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

REPORT ON THE DENTAL AUDIT OF

LIBERTY DENTAL PLAN of CALIFORNIA, INC.

Contract Numbers: 12-89343
13-90117

Audit Period: May 1, 2018
Through
April 30, 2019

Report Issued: November 25, 2019

TABLE OF CONTENTS

I. INTRODUCTION 1

II. EXECUTIVE SUMMARY 2

III. SCOPE/AUDIT PROCEDURES 4

IV. COMPLIANCE AUDIT FINDINGS
Category 1 – Utilization Management...6
Category 3 – Access and Availability of Care 16
Category 4 – Member's Rights 20
Category 5 – Quality Management 22

I. INTRODUCTION

Liberty 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 has provided dental services for Sacramento Geographic Managed Care (GMC) and Los Angeles Prepaid Health Plan (PHP) programs since 2005.

The Plan has approximately 160 general providers and 117 specialists for Sacramento County and has approximately 841 general providers and 348 specialists for Los Angeles County.

The Plan currently serves 259,111 Medi-Cal members in California. As of April 2019, the Plan’s membership was composed of 186,549 GMC and 72,562 PHP members.

EXECUTIVE SUMMARY

This report presents the audit findings of DHCS dental review audit for the review period of May 1, 2018 through April 30, 2019. The onsite review was conducted from May 13, 2019 through May 24, 2019. The audit consisted of document review, verification studies, and interviews with the Plan's personnel.

An Exit Conference with the Plan was held on October 30, 2019. 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 (UM), Access and Availability of Care, Members' Rights, and Quality Management (QI).

The summary of the findings by category follows:

Category 1 – Utilization Management

The Plan did not have an established process for oversight, monitoring, and evaluation of the delegated UM activities. The procedures on delegation oversight policy were not implemented. The Plan did not conduct any annual oversight audits to ensure the delegated entity conformed to DHCS regulations.

The Plan did not monitor the delegate's clinical criteria guidelines for UM to ensure compliance with Medi-Cal Dental policy and procedures, as described in the Medi-Cal Dental Manual of Criteria.

The Plan did not ensure their delegate sent clear and concise explanations for denials in their Notice of Authorizations (NOAs) letters to members. The NOA letters did not consistently describe the criteria or guidelines the Plan used in making its determination. The Plan did not monitor the delegate's process to issue NOA letters to ensure compliance.

The Plan did not ensure that its clinical dental guidelines for utilization review were consistent with Medi-Cal dental policy and procedures, as described in the Medi-Cal Dental Manual of Criteria. The Plan's clinical criteria was established for all state Medicaid programs and did not take into account the requirements specific to California's Medi-Cal Dental Program.

The Plan did not ensure a clear and concise explanation for denials in NOA letters. In addition, the denial explanations were not written at a sixth grade reading level. The NOA letters contained complex dental terminology not easily understood by members. The NOA letters use routine template denial codes that do not clearly identify the specific criteria and clinical reason.

The Plan did not have a process for continuous monitoring and tracking of clinical staff prior authorization decisions to ensure consistency and appropriateness of decisions.

The Plan did not ensure a clear and concise explanation consistent with the clinical review was included in the Notice of Appeal Resolutions (NARs). The clinical reasons to explain the denial of treatment to members were unclear and inaccurate. The Plan did not have a process to continuously monitor and track NAR letters to ensure they included a clear, concise, and accurate explanation of the reasons for its determination and the criteria, clinical guidelines, or dental policies used in reaching the determination.

Category 3 – Access and Availability of Care

The Plan did not ensure that a provider complied with the timely accessibility appointment standard for routine care. The Plan identified a provider who did not meet the appointment wait time standard and had an average routine wait time of 100 days.

The Plan did not evaluate and report wait times for specialist appointments. The Plan collected wait time data on specialist appointments, but did not report the data to the Access and Availability Committee for analysis and evaluation.

The Plan did not have a procedure to monitor wait times of members' call to be answered or returned by providers' offices. The Plan survey did not include results for monitoring the wait times of member's call to provider's offices.

The Plan did not inform providers of the correct appointment wait times standards in the Provider Reference Guide. The Plan allowed wait times to exceed the required timeframe specific to the Medi-Cal Dental Program.

