DEPARTMENT OF
Managed
Health Care

Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

320 West 4th Street, Suite 880
Los Angeles, CA 90013-2344
213-576-7618 voice
213-576-7186 fax
jlarsen@dmhc.ca.gov e-mail

November 15, 2010

Via USPS and eFile

Dr. Amir Neshat
President and Chief Executive Officer
LIBERTY DENTAL PLAN OF CALIFORNIA, INC.
Dba: Personal Dental Services
3200 El Camino Real, Suite 290
Irvine, CA 92602

FINAL REPORT OF ROUTINE EXAMINATION OF LIBERTY DENTAL PLAN OF CALIFORNIA, INC.

Dear Dr. Neshat:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of Liberty Dental Plan of California (the "Plan"), conducted by the Department of Managed Health Care (the Department"), pursuant to Section 1382(a) of the Knox-Keene Health Care Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on June 25, 2010. The Department accepted the Plan's electronically filed response on August 9, 2010, August 31, 2010, September 9, 2010, October 4, 2010 and November 2, 2010, as well as email response on August 19, 2010 (collectively the "responses").

This Final Report includes a description of the compliance efforts included in the Plan's responses, in accordance with Section 1382(c).

Section 1382(d) states "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and electronically file modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within ten (10) days whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and electronically file copies of those portions of the Plan's

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

response exclusive of information held confidential pursuant to Section 1382(c), no later than ten (10) days from the date of the Plan's receipt of this letter.

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the report or wishes to modify any information provided to the Department in its response, please provide the electronically filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter through the eFiling web portal. Please file this addendum electronically via the Department's eFiling web portal https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "File Documents".
- From the File Documents Menu for:
  1) File Type; select "Amendment to prior filing";
  2) Original Filing, select the **"**Filing No. 20091908**"** assigned by the Department; and
  3) Click "create filing".
- From the Original Filing Details Menu, click "Upload Amendments"; select # of documents; select document type: ""Plan addendum response to Final Report (FE5)"; then "Select File" and click "Upload".
- Upload all documents then upload a cover letter as Exhibit E-1 that references to your response.
- After upload, then select "Complete Amendment", complete "Execution" and then click "complete filing".

As noted in the attached Final Report, the Plan responded to the deficiencies raised in the Preliminary Report issued by the Department on June 25, 2010. However, the Plan is required to submit a response to the Department for a request for additional corrective action contained within the attached Final Report, within 30 days after receipt of the report, pursuant to Rule 1300.82.

Please file the Plan's response electronically via the Department's eFiling web portal https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "File Documents".
- From the File Documents Menu for:
  1) File Type; select "Amendment to prior filing";
  2) Original Filing, select the "Filing No. 20091908" assigned by the Department; and
  3) Click "create filing".
- From the Original Filing Details Menu, click "Upload Amendments"; select # of documents; select document type: "Plan's Response to Final Report (FE10)"; then "Select File" and click "Upload".
- Upload all documents then upload a cover letter as Exhibit E-1 that references to your response.

- After upload, then select "Complete Amendment", complete "Execution" and then click "complete filing".

Questions or problems related to the electronic transmission of the response should be directed to Rita Ultreras at (916) 322-5393 or email at rultreras@dmhc.ca.gov. You may also email inquiries to wpso@dmhc.ca.gov

The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter through the eFiling system. The report will be located at the Department's web site at www.dmhc.ca.gov.

If there are any questions regarding this report, please contact me.

Sincerely,

ORIGINAL SIGNED BY

JOAN LARSEN
Supervising Examiner
Office of Health Plan Oversight
Division of Financial Oversight

Cc: Maureen McKennan, Assistant Deputy Director, Office of Health Plan Oversight
Mike Cleary, Chief, Division of Financial Oversight
Kim Malme, Senior Examiner, Division of Financial Oversight
Ana Kyumba, Examiner, Division of Financial Oversight
Suhag Patel, Examiner, Division of Financial Oversight
Crystal McElroy, Staff Counsel, Counsel, Division of Licensing
Marcy Gallagher, Chief, Division of Plan Surveys

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

DIVISION OF FINANCIAL OVERSIGHT

LIBERTY DENTAL PLAN OF CALIFORNIA, INC.

FILE NO. 933-0052

DATE OF FINAL REPORT: NOVEMBER 15, 2010

SUPERVISING EXAMINER: Joan Larsen

EXAMINER-IN-CHARGE: Kim Malme

FINANCIAL EXAMINERS:

Ana Kyumba, Thomas Roedl, and Suhag Patel

BACKGROUND INFORMATION FOR LIBERTY DENTAL PLAN OF CALIFORNIA, INC.

