children or adults are unsafe in their homes, get injured or lose trained caregivers, they will suffer serious harm even though they might win their appeals. That is why the law provides for services pending appeal.

If you need an interpreter to be at the hearing, you should call or write the human services judge as soon as possible. Tell the human services judge what help you need. The human services judge will make sure that an interpreter is at the hearing. These services are available to you at no charge. Your request for an appeal and for your PCA services to continue during the appeal process must be sent, within 30 days of the notice, to:

**MN Dept. of Human Services--Appeals Office
P.O. Box 64941, St. Paul, MN 55164-0941**

**PHONE: 651-431-3600, Outstate (800) 657 3510
TTY: (800) 627-3529, FAX: 651-431-7523**

There are a number of organizations to call for help with your appeal. Arc Minnesota, NAMI Minnesota, Brain Injury Association of Minnesota, MS Society, Minnesota Disability Law Center (MDLC), Legal Aid office in your area. See a partial list of **Disability Advocacy Organizations & Legal Aid Offices** on the last page.

REFERRALS TO OTHER SERVICES REQUIRED

7. What if my hours of service are reduced or I am terminated because of the changes made to PCA services, but I think the assessment was accurate?

What if I cannot get along with fewer hours of PCA service, how can I get the help I need?

If you think the assessment was accurate and you no longer qualify for PCA services or your reduction in hours was consistent with the changes to PCA services, then it is most important to try to find other services if you need help at home, as soon as possible.

You should receive the PCA Assessment and Service Plan document within 10 working days of your assessment. This 10-page assessment should have been filled out by the public health nurse and signed when you were assessed. The public health nurse is supposed to provide you with a list of other services on the last page of the assessment, called **Recipient Referrals**.

You can call your county human services agency, listed on the MDLC & DHS websites, or health plan and request:

- A home and community waiver slot through your county;
- Adult or child mental health services, or
- Other MA home care services such as a home health aide;
- MA Health Care services such as physical therapy, psychology, etc.

You have the right to apply for these other services. If you are turned down, the county must provide you a written notice of denial and information on how to appeal the denial. Disability advocacy organizations may be able to help you appeal. See the resource list at the end of the questions. An appeal must be sent in writing within 30 days of the notice of denial to the DHS Appeals Office address listed in Questions 5 & 6.

8. Is there any way I can get more PCA hours than I qualify for under the new PCA assessment criteria?

Yes. Home and Community-Based Waiver services can include “extended” PCA services which can be more hours than you qualify for under the new PCA criteria. People who need more PCA hours may be able to get them through the CAC, CADI, DD or TBI waivers. Extended PCA service under the home and community waivers is defined in the PCA statute as including additional PCA hours beyond the amount allowed by the PCA assessment or PCA hours needed less frequently than daily. **2010 PCA Legislative Report #V.A.2.b.[256B.0659 subdiv.1(g)]**

Home and Community-Based Waivers are for those who qualify for institutional services such as a nursing home or intermediate care facility for persons with developmental disabilities, but need alternative services to remain in their homes, apartments or a community group home. Information about waivers can be found on the **DHS website**.

If you already get waiver services, your allowed waiver budget may have to be increased by your county if your health, safety and welfare are threatened without more PCA services. You can call the Disability Linkage Line to help you get a hold of your county to apply for waiver services or check www.MinnesotaHelp.info.

NOTE: Waiver slots are limited and you may be told there is a waiting list. You have the right to apply anyway and the right to appeal the denial of waiver services.

9. What if I had been referred for other services, but cannot find any providers?

If you need other services, such as child or adult mental health services, services for fetal alcohol or a brain injury, and cannot find anyone to provide them, call the Disability Linkage Line (1-866-333-2466) for help in locating a provider. If you cannot find a local provider, call a disability advocacy group, CCD, the Minnesota Disability Law Center, an ombudsman’s office or other Legal Aid office near you for help.

