



**GEHA Policies & Procedures
Connection Dental Network
State Specific Policies & Procedures - State of Maine**

The below policies and procedures are in addition to the contractual requirements and the GEHA Policies & Procedures for the CONNECTION Dental Network. In the event the below terms conflict with the contractual requirements or the GEHA Policies & Procedures for the CONNECTION Dental Network, the terms below shall supersede.

Appeal and Grievance Procedures

Please see Network Appeals/Grievances Policies and Procedures.

Termination Procedures

A carrier offering or renewing a managed care plan may not terminate or nonrenew a contract with a participating provider unless the carrier provides the provider with a written explanation prior to the termination or nonrenewal of the reasons for the proposed contract termination or nonrenewal and provides an opportunity for a review or hearing in accordance with law. The existence of a termination without cause provision in a carrier's contract with a provider does not supersede the requirements. This does not apply to termination cases involving imminent harm to patient care, a final determination of fraud by a governmental agency, a final disciplinary action by a state licensing board or other governmental agency that impairs the ability of a provider to practice. A review or hearing of proposed contract termination must meet the following requirements: The notice of the proposed contract termination or nonrenewal provided by the carrier to the participating provider must include: (1) The reason or reasons for the proposed action in sufficient detail to permit the provider to respond; (2) Reference to the evidence or documentation underlying the carrier's decision to pursue the proposed action. A carrier shall permit a provider to review this evidence and documentation upon request; (3) Notice that the provider has the right to request a review or hearing before a panel appointed by the carrier; (4) A time limit of not less than 30 days from the date the provider receives the notice within which a provider may request a review or hearing; and (5) A time limit for a hearing date that must be not less than 30 days after the date of receipt of a request for a hearing. Termination or nonrenewal may not be effective earlier than 60 days from the receipt of the notice of termination or nonrenewal. A hearing panel must be composed of at least 3 persons appointed by the carrier and one person on the hearing panel must be a clinical peer in the same discipline and the same or similar specialty of the provider under review. A hearing panel may be composed of more than 3 persons if the number of clinical peers on the hearing panel constitutes 1/3 or more of the total membership of the panel. A hearing panel shall render a written decision on the proposed action in a timely manner. This decision must be either the reinstatement of the provider by the carrier, the provisional reinstatement of the provider subject to conditions established by the carrier or the termination or nonrenewal of the provider. A decision by a hearing panel to terminate or nonrenew a contract with a provider may not become effective less than 60 days after the receipt by the provider of the hearing panel's decision or until the termination date in the provider's contract, whichever is earlier.

24-A M.R.S.A. § 4303

If a contract between a carrier and a provider is terminated or benefits or coverage provided by a provider is terminated because of a change in the terms of provider participation in a health plan and an enrollee is undergoing a course of treatment from the provider at the time of termination, the carrier shall provide continuity of care in accordance with the requirements of applicable law. The carrier shall notify an enrollee of the termination of the provider's contract at least 60 days in advance of the date of termination. When

circumstances related to the termination render such notice impossible, the carrier shall provide affected enrollees as much notice as is reasonably possible. The notice given to the enrollee must include instructions on obtaining an alternate provider and must offer the carrier's assistance with obtaining an alternate provider and ensuring that there is no inappropriate disruption in the enrollee's ongoing treatment. The carrier shall permit the enrollee to continue or be covered, with respect to the course of treatment with the provider, for a transitional period of at least 60 days from the date of notice to the enrollee of the provider's termination. A carrier may make coverage of continued treatment by a provider conditional upon the provider's agreeing to the following terms and conditions: (1) The provider agrees to accept reimbursement from the carrier at rates applicable prior to the start of the transitional period as payment in full and not to impose cost-sharing with respect to the enrollee in an amount that would exceed the cost-sharing that could have been imposed if the contract between the carrier and the provider had not been terminated; (2) The provider agrees to adhere to the quality assurance standards of the carrier responsible for payment and to provide the carrier necessary medical information related to the care provided; and (3) The provider agrees otherwise to adhere to the carrier's policies and procedures, including procedures regarding referrals and prior authorizations and providing services pursuant to any treatment plan approved by the carrier.

24-A M.R.S.A. § 4303

Dispute Resolution Process

Please see Network Appeals/Grievances.

Network Participation Procedures

If applicable, Participating Providers are required to comply with law which govern the practice of dentistry by a corporation.

32 M.R.S.A. § 1081

Quality of Care Procedures

No state-specific requirements.

Claims Procedures

All administrators who administer claims and who provide payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed health care practitioner must accept the current standardized claim form for professional services approved by the Federal Government and submitted electronically. An administrator may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to applicable law. All services provided by a health care practitioner in an office setting must be submitted on the standardized federal form used by noninstitutional providers and suppliers. Services in a nonoffice setting may be billed as negotiated between the administrator and health care practitioner.

24-A M.R.S.A. § 1912

A claimant, including a health care provider, may submit simultaneously a claim for payment with all carriers potentially liable for payment of the claim whether primary or secondary. Payment or denial of a claim by each carrier must be made within 30 calendar days after the carrier has received all information needed to pay or deny the claim whether or not another carrier with which it is attempting to coordinate has acted on the claim. Any payment made must be in accordance with rules adopted by the superintendent relative to coordination of benefits.

