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

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
Any health insurance issuer that requires a health care provider to be credentialed, recredentialed, or approved by the issuer prior to rendering health care services to an enrollee or insured shall complete a credentialing process within ninety days from the date on which the issuer has received all the information needed for credentialing, including the health care provider's correctly completed application and attestations and all verifications or verification supporting statements required by the issuer to comply with accreditation requirements and generally accepted industry practices and provisions to obtain reasonable applicant-specific information relative to the particular or precise services proposed to be rendered by the applicant. Within thirty days of the date of receipt of an application, a health insurance issuer shall inform the applicant of all defects and reasons known at the time by the issuer in the event a submitted application is deemed to be not correctly completed. A health insurance issuer shall inform the applicant in the event that any needed verification or a verification supporting statement has not been received within sixty days of the date of the issuer's request. In order to establish uniformity in the submission of an applicant's standardized information to each issuer for which he may seek to provide health care services, until submission of an applicant's standardized information in a hard-copy, paper format is superseded by a provider's required submission and a health insurance issuer's required acceptance by electronic submission, an applicant shall utilize and a health insurance issuer shall accept either of the following at the sole discretion of the health insurance issuer: (a) The current version of the Louisiana Standardized Credentialing Application Form, or its successor; or (b) The current format used by the Council for Affordable Quality Healthcare (CAQH), or its successor.
LSA-R.S. 22:1009

Quality of Care Procedures
No state-specific requirements.

Claims Procedures
No dental plan that is delivered, renewed, issued for delivery, or otherwise contracted for in this state may require that a dentist provide dental health care services to a covered person at a particular fee unless such services are covered services for which benefits are paid under a contract with such dentist. Nothing in this Section shall prohibit a dental service contractor or insurer from offering a dentist optional agreements for

participation in a dental plan in which a dentist may choose to participate either with or without a provision to provide discounts to covered persons for non-covered services provided that all of the following apply: (1) No dental service contractor or insurer may restrict in any manner the choice of any dentist to participate in the plan with or without an optional agreement providing for discounts on non-covered services except that the option for any dentist choosing to participate in the plan under such an optional agreement to cease providing such discounts under said optional agreement but still continue participating in the plan may be limited to each time said optional agreement is up for renewal. (2) The provision for discounts on non-covered services shall be the only material difference between agreements entered into with a dentist who accepts such an optional agreement and those with a dentist who accepts a contract without said optional agreement. As used in this Section, the following definitions shall apply: (1) "Covered person" means any subscriber, enrollee, member, or participant in a dental plan, or his dependent, for whom benefits are payable when that person receives dental health care services rendered or authorized by a licensed dentist. (2) "Covered service" means any dental service rendered or authorized by a licensed dentist on a covered person for which a dental service contractor or insurer is required to pay benefits to the dentist under a contractual agreement with such dentist. Such a service includes any service on which reimbursement is limited by a deductible, copayment, coinsurance, waiting period, annual maximum, or frequency limitation. (3) "Dental plan" means any insurance policy, benefit plan, or dental service contract providing for the payment of benefits for dental health care services.
LSA-R.S. 22:1157

Each health insurance identification card issued by a health insurance issuer shall contain sufficient information to clearly identify the health insurance issuer.
LSA-R.S. 22:1873

No health insurance issuer shall act as a Medical Necessity Review Organization for the purpose of determining medical necessity, determining the appropriateness of care, determining the level of care needed, or making other similar medical determinations unless authorized as an MNRO by the commissioner as provided by applicable law.
LSA-R.S. 22:1123

A contracted health care provider shall be prohibited from discount billing, dual billing, attempting to collect from, or collecting from an enrollee or insured a health insurance issuer liability or any amount in excess of the contracted reimbursement rate for covered health care services. No contracted health care provider shall bill, attempt to collect from, or collect from an enrollee or insured any amounts other than those representing coinsurance, copayments, deductibles, noncovered or noncontracted health care services, or other amounts identified by the health insurance issuer on an explanation of benefits as an amount for which the enrollee or insured is liable. However, in the event that any billing, attempt to collect from, or the collection from an enrollee or insured of any amount other than those representing copayment, deductible, coinsurance, payment for noncovered or noncontracted health care services, or other amounts identified by the health insurance issuer as the liability of the enrollee or insured is based on information received from a health insurance issuer, the contracted health care provider shall not be in violation of this Subsection. A health insurance issuer contracting with a network of providers is obligated to pay to a contracted health care provider the contracted reimbursement rate of the network identified on the member identification card of the enrollee or insured, pursuant to applicable law, and established by the contract between the network of providers and the contracted health care provider. The payor must comply with all provisions of the specific network contract. To the extent that a health insurance issuer does not pay to the health care provider an amount equal to the health insurance issuer liability, the contracted health care provider may collect the difference between the amount paid by the health insurance issuer and the health insurance issuer liability from the enrollee or insured. No contracted health care provider may maintain any action at law against an enrollee or insured for a health insurance issuer liability or for payment of any amount in excess of the contracted reimbursement rate for such services. In the event of such an action, the prevailing party shall be entitled to recover all costs