Date Plan Licensed:	Liberty Dental Plan of California, Inc. acquired all the assets of Preferred Health Plans, Inc. [d.b.a. Preferred Dental Plan] on December 27, 2001. Preferred Health Plans, Inc. was licensed August 3, 1978. August 3, 1978.
Organizational Structure:	Liberty Dental Plan of California Inc. (the "Plan") is a for-profit dental benefit corporation. The Plan has an affiliate known as Liberty Plan Corporation ("CORP"). CORP has contracts with other health plans and entities located outside of California. The Plan has an Administrative Service Agreement with CORP to provide administrative services to these out of State entities.
Type of Plan:	The Plan is a specialized health care service plan which arranges for dental services for both commercial and Denti-Cal enrollees.
Provider Network:	The Plan contracts with independent dentists and various specialists. The general dentists are paid on a capitated basis. Non-contracted providers are paid on a fee-for-service basis or discounted Denti-Cal rates. The Plan also provides a commercial referral product.
Plan Enrollment:	The Plan reported 398,132 enrollees as of September 30, 2009, with 167,174 in commercial, 102,334 in Medi-Cal Risk, 92,799 in Healthy Families and 35,825 in Medicare Risk.
Service Area:	The Plan's service area consists of the major counties within California.
Date of last Final Routine Examination Report:	August 25, 2006.

FINAL REPORT OF A ROUTINE EXAMINATION OF LIBERTY DENTAL PLAN OF CALIFORNIA, INC.

This is the Final Report of a routine examination of the fiscal and administrative affairs of Liberty Dental Plan of California, Inc ("the Plan") for the quarter ended September 30, 2009. The examination was conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382 of the Knox-Keene Health Care Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on June 25, 2010. The Department accepted the Plan's electronically filed response on August 9, 2010, August 31, 2010, September 9, 2010, October 4, 2010 and November 2, 2010, as well as email response on August 19, 2010 (collectively the "responses").

This Final Report includes a description of the compliance efforts included in the Plan's responses to the Preliminary Report, in accordance with Section 1382(c). The Plan's response is noted in *italics*.

We examined the financial report filed with the Department for the quarter ended September 30, 2009, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions.

Our findings are presented in this report as follows:

Section I.	Financial Statements
Section II.	Calculation of Tangible Net Equity
Section III.	Compliance Issues
Section IV.	Non Routine Examination

Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contained within this report, within 30 days after receipt of this report.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

SECTION I. FINANCIAL REPORT

Our examination did not result in any adjustments or reclassifications to the Plan's quarter ended September 30, 2009 financial statements filed with the Department. A copy of the Plan's financial statements can be viewed at the Department's website by typing the link http://wpso.dmhc.ca.gov/fe/search.asp and selecting Liberty Dental Plan of California, Inc. on the first drop down menu.

No response required to this Section.

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth as reported by the Plan as of Quarter Ended September 30, 2009	$ 2,360,676
Less: Unsecured Affiliate Receivable	21,358
Intangible Assets and Goodwill-Net	245,985
Tangible Net Equity	$ 2,093,333
Required TNE	613,907
TNE Excess per Examination as of Quarter Ended September 30, 2009	$ 1,479,426

The Plan is in compliance with the TNE requirement of Section 1376 and Rule 1300.76 as of September 30, 2009.

No response required to this Section.

SECTION III. COMPLIANCE ISSUES

A. CLAIM SETTLEMENT PRACTICES – "UNFAIR PAYMENT PATTERN"

Section 1371.37 prohibits a health care service plan from engaging in an unfair payment pattern and sets forth the meaning of an "unfair payment pattern" the processing of a complete and accurate claims that result in payment delays; the reduction in the amount of payment or denying complete and accurate claims; failing on a repeated basis to pay uncontested portions of a claim with the required timeframes of Section 1371, 1371.1 or 1371.35; and, failing on a repeated basis to automatically include the interest due on claims.

Rule 1300.71 (a)(8) defines a "demonstrable and unjust payment pattern" or "unfair payment pattern" as any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims.

The Department's examination found that the Plan is engaging in an "unfair payment pattern" as summarized in the following table:

Deficiency	Type of Sample	Total Sample Population	Total Reviewed in the Sample	Number of Deficiencies Found	% of Compliance
Failure to reimburse claim accurately, including paying interest and penalty. Includes 4 claims that were originally denied incorrectly.	Late Paid Claims	90	25	5	80%

On June 15, 2010, the Plan filed the following acknowledgement with the Department in response to deficiencies found in its claims settlement practices during the Department's examination:

"Liberty Dental Plan of California acknowledges that it has deficiencies in its claims payment procedures, operations and related finalization processes which have resulted in the incorrect payment of interest and penalties on an unacceptable number of late claim payments. Liberty Dental Plan of California has requested that the Department discontinue its testing for interest and penalty payments on late claim payments in light of Liberty Dental Plan of California's acknowledgement of these deficiencies and the Plan acknowledges that the Department agreed to do so in reliance upon this document. Liberty Dental Plan of California further acknowledges its commitment to correcting these deficiencies in accordance with requirements stated in all Department reports, including examination reports, issued in connection with this routine examination.

