DEPARTMENT OF Managed Health Care

OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

FINAL REPORT

ROUTINE SURVEY

OF

ACCESS DENTAL PLAN

A DENTAL HEALTH PLAN

FEBRUARY 6, 2020

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EXECUTIVE SUMMARY

On October 1, 2018, the California Department of Managed Health Care (Department) notified Access Dental Plan (Plan) that it would conduct its scheduled Routine Survey pursuant to Health and Safety Code section 1380. The Department requested the Plan submit information regarding its health care delivery system in connection with the Routine Survey. The survey team conducted the onsite survey from February 19, 2019 through February 21, 2019.

The Department assessed the following areas:

Quality Assurance
Grievances and Appeals
Access and Availability of Services
Utilization Management
Language Assistance

The Department identified **nine** deficiencies during the Routine Survey. The 2019 Survey Deficiencies Table below notes the status of each deficiency.

2019 SURVEY DEFICIENCIES TABLE

#	DEFICIENCY STATEMENT	
	GRIEVANCES AND APPEALS	
1	**The Plan failed to process all expressions of dissatisfaction received by phone as grievances.** Section 1368(a)(1); Rule 1300.68(a)(1) and (2).	**Not Corrected**
2	**The Plan did not ensure adequate consideration and rectification of enrollee grievances.** Section 1368(a)(1).	**Not Corrected**
3	**The Plan's resolution notices to enrollees are not clear and concise.** Section 1368(a)(5); Rule 1300.68(d)(3).	**Not Corrected**
4	**For grievances involving coverage disputes, the Plan's resolution notices did not consistently include the specific provision in the contract, evidence of coverage document, or member handbook that excluded coverage of the requested services.** Section 1368(a)(5); Rule 1300.68(d)(5).	**Not Corrected**
5	**The Plan does not consistently include in acknowledgement notices the address of the Plan's representative who may be contacted about a grievance.** Section 1368(a)(4)(A)(iii); Rule 1300.68(d)(1).	**Not Corrected**

	UTILIZATION MANAGEMENT	
6	**The Plan's written communications to enrollees regarding decisions to deny or modify requested dental care services for reasons of medical necessity do not consistently include (i) a clear and concise explanation of the reasons for the decision; (ii) a description of the criteria or guidelines used; and, (iii) the clinical reason for the decision.** Section 1367.01(h)(4).	**Not Corrected**
7	**The Plan's written communications to enrollees regarding decisions to deny or modify requested dental care services for reasons of medical necessity did not include the statement required by Section 1368.02(b).** Section 1367.0(h)(4); Section 1368.02(b); Rule 1300.68(b)(2).	**Not Corrected**
8	**The Plan's written communications to enrollees regarding decisions to deny or modify requested dental care services for reasons of medical necessity did not include all required information about how to file a grievance with the Plan.** Section 1367.01(h)(4); Section 1368; Rule 1300.68(a) and (b)(2); Rule 1300.68.01(a); Rule 1368.015(b).	**Not Corrected**
	LANGUAGE ASSISTANCE	
9	**Plan does not ensure interpretation requirements are met for urgent appointments requested by commercial enrollees.** Section 1367.04; Rule 1300.67.04(c)(2)(G)(v); Rule 1300.67.2.2(c)(4).	**Corrected**

SURVEY OVERVIEW

At least once every three years the Department evaluates each licensed health care service plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975[1] through a routine survey that covers major areas of the plan's health care delivery system. Surveys are conducted pursuant to Section 1380 and include a review of the overall performance of the plan in providing health care benefits and meeting the health care needs of enrollees in the following areas:

Quality Assurance – Each plan is required to have a quality assurance program directed by providers and designed to monitor and assess the quality of care provided to enrollees, and to take effective action to improve the quality of care when necessary. The quality assurance program must address service elements, including accessibility, availability and continuity of care and must monitor whether the provision and utilization of services meets professionally recognized standards of practice.

Grievances and Appeals – Each plan is required to have a grievance system that ensures a written record and adequate consideration of grievances, appropriate and timely processing and resolution, continuous review to identify any emergent patterns of grievances, and reporting procedures to improve plan policies and procedures.

Access and Availability of Services – Each plan is required to provide or arrange for the provision of access to health care services in a timely manner, appropriate for the enrollees condition and consistent with good professional practice.

Utilization Management – Plan and delegate utilization management functions must ensure that decisions based on medical necessity are consistent with clinical criteria/guidelines, that utilization review and oversight operations are performed by appropriate personnel and that enrollees and requesting providers receive timely and appropriate information concerning approvals, denials and modifications of requested services. Plans must also ensure that utilization functions satisfy access and quality requirements.

Language Assistance – Each plan is required to implement a language assistance program to ensure interpretation and translation services are accessible and available to enrollees.

The Department issued the Preliminary Report to the Plan on September 23, 2019. The Plan had 45 days to file a written statement with the Director identifying each deficiency and describing the action taken to correct each deficiency and the results of such action.

[1] The Knox-Keene Act is codified at Health and Safety Code section 1340 et seq. All references to "Section" are to the Health and Safety Code unless otherwise indicated. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations section 1000 et seq. All references to "Rule" are to Title 28 of the California Code of Regulations unless otherwise indicated.

This Final Report describes the deficiencies identified during the survey, the Plan's compliance efforts, the status of each deficiency at the time of the Department's receipt of the Plan's 45 day response and actions for outstanding deficiencies requiring more than 45 days which will be reassessed at a Follow-Up Survey.

PLAN BACKGROUND

The Plan is a for-profit specialized plan and received a Knox-Keene Act license on December 22, 1993. The Plan's parent company, The Guardian Life Insurance Company of America, is headquartered in New York, New York. The Plan offers two types of products to Californian consumers: commercial dental health maintenance organization (DHMO) and Medi-Cal. The Department of Health Care Services (DHCS) is the contractor for the Plan's Medi-Cal line of business under the Geographic Managed Care (GMC) Program model in Sacramento and the Los Angeles Prepaid Health Plan (LAPHP) in Los Angeles. The Plan provides its commercial DHMO product to consumers in various counties throughout California. As of October 31, 2018, the Plan's enrollment was 353,251. The table below is a summary of the Plan's enrollment population by product type.

TABLE 1
Enrollment Size by Product Type and Service Area

PRODUCT TYPE	PRODUCT NAME	NUMBER OF ENROLLEES	COUNTIES
Medi-Cal	GMC	130,404	Sacramento
Medi-Cal	PHP	161,729	Los Angeles
Commercial DHMO	Group	46,718	Counties throughout California
Commercial DHMO	Individual	14,400	Counties throughout California
Total		**353,251**	

Administrative Services Agreement

Since March 24, 2006, the Plan has been subject to an undertaking issued in conjunction with an Order approving a Notice of Material Modification[2] concerning the Plan's delegation of administrative services to an Indian corporation, Data Telesis. Undertaking number 8 requires the Plan ensure that Data Telesis' out-of-country personnel will "process only claims of a ministerial nature" and Data Telesis' out-of-country personnel will "not engage in clinical decision-making, but reserve that function to California-based Plan personnel."

At a discussion about the Plan's utilization management (UM) program held at the Plan's offices during the onsite portion of the survey, Plan staff asserted that the Plan delegates medical necessity review of requests submitted by commercial enrollees to Data Telesis. Plan staff explained that Data Telesis has India licensed providers, but that those providers are not permitted to deny a request - modifications and delays are treated as denials. A monthly audit process is performed by which the Plan ensures that no one at Data Telesis has denied a request. The Plan's Dental Director also described a calibration process to ensure the accuracy of out-of-country personnel approval decisions. Every month one of the Plan's California licensed consultants reviews a portion of procedures approved by Data Telesis staff to confirm whether approval was justified. The Office of Plan Monitoring shared this information with the Department's Office of Enforcement (OE) for further review and investigation into the Plan's adherence with Undertaking number 8; the OE issued a cease and desisted order on August 15, 2019.

[2] eFile #20055174.

SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

On September 23, 2019, the Department issued the Plan a Preliminary Report that described each deficiency, as well as the legal and factual basis for each deficient finding. In that report, the Department instructed the Plan to within 45 days of issuance of the Preliminary Report:

(a) Develop and implement a corrective action plan (CAP) for each deficiency, and
(b) Provide the Department with evidence of the Plan's completion of, or progress toward, implementing those corrective actions.

