FINAL REPORT OF ROUTINE EXAMINATION OF DELTA DENTAL OF CALIFORNIA

Dear Mr. McCann:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of Delta Dental of California (Plan), conducted by the Department of Managed Health Care (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 August 11, 2014. The Department accepted the Plan’s electronically filed response on September 25, October 1 and October 20, 2014.

This Final Report includes a description of the compliance efforts included in the Plan’s September 25, October 1 and October 20, 2014 response, 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 provide 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

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1 References throughout this letter to “Section” are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the 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 Chapter 2 of Division 1, Title 28, of the California Code of Regulations, beginning with Section 1300.43.
response shall be appended, and electronically file copies of those portions of the Plan’s 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 September 25, October 1 and October 20, 2014 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 Corrective Action Plan system (CAP system) within the Online Forms Section of the Department's eFiling web portal [https://wpso.dmhc.ca.gov/secure/login/](https://wpso.dmhc.ca.gov/secure/login/), as follows:

- From the main menu, select “eFiling”.
- From the eFiling (Home) menu, select “Online Forms”.
- From the Existing Online Forms menu click on the “Details” for the DFO Corrective Action Plan S14-R-092
- Go to the “Messages” tab
  - Select “Addendum to Final Report” (note this option will only be available for 10 days after the Final Report has been issued)
  - Select the deficiency(ies) that are applicable
  - Create a message for the Department
  - Attach and Upload all documents with the name “Addendum to Final Report”
  - Click “Send Message”

The Department finds the Plan’s compliance efforts are responsive to the deficiencies cited and the corrective actions required. Therefore, no further response is required.

**The Plan is hereby advised that any violations listed in this report may be referred to the Office of Enforcement for appropriate administrative action upon the issuance of this report.**

Questions related to the electronic transmission of the response should be directed to Susan Levitt at (916) 255-2443 or email at susan.levitt@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 website at [View Department Issued Final Examination Reports](#).
If there are any questions regarding this Report, please contact me.

Sincerely,

ORIGINAL SIGNED BY

Bill Chang, CPA
Supervising Examiner
Office of Financial Review
Division of Financial Oversight

Cc:
Sandra Renner, Senior Regulatory Analyst, Delta Dental of California
Gil Riojas, Deputy Director, Office of Financial Review
Anna Belmont, Examiner, Division of Financial Oversight
Vasiliy Lopuga, Examiner, Division of Financial Oversight
Christina Hooke, Counsel, Office of Plan Licensing
Laura Dooley-Beile, Chief, Division of Plan Surveys
BACKGROUND INFORMATION FOR DELTA DENTAL OF CALIFORNIA

Date Plan Licensed: March 22, 1987

Organizational Structure: Delta Dental of California (Plan) is a non-profit California corporation. The Plan is a member of Dentegra Group Inc., a holding company that was formed for the purpose of providing management services to the Plan and its affiliate companies. Delta has ownership in the following companies:

- DDC Insurance Holdings, Inc. 100.0%
- Delta Dental of Puerto Rico 47.6%
- Celebration Dental Services 100.0%
- PaCa Management, LLC 50.0%

Type of Plan: Specialized – Dental

Provider Network: The Plan contracts with a network of providers for the provision of dental care services.

Plan Enrollment: The Plan reported total enrollment of 18,412,000 at quarter ending December 31, 2013.

Service Area: All major counties in California.

Date of last Final Routine Examination Report: October 9, 2013
FINAL REPORT OF A ROUTINE EXAMINATION OF
DELTA DENTAL OF CALIFORNIA

This is the Final Report of a routine examination of the fiscal and administrative affairs of Delta Dental of California (Plan), conducted by the Department of Managed Health Care (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 August 11, 2014. The Department accepted the Plan’s electronically filed response on September 25, October 1 and October 20, 2014.

This Final Report includes a description of the compliance efforts included in the Plan’s September 25, October 1 and October 20, 2014 response to the Preliminary Report, in accordance with Section 1382(c). The Plan’s response is noted in *italics*.

**The Plan is hereby advised that any violations listed in this report may be referred to the Office of Enforcement for appropriate administrative action upon the issuance of this report.**

The Department examined the Plan’s financial report filed with the Department for the quarter ended December 31, 2013, as well as other selected accounting records and controls related to the Plan’s various fiscal and administrative transactions. The Department’s 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

**The Department finds the Plan’s compliance efforts are responsive to the deficiencies cited and the corrective actions required. Therefore, no further response is required.**

¹ References throughout this letter to “Section” are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the 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 Chapter 2 of Division 1, Title 28, of the California Code of Regulations, beginning with Section 1300.43.
SECTION I. FINANCIAL STATEMENTS

The Department’s examination did not result in any adjustments or reclassifications to the Plan’s December 31, 2013 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 Delta Dental of California on the first drop down menu.

No response is required to this Section.

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth as reported by the Plan as of quarter ended December 31, 2013 $ 690,787,000

Less:
Intangible Assets and Goodwill 6,295,000
Unsecured Receivables from affiliates 92,176,000

Tangible Net Equity 592,316,000

Required TNE 84,943,000

TNE Excess per Examination as of quarter ended December 31, 2013 $ 507,373,000

The Plan is in compliance with the TNE requirement of Section 1376 and Rule 1300.76 as of December 31, 2013.

No response is required to this Section.

SECTION III. COMPLIANCE ISSUES

A. CLAIM SETTLEMENT PRACTICES

Section 1371 and Rule 1300.71 set forth various definitions and compliance requirements for claim settlement practices.

The Department’s examination found that the Plan failed to comply with the claim settlement requirements for the three-month period ending December 31, 2013, as summarized below:

1. INTEREST CALCULATION ON LATE CLAIMS– Repeat Deficiency

Section 1371 requires a specialized health care service plan to reimburse uncontested claims no later than 30 working days after receipt of the claim. This section also requires 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.

Rule 1300.71 (i)(2) and (j) requires that interest at the rate of 15 percent per annum for the period of time that the payment is late shall be automatically included in the claim payment of a complete claim. The penalty for failure to comply with this requirement shall be a fee of ten ($10) dollars paid to the claimant.

Rule 1300.71(a)(8)(K) describes an 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.