Category 4 – Member's Rights

The Plan sent resolution letters without completing the investigation process to resolve the grievance.

Category 5 – Quality Management

The Plan does not have a system to ensure new providers receive training within ten business days after the Plan places the contracted provider on active status.

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 May 13, 2019 through May 24, 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 Authorization: 14 denied prior authorizations 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).

Delegated Prior Authorization: 16 denied prior authorizations were reviewed. The sample was selected to cover the different specialties of dentistry, different age range, and to reflect both Sacramento and Los Angeles counties.

Member Appeal: Ten 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. All member appeals were routine. No appeals were expedited.

Provider Appeal: Nine 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

None

Category 4 – Member's Rights

Grievance Procedures (Quality of Care): 15 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): Ten member call inquiries, ten exempt grievances, and 20 regular Quality of Service grievances were reviewed to verify the reporting time frames and investigation process.

Category 5 – Quality Management

New Provider Training: 15 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.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Liberty Dental Plan of California, Inc.
AUDIT PERIOD: May 1, 2018 through April 30, 2019 **DATE OF AUDIT: May 13, 2019 through May 24, 2019**

CATEGORY 1 - UTILIZATION MANAGEMENT	
1.1	**UTILIZATION MANAGEMENT PROGRAM/ REFERRAL TRACKING SYSTEM / DELEGATION OF UM / DENTAL DIRECTOR & DENTAL DECISIONS**

1.1.1 Oversight, Monitoring, and Evaluation of delegated UM activities

If the Plan delegates UM activities, the Plan shall comply with Exhibit A, Attachment 5, Quality Improvement System, Provision F, Delegation of Quality Improvement Activities. (*Contract, Exhibit A, Attachment 7(E)*)

The Plan is accountable for all UM functions and responsibilities that are delegated to subcontractors, including the continuous monitoring, evaluation and approval of the delegated functions. (*Contract, Exhibit A, Attachment 5(F)*)

Finding: The Plan did not have an established process for oversight, monitoring, and evaluation of delegated UM activities.

The Plan delegated UM of standard prior authorizations to a delegated entity. The *Capitated Dental Service Agreement* stated the delegate shall allow the Plan or its designated agent, to perform an annual, or as needed, on-site audit. The delegate shall promptly provide access to files, records, and committee meeting minutes for conducting oversight of the delegate's UM activities.

The Plan's policy, *QM-PP Delegation Oversight Review,* was prepared on January 6, 2014, but the Plan did not approve the policy until February 28, 2019. The procedures on the delegation oversight policy were not implemented. The Plan did not conduct any annual oversight audits to ensure the delegated entity conformed to DHCS regulations.

The lack of delegate oversight can lead to non-compliance with the Medi-Cal Dental program and impair the delivery of needed dental services to members.

Recommendation: Implement oversight, monitoring, and evaluation of the delegated entity on a regular basis, including a comprehensive annual audit.

1.1.2 Delegated Entity's Clinical Criteria Guidelines

The Plan shall ensure that its prior authorization procedures are in accordance with Medi-Cal Dental policies and procedures, as described in the Medi-Cal Dental Manual of Criteria (MOC). The Plan shall ensure that there is a set of written criteria or guidelines for utilization review that is based on the dental standard of care, is consistently applied, regularly reviewed, and updated. (*Contract, Exhibit A, Attachment 7(B)*)

If the Plan delegates UM activities, the Plan shall comply with Exhibit A, Attachment 5, Quality Improvement System, Provision F, Delegation of Quality Improvement Activities. (*Contract, Exhibit A, Attachment 7(E)*)

The Plan is accountable for all UM functions and responsibilities that are delegated to subcontractors. (*Contract, Exhibit A, Attachment 5(F)*)

Finding: The Plan did not ensure the delegate's clinical criteria guidelines complied with the Medi-Cal Dental MOC.

The Plan delegated UM of prior authorizations to a delegated entity. The *Capitated Dental Service Agreement* stated the delegate shall develop, implement, and continuously update and improve their UM program. The Plan shall ensure appropriate processes were used to review and approve the provision of medically necessary dental covered services, as identified in the Medi-Cal Dental MOC.