The following describes the Department's preliminary findings, the Plan's corrective actions, and the status of the deficiency following the Department's review of the Plan's compliance efforts.

DEFICIENCIES

GRIEVANCES AND APPEALS

Deficiency #1: The Plan failed to process all expressions of dissatisfaction received by phone as grievances.

Statutory/Regulatory References: Section 1368(a)(1); Rule 1300.68(a)(1) and (2).

Assessment: Based on review of the Plan's policies and procedures, and analysis of audio recordings of enrollee phone calls to the Plan (call inquiries), the Department found the Plan is failing to comply with Knox-Keene Act grievance requirements, and the Plan's grievance processing policies, because Plan staff do not consistently process all expressions of dissatisfaction as grievances.

To adequately consider and rectify enrollee grievances, Section 1368 requires that the Plan maintain and follow a written grievance system approved by the Department. The Plan's *Grievance and Appeals* policy correctly defines "grievance" in accordance with Rule 1300.68(a)(1) and (2), by stating that a grievance is:

> a written or oral expression of dissatisfaction regarding the Plan and/or Provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal.... Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

The Plan provided the Department a log of all call inquiries received by the Plan between November 1, 2017 and September 30, 2018. Included in the log was a field titled NOTE_DESCRIPTION that summarized each call inquiry with a brief description of the purpose and outcome of each call. The Department drew from the log a list of call inquiries with words indicating an expression of dissatisfaction within the NOTE_DESCRIPTION field, such as "unhappy," "escalated" and "wrong." 7,767 call inquiries included words that indicated a possible expression of dissatisfaction. A

Department analyst listened to and analyzed 70 call inquiries randomly selected from the list of 7,767.

The Department found that the Plan is operating at variance with its own policy because Customer Service Representatives (CSRs) are not consistently processing call inquiries as grievances when there is a clear expression of dissatisfaction, evidenced by an enrollee's use of negative adjectives, references, or statements. The Department found 29[3] out of 70 (41%) call inquiries analyzed, involved expressions of dissatisfaction. The Department reviewed the standard and exempt grievance logs for that same period to determine if any of the 29 call inquiries that included expressions of dissatisfaction had been processed as grievances. Out of the 29 files, zero files were processed as a standard or exempt grievance.

Case Examples

- **File #3:** The audio recording captured the enrollee complaining about being sent to four providers for extraction of an infected, abscessed tooth without getting service. A CSR transferred the call to a supervisor and the recording ended at that point. The CSR's description of the outcome of the call was, "[M]ember upset, claims he's getting the run-around from dental surgeon regarding an extraction." Further notes were entered by the supervisor and indicate the supervisor was also told by enrollee that he was getting the run around. The supervisor determined that Plan had not authorized specialist care for lack of documentation from the enrollee's primary care dentist. The supervisor contacted the enrollee's primary care doctor twice to obtain records and called enrollee 3 days after the initial call to tell him Plan was waiting for claims review and approval.

Although the supervisor started a process to rectify the enrollee's situation, the inquiry call record does not document when the claims review was complete, nor whether the enrollee was scheduled for a procedure. There was also no indication of any grievance referral or further action even though the record indicates use of the words "upset" and "getting the run around".

- **File #12:** The enrollee called to complain about "issues with current PDO, wants to change to different location." CSR made the change effective on the first day of the following month. In a second phone call the same day, enrollee tells a different CSR that the enrollee "is at a new dental office, had gone to new assigned PDO but realized she's having the same issues with that company, asks to transfer to this different dental company and location."

CSRs reassigned enrollee as requested on each call, but neither CSR considered enrollee's use of the term "issues" as an oral expression of dissatisfaction. The case was closed/resolved. There was no evidence in either the standard or exempt grievance logs or files that this case was processed as a grievance.

[3] File #1; File #2; File #3; File #4; File #6; File #7; File #8; File #10; File #12; File #14; File #17; File #18; File #20; File #22; File #26; File #31; File #35; File #37; File #39; File #44; File #45; File #52; File #53; File #57; File #59; File #60; File #61; File #62; and File #64.

- **File #60:** The enrollee's father called the Customer Service Department. The CSR noted the following information: "Member's father [is] concerned that he can't get an appointment for his son because a required CT Scan has not been delivered to dentist." "CSR contacted specialist office, confirmed they're having technical problems with CT scan but will see son to address his pain."

There was no evidence in the file that the CSR considered the term "concern" as an expression of oral dissatisfaction, or the fact that the son was in pain and access was being delayed due to an equipment issue as a potential quality of service lapse. The case was closed/resolved. There was no evidence in either the standard or exempt grievance logs or files that this case was processed as a grievance.

TABLE 2
Call Inquiries

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Call Inquiries	70	Is there an expression of dissatisfaction regarding the Plan and/or provider, a complaint, dispute, request for reconsideration or appeal?	41 (59%)	29 (41%)

Plan's Compliance Effort: The Plan reported that it implemented additional oversight and training. The Plan's oversight of call center services going forward will include listening for expressions of dissatisfaction during quality monitoring, and ad-hoc silent monitoring and coaching of staff, when necessary. Listening for expressions of dissatisfaction will also be included in the Monthly Monitoring call audit, and the auditor will require a CAP when an audit reveals improper handling of expressions of dissatisfaction. Customer service managers will audit the records created by staff to ensure grievances are accurately logged and described. Training going forward will include quarterly refresher training focusing on grievance processing. Customer service staff will receive more initial training on identifying grievances, documenting appropriately and ensuring resolution. The curriculum will include case studies and discussion of how to recognize words that indicate dissatisfaction.

Supporting Documentation:

- Plan's Response to Preliminary Report (November 7, 2019)

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions proposed, the Department has determined that this deficiency has not been corrected.

Pursuant to Section 1368, the Plan must ensure that staff consistently identify all expressions of dissatisfaction as grievances. The Plan described several corrective actions it has taken to address this deficiency, including revision of its monitoring and training procedures. However, the Plan has not provided the Department with any documentation supporting implementation of its CAP, nor has the Plan had adequate time to demonstrate the effectiveness of its proposed changes. The Department cannot find the Plan has corrected this deficiency until it has had the opportunity to review call inquiry records to ensure Plan staff consistently identify expressions of dissatisfaction.

The Department will conduct a Follow-Up Survey to assess and verify the Plan's compliance with Section 1368. The Department will review the Plan's grievance policies and procedures, training materials, including evidence that all relevant Plan staff completed the training, and a sample of the Plan's inquiry files. The Department will also review meeting minutes for the Plan's Quality Management Committee to confirm the committee is engaged and overseeing the Plan's corrective action efforts. The Department may also conduct interviews and review any other documents deemed relevant.

Deficiency #2: The Plan did not ensure adequate consideration and rectification of enrollee grievances.

Statutory/Regulatory Reference: Section 1368(a)(1).

Assessment: Section 1368(a)(1) requires that the Plan have a grievance system that ensures "adequate consideration of enrollee grievances and rectification when appropriate." Based on a review of 57 standard grievance files randomly selected from a universe of 283, the Department found that the Plan did not fully consider and rectify all the grievance issues found in 18[4] (32%) of the files. The Plan's grievance procedures primarily failed to address complaints about quality of service when the quality of service issue was part of a complaint involving other issues, such as quality of care or access to care. The Plan's notices of resolution consistently included a complete description of an enrollee's complaint in the form of a bulleted list noting each concern the Plan identified in an enrollee's grievance communication. However, the Plan did not consistently address all the concerns in such bulleted lists, in particular overlooking many quality of service complaints.

Case Examples

- **File #11:** Plan received a written grievance by email from an enrollee. The enrollee asserted she had been advised, during an evaluation exam, to have a tooth pulled. When the enrollee returned for the extraction to the same provider's office, the provider then questioned the enrollee as to whether the enrollee was taking medication for osteoporosis. Since the enrollee was taking such medication, the provider then informed the enrollee that the dentist could not extract the enrollee's tooth without written approval by a medical physician. The

[4] File #1; File #3; File #9; File #11; File #13; File #14; File #16; File #21; File #30; File #31; File #32; File #34; File #36; File #40; File #41; File #46; File #50; and File #52.

enrollee expressed her frustration that the provider's office had not questioned her about her medical history during the evaluation exam. The enrollee also asserted that the extraction was rescheduled to be performed at the same office, and the enrollee returned with written approval. The bulleted list describing the enrollee's concerns stated the following in regards to the rescheduled appointment:

- At your rescheduled appointment, the office said the Oral Surgeon did not take your insurance.
- You cannot believe that the office did not call you to tell you this.
- You will never return to the office.
- You still have your bad tooth and it does not hurt but half of the tooth is gone.