DELTA CARE CLAIMS

The Department’s examination of late paid Delta Care claims disclosed that the Plan failed to pay the correct amount of interest on 48 out of 50 late claims (or 4% compliance rate) for the three month period ended December 31, 2013. The Plan’s interest calculation accrued interest on working days instead of calendar days (Samples LP20 and LP24 were the only claims reviewed that were paid the correct amount of interest).

The Plan’s failure to use working days to determine amount of interest owed on late claims is a repeat deficiency, as this issue was previously reported in the Department’s Final Report of Non-Routine Examination dated October 9, 2013 (for the periods beginning December 1, 2011 through February 28, 2012 and April 1, 2012 through June 30, 2012). This examination disclosed that the Plan’s compliance efforts in response to the prior examination report have not achieved the necessary levels of compliance with the Act and Regulations cited.

The Plan was required to submit a Corrective Action Plan (CAP) to substantiate the corrective actions implemented to comply with the above Section and Rules. The CAP should address the deficiencies cited above and include the following:

1) Identification of all Delta Care late paid claims for which interest and penalties were not correctly paid, from July 1, 2012 through the date corrective action is implemented by the Plan.

2) Evidence that interest and penalties, as appropriate, are paid retroactively for the claims identified in paragraph “1” above. This evidence is to include an electronic data file (Excel or dBase) or schedule that identifies the following:

- Claim number
- Date of service
- Date original claim received
- Date new information received
- Date complete claim received
• Total billed
• Total paid
• Paid date (mailed date)
• Number of days late used to calculate interest
• Interest amount paid
• Date interest paid
• Penalty amount paid
• Additional interest amount paid, if applicable
• Date additional interest paid, if applicable
• Check number for additional interest and penalty paid
• Provider name

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

3) Policies and procedures implemented to ensure that the correct interest is calculated based on calendar days on all late paid Delta Care claims, as a result of the deficiency cited above, pursuant to the above Section and Rules.

The Plan was required to explain why the previous corrective action taken was not effective in preventing this repeat deficiency and to state the measures taken to prevent further recurrence of noncompliance in this area.

The Plan was also required to demonstrate that it provided training to its staff and established internal auditing procedures to ensure that policies and procedures are followed. In addition, the Plan was required to provide the date of implementation and the management position(s) responsible for ensuring continued compliance.

**PLAN’S RESPONSE**

The Plan responded that the Department’s deficiency above is directed at the Plan’s DeltaCare claims. The DeltaCare program is a closed panel, DHMO program where enrollees are assigned to specific General Dentists and do not generate claims; claims under the DeltaCare program are almost exclusively for specialist services. The Plan currently runs its DeltaCare program on a legacy system called the Capitated Payment System (CPS). The Plan has been working to convert all its dental programs, including DeltaCare, to a claims processing system in MetaVance. The Plan has successfully completed the conversion of its fee-for-service (PPO and Premier) programs to MetaVance, and is in the middle of conversion of its DeltaCare program.

The Plan was applying interest to late DeltaCare claims in the legacy claims system, however, it was discovered during the DMHC exam that the legacy claims system was applying the interest on every business day, instead of every calendar day that the claim was late. Upon discovery of this error, the Plan immediately reconfigured its
interest calculator on May 14, 2014 to calculate interest starting on the day following the 30 working days after the date of receipt of the claim day, and to apply interest on every calendar day the claim was late. The Plan provided an Interest Payment Report, identifying all DeltaCare late paid claims for which interest and penalties were not correctly paid from July 1, 2012 through May 14, 2014, the period in which interest was underpaid.

The Department conducted a non-routine examination of the Plan’s commercial fee-for-service programs (Delta Dental PPO and Premier) in 2012, and issued a Final Report October 9, 2013. The underlying reason for the 2012 non-routine exam was complaints to the Department by Plan providers stating payments were not made timely due to the Plan’s large-scale claims processing system conversion that began in mid-2012. The Plan corrected deficiencies for its commercial fee-for-service programs, as noted during the non-routine exam, and put into place policies and procedures for the accurate and timely payment of claims.

The work the Plan did to correct its MetaVance system and create policies going forward were noted as responsive by the Department, however, the corrections and policies were applied to the Plan’s MetaVance system that processed PPO and Premier claims; the corrections were not applied to the Plan’s legacy system which processed DeltaCare claims. The use of two separate systems, one for fee-for-service program and another for the DHMO program, resulted in this inadvertent gap in the corrective action plan, which the Plan truly regrets. Because the 2012 non-routine exam specifically focused on the Plan’s claims-based PPO and Premier programs, the Plan focused on reconfiguring its MetaVance system in order to ensure that any claim paid on MetaVance would be processed correctly.

As a DHMO Program, DeltaCare is not a large scale claims-based program like PPO or Premier. The conversion of DeltaCare to MetaVance is still in progress, so DeltaCare claims were processed on a legacy system that had not been updated simultaneously with the MetaVance system. The Plan recognizes that using working days to calculate interest owed on DeltaCare late claims is a deficiency, but it is a deficiency of first impression with the DeltaCare program and not a repeat deficiency. To ensure proper oversight and monitoring for ongoing compliance with all its program lines, the Plan’s Compliance department maintains current interest regulations for California. The Delta Care Claim Manager, who is responsible for manually configuring and maintaining the Interest Calculator in Excel, receives an alert via email when any changes to the Interest Regulations (Prompt Payment matrix) are made. The DeltaCare Claims Manager then updates the Excel Interest Calculator accordingly.

When DeltaCare is converted to the MetaVance system, the manual Interest Calculators will no longer be used. The Finance’s Configuration Lead, who is responsible for configuring and maintaining the interest functionality in MetaVance, receives an alert via email when any changes to the Compliance matrix is made. The Finance Configuration Lead would then proceed to update the system accordingly.
Delta has stringent controls and processes to safeguard the system from unauthorized and erroneous changes. The Plan restricts update access to the interest configuration windows to specific employees in the organization.

Responsible Management Positions:
Alicia Weber – Senior Vice President of Finance
Russ Bradley – Vice President of Enterprise Claims
Bob Menhart – Vice President of Contract Center
Glenda Broadnax-McCoy – Claims Manager

The Plan submitted the following Supporting Documentation:
- Interest Payment Report
- Interest Calculator: DeltaCare California
- DLP: MTV Configuration Maintenance Request
- DLP: MTV Maintaining Interest Configuration

The Department finds that the Plan’s compliance effort is responsive to the corrective action required.

