Requesting Preauthorization

Section 3 in FEHB Plan Brochures

How to request precertification for an admission or get prior authorization for Other services	First, your physician, your hospital, you, or your representative, must call us at 888-238-6240 before admission or services requiring prior authorization are rendered. Next, provide the following information: • enrollee's name and Plan identification number; • patient's name, birth date, identification number and phone number; • reason for hospitalization, proposed treatment, or surgery; • name and phone number of admitting physician; • name of hospital or facility; and • number of days requested for hospital stay. If the admission is a non-urgent admission or if you are being admitted to a Non-network hospital, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an emergency or an urgent admission, you, the person's physician, or the hospital must get the days certified by calling the number shown on your ID card. This must be done: • Before the start of a confinement as a full-time inpatient which requires an urgent admission; or • Not later than one (1) business day following the start of a confinement as a full-time inpatient which requires an emergency admission; unless it is not possible for the physician to request certification within that time. In that case, it must be done as soon as reasonably possible. In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours. If, in the opinion of the person's physician, it is necessary for the person to be confined for a longer time than already certified, you, the physician, or the hospital may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified. Written notice of the number of days certified will be sent promptly to the hospital. A copy will be sent to you and to the physician.
• **Non-urgent care claims**	For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 45 days from the receipt of the notice to provide the information.

Requesting Preauthorization

Medical Policy Requirements

I. **Requirements for Breast Removal**

A. Single letter of referral from a qualified mental health professional (see Appendix); *and*
B. Persistent, well-documented gender dysphoria (see Appendix); *and*
C. Capacity to make a fully informed decision and to consent for treatment; *and*
D. For members less than 18 years of age, completion of one year of testosterone treatment; *and*
E. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Note: A trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy in adults.

II. **Requirements for Breast Augmentation (Implants/Lipofilling)**

A. Single letter of referral from a qualified mental health professional (see Appendix); *and*
B. Persistent, well-documented gender dysphoria (see Appendix); *and*
C. Capacity to make a fully informed decision and to consent for treatment; *and*
D. Member is 18 years of age or older; *and*
E. Completion of one year of feminizing hormone therapy prior to breast augmentation surgery (unless the member has a medical contraindication or is otherwise medically unable to take hormones); *and*
F. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Requesting Preauthorization

Additional Resources

What types of documents should I send?

You should always discuss with your surgeon what your plan requires for preauthorization and what you (or your doctor) need to submit to them. You will typically have to submit at least two different documents. The first one is a letter from you to your health plan. The second is a letter from your health care provider (typically a mental health or your primary care provider). **Always check the plan documents for specific letter requests.**

Don't know where to start? We can help! Check out the links below for templates and resources you can use.

> *Always remember to have in hand the specific plan policy on coverage for transition-related care to know the specific requirements that your letter and your doctor's letter should address. You can call your health plan or check your member handbook for this information.*

- **Template for writing a letter to your health plan to request preauthorization.** This template will help you create a letter explaining why you need the treatment and why refusing to cover it might be illegal. We'll provide you with an explanation of the law that you can copy right into your letter. The legal explanations will be particularly useful in cases where your plan has a blanket exclusion or an exclusion of a specific procedure. The legal explanations can also be useful to appeal a denial of a preauthorization or claim request.
- **A guide to health care provider letters.** In addition to your own letter, your health care provider should write a letter explaining why the treatment you're seeking is medically necessary for you. Click the link for information on what the letter should typically include and resources for your provider.

- **Templates for people with a self-funded health plan.** This page includes information and templates for people who have a self-funded health plan.

Disputing a Prior Authorization Denial

Section 3 in FEHB Plan Brochures

If you disagree with our pre-service claim decision	If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.
• **To reconsider a non-urgent care claim**	Within six (6) months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure. In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to 1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or 2. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision. 3. Write to you and maintain our denial.

Disputing a Preauthorization Denial Cont.