Since DHS told the Legislature that some PCA recipients would be better served with other services, if you cannot find the other services, it is important for the Commissioner of DHS, the Governor and your legislators to know this. If services are really not available, it is important for you to provide information about your experience so that

those advocacy groups working for change have your information. You can document your problems and efforts through the PCA survey link on the CCD website, www.mnccd.org

10. I have a chronic illness or disability and have used PCA services but now have been terminated. What other service can come to my home and help me with medications, meals, doctor's appointments and maintaining my apartment?

There are a variety of services that may be helpful to you. You can find the services below on the DHS website: www.dhs.state.mn.us or call your county human service agency and ask to talk to a disability social worker. You can, also, find information about these services in this Manual in the **DHS & Children's Mental Health Packets**.

One service that may help you if you are an adult, is called Home Health Aide (HHA). A Home Health Aide is provided through a Medicare certified home health agency.

You may also qualify for Adult or Children's Mental Health Services through your county. These services can include mental health aides who can come to your home. For adults, these aides are called AMHRS (Adult Mental Health Rehabilitative Services). For children, a behavioral aide can come to your home as part of a mental health service called CTSS (Children's Therapeutic Services and Supports).

You can start by calling the Disability Linkage Line, 1-866-333-2466, for providers of home health aides or adult or children's mental health services near you.

If you cannot get the services you need to maintain your home or apartment in the community, call a disability advocacy organization, CCD, Minnesota Disability Law Center, Ombudsman's Office or other Legal Aid office for help. Also, consider documenting your problems and efforts through the survey link on the CCD website, www.mnccd.org. You can also file a complaint with the **Office of Civil Rights in Chicago**. www.hhs.gov/ocr/civilrights/complaints/index.html

11. I had been getting PCA services under the MT or CS rating which was eliminated. What should I do?

The MT and CS ratings have been eliminated. People with those ratings are being offered a home and community waiver service slot. If you are cut and do not have replacement services, it is important to appeal as soon as you receive the notice of your cut.

Also, if you have not yet had a PCA reassessment but know that you have a CS or MT home care rating currently, go to your county and apply for a home and community waiver slot as soon as possible. The legislation provided funding for waiver slots for people in the MT and CS home care rating to move to waivers, about 70 people across the state.

QUESTION ON CIVIL RIGHTS UNDER OLMSTEAD DECISION, AMERICANS WITH DISABILITIES ACT (ADA)

12. What if I have to leave my apartment or home because of cuts to my PCA services?

You may have a civil rights claim under the Americans with Disabilities Act (ADA) Olmsted Decision. People should not have to live in more restrictive settings when they have been able to live in homes and apartments with PCA services. If you are at risk of losing your home or apartment because of cuts in your PCA services, call the Minnesota Disability Law Center or other Legal Aid office for help (See question #16 for contact information) and fill out the survey linked on the CCD website: www.mnccd.org. You can also file a complaint with the **Office of Civil Rights in Chicago**. www.hhs.gov/ocr/civilrights/complaints/index.html

QUESTIONS ON 275 HOUR LIMIT PCAs CAN BE PAID PER MONTH

3. What should I do if my PCA had usually worked more than 275 hours per month?

You are still eligible for your authorized hours of care, so it is important for you to find and train an appropriate

person to provide all of the hours you need. If your PCA provides care to you for your authorized hours over 275 hours per month without pay, you may not be assessed to need the hours of service you need. Also, it is important for everyone to have more than one person trained to provide the care they need in case of illness, emergency or other change in staff.

14. What if I am not able to find someone to fill my hours or have hired people who are not competent or leave after a short time?

It is very important that you document the difficulties you have in filling your PCA hours of care. Go to the website www.mnccd.org which allows you to provide information about your difficulties. You do not have to use your name to submit your experience. This information can be used to keep track of the impacts of PCA changes and to try to get changes to these PCA cuts.

If your well-being is threatened or you cannot continue to live at home, you should call the Minnesota Disability Law Center intake line for help: 612-334-5970; 1-800-292-4150; TDD: 612-332-4668.

15. What if I live in a home owned or controlled by my PCA agency?

You will be required to either choose a new agency which does not own or control your home, group home or apartment or move to a different home and continue with the same PCA agency. By August 1, 2010, PCA agencies are prohibited from providing PCA services to persons living in PCA agency owned, leased or rented homes or apartments.

