



**GEHA Policies & Procedures
Connection Dental Network
State Specific Policies & Procedures - State of Kentucky**

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

An insurer that offers a health benefit plan that is not a managed care plan but provides financial incentives for a covered person to access a network of providers shall establish a policy governing the removal of and withdrawal by health care providers from the provider network that includes the following: (a) The insurer shall inform a participating health care provider of the insurer's removal and withdrawal policy at the time the insurer contracts with the health care provider to participate in the provider network, and when changed thereafter; (b) If a participating health care provider's participation will be terminated or withdrawn prior to the date of the termination of the contract as a result of a professional review action, the insurer and participating health care provider shall comply with the standards in [42 U.S.C. sec. 11112](#); and (c) If the insurer finds that a health care provider represents an imminent danger to an individual patient or to the public health, safety, or welfare, the medical director shall promptly notify the appropriate professional state licensing board. This section does not apply to limited health service benefit plans subject to Kentucky regulation.

KRS § 304.17A-254

An insurer cannot terminate a Participating Provider Agreement without cause.

KRS 304.17C-020

Dispute Resolution Process

Please see Network Appeals/Grievances.

For disputes relating to payment of claims for limited health service benefit plans for the provision of dental-only benefits for limited health service benefit plans subject to Kentucky regulation, the provisions of KRS 304.17A-700 to 304.17A-730.

KRS 304.17C-090

An insurer subject to Kentucky regulation shall not request or require a provider to pursue any other course of action regarding the payment of health care claims outside of the provisions set forth in KRS 304.17A-700 to 304.17A-730 and KRS 205.593, 304.14-135, and 304.99-123.

KRS 304.17A-726

Network Participation Procedures

A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer.

KRS 304.17A-270

Any policy or contract of health insurance issued in this state which provides coverage for services which can be lawfully performed within the scope of the license of a duly licensed dentist, shall be deemed to provide benefits for such services whether performed by a duly licensed physician or a duly licensed dentist.

KRS 304.17-315

Insurers shall establish relevant, objective standards for initial consideration of providers and for providers to continue as a participating provider in the plan. Standards shall be reasonably related to services provided. Selection or participation standards based on the economics or capacity of a provider's practice shall be adjusted to account for case mix, severity of illness, patient age and other features that may account for higher-than- or lower-than-expected costs. All data profiling or other data analysis pertaining to participating providers shall be done in a manner which is valid and reasonable. Plans shall not use criteria that would allow an insurer to avoid high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher-than-average claims, losses, or health services utilization or that would exclude providers because they treat or specialize in treating populations presenting a risk of higher-than-average claims, losses, or health services utilization.

KRS 304.17A-525

Each insurer shall establish mechanisms for soliciting and acting upon applications for provider participation in the plan in a fair and systematic manner. These mechanisms shall, at a minimum, include: (a) Allowing all providers who desire to apply for participation in the plan an opportunity to apply at any time during the year or, where an insurer does not conduct open continuous provider enrollment, conducting a provider enrollment period at least annually with the date publicized to providers located in the geographic service area of the plan at least 30 days in advance of the enrollment periods; and (b) Making criteria for provider participation in the plan available to all applicants.

KRS 304.17A-525

Health insurers shall not issue contracts offering any preferred provider arrangement under which the difference between the benefit payable for services rendered by noncontract health care providers and the benefit payable for services rendered by contract health care providers exceeds 25%. Health insurers shall not issue contracts offering any exclusive provider arrangement.

806 KAR 18:020

Quality of Care Procedures

No state-specific requirements.

Claims Procedures

Except for claims involving organ transplants, each insurer shall reimburse a provider for a clean claim or send a written or an electronic notice denying or contesting the claim within 30 calendar days from the date that the claim is received by the insurer or any entity that administers or processes claims on behalf of the insurer. Clean claims involving organ transplants shall be paid, denied, or contested within 60 calendar days from the date that the claim is received by the insurer or any entity that administers or processes claims on behalf of the insurer. Within the applicable claims payment time frame, an insurer shall: (a) Pay the total amount of the claim in accordance with any contract between the insurer and the provider; (b) Pay the portion of the claim that is not in dispute and notify the provider, in writing or electronically, of the reasons the remaining portion of the claim will not be paid; or (c) Notify the provider, in writing or electronically, of the reasons no part of the claim will be paid.

KRS 304.17A-702

Within 48 hours of receiving an original or corrected claim submitted electronically, an insurer, its agent, or designee shall acknowledge the date of receipt of the claim by an electronic transmission to the provider, its billing agent, or designee that submitted the claim; and (b) Within 20 calendar days of receipt of an original or corrected claim submitted by mail or other nonelectronic means, an insurer, its agent, or designee shall acknowledge the date of receipt of the claim to the provider, its billing agent, or designee that submitted the claim. For claims containing all necessary information and having no errors, the insurer shall make available confirmation of receipt of the claim to the provider, its billing agent, or designee that submitted the claim. Acknowledgment may be in writing or the insurer, its agent, or designee may list the claim and the date it was received on a file that can be accessed electronically by the provider, its agent, or designee. Claims that contain errors or lack necessary information shall be acknowledged by an electronic transmission or in writing to the provider, its billing agent, or designee that submitted the claim. At the time of acknowledgment, an insurer, its agent, or designee, shall notify the provider, its billing agent, or designee that submitted the claim, in writing or electronically, of all information that is missing from the billing instrument, any errors in the billing instrument, or of any other circumstances which preclude it from being a clean claim. When an insurer, its agent, or designee has notified a provider, its billing agent, or designee that submitted the claim, that a claim contains errors, upon receipt of a corrected clean claim the insurer shall adjudicate the corrected clean claim within the applicable claims payment time frame for a clean claim.

