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

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 Colorado insurance regulation and not the network. Any Entities subject to regulation by the Colorado Department of Insurance shall be subject to all applicable laws, rules and regulations in Colorado.

Appeal and Grievance Procedures
Please see Network Appeals/Grievances Policies and Procedures.
To obtain information about appeals procedures for payors that use the CONNECTION Dental Network, please go to: http://www.connectiondental.com/payor_client_listing/Colorado.html.

Terminations Procedures
A carrier and a Participating Provider shall provide at least sixty days written notice to each other before terminating a Participating Provider Agreement without cause. The carrier shall make a good faith effort to provide written notice of termination within fifteen working days after receipt of or issuance of a notice of termination to all Covered Persons that are patients seen on a regular basis by the provider whose contract is terminating, regardless of whether the termination was for cause or without cause. Where a contract termination involves a primary care provider, all Covered Persons that are patients of that primary care provider shall also be notified. Within five working days after the date that the provider either gives or receives notice of termination, the provider shall supply the carrier with a list of those patients of the provider that are covered by a Plan of the carrier.
C.R.S.A. §10-16-705(7)
(See also Required Content in Contract below.)

A carrier who discontinues coverage completely from a market segment and otherwise remains in the market must continue to provide coverage through the first renewal period not to exceed 12 months after the notice provided has expired.
C.R.S.A. §10-16-201.5.

Each managed care Plan shall allow covered persons to continue receiving care for 60 days from the date a Participating Provider is terminated by the Plan without cause when proper notice has not been provided to the covered person.
C.R.S.A. §10-16-705

In the circumstance that coverage is terminated for any reason other than nonpayment of the premium, fraud, or abuse, every managed care Plan shall provide for continued care for Covered Persons being treated at an inpatient facility until the patient is discharged.
C.R.S.A. §10-16-705(4)(a)-(c)

Dispute Resolution Process
A carrier shall establish procedures for the resolution of administrative, payment, or other disputes between providers and the carrier.
C.R.S.A. §10-16-705(13)
Please see Network Appeals/Grievances.

Network Participation Procedures
In counties of the state that are neither part of a metropolitan statistical area nor a primary statistical area, a carrier offering a health benefit plan shall not discriminate between a physician and an advance practice nurse not practicing under the direction of a physician when establishing reimbursement rates for covered services that could be provided by an advance practice nurse or a physician.
C.R.S.A. § 10-16-125

A carrier providing a managed care plan must maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay. Covered persons must have access to health care services 24 hours a day, 7 days per week in case of emergency. Reasonable criteria used by the carrier may determine whether the network is sufficient. Criteria may include, but is not limited to: (a) provider-covered person ratios by specialty; (b) primary care provider-covered person ratios; (c) geographic accessibility; (d) waiting times for appointments with participating providers; (e) hours of operation; (f) the volume of technological and specialty services available to serve the needs of covered persons requiring covered technologically advanced or specialty care; and (g) an adequate number of acute care hospital services within a reasonable travel time, or both.
C.R.S.A. §10-16-704

If the carrier has no participating providers to provide a covered benefit, the carrier must arrange for a referral to a provider with the necessary expertise and ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers.
C.R.S.A. §10-16-704(2)(a)

A provider who is not licensed to furnish health care services in the State of Colorado and who participates in a network shall be licensed in the state in which the provider practices and shall meet minimum statutory and regulatory standards for that professional practice applicable in Colorado.
C.R.S.A. §10-16-705(16)

Health coverage plans and managed care plans that provide coverage of eye care services must allow each eye care provider on a health coverage plan or managed care plan panel to furnish covered eye care services to covered persons without discrimination between classes of eye care providers, and to provide such services as permitted by their license.
C.R.S.A. § 10-16-107

Quality of Care Procedures
No state-specific requirements.

Claims Procedures
To obtain information about the effects that edits might have on a claim a participating provider submits for payment to payors that use the CONNECTION Dental Network, please go to: http://www.connectiondental.com/payor_client_listing/Colorado.html.