The Plan's policy, *QM-PP Delegation Oversight Review,* was prepared on January 6, 2014, but the Plan did not approve the policy until February 28, 2019. The procedures on the delegation oversight policy were not implemented. The Plan did not conduct any annual oversight audits to ensure the delegated entity conformed to DHCS regulations. The Plan did not monitor the delegate's clinical criteria guidelines to ensure compliance with the Medi-Cal Dental MOC.

A verification study of 16 prior authorizations revealed the following:

- General anesthesia or intravenous sedation was disallowed for two members who had more than three partial-bony or full-bony impacted wisdom teeth. Under the Medi-Cal Dental MOC and *Dental All Plan Letter (APL) #17-004*, general anesthesia or intravenous sedation was allowed as multiple impacted wisdom teeth removal constituted extensive surgical treatment.
- A member had all fillings disallowed although the restorative procedures met Medi-Cal Dental MOC guidelines.
- A member had a "placement of device to facilitate eruption of impacted tooth" procedure denied. This procedure should have been covered as the surgical

access of an unerupted tooth was allowed. The patient was under 21 years of age and undergoing orthodontic treatment.

The lack of delegate oversight to ensure compliance with the Medi-Cal Dental MOC can lead to the denial of covered services to members.

Recommendation: Establish a monitoring process to ensure the delegated entity's prior authorization processes to comply with Medi-Cal Dental policy and procedures, as described in the Medi-Cal Dental MOC.

1.1.3 Delegated Entity's Notice of Authorization Letters

The Plan shall ensure that its reasons for prior authorizations and review decisions are clearly documented. Notification to members regarding denied, deferred, or modified referrals is made as specified in Exhibit A, Attachment 14, Member Services. (*Contract, Exhibit A, Attachment 7(B)*)

The Plan 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 letters shall contain all of the following:

a. A statement of the action the 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 Plan shall explicitly state how the member's condition does not meet the criteria or guidelines.
e. For written notification to the provider, the name and direct telephone number or extension of the decision maker. Decisions shall be communicated to the member in writing. In addition, decisions shall be communicated to the provider initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively. (*Dental All Plan Letter 17-003E*)

Finding: The Plan did not ensure their delegate sent clear and concise explanations for denials in their NOAs letters to members. The NOA letters did not consistently describe the criteria or guidelines the Plan used in making its determination.

The Plan's policy, *QM-PP Delegation Oversight Review,* was prepared on January 6, 2014, but the Plan did not approve the policy until February 28, 2019. The procedures on the delegation oversight policy were not implemented. The Plan did not conduct any

annual oversight audits to ensure the delegated entity conformed to DHCS regulations. The Plan did not monitor the delegate's process for issuing NOA letters to ensure compliance with the *Dental All Plan Letter 17-003E*.

A verification study of 16 NOA letters revealed the following:

- The name and phone number of the decision maker was not present in provider's NOAs.
- "Your Rights" attachment was not present in member NOA letters.
- The members NOA letters did not consistently describe the criteria or guidelines the Plan used in making its determination.
    - Three members were denied for orthodontic treatments. All three members did not meet the automated prior authorization criteria. However, the clinical findings of the members' malocclusion of the teeth were not considered.
    - A member had fillings denied without explanation.
    - A member had a denial of "placement of device to facilitate eruption of impacted tooth" without explanation.
    - Four members had general anesthesia or intravenous sedation denied without explanation.

Members did not consistently receive clear explanations for their denials, the criteria or guidelines used by the Plan, and "Your Rights" attachment in their NOA letters. Without understanding the reasons for the prior authorization denials, members cannot make informed decisions about their healthcare and it may hinder the members' ability to file a meaningful appeal.

Recommendation: Establish a monitoring process to ensure the NOAs letters sent by the delegated entity, include clear and concise explanations for the denial and a description of the criteria or guidelines used by the Plan in making its denial determination, as required in *Dental All Plan Letter 17-003E*.