16. What should I do with this information I am keeping track of?

It is extremely important to keep track of this information so that if bad things happen, you can use it in any appeal you may have and you can fill out the CCD survey so this information can go to your legislators and ask for changes and use it in other ways to try to help people continue to live at home with the services they need.

Disability Advocacy Groups and Legal Aid Resources

17. How do I contact disability advocacy organizations or local Legal Aid offices? (Partial List Below)

- Arc Minnesota www.arcmn.org
- Brain Injury Association of Minnesota www.braininjurymn.org
- Courage Center www.couragecenter.org
- National Multiple Sclerosis Society, MN Chapter www.nationalmssociety.org/chapters/MNM/index.aspx
- Minnesota Organization for Fetal Alcohol Syndrome (MOFAS) www.mofas.org
- National Alliance for Mental Illness-Minnesota (NAMI) www.namihelps.org
- Consortium for Citizens with Disabilities, CCD www.mnccd.org
- Link for Consortium members www.mnccd.org (Go to left column & click on MN-CCD Members)
- Link for PCA stories www.mnccd.org (Go to left column & click on Spotlight Issue: Tracking...PCA Prog.)
- Find a Legal Aid Office or other resource near you in Minnesota www.lawhelpmn.org/MN

18. What changes were made to the PCA program by the Legislature in 2010?

There were many policy changes affecting PCA provider requirements, definitions, staff training and other related areas. **Some problems which came to light after the 2009 law were fixed, including allowing IADLs (Instrumental Activity of Daily Living) for children who need immediate attention for health or hygiene reasons related to PCA services. This means a PCA can clean up or do a load of laundry, if needed and included in the service plan developed during the assessment.**

Also, changes were made to prohibit PCA agencies from limiting the future employment of PCAs and excluding family member PCAs from Unemployment Insurance coverage. A full list of the 2010 Legislative changes to PCA services can be found on the PCA Changes portion of the MNDLC website:

www.mylegalaid.org/mdlc/current-projects/pca-changes

APPEAL OPTIONS FOR PERSONS COVERED BY HEALTH PLANS

[NOTE: If you have Fee- For- Service Medical Assistance (MA), TEFRA, EMA or MA-EPD refer to the Welfare Appeals handout in this section. Or, call Minnesota Health Care Programs Member Help Desk 651-431-2670 or 1-800-657-3739. For Self Insured/Self Funded health plans refer to the Self Insured/Self Funded Health Plan Complaints in this section.]

Appeal Options for Persons Covered by Health Plans

There are several reasons, situations and appeal options when an enrollee is dissatisfied with their health plan. It may be something as simple as being charged an improper copayment or as complex as seeking coverage for an innovative procedure to treat a rare condition. Either way, if you have been denied any type of coverage, feel your rights have been infringed upon or are dissatisfied with how you have been treated or served, you have options.

Start With Your Health Plan for Help

Starting with your health plan may be the quickest and easiest option to resolve the dispute. It is important to read your health insurance policy AND health benefits handbook to find out how to appeal a decision with your health plan. This is an internal appeal. All Minnesota health plans are mandated by MN law to have an internal appeals process, though the steps you must take to appeal may vary somewhat depending on the type of health plan you have. **It is very important for you to know and follow your health plans specific timeline requirements for making an appeal.**

If you need help understanding your health plan's appeal process, call your health plan's member or customer services representative. The phone number should be on the back of your health plan card and in your benefit handbook. Or you can write a letter to your health plan. Make sure to keep a copy.

It is important to inform your health care provider that you want to make an appeal to your health plan. Your health care provider may be able to provide you with helpful information to support your appeal. If your health plan is purchased through work, you may also want to notify your employer of your appeal.

Your health plan is required to respond promptly to your appeal. MN state law, rules and regulations specify procedural rights and deadlines, including an expedited process for urgent medical matters. The health plan must notify you of its decision in writing. You may have the right to a second appeal if you still are not satisfied with your health plan's decision. You have the right to a hearing, if you request one.