When a Covered Person receives services or treatment in accordance with plan provisions at a network facility, the benefit level for all Covered Services and treatment received through the facility shall be the in-

network benefit. Covered Services or treatment rendered at a network facility, including covered ancillary services or treatment rendered by an out-of-network provider performing the services or treatment at a network facility, shall be covered at no greater cost to the Covered Person than if the services or treatment were obtained from an in-network provider.
C.R.S.A. §10-16-704(3)

The sole responsibility for obtaining any necessary preauthorization rests with the Participating Provider that recommends or orders said services, treatments, or procedures, not with the Covered Person.
C.R.S.A. §10-16-705(14)(a)

A Covered Person shall be allowed to receive a standing referral, as defined by state law, for medically necessary treatment, to a specialist or specialized treatment center participating in the carrier's network or participating in a subdivision or subgrouping of the carrier's network if the subdivision or subgrouping demonstrates network adequacy pursuant to state law. The primary care provider for the Covered Person, in consultation with the specialist and Covered Person, shall determine that the Covered Person needs ongoing care from the specialist in order to make the standing referral. A time period for the standing referral of up to one year, or a longer period of time if authorized by the carrier or any entity that contracts with the carrier, shall be determined by the primary care provider in consultation with the specialist or specialized treatment center. The specialist or specialized treatment center shall refer the Covered Person back to the primary care provider for primary care. To be reimbursed by the carrier or entity contracting with a carrier, treatment provided by the specialist shall be for a Covered Person and must comply with provisions contained in the Covered Peron's certificate or policy. The primary care physician shall record the reason, diagnosis, or treatment plan necessitating the standing referral.
C.R.S.A. §10-16-705(14)(b)

All claims paid by a carrier shall be considered final unless adjustments are made pursuant to state law. Adjustments to claims by the Participating Provider or a carrier shall be made within twelve months of the date of the original explanation of benefits. Adjustments to claims related to coordination of benefits with federally funded health benefit plans Medicare and Medicaid, shall be made within thirty-six months after the date of service. A carrier subject to Colorado insurance regulation shall not retroactively adjust a claim based on eligibility if the provider received verification of eligibility within two business days prior to the delivery of services unless (i) a carrier reports to a provider that eligibility is contingent on payment of premium; or (ii) a provision of benefits is a required policy provision pursuant to state law, or (iii) a carrier has reported fraud or abuse committed by a provider pursuant to state law. A carrier may require an enrollee to reimburse the carrier due to ineligibility, fraud or material misrepresentation. Any adjustment made by the carrier that recovers carrier overpayments to a provider shall include a written notice to the provider and shall contain a complete and specific explanation of such adjustments and information regarding the carrier's provider dispute resolution procedures. Such notice shall be made to both the provider and the enrollee to the extent that the adjustment will result in enrollee liability. Notice to the enrollee shall include information regarding the carrier's enrollee appeals procedure rather than the carrier's provider dispute resolution procedures. For claims adjusted by the carrier due to coordination of benefits, upon request by the provider, the carrier shall provide all available information regarding the party responsible for payment of the claim to the provider. The carrier shall also provide notice to the provider with the explanation of benefits regarding the availability of the information related to the party responsible for payment of the claim.
C.R.S.A. §10-16-704(4.5)

If a health benefit Plan provides coverage for a second opinion, the carrier and any entity that contracts with the carrier shall disclose the availability of the second opinion along with the health benefit description form.
C.R.S.A. §10-16-705(9.5)

A carrier shall notify the Participating Providers of their obligations, if any, to collect applicable coinsurance, copayments, or deductibles from Covered Persons pursuant to the evidence of coverage or of the providers' obligations, if any, to notify Covered Persons of their personal financial obligations for noncovered services.
C.R.S.A. §10-16-705(10)

A carrier shall establish one or more mechanisms by which the Participating Providers may determine, at the time services are provided, whether or not a person is covered by the carrier. If a carrier maintains only one mechanism, such mechanism shall not require electronic access.
C.R.S.A. §10-16-705(12)(a)

Each carrier, regardless of the mechanism used, shall (i) submit written confirmation to a provider within two business days; or (2) issue a verification code that the Participating Provider may use as proof of verification with respect to adjustments of claims based on verification of eligibility. If a carrier provides electronic access as a mechanism to verify coverage, the carrier may, in lieu of the requirement to issue a verification code through such mechanism, accept as proof of verification a dated screen print from the carrier's electronic verification mechanism demonstrating that the member is eligible based on payment of premium or that the carrier is not required to pay for services pursuant to a premium not being received. In lieu of the requirements of this paragraph, a carrier may institute a policy providing that adjustments to claims related to eligibility will be made only if the carrier can demonstrate that the member did not appear as eligible on any of the carrier's verification mechanisms on the date of service.
C.R.S.A. §10-16-705(12)(b) and (c)

A carrier shall notify Participating Providers of the mechanisms available to verify eligibility and the carrier's intent with respect to the requirements of the eligibility verification process.
C.R.S.A. §10-16-705(12)(d)

