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

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.

In addition, if the Participating Provider Agreement or the below terms contain definitions or other provisions that conflict with the definitions or provisions contained in a managed care plan or Miss. Admin. Code 19-3:14.06, the definitions and provisions contained in the managed care plan or Miss. Admin. Code 19-3:14.06 shall supersede.
Miss. Admin. Code 19-3:14.06

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

Termination Procedures
A Mississippi health carrier shall make a good faith effort to provide written notice of a termination within thirty (30) days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. Within five (5) working days of the date that the provider either gives or receives notice of termination, the provider must supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.
Miss. Admin. Code 19-3:14.06

Dispute Resolution Process
A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.
Miss. Admin. Code 19-3:14.06

Network Participation Procedures
Whenever any policy of insurance or any medical service plan or hospital service contract or hospital and medical service contract issued in this state provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed dentist, as defined by the laws of the State of Mississippi, the insured, or other person entitled to benefits under such policy, shall be entitled to reimbursement for such services, whether such services are performed by a duly licensed physician or by a duly licensed dentist, notwithstanding any provision to the contrary in any statute or in such policy, plan or contract; duly licensed dentists shall be entitled to participate in such policies, plans or contracts providing for dental services, as authorized by the laws of the State of Mississippi.
Miss. Code Ann. § 83-41-209

No health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state shall deny any dentist the right to participate as a contracting provider for

such policy or plan, provided the dentist is licensed to furnish the dental care services offered by such policy or plan.
Miss. Code Ann. § 83-51-3(b)

Quality of Care Procedures
No health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state shall require that any dentist furnishing dental care services make or obtain dental x-rays or any other diagnostic aids for the purpose of preventing, alleviating, curing or healing dental illness or injury; provided, however, that nothing herein shall prohibit requests for existing dental x-rays or any other existing diagnostic aids for the purpose of determining benefits payable under a health insurance policy or employee benefit plan.
Miss. Code Ann. § 83-51-3(d)

Claims Procedures
A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered or non-covered health services for which the provider will be responsible, including any limitations or conditions on services.
Miss. Admin. Code 19-3:14.06

A health carrier must notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.
Miss. Admin. Code 19-3:14.06

A health carrier must establish a mechanism by which the participating providers may determine in a timely manner whether or not a person is covered by the health carrier.
Miss. Admin. Code 19-3:14.06

No contract between a health care entity that offers a dental plan or plans and a dentist for the provision of services to subscribers may require that a dentist provide services to his subscribers at a fee set by the health care entity unless the services are covered services under the applicable subscriber agreement. For the purposes of this section, “covered services” means services that are reimbursable under the applicable subscriber agreement, notwithstanding any deductibles, waiting periods or frequency limitations that may apply. For the purposes of this section, “dental plan” means any policy of insurance that is issued by a health care entity that provides for coverage of dental services not in connection with a medical plan.
Miss. Code Ann. § 83-51-31

All benefits payable under a policy for any loss, other than loss for which the policy provides any periodic payment, shall be paid within twenty-five (25) days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically, and will be paid within thirty-five (35) days after receipt of due written proof of such loss in the form of clean claim where claims are submitted in paper format. Benefits due under the policies and claims are overdue if not paid within twenty-five (25) days or thirty-five (35) days, whichever is applicable, after the insurer receives a clean claim containing necessary medical information and other information essential for the insurer to administer preexisting condition, coordination of benefits and subrogation provisions. A “clean claim” means a claim received by an insurer for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the insured in order to be processed and paid by the insurer. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. A clean claim does not include any of the following: (a) A

duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim; (b) Claims which are submitted fraudulently or that are based on material misrepresentations; (c) Claims that require information essential for the insurer to administer preexisting condition, coordination of benefits or subrogation provisions; or (d) Claims submitted by a provider more than thirty (30) days after the date of service; if the provider does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the insured.
Miss. Code Ann. § 83-9-5

Not later than twenty-five (25) days after the date the insurer actually receives an electronic claim, the insurer shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date the insurer actually receives a paper claim, the insurer shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by the insurer shall be paid within twenty (20) days after receipt. If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, the insurer must pay the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) interest on accrued benefits at the rate of one and one-half percent (1- 1/2 %) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than One Dollar ($1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed.
Miss. Code Ann. § 83-9-5

If any health insurance insurer or other health insurance benefit payer limits the time in which a health care provider or other person is required to submit a claim for payment, the health insurer or other health insurance benefit payer shall have the same time limit following payment of the claim to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim. If any health insurance issuer or other health insurance benefit payer does not limit the time in which a health care provider or other person is required to submit a claim for payment, the health insurance issuer or other health insurance benefit payer may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than twelve (12) months after the payment of an invalid or overpaid claim. Nothing in this section shall apply to claims submitted in the context of misrepresentation, omission, concealment, or fraud by the health care provider or other person.
Miss. Code Ann. § 83-41-219

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
No health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state shall prevent any person who is a party to or beneficiary of any such health insurance policy or employee benefit plan from selecting the dentist of his choice to furnish the dental care services offered by such policy or plan, or interfere with such selection, provided the dentist selected is licensed to furnish such dental care services in this state.
Miss. Code Ann. § 83-51-3(a)

No health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state shall authorize any person to regulate, interfere or intervene in any manner in the diagnosis or treatment rendered by a dentist to his patient for the purpose of preventing, alleviating, curing or healing dental illness or injury, provided such dentist practices within the scope of his license.
Miss. Code Ann. § 83-51-3(c)

Required Content in Contract
Provider agrees that in no event, including but not limited to nonpayment by the health carrier or GEHA, insolvency of the health carrier or GEHA, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or GEHA) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy.
Miss. Admin. Code 19-3:14.06

In the event of a health carrier or GEHA insolvency or other cessation of operations, covered services to covered persons will continue through the period for which a premium has been paid to the health carrier on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary.
Miss. Admin. Code 19-3:14.06

The rights and responsibilities under a contract between a health carrier and a participating provider cannot be assigned or delegated by the participating provider without the prior written consent of GEHA, on behalf of the health carrier.
Miss. Admin. Code 19-3:14.06

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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