

**Delta Dental of Rhode Island
Market Conduct Examination Report
Prepared on Behalf of the
Office of the Health Insurance Commissioner**

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June 24, 2011**

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June 24, 2011

Honorable Christopher Koller
Health Insurance Commissioner
State of Rhode Island

Dear Commissioner Koller:

In accordance with your instructions and pursuant to statutes of the State of Rhode Island, a targeted Market Conduct Examination was conducted with regard to certain claims payment and denial activities that were the subject of or relate to complaints received by the Commissioner since January 1, 2009, in order to determine appropriate patterns of payment and denial; to determine consistent application of processes, procedures and requirements; and to determine compliance with applicable statutes and regulations of:

**Delta Dental of Rhode Island (“Delta”)
Providence, Rhode Island**

The examination was conducted by Charles C. DeWeese of DeWeese Consulting, Inc. of Canton CT, Linda Johnson of Johnson & Associates of East Providence RI and John Aloysius Cogan Jr. of Centre Hall PA (the “examiners”). It was conducted in accordance with the standards contained in the NAIC Market Analysis Handbook. The examination involved preparation of information requests and analysis of responses and records submitted by Delta and on-site interviews and examination of records at Delta’s offices. The results of the examination are reported here on a test basis.



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1. Warrant ordering a targeted Market Conduct Examination

A targeted market conduct examination of Delta Dental of Rhode Island (“DDRI”) was ordered by Commissioner Christopher F. Koller (the “Commissioner”) of the Office of the Health Insurance Commissioner (“OHIC”) on May 14, 2010. The warrant for the examination appointed Charles C. DeWeese and Linda Johnson (“the Examiners”) to represent the Commissioner in the examination, and stated that the examination was a targeted examination of certain claims payment and denial activities of DDRI that are the subject of or relate to complaints received by the Commissioner since January 1, 2009 to determine appropriate patterns of payment and denial; to determine consistent application of processes, procedures and requirements; and to determine compliance with applicable statutes and regulations. The warrant was amended on September 7, 2010 to add John A. Cogan, Jr. as an Examiner.

2. Background and Reason for examination

DDRI is a nonprofit dental service corporation licensed under R.I. Gen Laws § 27-20.1. Nonprofit dental service corporations are subject to the authority of the Commissioner, as provided in R.I. Gen Laws § 42-14(5).

DDRI provides dental insurance to subscribers and members under Rhode Island group contracts. DDRI contracts with Rhode Island dentists to provide services to those members. Since January 1, 2009, OHIC has received approximately twenty-three (23) complaints from DDRI members or providers, three of which came in while the examination was in progress. The complaints covered allegations in the following general areas:

- Dental claims management, particularly post-treatment review of endodontic procedures, denial of subsequent procedures to patients who had received certain endodontic services, and unequal treatment of providers.

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- Inadequate customer service to providers, including unreasonable call wait times and procedures and conflicts between telephone and website information.
- Benefit payment disputes, including handling of coordination of benefits (“COB”) claims, payment for x-rays, and the determination of plan maximum benefit limits.
- Status of network and non-network providers.
- Submission of digital supporting media (x-rays, photographs)

OHIC requested that DDRI provide information about each of the complaints. After review of DDRI’s responses, the Commissioner issued the warrant referred to above, in order to gather and analyze complete information on the circumstances leading to these specific 23 complaints and DDRI’s response to them, and more broadly on DDRI’s policies, procedures and operations with regard to dental claims management, including claims adjudication, utilization review, quality assurance and appeals, and with regard to customer service generally.

3. Examination Methodology

The examination was conducted by a combination of on-site meetings with DDRI personnel and review of DDRI records, and transmitting questions and information requests to DDRI, to which it responded. The first set of requests for information was sent to DDRI on June 4, 2010, with a return date of June 24, 2010. The requests were discussed with DDRI personnel at an on-site meeting on June 10, 2010. DDRI responded timely to all questions. A second set of requests for information was sent to DDRI on July 15, 2010 with a return date of August 4, 2010. DDRI responded timely to all questions. Subsequent questions were sent informally and DDRI responded by providing answers and access to documents as appropriate.

Where specific requests for information and the responses to those requests are referenced in the report, they are designated in the form “RFI x” or “RFI x-y”, where RFI indicates “Request for Information”. The first number (“x”) refers to the set of requests

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(of which there were 2 in total). If present, the second (“y”) refers to the specific request within the set of requests.

The primary contact persons at DDRI for the purposes of the exam were Melissa Gennari, Director of Compliance and Julie Ferrini, Director of Program Integrity.

Other members of DDRI staff who were interviewed or otherwise assisted with the examination were:

Kathryn Shanley, Vice President External Affairs

Dr. James Balukjian, Dental Director

Carole Gioffreda, Quality Assurance Coordinator

Linda Pedro, Analyst, Dental Case Management

Mary Ann Lonczak-Perri, Director, Customer Service

Steve Maxwell, Director, Operations

The examination was conducted in consideration of the methodologies and procedures included in the NAIC Market Regulation Handbook.

4. Applicable statutes and regulations

Nonprofit dental service corporations are licensed under R.I. Gen Laws § 27-20.1. Dental insurance is subject to the authority of the Commissioner, as provided in R.I. Gen Laws § 42-14(5), including in particular protecting the interests of consumers and encouraging fair treatment of providers¹. Dental claims administration is subject to the requirements of R.I. Gen Laws § 27-9.1, the Unfair Claims Settlement Practices Act, R.I. Gen Laws § 27-29, Unfair Competition and Practices, R.I. Gen Laws § 23-17.12, the Health Care Services – Utilization Review Act and R.I. Gen Laws § 23-17.13, the Health Care Accessibility and Quality Assurance Act.