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

Providers are prohibited from discriminating, with respect to the provision of medically necessary covered benefits, against Covered Persons that are participants in a publicly financed program.
C.R.S.A. §10-16-705(9)

A carrier shall not penalize a provider because the Participating Provider, in good faith, reports to state or federal authorities any act or practice by the carrier that jeopardizes patient health or welfare, or because the Participating Provider discusses the financial incentives or financial arrangements between the provider and the managed care Plan.
C.R.S.A. §10-16-705(11)

A carrier or entity that contracts with the carrier shall not penalize a primary care provider who makes a standing referral of a Covered Person to a specialist, nor shall the specialist treating the Covered Person be penalized, with actions that include but are not limited to disincentives or disaffiliation, except in instances of insurance fraud.
C.R.S.A. §10-16-705(11.5)

Required Content in Contract

Upon completion of processing of a claim, the Person or Entity shall provide information to the Health Care Provider stating how the claim was adjudicated and the responsibility for any outstanding balance of any party other than the Person or Entity.
C.R.S.A. §25-37-101(5)

If a change to the Contract is administrative only and is not a Material Change, the change shall be effective upon at least fifteen days' notice to the Health Care Provider. All other notices shall be provided pursuant to the Contract.
C.R.S.A. §25-37-101(2)(e)(II)

A Material Change to a Contract shall occur only if the Person or Entity provides in writing to the Health Care Provider the proposed change and gives ninety days' notice before the effective date of the change. The writing shall be conspicuously entitled "Notice of Material Change to Contract".
C.R.S.A. §25-37-101(7)(a)

If the Health Care Provider objects in writing to the Material Change within fifteen days and there is no resolution of the objection, either party may terminate the Contract upon written notice of termination provided to the other party not later than sixty days before the effective date of the Material Change.
C.R.S.A. §25-37-101(7)(b)

If the Health Care Provider does not object to the Material Change pursuant to this subsection, the change shall be effective as specified in the notice of Material Change to the Contract.
C.R.S.A. §25-37-101(7)(c)

If a Material Change is the addition of a new Category of Coverage and the Health Care Provider objects, the addition shall not be effective as to the Health Care Provider, and the objection shall not be a basis upon which the Person or Entity may terminate the Contract.
C.R.S.A. §25-37-101(7)(d)

A Contract may be modified by operation of law as required by any applicable state or federal law or regulation, and the Person or Entity may disclose this change by any reasonable means.
C.R.S.A. §25-37-101(8)

The individuals receiving services under the Health Care Provider's Contract must be provided with appropriate identification stating where claims should be sent and where inquiries should be directed.
C.R.S.A. §25-37-101(10)(d)

Any third party accessing the Health Care Provider's services through the Health Care Provider's Contract is obligated to comply with all applicable terms and conditions of the Contract; except that a self-funded plan receiving administrative services from the Person or Entity or its affiliates shall be solely responsible for payment to the provider.
C.R.S.A. §25-37-101(10)(e)

Except as permitted by law, a Person or Entity shall not require, as a condition of contracting, that a Health Care Provider waive or forego any right or benefit to which the Health Care Provider may be entitled under state or federal law or regulation that provides legal protections to a person solely based on the person's status as a Health Care Provider providing services in this state.
C.R.S.A. §25-37-101(11)

Upon sixty days' notice, a Health Care Provider may decline to provide service pursuant to a Contract to new patients covered by the Person or Entity. The notice shall state the reason or reasons for this action. For the purposes of this subsection, "new patients" means those patients who have not received services from the Health Care Provider in the immediately preceding three years. A patient shall not become a "new patient" solely by changing coverage from one Person or Entity to another Person or Entity.
C.R.S.A. §25-37-101(12)

A term for compensation or payment shall not survive the termination of a Contract, except for a continuation of coverage required by law or with the agreement of the Health Care Provider.
C.R.S.A. §25-37-101(13)

A Contract shall not preclude its use or disclosure to a third party for the purpose of enforcing the provisions of this Article or enforcing other state or federal law. The third party shall be bound by the confidentiality requirements set forth in the Contract or otherwise.
C.R.S.A. §25-37-101(14)

In addition to certain provisions of this section, a Contract with a duration of less than two years shall provide to each party a right to terminate the Contract without cause, which termination shall occur with at least ninety days' written notice. For Contracts with a duration of two or more years, termination without cause may be as specified in the Contract.
C.R.S.A. §25-37-101(15)

