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

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
Arizona requires that a health care services organization submit monthly to the Director of the Department of Insurance a list of all providers that have been terminated during the prior month.
A.R.S. §20-1074.

Dispute Resolution Process
Please see Network Appeals/Grievances.

Network Participation Procedures
Notwithstanding any provision of any disability insurance contract, benefits shall not be denied under the contract for any medical or surgical service performed by a holder of a license issued pursuant to title 32, chapter 7 or 11, or a registered nurse practitioner who is licensed pursuant to title 32, chapter 15, if the service performed is within the lawful scope of such person's license, and if the service is surgical, such person is a member of the staff of an accredited hospital, and if such contract would have provided benefits if such service had been performed by a holder of a license issued pursuant to title 32, chapter 13.
A.R.S. § 20-1376

Quality of Care Procedures
The Participating Provider Agreement does not contain a financial incentive plan that includes a specific payment made to or withheld from the health care professional as an inducement to deny, reduce, limit or delay medically necessary care that is covered by the contract with a subscriber or group of subscribers for a specific disease or condition.
A.R.S. § 20-822

In the event of insolvency of GEHA or Payor or other cessation of operations, the provider will continue to provide services to enrollees at the same rates and subject to the same terms and conditions established in the Participating Provider Agreement for the duration of the period after the health care services organization is declared insolvent, until the earliest of the following:
a. A determination by the court that the organization cannot provide adequate assurance it will be able to pay contract providers' claims for covered services that were rendered after the health care services organization is declared insolvent.
b. A determination by the court that the organization cannot provide adequate assurance it will be able to pay contract providers' claims for covered services that were rendered after the health care services organization is declared insolvent.

c. A determination by the court that the insolvent organization is unable to pay contract providers' claims for covered services that were rendered after the health care services organization is declared insolvent.
d. A determination by the court that continuation of the contract would constitute undue hardship to the provider.
e. A determination by the court that the health care services organization has satisfied its obligations to all enrollees under its health care plans.

Claims Procedures

A. If a person receiving dental care is a member of a prepaid dental plan and is an insured or certificate holder under an indemnity health insurance policy which provides benefits for the same treatment as the person's prepaid dental plan, the indemnity health insurance policy, if issued after the effective date of this section, shall pay benefits to its insured or certificate holder or the assignee thereof without regard to the existence of the prepaid dental plan.
B. Notwithstanding subsection A, the indemnity plan insurer is not obligated to pay any amount for a procedure covered without charge to the member of the prepaid dental plan or to pay in excess of the amount of the member's obligation under the prepaid dental plan.
C. In the event that the member's copayment obligation under the prepaid dental plan has been met, then the indemnity insurer shall remit any payments due under this section directly to its insured or certificate holder.
A.R.S. § 20-1019

Timely payment of health care providers' claims; grievances

In this chapter, unless the context otherwise requires:

1. "Adjudicate" means an insurer's decision to deny or pay a claim, in whole or in part, including the decision as to how much to pay.
2. "Clean claim" means a written or electronic claim for health care services or benefits that may be processed without obtaining additional information, including coordination of benefits information, from the health care provider, the enrollee or a third party, except in cases of fraud.
3. "Enrollee" means an individual who is enrolled under a health care insurer's policy, contract or evidence of coverage.
4. "Grievance" means any written complaint that is subject to resolution through the insurer's system that is prescribed in section 20-3102, subsection F and submitted by a health care provider and received by a health care insurer. Grievance does not include a complaint:
   (a) By a noncontracted provider regarding an insurer's decision to deny the noncontracted provider admission to the insurer's network.
   (b) About an insurer's decision to terminate a health care provider from the insurer's network.
   (c) That is the subject of a health care appeal pursuant to chapter 15, article 2 of this title.
5. "Health care insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, prepaid dental plan organization, hospital service corporation, medical service corporation, dental service corporation, optometric service corporation, or hospital, medical, dental and optometric service corporation.

A. A health care insurer shall adjudicate any clean claim from a contracted or noncontracted health care provider relating to health care insurance coverage within thirty days after the health care insurer receives the clean claim or within the time period specified by contract. Unless there is an express written contract between the health care insurer and the health care provider that specifies the period in which approved claims shall be paid, the health care insurer shall pay the approved portion of any clean claim within thirty days after the claim is adjudicated. If the claim is not paid within the thirty day period or within the time period specified in the contract, the health care insurer shall pay interest on the claim at a rate that is equal to the legal rate. Interest shall be calculated beginning on the date that the payment to the health care provider is due.