¹ R.I. Gen Laws § 42-14(5)-2(2) and § 42-14(5)-2(3)

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As provided by R.I. Gen Laws § 23-17.12 and R.I. Gen Laws § 23-17.13 noted above, the provision of dental insurance benefits is regulated concurrently by the Rhode Island Department of Health (“RIDH”) under R23.17.12-UR, Rules and Regulations for the Utilization Review of Health Care Services (“Regulation R23.17.12-UR”) and R23.17.13-CHP, Rules and Regulations for the Certification of Health Plans (“Regulation R23.17.13-CHP”). While OHIC does not directly enforce RIDH regulations, OHIC construes the Rhode Island Healthcare Reform Act of 2004, the Unfair Claims Settlement Practices Act, and the Unfair Competition and Practices chapter, including but not limited to §§ 27-9-1(4)(3) and 27-9-1-4(4), such that a violation of the Department of Health Regulations R23.17.12-UR and Regulation R23.17.13-CHP constitutes a violation of the Rhode Island Health Care Reform Act of 2004, the Unfair Claims Settlement Practices Act, and the Unfair Competition and Practices chapter. The standard for prompt payment of claims is contained in OHIC Regulation 7, Prompt Processing of Claims (“Regulation 7”).

The provision of dental services, generally, is under the authority of R.I. Gen Laws § 5-31.1 (Businesses and Professions – Dentists and Dental Hygienists), which is relevant to DDRI’s quality assurance role.

5. Overview of DDRI’s Business

DDRI covered approximately 306,190 Rhode Island members² enrolled in premium groups as of December 31, 2009. As of October 31, 2010, DDRI reported 287,418 members in premium groups and 615,505 members in all groups (both premium and ASO), in 4,050 total accounts, 1,800 of which are individual Chamber of Commerce accounts.³ DDRI is authorized to operate as a nonprofit dental service corporation in Rhode Island. DDRI also covers many out of state employees of Rhode Island employers, particularly employees of DDRI’s largest group customer, CVS. In addition,

² Reported in Exhibit 1 of DDRI’s December 31, 2009 Annual Statement filed with the Rhode Island Department of Business Regulation (“DBR”). This does not include Altus members.

³ Email response from J. Ferrini November 15, 2010.

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DDRI operates in other states through its related organization, Altus Insurance Company, and processes claims under contract where out of state groups use DDRI's network. As of December 31, 2009 DDRI contracted with 548 participating dentists⁴ in Rhode Island (in-network dentists). DDRI provides insurance benefits for services provided by non-network dentists as well. DDRI has two types of contracts with in-network dentists. DDRI's PPO dentists are members of a restricted network who are contracted to provide benefits at the lowest rates, and who are precluded by contract from balance billing above the PPO allowance. DDRI's Premier dentists are a less-restricted network, and they are permitted to balance bill up to a higher contracted rate in situations where patients are not restricted to the PPO network.

6. Overview of DDRI's Customer Service Organization, Policies and Procedures.

The examiners met with Mary Ann Lonczak-Perri, Director, Customer Service, and discussed the general operation of DDRI's customer service operation. We also met with Rhonda Mancini, Supervisor of Customer Service, In addition to the Director and Supervisor, there are 15 customer service representatives ("CSRs") who handle telephone and other requests. According to Ms. Lonczak-Perri, there is coverage with live Customer Service response staff Monday through Thursday 8AM-7PM and Friday 8AM-5PM. Ms. Mancini monitors and records a minimum of 15 calls per CSR per month. The review consists of proper telephone etiquette, accuracy of information, and tone. If an inquiry is opened, the documentation is reviewed for accuracy, follow up, and proper questioning. Each call is rated on a scale of 1 to 5. Feedback is immediate if required, and a monthly review of calls is provided to each CSR.

DDRI collects and analyzes call response data and provided monthly summaries in files called OHIC monthly call reports. We were provided summaries of these reports for 2009 and 2010⁵. The 2010 file had data through mid-June 2010, consistent with when

⁴ Reported in section 8.2 of the Health Interrogatories, Part 2 of DDRI's December 31, 2009 Annual statement filed with DBR. This does not include any providers who may be contracted with Altus but not DDRI.

⁵ RFI 1

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the files were provided to the examiners. The files included call abandonment rates for both provider and member contacts. A call is considered abandoned if it overflows the queue of calls transferred to customer service, or if the caller is placed on hold and hangs up. The abandonment rate has dropped significantly from its high point in June 2009. In that month, 49.9% of calls were considered abandoned. During 2010, the monthly abandoned call rate has been consistently under 2% of total calls. According to Ms. Lonczak-Perri, ninety-five percent of questions are answered at the first contact. Approximately 1,500 calls per work day are received by the Customer Service Department (“CSD”). Approximately 40% of calls are answered by the current Voice Response Unit (“VRU”)⁶ while the remainder are directed to the CSRs, who average between two and three minutes per call⁷. A new call system was scheduled to be in place by the end of 2010, but the implementation has extended into 2011. The new system is expected to allow for recording of calls but it is not scheduled to provide data gathering on complaints or tracking of complaints for reporting purposes.

The current DDRI call system cannot accommodate electronic tracking of telephone calls to a specific patient and/or member. Details of calls are documented at the discretion of the CSR and only when the CSR determines that follow up is necessary by the CSD or another DDRI department. The CSR can file an inquiry in the Inquiry Management System which is an electronic tool used to transmit communications among DDRI staff. The CSR can also complete a DDRI Complaint Form if the CSR determines that the contact requires complaint follow up by the Quality Assurance Coordinator. Even when calls are noted as inquiries and there is some documentation, contacts are tracked only by the name of the individual making the initial contact with DDRI. There is no process to extract usable reports from the inquiry system. A CSR can make a note on an adjudication screen related to a specific claim, but data extraction and tracking is not available via this process either. Inquiries get assigned to staff for follow up. On the date of the interview with Ms. Lonczak-Perri, 74 inquiries (about one day’s volume) had not

⁶OHIC monthly call reports.

⁷OHIC monthly call reports.

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yet been delegated to a DDRI staff person for follow up. We considered this an indication of a reasonable inquiry travel time.