The Plan categorized the issues in the grievance as "Access to Care" and "Benefit Understanding" in the PQI Log, and the Plan's Dental Director categorized the grievance as an "Access to Care" concern. The resolution notice indicated the Plan had advised the provider concerning review of a patient's health history at evaluation and noted that the provider offered regrets concerning the failure to tell the enrollee about a medical release. The Statement of Resolution also noted that the Plan had approved a referral to oral surgery for the extraction.

However, based on the *Grievance and Appeals: Policy ID GA.001.01*, the grievance contained a quality of service issue due to the unprofessional behavior exhibited by the dental office. The Statement of Resolution did not address's the enrollee's assertion that she had returned to the provider with authorization but treatment was delayed again for failure to process a referral. The dental office did not communicate clearly with the enrollee regarding the need for a medical release and did not explain to the enrollee that her primary care dentist (PCD) would need to make a referral for her to visit an oral surgeon for the tooth extraction.

- **File #30:** An enrollee's employer sent an email to the Plan to file a grievance against the enrollee's provider on the enrollee's behalf. The employer's message asserted that enrollee's selected provider told enrollee the provider had cancelled their contract with Plan and would not continue with the enrollee's treatment. Additionally, the employer's message asserted the provider made the member pay for all services out of pocket and the invoice used incorrect billing copays. The Plan's Statement of Resolution stated that the enrollee's additional concerns were:
  - You want to know if the office can stop treatment in progress if they are cancelling their contract with the Plan.
  - You would like the Plan to contact the office to submit claims for your services completed in February.
  - You would also like to be refunded for the money you paid to the office for covered services.

The Plan categorized the issues in the grievance as "coverage benefits dispute." The resolution notice discussed the billing and refund issues, confirming that the provider had added to enrollee's account the cost of services that were covered by the Plan. However, although the resolution letter confirms the Plan's knowledge of the enrollee's question, the Plan failed address whether the

provider could terminate treatment in progress due to cancellation of the contract with the Plan.

TABLE 3
Adequate Consideration and Rectification of Grievances

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard Grievances	57	The Plan adequately considered and rectified the complainant's grievance	39 (68%)	18 (32%)

Plan's Compliance Effort: The Plan reported that it implemented additional oversight and training. Going forward standard review of grievance resolutions will include review by the Dental Director, or designee, to ensure all issues are addressed and resolved. On October 4, 2019, the Plan also conducted additional training which focused on grievance processing and included a discussion about the requirement to address all concerns expressed in a grievance.

Supporting Documentation:

- Plan's Response to Preliminary Report (November 7, 2019)

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions proposed, the Department has determined that this deficiency has not been corrected.

Pursuant to Section 1368(a)(1), the Plan must ensure that all grievance issues are adequately considered and rectified. The Plan reports it has revised its monitoring procedures and conducted additional training. However, the Plan has not provided the Department with supporting documentation, nor has the Plan had adequate time to demonstrate the effectiveness of its proposed changes. The Department cannot find the Plan has corrected this deficiency until it has had the opportunity to review grievance files to ensure Plan staff consistently consider and resolve all issues involved in a grievance.

The Department will conduct a Follow-Up Survey to assess and verify the Plan's compliance with Section 1368. The Department will review the Plan's grievance policies and procedures, training materials, including evidence that all relevant Plan staff completed the training, and a sample of the Plan's grievance files. The Department will also review meeting minutes for the Plan's Quality Management Committee to confirm the committee is engaged and overseeing the Plan's corrective action efforts. The Department may also conduct interviews and review any other documents deemed relevant.

Deficiency #3: The Plan's resolution notices to enrollees are not clear and concise.

Statutory/Regulatory References: Section 1368(a)(5); Rule 1300.68(d)(3).

Assessment: Section 1368(a)(5) and Rule 1300.68(d)(3), require that the Plan send a written explanation of the Plan's resolution of a grievance, which shall be "clear and concise." Based on a review of 57 standard grievance files randomly selected from a universe of 283, the Department found the Plan's resolution notices consistently lacked clarity and conciseness. The Department found 28[5] (49%) of resolution notices did not contain a clear and concise explanation of the Plan's determination. The three standard grievance cases below demonstrate the Plan's resolution notices lacking a clear and concise explanation of the Plan's decision.

Case Examples

- **File #1:** The enrollee filed a grievance against her dental provider for refusing to extract tooth #31. The dentist stated at an initial appointment that there was no clinical reason to extract the tooth. The enrollee returned to the dental office as an emergency because she was having pain on tooth #31. The dentist advised the enrollee at that time to see a periodontist and endodontist.

The Plan included the following in its resolution letter:

> Your coverage with the Plan began on 07/01/2016. On 12/22/17, you called the Plan, requesting [Dental Group A], as your Primary Care Dentist (PCD). Per your request, you were assigned there, starting on 12/22/17. ... On 02/02/18 the Plan received an emergency referral from your PCD, [Dental Group A]. The Plan approved your referral, the same day; 02/02/18, to see specialty-care provider at [Dental Specialty A] for evaluation of tooth #31. On 02/12/18, the Plan received a second emergency referral from your PCD. The Plan approved your second referral on 02/13/18. The Plan referred you to the same provider, at [Dental Specialty A], the Plan contacted you and told you that your referral was approved. Please note your Primary Care Dentist (PCD) will determine if you need to be referred to a specialist. PCD must send specialty-care referral requests to the Plan. The Plan will approve or deny referrals, based on information sent by the PCD. The Plan will choose a specialty-care provider and facility; then notify the member, PCD and Specialty-Care office, of approved referrals. You do not need a referral for; visits to your PCD or urgent/emergency care (to relieve pain).

In the resolution notice, the Plan included the enrollee's eligibility information and dental history, which is not relevant to the enrollee's primary grievance. The information above

[5] File #1; File #3; File #5; File #8; File #9; File #11; File #13; File #15; File #16; File #18; File #20; File #21; File #22; File #24; File #26; File #29; File #34; File #38; File #44; File #46; File #47; File #48; File #49; File #50; File #53; File #54; File #56; File #57.

does not relate to the enrollee's complaint about the dentist's refusal to extract tooth #31. Additionally, the body of the notice is over two pages long. The resolution letter was not clear nor concise.

- **File #5:** The enrollee's mother called the Plan to check on the status of an emergency referral to a pedodontist for her son. During the call, the enrollee's mother learned that the primary care dentist that recommended an emergency referral for treatment of two large cavities had not yet submitted a referral request. She then expressed concern and dissatisfaction, so the Plan processed the communication as a standard grievance. The Plan's *Statement of Resolution* stated that the enrollee's concerns included:

  • You would like to file a complaint ... because the office is not child friendly. The office is not equipped for children to be seen for general exams.
  • The staff's "bed-side manners" are not acceptable when dealing with small children in an emergency.
  • You called the Plan ... to check the status of your son's Pedodontist referral. The Plan said it was not on file.

In response to the concerns, the Plan's *Statement of Resolution* stated, in part:

> As Administrators of your Plan, we were not witness to the events or conversations that took place ... Therefore, we are unable to determine what happened during his office visit.... Your son visited the office and a visual exam was completed. The dentist diagnosed large cavities on teeth #L and #S and referred your son to a Pedodontist for treatment. The office offered their regrets and apologized for any inconvenience you or your son may have experienced.

It is unclear from this statement whether the Plan investigated both the concerns about staff behavior during the appointment and the failure to promptly submit an urgent referral request. The notice also included extraneous information that rendered the notice not concise. The notice listed the enrollee's entire service history, including the date of enrollment, the date the enrollee selected the primary care dentist, and the dates of several visits to the primary care dentist before the emergency exam that became the subject of the complaint.

- **File #24:** Enrollee called the Customer Service Department to file a grievance against her primary care dentist. The enrollee received dentures that were in a children's size. When the enrollee stated her concerns to the dentist, the dentist "forced her to take them anyhow," as noted by the CSR. The enrollee later returned to the office and left the dentures due to her dissatisfaction with the product.