2. INCORRECT DATE OF RECEIPT – Repeat Deficiency

Rule 1300.71(a)(6) defines the date of receipt of a claim as the working day when a claim is first delivered to either the plan’s claim payment facility.

Rule 1300.77.4 requires all plans to institute procedures whereby all claims received by the plan are maintained and accounted for in a manner which permits the determination of date of receipt of any claim.

The Department's examination disclosed that the Plan’s procedures did not ensure an accurate capture of the original date of receipt on six (6) Delta Care denied claim samples (D11, D24, D51, D53, D58, and D74) and two (2) late paid Delta Care claims samples (LP26, LP39).

The Plan’s failure to accurately capture the original date of receipt is a repeat deficiency, as this issue was previously reported in the Department’s Final Report of Non-Routine Examination dated October 9, 2013 (for the periods beginning December 1, 2011 through February 28, 2012 and April 1, 2012 through June 30, 2012). This examination disclosed that the Plan’s compliance efforts in response to the prior examination report have not achieved the necessary levels of compliance with the Act and Regulations cited.

The Plan was required to explain why the previous corrective action taken was not effective in preventing this repeat deficiency and to state the measures taken to prevent further recurrence of noncompliance in this area.
The Plan was required to submit policies and procedures implemented to ensure the accurate capture of the original date of receipt of a claim. The Plan was also required to demonstrate that it provided training to its staff and established internal auditing procedures to ensure that policies and procedures are followed. In addition, the Plan was required to provide the date of implementation and the management position(s) responsible for ensuring continued compliance with the above Rules.

**PLAN’S RESPONSE**

The Plan responded that the Department states that the receipt date for claims D11 and D74 was incorrect. The Plan has reviewed these claims and disagrees with the Department’s assessment of these particular claims. The receipt dates for both claims were accurately captured in the system. The receipt date for claim D11 is 9/27/13, but the Department incorrectly listed 6/4/13 as the receipt date for claim D11. This error was brought to the Department’s attention during the exam. For claim D74, the Julian date is 266 which represents 9/23/13. The system accurately reflects 9/23/13 as the receipt date.

The Plan does acknowledge that the remaining cases cited by the Department, D24, D51, D53, D58, LP26, and LP39, have receipt dates that were not the original date the Plan received the claim. Unlike claims on the fee-for-service side (PPO and Premier programs), when a DeltaCare claim is received and additional information is needed to process the claim, the claim is “pended” and not denied. Specifically, the claims examiner ‘pends’ the claim and requests any required additional information. If additional information is not received within 15 days, a second letter is sent to the provider with an additional 15 days extension. If the missing information is not received within 15 days of the second letter (30 days total), the claim is automatically denied by the Legacy system and the receipt date of the claim is automatically changed to the date the claim is denied.

**Plan’s Corrective Action Plan**

The Plan understands the claims receipt date is a key date for ensuring compliance with claims processing turn-around time requirements. The errors in receipt date for denied claims regrettably was due to the Plan using a decades old claims processing system, which the Plan is in the process of retiring. The Plan would like to make clear to the Department this was not a situation of the Plan trying to circumvent denying claims timely. DeltaCare will soon be converted to the MetaVance processing systems which is used for the fee-for-service programs and which correctly records the receipt date on claims and eliminates the process of “pending” claims. The Plan has completed the following:

1. Manually corrected the receipt dates identified by the DMHC exam.
2. Scheduled the second phase of system conversion to MetaVance by year-end which will provide a long term solution to this issue as MetaVance used the correct business and IT systems Logic.
The Department conducted a non-routine examination of the Plan’s commercial fee-for-service programs (PPO and Premier) in 2012, and issued a Final Report October 9, 2013. The Plan corrected deficiencies for those programs as noted during the non-routine exam, and put into place policies and procedures for the accurate and timely payment of claims.

The work the Plan did to correct its MetaVance system to create policies going forward was accepted by the Department, however, the corrections and policies were not applied to the Plan’s legacy system for DeltaCare claims. The Plan truly regrets this inadvertent gap in the corrective action plan. Because the 2012 Non-Routine exam specifically targeted the Plan’s claims-based PPO and Premier programs, the Plan focused modifying its MetaVance system. DeltaCare is a capitated DHMO dental plan and not a large scale claims-based program like PPO and Premier. This conversion of DeltaCare to MetaVance is still in progress, so DeltaCare claims were processed on a legacy system that had not been updated simultaneously with the MetaVance system. The Plan recognizes that its failure to accurately capture the receipt date of DeltaCare claims that were denied for lack of information is a deficiency, but it is a deficiency of first impression with the DeltaCare program and not a repeat deficiency.

Responsible Management Positions:
Bob Menhart – Vice President of Contract Center
Glenda Broadnax-McCoy – Claims Manager

The Plan submitted the following Supporting Documentation:
  • Claim D11 and D74
  • Corrected Claims Sample LP26 and LP29
  • Corrected Claims Sample D24, D51, D53, D58

The Department finds that the Plan’s compliance effort is responsive to the corrective action required. No further action is required.

3. FAILURE TO DENY A CLAIM WITHIN REQUIRED TIMEFRAME—Repeat Deficiency

Rule 1300.71(a)(8)(L) states that the failure to contest or deny a claim, or portion thereof, within the timeframes of section (h) and sections 1371 of the Act at least 95% of the time for the affected claims over the course of any three-month period may constitute a basis for finding that the Plan has engaged in a “demonstrable and unjust payment pattern.”

Section 1371 and Rule 1300.71(h) provide that a plan may contest or deny a claim, or portion thereof, by notifying the provider, in writing, that the claim is contested or denied, within thirty (30) working days after the date of receipt of the claim by a specialized plan.

The Department's examination disclosed that 30 out of 50 denied DeltaCare claims (or 40% compliance rate) (samples D4, D6, D7, D8, D11, D12, D15, D17, D18, D24, D26,
D30, D33, D37, D43, D50, D52, D54, D57, D58, D60, D64, D65, D66, D67, D68, D69, D70, D72, D74), were denied beyond thirty (30) working days allowed by the above Section and Rules.