B. If the claim is not a clean claim the health care insurer requires additional information to adjudicate the claim, the health care insurer shall send a written request for additional information to the contracted or noncontracted health care provider, enrollee or third party within thirty days after the health care insurer receives the claim. The health care insurer shall notify the contracted or noncontracted health care provider of all of the specific reasons for the delay in adjudicating the claim. The health care insurer shall record the date it receives the additional information and shall adjudicate the claim within thirty days after receiving all the additional information. The health care insurer shall also pay the approved portion of the adjudicated claim within the same thirty day period allowed for adjudication or within the time period specified in the provider's contract. If the health care insurer fails to pay the claim as prescribed in this subsection, the health care insurer shall pay interest on the claim in the manner prescribed in subsection A.
C. A health care insurer shall not delay the payment of clean claims to a contracted or noncontracted provider or pay less than the amount agreed to by contract to a contracted health care provider without reasonable justification.
D. A health care insurer shall not request information from a contracted or noncontracted health care provider that does not apply to the medical condition at issue for the purposes of adjudicating a clean claim.
E. A health care insurer shall not request a contracted or noncontracted health care provider to resubmit claim information that the contracted or noncontracted health care provider can document it has already provided to the health care insurer unless the health care insurer provides a reasonable justification for the request and the purpose of the request is not to delay the payment of the claim.
F. A health care insurer shall establish an internal system for resolving payment disputes and other contractual grievances with health care providers. The director may review the health care insurer's internal system for resolving payment disputes and other contractual grievances with health care providers. Each health care insurer shall maintain records of health care provider grievances. Semiannually each health care insurer shall provide the director with a summary of all records of health care provider grievances received during the prior six months. The records shall include at least the following information:
    1. The name and any identification number of the health care provider who filed a grievance.
    2. The type of grievance.
    3. The date the insurer received the grievance.
    4. The date the grievance was resolved.
G. On review of the records, if the director finds a significant number of grievances that have not been resolved, the director may examine the health care insurer.
H. This section does not require or authorize the director to adjudicate the individual contracts or claims between health care insurers and health care providers.
I. Except in cases of fraud, a health care insurer or contracted or noncontracted health care provider shall not adjust or request adjustment of the payment or denial of a claim more than one year after the health care insurer has paid or denied that claim. If the health care insurer and health care provider agree through contract on a length of time to adjust or request adjustment of the payment of a claim, the health care insurer and health care provider must have the same length of time to adjust or request adjustment of the payment of the claim. If a claim is adjusted, neither the health care insurer nor the health care provider shall owe interest on the overpayment or underpayment resulting from the adjustment, as long as the adjusted payment is made or recoupment taken within thirty days of the date of the claim adjustment.
J. This chapter does not apply to licensed health care providers who are salaried employees of a health care insurer.
K. If a contracted or noncontracted health care provider files a claim or grievance with a health care insurer that has changed the location where providers were instructed to file claims or grievances, the health care insurer shall, for ninety days following the change:
    1. Consider a claim or grievance delivered to the original location properly received.
    2. Following receipt of a claim or grievance at the original location, promptly notify the health care provider of the change of address through mailed written notice or some other written communication.

A.R.S. §20-3101 and A.R.S. §20-3102

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>
Hospital service corporations, medical service corporations, dental service corporations and optometric service corporations may not discriminate against podiatrists or dentists that perform medical or surgical services as long as the services performed is within the lawful scope of the person's license.
A.R.S. §20-822

Enrollees of a hospital, medical, dental and/or optometric service corporation ("service corporation") may choose either an optometrist or a physician to provide covered eye care services, if these services are otherwise covered by the insurance contract. If a service corporation covers the services of a chiropractor, a psychologist and/or a nurse practitioner or certified registered nurse, a service corporation cannot deny payment for services provided by a chiropractor, psychologists or nurse practitioner rather than a physician if such service is within the scope of practice for that provider. Enrollees also have freedom of choice between a general hospital or a psychiatric hospital for covered psychiatric, drug abuse or alcoholism treatments.
A.R.S. §20-841

While a service corporation can restrict enrollees to a particular network of providers, a service corporation cannot influence an enrollee in the free choice of a hospital, physician, dentist or optometrist.
A.R.S. §20-833

No insurer can restrict or prohibit, by means of policy or contract, a provider's good faith communication with patients concern the patient's health care or medical needs, treatment options, health care risks or benefits. A.R.S. §20-1061

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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