7. Review of DDRI's Claims Processing and Adjudication Policies, Procedures and Operations.

The examiners met with Steve Maxwell, Director of Operations and Mario Furtado, Supervisor, Claims Administration to discuss claims administration. Approximately 26% of DDRI's claims are submitted in paper form, including all claims that have attached x-rays or photographs. These claims are scanned and transmitted to DDRI's outside data contractor, Rocky Mountain Data Control for data entry. The electronic data entry files are returned the next business day for entry into the system and auto-adjudication. Approximately 36% of claims are submitted via electronic claims submission, while 28% are submitted via the DDRI website. The trend is toward electronic and web submission. Approximately 86% of claims are auto-adjudicated. Designated services and procedures that require pre-treatment or claims review are subject to individual review by utilization review analysts in the Program Integrity Department. All claims for which x-rays or other written documentation are required are submitted in paper form. X-rays and pictures are imaged. Once the initial claim evaluation is made, the originals are destroyed.

Consolidated Explanation of Benefits ("CEOB") and Explanation of Benefits ("EOB") statements are sent to providers and members, respectively when a claim is paid, denied or suspended for more investigation. In our interview with Mr. Maxwell on June 15, 2010, he described a system of "cascading rules" used to determine if a claim is paid or suspended. Rules are the foundation of the claims processing system. Procedure codes, subscriber identification numbers and group accounts are set up in the claim system and may be associated with various rules or "if" statements. Most claims are auto-adjudicated. The final outcome of processing may reveal a provider processing code and/or a member message on a CEOB and/or an EOB. Other messages can be applied

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manually when a claim is suspended for analyst review, coordination of benefits (“COB”), or special handling. According to Mr. Maxwell, if a submitted claim fails to meet one rule, the claim is suspended with the corresponding provider processing code. If that situation is resolved and the claim becomes active again, it can return to a “suspended” status if it then fails to meet another rule. Each time a claim is received it is processed by DDRI electronically and a DDRI claim “rule” is applied. This also applies to claims received on paper as they are put into the electronic payment system. The claim only has to fail to satisfy one rule for the claim to be suspended.

The examiners were provided a list of the DDRI provider processing and member message codes. These are the notifications to the providers and members explaining what rules or criteria are not being met, why a claim was not being paid or transmitting a decision on a claim appeal. There are approximately 600 provider/member processing codes that could appear on a CEOB. An equal number of member message codes could appear on an EOB. A CEOB contains records for all patients for whom that provider has claims being processed. A CEOB often contains multiple provider processing codes, reflecting the reason for payment, suspense or denial for each claim. Because of the number of codes and the multiple claims, this can be a difficult document to interpret.

The examiners reviewed the complaint files kept by DDRI with regard to each of the complaints filed with OHIC, and prepared a summary of each complaint. The examiners found a pattern of unclear communication of information from DDRI to the provider and to the member using the CEOB and EOB process. In some cases, CEOBs for some providers may be sent to the provider’s billing company.

8. Review of DDRI’s Utilization Review Policies, Procedures and Operations.

The examiners met several times with Julie Ferrini, Director, Program Integrity. Ms. Ferrini supervises five dental claims analysts who review and process claims and pretreatment estimates for procedures requiring clinical review based on Dental Policy and Utilization Review Guidelines. Each is a licensed dental hygienist or certified dental

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assistant. For claims that require professional peer review, DDRI has six practicing dentists under contract for approximately four hours per week each. These dentists review claims and pretreatment review requests that are referred to them by the dental claims analysts. They also review appeals. When they are reviewing claims, they work onsite at DDRI.

Utilization review is a regulated activity governed by R.I. Gen Laws § 23-17.12 and by Regulation R23-17.12-UR. According to paragraph 1.34 of Regulation R23-17.12-UR, utilization review is the prospective, concurrent, or retrospective assessment of the necessity and/or appropriateness of the allocation of health care services of a provider, given or proposed to be given to a patient. Among other things, utilization review does not include benefit determination, or claims review other than for the assessment of medical necessity and appropriateness.

The examiners reviewed records related to providers associated with complaints that encompassed 16 claims that went through the utilization review process. This is not a random sample, in that only claims that resulted in complaints, or that involved providers who had filed complaints were reviewed.

All records requested were provided, and the documentation provided was sufficient to assess the utilization review process. Electronic notes were kept by the dental analyst as well as by the peer reviewers (i.e. the DDRI reviewing dentists) for analysis and communication among DDRI staff and reviewers. As required by DDRI's utilization review policies, a claim is reviewed by different peer reviewers at each level of appeal. In some cases a claim may be assessed by more than one peer reviewer before an initial determination is made if deemed necessary by the analyst. The electronic notes identify the peer reviewer who takes the action.

A snapshot of claims data on June 15, 2010 provided by Ms. Ferrini showed 3,951 claims in the queue for processing. Of these claims, 2,406 (61%) were adjudicated without further review, 643 (16%) were pre-treatment estimates, 75 (2%) went to a consultant for

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review, 126 (3%) could not be tied to an eligible member, while the balance were pending for operational or other reasons. Prior to being reviewed by a dental consultant, a claim is reviewed by a dental analyst who assesses the claim using DDRI utilization review (“UR”) criteria to determine whether to authorize payment for the claim. If there are questions about the medical necessity or appropriateness of a claim or course of treatment, the analyst sends the claim to be reviewed by a consulting DDRI dentist. Claims are placed in a queue, and the next available dentist gets assigned a claim from the queue. Ms. Ferrini advised us during the June 15, 2010 interview that approximately 10% of analyst reviewed cases go to a consulting dentist for further review. She also told us that each DDRI consulting dentist reviews approximately 40 cases per week. Since each consulting dentist works four hours per week, this appears to result in an average of six minutes spent reviewing the file and the associated documentation.