The Plan’s failure to deny a claim within thirty (30) working days is a repeat deficiency, as this issue was previously reported in the Department’s Final Report of Non-Routine Examination dated October 9, 2013 (for the periods beginning December 1, 2011 through February 28, 2012 and April 1, 2012 through June 30, 2012). This examination disclosed that the Plan’s compliance efforts in response to the prior examination report have not achieved the necessary levels of compliance with the Act and Regulations cited.

The Plan was required to explain why the previous corrective action taken was not effective in preventing this repeat deficiency and to state the measures taken to prevent further recurrence of noncompliance in this area.

The Plan was required to submit policies and procedures implemented to ensure that claims are denied timely in compliance with the above Section and Rules. The Plan was also required to demonstrate that it provided training to its staff and established internal auditing procedures to ensure that policies and procedures are followed. In addition, the Plan was required to provide the date of implementation and the management position(s) responsible for ensuring continued compliance.

**PLAN’S RESPONSE**

The Plan responded that the Plan implemented new optical character recognition software (Form Works) in July, 2013. Form Works highlights missing information on submitted claims. The new system had a steep learning curve by staff, and claims processing experienced a temporary drop in production, which in turn resulted in slightly higher than normal claims inventory. Additionally, extensive weather closures in January and February 2014 also contributed to the increased claims inventory.

**Plan’s Corrective Action Plan**

In response to the elevated claims inventory, the Plan added staff resources and immediately drove claims inventory down. Implementation of Form Works was the main root cause of the slower processing times, but inventory and processing times returned to normal. However, to ensure claims continue to be paid or denied timely, the Plan is currently employing inventory monitoring as a multi-prong approach. Each morning, the Claims manager holds a mandatory meeting to discuss the inventory needs for the day. The team focuses on maintaining a first-in-first-out (FIFO) inventory at all times. The inventory is distributed equally among Claims staff. The Plan produces a morning and mid-day inventory report that is monitored by Claims management personnel. This same report can be produced or gathered at any time during the work day by any management personnel.
The inventory is monitored throughout the day by the claims management personnel to discuss any new needs or issues that have arisen during the morning. Special attention is given to any claim nearing the Plan’s internal 15-day threshold. Those claims are adjudicated immediately.

The Plan has built staffing models identifying optimal staffing levels in order to maintain inventory of 15 days or less. The Plan’s staffing models are updated each month based on current data and are evaluated against current staffing to ensure adequate staffing. The Plan’s monitoring efforts have resulted in dramatically reduced inventory. The Plan’s claims turnaround time has also improved – between April 2014 and July 2014, the Plan processed roughly 99.34% of all claims within 15 days, well within the applicable timeframe under the Act.

The Department conducted a non-routine examination of the Plan’s commercial fee-for-service programs (PPO and Premier) in 2012, and issued a Final Report October 9, 2013. The previous corrective action plans instituted in response to the non-routine exam corrected deficiencies for the Plan’s fee-for-service programs using Form Works. The Plan recognizes that its failure to deny DeltaCare claims within the required timeframe, but it is a deficiency of first impression with the DeltaCare program and not a repeat deficiency.

Responsible Management Positions:
Bob Menhart – Vice President of Contract Center
Glenda Broadnax-McCoy – Claims Manager

The Plan submitted its Claims Processing Report as Supporting Documentation.

The Department finds that the Plan’s compliance effort is responsive to the corrective action required.

B. PROVIDER DISPUTE RESOLUTION (PDR) PROCESS

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 dispute resolution mechanism for the three-month period ending December 31, 2013, as summarized below:

1. FAILURE TO PAY INTEREST ON OVERTURNED PROVIDER DISPUTES

Section 1371 requires a specialized health care service plan to reimburse uncontested claims no later than 30 working days after receipt of the claim. This section also requires 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.

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.

Rule 1300.71.38 (g) requires that if a provider dispute is determined in favor of the provider the Plan shall pay any outstanding monies determined to be due and all interest and penalties, as set forth in Rule 1300.71 (g).

Rule 1300.71 (i)(2) and (j) requires that interest at the rate of 15 percent per annum for the period of time that the payment is late shall be automatically included in the claim payment of a complete claim. The penalty for failure to comply with this requirement shall be a fee of ten ($10) dollars paid to the claimant.

The Department's examination disclosed that the Plan failed to pay or underpaid interest on seven (7) out of 50 Delta Care PDRs (86% compliance rate). The PDR samples are PDR12, PDR29, PDR33, PDR36, PDR44, PDR45, and PDR47.

The Plan’s failure to pay interest on overturned disputes is a repeat deficiency, as this issue was previously reported in the Department’s Final Report of Non-Routine Examination dated October 9, 2013 (for the periods beginning December 1, 2011 through February 28, 2012 and April 1, 2012 through June 30, 2012). This examination disclosed that the Plan’s compliance efforts in response to the prior examination report have not achieved the necessary levels of compliance with the Act and Regulations cited.

The Plan was required to explain why the previous corrective action taken was not effective in preventing this repeat deficiency and to state the measures taken to prevent further recurrence of noncompliance in this area.

The Plan was required to submit a CAP to substantiate the corrective actions implemented to comply with the above Section and Rules. The CAP should address the deficiencies cited above and include the following:

a) Identification of all overturned PDRs for which interest and penalties were not correctly paid, from July 1, 2012 through the date that corrective action is implemented by the Plan.

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

- Claim number
- PDR number
- Date of service
- Date original claim received
• Date new information received
• Date complete claim was received
• Total billed
• Total paid
• Paid date (mailed date)
• Number of days late used to calculate interest
• Interest amount paid
• Date interest paid
• Penalty amount paid
• Additional interest amount paid, if applicable
• Date additional interest paid, if applicable
• Check number for additional interest and penalty paid
• Provider name

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

c) Policies and procedures implemented to ensure the correct payment of interest and penalty on all late claims resulting from overturned provider disputes, as a result of the deficiencies cited above.

The Plan was required to explain why the previous corrective action taken was not effective in preventing this repeat deficiency and to state the measures taken to prevent further recurrence of noncompliance in this area.

The Plan was also required to demonstrate that it provided training to its staff and established internal auditing procedures to ensure that policies and procedures are followed. In addition, the Plan was required to provide the date of implementation and the management position(s) responsible for ensuring continued compliance.

