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

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.

Terminations Procedures
In the event that an insurance carrier, plan, network, panel, or any agent thereof should terminate a physician's contract or a physician should terminate his or her contract with an insurance carrier, plan, network, panel or any agent thereof and thereby affect any enrollee's opportunity to continue receiving health care services from that physician under the plan, any such enrollee who is suffering from and receiving active health care services for a chronic or terminal illness or who is an inpatient shall have the right to continue to receive health care services from that physician for a period of up to 60 days from the date of the termination of the physician's contract. Any enrollee who is pregnant and receiving treatment in connection with that pregnancy at the time of the termination of that enrollee's physician's contract shall have the right to continue receiving health care services from that physician throughout the remainder of that pregnancy, including six weeks' post delivery care. During such continuation of coverage period, the physician shall continue providing such services in accordance with the terms of the contract applicable at the time of the termination, and the carrier, plan, network, panel, and all agents thereof shall continue to meet all obligations of such physician's contract. The enrollee shall not have the right to the continuation provisions provided in this section if the physician's contract is terminated because of the suspension or revocation of the physician's license or for reasons related to the quality of health care services rendered or if the carrier, plan, network, panel, or any agent thereof determines that the physician poses a threat to the health, safety, or welfare of enrollees.
Ga. Code Ann., § 33-20A-61

Dispute Resolution Process
Please see Network Appeals/Grievances for the provider complaint mechanism.

Network Participation Procedures
Subject to the approval of the Commissioner of Insurance of the State of Georgia, under such procedures as he may develop, health care insurers may place reasonable limits on the number or classes of preferred providers which satisfy the standards set forth by the health care insurer, provided that there be no discrimination against providers on the basis of religion, race, color, national origin, age, sex, or marital or corporate status, and provided, further, that all health care providers within any defined service area who are licensed and qualified to render the services covered by the preferred provider arrangement and who satisfy the standards set forth by the health care insurer shall be given the opportunity to apply and to become a preferred provider.
Ga. Code Ann. § 33-30-25

Every doctor of medicine, every doctor of dental surgery, every podiatrist, and every health care provider within a class approved by the health care corporation who is appropriately licensed to practice and who is reputable and in good standing shall have the right to become a participating physician or approved health care provider for medical or surgical care, or both, as the case may be, under such terms or conditions as are imposed on other participating physicians or approved health care providers within such approved class under similar circumstances in accordance with this chapter.
Ga. Code Ann., § 33-20-16

Quality of Care Procedures
No managed care plan that uses the network will use a financial incentive or disincentive program that directly or indirectly compensates a health care provider or hospital for ordering or providing less than medically necessary and appropriate care to his or her patients or for denying, reducing, limiting, or delaying such care.
Ga. Code Ann., § 33-20A-6

When medically necessary, providers must provide health care services 24 hours a day and seven days a week. Ga. Code Ann., § 33-20A-5

Claims Procedures
For any managed care plan offered by any managed care entity, when an enrollee, provider, facility, or home health care provider calls during regular business hours to request verification of benefits from a managed care plan, the caller shall have the clear and immediate option to speak to an employee or agent of such managed care plan who shall advise the caller that:
(A) Such verification is only a determination of whether given health care services are a covered benefit under the health benefit plan and is not a guarantee of payment for those services; and
(B) If the health care services so verified are a covered benefit, whether precertification is required and the phone number to request precertification.
If a managed care plan provides verification of benefits after regular business hours or by electronic or recorded means, the enrollee, provider, facility, or home health care provider making the request shall be provided by either electronic or recorded means or, at the option of the insurer, by a live person the information required in this subsection.
Ga. Code Ann., § 33-20A-7.1

For any managed care plan offered by any managed care entity, when an enrollee, provider, facility, or home health care provider obtains precertification for any covered health care service, the managed care plan is liable for such precertified services at the reimbursement level provided under the health benefit plan for such services where rendered within the time limits set in the precertification unless the enrollee is no longer covered under the plan at the time the services are received by the enrollee, benefits under the contract or plan have been exhausted, or there exists substantiation of fraud by the enrollee, provider, facility, or home health care provider.
Ga. Code Ann., § 33-20A-7.1

Any managed care plan which requires precertification shall have sufficient personnel available 24 hours a day, seven days a week, to provide such precertifications for all procedures, other than nonurgent procedures; to advise of acceptance or rejection of such request for precertification; and to provide reasons for any such rejection. Such acceptance or rejection of a precertification request may be provided through a recorded or computer generated communication, provided that the individual requesting precertification has the clear and immediate option to speak to an employee or representative of the managed care plan capable of providing information about the precertification request.
Ga. Code Ann., § 33-20A-7.1

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

<u>Provider-Patient Relationship</u>
Upon written request from the patient or a person authorized to have access to the patient's record under an advance directive for health care or a durable power of attorney for health care for such patient, the provider having custody and control of the patient's record shall furnish a complete and current copy of that record, in accordance with the provisions of this section. If the provider reasonably determines that disclosure of the record to the patient will be detrimental to the physical or mental health of the patient, the provider may refuse to furnish the record; however, upon such refusal, the patient's record shall, upon written request by the patient, be furnished to any other provider designated by the patient. A provider shall not be required to release records in accordance with this Code section unless and until the requesting person has furnished the provider with a signed written authorization indicating that he or she is authorized to have access to the patient's records. Any provider shall be justified in relying upon such written authorization. Any provider or person who in good faith releases copies of medical records in accordance with this Code section shall not be found to have violated any criminal law or to be civilly liable to the patient, the deceased patient's estate, or to any other person.
Ga. Code Ann., § 31-33-2

<u>Required Content in Contract</u>
All signs, cards, announcements, advertisements, or methods used to state or imply that dentistry may or will be done by anyone at any place in this state shall be required to list the full name of at least one individual practicing dentistry in such place; provided, however, that the names of all dentists practicing at a location shall

be supplied to any person who inquires, and a list containing the names of all dentists practicing at a location shall be posted at the entry of such location.
Ga. Code Ann., § 43-11-18

An insured shall be held harmless for provider utilization review decisions over which he has no control.
GA COMP. R. & REGS. 120-2-44-.04

Preferred Provider Arrangements or Preferred provider insurance policies or certificates may not contain terms or conditions that would operate unreasonably to restrict the accessibility and availability of health care services for the insured.
GA COMP. R. & REGS. 120-2-44-.05

Preferred provider arrangements shall contain provisions for the continuous review of the utilization of services and facilities, and costs.
GA COMP. R. & REGS. 120-2-44-.04

Every contract between a physician and an insurer which offers a health benefit plan under which that physician provides health care services shall be in writing and shall state the obligations of the parties with respect to charges and fees for services covered under that plan when provided by that physician to enrollees under that plan. Neither the insurer which provides that plan nor the enrollee under that plan shall be liable for any amount which exceeds the obligations so established for such covered services.
Ga. Code Ann., § 10-1-393

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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