Within the OHIC complaint cases, 12 claims represented initial denials⁸ or disallowances⁹ of coverage for major restorative work, primarily because of questions about the underlying endodontic (root canal) work or other long term prognosis of the tooth. When a root canal is improperly filled, there is an increased chance of re-infection, leading to a need for re-treatment or possible loss of the tooth. Because DDRI does not ordinarily review endodontic claims, they only become aware of an improperly filled tooth when a PTR request or claim is submitted for major restoration on a tooth that has had a root canal. Restorative work in these 12 cases, such as crowns and bridges, was denied or disallowed based on one or more of the following summarized processing policies or rules:

- # 73: The contract provides benefits for crowns, build ups and metallic/porcelain onlays only when teeth have been broken down by decay or when there is significant loss of tooth structure due to fracture. Based on the documentation reviewed by the dental consultant, the procedure does not qualify.

⁸ “Denial” means that the benefit is not deemed dentally necessary and appropriate, in accordance with DDRI Utilization Review Guidelines, and that no benefits are provided.

⁹ “Disallowance” means that the procedure may have been performed, but that Delta will not pay and the participating provider may not bill the patient.

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- #118: Root canals are benefited based on review of post operative x-rays that show completely filled canals. Based on the documentation submitted, the reported procedure does not qualify for benefits.
- #167: Due to the uncertain periodontal prognosis of this tooth, benefits for major restorative services are denied.
- #168: Due to the uncertain endodontic prognosis of this tooth, benefits for major restorative services are denied.
- #219: To be covered, restorations must be caused by decay or loss of tooth structure due to fracture. Restorations due to attrition, erosion, or abrasion are not covered.
- #286: The contract provides benefits for build-ups when the treatment is necessary to obtain adequate retention for crown placement. Based on the documentation reviewed by the dental consultant, the reported procedure does not qualify for benefits.
- #299: The treatment plan submitted appears to indicate a compromised long-term prognosis. Based on the documentation reviewed by our dental consultant, the reported procedure does not qualify for benefits.

9. Review of Complaint Policies and Procedures.

Various statutes and regulations govern the different types of complaints that can be made by providers or members. For example, OHIC Regulation 7, Section 9, governs complaints related to the prompt processing of claims. Prompt processing complaints by providers must first be made in writing to the insurer before being filed with OHIC. In the context of utilization review, R.I. Gen Laws § 23-17.12-2(6) and Section 1.9 of Regulation R23-17.12-UR both deal with written complaints. Under these authorities, the appeal of an adverse determination is not considered a complaint. However, Regulation R23-17.13-CHP section 1.1 defines a complaint as any “contact made by an enrollee or provider to the health plan indicating dissatisfaction. . .”

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R.I. Gen Laws § 27-9.1-4(3) requires insurers “to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies.”

R.I. Gen Laws § 27-9.1-4(2) requires insurers to “act with reasonable promptness upon pertinent communications with respect to claims arising under its policies.” These statutes suggest that insurers should have policies and procedures in place to process and promptly respond to complaints.

DDRI has a written complaint policy, which is updated frequently, including most recently on February 18, 2010¹⁰. A copy of the policy is attached as Exhibit 1. Although the written policy generally conforms with the utilization review regulation as described above, page 3 directs all utilization review complaints to be processed under its utilization review determination and appeal policy¹¹ (designated as UR-03RI), which is a medical necessity denial and appeal process not a complaint processing policy. Though this aspect of the DDRI written policy was not in compliance with the utilization review regulations, DDRI did conform to the utilization review regulations when processing utilization review complaints. Generally, the written complaint policies reviewed do not clearly distinguish appeals from complaints and utilization review, quality assurance and administrative processes. In addition, in the processing of a quality of care complaint, page 2 Section 3 of the quality assurance policy¹² does not include a mechanism to process a verbal complaint should a member fail to submit a written complaint.

DDRI written complaint policies do require non-written complaints to be fully processed according to its policy and procedures. However, based on a review of DDRI complaint files and interviews with the Ms. Lonczak-Perri and Ms. Gioffreda, DDRI has required most complaints to be put in writing by the complainant in order to consider them complaints and track them. Failure to act on verbal complaints appears to conflict with the requirement of R.I. Gen. Laws §27-9.1-4(2) that insurers must “act with reasonable promptness upon pertinent communications with respect to claims arising under its

¹⁰ DDRI designates this policy as QA-01RI. It was provided as part of RFI 1.

¹¹ Designated as UR-03RI, and provided as part of RFI 1.

¹² DDRI’s policy for Quality of Care Complaints (for RI services and/or patients) is designated as QA-02RI, and provided as part of the response to RFI 1.

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policies.” “Pertinent communications” should not be seen as limited to written communications only. DDRI’s complaint policy discusses how complaints are received, categorized, tracked, evaluated and investigated. DDRI maintains a complaint log, but the examiners found that the log did not reflect a complete listing of those communications meeting the regulatory definition of complaint. For example, it does not include verbal complaints, and it does not fully track complaints that are resolved. DDRI does not, therefore, have a mechanism to assure that its complaint processes are fully implemented as required by its own complaint policies and procedures and by Sections 1.3 and 6.9 of Regulation 23-17.13-CHP.

As a practical matter, DDRI’s implementation of its complaint policy has been incomplete. Contrary to the stated policy, and contrary to the requirement to act on pertinent communications as stated in R.I. Gen. Laws §27-9.1-4(2) , when a complaint is made over the telephone, DDRI does not act on or log the complaint, but instead directs the complainant to file a written complaint. Because individual telephone calls are not logged, it is therefore not possible to verify elements of a written complaint that relate to attempts to resolve problems by telephone, and it is not possible to determine the volume and scope of complaints that were made, but not reduced to writing.

DDRI provided copies of its complaint logs for 2009 and for 2010 through June 14, 2010 in response to a request (RFI-1). There were only 49 complaints logged for 2009 and 26 for 2010 through June 14. This appears to be a very low number, considering that 22 complaints ended up being forwarded to OHIC during this period. It is possible that DDRI’s practice of failing to log oral complaints suppresses the overall number of complaints that appear in its records and can therefore be tracked. There is also evidence in the Case Evaluation Documents that shows members having contacted the DDRI Customer Service Department, while there was no recorded evidence of the contact recording it as a complaint.

