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

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
No state-specific requirements.

Dispute Resolution Process
Please see Network Appeals/Grievances.

Network Participation Procedures
Notwithstanding any provisions of any policy of insurance covering dental health, whenever such policy provides for reimbursement for any service which is within the lawful scope of practice of a denturist, the insured under such policy shall be entitled to reimbursement for such service, whether the service is performed by a licensed dentist or a licensed denturist.
I.C. § 54-3318

Quality of Care Procedures
No state-specific requirements.

Claims Procedures
No health care provider shall require an insured to make additional payments for covered services under a policy, other than specified deductibles, copayments or coinsurance once a provider has agreed in writing to accept the insurer's reimbursement rate to provide a covered service.
I.C. § 41-1846

If a beneficiary, practitioner or facility submits an electronic claim to an insurer within thirty (30) days of the date on which service was delivered, an insurer shall pay or deny the claim not later than thirty (30) days after receipt of the claim. If a beneficiary, practitioner or facility submits a paper claim for payment to an insurer within forty-five (45) days of the date on which service was delivered, an insurer shall pay or deny the claim not later than forty-five (45) days after receipt of the claim. If an insurer denies the claim or needs additional information to process the claim, the insurer shall notify the practitioner or facility and the beneficiary in writing within thirty (30) days of receipt of an electronic claim or within forty-five (45) days of receipt of a paper claim. The notice shall state why the insurer denied the claim. If the claim was denied because more information was required to process the claim, the notice shall specifically describe all information and supporting documentation needed to evaluate the claim for processing. If the practitioner or facility submits the information and documentation identified by the insurer within thirty (30) days of receipt of the written notice, the insurer shall process and pay the claim within thirty (30) days of receipt of the additional information or, if appropriate,

deny the claim. Any claim submitted pursuant to this chapter shall use the current procedural terminology (CPT) code in effect, as published by the American medical association, the international classification of disease (ICD) code in effect, as published by the United States department of health and human services, or the healthcare common procedural coding system (HCPCS) code in effect, as published by the United States centers for Medicaid and Medicare services (CMS).
I.C. § 41-5602

An insurer that fails to pay, request additional information or documentation or deny a claim from a beneficiary, practitioner or facility within the time periods established in this chapter shall pay interest at the contract statutory rate pursuant to section 28-22-104, Idaho Code, on the unpaid amount of a claim that is determined to be due and owing. The interest shall accrue from the date payment was due, pursuant to the provisions of this chapter, until the claim is paid. Payment of any interest amount of less than four dollars ($4.00) shall not be required. Insurers may add any interest due to a future payment to the beneficiary, practitioner or facility.
I.C. § 41-5603

Nothing in the prompt pay rule requires an insurer to accept an assignment of payment by the beneficiary to the practitioner or facility.
I.C. § 41-5604

There are a number of exceptions to the prompt pay rule. The time periods shall not apply to claims that the insurer reasonably believes involve fraud or misrepresentation by the practitioner or facility or the beneficiary or to instances where the insurer has not been provided the information necessary to evaluate the claim after notice has been given requesting additional information by the insurer. The time periods shall not apply to claims that the insurer reasonably believes require medical records, including accident reports, for the purpose of investigating whether a claim is valid for subrogation, or the coordination of benefits payable by the insurer with benefits payable by another insurer or payable under federal or state law. An insurer is not required to comply with the time periods if the insurer is in compliance with a contract with the practitioner or facility which specifies different payment requirements. Payments made within the time periods shall be deemed to be made in a reasonable and timely manner. An insurer is not required to comply with the periods if the fee or premium entitling a beneficiary to insurance benefits has not been paid in full. An insurer is not required to comply with the time periods if failure to comply is due to an act of God, bankruptcy, an act of a governmental authority responding to an act of God or emergency or the result of a strike, walkout or other labor dispute, or act of terrorism.
I.C. § 41-5605

Providers are not required to adopt fees set by the Participating Provider Agreement for services that are not covered services. “Covered services” as used in this section means services under the applicable dental plan, dental plan contract or plan benefits subject to such contractual limitations on benefits of the dental plan, dental plan contracts or plan benefits as may apply.
I.C. § 41-1849(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

Provider-Patient Relationship
No state-specific requirements.

Required Content in Contract
No state-specific requirements.

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 January 12, 2017.