Liberty Dental Plan of California acknowledges the Department's findings regarding Health and Safety Code sections 1371 and 1371.37; and California Code of Regulations, Title 28, sections 1300.71(a)(8)(K), 1300.71 (i) and 1300.71 (j). For purposes of assessing a penalty, Liberty Dental Plan of California agrees that the deficiency rate of 20 percent found in the sample of 25 late claim payments is conclusive evidence of the percentage of deficiencies present in the entire universe of late claim payments adjudicated during the time frame defined by the Department's examination, specifically May 1, 2009 through July 31, 2009."

The following details the unfair payment practices by the Plan found during the Department's examination:

INTEREST ON LATE CLAIM PAYMENTS

Section 1371 requires a specialized health care service plan to reimburse uncontested claims no later than 30 working days after receipt of the claim. Section 1371 and Rule 1300.71(i) (2) also require that if an uncontested claim is not reimbursed within 30 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30 working day period. Section 1371 and Rule 1300.71 (j) requires a plan that fails to automatically include the interest due on a late claim payment to pay the provider $10 for that late claim in addition to any amounts due pursuant to section 1300.71(i).

Rule 1300.71 (a)(8)(K) describes one unfair payment pattern as the failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

Our examination disclosed that the Plan either underpaid or failed to pay interest on 5 out of 25 late paid claims reviewed (a non-compliance rate of 20 percent).

The Preliminary Report required the Plan to submit a detailed Corrective Action Plan ("CAP") to bring the Plan into compliance with the above Section and Rule that should include, but not be limited to, the following:

a. Identification of all late paid claims processed from March 1, 2006 (date after last examination balance sheet date) to the date corrective action was implemented where interest was not paid or interest was underpaid. The Plan was to specifically state the date corrective action was implemented.

b. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in paragraph "a" above. This evidence was to include an electronic data file/schedule (Excel or dBase) that identifies the following:

- Claim number
- Date of service
- Date original claim received
- Date new information received (date claim was complete)
- Total billed
- Amount original payment
- Date of original payment
- Amount of adjustment paid
- Check number for adjusted payment
- Date adjustment paid
- Amount of original interest paid
- Date original interest paid
- Number of days for calculating interest (w/formula)
- Amount of additional interest paid (w/ formula)
- Date additional interest paid

- Amount of penalty paid
- Date penalty paid
- Check number for interest and penalty
- Provider name

The data file is to provide the detail of all claims remediated; and, to include the total number of claims and the total additional interest and penalty paid, as a result of remediation.

c. Policies and procedures implemented to ensure that the payment of claims includes interest and penalty, and is in compliance with the above Section and Rules.

d. Date the policies and procedures were implemented, the management position responsible for overseeing the CAP, and a description of the monitoring system implemented to ensure ongoing compliance.

The Preliminary Report provided that if the process of identification and payment is not completed at the time the Plan files its response to the Preliminary Report, then the CAP must state the timeframe in which the process will be completed, and provide a matrix with the action steps and timelines for completion of each step. In addition, the Plan was required to submit monthly status reports until the CAP is completed**.**

This violation was referred to the Office of Enforcement for appropriate administrative action.

The Plan responded that they identified a system processing issue with claim resubmissions where interest was not paid correctly under specific scenarios. The Plan represented that the issue was fully corrected and implemented as of June 30, 2010. The Plan stated that it is now able to identify all late claims and automatically include interest with claim payment pursuant to Section 1371.

The Plan represented that on July 27, 2010 they identified 4,878 late claims paid from March 1, 2006 until June 30, 2010 which interest should be paid. The Plan provided monthly status reports on September 9, 2010 and October 1, 2010 that stated validation of interest and penalty was done by August 26, 2010, with check to providers issued during August and September 2010. The Plan reported that 4,145 claims were remediated for a total of $52,139 ($41,450 in penalty and $10,689 in interest).

The Plan stated that its procedure on handling late claims was updated to ensure proper identification of late claims and timely payment of interest and penalty. The Plan included a Policy and Procedure for Claims Settlement Practice and Provider Dispute Resolution Mechanism implemented as of June 30, 2010, which requires a weekly verification process to be completed in order to assure accurate interest application.

The Plan stated that the Chief Financial Officer will be responsible for ensuring that the required actions, as well as the Policies and Procedures, will be implemented.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required.