In the resolution notice the Plan included eligibility information and the enrollee's entire history for the dentures, which was not relevant to the enrollee's grievance. For example, the resolution notice included the following information:

- You became effective with the Plan on 01/01/99. The Plan assigned you to [REDACTED] Dental Group as your Primary Care Dentist (PCD) effective [DATE].
- On [DATE], you visited the office for an exam and panoramic x-rays, to pre-authorize full upper and lower dentures.
- On [DATE], the Plan received a Notice of Authorization (NOA) for full Upper and Lower dentures and denied the Authorization (NOA) because we did not receive pre-operative x-rays from [REDACTED] Dental Group.
- On [DATE], the Plan received requested x-rays from the office and approved your dentures on [DATE].
- On [DATE], you returned to the office to take impressions for your full upper and lower dentures.

The enrollee complained about the quality of her dentures, thus, information on eligibility and her dental history for the service was superfluous and made the notice verbose. The Plan did not address the core of the grievance until page 2 of the notice. The letter was not clear nor concise.

TABLE 4
Standard Grievance Resolution Notices

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard Grievances	57	The resolution notice contains a clear and concise explanation of the Plan's decision	29 (51%)	28 (49%)

Plan's Compliance Effort: The Plan reported that it implemented additional oversight and training. Going forward standard review of grievance resolutions will include review by the Dental Director, or designee, to ensure all issues are addressed and resolved. On October 4, 2019, the Plan conducted additional training, which focused on grievance processing and discussed the requirement that resolution letters be clear and concise. The Plan also updated written policies, which now instruct staff to draft resolution letters that address the grievance issue near to the beginning of the letter and be no more than two pages long.

Supporting Documentation:

- Plan's Response to Preliminary Report (November 7, 2019)
- Grievance resolution letter sample dated October 10, 2019

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions proposed, the Department has determined that this deficiency has not been corrected.

Pursuant to Section 1368(a)(5) and Rule 1300.68(d)(3), the Plan must send a “clear and concise” written explanation of the Plan’s resolution of an enrollee’s grievance. The Plan reports it has revised its monitoring procedures and conducted additional training. The Plan’s sample grievance resolution letter is a clear and concise response to an enrollee’s customer service complaint. However, the Plan has not had adequate time to demonstrate the effectiveness of its proposed changes. The Department cannot find the Plan has corrected this deficiency until it has had the opportunity to review grievance files to ensure the Plan consistently sends a “clear and concise” written explanation of the Plan’s resolution of an enrollee’s grievance.

The Department will conduct a Follow-Up Survey to assess and verify the Plan’s compliance with Section 1368. The Department will review the Plan’s grievance policies and procedures, training materials, including evidence that all relevant Plan staff completed the training, and a sample of the Plan’s grievance files. The Department will also review meeting minutes for the Plan’s Quality Management Committee to confirm the committee is engaged and overseeing the Plan’s corrective action efforts. The Department may also conduct interviews and review any other documents deemed relevant.

Deficiency #4: **For grievances involving coverage disputes, the Plan’s resolution notices did not consistently include the specific provision in the contract, evidence of coverage document, or member handbook that excluded coverage of the requested services.**

Statutory/Regulatory References: Section 1368(a)(5); Rule 1300.68(d)(5).

Assessment: Based on review of the Plan’s policies and procedures, and analysis of grievance files documenting how the Plan processes standard grievances, the Department found the Plan is failing to comply with Knox-Keene Act grievance requirements. The Plan staff do not consistently specify, in notices resolving grievances concerning coverage disputes, the provision in the coverage contract, evidence of coverage or member handbook that excludes coverage of the service.

Section 1368(a)(5) and Rule 1300.68(d)(5), dictate some information that must be included in a written notice that resolves a grievance concerning denial of a service based on the finding that the requested service is not a covered benefit under the contract that applies to the enrollee, i.e. a coverage dispute. Those written notices must specify the provision in the coverage contract, evidence of coverage or member handbook that excludes coverage of the service. Rule 1300.68(d)(5), further requires that resolution notices, either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee.

The Plan’s *Grievance and Appeals* policy, at page 5, instructs staff that notices of resolution:

> [F]or grievances involving the delay, denial, or modification of dental care services, based in whole or in part on a finding that the proposed services are not a covered benefit under the Member's contract, the letter of resolution will clearly specify the provisions in the contract that exclude the coverage.

The Department reviewed 57 standard grievances randomly selected from a universe of 283, of which 17 files were grievances involving a coverage dispute. Out of those 17 files, 15[6] (88%) did not comply with Section 1368(a)(5) and Rule 1300.68(d)(5). The written notice of resolution in each of the non-compliant files failed to either identify the document and page where an exclusion provision could be found, describe the applicable section of the contract containing an exclusion provision, or provide a copy of an exclusion provision. Rather, the written notices of resolution in non-compliant files advised the enrollee to formally request a copy of all information used to make the decision.

Case Examples

- **File #15:** Plan denied a claim for routine hygiene services performed by a pediatric dentist (specialist) on a 9-year-old child. The notice of resolution stated, "Except for Emergency Dental Care, any services obtained from any provider other than the member's [Primary Care Dentist] without an approved referral by the Plan will not be paid by the Plan." The notice of resolution further explained that the provider who performed the services was not the enrollee's primary care dentist, participates as a pediatric specialist for enrollee's plan, and that specialists cannot be assigned as an enrollee's primary care dentist. So, enrollee should have sought authorization from the Plan through the enrollee's assigned primary care dentist before enrollee received services from the pediatric specialist. The resolution notice did not specify the provision in the Member Handbook that excludes the service for lack of prior authorization. Also, the resolution notice encouraged the enrollee to contact the Plan for a copy of the Member Handbook, but did not identify the page or section where the limitation on specialist services could be found, nor provide a copy of the provision.

- **File #39:** Enrollee appealed the denial of maxillary and mandibular (upper and lower) partial dentures with cast metal framework. The Plan denied the appeal because the enrollee's benefit covered a partial denture for the upper jaw only if the lower jaw had a full denture, and vice versa. The resolution notice stated, "Your prior authorization request for two (2) partial dentures (upper and lower;...) indicates there is no opposing full denture. The Plan does not dispute the need for upper and lower partial dentures. However, we are obligated to adhere to the benefits and guidelines of your Plan." The resolution notice did not specify whether a plan contract contained the exclusion applicable to the Plan's decision. Also, the resolution notice encouraged the enrollee to contact the Plan for a copy of all information used to make the decision, but did not identify a page or section

[6] File #7; File #15; File #17; File #19; File #23; File #31; File #32; File #34; File #37; File #39; File #41; File #42; File #45; File #52; File #53; File #55; and File #56.

in a member handbook where the limitation on dentures could be found, nor provide a copy of the provision.

- **File #55:** Enrollee lost her upper denture and requested a replacement. The Plan denied the appeal. The resolution notice stated, “Replacement of lost dentures is not a benefit of your ... Plan. However, in the event of a catastrophic loss (dentures stolen), beyond the control of the patient, documentation from a public service agency (police or fire report) may be sent to the Plan for review for benefit allowance.” The resolution notice did not specify whether a plan contract contained the exclusion applicable to the Plan’s decision. Also, the resolution notice encouraged the enrollee to contact the Plan for a copy of all information used to make the decision, but did not identify a page or section in a member handbook where the limitation on replacement dentures could be found, nor provide a copy of the provision.

TABLE 5
Standard Grievances and Appeals

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard Grievances and Appeals concerning Benefits/Coverage	17	Resolution notice cites contract provision that excludes coverage.	2 (12%)	15 (88%)

Plan’s Compliance Effort: The Plan reported that it implemented additional oversight and training. Going forward standard review of grievance resolutions will include review by the Dental Director, or designee, to ensure that appropriate references are cited when covered benefits are excluded. On October 4, 2019, the Plan conducted additional training, which focused on grievance processing and discussed the requirement to include the coverage exclusion in a resolution letter upholding a decision to deny benefits.

Supporting Documentation:
- Plan’s Response to Preliminary Report (November 7, 2019)
- Grievance resolution letter sample dated October 10, 2019

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions proposed, the Department has determined that this deficiency has not been corrected.