If the Plan was not able to complete the CAP or portions of the CAP by the response due date of this report, then the Plan was required to submit with its response a matrix that outlines the specific steps required towards full compliance, with specific dates for completing each step within 90 calendar days from the date of this Preliminary Report. If the Plan is not able to meet this timeframe, it must provide a justification for the delay and request approval from the Department for the proposed extended timeframe. The Plan must also submit monthly status reports until the CAP is completed.

**PLAN’S RESPONSE**

The Plan responded that the Department conducted a non-routine examination of the Plan’s fee-for-service programs noted during the non-routine exam, and put into place policies and procedures for the accurate and timely processing of provider disputes, including interest payments (see the Enterprise Policy and Guideline Interest Calculation and Payment on late Claims). As the Plan articulated in its response to
Deficiency A.1.a., the work the Plan did to correct its MetaVance system and to create policies going forward were noted as responsive by the Department, however, the corrections and policies were not applied to the Plan’s DeltaCare provider disputes, which were/are processed on a completely separate system/platform than MetaVance. The conversion of DeltaCare to MetaVance will result in DeltaCare providers being processed in the same corrected manner as fee-for-service provider disputes.

**Plan’s Corrective Action Plan**

a. Identify and retroactively pay interest and penalties from July 1, 2012 until the process was corrected on May 14, 2014.

The Plan reviewed all provider disputes paid between July 1, 2012 and May 14, 2014 and based on that analysis paid providers any interest owned plus penalties. The following table summarizes the payments made:

<table>
<thead>
<tr>
<th>Payment Date</th>
<th># Disputes</th>
<th>Interest</th>
<th>Penalties</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/12/2014</td>
<td>444</td>
<td>$7,573.07</td>
<td>$3,990</td>
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<td>$20</td>
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</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>447</strong></td>
<td><strong>$7,607.02</strong></td>
<td><strong>$4,020.00</strong></td>
<td><strong>$11,627.02</strong></td>
</tr>
</tbody>
</table>

b. Evidence that interest and penalties, as appropriate, were paid retroactively for the overturned provider disputes identified in paragraph “a”, was included as an attachment to the Plan’s response.

c. Policies and Procedures

The Plan’s Enterprise Interest policy states that disputes which are resolved in favor of the provider without new information must be paid from the original claims date, but disputes resolved in favor of the provider based on new or additional information are adjusted to the date the new information is received.

The Plan recirculated the Enterprise Interest and Penalty Payment Policy to the DeltaCare product line on May 14, 2014. On June 4, 2014, the Office of Compliance met in person with the managers for DeltaCare claims and grievance unit and reviewed the policy. The Grievance Manager reviewed the policy with her staff on June 5, 2014. Claim’s staff is being retrained on an ongoing basis. Both teams have instituted internal quality assurance reviews to ensure staff are processing and paying provider disputes correctly. In addition, the Office of Compliance plans to facilitate monthly meetings with both teams to discuss any issues and answer questions.

Within the DeltaCare Quality Management Department, responsibility for compliance and monitoring of the provider dispute procedures belongs to:
For DeltaCare Claims processing, responsibility for compliance and monitoring belongs to:

- Robert Menhart, Vice President Enterprise Claims
- Glenda Broadnax-McCoy, Manager of Claims

The Plan submitted the following Supporting Documentation:

- Provider Dispute, Interest and Penalty Payments
- Enterprise Policy and Guideline Interest Calculation and Payment on late Claims

The Department finds that the Plan’s compliance effort is responsive to the corrective action required.

2. PAST DUE PAYMENT ON PROVIDER DISPUTES – Repeat Deficiency

Rule 1300.71.38 (g) provides 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 shall pay any outstanding monies determined to be due within five (5) working days of the issuance of the Written Determination.

The Department’s examination disclosed that the Plan did not pay the provider the outstanding amount determined to be due within five (5) working days of the issuance of the Written Determination on eight (8) Delta Care PDRs. These included PDR samples PDR6, PDR18, PDR20, PDR21, PDR24, PDR36, PDR42, and PDR46.

The Plan’s failure to pay additional amounts due to providers within five (5) working days from the determination letter date is a repeat deficiency, as this issue was previously reported in the Department’s Final Report of Non-Routine Examination dated October 9, 2013 (for the periods beginning December 1, 2011 through February 28, 2012 and April 1, 2012 through June 30, 2012). This examination disclosed that the Plan’s compliance efforts in response to the prior examination report have not achieved the necessary levels of compliance with the Act and Regulations cited.

The Plan was required to explain why the previous corrective action taken was not effective in preventing this repeat deficiency and to state the measures taken to prevent further recurrence of noncompliance in this area.

The Plan was required to submit its revised policy and procedures for ensuring that payments resulting from a dispute are paid within five (5) working days of the date of the determination letter. The Plan was also required to demonstrate that it provided training to its staff and established internal auditing procedures to ensure that policies and
procedures are followed. In addition, The Plan was required to provide the date of implementation and the management position(s) responsible for ensuring continued compliance with this Rule.

**PLAN’S RESPONSE**

The Plan responded that the Plan’s previous corrective action was based on the Department’s Non-Routine Examination for its PPO and Premier product lines and the conversion from the legacy processing system to be MetaVance system. In response to that exam, the Plan developed corrective action plans focused on the MetaVance system to support claims and provider disputes. The work the Plan did to correct its MetaVance system and to create policies going forward were noted as responsive by the Department, however, the corrections and policies were applied to the Plan’s PPO and Premier programs; the corrections were not applied to the Plan’s DeltaCare provider disputes process. The Plan truly regrets this inadvertent gap in the corrective action plan.

**Plan’s Corrective Action Plan**

Currently, Claims paid by the Plan for the DeltaCare program are processed in its CPS legacy claims processing system. In October of 2014, processing will be converted to the enterprise MetaVance system and going forward claims will be paid from MetaVance.

On May 14, 2014, the Plan implemented a new interdepartmental claims adjustment processing form to manage this process. The Quality Management team completes the form, informing the Claims team of the final determination, required payment and the time frame for completion. On May 14, 2014, the Plan retrained the Delta Care Quality Management and Claims Processing management teams on the form and its use. Specifically, supervisors and managers were trained on the requirement to pay disputes within 5 working days after issuing a determination letter.

Following this initial implementation, the Quality Management department amended its quality audit review tool to include verification of the 5-working-day payment requirement in its regular, weekly review process.