B. OTHER CLAIM SETTLEMENT DEFICIENCIES

The following details other claim settlement deficiencies found during the Department's examination:

1. ELIGIBILITY UPDATES

Section 1371 requires a specialized health care service plan to reimburse uncontested claims no later than 30 working days after receipt of the claim. Section 1371 and Rule 1300.71(i) (2) also require that if an uncontested claim is not reimbursed within 30 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30 working day period. Section 1371 and Rule 1300.71 (j) requires a plan that fails to automatically include the interest due on a late claim payment to pay the provider $10 for that late claim in addition to any amounts due pursuant to section 1300.71(i).

Our examination disclosed that in 4 of the 25 late paid claims the member's eligibility status had not been updated in a timely manner or was not matched to eligibility records based on date of service. As a result, the original claim was automatically denied as "not eligible", due to eligibility not matched to the date of service. Upon resubmission by the provider the eligibility was researched and validated with date of service by the plan, but interest was not paid back to the original date of receipt of the claim.

The Preliminary Report required the Plan to submit a description of its process to ensure that eligibility is updated in a timely manner and that eligibility is matched based on the date of service. The Plan is also required to submit evidence that a sweep was performed to determine that all claims denied due to eligibility were remediated with claim payment and appropriate interest and penalty for the time period of March 1, 2006 to the date corrective action was implemented. The Plan is directed to provide evidence as required above in paragraph A., subparagraph b. The Plan is to specifically state the date corrective action was implemented. The Plan is also required to provide the management position(s) responsible to ensure continued compliance with the above Section and Rules.

The Plan responded that they disagree with the eligibility deficiency stating that member's eligibility status was not updated timely. The Plan stated that eligibility files are processed in a timely manner according to the Policy and Procedures for Eligibility included in the response. Members in four of the samples had multiple coverage time slices and the Plan's IS system was picking up incorrect time slice during the auto-adjudication process. The Plan stated that it's internal audit process found that this issue affected only Health Net Healthy Families groups that had initial effective date of July 1, 2008. The problem occurred in July of 2009 when the Plan created several different

groups for members due to the benefit changes that split one group into two separate groups. An enhancement to system was required. As of December 4, 2009 Plan's IS system was enhanced and now will search to find active eligibility as it relates to the date of service throughout the enterprise to ensure all potential eligibility sources are researched before claim is auto-adjudicated.

The Plan stated that a sweep was completed on January 15, 2010 and identified a total of 92 claims affected by this system issue out of 552 claims reviewed. As of September 30, 2010, the Plan stated that all claims involved were confirmed, corrected and the associated interest and penalty was paid. The Plan included the sweep report in the response that supports that 48 claims resulted in remediation for a total of $792 ($480 in penalty and $312 in interest).

The Plan stated the Director of Claims will be responsible for ensuring continued compliance with Section 1371.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required.

2. DENIAL DATE AND EVIDENCE OF PAYMENT ("EOP")

Rule 1300.71 (a) (4) sets forth that the "date of denial" means the date of postmark setting forth the date when the denial was deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record with proper postage prepaid.

Rule 1300.71(d) (1) states that a plan or plan's provider shall not improperly deny, adjust, or contest a claim. For each claim that is denied, adjusted or contested, the plan shall provide an accurate and clear written explanation of the specific reasons for the action taken within the timeframes specified in sections (g) and (h).

Our examination disclosed that the EOP is used as the written notification for the payment and/or denial of a claim and includes the reason for denial. The actual check is used as the cover letter for the EOP and provides the date of issuance. If the provider only has a denied claim, the EOP is sent to the provider without a check, but is provided with a dated cover letter. However, this dated cover letter cannot be reproduced with the original date for support of the "date of denial".

The Preliminary Report required the Plan to submit a description of the corrective action taken to retain support for the date of denial (i.e., hardcopy or PDF file of denial cover letter) for compliance with Rule 1300.71(a)(1) and (d)(1). The Plan was also required to provide the date corrective action was implemented and the management position(s) responsible to ensure continued compliance with this Rule**.**

The Plan responded that the Plan's Claim Processing system currently retains the denial date on the claim financial screen for future reference. The Plan represented that the corrective action included adding a denial date on the EOP report that is sent to the provider. Prior to this, the Plan stated the EOP cover page was showing the denial date; and the enhancement will allow for the date to be shown on both the cover page and the enclosed EOP. The Plan stated that a copy of the EOP with the original denial date will be retained in the system. This new process was implemented in January 2010.

The Plan stated the Director of Accounting will be responsible for ensuring continued compliance with Rule 1300.71(a)(1) and (d)(1).

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required.

