MEDICAL REVIEW – NORTHERN SECTION II
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE DENTAL AUDIT OF

Access Dental Plan

Contract Number: 13-90115
12-89341

Audit Period: January 1, 2019
Through
December 31, 2019

Report Issued: June 26, 2020

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I. INTRODUCTION

Access Dental Plan of California, Inc. (Plan) has a contract with the California Department of Health Care Services (DHCS) to provide dental services to members in Sacramento and Los Angeles counties. The Plan has a license in accordance with the provisions of the Knox-Keene Health Care Service Plan Act of 1975.

The Plan is a specialty health plan with its own statewide network of contracted general and specialty dental providers. The Plan provides dental services to members under their Sacramento Geographic Managed Care (GMC) and Los Angeles Prepaid Health Plan (PHP) programs.

The Plan has approximately 451 general providers and 168 specialists for Sacramento County and has approximately 2,309 general providers and 958 specialists for Los Angeles County.

The Plan currently serves 257,280 Medi-Cal members in California. As of February 2020, the Plan’s membership was composed of 123,077 GMC and 134,203 PHP members.

II. EXECUTIVE SUMMARY

This report presents the audit findings of DHCS dental audit for the review period of January 1, 2019 through December 31, 2019. The onsite review was conducted from February 24, 2020 through February 28, 2020. The audit consisted of document review, verification studies, and interviews with the Plan's personnel.

An Exit Conference with the Plan was held on June 4, 2020. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. The findings in the report reflect the evaluation of all relevant information received prior and subsequent to the Exit Conference.

The audit evaluated four categories of performance: Utilization Management, Access and Availability of Care, Members' Rights, and Quality Management.

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan is required to explain why prior authorizations were denied in Notice of Action (NOA) letters, however the Plan's NOA letters contained denial reasons that were written using dental terminology that may be difficult for members to understand. Additionally, the Plan did not complete prior authorization decisions, nor submit NOA letters within timeframes required by the Contract.

The Plan did not have a process in place to ensure clinical decisions were made in compliance with the Medi-Cal Manual of Criteria as required by the Contract, nor did it ensure member appeals were routed to the appropriate clinical staff.

The Plan did not communicate with members' providers and consider all available information about the enrollee's condition when approving, modifying, or denying prior authorizations.

The Plan did not inform DHCS of the change of Dental Director within ten calendar days.

Category 3 – Access and Availability of Care

The Plan did not document its process for monitoring of telephone wait times in the provider offices, nor did it ensure member phone calls were returned in a timely manner.

Category 4 – Member's Rights

The Plan did not address all grievance complaints when there were multiple complaints within one grievance, and grievance resolution letters were not clear and concise.

III. SCOPE/AUDIT PROCEDURES

SCOPE

DHCS, Medical Review Branch, conducted this audit to ascertain whether the dental services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's GMC/PHP contract.

PROCEDURE

The onsite review was conducted from February 24, 2019 through February 28, 2019. The audit included a review of the Plan's contract with DHCS, its policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan's administrators and staff.

The following verification studies were conducted:

Category 1 – Utilization Management

Prior Authorizations: 20 denied prior authorization files were reviewed. The sample was selected to cover the different specialties of dentistry, different age range of members, and to reflect both counties (Sacramento and Los Angeles).

Member Appeals: Seven member appeals were reviewed and included the different specialties in dentistry, children and adults, and to reflect both Los Angeles and Sacramento counties. In addition, the sample comprised of resolutions that were upheld and overturned.

Provider Appeals: Seven provider appeals were reviewed. The sample was selected to cover the different specialties in dentistry, children and adults, and to reflect both Los Angeles and Sacramento counties.

Category 3 – Access and Availability of Care

No verification studies were done for Access and Availability of Care.

Category 4 – Member's Rights

Grievance Procedures (Quality of Care): 17 Quality of Care grievances were reviewed for timely resolution, response to complainant, and submission to the appropriate level for review.

Grievance Procedures (Quality of Service): 11 regular Quality of Service grievances were reviewed to verify the reporting time frames and investigation process.

Category 5 – Quality Management

New Provider Training: Ten new provider-training records were reviewed for timely Medi-Cal Managed Care Program training.

A description of the findings for each category is contained in the following report.