1.2	PRIOR AUTHORIZATION REVIEW REQUIREMENTS

1.2.1 Clinical Criteria for Utilization Review

The Plan shall ensure that its prior authorization procedures are in accordance with the Medi-Cal Dental policy and procedures as described in the Medi-Cal Dental MOC. The Plan shall ensure there is a set of written criteria or guidelines for Utilization Review that is based on the dental standard of care, is consistently applied, regularly reviewed, and updated. (*Contract, Exhibit A, Attachment 7(B)*)

Finding: The Plan did not ensure that its clinical dental guidelines for Utilization Review were consistent with Medi-Cal Dental policy and procedures, as described in the Medi-Cal Dental MOC.

The Plan's clinical criteria was established for all state Medicaid programs and did not take into account the requirements specific to California's Medi-Cal Program. The requirements specific to the Medi-Cal Program were not expressed in the Plan's clinical dental guidelines.

The Plan administered the Medicaid Program for multiple states. The Plan's clinical dentistry guidelines for UM were developed with input from general dentists and specialists and utilized National Committee for Quality Assurance Standards, Americans with Disability Act of 1990 Guidelines, and other dental clinical principles. However, the Plan's UM policies for prior authorization reviews: *UM-PP Authorization Criteria, UM-PP Clinical Criteria for UM Decision,* and *UM-PP Criteria for Dental UM Development and Application* did not incorporate the requirements specific to the Medi-Cal Dental Program.

A verification study of 14 prior authorizations revealed the following examples:

- A member's root canal procedure was denied when it was documented that the tooth was ready to be sealed following an apexification treatment. Apexification involves a series of treatments to facilitate the apical closure of a permanent tooth. The treatments were customarily billed with a specific series of procedure codes from start to completion. However, pursuant to the Medi-Cal Dental MOC, following the treatment phase of apexification, the final and completed visit may be prior authorized with the customary root canal procedure codes. This billing requirement is different from other Medicaid and commercial programs.
- For a member's exam visit, the Plan required the attachment of a radiograph when treatment was submitted for payment. The Medi-Cal Dental MOC had no requirement for the submission of radiographs with any type of exams.
- Adjudication code attached to NOA specified that "only 2 quadrants were allowed

for Scaling & Root Planning per date of visit, exception may be considered on a case by case basis". Medi-Cal MOC does not have this requirement.

If the Clinical Dentistry Guidelines does not include Medi-Cal Dental Program specific requirements, the Plan cannot ensure consistency in treatments and members may be denied medically necessary services.

Recommendation: Revise Clinical Dentistry Guidelines to conform with Medi-Cal Dental policy and procedures as described in the Medi-Cal Dental MOC.

1.2.2 Notice of Authorization Letters

The Plan shall ensure that its reasons for prior authorizations and review decisions are clearly documented. Notification to members regarding denied, deferred, or modified referrals is made as specified in Exhibit A, Attachment 14, Member Services. (*Contract, Exhibit A, Attachment 7(B)*)

The Plan shall ensure that all written member information is provided to members at a sixth grade reading level. The written member information shall ensure members' understanding of the covered services, processes, and ensure the member's ability to make informed dental health decisions. (*Contract, Exhibit A, Attachment 14(D)3*)

The Plan 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 letters shall contain all of the following:

a. A statement of the action the 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 Plan shall explicitly state how the member's condition does not meet the criteria or guidelines.
e. For written notification to the provider, the name and direct telephone number or extension of the decision maker. Decisions shall be communicated to the member in writing. In addition, decisions shall be communicated to the provider initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively. (*All Plan Letter 17-003E*)

Finding: The Plan did not ensure a clear and concise explanation for denials in NOA letters. In addition, the denial explanations were not written at a sixth grade reading

level. The NOA letters contained complex dental terminology not easily understood by members.

The NOA letters use routine template denial codes that do not clearly identify the specific criteria and clinical reason. The Plan had a denial rationale workgroup to review denial codes. However, the Plan workgroup did not demonstrate any improvement or clarification of denial code language. The Plan's Policy, *GA-PP Grievance and Appeals Process,* does not outline a quality control and monitoring process to ensure clear and concise explanation for denials in NOA letters.