3. PROVIDER CONTRACT

Rule 1300.67.8 requires written contracts to be executed between the Plan and each provider of health care services, which regularly furnishes services under the Plan. Rule 1300.71 (b)(1) states that the plan that pays claims shall not impose a deadline for the receipt of a claim that is less than 90 days for contracted providers and 180 days for non-contracted providers after the date of service, except as required by any state or federal law or regulation. If a plan is not the primary payer under coordination of benefits, the plan shall not impose a deadline for submitting supplemental or coordination of benefits claims to any secondary payer that is less than 90 days from the date of payment or date of contest, denial or notice from the primary payer.

Section 5.2 of the Plan's Master Provider Contract states that "…LDP reserves the right to deny or modify any claim received after (30) days from the date of service." This language does not comply with the claim filing deadline requirement of Rule 1300.71(b)(1), as the Plan's deadline to deny or contest a claim within 30 days from the date of service is less than the required 90 days.

The Preliminary Report required the Plan to review all provider contracts and correct this language to comply with Rule 1300.71. The Plan was required to file all revised master provider contracts and the addendum to existing provider contracts as an amendment with the Department.

The Plan was also required to state the corrective action taken to ensure that all current providers are aware of this contract language change through the issuance of an addendum to the existing contract or new amended contract, as filed with the Department. In addition, the Plan was required to provide a timeframe for ensuring that all current providers enter into and execute addendum to their contract. Furthermore, the Plan was required to identify the management position responsible for ensuring compliance with this corrective action**.**

The Plan responded that the Plan's current Master Provider Agreement Section 3.9 includes the following language that ensures regulatory compliance in all aspects:

"DENTIST agrees that any new amendments to the Knox-Keene Act or its regulations shall when applicable, automatically become part of this contract, and in any inconsistency, the Law and Regulations shall prevail over any provision of this contract."

Nevertheless, the Plan stated to correct the language of Section 5.2, the Plan filed an amendment to the Master Provider agreement with language that complies fully with Rule 1300.71 and included a copy with the response.

The Plan stated that its corrective action plan, to ensure that all Plans' providers are aware of the contract language change, includes written communication in the form of passive contract addendum. The Plan indicated that a copy of the provider communication was placed in each contracted provider's permanent file, with the notification process completed on August 6, 2010.

The Plan stated the Vice President of Professional Services will be responsible for ensuring that the required actions are fully implemented.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required. The Department acknowledges that the amendment to master provider contract was submitted as eFile No. 20101449 on August 2, 2010 and review completed on August 30, 2010.

C. PROVIDER DISPUTE VIOLATIONS

Rule 1300.71.38 (m)(2) states that the failure of a plan to comply with the requirements of a fast, fair and cost-effective dispute resolution mechanism shall be a basis for disciplinary action against the plan.

The Department's examination found that the Plan failed to comply with the requirements of a fast, fair and cost-effective resolution mechanism for providers as summarized below:

Deficiency	Type of Sample	Total Sample Population	Total in the Sample	Number of Deficiencies Found	% of Compliance
Dispute paid date > 5 working days from determination date.	PDR	23	23	13	43%

LATE PAYMENT OF PROVIDER DISPUTES PAYMENTS

Rule 1300.71.38 (g) states that if the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, the plan or the plan's capitated provider shall pay any outstanding monies determined to be due, and all interest and penalties required under Section 1371 and Rule 1300.71, within five (5) working days of the issuance of the Written Determination.

Our examination disclosed that the Plan failed to pay additional amounts due providers, resulting from provider disputes, within five (5) working days from the date of the determination letter in 13 of the 23 provider dispute samples paid in the 17 month time period of February 1, 2008 to June 30, 2009 (a non compliance rate of 57%).

The Preliminary Report required the Plan to submit its policy and procedures for ensuring that payments are issued to providers within five (5) working days of the date of determination in compliance with the above Rule. The Plan was also required to provide the date of implementation and the management position(s) responsible for ensuring continued compliance with this Rule.

The Plan responded that the Plan makes every effort to comply with the regulations of the DMHC. The Plan believes that its goodwill intentions were perceived incorrectly. Since the claims in question were not PDR(s) plan should not be subject to a deficiency for PDR(s) when it misclassifies a claims inquiry as a PDR. The Plan provided a policy that defines how the plan will move forward in the future. The Plan stated that it finds it onerous by being found deficient when it acted in good faith to pay claims that it was not obligated to pay.

The Plan provided revised Policy and Procedure for Claim Settlement Practice and Provider Dispute Resolution Mechanism that ensures improved processes for identifying and tracking PDRs and making sure that they are being handled according to Rule1300.71.38(g). The Plan stated the revised procedure was implemented on January 7, 2010.

The Plan represented the Dental Director will be responsible for ensuring continued compliance with this rule.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required.

However, the Department's review of the Plan's Policy and Procedure for Claims Settlement Practice and Provider Dispute Resolution Mechanism noted the following:

- **The "Purpose" should include reference to Rule 1300.71.38 which addresses provider dispute requirements.**

- **The "Time Period for acknowledgment and resolution" should be revised from 30 days to 45 working days, as Rule 1300.71.38(f) states that a Plan issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute.**

The Plan is requested to submit revised, executed Policy and Procedure with its response to this report.