**Management Responsibilities:**

Within the DeltaCare Quality Management Department, responsibility for compliance and monitoring of the provider dispute procedures belongs to:

- John Yamamoto, Vice President, Professional Services,
- Preddis Sullivan, Director, Professional Services,
- James Saunders, Dental Director, DeltaCare USA, and
- Susie Muniz, Manager of Professional Service and Quality Assessment.

Within the DeltaCare Claims Department, responsibility for compliance and monitoring the claims process belongs to:
Robert Menhart, Vice President Enterprise Claims,
Glenda Broadnax-McCoy, Manager of Claims.

The Plan submitted the following Supporting Documentation:
- Provider Dispute Process Quality Control Form
- Audit tool form

The Department finds that the Plan’s compliance effort is responsive to the corrective action required.

3. REQUEST FOR REIMBURSEMENT OF AN OVERPAYMENT

Rule 1300.71(a)(8)(D) states that the failure to request reimbursement of an overpayment of a claim consistent with the provisions of sections (b)(5) and (d)(3), (4), (5) and (6) at least 95% of the time for the affected claims over the course of any three-month time period is a basis for a finding that the plan has engaged in a “demonstrable and unjust payment pattern.”

Rule 1300.71 (b)(5) states that a Plan shall not request reimbursement for the overpayment of a claim unless the Plan sends a written request for reimbursement within 365 days of the Date of Payment on the overpaid claim. The written notice shall include the information specified in Rule 1300.71 (d)(3).

The Department’s examination disclosed that in three (3) out of 50 PDRs (or 94% compliance rate) reviewed, the Plan requested reimbursement for overpayment beyond the statutorily allowed 365-day timeframe. The Plan conducted a project to collect overpayments that were caused by a system conversion in 2012. The PDR samples are PDR6, PDR13 and PDR14.

The Plan was required to submit a CAP to address the reimbursement of all the providers from whom the Plan improperly collected an overpayment. The CAP should address the deficiency cited above and include the following:

1) Identification of all improper requests for reimbursement of overpayments from July 1, 2012 through the date that corrective action is implemented by the Plan.

2) Evidence that it has reimbursed all the providers for overpayments that the Plan improperly collected, as identified in paragraph “1”, above. This evidence is to include an electronic data file (Excel or dBase) or schedule that identifies the following:
   - Claim number
   - PDR number
   - Date of service
   - Date original claim received
• Date new information received
• Date complete claim was received
• Total billed
• Total paid
• Paid date (mailed date)
• Amount of reimbursement for overpayment requested
• Request date
• Amount of overpayment collected
• Date overpayment received
• Amount of improperly collected overpayment refunded
• Date of refund (mailed date)
• Check number for overpayment refund
• Provider name

The data file is to include the total amount of overpayment refunded as a result of remediation.

3) Policies and procedures implemented to ensure that all the requests for reimbursement are made within the 365-day timeframe.

The Plan was also required to demonstrate that it provided training to its staff and established internal auditing procedures to ensure that policies and procedures are followed. In addition, the Plan was required to provide the date of implementation and the management position(s) responsible for ensuring continued compliance.

If the Plan was not able to complete the CAP or portions of the CAP by the response due date of this report, then the Plan was required to submit with its response a matrix that outlines the specific steps required towards full compliance, with specific dates for completing each step within 90 calendar days from the date of this Preliminary Report. If the Plan was not able to meet this timeframe, it was to provide a justification for the delay and request approval from the Department for the proposed extended timeframe. The Plan was also required to submit monthly status reports until the CAP is completed.

**PLAN’S RESPONSE**

The Plan responded that the Department found in PDR6, PDR13 and PDR14 that the Plan incorrectly requested overpayments from 3 providers beyond the allowed 365-day timeframe. In each of the three cases, the providers submitted claims for a non-covered procedure (a third exam). The claims should have been denied, but the claims system processed and paid the non-covered procedures in error.

Following the discovery of the system errors, the Plan ran periodic reports to identify and correct claims when a non-covered procedure was paid. Typically, the Plan’s approach is to adjust the system and issue new EOB’s informing the provider of the overpayment. In those instances, where the Plan makes an adjustment less than 365 days after the original claim is
paid, the Plan informs the provider of the negative balance through the Provider EOB and collects the funds. In those instances where the Plan makes an adjustment more than 365 days after the claim is paid, the Plan will not collect funds and will instead write off the negative amounts.

In the three cases noted, the Plan identified the error more than 365 days after the original claim date. In the three cases, although the providers received EOB’s for the negative balance, informing them that an overpayment was made, the Plan did not actually collect the funds and subsequently wrote off the negative amounts.

- **PDR6** – The original claim was paid on 12/1/2011. The claim was adjusted on 09/10/2013 and an EOB mailed to the provider notifying provider of overpayment on 09/19/2013. The overpayment was written off by Delta on 10/1/2013 and not collected.

- **PDR13** – The original claim was paid on 08/23/2012. The claim was adjusted on 09/10/2013 and an EOB mailed to the provider notifying provider of overpayment on 09/12/2013. The overpayment was written off and not collected. The date of the write-off was 10/1/2013.

- **PDR14** – The original claim was paid on 08/23/2012. The claim was adjusted on 11/18/2013 and an EOB mailed to the provider notifying provider of overpayment on 11/21/2013. The overpayment was written off on 11/29/2013 and not collected.

**Plan’s Corrective Action Plan**

The Plan corrected the claims processing system issue that caused the overpayments in PDR6, PDR13 and PDR14. Additionally, the Plan identified 742 claims from 7/1/2012 to 9/15/2013 where an overpayment was requested and collected more than 365 days after the original claim paid date. There are two categories of claims that fall within this population of 742.

1. The first category of overpayments occurred when the Plan was in error and incorrectly overpaid a claim similar to the three cases noted above. In this situation the Plan was at fault.

2. The second category of overpayments occurred when a provider made an error and notified the Plan of the error and requested the claim be adjusted. In this situation the provider was at fault – not the Plan. In these instances, the Plan’s position is that the adjustment date is the overpayment date, therefore, 365 days are calculated from the date the claim was adjusted. The overpayment requests in this category were made within 365 days of the adjustment and the overpayment amounts collected were appropriate.