A carrier shall maintain a mechanism by which providers can access information on the covered health services for which the provider is responsible, including any limitations or conditions on services.
C.R.S.A. §10-16-705(2)

Covered Persons shall, in no circumstances, be liable for money owed to Participating Providers by the Plan and in no event shall a Participating Provider collect or attempt to collect from a Covered Person any money owed to a provider by a carrier. Nothing in this section shall prohibit a Participating Provider from collecting

coinsurance, deductibles, or copayments as specifically provided in the Covered Person's contract with the managed care Plan.
C.R.S.A. §10-16-705(3)

A carrier shall remain responsible for the payment of all Participating Providers that have provided covered health care services to Covered Persons of the carrier in the event of nonpayment by, or insolvency of, carrier's contractors, subcontractors or intermediaries. A carrier may be granted approval by the commissioner for use of an alternative mechanism to ensure that all Participating Providers receive payment due.
C.R.S.A. §10-16-705(5)(a) and (b)

A carrier shall notify Participating Providers of the providers' responsibilities with respect to the carrier's applicable administrative policies and programs, including but not limited to, payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable federal or state programs.
C.R.S.A. §10-16-705(6)

The rights and responsibilities under a contract between a carrier and a Participating Provider shall not be assigned or delegated by the provider without the prior written consent of the carrier, and any subcontracts shall comply with the requirements of state law.
C.R.S.A. §10-16-705(8)

A provider cannot be subjected to financial disincentives based upon the number of referrals made to Participating Providers in the health Plan for covered benefits, so long as the provider making the referral adheres to the carrier's or the carrier's intermediary's utilization review policies and procedures. C.R.S.A. §10-16-121(1)(d

> No individual Participating Provider or group of Participating Providers covered by the Participating Provider Agreement shall be prohibited from protesting or expressing disagreement with a medical decision, medical policy or medical practice of a carrier or an entity representing or working for the carrier (e.g., a utilization review company). Carrier or an entity representing or working for the carrier shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of an individual Participating Provider or group of Participating Providers covered by the Participating Provider Agreement.
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> The carrier may not take an adverse action against a provider because the provider expresses disagreement with a carrier's decision to deny or limit benefits to a covered person or because the provider assists the covered person to seek reconsideration of the carrier's decision or because a provider discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the plan or not, policy provisions of a plan, or a provider's personal recommendation regarding selection of a health plan based on the provider's personal knowledge of the health needs of such patients. CRS 10-16-121(1)(b)(I).

The carrier shall not terminate a contract with a Participating Provider because the Participating Provider expresses disagreement with a carrier's decision to deny or limit benefits to a Covered Person or because a Participating Provider assists a Covered Person to seek reconsideration of the carrier's decision or because a Participating Provider discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by a Plan or not, policy provisions of a Plan, or a Participating Provider's personal recommendation regarding selection of a health Plan based on the Participating Provider's personal knowledge of the health needs of such patients.

C.R.S.A. §10-16-121(1) and Regulation 4-2-15

A contract between a carrier and a Participating Provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care Plan or Colorado Statutes/Title 10 Insurance/Health Care Coverage/Article 16 Health Care Coverage/Part 7 Consumer Protection Standards Act for the Operation of Managed Care Plans/10-16-705/Requirements for Carriers and Participating Providers. C.R.S.A. §10-16-705(15)

> The carrier may not take an adverse action against a provider because the provider, acting in good faith who:
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> Communicates with a public official or other person concerning public policy issues related to health care items or services;
> Files a complaint, makes a report, or comments to an appropriate governmental body regarding actions, policies, or practices of the carrier the provider believes might negatively affect the quality of, or access to, patient care;
> Provides testimony, evidence, opinion, or any other public activity in any forum concerning a violation or possible violation of any provision of this section;
> Reports what the provider believes to be a violation of law to an appropriate authority; or
> Participates in any investigation into a violation or possible violation of any provision of this section. CRS 10-16-121(1)(b)(II).
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> The provider shall not be subjected to financial disincentives based on the number of referrals made to participating providers in the health plan for covered benefits so long as the provider making the referral adheres to the carrier's or the carrier's intermediary's utilization review policies and procedures. CRS 10-16-121(1)(d).
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> The carrier shall not take an adverse action against a provider or provide financial incentives or subject the provider to financial disincentives based solely on a patient satisfaction survey or other method of obtaining patient feedback relating to the patient's satisfaction with pain treatment.

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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