24-A M.R.S.A. § 2436

The U.S. Office of Personnel Management (OPM) has contracting authority for both the Federal Employees Dental and Vision Insurance Program (FEDVIP) and the Federal Employees Health Benefits (FEHB) plans.

GEHA is contracted with the OPM for both its Connection Dental Federal FEDVIP plan and GEHA Health FEHB plans.

5 U.S.C.A. § 8902

The terms of GEHA's contracts with the OPM which relate to the nature, provision, or extent of coverage or benefits (including payment with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relate to health insurance or plans.

5 U.S.C.A. §8902(m)(1)

The GEHA Health plan, like other FEHB medical plans, offers limited dental coverage to its members and, by law, the FEHB plans are the first Payor (before FEDVIP plans) for dental coverage provided to FEDVIP Covered Enrollees.

5 U.S.C.A. § 8954(e)

To ensure consistency in the coordination of benefits among the FEDVIP carriers, the OPM has amended its contract with GEHA to state that when treating a FEDVIP Covered Enrollee, the Plan Allowance (which, for Connection Dental Federal is defined as the amount we allow for a specific procedure) is the maximum amount that may be charged to a FEDVIP Covered Enrollee. Neither GEHA nor any FEDVIP Covered Enrollee shall be held responsible or liable for any amounts greater than the FEDVIP allowable amount for services rendered by a Participating Provider to a FEDVIP Covered Enrollee. FEDVIP Covered Enrollees cannot be billed the difference between FEDVIP Plan Allowance and the first Payor's allowance, when the first Payor's allowance is greater than the FEDVIP allowable amount. Thus, FEDVIP Covered Enrollees will only be responsible for payment of the balance of the FEDVIP Plan Allowance minus all payments made by the first Payor and GEHA. FEDVIP Covered Enrollees and GEHA will not be responsible for increased out-of-pocket costs when Covered Enrollees utilize the services of a Connection Dental Participating Provider that also participates in another Payor's PPO network. This is applicable to GEHA Connection Dental Federal and the GEHA Health Plan. FEDVIP Technical Guidance, Amendment 0005

Provider-Patient Relationship

A carrier offering or renewing a managed care plan may not terminate or otherwise discipline a participating provider because the provider advocates for medically appropriate health care. A carrier may not restrict a provider from disclosing to any enrollee any information the provider determines appropriate regarding the nature of treatment and any risks or alternatives to treatment, the availability of other therapy, consultations or tests or the decision of any plan to authorize or deny health care services or benefits.

24-A M.R.S.A. § 4303

Except for certain exemptions, a health care practitioner may refer a patient to an outside facility in which that health care practitioner is an investor only when that health care practitioner directly provides health services within the facility and will be personally involved with the provision of care to the referred patient.

Notwithstanding any provision of this chapter, a health care practitioner may refer a patient who is a member of a health maintenance organization or a preferred provider organization licensed in this State for health services to a facility outside that health care practitioner's office or group practice in which that health care practitioner is an investor when the referral is made pursuant to a contract with the organization.

22 M.R.S.A. § 2085

Required Content in Contract

The Participating Provider Agreement does not require the provider to indemnify the carrier for any expenses and liabilities, including, without limitation, judgments, settlements, attorney's fees, court costs and any associated charges incurred in connection with a claim or action brought against the health plan based on the carrier's own fault. Nothing in this section may be construed to remove responsibility of a carrier or provider for

expenses or liabilities caused by the carrier's or provider's own negligent acts or omissions or intentional misconduct.

24-A M.R.S.A. § 4308

A carrier offering or renewing a health plan in Maine shall notify a participating provider of a proposed amendment to a provider agreement at least 60 days prior to the amendment's proposed effective date. If an amendment that has substantial impact on the rights and obligations of providers is made to a manual, policy or procedure document referenced in the provider agreement, such as material changes to fee schedules or material changes to procedural coding rules specified in the manual, policy or procedure document, the carrier shall provide 60 days' notice to the provider. After the 60-day notice period has expired, the amendment to a manual, policy or procedure document becomes effective and binding on both the carrier and the provider subject to any applicable termination provisions in the provider agreement, except that the carrier and provider may mutually agree to waive the 60-day notice requirement. This subsection may not be construed to limit the ability of a carrier and provider to mutually agree to the proposed change at any time after the provider has received notice of the proposed amendment.

24-A M.R.S.A. § 4303

These policies and procedures are subject to change without notification as permitted by law. Any changes in state and/or federal laws that are applicable to the GEHA Participating Provider Agreements or the CONNECTION Dental Network are hereby incorporated into these policies and procedures.

Please note: Government Employees Health Association, Inc.'s Federal Employee Health Benefits Plans are not subject to state law. GEHA owns and operates the CONNECTION Dental Network, which is a non-risk bearing PPO network. The above policies and procedures may or may not be applicable to the CONNECTION Dental Network, depending on whether the network is included within the state-specific definitions that are applicable to state laws, rules and regulations.

GEHA Covered Persons are participants in the Federal Employees Health Benefits Program, and benefit matters for such participants shall be resolved by the United States Office of Personnel Management ("OPM") in accordance with the disputed claims procedures in the Federal Employees Health Benefits Act and the regulations of the OPM.

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