



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

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.

The following provisions relating to carriers are the obligation of Entities subject to Virginia insurance regulation and not the network. Any Entities subject to regulation by the Virginia Department of Insurance shall be subject to all applicable laws, rules and regulations in Virginia.

Appeal and Grievance Procedures

Please see Network Appeals/Grievances Policies and Procedures.

Terminations Procedures

Providers shall be notified at least 90 days prior to the date of the termination of the provider, except when a provider is terminated for cause.

VA Code Ann. § 38.2-3407.10

Except when a provider is terminated for cause, carriers must notify enrollees of the termination of a primary care provider who was furnishing services to the enrollee and the right of the enrollee to request continued coverage for services for a period of up to ninety days from the date of the primary care provider's notice of termination from the network.

VA Code Ann § 38.2-3407.10

Dispute Resolution Process

Please see Network Appeals/Grievances.

Network Participation Procedures

An insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider (as listed by statute) in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health care providers. No hospital, physician or type of provider (as listed by statute) willing to meet the terms and conditions offer to it or him shall be excluded.

VA Code Ann. § 38.2-3407

If the Participating Provider Agreement requires that a provider, as a condition of participation in the network, participate in other provider panels owned or operated by GEHA, the provider is hereby given the right to refuse to participate in one or more such other provider panels at the time the Participating Provider Agreement is executed. If a carrier that is unaffiliated with GEHA imposes participation terms with respect to such provider that differ materially in reimbursement rates or in managed care procedures, such as conducting economic profiling, from the terms agreed to by the provider in the original contract, the provider may refuse to participate with any such unaffiliated carrier. The status of a physician as a member of or as being eligible for

other existing or new provider panels shall not be adversely affected by the exercise of such right to refuse participation.

VA Code §38.2-3407.10.

Carriers must make a list of the provider panel members available to enrollees at least annually. The list may be given in a non-paper format, so long as the enrollee is given information about how to obtain a printed copy.

VA Code Ann. § 38.2-3407

The network will not deny an application for participation or terminate participation on its provider panel on the basis of gender, race, age, religion or national origin.

VA Code Ann § 38.2-3407.10

Quality of Care Procedures

No state-specific requirements.

Claims Procedures

No carrier may impose any retroactive denials of a previously paid claim unless the carrier has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. A carrier shall notify a provider at least 30 days in advance of any retroactive denial of claim.

Notwithstanding the foregoing, no carrier shall impose any retroactive denial of payment or in any way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted.

VA Code Ann. § 38.2-3407.15

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

For dental plans subject to Virginia regulation, the Participating Provider Agreement does not establish a fee or rate that a dentist or oral surgeon is required to accept for the provision of health care services, nor does it require that a dentist or oral surgeon accept the reimbursement paid as payment in full, unless the services are covered under the applicable dental plan.

VA Code Ann 38.2-3407.17

Provider-Patient Relationship

Enrollees, upon request, may continue to receive health care services for a period of up to 90 days from the date of the primary care provider's notice of termination from a carrier's provider panel, except when a provider is terminated for cause. The provider shall be permitted by the carrier to render health care services to any of the carrier's enrollees who were in an active course of treatment from the provider prior to the notice of termination; and request to continue receiving health care services from the provider. A carrier shall reimburse a provider under this subsection in accordance with the carrier's agreement with such provider existing immediately before the provider's termination of participation.

VA Code Ann. § 38.2-3407.10

Urgent Care and Emergency Services

"Emergency services" means those health care services as defined in § [38.2-3438](#) of the Code of Virginia. Covered persons shall be allowed immediate access to emergency services and access within no more than 24 hours for urgent care. Urgent care access may be provided sooner with appropriate authorization. 12VAC5-408-280

Required Content in Contract

Provider hereby agrees that in no event, including, but not limited to nonpayment by the managed care health insurance plan (MCHIP) or its health carrier or any intermediary organization, the insolvency of the health carrier, or breach of this agreement, shall Provider bill, charge, collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against subscribers or persons other than the health carrier for services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable copayments or deductibles billed in accordance with the terms of subscriber agreement for the MCHIP. Provider further agrees that (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the plan's subscribers and (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and the subscriber or persons acting on the subscriber's behalf.