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A review of the 2009 complaint log provided by DDRI revealed that three of the 49 recorded complaints were withdrawn¹³. The examiners reviewed the files for the complaints classified as “withdrawn”. In two instances, DDRI assisted the member to receive either re-treatment or a refund with regard to a restoration that was done improperly and had to be redone. Characterizing these cases as “withdrawn” understates the positive help DDRI gave the member in the resolution of a problem. The other case involved a member complaining about substandard care. DDRI advised the member to contact the dentist to work out a resolution. The member called back to report that the dentist had not responded to his inquiry. DDRI then asked the member to call back to decide if he wanted to pursue the matter. After approximately one month with no further contact from the member, DDRI sent the member a letter stating that they considered the complaint withdrawn, but that the member could contact DDRI if he wanted to re-open it. In the opinion of the examiners, DDRI was not adequately helpful to this member. He had contacted DDRI twice about this case, and it would have been appropriate for DDRI to follow up with the dentist.

In response to the advice of the examiners, DDRI contacted the member on April 26, 2011, asked if he wished to pursue the matter further, and determined that he had resolved it with the dentist to his satisfaction. No further action with regard to this specific claim is recommended.

Recommendation 1: As part of its written complaint processing policy, DDRI should establish a clear definition of what constitutes a “withdrawn” complaint as well as a mechanism for the application of a consistent procedure.

One case in each of 2009 and 2010 logs was submitted anonymously and was therefore categorized by DDRI as “not pursued.”¹⁴ In these two cases DDRI determined that the

¹³ A withdrawn complaint occurs when the member reaches resolution with the dentist or does not respond to follow-up requests for information from DDRI. Withdrawn complaints are maintained for tracking purposes, but DDRI does not investigate them further.

¹⁴ Complaints are also considered “not pursued” if the member wishes to remain anonymous and asks that the dentist not be contacted.

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content of the complaint would not be investigated and followed up even though there were allegations of quality of care issues and potential abuse of services. However, it appears that Regulation R23-17.13-CHP sections 1.3 and 6.9 require that complaints be evaluated, investigated and followed up with or without the complainant's name. DDRI advised the examiners that they did track these complaints for trend and to see if there was a pattern with regard to that dentist. However, they did not present documentation of any tracking or investigation. These were both potentially serious allegations. One involved an allegation of malfeasance regarding DDRI audit of the dental office, while the other involved a dentist purportedly recommending unnecessary fillings on a child's healthy teeth.

DDRI has advised the examiners that they ordinarily do track anonymous complaints for trend and investigate further when they deem it appropriate. DDRI advised the examiners of a situation in which they conducted an audit of a dentist's office after receiving two anonymous complaints. However, we did not see evidence of that policy in the complaint log.

Recommendation 2: DDRI should maintain documentation of any monitoring related to anonymous claims, and should investigate potentially serious matters, even if the complaints have been made anonymously.

Recommendation 3: As part of its written complaint processing policy, DDRI should clearly define a process for the consistent processing of anonymous complaints that includes the tracking and trending of similar complaints against a provider as well as the documentation of all investigative efforts.

Supervisor Call Sheets are manually completed by the Customer Service Supervisor (Ms. Mancini) when a CSR is unable to address the caller's concerns and the caller insists on speaking with someone else. A review of 19 Supervisor Call Sheets randomly selected by Ms. Mancini revealed that 11 (58%) contacts constituted a complaint according to

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DDRI's definition of complaint in its complaint policy, but they were not tracked as complaints in the complaint log.

The examiners advised DDRI of this discrepancy and they have told us that they are now logging verbal complaints. However, they are not able to track them and monitor them electronically from the customer service contacts, but must rely on the CSR providing a written complaint record using the DDRI Complaint Form.

Recommendation 4: DDRI should institute processes to record and act on all complaints, whether written or verbal.

In 14 (61%) of the 23 OHIC complaint cases DDRI did not fully address a potential or actual complaint. For example (by OHIC tracking number):

29992: DDRI denied coverage for a crown for a tooth, because it does not provide coverage for damage due to attrition. When the dentist responded that the tooth was fractured, DDRI processed an appeal and sustained its original determination, but did not respond to the dentist's assertion that the tooth was fractured. DDRI's position is that any fracture of the teeth was minor and was caused by the attrition. DDRI determined that a major restoration was not required by the extent of fracture and decay present. However, that explanation was not documented in the complaint file, and could not be determined from the processing codes associated with the appeals or from the DCN notes maintained in the file.

33435: One of the elements in this complaint was a missing photograph of a tooth that the dentist claimed to have sent in. DDRI did not investigate whether the photograph had been submitted or respond to that portion of the inquiry. DDRI believes it responded adequately through a dental consultant contact with the dentist, but the contact was not adequately documented in the appeal file. Instead, the file shows a claim form from the dentist appealing the initial denial that included the phrase, "see attached photo." DDRI should have investigated the possibility that there was in fact a photo sent to assure that

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DDRI did not misplace it. DDRI's protocol with regard to x-rays and photographs is to accept them only in hard copy form, and then to scan them to create electronic records. The original documents are then destroyed by DDRI. The examiners did not find evidence of effort on the part of DDRI to determine whether a photo existed, or documentation of agreement by the dentist that the photo did not exist. This would have been appropriate, since the absence of a photo appeared to be an important factor in the denial being upheld on internal and external appeal. DDRI's examination of the claim file leads them to conclude that there is no evidence that the dentist submitted a photo with the claim. DDRI's position is that in the conversation between the provider and DDRI's dental consultant, the provider did not challenge DDRI's assertion that DDRI never received a photo. The examiners' review of the claim file, on the other hand, did not reveal a conclusive determination as to whether there had been a photo.

