GEHA Policies & Procedures
Connection Dental Network
State Specific Policies & Procedures - State of Rhode Island

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
GEHA offers due process for all adverse decisions resulting in a loss of status as a network Participating Provider. GEHA notifies the provider of the proposed action and the reasons for the proposed action. Providers are given the opportunity to contest the proposed action and if the provider appeals the action, GEHA will use its network appeals process to resolve the appeal.
R.I. Gen.Laws § 27-18.8-3
Please also see Network Appeals/Grievances Policies and Procedures.

Terminations Procedures
Plans shall not be allowed to include clauses in physician or other provider contracts that allow for the plan to terminate the contract "without cause"; provided, however, cause shall include lack of need due to economic considerations.
R.I. Gen.Law § 27-18.8-3

Dispute Resolution Process
Please see Network Appeals/Grievances.

Network Participation Procedures
Participating Providers may provide input into the network's quality and credentialing criteria through use of the network's Participating Provider Satisfaction Evaluations, which are mailed to provider on request, posted on the network website at connectiondental.com and also periodically mailed to Participating Providers to obtain feedback about the network.
R.I. Gen.Laws § 27-18.8-3

A health plan shall not refuse to contract with or compensate for covered services an otherwise eligible provider or non-participating provider solely because that provider has in good faith communicated with one or more of his or her patients regarding the provisions, terms or requirements of the insurer's products as they relate to the needs of that provider's patients.
R.I. Gen.Laws § 27-18.8-3

A health plan shall not exclude a provider of covered services from participation in its provider network based solely on the provider's degree or license as applicable under state law; or the provider of covered services lack of affiliation with, or admitting privileges at a hospital, if that lack of affiliation is due solely to the provider's type of license.
R.I. Gen.Laws § 27-18.8-3

Health plans shall not discriminate against providers solely because the provider treats a substantial number of patients who require expensive or uncompensated medical care.
R.I. Gen.Laws § 27-18.8-3

Network applicants shall be provided with all reasons used if the application is denied.
R.I. Gen.Laws § 27-18.8-3

Quality of Care Procedures
See Required Content in Contract below.

Claims Procedures
A health care entity or health plan operating in the state shall pay all complete claims for covered health care services submitted to the health care entity or health plan by a health care provider or by a policyholder within forty (40) calendar days following the date of receipt of a complete written claim or within thirty (30) calendar days following the date of receipt of a complete electronic claim. Each health plan shall establish a written standard defining what constitutes a complete claim and shall distribute this standard to all participating providers. (b) If the health care entity or health plan denies or pends a claim, the health care entity or health plan shall have thirty (30) calendar days from receipt of the claim to notify in writing the health care provider or policyholder of any and all reasons for denying or pending the claim and what, if any, additional information is required to process the claim. No health care entity or health plan may limit the time period in which additional information may be submitted to complete a claim. (c) Any claim that is resubmitted by a health care provider or policyholder shall be treated by the health care entity or health plan pursuant to the provisions of subsection (a) of this section. (d) A health care entity or health plan which fails to reimburse the health care provider or policyholder after receipt by the health care entity or health plan of a complete claim within the required timeframes shall pay to the health care provider or the policyholder who submitted the claim, in addition to any reimbursement for health care services provided, interest which shall accrue at the rate of twelve percent (12%) per annum commencing on the thirty-first (31st) day after receipt of a complete electronic claim or on the forty-first (41st) day after receipt of a complete written claim, and ending on the date the payment is issued to the health care provider or the policyholder. (e) Exceptions to the requirements of this section are as follows: (1) No health care entity or health plan operating in the state shall be in violation of this section for a claim submitted by a health care provider or policyholder if: (i) Failure to comply is caused by a directive from a court or federal or state agency; (ii) The health care entity or health plan is in liquidation or rehabilitation or is operating in compliance with a court-ordered plan of rehabilitation; or (iii) The health care entity or health plan's compliance is rendered impossible due to matters beyond its control that are not caused by it. (2) No health care entity or health plan operating in the state shall be in violation of this section for any claim: (i) initially submitted more than ninety (90) days after the service is rendered, or (ii) resubmitted more than ninety (90) days after the date the health care provider received the notice provided for in subsection (b) of this section; provided, this exception shall not apply in the event compliance is rendered impossible due to matters beyond the control of the health care provider and were not caused by the health care provider. (3) No health care entity or health plan operating in the state shall be in violation of this section while the claim is pending due to a fraud investigation by a state or federal agency. (4) No health care entity or health plan operating in the state shall be obligated under this section to pay interest to any health care provider or policyholder for any claim if the director of business regulation finds that the entity or plan is in substantial compliance with this section. A health care entity or health plan seeking such a finding from the director shall submit any documentation that the director shall require. A health care entity or health plan which is found to be in substantial compliance with this section shall thereafter submit any documentation that the director may require on an annual basis for the director to assess ongoing compliance with this section. (5) A health care entity or health plan may petition the director for a waiver of the provision of this section for a period not to exceed ninety (90) days in the event the health care entity or health plan is converting or substantially modifying its claims processing systems.
Gen.Laws 1956, § 27-18-61

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 state-specific requirements.

Required Content in Contract
A health insurer shall reimburse a health care provider for covered services rendered by the health care provider to the health insurer's subscribers or members following the first business day after the credentialing committee's approval, provided that the health care provider returns a signed health care contract within fifteen (15) business days of receipt from the health insurer.
Gen.Laws 1956, § 27-20.9-2

A health insurer shall not require a physician, as a condition of contracting, to participate in any financial or reimbursement incentive program, commonly referred to as pay-for-performance programs unless such program meets the principles and guidelines for pay-for-performance programs endorsed by the national quality forum and adopted by the AQA Alliance or the hospital quality alliance, or similar principles and guidelines for pay-for-performance programs approved by the office of the health insurance commissioner.
Gen.Laws 1956, § 27-20.9-3

For health care entities with dental plans, the Participating Provider shall only be required to accept the Fee Schedule amount for services listed on the Fee Schedule when the services provided to its subscribers are covered services under the applicable subscriber agreement.

2009 Rhode Island Laws Ch. 09-41 (09-H 5454A)

tWhen there is evidence that a Covered Enrollee sought and received a referral from a network provider, the Covered Enrollee will not be held financially responsible beyond in-network cost shares attributable to the failure of a referring network provider to adhere to the referral process. This section is not applicable in cases where the beneficiary has self-referred.

A health plan may materially modify the terms of a participating agreement it maintains with a physician only if the plan disseminates in writing by mail to the physician the contents of the proposed modification and an explanation, in nontechnical terms, of the modification's impact. The health plan shall provide the physician an opportunity to amend or terminate the physician contract with the health plan within sixty (60) days of receipt of the notice of modification. Any termination of a physician contract made pursuant to this section shall be effective fifteen (15) calendar days from the mailing of the notice of termination in writing by mail to the health plan. The termination shall not affect the method of payment or reduce the amount of reimbursement to the physician by the health plan for any patient in active treatment for an acute medical condition at the time the patient's physician terminates his, her, or its physician contract with the health plan until the active treatment is concluded or, if earlier, one year after the termination; and, with respect to the patient, during the active treatment period the physician shall be subject to all the terms and conditions of the terminated physician contract, including but not limited to, all reimbursement provisions which limit the patient's liability.
.R.I. Gen.Laws § 27-18.8-3

A health plan shall not include a most favored rate clause in a provider contract.
R.I. Gen.Laws § 27-18.8-3

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 September 28, 2023.