Many complaints and appeals are resolved internally by the health plans to the member's satisfaction. Unfortunately some are not. If you are not satisfied, there are other places outside of the health plan to go for help. If a delay in the process will seriously jeopardize your life, health or ability to regain maximum function, an expedited appeal is available. Call your health plan's member services and tell them you want an expedited appeal.

Help From Outside the Health Plan

If you are enrolled in a Prepaid Minnesota Public Health Care Program such as **MinnesotaCare, Prepaid Medical Assistance (PMAP) or Prepaid General Assistance Medical Care**, and your health plan has not resolved your concern or granted your appeal request, you can:

- Contact your **local Managed Care County Advocate**. The advocate can be contacted by calling your local county Human Services/Family Services agency found in the county government section of the phone book; **and/or**

- Contact the **Ombudsman Office for State Managed Health Care Programs** 651-431-2660 or 1-800-657-3729. They are located in the MN Department of Human Services <http://www.dhs.state.mn.us> and/or request a state fair hearing.
- Review the Grievances and Appeals section on the Department of Human Services website at: <http://www.dhs.state.mn.us> and use the search engine to look for Grievances and Appeals

If a delay in the process will seriously jeopardize your life, health or ability to regain maximum function, an expedited appeal is available. Call your health plan's member services or call the Ombudsman office at (651) 431-2660 or (800) 657-3729 and tell them you want an expedited appeal.

Help From a State Regulatory Agency

If you have a Minnesota-licensed health plan, the telephone number to call for state agency or regulatory help is frequently listed on the back of your membership card & in your member handbook. The state has the power to investigate and overturn a health plan's decision. The state regulatory agency has the power to impose fines or revoke a health plan's license.

- **If your health plan is a Minnesota-licensed HMO**, you can appeal to the Minnesota Department of Health, the state agency that regulates HMOs. 651-201-5100 or 1-800-657-3916.

www.health.state.mn.us/divs/hpsc/mcs/options.htm

- **If your health plan is a Minnesota-licensed health insurance company**, you can appeal to the Minnesota Department of Commerce, the agency that regulates health insurance companies. (651) 296-2488 or 1-800-657-3602. www.commerce.state.mn.us

Help From an External Review

- If you have a health insurance claim that continues to be denied by a health plan company, you have the right to appeal that denial by an external appeal. The State of Minnesota contracts with an independent company to review appeals for persons who are dissatisfied with the health plans internal complaint and appeal process. Minnesota law establishes procedures and deadlines for the **external review**. External Review may be available to persons enrolled in a fully insured plan, issued by a state licensed health plan company, and after the internal appeal process has been exhausted. There is a \$25 fee for each External Review unless it is waived for hardship. Maximus, the independent company, its employees and physicians are impartial, separate from and has no affiliation with any health plan. The result of an External Appeal is nonbinding on you, the insured, but is binding on the health plan company. If you lose, you have the right to appeal the decision in court. If the health plan company loses, it cannot appeal the decision. To learn more about the External Review Process and to print a Request for an External Review go to www.health.state.mn.us/divs/hpsc/mcs/options.htm

Help From the Court System

- You may choose to file a lawsuit with the courts. Patients may file a lawsuit to enforce their rights under their health plan contract and require the health plan to pay for treatment.

Information from www.mnhealthplans.org, <http://www.health.state.mn.us/divs/hpsc/mcs/options.htm> and www.commerce.state.mn.us

Self Insured/Self Funded Health Plan Complaints

Minnesotans who receive coverage through their employers in a self-funded plan should work directly with their employer.

What is a self-insured health plan?

A self-insured group health plan (or a 'self-funded' plan as it is also called) is one in which the employer assumes the financial risk for providing health care benefits to its employees. In practical terms, self-insured employers pay for each - out of pocket - as they are incurred instead of paying a fixed premium to an insurance carrier, which is known as a fully-insured plan.