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CATEGORY 1 - UTILIZATION MANAGEMENT

1.1	UTILIZATION MANAGEMENT PROGRAM/ REFERRAL TRACKING SYSTEM / DELEGATION OF UTILIZATION MANAGEMENT / DENTAL DIRECTOR & DENTAL DECISIONS

1.1.1 Dental Director Changes

Contractor shall report in writing to DHCS any changes in the status of the Dental Director within ten calendar days.
(GMC 12-89341 and PHP 13-90115 Contracts, Exhibit A, Attachment 2, Provision G)

Finding: The Plan did not inform DHCS of the change of Dental Director within ten calendar days.

A provision to inform DHCS of a change in Dental Director was not included in any of the Plan's policies and procedures.

Communication of a Dental Director change with DHCS is important for the continuity of the Medi-Cal Dental program.

Recommendation: Revise and implement policy and procedures to ensure reporting of Dental Director changes to the State within ten calendar days.

1.1.2 Dental Staff Decision Making and Adherence to the Medi-Cal Manual of Criteria

Contractor shall ensure that its pre-authorization procedures are in accordance with the Medi-Cal Dental policy and procedures as described in the Medi-Cal Dental Manual of Criteria.
(*GMC 12-89341 and PHP 13-90115 Contracts, Exhibit A, Attachment 7, Provision B)*

The Plan is required to maintain procedures for continuously reviewing the performance of dental care personnel, the utilization of services and facilities, and cost.
(GMC 12-89341 and PHP 13-90115 Contracts, Exhibit A, Attachment 7, Provision A)

Finding: The Plan did not have a process in place to ensure consistency and compliance with the Medi-Cal Manual of Criteria when making clinical dental decisions.

The only record reviewed of dental care personnel was provided by the Plan from August 2019. The procedures of how the review was conducted and the details of what was discussed were not documented in the record. In addition, the Medi-Cal Dental Manual of Criteria was not referenced in the documentation.

DHCS conducted a verification study of the Plan's prior authorizations. The following are two examples of decisions made by Dental Consultants that exhibited inconsistency with the Medi-Cal Dental Manual of Criteria:

Prior Authorization Verification Study Sample 4
Procedures D5211 (Maxillary Partial Denture-Resin base) and D5212 (Mandibular Partial Denture-Resin base) were allowed but extractions of teeth 2 and 18 were denied with 1M (submit FMX).

Prior authorization of partial dentures should not have been allowed if the teeth were not allowed to be removed in the first place. The Plan should not have allowed procedure codes D5211 and D5212, since the tooth extractions that the dentures would replace, were denied.

Prior Authorization Verification Study Sample 12:
Tooth 30 sealant was denied using denial code 103M (once per tooth within 36 months). According to an email dated February 27, 2020, a different provider requested the new sealant.

The Manual of Criteria under D1351 paragraph four states the original provider is responsible for any repair or replacement during the 36-month period, but this request for sealant can be allowed because it is being requested by a different provider.

Members can be harmed when clinical decision makers do not follow criteria established in the Medi-Cal Dental Manual of Criteria.

Recommendation: Establish a process to ensure consistency among clinical staff in dental decision making and to ensure compliance with the Medi-Cal Dental Manual of Criteria.

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1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Notice of Action Letters

Dental Manage Care (DMC) plans shall comply with all other existing state laws and regulations in determining whether to approve, modify, or deny requests by providers prospectively, concurrently, or retrospectively. For decisions based in whole or in part on medical necessity, the written NOA shall contain all the following:
a. A statement of the action the DMC plan intends to take.
b. A clear and concise explanation of the reasons for the decision.
c. A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedures that support the decision, as well as an explanation of the criteria or guideline.
d. The clinical reasons for the decision. The DMC plan shall explicitly state how the member's condition does not meet the criteria or guidelines.
(D-APL-17-003E)

Finding: The Plan's prior authorization denial reasons are written using dental terminology that may be difficult for members to understand. Below are examples of language used in denial letters that are difficult to understand:

Plan Denial Reasons:
"Required referral/NOA"

"Plan did not receive any or enough number of x-rays and/or documentation to evaluate for services or payments."

"Procedure denied, requested tooth, surface, arch or quad is not a benefit of this procedure."

"Minimum requirements for orthodontic treatment could not be verified by the Handicapping Labio-Lingual Deviation index or submitted study models."

Members may not understand what, for example, the "Handicapping Labio-Lingual Deviation index" is. The Plan did not explain the meanings of these, and other denial reasons, in order to make denial reasons clear and concise for the member.