33494: DDRI denied coverage for a crown, and its internal notes said that the crown was "ill-fitting". However, the communication of the denial did not talk about an ill-fitting crown, but instead requested an x-ray. The dentist documented 7 calls to DDRI in an attempt to resolve the claim, but DDRI did not address the number of calls in its response.

33615: A dentist provided a crown and build-up and complained about it taking 5 months to get the claim paid, and about incorrect information about the status of the claim received from DDRI. DDRI responded to the complaint by noting that the claim had been paid, and by providing a timeline of its written records. Their timeline did not include the specific telephone contacts enumerated by the dentist. They also did not adequately explain the alleged misinformation and delay referenced in the complaint.

33813: This complaint involved multiple calls and conflicting information from DDRI about the location of the patient's x-rays. This patient documents that she contacted DDRI customer service four times to determine the status of her x-rays. During a June 9, 2009 telephone communication, this patient was told by DDRI that there was no evidence that her x-rays had been returned as she had been told in a May 8, 2009 telephone

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communication. However, during a subsequent June 15, 2009 contact the patient was told that her x-rays had been received by DDRI on June 1, 2009. Given that DDRI does not document its calls from customer service, it is difficult to verify these calls. The patient recorded the date and content of each telephone contact. The response by DDRI did not address the multiple telephone contacts by the patient, the lack of logging and processing of the patient's issues as a complaint until written communication was received from OHIC in August 2009, and the conflicting information received by the patient when contacting DDRI.

33895: This was a complaint with regard to investigation and denial of root canals. DDRI did not respond to the allegation in the complaint that 50% of root canals from this dentist's office were being denied without a valid reason as noted in this dentist's complaint, which states in part: "...I am referring to Delta Dental of RI's baseless and unexplainable denials of Root Canal Therapy performed by my endodontic specialist, (Dr. B.). Over this past year, I would say that almost 50% of the claims sent in get denied. Upon further inquiry, no valid reason is offered by them for the denials, other than that it is their right to deny any claims they feel like denying." This identical complaint was made by several dentists, all related to the root canals performed by a traveling dentist working out of their offices.

33932: This was a claim involving crowns. While DDRI responded fully to the specific patient's complaint, DDRI did not respond to the dentist's allegation that crowns that would otherwise be covered at 100% were being denied disproportionately and without reason. DDRI has explained to the examiners that its dental reviewers and dental consultants do not have access to information about the percentage coinsurance when they are evaluating claims, and that the percentage coverage is not, therefore, a consideration in approval or denial. In addition, DDRI provided the examiners a screen print showing that the information reviewed by the dental reviewers and consultants does not include benefit information. However, DDRI did not provide that information to the complainant.

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34332: This complaint had many parts. It included an assertion that DDRI had compromised the privacy of an endodontist by communicating quality concerns to a dental office in which he performed services. DDRI did not address this issue in responding to the complaint. The examiners understand that DDRI was providing information to the dentist who maintained the dental office about a major restoration he was doing, and that it was necessary for DDRI to advise that dentist that the underlying endodontic work was inadequate. In the opinion of the examiners, DDRI did not compromise the endodontist's privacy. However, the response to the endodontist did not explain this adequately.

34395: A dentist inquired as to a patient's benefit eligibility and received incorrect information from the website and was not able to get questions answered from Customer Service. Based on the information provided by DDRI, the patient proceeded to have the procedure performed assuming he had coverage. His complaint about coverage was eventually and correctly answered in a manner understood by both the dentist and the patient, but DDRI did not address or take responsibility for the incorrect benefit eligibility information it had provided or the negative financial impact these benefit communications has on the patient..

34412: In the course of this complaint, the dentist made some statements about copays and deductibles and about the right of the dentist to bill for these amounts. It was apparent to the examiners (and to DDRI) that the dentist did not adequately understand the correct billing procedures, but the response did not take the opportunity to educate him. Instead, it contained a statement that he could charge whatever he wanted. This is technically true, but not helpful. Since he is a participating dentist, he is only paid the allowed amount and cannot balance bill.

35732: A number of communications were exchanged between this provider and DDRI and between the provider and DDRI's legal counsel. The provider made complaints regarding the alleged unreasonableness of DDRI information requests and denial process, The provider had been placed on review for surgical extractions. He requested

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information related to DDRI's decision to place him on review. DDRI did not provide adequate and complete responses to this provider's concerns, and did not provide him details with regard to its analysis that led to him being placed on review. DDRI reasoned that it did not have to give him that information because they were not recouping money for the procedures they reviewed. The examiners disagree. The results of this review were important to his claims processing and he was entitled to see the review and to challenge any conclusions that he may have found inaccurate.

37583: The response to this complaint did not address the assertion that a particular dentist was being unfairly targeted for denials. This related to a dentist who is being reviewed on all his endodontic claims. A particular claim was miscoded as having been performed by another dentist in the office (who is not on review) and DDRI approved it. Subsequently, DDRI was advised as to the correct treating dentist, whereupon they reviewed the claim and denied it as being improperly done. The dentist perceived that the denial indicated that DDRI's claim decision was based not on the tooth, but on the dentist, and he alleged that he was being treated unfairly. DDRI responded to the complaint, saying that it did not have a "vendetta" against him. DDRI apparently spent a great deal of time communicating with this dentist. However, the documentation available in the file does not show that DDRI adequately explained to him why he was being treated differently (as he surely was) and what information he needed to provide routinely in order to get his claims approved.

38406: DDRI's response involved ultimately paying the claim, and apologizing to the patient for the error it made in basing its claim approval process on the wrong tooth. DDRI did not address its unwillingness to investigate a call from dentist's office providing the correct tooth information. DDRI's failure to investigate promptly and to make it clear to the patient that the provider attempted to communicate the problem to DDRI appears to have resulted in the provider losing this patient.