Self-insured plans are set up by employers to pay the health claims of its employees. The employer sets aside funds for the health claims. The *employer* assumes the risk of providing the benefits and is obligated to pay all the claims. Sometimes self-insured plans are confused with fully insured plans because employers often hire an insurance company to pay the claims. If you do not know what kind of plan you have; ask your employer or plan administrator. Federal laws enforced by the US Department of Labor govern legitimate self-insured plans. States are not allowed to regulate these plans. This means that state laws requiring specific benefits in health care plans do not apply to self-insured plans.

What kind of health plan do you have?

If you have health insurance through your employer, you can find what you need to know about the plan by reading your benefits handbook. Then, if you are still not sure, ask the people who work in your human resources or union benefits office. If you work for a large company or government, there's a chance your health plan is self-insured.

These self-funded plans are not insurance. The employer pays employee health care costs from the employer's own pocket. That's why these self-funded plans tend to work best for companies that are large enough to offer good coverage and pay large claims for expensive medical services. A self-insured plan may seem just like traditional insurance to you, but it does not always work the same way. And the differences can be important. As long as claims are being paid you may not notice whether your employer is fully insured or self-funded.

Find out how your health plan works

All self-insured employer plans do not work exactly the same way. Your plan's details are explained in your benefits handbook. It's your right and responsibility to know how your plan works... so read your handbook.

Self-insured employers & TPAs

It is common for self-insured plans to turn over the administration of their health plans to a Third Party Administrator (TPA). The TPA handles all administrative tasks including claims processing and payments.

- Often the employer can contract with an insurance company to act as a TPA for all health care claims. This can disguise the facts if your plan is self-funded.
- The names of both the TPA and employer appear on the benefits handbook and claim forms... just as if the TPA were actually your insurance company.
- A self-funded employer takes on the roles the insurance company usually plays. These roles can include paying claims, deciding on benefits, and determining which claims to pay.
- TPAs simply follow the employer's orders.

Why do employers self fund their health plans?

There are several reasons why employers choose the self-insurance option. The following are the most common reasons:

1. The employer can customize the plan to meet the specific health care needs of its workforce, as opposed to purchasing a 'one-size-fits-all' insurance policy.
2. The employer maintains control over the health plan reserves, enabling maximization of interest income - income that would be otherwise generated by an insurance carrier through the investment of premium dollars.
3. The employer does not have to pre-pay for coverage, thereby providing for improved cash flow.
4. The employer is not subject to conflicting state health insurance regulations/benefit mandates, as self-insured health plans are regulated under federal law (ERISA).
5. The employer is not subject to state health insurance premium taxes, which are generally 2-3 percent of the premium's dollar value.
6. The employer is free to contract with the providers or provider network best suited to meet the health care needs of its employees.

If your claim is denied

Self-funded plans usually have an internal process to review claim denials. You must complete that process before seeking outside help. The process is explained in your health benefits handbook.

What you can do

- Read and make sure you understand your benefits handbook.
- Your company's benefits manager can help if you need to file a claim for payment. Then, if the claim is denied, you should request that the denial be reviewed.
- Are you in a labor union? The union can file a grievance for you, investigate the employer's financial status, and help you negotiate payments on your past medical bills.
- If you are still not satisfied, file a complaint with the U.S. Department of Labor. That federal agency investigates complaints about self-funded employers.
- Consider legal assistance as another resort. The company may have violated an implied contract by refusing to pay medical bills which came about while self-insured health benefits were being offered.

The U.S. Department of Labor investigates consumer complaints about self-insured employer plans

Most self-insured health plans fall under the Employee Retirement Income Security Act (ERISA). ERISA is federal law that is enforced by the U.S. Department of Labor, Employee Benefits Security Administration (DOL-EBSA). If you are a member of a self-insured health plan through your employer security or union, then you can contact the DOL-EBSA for assistance.

However, the DOL-EBSA does **not** regulate self-insured health plans that are sponsored through school districts, other municipalities, and churches. If you are a member of this type of plan, you can file a complaint with the plan directly or you may seek a legal remedy through a court of law. The DOL-EBSA is available to answer questions about self-insured employer plans that come under ERISA regulation. You can gain information on the type of plan that you participate in by contacting your employer or union. If there is still some question, then you can contact the DOL-EBSA for clarification.