incurred, including reasonable attorney fees and court costs. However, nothing in this Subsection shall be construed to prohibit a contracted health care provider from maintaining any action at law against an enrollee or insured after a health insurance issuer determines that the health insurance issuer is not liable for the health care services rendered.
LSA-R.S. 22:1874

Prior to any recoupment unrelated to a claim for payment of medical services provided by a health care provider or any other amount owed by a health insurance issuer to a health care provider, the health insurance issuer shall provide the health care provider written notification that includes the name of the patient, the date or dates of health care services rendered, and an explanation of the reason for recoupment. A health care provider shall be allowed thirty days from receipt of written notification of recoupment to appeal the health insurance issuer's action and to provide the health insurance issuer the name of the patient, the date or dates of health care services rendered, and an explanation of the reason for the appeal. When a health care provider fails to respond timely and in writing to a health insurance issuer's written notification of recoupment, the health insurance issuer may consider the recoupment accepted. If a recoupment is accepted, the health care provider may remit the agreed amount to the health insurance issuer at the time of any written notification of acceptance or may permit the health insurance issuer to deduct the agreed amount from future payments due to the health care provider. If a health care provider disputes a health insurance issuer's written notification of recoupment and a contract exists between the health care provider and the health insurance issuer, the dispute shall be resolved according to the general dispute resolution provisions in the contract. If the recoupment directly affects the payment responsibility of the insured, the health insurance issuer shall provide at the same time a revised explanation of benefits to the health care provider and the covered person for whose claim the recoupment is being made. Unless the recoupment of a health insurance claim payment directly affects the payment responsibility of the insured, such recoupment shall not result in any increased liability of an insured.
LSA-R.S. 22:1838

Any nonelectronic claim by a health care provider under a contract with a health insurance issuer, for provision of health care services, submitted by the provider or its agent within forty-five days of the date of service, or date of discharge from a health care facility or institution, shall be paid, denied, or pended not more than forty-five days from the date upon which a nonelectronic clean claim is received by the issuer or its agent, unless it is not payable under the terms of the applicable contract of health insurance coverage or unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard. Any nonelectronic claim by a health care provider under a contract with a health insurance issuer, for provision of health care services, submitted by the provider or its agent more than forty-five days after the date of service, or date of discharge from a health care facility or institution, or resubmitted because the original claim was not an accepted claim or not a clean claim shall be paid, denied, or pended not more than sixty days from the date upon which a nonelectronic clean claim is received by the issuer or its agent, unless it is not payable under the terms of the applicable contract of insurance or unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard. The issuer shall either provide written notice to the provider that a claim is pended or allow the provider Internet access to such information. Health insurance issuers shall have appropriate handling procedures for the acceptance of nonelectronic claim submissions. Such procedures shall include but not be limited to the following: (a) A process for documenting the date of actual receipt of nonelectronic claims; and (b) A process for reviewing nonelectronic claims for accuracy and acceptability; and (c) A process for prevention of loss of such claims. Such procedures shall assure that all such claims received are reviewed for determination as to whether such claims are accepted or clean claims. Health insurance issuers shall establish appropriate procedures to assure that any health care provider who is not paid within the time frames specified in this Section receives a late payment adjustment equal to twelve percent per annum of the amount due.
LSA-R.S. 22:1832