KRS 304.17A-704

An insurer may contest a clean claim only in the following instances: (a) The insurer has reasonable documented grounds to believe that the clean claim involves a preexisting condition, coordination of benefits within the meaning of applicable state law, or that another insurer is primarily responsible for the claim; (b) The insurer will conduct a retrospective review of the services identified on the claim; (c) The insurer has information that the claim was submitted fraudulently; or (d) The covered person's or group's premium has not been paid. If an insurer requires a provider to submit health claim attachments to the claim before the claim will be paid, the insurer shall identify the specific required health claim attachments in its provider manual or other document that sets forth the procedure for filing claims with the insurer. The insurer shall provide 60 days' advance written notice of modifications to the provider manual that materially change the type or content of the health claim attachments or other documents to be submitted. If a provider submits a clean claim with the required health claim attachments as specified in the provider manual or other document that sets forth the procedure for filing claims with the insurer, the insurer shall pay or deny the claim within the required claims payment time frame established in applicable state law. If an insurer conducts a retrospective review of a claim and requires an attachment not specified in the provider manual or other document that sets forth the procedure for filing claims, the insurer shall: (1) Notify the provider, in writing or electronically within the claims payment time frame established in applicable state law, of the service that will be retrospectively reviewed and the specific information needed from the provider regarding the insurer's review of a claim; (2) Complete the retrospective review within 20 business days of the insurer's receipt of the medical information; and (3) Subject to receipt of the requested information in a timely manner as set forth by state law, add interest to the amount of the claim, to be paid at a rate of 12% per annum, or at a rate in accordance with applicable state law, accruing from the appropriate claim payment time frame established by applicable law after the claim was received by the insurer through the date upon which the claim is paid. If a claim or portion thereof is contested by an insurer on the basis that the insurer has not received information reasonably necessary to determine insurer liability for the claim or portion thereof, or if the insurer contests the claim on the reasonable and documented belief that the claim involves the coordination of benefits, or questions of pre-existing conditions, the insurer shall, within the applicable claims payment time frame established by law, provide written or electronic notice to the provider, covered person, group policyholder, or other insurer, as appropriate, with an itemization of all new, never-before-provided information that is needed. The insurer shall pay or deny the claim within 30 calendar days of receiving the additional information. If the insurer does not receive the additional information within 15 business days from the date of receipt of the notice, the insurer may deny the claim. Any claim denied under this paragraph may be resubmitted by the provider and any resubmitted claim

shall not be denied on the basis of timeliness if the resubmitted claim is made with the timeframe for submitting claims established by the insurer beginning on the date of denial.

KRS 304.17A-706

Except for overpayments which are a result of an error in the payment rate or method, an insurer that determines that a provider was overpaid shall, within 24 months from the date that the insurer paid the claim, provide written or electronic notice to the provider of the amount of the overpayment, the covered person's name, patient identification number, date of service to which the overpayment applies, insurer reference number for the claim, and the basis for determining that an overpayment exists. Electronic notice includes e-mail or facsimile where the provider agreed in advance in writing to receive such notices. The insurer shall either: (a) Request a refund from the provider; or (b) Indicate on the notice that, 30 calendar days from the postmark date or electronic delivery date of the insurer's notice, if the insurer does not receive a notice of provider dispute in accordance with this section, the amount of the overpayment will be recouped from future payments. If a provider disagrees with the amount of the overpayment, the provider shall within 30 calendar days from the postmark date or the electronic delivery date of the insurer's written notice dispute the amount of the overpayment by submitting additional information to the insurer. If a provider files a dispute in accordance with this section, no recoupment shall be made until the dispute is resolved. If a provider does not dispute the amount of the overpayment and does not provide a refund as required in this section, the insurer may recoup the amount due from future payments. All disputes submitted by providers pursuant to this section shall be processed in accordance and completed within 30 days with the insurer's provider appeals process. An insurer may recover an overpayment resulting from an error in the payment rate or method by requesting a refund from the provider or making a recoupment of the overpayment from the provider, subject to this section. A provider may dispute such recoupment in accordance with the provisions contained in applicable law. If an insurer chooses to collect an overpayment made to a provider through a recoupment against future provider payments, the insurer shall, within 24 months from the date that the insurer paid the claim, and at the actual time of recoupment give the provider written or electronic documentation that specifies: (a) The amount of the recoupment; (b) The covered person's name to whom the recoupment applies; (c) Patient identification number; and (d) Date of service.