If members are unable to understand the Plan's denial reasons, their ability to file a meaningful appeal is hindered.

Recommendation: Establish a process to ensure that all NOA letters are clear and concise for members.

1.2.2 Prior Authorization Decisions

The Plan must adjudicate routine authorizations within five business days from the receipt of the information that is reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network services not otherwise exempt from prior authorization).
(GMC 12-89341 and PHP 13-90115 Contracts, Exhibit A, Attachment 7, Provision B, 2)

Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the time period for review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the Plan's receipt of the information reasonably necessary and requested by the Plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.
(Health & Safety Code Section 1367.01(h)(1))

Finding: The Plan did not communicate with members' providers nor consider all information available to them about the enrollee's condition when making decisions to approve, modify, or deny prior authorizations.

In certain cases, the Plan denied medically necessary services multiple times because the member's provider submitted an incorrect procedure code. In these cases, the Plan did not communicate with the provider regarding the incorrect procedure code, nor did it use the information from previous records to modify the code appropriately based on the member's condition. In effect, the Plan was denying these services administratively instead of reviewing for medical necessity.

DHCS conducted a verification study of prior authorizations. Below are two examples from the prior authorization verification studies:

Prior Authorization Verification Study File Eight
The provider incorrectly submitted a prior authorization request for amalgam fillings (D2160) on the member's front teeth. Since, Medi-Cal only covers white fillings (D2332) for front teeth, the Plan denied the request. The Plan had the information necessary to modify the procedure code to D2332, or communicate with the provider instead of denying the request several times.

Prior Authorization Verification Study File 13
The Plan received information from the provider that the new request was for an infected abscess of a previously completed root canal on the same tooth. Due to previous treatments, the Plan possessed the information it needed to modify the procedure code to D3348 (retreatment of a previous root canal therapy) instead of denying code D3330 (root canal), which was incorrectly submitted by the provider.

Medically necessary services may be unnecessarily delayed due to Plan's decision not to communicate with providers or modify procedure codes when reasonable documentation is available on a prior authorization submission form.

Recommendation: Establish a process to ensure that decisions to approve, modify, or deny prior authorizations are based on medical necessity and are appropriate for the nature of the enrollee's condition.

1.2.3 Prior Authorization and Notice of Action Letter (NOA) Timeframes

DMC plans must approve, delay, modify, or deny a provider's prospective or concurrent request for dental services in a timeframe which is appropriate for the nature of the member's condition, but no longer than five business days from the DMC Plan's receipt of information reasonably necessary to make a determination. The DMC Plan's written response, a NOA, shall be dated and postmarked no later than 14 calendar days from the date of receipt of the request. An extension of 14 calendar days may be granted if either the member or provider requests the extension, or the DMC Plan justifies a need for additional information and how the extension is in the member's best interest. If the DMC Plan fails to issue a NOA within the required timeframe, it shall be considered a denial and therefore constitutes an adverse benefit determination on the date that the timeframe expires. The member would then have the right to request an appeal with the DMC Plan.

In instances where the DMC Plan cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe because it is not in receipt of information reasonably necessary and requested, the DMC Plan shall send out a delay NOA to the provider and member within the required timeframe or as soon as the DMC

Plan becomes aware that it will not meet the timeframe. A delay NOA is warranted if the DMC Plan extends the timeframe an additional 14 calendar days because either the member or provider requests the extension, or upon DHCS satisfaction, the DMC Plan justifies a need for additional information and how the extension is in the member's best interest. The delay NOA shall specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The DMC Plan shall also include the anticipated date when a decision will be rendered. *(D-APL-17-003E)*

Finding: The Plan did not meet prior authorization decision and NOA letter timeframes.

According to the verification study, five of 20 prior authorizations exceeded the requirement to submit NOA letters to the member five business days from the Plan's receipt of information.

Another five prior authorization files were deferral cases that exceeded the additional 14 calendar day extension for delayed NOAs.

The Plan was unable to provide documentation showing it conducted oversight to ensure timeliness of prior authorization decisions and completion of NOA letters.

When prior authorizations are completed late, medically necessary treatment for members could be delayed.

Recommendation: Establish a process to ensure the timely adjudication of all prior authorizations as required by DHCS.