Section 8 Step 1 in FEHB Plan Brochures

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Aetna Inc., Attention: National Accounts, P.O. Box 14463, Lexington, KY 40512; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address, if you would like to receive our decision via email. Please note that by providing us your email address, you may receive our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

Appealing Denial to OPM

Section 8 Step 3 in FEHB Plan Brochures

3	If you do not agree 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 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Coverage Limiting Phrasing

- “Limited to”
- Excluding gender affirming services not listed as covered
- “Medically necessary”
- * “Cosmetic surgery”

- **Gender reassignment surgical benefits** are limited to the following:

Not covered:

- *Gender affirming surgery, other than the surgeries listed as covered*
- *Reversal of gender affirming surgery*

Not covered:

- Gender affirming services that are not considered medically necessary

Appealing Denial to OPM Cont.

Section 8 Step 4 in FEHB Plan Brochures

4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Timeline Review

	Submission Due	3rd Party Response Due
Submit Preauthorization	3+ months prior to procedure	15 days
Preauthorization Requiring additional information	45 days from request for additional information	15 days
Reconsideration Request	Within 6 months of preauthorization decision	30 days
Reconsideration Request requiring additional information	60 days from request for additional information	30 days
OPM Appeal	90 days after reconsideration decision	60 days
Legal Action	3* years from OPM decision	N/A

Filing an EEO Complaint against OPM

Discriminatory exclusions based on gender

- Anti-Discrimination Policy
- File within 45 days of reconsideration or OPM decision
- Can be filed simultaneously with appeal to OPM
- Contact an EEO Counselor at your agency
- Mediation and formal hearing options

Helpful Resources

- Federal Associations and Unions
- Transgender Legal Defense & Education Fund (TLDEF)
- NCTE's Trans Legal Services Network Directory
- NCTE’s Getting Your Health Care Covered Guide
- Additional resources documented in the spreadsheet

DC

Correia & Puth, PLLC
1400 16th Street NW, Suite 450, Washington DC 20006
https://www.correiaputh.com
Jonathan C. Puth: 202.602.6500 jputh@correiaputh.com
Represents transgender clients who have experienced discrimination due to their gender identity in the workplace, at schools or universities, in healthcare settings, or other places of public accommodation.

Pershing Law PLLC
1416 E St NE, Washington DC 20009
202.642.1431 http://www.pershinglaw.us/
Stephen B. Pershing, Esq: 202.642.1431 steve@pershinglaw.us
Name and gender marker changes, discrimination

TransLAW
Washington, DC
https://www.translawdc.org/
Steering Committee: translawdc@gmail.com
Partners with WWH to run the name and gender marker change clinic and offers financial assistance for individuals changing their identity documents.

NATIONAL

ACLU LGBT & HIV Project
125 Broad St., 18th Floor New York, NY 10004
https://www.aclu.org/other/about-aclu-lesbian-gay-bisexual-transgender-aids-project
Chase Strangio, Attorney: 212.549.2500 cstrangio@aclu.org

Human Rights Campaign
1640 Rhode Island Ave. N.W. Washington, DC 20036
http://www.hrc.org/
202.628.4160

Lambda Legal
120 Wall St., 19th Floor New York, NY 10005
http://www.lambdalegal.org
212.809.8585

National Center for Lesbian Rights
870 Market Street, Suite 370 San Francisco, CA 94102
http://www.nclrights.org
Ming Wong, Helpline Attorney: 800.528.6257 mwong@nclrights.org

National Center for Transgender Equality
1400 16th Street NW, Suite 510 Washington, DC 20036
http://www.transequality.org
202.745.2314

National LGBTQ Task Force
1325 Massachusetts Ave NW Washington, DC 20005
http://www.thetaskforce.org
202.393.5177

Transgender Legal Defense and Education Fund
20 West 20th Street, Ste. 705 New York, NY 10011
http://www.transgenderlegal.org/
AC Dumlao, Name Change Project: 646.862.9396 adumlao@transgenderlegal.org