GEHA Policies & Procedures
Connection Dental Network
State Specific Policies & Procedures - State of New Mexico

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.

Termination Procedures
Contractual rights and responsibilities may not be assigned or delegated by the provider without the prior written consent of GEHA.
N.M. Admin Code 13.10.22.12

Please also see Network Appeals/Grievances Policies and Procedures.

Dispute Resolution Process
Please see Network Appeals/Grievances.

Network Participation Procedures
For nonprofit health care plans subject to state regulation, an individual or group subscriber contract delivered or issued for delivery in New Mexico that, on a prepaid, service or indemnity basis provides for treatment of persons for the prevention, cure or correction of any illness or physical or mental condition shall include coverage for the services of a dental hygienist in a collaborative practice pursuant to the Dental Health Care Act.
N. M. S. A. 1978, § 59A-47-28.4

Each health care insurer subject to state regulation must include the following information on an insurance card to a subscriber: "If you have a complaint about the coverage under your health plan, you may contact: Managed Health Care Bureau, www.nmprc.state.nm.us/mheb.htm, 1(888) 4ASK-PRS (427-5772)."

Quality of Care Procedures
Health care professionals and health care facilities shall observe, protect, and promote the rights of Covered Persons as patients.
N.M. Admin Code 13.10.22.12

Claims Procedures
No health service contractor subject to state regulation that covers any dental services may require that a Participating Provider provide services to an enrolled participant at a fee set by, or at a fee subject to the approval of, the health care service contractor unless the dental services are covered services. No health care service contractor or other person providing third party administrator services shall make available any providers in its dentist network to a plan that sets dental fees for any services except covered services.
N.M.S.A. 1978, § 59A-22-51

A health plan subject to state regulation shall provide for payment of interest on the plan's liability at the rate of one and one-half percent a month on: (1) the amount of a clean claim electronically submitted by the participating provider and not paid within thirty days of the date of receipt; and (2) the amount of a clean claim manually submitted by the participating provider and not paid within forty-five days of the date of receipt. If a health plan is unable to determine liability for or refuses to pay a claim of a participating provider within the times specified in this section, the health plan shall make a good-faith effort to notify the participating provider by fax, electronic or other written communication within thirty days of receipt of the claim if submitted electronically or forty-five days if submitted manually of all specific reasons why it is not liable for the claim or that specific information is required to determine liability for the claim. The Participating Provider Agreement does not include a clause that has the effect of relieving either party of liability for its actions or inactions.
N. M. S. A. 1978, § 59A-16-21.1

Retroactive adjustments by a health care insurer or MHCP subject to state regulation for overpayment must be made within 18 months absent health care professional miscoding, claim submission error, suspected fraud and abuse; or retroactive adjustments required by other federal or state agencies.
N.M. Admin Code 13.10.22.12

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>
Any health care insurer or MHCP subject to state regulation shall provide interpreters for limited English proficient (LEP) individuals and interpretative services for patients who qualify under the Americans with

Disabilities Act (ADA). Such interpretive services will be made available to provider's office at no cost to the provider.
N.M. Admin Code 13.10.22.12

Required Content in Contract
Health care professional/health care facility agrees that in no event, including but not limited to nonpayment by the health insuring corporation, insolvency of the health insuring corporation, or breach of this agreement, shall health care professional/health care facility bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, covered person, or person acting on behalf of the covered person, for health care services provided pursuant to this agreement. This does not prohibit health care professional/health care facility from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor. This provision required by 13.10.22.12 NMAC shall survive the termination of the contract regardless of the reason for the termination, including the insolvency of the health care insurer or managed health can plan.
N.M. Admin Code 13.10.22.12

Health care professional and health care facilities shall maintain adequate professional liability and malpractice insurance and shall notify GEHA not more than ten days after the provider's receipt of notice of any reduction or cancellation of such coverage.
N.M. Admin Code 13.10.22.12

The terms used in the provider contract and that are defined by New Mexico statutes and division regulations will be used in the provider contract in a manner consistent with definitions contained in applicable laws or regulations.
N.M. Admin Code 13.10.22.12

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 13, 2017.