D. OTHER PROVIDER DISPUTE DEFICIENCIES

The following details other provider dispute deficiencies found during the Department's examination:

1. ACCURACY OF WRITTEN DETERMINATIONS

Rule 1300.71.38 (f) requires that a written determination state the pertinent facts and explain the reasons for the Plan's determination.

Our examination disclosed that 16 out of 23 disputes were paid an additional payment without interest and penalties due to a one time "goodwill" gesture by the Plan. The determination letter did not provide proper disclosure to explain to the provider why interest was not paid. One provider submitted 12 disputes for the same reason.

The Preliminary Report required the Plan to submit its policy and procedures for ensuring that proper disclosure for any "goodwill" gesture is made in the written determination letter for compliance with the above Rule. The Plan was also required to provide the date of implementation, the management position(s) responsible for compliance, and a description of the monitoring system implemented to ensure continued compliance with this Rule.

The Plan responded that the Plan makes every effort to comply with the regulations of the DMHC. The Plan believes that its goodwill intentions were perceived incorrectly. Since the claims in question were not PDR(s) plan should not be subject to a deficiency for PDR(s) when it misclassifies a claims inquiry as a PDR. The Plan provided a policy that defines how the plan will move forward in the future. The Plan stated that it finds it onerous by being found deficient when it acted in good faith to pay claims that it was not obligated to pay.

The Plan provided a revised Policy and Procedure for Claim Settlement Practice and Provider Dispute Resolution Mechanism and prepared a Policy and Procedure for Goodwill Payment to ensure proper disclosure for any "goodwill" payment in the written determination letter. The Plan stated the revised procedures were implemented on January 7, 2010.

The Plan represented the Dental Director will be responsible for ensuring continued compliance.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required.

2. DISPUTES CONTAINED IN A BUNDLED SUBMISSION

Rule 1300.71.38 (k) (2) requires that disputes contained in a bundled submission shall be reported separately as individual disputes.

Our examination disclosed that the Plan's was tracking bundled disputes under one tracking number; 12 separate disputes were logged as one dispute out of 23 samples reviewed.

The Preliminary Report required the Plan to submit its revised policy and procedures for ensuring that bundled provider disputes are reported individually in compliance with the above Rule. The Plan was also required to provide the date of implementation, the management position(s) responsible for compliance, and a description of the monitoring system implemented to ensure continued compliance with this Rule.

The Plan responded that the Plan makes every effort to comply with the regulations of the DMHC. The Plan believes that its goodwill intentions were perceived incorrectly. Since the claims in question were not PDR(s) plan should not be subject to a deficiency for PDR(s) when it misclassifies a claims inquiry as a PDR. The Plan provided a policy that defines how the plan will move forward in the future. The Plan stated that it finds it onerous by being found deficient when it acted in good faith to pay claims that it was not obligated to pay.

The Plan provided a revised Policy and Procedure for Claim Settlement Practice and Provider Dispute Resolution Mechanism to ensure individual reporting of bundled provider disputes according to Rule 1300.71.38(k)(2). The Plan stated the revised procedure was implemented on January 7, 2010.

The Plan represented the Dental Director will be responsible for ensuring continued compliance with this rule.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required.

3. ACCURACY OF DISPUTE DATABASE

Rule 1300.71.38 (k) (2) requires the Plan to maintain an accurate record of disputes received from providers.

Our examination disclosed that the Plan was including enrollee grievances, appeals, pre-authorizations, questions and answers, and notes in the dispute log/database. The database provided 297 total records, while only 23 provider disputes were actually noted, with 12 provider disputes bundled under the description of "Notes". Those disputes reviewed and determined not to be disputes included dispute samples No. 1, 2, 19, and 20.

The Preliminary Report required the Plan to submit its policy and procedures for ensuring that only provider disputes, as defined in Rule 1300.71.38(a), are reported individually and tracked in the dispute database for compliance with the above Rule. The Plan was also required to provide the date of implementation, the management position(s) responsible for compliance, and a description of the monitoring system implemented to ensure continued compliance with this Rule.

The Plan responded that the Plan makes every effort to comply with the regulations of the DMHC. The Plan believes that its goodwill intentions were perceived incorrectly. Since the claims in question were not PDR(s) plan should not be subject to a deficiency for PDR(s) when it misclassifies a claims inquiry as a PDR. The Plan provided a policy that defines how the plan will move forward in the future. The Plan stated that it finds it onerous by being found deficient when it acted in good faith to pay claims that it was not obligated to pay.