The Plan identified 530 overpayments (out of 742 claims) collected between July 1, 2012 and September 15, 2013, which is the date the claims processing system was corrected. The Plan has manually reviewed all 530 overpayments and determined that 178 were caused by the
provider and had to be adjusted by the Plan. The overpayment amounts collected for the 178 were properly collected and no further action is needed. The remaining 352 overpayments were caused by an issue in the Plan’s claim processing system. As a result, the Plan has returned to the providers the overpayment amounts incorrectly collected including a $10 penalty. The total amount of payments including penalties is $71,488.88. The checks were mailed to providers on October 17, 2014. The Plan provided an Excel file evidencing that overpayment amounts including penalties were returned to providers.

The Department finds that the Plan’s compliance effort is responsive to the corrective action required.

4. FAILURE TO RECORD PROVIDER DISPUTES

Rule 1300.71.38 (a)(1) and (2) defines a contracted and non-contracted provider dispute as a provider’s written notice to the Plan challenging, appealing or requesting reconsideration of a claim that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute or disputing a request for reimbursement of an overpayment of a claim.

According to the Plan’s policy, providers must submit a dispute on “PROVIDER DISPUTE FORM”. If a provider submits a complaint or a request for payment reconsideration that is not on the required form, it is not forwarded to the Provider Dispute Department, but is processed by the Correspondence Department. The Department’s examination finds that the Plan’s requirement that a prescribed form be completed in order for a provider complaint to be considered a dispute is not in compliance with the above Rule. The Plan was required to consider any written notice received from a provider as a dispute, as long as the provider’s complaint is about a claim determination or a contract dispute, as specifically set forth in the above Rule.

The Plan was required to provide a written confirmation that it will consider any written provider complaint, that complies with the above Rule, as a provider dispute. The Plan may continue to provide the prescribed form as an option to the provider for submitting a complaint. In addition, the Plan is to submit revised policies and procedures implemented to ensure that all written provider complaints are forwarded to the Provider Dispute Department for review and accounted for as a provider dispute.

The Plan was also required to demonstrate that it provided training to its staff and established internal auditing procedures to ensure that policies and procedures are followed. In addition, The Plan was required to provide the date of implementation and the management position(s) responsible for ensuring continued compliance.

PLAN’S RESPONSE

The Plan responded that the Plan believes the provider dispute form is an effective way for providers to articulate their concerns and correctly elicit the required information to review a dispute. The Plan proposes to continue using the existing provider dispute form,
but changed its policy and procedures to also consider other written provider correspondence as a provider dispute.

To support this approach, the Plan is implementing new procedures designed to identify provider disputes within the general mail correspondence and to route such cases to the Provider Dispute Team for acknowledgement and resolution.

- Any disputes on the Provider Dispute Form will be sent directly to the Provider Dispute Team.
- Correspondence will continue to be reviewed by the Correspondence Team, with the goal of sorting provider correspondence, reviewing for the elements of a provider dispute, and forwarding these to the Provider Dispute Team for action.
- Quality Assurance audits will be established to assure that the appropriate correspondence is identified as a dispute and forwarded to the Provider Dispute Team.

To assure that this procedure change is effectively implemented, the following documentation has been prepared:

- Workflow Document.
- Grievance and Appeals Procedure Manual.

This new workflow was introduced to the Customer Service Team and Grievance and Appeals Department’s Provider Dispute Team on August 29, 2014. The updated procedure documents were distributed, training completed, and the process was fully implemented by September 15, 2014.

Responsible Management Positions

- John Yamamoto – Vice President, Professional Services
- Preddis Sullivan – Director, Professional Services
- Alice Strobel – Manager of Grievance & Appeals Department

The Plan submitted following Supporting Documentation:

- Customer Service – Provider Dispute Team Workflow
- Procedural Manual – Identification and Routing of Provider Disputes
- Procedural Manual – Receipt and Processing of Provider Disputes

The Department finds that the Plan’s compliance effort is responsive to the corrective action required.
5. INCORRECT DATE OF RECEIPT—Repeat Deficiency

Rule 1300.71.38(a)(3) defines "Date of receipt" as the working day when the provider dispute or amended provider dispute is first delivered to the Plan.

The Department's examination disclosed that the Plan’s procedures did not ensure an accurate capture of the date of receipt on five (5) Delta Care PDRs. The samples reviewed were PDR22, PDR29, PDR30, PDR34, and PDR35.

The Plan’s failure to capture the correct date of receipt of PDRs is a repeat deficiency, as this issue was previously reported in the Department’s Final Report of Non-Routine Examination dated October 9, 2013 (for the periods beginning December 1, 2011 through February 28, 2012 and April 1, 2012 through June 30, 2012). This examination disclosed that the Plan’s compliance efforts in response to the prior examination report have not achieved the necessary levels of compliance with the Act and Regulations cited.

The Plan was required to explain why the previous corrective action taken was not effective in preventing this repeat deficiency and to state the measures taken to prevent further recurrence of noncompliance in this area.

The Plan was required to submit its revised policy and procedures implemented to capture the correct PDR receipt date in compliance with the above Rule. The Plan was also required to demonstrate that it provided training to its staff and established internal auditing procedures to ensure that policies and procedures are followed. In addition, the Plan was required to provide the date of implementation and the management position(s) responsible for ensuring continued compliance with this Rule.

**PLAN’S RESPONSE**

The Plan responded that the Plan’s previous corrective action was based on the Department’s 2013 Final Report of Non-Routine Examination for its PPO and Premier product lines and the conversion from its legacy processing system to the MetaVance system. In response to that exam, the Plan developed a corrective action plan that was focused on the Premier and PPO grievance units, and an implementation plan with the provider dispute team that handles Premier and PPO product lines. Unfortunately, the Plan did not extend the implementation of the corrective action to the DeltaCare provider dispute team.

**Plan’s Corrective Action Plan**

In order to ensure the correct receipt date is captured on its DeltaCare PDRs, the Plan completed the following:

- The Plan has created a new DeltaCare PDR processing control form, to ensure that the Provider Dispute Team correctly informs the Claims Team of the PDR determination, the receipt date of the PDR, and the requirement to make payment
within 5 days. The implementation date of May 14, 2014 coincided within the completion of training of Quality Management and Claims Department Staff.

- The Plan’s Quality Management Department developed audit procedures to ensure that staff is using the new form and also to ensure that the Claims Team is correctly capturing the dates and paying on time.
- The Quality Management Department amended its written procedures to document the new procedures, including use of the form, recording of the determination date, and payment within 5 days.