Pursuant to Section 1368(a)(5) and Rule 1300.68(d)(5), the Plan must include in notices resolving grievances concerning coverage disputes, the provision in the coverage contract, evidence of coverage or member handbook that excludes coverage of the service. The Plan has revised its monitoring procedures and conducted additional

training. Although, the Plan's sample grievance resolution letter does not involve a coverage dispute, the letter references the *Member Handbook*. However, the Plan should note that, in letters resolving coverage dispute grievances, the Plan must identify the document and page where the provision is found, or the letter must direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision.

The Plan has not had adequate time to demonstrate the effectiveness of its proposed changes. The Department cannot find the Plan has corrected this deficiency until it has had the opportunity to review grievance files to ensure the Plan consistently includes appropriate references in resolution letters when covered benefits are excluded.

The Department will conduct a Follow-Up Survey to assess and verify the Plan's compliance with Section 1368. The Department will review the Plan's grievance policies and procedures, training materials, including evidence that all relevant Plan staff completed the training, and a sample of the Plan's grievance files. The Department will also review meeting minutes for the Plan's Quality Management Committee to confirm the committee is engaged and overseeing the Plan's corrective action efforts. The Department may also conduct interviews and review any other documents deemed relevant.

Deficiency #5: The Plan does not consistently include in acknowledgement notices the address of the Plan's representative who may be contacted about a grievance.

Statutory/Regulatory References: Section 1368(a)(4)(A)(iii); Rule 1300.68(d)(1).

Assessment: Section 1368(a)(4)(A)(iii) and Rule 1300.68(d)(1), requires that the Plan provide a written acknowledgement of a grievance within 5 days of receipt. Those subdivisions require that the written acknowledgment include the name, phone number and address of the Plan representative who may be contacted about the grievance. The Department reviewed 57 standard grievance files randomly selected from a universe of 283. Of the 57 standard grievances, 38[7] (67%), had acknowledgment notices that were deficient. In all 38 cases, the Plan did not include in the acknowledgement notice the address of the Plan representative who may be contacted about the grievance.

[7] File #1; File #4; File #5; File #6; File #7; File #8; File #9; File #10; File #13; File #14; File #16; File #17; File #18; File #19; File #22; File #23; File #24; File #26; File #27; File #28; File #29; File #34; File #37; File #39; File #40; File #42; File #44; File #45; File #47; File #48; File #49; File #50; File #52; File #54; File #55; File #56; File #57; File #58.

TABLE 6
Acknowledgement Notices

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard Grievances	57	The acknowledgement notice to the grievant contains the name, address, and telephone number of the Plan's contact person	19 (33%)	38 (67%)

Plan's Compliance Effort: The Plan reported that it had implemented use of a revised acknowledgment template, effective October 14, 2019. The template contains the address of the representative that may be contacted concerning a grievance added below the Plan's logo on the upper left part of the first page.

Supporting Documentation:

- Plan's Response to Preliminary Report (November 7, 2019)
- Grievance acknowledgment letter dated March 15, 2018

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions proposed, the Department has determined that this deficiency has not been corrected.

Pursuant to Section 1368(a)(4)(A)(iii) and Rule 1300.68(d)(1), the Plan must include in the written acknowledgment of a grievance the address of the Plan representative who may be contacted about the grievance. The Plan states it has revised its acknowledgment letter template; however, the Plan did not submit a copy of the revised acknowledgement letter template for the Department's review. In addition, the Plan has not had adequate time to demonstrate the effectiveness of its proposed changes. The Department cannot find the Plan has corrected this deficiency until it has had the opportunity to review grievance files to ensure the Plan consistently includes the address of the Plan representative who may be contacted about the grievance in acknowledgment letters.

The Department will conduct a Follow-Up Survey to assess and verify the Plan's compliance with Section 1368. The Department will review the Plan's grievance policies and procedures and a sample of the Plan's grievance files.

Within 60 days of issuance of this Final Report, the Plan shall submit a supplemental response consisting of a copy of the revised acknowledgment template and provide a status report on the Plan's compliance efforts.

UTILIZATION MANAGEMENT

Deficiency #6: **The Plan's written communications to enrollees regarding decisions to deny or modify requested dental care services for reasons of medical necessity do not consistently include (i) a clear and concise explanation of the reasons for the decision; (ii) a description of the criteria or guidelines used; and, (iii) the clinical reason for the decision.**

Statutory/Regulatory Reference: Section 1367.01(h)(4).

Assessment: Section 1367.01(h)(4), requires that all communications to enrollees regarding decisions to deny, delay, or modify requested services based on medical necessity be in writing, and shall include a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decision.

During the survey, the Department reviewed the Plan's UM policies and procedures, including the Plan's policy describing procedures to deny a requested dental service, and examined UM denial files. The Plan's policy instructs UM staff to include the information required by Section 1367.01(h)(4), "in language that can be reasonably understood by laypersons". However, the Department determined from file review that the Plan's written communications to enrollees, which is a Notice of Authorization/Denial for a request submitted prior to receiving services and an Explanation of Benefits for a claim submitted after receipt of services, consistently failed to include a clear and concise explanation of the reason for the denial, the criteria or guidelines used to make the determination, and clinical reasoning.

The Department reviewed 70 randomly selected files containing documentation of the Plan's denial of dental services for reasons of medical necessity, i.e. UM denial files, out of a universe of 5,167. Of the 70 files reviewed, 61[8] (87%), had a denial notice that lacked a clear and concise explanation of the denial reason, a description of the criteria or guidelines used for the decision, and a clinical reason for the decision.

Case Examples

- **File #20:** The requesting provider submitted an emergency referral request due to a diagnosis of moderate chronic periodontitis .The requesting provider's examination notes stated, "past root canal treatment/radiolucency at apex," for tooth number 7. The examination notes specifically recommended, "Scaling, Root Planning due to moderate calculus levels and deep pockets in posterior quads. Recommend crowns on #18 and #30. Root Canal Therapy retreat/endo referral crowns for #7 and #10, upper partial." Although the exam notes

[8] File #1; File #2; File #5; File #6; File #8; File #9; File #10; File #11; File #12; File #14; File #15; File #16; File #17; File #18; File #19; File #20; File #21; File #24; File #26; File #27; File #28; File #29; File #30; File #31; File #32; File #33; File #34; File #35; File #36; File #37; File #38; File #39; File #40; File #41; File #42; File #43; File #44; File #45; File #46; File #47; File #48; File #49; File #50; File #51; File #52; File #53; File #54; File #55; File #58; File #59; File #60; File #61; File #62; File #63; File #64; File #65; File #66; File #67; File #68; File #69; File #70.

recommended several types of procedures, the referral request in this file concerned only endodontic therapy for tooth numbers 7 and 10.

The Notice of Authorization/Denial denied treatment by an endodontist by denying an endodontic evaluation exam. The Notice stated, “it appears the requested procedure is within the scope of the primary care dentist,” and that the enrollee or provider could “submit further documentation to justify the need for a specialist.” The Notice did not specify whether the requesting provider was being authorized to perform the recommended root canal retreatment for tooth numbers 7 and 10.

The Notice was not a clear and concise explanation of the reason for denial because it did not address the service actually requested, endodontic therapy or root canal retreatment, rather than an evaluation exam. In addition, the Notice does not specify the clinical/medical reasons that a primary care dentist should be able to perform the procedures necessary to treat the affected teeth. The Notice also failed to describe the criteria used for the decision, such as the criteria that must be met to obtain treatment by an endodontist or guidelines for determining procedures that may be performed by a primary care dentist.

Further, the Department’s quality assurance reviewer, an appropriately licensed professional, commented that the general denial reason did not address that tooth number 7 has a radiolucency at the apex and needed urgent retreatment, which is typically beyond the expertise of a primary care dentist and requires an endodontist. Therefore, the Plan’s general denial did not include provision for the emergency referral for tooth number 7.

- **File #26:** The requesting provider recommended periodontal scaling and root planing, localized delivery of antimicrobial agents, and sealant for 8 teeth. The requesting provider’s remarks were, “patient has pocket depth of 4-5mm. deep scaling is needed. please consider treatment options.” The Notice of Authorization/Denial denied authorization for the periodontal scaling, root planing and localized delivery of antimicrobial agents, but approved sealant. The Notice stated the reason for denial as, “Submitted information did not indicate the need for the requested procedure. Based on x-rays and/ or documentation submitted, we believe that the treatment is not needed at this time.”

