GEHA preauthorization FAQs

Submitting a preauthorization

Why do I need to request preauthorization?	GEHA requires preauthorization to ensure evidence-based medicine supports the requested service. Preauthorization helps decrease avoidable complications and prevent unnecessary treatment, which can help reduce the premiums for our members.
What information is required to submit for preauthorization?	In general, documentation requirements include a current medical history and physical, clinical notes, tried and failed treatments (if applicable) and a letter of medical necessity from your physician. If additional information is needed to complete the review, we will reach out to your provider to request the additional information.
What services require preauthorization?	Many services require preauthorization. You may find a list of these services in the plan brochure. Refer to the back of your member ID card under the heading 'Prior Authorization' for the contact information.
How do I submit a preauthorization request?	For information related to preauthorizations, visit **geha.com/Authorizations**
How do I contact GEHA regarding my preauthorization request?	You may contact GEHA Monday–Friday, 7 a.m.–7 p.m. Central time, at **800.821.6136**.
How do I precertify an admission to a hospital, residential treatment center, skilled nursing facility, long-term acute care or rehab facility?	You should work with your provider or facility to obtain preauthorization before admission to one of these types of facilities. Please refer to the back of your member ID card under the heading 'Prior Authorization' for the contact number.
How do I preauthorize a radiology/imaging procedure?	You should work with your provider to obtain preauthorization by contacting eviCore Healthcare at **866.879.8317**
What durable medical equipment (DME) requires preauthorization?	Most DME requires preauthorization. You may find more information about this in the Plan Brochure at **geha.com/PlanBrochure**

Understanding preauthorization decisions

Why does GEHA say "no" when my doctor says "yes"?	GEHA, like other federal health plans, requires providers to obtain authorization before some services and procedures are performed. Just because your physician has prescribed a treatment, service or drug does not mean it is a covered benefit under the plan. GEHA reviews service requests for medical necessity according to evidence-based medicine and plan exclusions and limitations.
Who reviews my preauthorization request?	Nurses, doctors, non-clinical support staff and management work together to complete medical necessity reviews.
How will I find out if my prior authorization request is approved or denied?	After the preauthorization review is complete, you will receive a letter in the mail. Your provider will receive a fax and letter via mail detailing the determination. If you have not received your determination letter, GEHA recommends working with your provider. You may contact GEHA at **800.821.6136**
Why do I have to submit a request for something I have been using for years?	GEHA requires preauthorization for certain services. The list of services that require preauthorization may change from year to year based on many reasons. Please refer to your plan brochure to stay updated on preauthorization requirements. You may find your plan brochure by visiting **geha.com/PlanBrochure**
How are the decisions to approve or deny made?	Decisions are made based on plan coverage and medical necessity based on evidence-based medicine.
Who is responsible for ensuring preauthorization is submitted?	You are ultimately responsible for ensuring that a service request is reviewed and approved for benefit coverage before receiving that service. However, your physician will need to submit the request along with the supporting documentation to GEHA for review.
Are there any exceptions to requiring preauthorization?	Yes, there are exceptions to requiring preauthorization. You do not need preauthorization in these cases: • You have another health insurance policy that is the primary payor, including Medicare Part A and B or Part B only; • The procedure is performed outside the United States; • You are an inpatient in a hospital or observation stay; or • The procedure is performed as an emergency. This information can be found in the plan brochure.

Do you reward health care providers or other people when a denial is issued?	GEHA does not reward internal staff, physicians or external organizations for denying services.
Why was my request denied?	According to the plan brochure, GEHA may deny a request because it is an excluded benefit. In addition, GEHA may deny a request because it has not met the medical necessity criteria for coverage.
How many appeals do I get?	You are allowed two appeals. You may find the details on how to submit an appeal in the GEHA plan brochure **geha.com/PlanBrochure**
How do I file an appeal with OPM?	If you disagree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us — if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare, and Insurance, Federal Employee Insurance Operations, FEHB 2 1900 E Street NW Washington, DC 20415-3620 In addition, you may call OPM's Program Manager, FEHB 2 at **202.606.3818** between 8 a.m. and 5 p.m. Eastern time. Reference the plan brochure for details on the documentation required to submit to OPM.

Decision turnaround time

How long does my provider have to submit my medical records?	Your provider is given 60 days from the date of the request to submit additional information. The review will be on hold until the records arrive, or the 60 days are complete. We may delay processing or deny benefits for your claim if you or your provider do not respond.
When should I hear back about my preauthorization request?	You should hear back about your non-urgent preauthorization request within 15 days. If your request is urgent, you should hear back within 24 hours. If you have already received the service, you should hear back within 30 days. These timeframes will extend if additional information is needed.

Preauthorization denial after medical service completion

Why did I get my denial after my service was already completed?	You may receive a denial after service for different reasons, including: • Your provider did not submit a request for preauthorization • Your provider did not send in the necessary records to determine medical necessity • Your provider sent in the information too close to the service date
What do I do if my provider just sent in a preauthorization request but my procedure is scheduled soon?	You may complete the service as scheduled, but GEHA does not guarantee benefit coverage. You or your provider must submit the request for services along with the required documentation and meet the requirements as outlined in GEHA coverage policies.

Locating preauthorization resources on geha.com

How do I find a PPO (in-network) provider?	To find in-network PPO providers, use the GEHA Find Care tool at **geha.com/Find-Care** or call **800.296.0776**.
Where can I find the coverage policies?	You may find GEHA coverage polices by visiting **geha.com/Authorizations**
Where can I find a copy of GEHA's plan brochures?	You can find a copy of GEHA's plan brochures by visiting **geha.com/PlanBrochure**

Definitions

Coverage policy	Lists the requirements and documentation needed to support the medical necessity for a procedure, treatment or service. The coverage policy is created by using evidence-based medicine.
Evidence-based medicine	Using scientific evidence from up-to-date clinical research to provide the best and most appropriate care available to improve health outcomes.
Medically necessary	Evidence-based medicine has proven how to help treat or diagnose illness, injury, disease, a condition or the symptoms.
Appeal	A request for your insurance company to review a request for service previously denied for payment or coverage.
Plan brochure	A document that outlines your health care coverage and what is not covered. The brochure also includes other information, such as what requires preauthorization and how to appeal.
Covered service	Your medical insurance will pay a portion of the cost for the service, as defined in the plan brochure.
Benefit denial	The medical insurance plan will not cover the cost of the service. Therefore, it is considered a non-covered service. Sections 5 and 6 of the plan brochure list the non-covered services.
Nonprofit	A business that puts its profits back into the company to benefit the people it serves rather than its shareholders. For example, GEHA is a nonprofit company, an added benefit to our members because profits are given back directly by offering additional health services.
Preauthorization	Your health insurance plan must review and approve a service request before benefit coverage can be applied.
Experimental/ investigational	There are not enough clinical studies to prove the service is an effective treatment for a condition or is the standard of care.

This is a brief description of the features of Government Employees Health Association, Inc.'s medical plans. Before making a final decision, please read the GEHA Federal brochures which are available at **geha.com/PlanBrochure**. All benefits are subject to the definitions, limitations and exclusions set forth in the Federal brochures.

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