1.3	PRIOR AUTHORIZATION APPEAL PROCESS

1.3.1 Prior Authorization Appeals

The DMC Plan shall ensure that the person making the final decision for the proposed resolution of a grievance or appeal has not participated in any prior decisions related to the grievance or appeal and is a health care professional with clinical expertise in treating a member's condition or disease if any of the following apply:
1. An appeal of an adverse benefit determination that is based on lack of medical necessity.
2. A grievance regarding denial of an expedited resolution of an appeal.
3. Any grievance or appeal involving clinical issues.
(D-APL-17-00E)

Finding: Clinical appeals were not routed to appropriate clinical staff.

The Plan did not route appeals concerning clinical treatment to a qualified secondary reviewer that did not participate in the initial prior authorization decision.

Below are examples from the appeals verification study.

Member Appeal Verification Study File Four
The Plan upheld a denial for orthodontic treatment before the appeal was routed to a second orthodontic Dental Consultant for secondary review.

Provider Appeal Verification Study File Three
The Plan made its final decision on an appeal without routing it to an appropriate secondary reviewer.

When clinical appeals are not routed to appropriate staff for review, decisions may be wrongly upheld to the detriment of the member.

Recommendation: Establish a process to ensure all clinical appeals are routed to the appropriate clinical reviewers, even if no new documentation has been submitted.

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CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE	
3.1	**APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES**

3.1 Monitoring Provider Office Wait times and Callbacks to Members

The contractor shall develop, implement, and maintain a procedure to monitor waiting times in the provider' offices for telephone calls (to answer and return).
(GMC/PHP Contract Exhibit A, Attachment 11(B)2)

Finding: The Plan did not document its monitoring of telephone wait times in the provider offices, nor did it ensure member phone calls were returned in a timely manner.

The Plan stated during the onsite review that the Internal Provider Relations team calls providers' offices to conduct surveys on call wait times. DHCS requested documentation of the telephone wait time surveys for the audit period, however the Plan did not provide any.

In addition, a provision to monitor and ensure provider offices return member telephone calls is not contained in any Plan policies. During the audit period, there was no documented oversight by the Access Dental Quality Management Committee to ensure member telephone calls were returned by providers or that call wait time surveys were completed and documented.

If providers do not return phone calls, or if their telephone wait times are too long, members may not receive timely access to care.

Recommendation: Establish and implement a process to document results from the telephone wait time surveys for provider offices and develop policy and procedures to monitor and ensure the timely return of telephone calls by provider offices.

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CATEGORY 4 – MEMBER'S RIGHTS

4.1	GRIEVANCE SYSTEM

4.1.1 Grievance Resolution Letters

The DMC Plan's written resolution shall contain a clear and concise explanation of the DMC Plan's decision.
(D-APL – 17-003E, III. Grievances, section C (2b))

Finding: The Plan's grievance resolution letters were not clear and concise. The letters consisted of extensive explanations written using several paragraphs and uncommon dental terminology.

The Plan did not have a process in place to review the readability of resolution letters. During the audit period, resolution letters were not routinely sampled to ensure they were clear and concise for members.

If members do not fully understand grievance letters because the letters are not clear and concise, they may not be fully able to take part in choosing the appropriate treatment.

Recommendation: Establish a process to ensure that letters of resolution are written in a clear and concise manner, as well as a process to regularly evaluate grievance letters for readability and ease of member understanding.

4.1.2 Addressing Member Grievances

The DMC Plan shall ensure adequate consideration of grievances and appeals and rectification when appropriate. If multiple issues are presented by the member, the DMC Plan shall ensure that each issue is addressed and resolved.
(D-APL-17-00E)

Finding: The Plan did not address all grievance complaints when there were multiple complaints within one grievance.

A review of Quality of Care Grievance Files showed that six of 17 files had quality of service issues that were not addressed in the resolution letter. Below are examples of

Grievances that were not addressed.

Verification Study File Seven
The Plan addressed a complaint about the member being unhappy with the fit of dentures. Issues from the same grievance that were not addressed:
-Office never returned member's call so member could get dentures adjusted.
-Office did not help member file a grievance.

Verification Study File 11
The Plan addressed the complaint that the cleaning took only five minutes.
Issues not addressed:
-Dentist did not look at member's radiographs prior to doing treatment.

When grievances are not appropriately addressed and tracked by the Plan, members' problems continue unresolved and impair quality of care and services.

Recommendation: Establish a process to ensure that all complaints in grievances are categorized and addressed appropriately.