How to contact the U.S. Department of Labor:

Employee Benefits Society Administration
1100 Main Street, Suite 1200
Kansas City, MO 64105
(816) 426-5131 Tel. (816) 426-5511 Fax
(866) 444-3272 (toll free)
website: www.dol.gov/ebsa/

With what laws must self-insured group health plans comply?

Self-insured group health plans come under all applicable federal laws, including the Employee Retirement Income Security Act (ERISA), Health Insurance Portability and Accountability Act (HIPAA), Consolidated Omnibus Budget Reconciliation Act (COBRA), the Americans with Disabilities Act (ADA), the Pregnancy Discrimination Act, the Age Discrimination in Employment Act, the Civil Rights Act, and various budget reconciliation acts such as Tax Equity and Fiscal Responsibility Act (TEFRA), Deficit Reduction Act (DEFRA), and Economic Recovery Tax Act (ERTA).

8/13/08 Adapted from MN Department of Commerce Website www.commerce.state.mn.us Click on Consumer Information & Services, Click Insurance & then Medical Insurance.

Resources for Letters of Medical Necessity and Appeals

1. **Utah Collaborative Medical Home Project**

<http://www.medicalhomeportal.org/issue/writing-letters-of-medical-necessity>

This website describes how important it is for the clinician to understand the legal issues involved in writing a letter of medical necessity, pertinent components of a medical necessity letter, and how to write the letter in a manner that lays the groundwork for an appeals letter if needed. What to confirm before even beginning to write the letter, key components of a letter of medical necessity and links to sample letters are also available.

2. **Dr John Bach's sample letters** <http://www.doctorbach.com/letters>

This site developed by Dr. John Bach, Professor of Physical Medicine Rehabilitation and Co-Director of the Jerry Lewis Muscular Dystrophy Association Clinics, offers a variety of sample letters of medical necessity and allows the user to create his/her own letter by filling in the blanks.

3. **Rifton Equipment** <http://www.rifton.com/resources/lettersofmedicalneed/index.html> 1-800-571-8198

This website has pictures of equipment to include when writing a letter of medical necessity as well as sample letters for Rifton pieces of equipment (IE: bathing system, dynamic standers, supine standers, seating system, trikes & their toileting system). Also included on this website is an excellent article "Letters of Medical Necessity" written from a legal perspective by Sarah Rollman.

4. **Family Voices of Colorado** <http://www.familyvoicesco.org/hp/index.htm#private>

Family Voices of Colorado has a template on their website to assist providers and families in crafting expert letters of medical necessity and/or appeals packets to be able to use to get funding sources to cover necessary, medical services and supports.

5. **Appeal Solutions: Claims Resolutions for Healthcare Providers** <http://www.appealletteronline.com>

This website has a database of over 1400 medical appeal letters that can be emailed to the provider and a monthly email newsletter called "The Appeal Letter". The sample appeal letters are designed to assist medical providers with appealing wrongfully denied insurance claims. The site also offers audio conferences on Appeals to train health care staff on reducing denied and underpaid claims. Power of Appeals Software is available.

6. **Patient Advocate Foundation (PAF)** www.patientadvocate.org 1-800-532-5274

PAF is a national non profit organization, which seeks to safeguard patients through effective mediation assuring access to care, maintenance of employment and preservation of their financial stability relative to their diagnosis of life threatening or debilitating disease. Examples of direct services provided to patients, by phone or internet, at no cost include mediating and expediting insurance appeals, negotiating pre-authorization approvals, resolutions to coding and billing errors and negotiating access to pharmaceutical agents, chemotherapy, medical devices and surgical procedures. The Patient Advocate Foundation (PAF) Co-Pay Relief Program (CPR) currently provides direct financial support to insured patients. The program offers personal service to all patients through the use of call counselors; personally guiding patients through the enrollment process. Their website includes numerous publications including: Fundraising Ideas for Patients, Your Guide to the Appeals Process and A Greater Understanding, Financial Assistance & Debt Crisis Intervention.