A verification study of 14 NOA letters revealed the following examples:

- Members had denials of fillings, prophy and fluoride, scaling, root planning, and partial removable denture with the same denial code. This same denial code stated: "The procedure is not covered based on an applicable plan limitation or exclusion. See your Evidence of Coverage booklet for details." The code is generic, is applied to different procedures, and the explanation used was ambiguous and difficult to identify the specific reason for the denial.
- A member's NOA letter used the following language: "The minimum requirements for orthodontic treatment could not be verified with Handicapping Labio-Lingual Deviation Index or submitted model." The code and explanation used contained complex dental terminology not easily understood by members.

Members did not get clear and understandable explanations for denials in their NOA letters. Without understanding the reasons for the prior authorization denials, members cannot make informed decisions about their healthcare and it may hinder the members' ability to file a meaningful appeal.

Recommendation: Establish a process to ensure clear and concise explanations for denials in NOA letters to members.

1.2.3 Consistent Application of Criteria in reviewing Prior Authorizations

The Plan shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of medically necessary dental covered services as identified in the Medi-Cal Dental MOC. (*Contract, Exhibit A, Attachment 7(A)*)

The Plan shall ensure that its prior authorization procedures are in accordance with the Medi-Cal Dental policy and procedures as described in the Medi-Cal Dental MOC. The Plan shall ensure there is a set of written criteria or guidelines for Utilization Review that is based on the dental standard of care, and is consistently applied, regularly reviewed, and updated. (*Contract, Exhibit A, Attachment 7(B)*)

Finding: The Plan did not have a process to continuously monitor and track clinical staff decisions to ensure consistency and appropriateness of decisions.

The Plan's policy, *UM-PP Inter Rater Reliability Program,* indicated the State Dental Director was responsible for continuous monitoring and tracking clinical staff decisions by random sampling clinical reviews to ensure consistency and appropriateness of decisions.

While calibrations was regularly conducted in Inter Rater Reliability (IRR) exercises regarding the clinical decisions in different dental specialties, the Plan had no quality control process of adjudicated prior authorizations. The Plan did not conduct a random sampling survey of prior authorizations adjudicated by staff dentists to verify that the claims were adjudicated accurately and consistently.

A verification study of 14 prior authorization requests revealed inconsistency among Plan staff dentists on when to modify the submitted treatment requests to an appropriate procedure code.

- A member's prior authorization request was submitted with an incorrect restorative code for the tooth number and surface submitted. Instead of denying the request, staff dentist should have modified request with the correct restorative code.
- Conversely, a member had requests with molar root canal procedures and they were modified to the appropriate codes for bicuspid root canal services.

The Plan does not have a process to continuously monitor and track clinical staff decisions. This may lead to medically necessary treatments being denied or delayed due to inconsistencies in when and how to modify treatment procedures.

Recommendation: Establish a process of quality control and monitoring to ensure consistency with the Medi-Cal Dental MOC in the adjudication of prior authorizations requests.

1.3	**PRIOR AUTHORIZATION APPEAL PROCESS**

1.3.1 Notice of Appeal Resolutions

The Plan shall ensure that its reasons for prior authorizations and review decisions are clearly documented. Notification to members regarding denied, deferred, or modified referrals are made as specified in Exhibit A, Attachment 14, Member Services. (*Contract, Exhibit A, Attachment 7(B)*)

The written member information shall ensure members' understanding of the covered services, processes, and ensure the member's ability to make informed dental health decisions. (*Contract, Exhibit A, Attachment 14(D)3*)

If the Plan's determination is based in whole or in part that the service is not medically necessary, the Plan shall include in its written NAR response the reasons for its determination and clearly state the criteria, clinical guidelines, or dental policies used in reaching the determination. (*APL 17-003E* and *California Code of Regulations (CCR), Title 28, section 1300.68(d)(4)*)

Finding: The Plan did not ensure a clear and concise explanation consistent with the clinical review was included in NARs. The clinical reasons to explain the denial of submitted treatment to members were unclear and inaccurate.

The Plan did not have a process to continuously monitor and track NAR letters to ensure clear and concise explanation of the reasons for its determination and the criteria, clinical guidelines, or dental policies used in reaching the determination. The Plan's Policy, *GA-PP Grievance and Appeals Process,* did not outline a quality control and monitoring process to ensure clear and concise explanation for the determinations in NAR letters to members.