A health insurance issuer shall allow a health care provider access to information in the issuer's Payer's Companion Guide, or its successor, listing issuer-specific data requirements for accepted electronic claims. Such access shall be provided through a written notice to the provider or through Internet access. Within five working days of receipt of an electronic claim, a health insurance issuer or its agent shall review the entire claim and, if the issuer determines that the claim is not an accepted claim, issue an exception report to the provider or its agent indicating all defects or reasons known at that time that the claim is not an accepted claim. A provider who submits a claim that is not an accepted claim shall be deemed to have timely submitted a claim for the payment of covered health care services if the health insurance issuer or its agent fails to notify the health care provider, or the health care clearinghouse from which the claim was received, of all defects or reasons known at that time that the claim is not an accepted claim. Such exception report shall contain at a minimum the following information, if known at that time, for each claim submitted: (a) Patient name; (b) Provider claim number, patient account number, or unique insured/enrollee identification number; (c) Date of service; (d) Total billed charges; (e) Exception report issuer's name; and (f) The date upon which the exception report was generated. When the issuer or its agent rejects an entire batch of claims, the issuer or its agent shall send a batch rejection report to the entity from which the rejected batch of claims was received. Such batch rejection report shall contain at a minimum the following information: (a) Date batch was received by the issuer or its agent; (b) Date of rejection report; (c) Name or identification number of entity issuing batch rejection report; (d) Batch submitter's name or identification number, whichever is available; and (e) Reason batch is rejected. Any electronic claim shall be paid, denied, or pended not more than twenty-five days from the date upon which an electronic clean claim is electronically received by the health insurance issuer or its agent, unless it is not payable under the terms of the applicable contract of insurance or unless just and reasonable grounds exist such as would put a reasonable and prudent businessman on his guard. The issuer shall either provide written notice to the provider that a claim is pended or allow the provider Internet access to such information. Health insurance issuers shall have appropriate handling procedures approved by the department for the acceptance of electronic claim submissions. Such procedures shall include but not be limited to the following: (1) A process for electronically recording the time and date of actual receipt of electronic claims; (2) A process for electronic review of transmitted claims that assures all such claims received are reviewed for determination of whether such claims are deemed accepted in accordance with law; and (3) A process for reporting all claims not accepted and batches of claims rejected and all defects or reasons known at that time that such claims were not accepted or batches of claims were rejected. Health insurance issuers shall establish appropriate procedures approved by the department to assure that any health care provider who is not paid within the time frame specified in this Section receives a late payment adjustment equal to twelve percent per annum of the amount due.
LSA-R.S. 22:1833

Each remittance advice generated by a health insurance issuer or its agent to a health care provider or its agent shall include the following information, if known at that time, clearly identified for each claim listed: (1) The name of the enrollee or insured; (2) Unique enrollee or insured identification number; (3) Patient claim number or patient account number; (4) Date of service; (5) Total provider charges; (6) Health insurance issuer contractual discount amount; (7) Enrollee or insured liability, specifying any coinsurance, deductible, copayment, or noncovered amount; (8) Amount paid by health insurance issuer; (9) Amount adjusted by health insurance issuer and the reason for adjustment; and (10) Amount denied and the reason for denial. A health insurance issuer that prescribes the period of time that a health care provider under contract for provision of health care services has to submit a claim for payment shall have the same prescribed period of time following payment of such claim to perform any review or audit for purposes of reconsidering the validity of such claim. Notwithstanding any other provision of law to the contrary, no health insurance insurer shall limit the right of a rural hospital to receive payment for covered health care services as long as a claim for payment of such services is submitted within one year after the date on which the rural hospital provided the services. Notwithstanding any other provision of law to the contrary, for health services rendered in good faith and pursuant to the benefit plan, no health insurance issuer shall retroactively deny payment or recoup any monies paid beyond ninety days from the expiration of the allowable thirty-day period for the payment of any claim

when the denial or recoupment is based on a determination that the insured was no longer covered under the plan at the time of the service.
LSA-R.S. 22:1834

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>
A health care provider may communicate with a patient regarding his or her health care, including but not limited to communications regarding treatment options and medical alternatives, or other coverage arrangements. No managed care organization shall refuse to contract, renew, cancel, restrict, or otherwise terminate a contract with a health care provider solely on the basis of a medical communication. No managed care organization shall refuse to refer patients to or allow others to refer patients to the health care provider, refuse to compensate the health care provider for covered services, or take other retaliatory action against the health care provider. No communication regarding treatment options shall be represented or construed to expand or revise the scope of benefits or covered services under a managed care plan or insurance contract. No managed care organization or managed care entity shall by contract, written policy, or written procedure prohibit or restrict any provider from filing a complaint, making a report, or commenting to an appropriate governmental body regarding the policies or practices of such managed care organization or managed care entity which may negatively impact upon the quality of, or access to, patient care. No managed care organization or managed care entity shall by contract, written policy, or written procedure prohibit or restrict any health care provider from advocating to the managed care organization or managed care entity on behalf of the enrollee or subscriber for approval or coverage of a particular course of treatment or for the provision of health care services. The Participating Provider Agreement does not purport to transfer to the health care

provider by indemnification or otherwise any liability relating to activities, actions, or omissions of a managed care organization or managed care entity.
LSA-R.S. 22:1007

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.

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