7. **Office of the Attorney General Lori Swanson.** www.ag.state.mn.us 651-296-3353 or 1-800-657-3787

How to get the Health Care you Need: This section is for consumers who have encountered a problem with their health plan. Such as, not being able to get a referral to a specialist. Or health plan administrators are saying that treatment is not "medically necessary" or is "experimental." Or the health plan says that the treatment your health care provider recommends is not covered. There are general tips to help consumers navigate the health care maze. http://www.ag.state.mn.us/consumer/health/mmhc/mmhc_fighting.asp

Mental Health Care <http://www.ag.state.mn.us/Brochures/pubMentalHealthCare.pdf>

This 4 page fact sheet offers tips for a person to get the mental health care they need when they are having a problem with their health plan. It, also, lists regulatory agencies in Minnesota, briefly discusses group health plans, including self insured health plans (ERISA), mental health consumer protection laws and health maintenance organizations, (“HMOs”).

8. **A Consumer Guide to Handling Disputes with Your Employer or Private Health Plan**

<http://www.kff.org/consumerguide/7350.cfm>

This booklet is written by The Henry J. Kaiser Family Foundation and can be found at their website. Anyone enrolled in a health plan should be familiar with their plan’s internal review process and any external review program in their state in case problems arise. (This guide is not applicable for resolving disputes if you have Medical Assistance (MA) or Medicare coverage). The report includes understanding your type of coverage and what laws apply, appealing to your health plan (informal and formal appeals, health plan review and arbitration), getting an independent opinion—external review in your state, and state by state external review programs.

9. **HealthCareCoach.com** www.healthcarecoach.com

This website is packed with facts and do-it-yourself tips on everything from health insurance to patient care to help you help yourself and take control of your health care. For over three decades, their independent, non-profit group of health law specialists has given the consumers the information they need to get the best out of the health care system.



SSI APPEALS

Social Security has to send you a written notice to deny your application, cut you off or lower your SSI. To get SSI, you must show that you have a long-lasting disability that keeps you from working. It can be mental or physical. You have the right to appeal an SSI decision if you think it's wrong. The first step of an appeal is called "reconsideration." We will call this "recon".

1ST STEP: RECON

- Get the form "Request for Reconsideration" from the Social Security Office. Fill it out and send it to Social Security.
- Social Security must get your request within **60 days** from when you got the denial notice from them. If your papers are late, you have to give a good reason, or they make you start all over with a new application.
- If Social Security wants to cut off your benefits, you can keep getting SSI while you appeal. But you have to send the request within **10 days** of getting the notice.
- If you don't appeal, you lose your right to appeal. But, if you apply again within a certain time, you can ask that the first decision be opened, and ask for back benefits to that date.



You can do this yourself or get an attorney. Call your legal aid office.

There are 3 kinds of recon: case review, informal conference, and formal hearing. Choose the one that works best for your situation.

- To appeal denial of an application for disability benefits, a **case review** is your only choice. In a case review, you can add more evidence and facts to your file. You don't meet with the person who reviews your file.
- To appeal overpayments, you can get an **informal conference**. You get to meet with the person who decides your appeal. The meeting is usually at the Social Security office.
- To appeal a decision to cut off your benefits, you can choose a **formal conference**. You get to meet with a hearing officer who reviews your file. This meeting usually takes place at the state Disability Determination Services (DDS) office.

Be ready for your meeting. Write out a statement of the facts, including any new evidence. Tell Social Security about any new doctors, hospital stays, or medical treatments.

2ND STEP: THE HEARING

If you lose the recon, you can ask for a hearing with an administrative law judge (ALJ). This is the most important step. Try to get a lawyer or advocate. To ask for a hearing, file a "Request

for Hearing” form with Social Security within **60 days** of the date on your recon decision. You must file it within **10 days** to keep getting SSI while you appeal a termination.

- Prepare for your hearing! Look at your social security file. It has your medical records, statements and forms filled out by you or Social Security. The file is at the Office of Hearings and Appeals. You can call the Hearings office at (612) 348-1230 to set up a time to go see your file.
- If any of the papers in your file are wrong, or need to be explained, be ready to do this at your hearing.
- If you have new doctors’ reports or letters from employers or social workers about your ability to work, give them to the Hearing Office before the hearing.
- You can take someone with you to the hearing to testify, or just to support you.