Recommendation 5: DDRI should institute processes to ensure that it investigates the full scope of each complaint, including addressing any potential issues related to

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the discoveries made at the initial point of contact by the complainant and in the course of any complaint investigation.

10. Review of DDRI's Quality Assurance Policies, Procedures and Operations

According to R.I.G.L. §23-17.13 and Regulation R23-17.13-CHP, DDRI is required to maintain a process to address substandard care in addition to addressing quality of care complaints. DDRI has a written quality of care complaint policy, which is updated frequently, including most recently on February 18, 2010. A copy of the policy is attached as Exhibit 2. The quality of care complaint policy and processing issues are noted in section 9 of this report, "Review of Complaint Policies and Procedures."

DDRI does not, however, maintain a policy to address how it will handle quality of care issues that arise through DDRI's independent investigation and not in response to a complaint. As noted in several of the files related to the OHIC complaints, DDRI became aware of care that it considered substandard, but did not address it through its Quality Assurance program. Rather, it addressed substandard care through its utilization review program. The examiners found that in certain cases when substandard care was identified by DDRI, it chose to deny/disallow payment for the care instead of directly addressing the concern that poor quality care was rendered. For a select number of providers who either were identified as meeting a level of fraud and abuse (e.g. billing for services not rendered) or as having a history of poor procedural outcomes (e.g. poorly done root canals) over a long period of time, DDRI did forward these providers to its Quality Management Committee ("QMC") with recommendations to terminate as network providers.

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For example, Dr. A (as discussed below) had complaints dating from May 2009 that were characterized as “quality/fraud” complaints, yet DDRI did not conduct an audit until February 2010. DDRI’s handling of this situation was consistent with its Complaint Policy, “Any dentist that acquires three (3) or more complaints regarding the same or a similar issue will be brought to the attention of Senior Management for possible remedial action.” However, it is the opinion of the examiners that complaints alleging fraud are serious matters, and should be investigated before three occurrences accumulate.

Dr. B (as discussed below) was identified as providing allegedly substandard endodontic care and placed on full review as of May 1, 2008. However, the focus of this review was on denying/disallowing payment for his work, not on actively addressing the quality of care. Dr. B remained a network dentist until he resigned in May 2010.

At some point, DDRI must take responsibility for work it considers substandard provided by dentists it retains in its network.

The QMC reviews summary reports including denial and appeal statistics, as well as quality of care complaints. It also discusses a relatively small number of providers with regard to specific issues (noted above.) In addition to the QMC, DDRI has a Quality Assurance Coordinator (Ms. Gioffreda).

The examiners noted the following items with regard to DDRI’s quality assurance program.

In situations involving quality of care, DDRI has advised the examiners that it provides counseling to dentists when it has determined substandard services have been rendered to a patient. However, we also saw evidence that DDRI sometimes deals with its dissatisfaction with substandard work by a dentist by withholding payment or demanding repayment, rather than by ensuring that adequate services are provided to patients. An example of this is when DDRI has determined a root canal has not been done properly and will not pay for the crown. The patient is

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unable to secure payment for the crown until the root canal is done in accordance with the standard of care.

- a. Because of the focus on payment instead of counseling, referral or dismissal, dentists with identified quality problems have continued to deliver dental care that DDRI has reason to believe may be substandard.

- b. When DDRI identifies a problem dentist, even a dentist who commits fraud, DDRI is slow to act. DDRI is reluctant to openly criticize a dentist in confronting quality of care issues. For example, DDRI prepares quarterly Program Integrity Audit and Fraud & Abuse reports. DDRI's report as of December 31, 2009, identified a case of suspected fraudulent submissions by a provider referred to here as "Dr. A". DDRI's report as of March 31, 2010, stated that there were three quality of care/fraud complaints related to Dr. A from May through October 2009. As a result, DDRI audited Dr. A's claims on February 2, 2010, and put his root canal submissions on full review beginning January 26, 2010. At least 8 months passed between the first quality of care/fraud complaint and the actions to audit and review Dr. A's claims. Meanwhile, Dr. A remained a DDRI network provider and continued to treat DDRI members.

- c. The QMC meets only about once a year. This meeting schedule seems too infrequent to timely and appropriately deal with significant problems that are identified by DDRI. The QAC appears to review quality complaints and issues superficially, based on our review of the 2009 QMC committee notes and the infrequency of their meetings. When confronted with a provider (e.g. Dr. A as described above, or Dr. B as described in section 13 of this report) who has had long standing quality issues, this committee did not take immediate action. Instead it asked for further review of these providers and in one case (Dr. B) it asked that additional reviews be imposed under DDRI UR programs resulting in subsequent initial denials of care. This approach did not

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sufficiently and expeditiously address care that has been identified by DDRI as substandard given that the provider was still allowed to perform services for DDRI members under a provider contract with DDRI. Further, while this committee has been charged with reviewing each quality of care complaint, there is no evidence that this occurs. Based on our review of QMC committee notes from 2009, the QMC appears to receive summaries of complaints and denial and appeal statistics along with “Compliance Updates.” No evidence was presented to the examiners of in-depth discussions by the QMC regarding quality complaints.

Recommendation 6: DDRI should modify its Quality Management Program in order to address provider specific quality problems. DDRI should discontinue use of the utilization management program as DDRI’s primary mechanism to address poor quality care. A quality management program should incorporate a process to address substandard care to protect DDRI members from providers that DDRI have identified as providing poor quality care.

11. Review of Denial and Appeals Process

When DDRI makes an adverse determination with regard to the medical necessity or appropriateness of a covered benefit, they offer an appeals process, as required by R.I. Gen Laws § 23-17.12-9 and Regulation R23-17.12-UR. Although DDRI has occasionally accepted oral appeals, it generally requires the appellant to send a written appeal. A review of the OHIC complaint files shows DDRI electronic notes filed by CSRs and dental analysts requiring that a written appeal be filed prior to DDRI processing the appeal. Although DDRI’s written utilization review policy (UR-03RI) requires that appeals be in writing, this does not appear to be consistent with the definition of an appeal at R.I. Gen Laws § 23-17.12-2(2), which states that an appeal rises from “a request from a patient or provider to reconsider all or part of an original

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decision,” with no limitation that the request be written. At an interview on June 15, 2010 DDRI Appeal Coordinator Frances Ward-Smith confirmed that DDRI has required appeals to be made in writing.

