GEHA Policies & Procedures
Connection Dental Network
State Specific Policies & Procedures - State of Massachusetts

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.

The following provisions relating to carriers are the obligation of Entities subject to Massachusetts insurance regulation and not the network. Any Entities subject to regulation by the Massachusetts Department of Insurance shall be subject to all applicable laws, rules and regulations in Massachusetts.

Appeal and Grievance Procedures
Please see Network Appeals/Grievances Policies and Procedures.

Terminations Procedures
Neither GEHA nor a health care provider can terminate the Participating Provider Agreement without cause.
211 CMR 52.12(5)

Carriers, or GEHA on behalf of a carrier, shall provide a written statement to health care providers of the reason or reasons for such health care provider's involuntary disenrollment.
211 CMR 52.12(6)

Dispute Resolution Process
Please see Network Appeals/Grievances.

Network Participation Procedures
The network shall not: (1) condition its willingness to allow a health care provider to participate in a preferred provider arrangement on the provider's agreeing to enter into other contracts or arrangements not related to the preferred provider arrangement; and (2) refuse to contract with or compensate a provider for services solely because the provider has in good faith communicated with one or more of his current, former or prospective patients regarding the provisions, terms or requirements of the network's products as they relate to the needs of such provider's patients.
M.G.L.A. 176I § 2

The network will not discriminate against a willing provider on the basis of religion, race, color, national origin, age, sex, marital status, sexual orientation, or a provider's relationship with any other organization.
M.G.L.A. 176I § 4

A carrier, or GEHA on behalf of a carrier, shall provide to a provider, a written reason or reasons for denying the application of any provider who has applied to be a participating provider.
211 CMR 52.14(7) – M.G.L.C. 176O §15(I)

Participating Providers shall not be permitted to charge Covered Enrollees a fee as a condition of participation in the Connection Dental Network.

In accordance with the letter of March 6, 2002, issued by the General Counsel of the Division of Insurance

Quality of Care Procedures

No contract with a licensed health care provider group may contain any incentive plan that includes a specific payment made to a health care professional as an inducement to reduce, delay or limit specific medically necessary services covered by the health care contract.

(a) Health care professionals shall not profit from provisions of covered services that are not medically necessary or medically appropriate.

(b) Carriers shall not profit from denial or withholding of covered services that are medically necessary or medically appropriate.

(c) Nothing in 211 CMR 52.12(3) shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are made with respect to providers or which are made with respect to groups of insureds if such contracts, which impose risk on such providers for the costs of care, services and equipment provided or authorized by another health care provider, comply with 211 CMR 52.12(4).

211 CMR 52.12(3) – M.G.L. c. 176O, § 10(a)&(b)

Claims Procedures

Within 45 days after the receipt by the carrier of completed forms for reimbursement to the health care provider, the carrier shall (i) make payment, (ii) notify the provider in writing of the reason or reasons for nonpayment, or (iii) notify the provider in writing of what additional information or documentation is necessary to complete the forms for reimbursement. If the carrier fails to comply with these requirements for any claims related to the provision of health care services, the carrier shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which shall accrue beginning 45 days after the carrier's receipt of request for reimbursement at the rate of 1.5 percent per month, not to exceed 18 percent per year. The provisions relating to interest payments shall not apply to a claim that the carrier is investigating because of suspected fraud.

M.G.L. c. 176I § 2

Health care providers shall not bill patients for charges for covered services other than for deductibles, copayments, or coinsurance.

211 CMR 52.12(8)

Health care providers are prohibited from billing patients for nonpayment by the carrier of amounts owed under the contract due to the insolvency of the carrier. This requirement shall survive the termination of the contracts for services rendered prior to the termination of the contracts, regardless of the cause of the termination.

211 CMR 52.12(9)

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

Carriers shall not refuse to contract with or compensate for covered services an otherwise eligible health care provider solely because such provider has in good faith:

(a) communicated with or advocated on behalf of one or more of his prospective, current or former patients regarding the provisions, terms or requirements of the carrier's health benefit plans as they relate to the needs of such provider's patients; or

(b) communicated with one or more of his prospective, current or former patients with respect to the method by which such provider is compensated by the carrier for services provided to the patient.

211 CMR 52.12(1)(a) and (b)

Required Content in Contract

Health care providers are not required to indemnify the carrier for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the carrier based on the carrier's management decisions, utilization review provisions or other policies, guidelines or actions.
211 CMR 52.12(2) – M.G.L. c. 176O, § 5

Carriers shall notify health care providers in writing of modifications in payments, modifications in covered services or modifications in a carrier's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the providers, and the effective date of the modifications. The notice shall be provided 60 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the carrier and the provider.
211 CMR 52.12(7)

Health care providers shall comply with the carrier's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.
211 CMR 52.12(10)

The following definitions shall have the following meanings, if used within a health care provider contract or this document, as outlined in 211 CMR 52.03:

1. Carrier, an insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit medical service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a health maintenance organization organized under M.G.L. c. 176G; and an organization entering into a preferred provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer. Unless otherwise noted, the term "carrier" shall not include any entity to the extent it offers a policy, certificate, or contract that provides coverage solely for dental care services or vision care services.
2. Dental carrier, an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a dental service corporation organized under chapter 176E, or an organization entering into a preferred provider arrangement under chapter 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one ore more subsidiaries or affiliated corporations of the employer, that offers a policy, certificate or contract that provides coverage solely for dental care services.
3. Dental benefit plan, a policy, contract, certificate or agreement of insurance entered into, offered or issued by a dental carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs solely for dental care services.
4. Dental care professional, a dentist or other dental care practitioner licensed, accredited or certified to perform specified dental services consistent with the law.
5. Dental care provider, a dental care professional or facility.
6. Dental care services, or dental services, services for the diagnosis, prevention, treatment, cure or relief of a dental condition, illness, injury or disease.
7. Health benefit plan, a policy, contract, certificate or agreement of insurance entered into, offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Unless otherwise noted, "health benefit plan" shall not include a dental benefit plan or a vision benefit plan.
8. Material change, a modification to any of a carrier's, including a dental or vision carrier's procedures or documents required by 211 CMR 52.00 that substantially affects the rights or responsibilities of an insured, carrier, including a dental or vision carrier, or health, dental or vision care provider.
9. Network, a group of health, dental or vision care providers who contract with a carrier, including a dental or vision carrier, or affiliate to provide health, dental or vision care services to insureds covered by any or all of the carrier's including a dental or vision carrier's or affiliate's plans, policies, contracts or other arrangements. Network shall not mean those participating providers who provide services to subscribers of a nonprofit hospital service corporation organized under M.G.L. c. 176A, or a nonprofit medical service corporation organized under M.G.L. c. 176B.
10. Participating provider, a provider who, under a contract with the carrier, including a dental or vision carrier, or with its contractor or subcontractor, has agreed to provide health, dental or vision care services to insureds with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the carrier, including a dental or vision carrier.
11. Service area, the geographical area as approved by the Commissioner within which the carrier, including a dental or vision carrier, has developed a network of providers to afford adequate access to members for covered health, dental or vision services.

Nothing in 211 CMR 52.12 shall be construed to preclude a carrier from requiring a health care provider to hold confidential specific compensation terms.
211 CMR 52.12(11)

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.

Last modified May 13, 2017.