Management Responsibilities:

Within the DeltaCare Quality Management Department, responsibility for compliance and monitoring of the provider dispute procedures belongs to:

- John Yamamoto, Vice President, Professional Services
- Peddis Sullivan, Director, Professional Services
- James Saunders, Dental Director, DeltaCare USA
- Susie Muniz, Manager of Professional Services and Quality Assessment

Within the Delta Care Claims Department, responsibility for compliance and monitoring the claims process belongs to:

- Robert Menhart, Vice President Enterprise Claims
- Glenda Broadnax-McCoy, Manager of Claims

The Plan submitted the following Supporting Documentation:

- Provider Dispute Process Quality Control Form
- Procedure Manual, Provider Disputes

The Department finds that the Plan’s compliance effort is responsive to 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 to this Section.
Delta Dental of California (“Delta Dental”), a specialized health care service plan, respectfully submits the following as an addendum to the Final Report issued by the Department of Managed Health Care (“Department”) on December 29, 2014.

Delta Dental would like to make the following additions and/or changes to the report (shown in red font):

SECTION III. COMPLIANCE ISSUES

A. CLAIM SETTLEMENT PRACTICES

1. INTEREST CALCULATIONS ON LATE CLAIMS

   DELTA CARE CLAIMS

   Delta Dental reiterates that this is a deficiency of first impression with the DeltaCare Program and not a repeat deficiency.

   The first sentence of the second paragraph of the deficiency should read, “The Plan's failure to use working calendar days to determine amount of interest owed ....”

   Amend paragraph 1 of the Plan's Response to say:

   "The Department’s deficiency above is directed at the Plan’s DeltaCare claims. The DeltaCare program is a closed panel, DHMO program where enrollees are assigned to specific General Dentists who are generally compensated on capitation basis. Services provided by General Dentists do not generate claims; claims under the DeltaCare program are almost exclusively for specialist services."

   Amend paragraph 3, sentence 2 to say:

   "The underlying reasons for the 2012 non-routine exam were complaints to the Department by Plan providers stating payments were not made timely due to the Plan’s large-scale claims processing system conversion that began in mid-2012 2011."

   Amend paragraph 6 by adding the following sentence as sentence 5:

   "Delta Dental also has a QA process where any change made by the Configuration Lead is validated by another staff member before the payment cycle is affected by the change."
2. INCORRECT DATE OF RECEIPT

Delta Dental reiterates that this is a deficiency of first impression with the DeltaCare Program and not a repeat deficiency.

Amend Item 2 under the Plan’s Corrective Action Plan to say:

Scheduled the second phase of system conversion to MetaVance by year-end which will provide a long-term solution to this issue as MetaVance uses the correct business and IT systems Logic.

3. FAILURE TO DENY A CLAIM WITHIN REQUIRED TIMEFRAME

Delta Dental reiterates that this is a deficiency of first impression with the DeltaCare Program and not a repeat deficiency.

B. PROVIDER DISPUTE RESOLUTION (PDR) PROCESS

1. FAILURE TO PAY INTEREST ON OVERTURNED PROVIDER DISPUTES

Delta Dental reiterates that this is a deficiency of first impression with the DeltaCare Program and not a repeat deficiency.

Amend paragraph 1 of the Plan’s Response to say:

The Department conducted a non-routine examination of the Plan’s fee-for-service programs (PPO and Premier) in 2012, and issued a Final Report October 9, 2013. The Plan corrected deficiencies for its fee-for-service programs noted during the non-routine exam, and put into place policies and procedures for the accurate and timely processing of provider disputes, including interest payments (see the Enterprise Policy and Guideline Interest Calculation and Payment on Late Claims). As the Plan articulated in its response to Deficiency A.1.a., the work the Plan did to correct its MetaVance system and to create policies going forward were noted as responsive by the Department, however, the corrections and policies were not applied to the Plan’s DeltaCare provider disputes, which were processed on a completely separate system/platform than MetaVance. The conversion of DeltaCare to MetaVance will result in DeltaCare provider disputes being processed in the same corrected manner as fee-for-service provider disputes. The Plan recognizes that its failure to pay interest on overturned DeltaCare disputes is a deficiency, but it is a deficiency of first impression with the DeltaCare program and not a repeat deficiency.

2. PAST DUE PAYMENT ON PROVIDER DISPUTES

Delta Dental reiterates that this is a deficiency of first impression with the DeltaCare Program and not a repeat deficiency.

Amend paragraph 1, sentence 1 of the Plan’s Response to say:

The Plan’s previous corrective action was based on the Department’s Non-Routine Examination for its PPO and Premier product lines and the conversion from the legacy processing system to the MetaVance system.
3. REQUEST FOR REIMBURSEMENT OF AN OVERPAYMENT

No Change

4. FAILURE TO RECORD PROVIDER DISPUTES

Amend the Plan’s Response by adding:

PLAN’S RESPONSE

The plan uses the written provider dispute form as a clear demarcation that a provider wishes to dispute a claim or contract issue. The Plan’s process, including the use of a provider form has been filed and approved by the Department. The plan has processes and procedures in place to route those forms directly to the proper department and acknowledge receipt of the dispute. This process is an effective and efficient process for the Mailroom and Correspondence Unit to quickly sort and forward disputes that belong to the Provider Dispute Team. Prior to instituting the use of a form, the Plan would receive scraps of paper with sometimes illegible comments from providers (some on the back of envelopes and post-it notes) that left it unclear what action needed to be taken. If provider disputes are lumped in with other correspondence, it will take longer to read each letter, determine if it is a dispute, and forward to the appropriate department.

An important component of the form is that it is designed to elicit key information required to quickly review the facts of the case. Without the form, the Plan is much more likely to have to request additional information via the amended dispute process which would only postpone the ultimate resolution of the dispute. Note that the Plan uses a form in its fee-for-service (PPO and Premier) programs where there is only retrospective review for general dentists and specialists and no prior authorization process. Often correspondence from providers are only inquiries and not disputes. Relabeling inquiries as disputes and shifting work from one team to another is not effective or efficient and does not assure that provider disputes will be handled correctly.

Plan’s Corrective Action Plan

The Plan responded....

5. INCORRECT DATE OF RECEIPT

Delta Dental reiterates that this is a deficiency of first impression with the DeltaCare Program and not a repeat deficiency