The Notice was not a clear and concise explanation of the reason for denial and did not specify the clinical/medical reasons for denial. The Notice did not explain what the x-rays or other information indicated, nor what medical information, such as symptoms or exam results, were needed for authorization. The Notice also failed to describe the criteria used for the decision, such as the criteria that must be met to obtain periodontal scaling, root planing and localized delivery of antimicrobial agents.

- **File #45:** The requesting provider recommended orthodontic treatment for overjet and overbite. The Notice of Authorization/Denial denied treatment by an orthodontist by denying an orthodontic evaluation exam. The Notice stated, “The minimum requirements for orthodontic treatment could not be verified by the handicapping labial-lingual deviation index or submitted study models ... Member did not meet the minimum score of 26 points....”

The Notice was not a clear and concise explanation of the reason for denial because the Notice did not explain what the "handicapping labial-lingual deviation index" is and how it is used to determine eligibility for treatment. The use of industry terms without defining the terms made the Notice unclear for the enrollee. In addition, there was no explanation of the medical information in the Index that was specific to the enrollee, nor explanation of how that medical information impacted the determination. So the denial reasoning did not explain the clinical/medical reasons for denial, nor the criteria or guidelines used for the decision. Further, the denial statement indicated the denial was based on the "Index" form or submitted "study models", so it is not clear which was the determining factor, or explain what the "study models" are and how the studies impacted the determination.

TABLE 7
Standard Utilization Management Medical Necessity Denials

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard UM Medical Necessity Denials	70	Denial letters include (i) clear and concise reasoning; (ii) description of the clinical criteria or guidelines; and (iii) clinical reasoning.	9 (13%)	61 (87%)

Plan's Compliance Effort: The Plan's UM denial letters use "Reason Codes" and "Reason Code Descriptions" to explain the reasoning for a denial. A UM denial letter will list the treatment procedures requested and each denied procedure will be marked with a "Reason Code". Below the list of treatment procedures is a table that lists the "Reason Code" and the corresponding "Reason Code Description." For example, in a UM denial letter sent March 21, 2018[9] a request for surgical removal of a tooth was marked with "Reason Code" *2M*. Below the list of requested treatment procedures, a "Reason Code Description" table indicated that "2M" means the procedure was denied because the "[t]ooth is not present on submitted x-ray, a) unerupted, b) tooth # may be incorrect c) x-ray taken did not included this tooth (teeth)."

The Plan asserts that it is in the process of revising Reason Codes and Reason Code Descriptions to ensure UM Denial letters have an understandable and clear explanation of the reason for denial in language that can be reasonably understood by laypersons. The Dental Director will review and approve revised Reason Codes and the edited Codes will be presented to the QMC in the Fourth Quarter of 2019. The Plan expects to begin using revised Reason Codes in UM denial letters beginning February 1, 2020.

Supporting Documentation:

[9] File #2.

- Plan's Response to Preliminary Report (November 7, 2019)

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions proposed, the Department has determined that this deficiency has not been corrected.

Section 1367.01(h)(4), requires that all communications to enrollees regarding decisions to deny, delay, or modify requested services based on medical necessity be in writing, and shall include a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decision

The Plan reported that it has begun a process to improve the clarity of its UM denial letters, but expects that changes will not take effect until February 2020. Therefore, the Plan has not had adequate time to demonstrate compliance. The Department cannot find the Plan has corrected this deficiency until it has had the opportunity to review UM denial files to ensure the Plan consistently complies with the requirements of Section 1367.01.

The Department will conduct a Follow-Up Survey to assess and verify the Plan's compliance with Section 1367.01. The Department will review the Plan's UM policies and procedures and a sample of the Plan's UM denial files.

Deficiency #7: The Plan's written communications to enrollees regarding decisions to deny or modify requested dental care services for reasons of medical necessity did not include the statement required by Section 1368.02(b).

Statutory/Regulatory References: Section 1367.01(h)(4); Section 1368.02(b); Rule 1300.68(b)(2).

Assessment: Based on a review of the Plan's policy and procedure, Notice of Authorization/Denial (NOA) letter template, and 70 medical necessity denial letters, the Department determined that the Plan does not ensure that denial notifications sent to enrollees include the statement required by Section 1368.02(b), which concerns IMR rights, grievance rights and how to submit a grievance to the Plan and the Department.

Section 1367.01(h)(4), requires that the Plan's written communications to enrollees regarding decisions to deny or modify requested dental care services for reasons of medical necessity "include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368." The Plan must offer an enrollee the opportunity to participate in the Plan's grievance program when an enrollee's request for services is denied. Section 1368.02(b) requires that the Department's toll-free telephone number, the Department's TDD line for the hearing and speech impaired, the Plan's telephone number, and the Department's Internet address be printed on every written communication to an enrollee that offers the enrollee the opportunity to participate in the grievance process of the Plan. This information must be printed in 12-point boldface type within the following regular type statement:

> The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (**insert health plan's telephone number**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Rule 1300.68(b)(2) indicates that where a plan has an obligation to notify enrollees about the plan's grievance system, the plan must also include "information regarding the Department's review process, the independent medical review system, and the Department's toll-free telephone number and website address."

The Plan's policy and procedure that instructs Plan staff as to how to draft a denial Notice, Policy No. CL.012.01, states at Item 7 under the **Procedure** heading:

> Written communication includes instructions on how to file a grievance so that members who believe that dental services have been improperly denied, modified, or delayed by The Plan or a contracting provider have an opportunity to file a grievance.

However, *Policy No. CL.012.01* does not address inclusion of the statement required by Section 1368.02(b), nor IMR information. The Plan's Notice of Authorization template, which is used to notify members and providers of denial determinations prior to performance of services does not include the statement required by Section 1368.02(b).

The Department reviewed 70 randomly selected UM denial files out of the universe of 5,167. File review confirmed that of the 70 files, 63[10] (90%) were not compliant for failure to include the required paragraph in Section 1368.02(b).

TABLE 8

[10] File #1; File #2; File #3; File #4; File #5; File #6; File #7; File #8; File #9; File #10; File #11; File #12; File #13; File #14; File #15; File #16; File #17; File #18; File #19; File #20; File #21; File #22; File #23; File #25; File #26; File #27; File #28; File #29; File #30; File #31; File #32; File #33; File #34; File #35; File #36; File #37; File #38; File #39; File #40; File #41; File #42; File #43; File #44; File #45; File #46; File #47; File #49; File #50; File #51; File #52; File #53; File #54; File #55; File #57; File #60; File #61; File #62; File #64; File #66; File #67; File #68; File #69; and File #70.

Standard Utilization Management Medical Necessity Denials

FILE TYPE	NUMBER OF FILES	REQUIREMENT	COMPLIANT	DEFICIENT
Standard UM Medical Necessity Denials	70	Written communication contains the Section 1368.02(b) paragraph.	7 (10%)	63 (90%)

Plan's Compliance Effort: The Plan asserted that it had inadvertently left out of UM denial files copies of attachments that contain the statement required by Section 1368.02(b), and that are sent with every UM denial letter. The Plan provided samples of each attachment, a three-page attachment titled *Your Rights Under Dental Managed Care* that is inserted into UM denial notices sent to enrollees of the Plan's Geographic Managed Care and Partnership Health Plan (PHP) lines of businesses, and a one-page attachment titled *Grievance, Appeal and Independent Medical Review Insert* that is inserted into UM denial notices sent to enrollees of the Plan's commercial line of business. The Plan also updated its policy concerning drafting of UM denial notices to specify that such notices must include the statement required by Section 1368.02(b). The Plan asserted that a staff member daily performs an audit of mailroom materials to ensure that attachments are being correctly added to UM denial notices.

Supporting Documentation:

- Plan's Response to Preliminary Report (November 7, 2019)
- *Grievance, Appeal and Independent Medical Review Insert* (November 7, 2019)
- *Your Rights under Dental Managed Care* (November 7, 2019)
- Plan Policy No. CL-012-01 titled *Denials* (effective January 1, 2013, revised November 7, 2019)

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions proposed, the Department has determined that this deficiency has not been corrected.