A verification study of 19 NAR letters revealed the following examples:

- A member's request for a periodontist consultation for crown lengthening was denied and the denial was upheld. The member's NAR letter implied that the consultation was global to another procedure and did not have a separate fee. In addition, the letter stated that the tooth cannot support the procedure. The NAR letter did not explain that crown lengthening was considered part of a restorative procedure.
- A member's request for partially bony impacted extractions of two wisdom teeth was denied and the denial was upheld. The NAR letter stated, "The guidelines say that the removal of the tooth will only be covered when a raise of the gum is required to show the bone covering the tooth that has not came out yet." The

NAR letter did not explain that the extraction of asymptomatic wisdom teeth was considered an elective procedure and was not a benefit.

- A member's NAR letter did not clearly explain why denial of Nitrous Oxide was upheld. The denial was upheld and the reason given was that "no additional benefit for payment is allowed for procedures that are considered to be part of the more inclusive procedure". Since non-intravenous conscious sedation was allowed, the NAR letter should have explained that only one anesthesia procedure is payable, per date of service, regardless of the methods of administration.

When members do not understand the clinical reasons for the denials, members cannot be active participants in their dental care and cannot take part in choosing the appropriate treatment.

Recommendation: Establish a process to ensure clear, concise, and accurate explanations for denials in NAR letters to members.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Liberty Dental Plan of California, Inc.
AUDIT PERIOD: May 1, 2018 through April 30, 2019 **DATE OF AUDIT: May 13, 2019 through May 24, 2019**

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

3.1.1 Corrective Action for Non-Complying Providers

The Plan shall establish acceptable accessibility standards in accordance with CCR, Title 28, section 1300.67.2. The Plan shall communicate, enforce, and monitor providers' compliance with access standards. (*Contract, Exhibit A, Attachment 11(B)*)

The Plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments. (*CCR, Title 28, section 1300.67.2(f)*)

The Plan's policy, *Access and Availability Guidelines,* states, "Corrective actions are required for offices found non-compliant with timely access standards."

Finding: The Plan did not ensure that a provider complied with the timely accessibility appointment standard for routine care.

The Q2 2018 Network Management Committee meeting minutes identified one provider in the contracted area of service who did not meet the routine appointment wait time standard of four weeks for the audit period. The Provider Service Survey indicated that the provider had average routine wait time of 100 days. The *2018-2nd* Quarter Access and Availability committee meeting minutes indicated that this was the second time the provider did not meet the time frame requirements.

Plan representatives communicated with the provider regarding the required routine appointment time frame of 30 days. The provider promised to improve its adherence to the requirement. The provider indicated that he was doing quadrant dentistry and provided many treatment services. Despite the provider's history of failing to meet the required routine appointment time frame, the Plan did not require any corrective measures to ensure compliance with the accessibility standard.

Without effective corrective action, the Plan will continue to have non-complying providers that could delay needed medical services to its members.

Recommendation: Develop and implement effective Corrective Action Plans to ensure compliance with established access and availability standards

3.1.2 Monitoring Wait Times for Specialist Appointments

The Plan shall establish acceptable accessibility standards in accordance with CCR, Title 28, section 1300.67.2. The Plan shall communicate, enforce, and monitor providers' compliance with access standards. The Plan shall develop, implement, and maintain a procedure to monitor waiting times in the provider's offices for scheduled appointments, telephone calls (to answer and return), and time to obtain various types of appointments. The standard for specialist appointments is within 30 business days from authorized request. (*Contract, Exhibit A, Attachment 11(B)*)

The Plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments. (*CCR, Title 28, section 1300.67.2(f)*)

Finding: The Plan did not evaluate and report wait times for specialist appointments. The Plan collected data on specialist appointment wait times, but did not report the data to the Access and Availability Committee for analysis and evaluation.

The Plan's policy, *Access and Availability Guidelines,* stated the standard wait time for specialist appointments was within 30 days of referral. The policy indicated the procedures for monitoring urgent, non-urgent, initial, and preventive appointment wait times. However, it did not specify procedures for monitoring specialist appointment wait times.