VA Code Ann. § 38.2-5805

If an action to recover the claim proceeds due under an individual or group accident and sickness policy results in a judgment against an insurer, interest on the judgment at the legal rate of interest shall be paid from the date of presentation to the insurer of proof of loss to the date judgment is entered. If no action is brought, interest upon the claim proceeds paid to the policyholder, insured, claimant, or assignee entitled thereto shall be computed daily at the legal rate of interest from the date of fifteen working days from the insurer's receipt of proof of loss to the date of claim payment.

VA Code Ann § 38.2-3407.1

No dental services plan shall refuse to accept or make reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon by an insured, subscriber or plan enrollee.

VA Code Ann. § 38.2-3407.13

The Participating Provider Agreement does not require the provider to indemnify the carrier for the carrier's negligence, willful misconduct or breach of contract, if any, or to waive any right to seek legal redress against the carrier. The Participating Provider Agreement is not intended to prohibit, impede or interfere in the discussion of medical treatment options between a patient and a provider. The Agreement specifically permits and requires the Participating Provider to discuss medical treatment options with the patient.

VA Code Ann. § 38.2-3407.10

Payment of services to nonpreferred providers is based upon the applicable benefit plan and not the Participating Provider Agreement.

VA Code Ann § 38.2-3407(D)

The following provisions are required by the State of Virginia to be in every PPO contract and are therefore included in the Agreement:

1. A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:
 - a. The claim is determined by the carrier not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or
 - b. The claim was submitted fraudulently.Each carrier shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.
2. A carrier shall, within 30 days after receipt of a claim, request electronically or in writing from the person submitting the claim the information and documentation that the carrier reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 6 of this subsection. Nothing in this subsection shall require a carrier to pay a claim which is not a clean claim.
3. Any interest owing or accruing on a claim under Virginia regulation under any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter.
4. a. Every carrier shall establish and implement reasonable policies to permit any provider with which there is a provider contract (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider (or to

the type of health care services which the provider has contracted to deliver under the provider contract) for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If a carrier routinely, as a matter of policy, bundles or downcodes claims submitted by a provider, the carrier shall clearly disclose that practice in each provider contract. Further, such carrier shall either (i) disclose in its provider contracts or on its website the specific bundling and downcoding policies that the carrier reasonably expects to be applied to the provider or provider's services on a routine basis as a matter of policy or (ii) disclose in each provider contract a telephone or facsimile number or e-mail address that a provider can use to request the specific bundling and downcoding policies that the carrier reasonably expects to be applied to that provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, a carrier shall provide the requesting provider with such policies within 10 business days following the date the request is received.

- b. Every carrier shall make available to such providers within 10 business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the carrier may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.
5. Every carrier shall pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:
 - a. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; or
 - b. The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the health care services was not eligible to receive them on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status.
6. No carrier may impose any retroactive denial of a previously paid claim unless the carrier has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. Effective July 1, 2000, a carrier shall notify a provider at least 30 days in advance of any retroactive denial of a claim.
7. Notwithstanding subdivision 6 of this subsection, with respect to provider contracts entered into, amended, extended, or renewed on or after July 1, 2004, no carrier shall impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted.
8. No provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated

and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules and exhibits thereto and any policies (including those referred to in subdivision 4 of this subsection) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

9. No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract.
10. In the event that the carrier's provision of a policy required to be provided under subdivision 8 or 9 of this subsection would violate any applicable copyright law, the carrier may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.
11. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers.
12. A provider is prohibited from discriminating against any enrollee solely due to the enrollee's status as a litigant in pending litigation or a potential litigant due to being involved in a motor vehicle accident.
If the Commission has cause to believe that any provider has engaged in a pattern of potential violations of subdivision B 10, with no corrective action, the Commission may submit information to the Board of Medicine or the Commissioner of Health for action.

VA Code Ann §38.2-3407.15

CONNECTION Dental Network is not considered a carrier or a dental plan organization (DPO).

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 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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