Section 1367.01(h)(4) and Section 1368.02(b), require that the Department's toll-free telephone number, the Department's TDD line for the hearing and speech impaired, the Plan's telephone number, and the Department's Internet address be printed on UM denial notices. That contact information must be provided in the statement describing the Department and the IMR process set forth in Section 1368.02(b).

The Plan asserted that the statement required by Section 1368.02(b) has been consistently included with UM denial notices by way of an attachment, but the Plan did not provide a sample UM denial notice with an attachment included. The Plan had provided a copy of its *ADP Mailroom Member Notice Audit* policy during the onsite part of the survey. That policy indicates it was implemented in February 2019 and the auditor is required to complete a daily log noting any issues. The Plan did not provide any evidence of completion of a daily mailroom audit log.

Therefore, the Plan has not had adequate time to demonstrate compliance. The Department cannot find the Plan has corrected this deficiency until it has had the opportunity to review UM denial files and audit logs to ensure the Plan consistently includes the statement required by Section 1368.02(b).

The Department will conduct a Follow-Up Survey to assess and verify the Plan's compliance with Section 1367.01(h)(4), Section 1368.02(b), and Rule 1300.68(b)(2). The Department will review the Plan's UM policies and procedures and a sample of the Plan's UM denial files. In taking corrective actions regarding this deficiency, the Plan should note the passage of Assembly Bill 1802,[11] which contains amendments to the statement prescribed by Section 1368.02(b).

Deficiency #8: **The Plan's written communications to enrollees regarding decisions to deny or modify requested dental care services for reasons of medical necessity did not include all required information about how to file a grievance with the Plan.**

Statutory/Regulatory References: Section 1367.01(h)(4); Section 1368; Rule 1300.68(a) and (b)(2); Rule 1300.68.01(a); Rule 1368.015(b).

Assessment: Section 1367.01(h)(4) requires that written communications to enrollees concerning a decision to deny or modify a requested service "include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368." Rule 1300.68(b)(2) requires that notifications to enrollees about submitting a complaint or grievance include information on the Plan's procedures for filing and resolving grievances, the telephone and mailing address for submitting grievances to the Plan, information on the Department's review process, information on the independent medical review system and the Department's toll-free number and website address. Rule 1300.68(a)(1) defines a grievance to include a request for reconsideration or appeal.

The Plan is not in compliance with Section 1367.01(h)(4), as it does not consistently include all required information about how to file a grievance with the Plan in its written communications to enrollees regarding decisions to deny or modify requested dental care services for reasons of medical necessity ("denial notices)," which is a Notice of Authorization/Denial for a request submitted prior to receiving services and an Explanation of Benefits for a claim submitted after receipt of services. The Plan failed to include the Plan's telephone number and mailing address for filing an appeal or grievance in all denial notices. All the Plan's denial notices do not include the Plan's website address for submitting grievances, which is a procedure for filing grievances that the Plan must provide pursuant to Rule 1368.015(b). The Plan's denial notices also consistently fail to include sufficient details about the grievance resolution process to which the Plan must adhere, specifically that the Plan must resolve standard grievances within 30 days, pursuant to Rule 1300.68(a), and resolve urgent grievance within a time

[11] See Assembly Bill 1802.

consistent with an enrollee's condition and no more than 72 hours after notice of the urgent condition, pursuant to Rule 1300.68.01(a).

The Department reviewed the Plan's Notice of Authorization template, which contains the following paragraph:

> Claimants Right to Appeal
>
> You are entitled to receive, upon request and free of charge, copies of documentation and other relevant information related to your claim for benefits. You have a right to appeal this benefit decision by writing to Access Dental Plan within 180 days of receipt of this EOB. Access Dental Plan will review and notify you of its decision within 60 (disability appeals within 45) days (or less if your state requires a shorter response time) after receipt of your request. You have the right to bring a civil action under ERISA section 502(a) following an adverse benefit determination and you may have other alternative dispute resolution options under your plan. Contact your employer, the Department of Labor and/or the applicable state insurance regulatory agency for more information regarding your options and your rights under ERISA section 502(a).

The above statement is the only reference in the Notice of Authorization template instructing the enrollee regarding how to file a grievance. While the above statement advises the enrollee that they may contact the Plan directly regarding a denial, it incorrectly states the time within which the Plan must resolve the appeal, since for purposes of the Knox-Keene Act an appeal is a grievance, pursuant to Rule 1300.68(a)(1). Also, the above statement does not advise an enrollee that an appeal or grievance may be submitted by phone or at the Plan's website and state the Plan's phone number for submitting grievances and the Plan's website address for submitting grievances.

The Department reviewed 70 randomly selected UM denial files out of the universe of 5,167. None of the 70 files had denial notices that included all required information about how to file a grievance with the Plan.

Review of the files showed that the Plan includes the above quoted "Claimants Right to Appeal" statement in every Explanation of Benefits, as well as in every Notice of Authorization/Denial In addition, for 6[12] files, a form titled *Grievance, Appeal and Independent Medical Review Insert* was included with the denial notice sent to the enrollee. That insert states that an enrollee may appeal the decision within 30 days by either writing or calling the Plan's Grievance Department Coordinator, and states the phone number and mailing address for submitting grievances or appeals.

Consequently, all the denial notices found in the files lacked a statement that the Plan must resolve an urgent appeal or grievance within a time consistent with an enrollee's condition, and no more than 72 hours after notice of the urgent condition. All denial notices lacked advice as to how an enrollee may submit a grievance or appeal at the

[12] File #48; File #56; File #58; File #59; File #63; and File #65.

Plan's website. Urgent appeal information is not included in the "Claimants Right to Appeal" statement, nor the *Grievance, Appeal and Independent Medical Review Insert*, nor anywhere else in the reviewed notices. While the denial notices included website addresses for provider disputes, reporting fraud, obtaining a privacy notice, or reviewing benefit information, an explanation of how to submit a grievance or appeal at the Plan's website was not anywhere in the reviewed notices.

Also consequently, all denial notices incorrectly stated the time within which the Plan must resolve a standard grievance or appeal. The "Claimants Right to Appeal" statement states the Plan has 60 days to decide an appeal, which is inconsistent with Rule 1300.68(a). In addition, six[13] denial notices give conflicting advice as to the time period within which an enrollee may file a grievance or appeal. The "Claimants Right to Appeal" statement states an enrollee has 180 days from receipt of an Explanation of Benefits to file an appeal, but the *Grievance, Appeal and Independent Medical Review Insert* states an enrollee must appeal within 30 days of the decision. Rule 1300.68(b)(2), requires that the Plan's grievance system allow enrollees to file a grievance or appeal for at least 180 days following the incident that is the subject of an enrollee's dissatisfaction.

Finally, 64[14] denial notices failed to include the Plan's phone number for filing grievances or appeals, because that information was clearly stated only in the *Grievance, Appeal and Independent Medical Review Insert*. The denial notices without the insert included phone numbers for reporting fraud, obtaining a privacy notice, or reviewing benefit information, but not specifically for submitting an appeal or grievance to the Plan.

Plan's Compliance Effort: The Plan asserted that it had inadvertently left out of UM denial files provided for the survey copies of attachments that contain the required language concerning the Plan's grievance process, and that are sent with every UM denial letter. The Plan provided samples of both attachments.

According to the Plan, a three-page attachment titled *Your Rights Under Dental Managed Care* is attached to UM denial notices sent to enrollees of the Plan's Geographic Managed Care and Partnership Health Plan (PHP) lines of businesses. Also, the Plan stated it sends a one-page attachment titled *Grievance, Appeal and Independent Medical Review Insert* with UM denial notices sent to enrollees of the Plan's commercial line of business.

The Plan also updated its policy concerning drafting of UM denial notices to specify that such notices must include the required language concerning the Plan's grievance process.

[13] *See* Footnote 14.

[14] File #1; File #2; File #3; File #4; File #5; File #6; File #7; File #8; File #9; File #10; File #11; File #12; File #13; File #14; File #15; File #16; File #17; File #18; File #19; File #20; File #21; File #22; File #23; File #24; File #25; File #26; File #27; File #28; File #29; File #30; File #31; File #32; File #33; File #34; File #35; File #36; File #37; File #38; File #39; File #40; File #41; File #42; File #43; File #44; File #45; File #46; File #47; File #49; File #50; File #51; File #52; File #53; File #54; File #55); File #57; File #60; File #61; File #62; File #64; File #66; File #67; File #68; File #69; and File #70.