KRS 304.17A-714

The provisions of applicable Kentucky law, relating to payment of claims, shall apply to limited health service benefit plans for the provision of dental-only benefits, except as follows: (1) A limited health service plan for the provision of dental-only benefits, its agent, or designee shall have 3 business days in which to respond to an original or corrected claim submitted electronically under applicable law or, within 3 business days, the limited health service benefit plan for the provision of dental-only benefits, its agent, or designee may list the claim and the date it was received on a file that can be accessed electronically by the provider, its agent, or designee. (2) Limited health service benefit plans for the provision of dental-only benefits shall be required to submit the reports required by applicable law on an annual basis. (3) Limited health service benefit plans for the provision of dental-only benefits shall be required to pay interest required under applicable law for a claim only if the interest calculated on that claim is equal to or greater than \$5.

KRS 304.17C-090

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

An insurer that offers a health benefit plan that is not a managed care plan but provides financial incentives for a covered person to access a network of providers shall:

- (1) Notify the covered person, in writing, of the availability of a printed document, in a manner consistent with applicable state law, containing the following information at the time of enrollment and upon request: (a) A current directory of the in-network providers from which the covered person may access covered services at a financially beneficial rate. The directory shall, at a minimum, provide the name, type of provider, professional office address, telephone number, and specialty designations of the network provider, if any; and (b) In addition to making the information available in a printed document, an insurer may also make the information available in an accessible electronic format;
- (2) Assure that contracts with the providers in the network contain a hold harmless agreement under which the covered person will not be balanced billed by the in-network provider except for deductibles, co-pays, coinsurance amounts, and noncovered benefits (see below);
- (3) File with the department a copy of the directory required under this section;
- (4) Have a process for the selection of health care providers who will be on the insurer's list of participating providers, with written policies and procedures for review and approval used by the insurer. The insurer shall establish minimum professional requirements for participating health care providers. An insurer may not discriminate against a provider solely on the basis of the provider's license by the state;
- (5) Not contract with a health care provider to limit the provider's disclosure to a covered person, or to another person on behalf of a covered person, of any information relating to the covered person's medical condition or treatment options;
- (6) Not penalize a health care provider, or terminate a health care provider's contract with the insurer, because the provider discusses medically necessary or appropriate care with a covered person or another person on behalf of a covered person. The health care provider may: (a) Not be prohibited by the insurer from discussing all treatment options with the covered person; and (b) Disclose to the covered person or to another person on behalf of a covered person other information determined by the health care provider to be in the best interests of the covered person;

(7) The insurer, or GEHA on behalf of the insurer, will, upon request of a health care provider, provide or make available to a health care provider, when contracting or renewing an existing contract with such provider, the payment or fee schedules or other information sufficient to enable the health care provider to determine the manner and amount of payments under the contract for the health care provider's services prior to the final execution or renewal of the contract and shall provide any change in such schedules at least 90 days prior to the effective date of the amendment pursuant to applicable law;

(8) (See above under Termination Procedures)

(9) Meet all requirements provided under applicable law related to utilization review and claims payment.

KRS 304.17A-254

There is no limitation on a provider's disclosure to an enrollee, or to another person on behalf of an enrollee, of any information relating to the enrollee's medical condition or treatment option. No health care provider shall be penalized, or a health care provider's contract with a limited health plan terminated, because a provider discusses medically necessary or appropriate care with an enrollee or another person on behalf of an enrollee. The health care provider is not prohibited by a plan from discussing all treatment options with the enrollee. Other information determined by a health care provider to be in the best interests of the enrollee may be disclosed by the provider to the enrollee or to another person on behalf of an enrollee. A health care provider shall not be penalized for discussing financial incentives and financial arrangements between the provider and the insurer with an enrollee. Upon request an insurer shall inform its enrollees in writing of the type of financial arrangements between the plan and the participating providers if those arrangements include an incentive or bonus.

KRS 304.17C-070

A provider may not, under any circumstance, including nonpayment of moneys due to providers by the insurer; insolvency of the insurer; or breach of the Participating Provider Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the subscriber, dependent of subscriber, enrollee, or any persons acting on their behalf, for services provided in accordance with the provider agreement. This provision shall not prohibit collection of deductible amounts, copayment amounts, coinsurance amounts, and amounts for non-covered services.

KRS 304.17C-060(1)(a)

The hold harmless cause in KRS 304.17C-060(1)(a) and continuity of care clause in the Agreement shall survive the termination of the Agreement between the provider and the insurer.

KRS 304-17C-060(1)(b)

If a provider enters into any subcontract agreement with another provider to provide health care services to a subscriber, dependent of the subscriber, or enrollee of a limited health service benefit plan, the subcontract agreement must meet all requirements of KRS 304.17C (and KRS 304.17A, where applicable) and all such subcontract agreements shall be filed with the commissioner in accordance with this subsection.

KRS 304.17C-060(1)(c)

The Participating Provider Agreement shall be governed by and construed in accordance with the laws of the State of Kentucky and any applicable federal law(s). The substantive law of Kentucky shall solely govern this Agreement and no cause of action not specifically recognized in the State of Kentucky shall be implied or construed to exist.

806 KAR 17:440 Section 3(2)

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 12, 2017.