The hearing is recorded. The judge will look at all the evidence and testimony and will mail the decision to you after the hearing. Make sure the Office of Hearings and Appeals has your mailing address.

3RD STEP: APPEALS COUNCIL

If you lose the hearing, you can ask for a review by the Appeals Council in Virginia.

- You must file a “Request for Review of Hearing Decision” within **60 days** of getting notice of the ALJ’s decision. Get the form from Social Security.
- Put in any new reports or evidence you have, but don’t put off filing the request because you can’t get the evidence together. File first if you have to, then send the new evidence as soon as you can.
- The Appeals Council reviews the recording of the hearing and the papers in your file plus any new written evidence that you send. They can send the case back for another hearing, deny your appeal, or overrule the ALJ and find you eligible.

4TH STEP: COURT

If the Appeals Council rules against you, you can appeal to federal court. You can get the paperwork for this appeal at the federal courthouse. There are federal courthouses in Minneapolis and St. Paul. You should have an attorney help you at this step.

*Minneapolis Legal Aid – CLE
MN Legal Services Coalition
2324 University Avenue W. – Suite 101B
St. Paul, MN 55114*

*Don’t use this fact sheet if it is more than 1 year old.
Write us for updates, a fact sheet list, or alternate formats.
Fact Sheets aren’t a complete answer to a legal problem.
See a lawyer for advice.*



SSI OVERPAYMENT

An overpayment means that you got more SSI money than you were supposed to. This can happen because you forgot to report a change in your income, that you were in the hospital, the death of a spouse, or other things. Or Social Security can make a mistake. Even if it was their fault, Social Security can ask you to pay back the money.

HOW CAN I AVOID AN OVERPAYMENT?

Report changes right away to Social Security. Even if you report right away, the next check may be sent before the amount can be changed. Then you have an overpayment.

Some examples of things that could cause an overpayment are: getting married; working; or getting a large payment, like an insurance award or car accident settlement. If you think such a change may happen, get legal advice about choices you can make to avoid an overpayment.



WHAT HAPPENS IF I GET AN OVERPAYMENT?

Social Security will try to get the money back from you. They can also report the overpayment to credit bureaus so it's on your credit report.

- SSI can ask you to repay the whole amount now, or to repay it over time. You do not have to agree to this.
- They can take the money out of your SSI checks. They can only take up to 10% of your check. This is called "recoupment."
- They can take your federal tax refund or other federal money due you or your spouse if your spouse is on SSI.
- They can sue in court for the overpayment plus court costs. They do not do this if you are still on SSI.

WHAT IF THE OVERPAYMENT IS SMALL?

If it is \$500 or less, Social Security will not try to get the money, if you ask them not to. This is called an "administrative waiver."

WHAT IF SOCIAL SECURITY IS GOING TO RECOUP FROM MY CHECK?

You can do these things:

- **Agree** to pay it back and work out a payment plan. This way you get some control of how much is taken out of your check. See if they will take less than 10% per check.
- **Appeal.** If you do not think you were overpaid, you can appeal. File a written appeal right away.
 - Appeal within **10 days** of getting the notice if you want your checks to stay at the same amount during the appeal
 - Appeal within **60 days** of getting the notice, or you lose the right to appeal.
- **Ask for a “waiver”.** This means that even if you were overpaid, you should not have to pay it back. If you cannot afford to pay the money back, file for a waiver right away. If you file within 30 days of getting the overpayment notice, Social Security cannot take money from your check until you have a meeting with them. They have to give you the waiver if **the overpayment wasn’t your fault, and:**
 - It would be unfair to make you repay it (for example, you cannot afford to pay it back, and it would be a great hardship), or
 - The overpayment is small and not worth the time and energy to collect it.

You can file for both an appeal and a waiver at the same time.

WHAT IF I LOSE MY APPEAL?

If your first overpayment appeal and waiver request is denied, you can appeal further. See our fact sheet, *SSI Appeals*.



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