The Plan provided revised Policy and Procedure for Claim Settlement Practice and Provider Dispute Resolution Mechanism to ensure improved processes for identifying and tracking PDRs and making sure that they are being handled according to Rule 1300.71.38(k)(2). The Plan stated the revised procedure was implemented on January 7, 2010.

The Plan represented the Dental Director will be responsible for ensuring continued compliance with this rule.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required.

E. FIDELITY BOND

Rule 1300.76.3 requires each plan to maintain a fidelity bond that covers each officer, director, trustee, partner, and employee of the plan, whether or not they are compensated. The fidelity bond shall provide for 30 days notice to the Director prior to cancellation. The fidelity bond shall provide at least the minimum coverage for the plan, as required by the schedule in this Rule.

The Plan provided a fidelity bond for which the Plan was a named insured on the policy for Liberty Dental Plan Corporation, Inc.—A Nevada Corporation. The policy did not provide the Plan with "exclusive right" to the minimum required coverage of $2,000,000. Also, the policy did not contain the required endorsement for coverage of each officer,

director and employee of the plan, whether or not compensated; or the required cancellation notice.

Corrective Action Taken During Examination: During our examination, the Plan provided its own fidelity bond with $2,000,000 in coverage for the policy period of November 1, 2009 to November 1, 2010 for the amount of $2,000,000 with the required endorsements.

The Preliminary Report required the Plan to state the corrective action implemented to ensure continue compliance with the above cited Rule. The Plan was also required to state the date of implementation and the management position responsible for continued compliance.

The Plan responded that the Chief Financial Officer will be responsible to ensure compliance with Rule 1300.76.3. The Plan provided a new Policy and Procedure implemented on July 1, 2010 to address all requirements of a fidelity bond during the annual renewal process.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required.

F. COMBINED REPORTS

Rule 1300.84(c) states that financial statements of a plan must be on a combining basis with an affiliate, if the plan or such affiliate is substantially dependent upon the other for the provision of health care, management or other services. An affiliate will normally be required to be combined, regardless of its form of organization, if the affiliate controls, is controlled by, or is under common control with the plan, either directly or indirectly (see Rule 1300.45(c) and (d)), and if the Plan or the affiliate is substantially dependent, either directly or indirectly, upon the other for services or revenue.

Our examination disclosed that the Plan does not file combined financial statements with Liberty Dental Plan Corporation ("Corp") and its subsidiaries on a quarterly and annual basis with its financial statement filings to the Department. The Plan is under common control with Corp and its subsidiaries, as these Boards all share common officers. Corp is an "affiliate", as defined in Rule 1300.45(c) (1) and (2), due to the sharing of officers, which are positions involving responsibility and authority. Corp is substantially and directly dependent upon the Plan for services provided through an Administrative Services Agreement. These contractual arrangements further support that the Corp is an "affiliate", as defined in Rule 1300.45 (d) which states "control" to mean the possession, direct or indirect, of the power to direct the management and policies of a person, whether through contract or otherwise.

Due to the influence over this affiliate and the affiliate's direct dependency upon Liberty for services, the Plan is to file financial statements on a combining basis with Corp and its subsidiaries.

The Preliminary Report required the Plan to file combining financial statements with the Corp on a quarterly and annual basis, beginning with the financial statement filing for the quarter ending June 30, 2010, pursuant to Rule 1300.84(c).

The Plan responded that they immediately implemented revision of reporting practices and filed combined financial statements with Liberty Dental Plan Corporation and its subsidiaries with the quarterly filing for June 30, 2010. On August 19, 2010, the Plan requested approval from the Department to file these combined statements on a confidential basis due to Corp being a privately held corporation and management believes that publicly displayed financials could undermine the company's competitive advantage.

The Department finds that the Plan's compliance effort is responsive to the corrective action required. The Plan filed the June 30, 2010 quarter ended combined financial statements with Liberty Corporation, Inc. on August 30, 2010, as a confidential filing with the Department.

G. BOOKS AND RECORDS

Section 1381 (a) requires all records, books, and papers of a plan shall be open to inspection during normal business hours by the director. Rule 1300.85 requires every Plan to maintain books and records on a current basis and requires the retention of specific records. Section 1385 requires that each Plan keep and maintain current such books of account and other records as the Director may by rule require for the purpose of this chapter. Rule 1300.85.1 requires every plan to preserve for a period of not less than five years, the last two years of which shall be in an easily accessible place at the offices of the plan, the books of account and other records required under the provisions of, and for the purposes of the Act. The easily accessible number of days shall be no more than 2 business days at the Plan's site, and the maximum number of days shall be no more than 5 business days for stored books and records.

Our examination disclosed that certain books and records were not easily accessible to the Department, as follows**:**

1. Two executed provider contracts and a check copy were requested on November 5, 2009 as part of the paid claim review, but not provided by the Plan until January 11, 2010.