The Plan initially collected raw data on specialty access. However, the data was not included in the Plan's activity reports. The Plan's quarterly activity report summaries outlined the Plan's monitoring of the timeliness of initial, preventive and routine appointments. In addition, the activity report summaries outlined emergency and afterhours care access, as well as wait time in the provider office, and compared data to established benchmarks and standards. However, the report did not include the monitoring results of specialist appointment wait times. The data on the specialist appointment wait times was not reported to the Access and Availability Committee for evaluation.

Without monitoring specialists' appointment time, Plan members will not have timely access to treatment.

Recommendation: Include specialist appointment wait time monitoring results in the activity summary report for analysis and evaluation.

3.1.3 Telephone Wait Times

The Plan shall establish acceptable accessibility standards in accordance with CCR, Title 28, section 1300.67.2. The Plan shall communicate, enforce, and monitor providers' compliance with access standards. The Plan shall develop, implement, and maintain a procedure to monitor waiting times in the provider's offices for scheduled appointments, telephone calls (to answer and return), and time to obtain various types of appointments. (*Contract, Exhibit A, Attachment 11(B)*)

The Plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments. (*CCR, Title 28, section 1300.67.2(f)*)

Finding: The Plan did not have a procedure to monitor waiting times for members' calls to providers' offices (to answer and return).

The Plan's Timely Access Survey did not include results for monitoring the wait times of members' calls to providers' offices. The Plan's Access and Availability Committee did not review any data related to telephone wait times.

In interviews, the Plan confirmed that they did not have time frame requirements and procedures to monitor telephone wait times at providers' offices.

Telephone communication is essential for members to contact providers for issues, concerns, and treatments. Without monitoring the wait time of telephone calls, Plan members may not have timely access for questions or to get treatment.

Recommendation: Develop policies and procedures to monitor telephone wait times for members' calls to providers' offices, including answering and returning calls.

3.1.4 Appointment Time Frame Standards in the Provider Reference Guide

The Plan shall communicate, enforce, and monitor providers' compliance with access standards. The Plan shall implement and maintain procedures for members to obtain appointments for routine care, emergency services, and specialty referral appointments. Contractor shall also include procedures for follow-up on missed appointments.

The following standards shall apply:

- Initial appointment – within four weeks
- Routine Appointment (non-emergency) – within four weeks
- Preventive Dental Care Appointment – within four weeks
- Specialist Appointment – within 30 business days from authorized request

(*Contract, Exhibit A, Attachment 11(B)*)

Finding: The Plan did not inform providers of the correct appointment wait times standards in the Provider Reference Guide. The Plan allowed wait times in excess of the required timeframe specific to the Medi-Cal Dental Program.

The appointment wait times requirements in the Plan's Provider Reference Guide were as follows:

- Initial appointment wait time was not indicated
- Routine care appointment time frame requirement was within 36 days
- Preventive care appointment time frame requirement was within 40 days
- Specialist appointment wait time was not indicated

During the onsite, the Plan stated the Provider Reference Guide was for all lines of California business. The Provider Reference Guide did not separate the Medi-Cal Program requirements from its other lines of business. The wait time requirements specific to the Medi-Cal Program were not included in the guide.

The Plan allowing wait times in excess of the requirements specific to the Medi-Cal Dental Program can lead to a delay in needed dentistry care.

Recommendation: Revise the Provider Reference Guide to conform to the Medi-Cal access standards, as specified in the Contract.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Liberty Dental Plan of California, Inc.
AUDIT PERIOD: May 1, 2018 through April 30, 2019 **DATE OF AUDIT: May 13, 2019 through May 24, 2019**

	CATEGORY 4 – MEMBER'S RIGHTS
4.1	**GRIEVANCE SYSTEM**

4.1.1 Grievance Resolution Letters

The Plan shall implement and maintain a Member Grievance System in accordance with CCR, Title 28, section 1300.68. The Plan shall resolve each grievance and provide notice to the members as quickly as the member's dental condition requires, or no later than 30 calendar days from the date the Plan receives the grievance. (*Contract, Exhibit A, Attachment 15(A)*)

"Resolved" means that the grievance has reached a final conclusion with respect to the enrollee's submitted grievance, and there are no pending enrollee appeals within the Plan's grievance system, including entities with delegated authority.
(Title 28, CCR, Section 1300.68(a)(4))

The Plan shall continue to comply with the state's established time frame of 30 calendar days for grievance resolution. "Resolved" means that the grievance has reached a final conclusion with respect to the member's submitted grievance as delineated and existing state regulations. (*APL 17-003E*)

Finding: The Plan sent resolution letters without completing the investigation process to resolve the grievance.

