GEHA Policies & Procedures
Connection Dental Network
State Specific Policies & Procedures - State of South Carolina

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
If a provider contract is terminated or nonrenewed, the issuer and the provider shall comply with the following requirements: (1) The issuer is liable for covered benefits rendered in the continuation of care by a provider to a covered person for a serious medical condition. Except as required by this section, the benefits payable for services rendered during the continuation of care are subject to the policy's or contract's regular benefit limits. (2) The issuer shall not require a covered person to pay a deductible or copayment which is greater than the in-network rate for services rendered during the continuation of care. (3) An issuer offering health insurance coverage shall not require a covered person, as a condition of continued coverage under the plan, to pay a premium or contribution which is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of covered benefits rendered as provided for in this section to the covered person or the dependent of a covered person. (4) The provider shall accept as payment in full for services rendered within in the continuation of care the negotiated rate under the provider contract. (5) Except for an applicable deductible or a copayment, a provider shall not bill or otherwise hold a covered person financially responsible for services rendered in the continuation of care and furnished by the provider, unless the provider has not received payment in accordance with item (4) of this subsection and in accordance with applicable law. (6) Upon receipt of the patient's request accompanied by the physician's attestation on the prescribed form, the issuer shall notify the provider and the covered person of the provider's date of termination from the network and of the continuation of care provisions as provided for in this section. (7) The issuer is responsible for determining if a covered person qualifies for continuation of care and may request additional information in reaching such determination.
Code 1976 § 38-71-243

Dispute Resolution Process
Please see Network Appeals/Grievances.

Network Participation Procedures
No state-specific requirements.

Quality of Care Procedures
No state-specific requirements.

Claims Procedures
An insurer shall direct the issuance of a check or an electronic funds transfer in payment for a clean claim that is submitted via paper within forty business days following the later of the insurer's receipt of the claim or the

date on which the insurer is in receipt of all information needed and in a format required for the claim to constitute a clean claim and is in receipt of all documentation which may be requested by an insurer which is reasonably needed by the insurer: (1) to determine that such claim does not contain any material defect, error, or impropriety; or (2) to make a payment determination.
An insurer shall direct the issuance of a check or an electronic funds transfer in payment for a clean claim that is submitted electronically within twenty business days following the later of the insurer's receipt of the claim or the date on which the insurer is in receipt of all information needed and in a format required for the claim to constitute a clean claim and is in receipt of all documentation which may be requested by an insurer which is reasonably needed by the insurer: (1) to determine that such claim does not contain any material defect, error, or impropriety; or (2) to make a payment determination.
An insurer shall affix to or otherwise maintain a system for determining the date claims are received by the insurer. An insurer shall send an electronic acknowledgement of claims submitted electronically either to the provider or the provider's designated vendor for the exchange of electronic health care transactions. The acknowledgement must identify the date claims are received by the insurer. If an insurer determines that there is any defect, error, or impropriety in a claim that prevents the claim from entering the insurer's adjudication system, the insurer shall provide notice of the defect or error either to the provider or the provider's designated vendor for the exchange of electronic health care transactions within twenty business days of the submission of the claim if it was submitted electronically or within forty business days of the claim if it was submitted via paper. Nothing contained in this section is intended or may be construed to alter an insurer's ability to request clinical information reasonably necessary for the proper adjudication of the claim or for the purpose of investigating fraudulent or abusive billing practices.
Code 1976 § 38-59-230

For each clean claim with respect to which an insurer has directed the issuance of a check or the electronic funds transfer later than the applicable period specified by applicable law, the insurer shall pay interest in the same manner and at the same rate set forth by state law on the balance due on each claim computed from the twenty-first or the forty-first business day, as appropriate, depending on the type of claim, up to the date on which the insurer directs the issuance of the check or the electronic funds transfer for payment of the clean claim. At the insurer's election, interest paid pursuant to this section must be included in the claim payment check or wire transfer or must be remitted periodically, but at least quarterly, in a separate check or wire transfer along with a report detailing the claims for which interest is being paid. No insurer has an obligation to make any interest payment: (1) with respect to any clean claim if within twenty business days of the submission of an original claim submitted electronically or within forty business days of an original claim submitted via paper, a duplicate claim is submitted while the adjudication of the original claim is still in process; (2) to any participating provider who balance bills a plan member in violation of the participating provider's agreement with the insurer; (3) with respect to any time period during which a force majeure prevents the adjudication of claims; or (4) when payment is made to a plan member.
Code 1976 § 38-59-240

An insurer shall initiate any overpayment recovery efforts by sending a written notice to the provider at least thirty business days prior to engaging in the overpayment recovery efforts, other than for recovery of duplicate payments or other similar adjustments relating to: (a) claims where a provider has received payment for the same services from another payor whose obligation is primary; or (b) timing or sequence of claims for the same insured that are received by the insurer out of chronological order in which the services were performed. The written notice required by this section shall include: (a) the patient's name; (b) the service date; (c) the payment amount received by the provider; and (d) a reasonably specific explanation of the change in payment. An insurer may not initiate overpayment recovery efforts more than eighteen months after the initial payment was received by the provider; however, this time limit does not apply to the initiation of overpayment recovery efforts: (1) based upon a reasonable belief of fraud or other intentional misconduct;
(2) required by a self-insured plan; or (3) required by a state or federal government program.

Code 1976 § 38-59-250

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 September 12, 2017.