2. Documentation (i.e., claim, claims screens, check copy, EOP) for 8 out of 39 claim denials were requested on December 9, 2009, but not provided by the Plan until January 7, 2010 .

The Preliminary Report required the Plan to submit a description of its processes to ensure books and records are accessible and retained in compliance with the above Section and Rules. The Plan was also required to provide the management position(s) responsible to ensure continued compliance.

The Plan responded that it keeps accurate and current books and records. They are easily accessible upon clear written request. Plan provided a revised Policy and Procedure for Books and Records that requires records to be provided within 2 business days if on site and 5 business days if in storage.

The Plan represented that the Chief Operating Officer will be responsible to ensure continued compliance.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required.

H. FINANCIAL STATEMENT PRESENTATION

Rule 1300.84.2 sets forth the requirements for the filing of quarterly financial statements with the Department. The rule states that the quarterly financial statements (which need not be certified) are to be prepared in accordance with generally accepted accounting principles and on a basis consistent with the certified financial report furnished by the plan pursuant to Section 1384(c). This rule also refers to Rule 1300.84.06(b) that sets forth the requirements for the supplemental information that is to accompany the DMHC Reporting Format.

Our examination noted the following concerns with the DMHC Reporting Format and supplemental information filed for the quarter ended September 30, 2009:

1. The Plan reported Unsecured Affiliate Receivable-current on Line 9 of Report #1-Part A: Assets, but did not properly report this in supplemental information item B.

2. The Plan did not complete supplemental information item F.25 to 27 as required to determine compliance with the noncontracting provider provision of Section 1377. If item 27 is over 10% then the plan must complete items G. 29 to 38.

3. Report #1-Part B: Liabilities and Net Worth does not report liabilities to non-contracting providers separately under column 3.

4. Non-contracted emergency services or out-of-area expense is not reported on line item 19 of Report #2: Revenue, Expense and Net Worth.

5. The Plan incorrectly reports the enrollment received from other health plans within the source of enrollment (such as Group (Commercial), Medicare Risk, Medi-Cal Risk), instead of reporting enrollment from other health plans on line 14 of Report #4: Enrollment and Utilization Table.

6. The Plan is not completing column 5 in Section III of Schedule G to report denied claims. The columns 3 and 4 do not agree with the claims data provided in February 2010 to the Department.

7. The Plan is not reporting Schedule H in dollar amounts.

8. The Plan is not completing column 5 of Schedule I.

The Preliminary Report required the Plan to state the corrective action taken to ensure that the DMHC Reporting Format and supplemental information is properly completed on all future financial statements and that the quarterly report for June 30, 2010 due to be filed on August 15, 2010 will demonstrate compliance. The Department recommends the Plan refer to the "General Information, Definition and Instruction" guide that provides instructions by line item for proper completion of the DMHC Report Forms and supplemental information.

The Plan was also to state the management position(s) responsible for ensuring continued compliance.

The Plan responded that they immediately implemented revised reporting practices to ensure proper completion of DMHC Reporting Format and supplemental information. The Plan stated the monthly report submitted for period ending June 30, 2010 is fully compliant.

The Plan represented the Chief Financial Officer will be responsible for ensuring future compliance with all regulatory reporting requirements.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required. The Department confirms that these items were corrected in the quarterly report for June 30, 2010.

I. DETERMINATION OF CLAIM STATUS

Rule 1300.77.4 states that every plan shall institute procedures whereby all claims forms received by the plan from providers for reimbursement on a fee-for-service basis and from subscribers and enrollees for reimbursement are maintained and accounted for in a manner which permits the determination of the date of receipt of any claim, the status of any claim, the dollar amount of unpaid claims at any time and rapid retrieval of any claim.

Our examination disclosed that the claims data provided to the Department included encounter data. The Plan should be able to identify and segregate encounters separately from payable claims data.

The Preliminary Report required the Plan to submit its policy and procedures for ensuring that encounters are separately tracked from payable claims data. The Plan was also required to state the date of implementation and the management position(s) responsible to ensure continued compliance.

The Plan responded that they completed a clean-up project which identified 26 provider contracts that were set up as specialty contracts as opposed to general practitioners. The encounters were processed correctly according to the correct fee schedule, but they were marked as claims in the Plan's system. The Plan represented that the clean-up project was done in September 2009 and a Policy and Procedure for Encounter Data was implemented to ensure provider set-up accuracy.

The Plan represented the Vice President of Professional Services will be responsible for ensuring continued compliance with Rule 1300.77.4.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required.

SECTION IV. NON-ROUTINE EXAMINATION

The Plan is advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this report. The cost of such examination will be charged to the Plan in accordance with Section 1382 (b).

No response is required for this Section