The Plan's policy, *Grievance and Appeal Process – Medicaid,* stated that the Plan collects the necessary information to properly evaluate each grievance. The grievance analyst will review all submitted information to resolve the complaint and issue a resolution letter.

During interviews, Plan personnel stated that they allow up to three days for providers to respond to records requests. If the provider did not respond within the three days, the Plan would try to call them. If there were still no response, the Plan would use their own judgment due to the time frame requirements and send the resolution letter.

A verification study of quality of service grievances revealed eight cases where the Plan did not receive the requested documents from the provider. In five of those cases, the provider did not provide any documentation.

For example:

- A member filed a grievance stating the provider did not want to see the member or treat their fillings. The member had an appointment in January 2018 and the member was never called to cancel the appointment. The member showed up to the appointment but the member was not treated. The member was told the dentist was not available and since it was a new year, all treatments needed to be priorly authorized. In addition, member stated the office staff was rude and unprofessional.
- A member requested a referral to a different specialist due to the dental assistant yelling at the member and making him upset. The member said the dental assistant did not know what she was doing and caused the member to bleed and left tiny pieces of metal in his mouth. The member had requested a different assistant for treatment. However, the dentist stated that the member had no choice on who will perform the treatment. The scheduling was based on which assistant was available during the appointment. The member requested a new specialist to continue treatment due to the unprofessional staff in this facility.

In both examples, the Plan sent a resolution letter to members without completing the investigation process to resolve the grievance. With insufficient or no documentation from the provider, the Plan used their own judgment in resolving these cases. In all eight cases, the Plan made decisions favorable to the provider without receiving any information regarding the grievance.

Resolution letters sent to members without actually resolving the issue does not correct non-compliant provider's behaviors and can lead to a loss of members trust in both Plan and its providers.

Recommendation: Develop a system to properly resolve the grievance before sending the resolution letter.

CATEGORY 5 – QUALITY MANAGEMENT	
5.2	**PROVIDER QUALIFICATIONS**

5.2.1 New Provider Training

The Plan shall ensure that all providers receive training regarding the Medi-Cal Dental Managed Care Program in order to operate in full compliance with the Contract and all applicable federal and state statutes and regulations. The Plan shall ensure that provider training relates to Medi-Cal Dental Managed Care services, policies, procedures, and any modifications to existing services, policies or procedures. Training shall include methods for sharing information between the Plan, provider, member and/or other healthcare professionals. The Plan shall conduct training for all providers within ten business days after the Plan places a newly contracted provider on active status. (*Contract, Exhibit A, Attachment 9(E)*)

Finding: The Plan does not have a system to ensure new providers receive training within ten business days after the Plan places the contracted provider on active status. The Plan provided orientation training to provider offices, but could not substantiate whether the contracted provider actually received the training.

The Plan's policy, *Provider Orientation,* stated that the Plan shall conduct provider orientations and distribute any applicable documentation standards prior to becoming effective on the network or within 30 days of activation on the provider network, or sooner as required by State or client requirements. The Plan had only one policy for all its California lines of business.

The Plan's policy did not correctly reflect the contract requirement of conducting training for all new providers within ten business days after the contractor places a newly contracted provider on active status.

The Plan provided onsite orientation for its initial visit to the provider offices before the new providers were credentialed. According to the Plan, the offices had the responsibilities to ensure any new providers receive training. However, the Plan did not have a process to ensure that the office provided the training on Medi-Cal Dental Managed Care services, policies, and procedures to the new providers.

A verification study of provider training files revealed the documentation provided by the Plan did not correctly show the actual training date. The reported dates reflected the date that the office became active with Plan, instead of the training date. The Plan could not identify the actual date of trainings.
Without ensuring the proper training, new providers will be unaware of covered services

and requirements of the Medi-Cal Dental Program.

Recommendation: Develop a process to monitor new providers' training to ensure all providers receive training within ten business days after the Plan places a newly contracted provider on active status.