Supporting Documentation:

- Plan's Response to Preliminary Report (November 7, 2019)
- *Grievance, Appeal and Independent Medical Review Insert* (November 7, 2019)
- *Your Rights under Dental Managed Care* (November 7, 2019)
- Plan Policy No. CL-012-01 titled *Denials* (effective January 1, 2013, revised November 7, 2019)

Final Report Deficiency Status: Not Corrected

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been corrected.

Section 1367.01(h)(4) and Rule 1300.68(b)(2), require that notifications to enrollees about submitting a complaint or grievance include information on the Plan's procedures for filing and resolving grievances, the telephone and mailing address for submitting grievances to the Plan, information on the Department's review process, information on the independent medical review system and the Department's toll-free number and website address.

The attachments the Plan asserts that it has consistently sent with UM Denial letters do not include all required information about the Plan's grievance process and also conflict with the "Claimants Right to Appeal" statement the Department found printed on every UM denial letter.

Regarding the *Your Rights under Dental Managed Care* attachment that would be sent to GMC and PHP enrollees:

- Neither of the versions of that attachment specify that the Plan must resolve an urgent grievance within a time consistent with an enrollee's condition, although those versions do specify the Plan has no more than 72 hours to resolve an urgent grievance.
- Both versions of the attachment conflict with the "Claimants Right to Appeal" statement. The "Claimants Right to Appeal" statement informs enrollees that they have up to 180 days to file an appeal or grievance, which is the minimum period permitted pursuant to Section 1300.68(b)(9). Whereas, the *Your Rights under Dental Managed Care* attachment states enrollees must submit an appeal within 60 days.
- The "Claimants Right to Appeal" statement informs enrollees that the Plan must resolve an appeal within 60 days, which is longer than permitted pursuant to Section 1300.68(a)(4). Whereas, the *Your Rights under Dental Managed Care* attachment correctly informs enrollees that they should receive a resolution within 30 days.

Regarding the *Grievance, Appeal and Independent Medical Review Insert* that the Plan states it sends to commercial enrollees, the attachment:

- Does not state the Plan's telephone number and mailing address for filing an appeal or grievance, nor the Plan's website address for submitting grievances.

- Does not specify that the Plan must resolve an urgent grievance within a time consistent with an enrollee's condition, but no more than 72 hours after notice of the urgent condition.
- Does not inform enrollees that the Plan must resolve standard grievances within 30 days. As a result, commercial enrollees would only receive the erroneous information in the "Claimants Right to Appeal" statement, which states the Plan must resolve an appeal within 60 days.[15]

Within 60 days of issuance of this Final Report, the Plan shall submit a supplemental response outlining a CAP that addresses all elements of this deficiency, and provide a status report on the Plan's compliance efforts.

LANGUAGE ASSISTANCE

Deficiency #9: Plan does not ensure interpretation requirements are met for urgent appointments requested by commercial enrollees.

Statutory/Regulatory References: Section 1367.04; Rule 1300.67.04(c)(2)(G)(v); Rule 1300.67.2.2(c)(4).

Assessment: Rule 1300.67.2.2(c)(4) (made applicable by subdivision (a)(2)), requires that, if interpreter services are required by Section 1367.04 and Rule 1300.67.04, those services shall be coordinated with scheduled appointments for dental care in a manner that ensures the provision of interpreter services at the time of the appointment. Section 1367.04 and Rule 1300.67.04 apply to the Plan's commercial plans. Rule 1300.67.04 (c)(2)(G)(v) requires that the Plan provide or arrange for interpretation services in a manner appropriate for the situation in which language assistance is needed. That subdivision further specifies, "Interpretation services are not timely if delay results in the effective denial of the service, benefit, or right at issue. A plan's language assistance program shall specify quality assurance standards for timely delivery of language assistance services for emergency, urgent and routine health care services, and shall include standards for coordinating interpretation services with appointment scheduling."

Accordingly, the Plan's *Language Assistance Program* policy states, "Members shall receive timely access to language assistance services. Access Dental Plan shall ensure that all timely access appointment requirements for emergency, urgent, routine appointments are upheld." The Plan's *Combined Evidence of Coverage and Disclosure Forms* for commercial plans also confirm the Plan's obligation to timely arrange for interpreter services. For example, the *Combined Evidence of Coverage and Disclosure Form* that describes the Plan's 100/300 dental health maintenance organization benefits, states at page 2:

> If you have a preferred language other than English, please inform your Primary Care Dentist. Your Primary Care Dentist will work with Access Dental to provide language assistance services to you at no charge. You may request face to face interpreting service for an appointment by calling

[15] Section 1300.68(a)(4), requires that enrollees receive a resolution within 30 days.

Access Dental's Customer Service Department. Access Dental will provide timely access to Language Assistance Services.

However, not all communications to enrollees are consistent with the Plan's policy to comply with Rule 1300.67.04(c)(2)(G)(v), by ensuring all timely access appointment requirements for urgent routine appointments are upheld.

The Department reviewed the Plan's new member ID Card Packets. Each packet included a page titled, "Timely Access to Care," that describes the timely access standard the Plan will follow for urgent requests – an appointment within 72 hours of the request. Also, on that page was the following notice, "Language and interpreter services are available for you. You can ask us to send an interpreter to your appointment. You must ask at least 2 weeks prior to your appointment." That notice, on a document titled "Timely Access to Care," prevents the Plan from ensuring interpretation requirements are met for urgent appointments requested by commercial enrollees because the notice makes it appear that interpretation services will not be arranged for urgent appointments.

Plan's Compliance Effort: Plan asserted that its practice was to schedule interpretation services in a manner consistent with the urgent needs of an enrollee, but acknowledged that the *Timely Access to Care* notice in the Plan's I.D. Card Packets does not clearly communicate that policy to enrollees. The Plan revised the *Timely Access to Care* notice and reported that packets with the revised notice will issue beginning in January 2020.

Supporting Documentation:

- Plan's Response to Preliminary Report (November 7, 2019)
- *Timely Access to Care* notice (November 7, 2019)
- *Annual Notices* for commercial enrollees (November 7, 2019

Final Report Deficiency Status: Corrected

Based upon the corrective actions undertaken, the Department has determined that this deficiency has been corrected.

Rule 1300.67.2.2(c)(4) (made applicable by subdivision (a)(2)), requires that, if interpreter services are required by Section 1367.04 and Rule 1300.67.04, those services shall be coordinated with scheduled appointments for dental care in a manner that ensures the provision of interpreter services at the time of the appointment. The Plan reported that it has a process in place to schedule interpretation services on an urgent basis, as necessary. Also, the Plan revised communications to enrollees so that they are consistent with the Plan's policy to comply with Rule 1300.67.04(c)(2)(G)(v), by ensuring all timely access appointment requirements for urgent routine appointments are upheld.

SECTION II: SURVEY CONCLUSION

The Department has completed its Routine Survey. Where indicated, the Plan shall submit a supplemental 60 day response through the Department's Web Portal. In addition, the Department may request subsequent supplemental responses to assess progress with the Plan's corrective actions.

If the Plan's corrective actions result in revisions to documents and/or information previously submitted to the Department's Office of Plan Licensing, or new documents required to be filed as an Amendment or Notice of Material Modification, please submit those documents to the Department's eFiling Web Portal using the File Documents link. Please indicate in the Exhibit E-1 that the filing is in response to the survey. All applicable documents must be submitted as an Amendment or Notice of Material Modification, as applicable (see Section 1352 and Rule 1300.52.4).

The Department will conduct a Follow-Up Review of the Plan and issue a Report within 18 months of the date of this Final Report.

In the event the Plan would like to append a brief statement to the Final Report as set forth in Section 1380(h)(5), please submit the response via the Department's Web Portal, eFiling application. Please click on the following link to login: **DMHC Web Portal**.

Once logged in, follow the steps below to submit the Plan's response to the Final Report:

- Click the eFiling link.
- Click the Online Forms link.
- Under Existing Online Forms, click the Details link for the **DPS Routine Survey Document Request** titled, **2019 Routine Dental Survey – Document Request**.
- Submit the response to the Final Report via the Department Communication tab.