Recommendation 7: DDRI should modify its appeals process to accept verbal appeals.

In several of the OHIC complaint cases reviewed by the examiners, confusion occurred when DDRI asked for additional information in connection with processing a claim and the responsive information was characterized as an appeal. This appears to be in conflict with the requirement of OHIC Regulation 7, Section 4(b)(i), which requires that when an insurer pends a claim, the insurer has 30 calendar days from receipt of a claim to notify in writing the health care provider or policyholder of any and all reasons for denying or pending the claim and what, if any, additional information is required to process the claim. In some cases observed in the complaint files, providers and members did not appear to understand the difference between a request for additional information and a denial. In those cases it was difficult to understand from the CEOBs and EOBs whether DDRI was requesting information in order to process a claim, or had reached a determination that benefits were not being allowed. As noted in a previous section of this report, the EOB/CEOB is used to communicate requests for information, utilization review denials, utilization review appeal decisions, administrative and benefit denials. Our review of complaint files revealed a number of instances of inadequate specificity in DDRI’s request for information necessary to complete the utilization review process and DDRI’s failure to comply with its own policies and procedures. DDRI believes that its use of CEOBs and EOBs is consistent with industry standards. DDRI provided the examiners with sample copies of EOBs provided by other insurers, which showed a wide range of edit codes, some more fully descriptive than others.

Recommendation 8: In the event of a claim or Pre-Treatment Review (“PTR”) denial, DDRI should provide clear communication as to the specific reason for the denial in order that the patient and/or provider is able to effectively appeal.

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Also, our review of a sample of Customer Service Department supervisor call sheets revealed that in seven of 19 instances, the call noted the patient and/or provider's lack of understanding of the information provided on the EOB/CEOB.

As required by Regulation R23-17.12-UR and its own internal policies, DDRI offers two levels of internal appeal in the case of a medical necessity denial. For the first level of appeal, DDRI employs six practicing dentists who each review cases on a part time basis. The appeal is assigned randomly to one of the dentists, depending on who is next available in DDRI's dental consultants queue. Adverse determinations are required by Regulation R23-17.12-UR section 5.1.1 to be made by a dentist. The examiners reviewed a sample of denials and confirmed that DDRI observes this requirement. An appeal is required by R23-17.12-UR section 4.1.9 to be assigned to a different dentist from the original reviewing dentist, and the examiners confirmed that requirement is also observed. If that dentist overturns the original decision, the procedure is authorized or paid. If that dentist upholds the original decision, the appellant may ask for a second level of appeal. If there is a second level of appeal, DDRI must then afford the member the opportunity to inspect and add information to the appeal file to determine the file to be "complete." The review at the second appeal level is done by a dentist specializing in the same branch of dentistry as the attending provider. If the dispute is still not resolved, the appellant can ask for an external review. The complete appeal file is then sent to an outside agency, Maximus. The Maximus dentist reviews the entire file and provides a written decision. The fee for a Maximus review is \$288, which is split equally between DDRI and the appellant. If Maximus finds in favor of the appellant, DDRI reimburses the appellant's half of the fee. There are required notification timeframes associated with each of these levels of appeal according to both DDRI policy and R23-17.12-UR sections 6.1.2, 6.1.3 and 6.1.9. As part of the second appeal, the appellant should be offered an opportunity to inspect the file and ensure that it is complete. This is particularly important because that is the file that is sent to external review in the event of an external appeal, but it is also important in making sure the second appeal is fairly heard.

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Recommendation 9: DDRI should take steps to ensure that appellants are given the opportunity to inspect the claim file and add information as necessary prior to the decision on the second level of appeal.

DDRI provided the examiners with appeals logs for each quarter of 2009 and the first quarter of 2010. These logs contained a total of approximately 5,700 appeals, of which 40% related to PTR and 60% to claims. A PTR determination is requested prior to the performance of a dental procedure, to determine whether DDRI will cover the procedure, deny coverage, or recommend an alternate procedure. A claim is submitted once the procedure has been performed. A provider or patient is not required to submit a PTR request, but providers and patients often do in order to confirm whether the procedure will be covered.

Of the appeals contained in the appeals logs provided to the examiners, approximately 5,100 were first appeals, while almost 600 were second appeals. Twenty-two claims went to external review. There may be some error introduced due to timing, since not all appeals have gone through to conclusion. Some claims in second appeal during this time frame may have had their first appeals prior to 2009, while some claims that have had a first appeal may go to second appeal after first quarter 2010. However, these differences should balance out. Comparing claims ultimately approved to the number of first appeals revealed that approximately 79% of PTRs or claims were eventually approved during either the first or second level of internal appeal or through external review.

It is not possible from the appeals log to determine whether the overturns resulted from a difference of opinion among reviewers, or from additional information provided in the appeals process. However, the high rate of ultimate approval—nearly 8 out of every 10 denied claims that are appealed are reversed on appeal—suggests that the original determination may be unduly conservative and/or that the UR process not is effectively

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implemented.¹⁵ If the original process is too conservative, and claims are inappropriately denied in the first instance, DDRI and dentists necessarily bear unnecessary expenditures of time and money navigating the appeals process. Also, patients may be affected due to delays of necessary care. DDRI should periodically review initial denial decisions to determine the appropriateness of these decisions given the high first and second level of appeal overturn rates. DDRI believes that the high rate of overturn on appeal is based primarily on the provision of additional information.

Recommendation 10: DDRI should institute a study of its claims denials to determine the reasons for the high rate of overturn on appeal. Among other possible explanations, DDRI should investigate whether its standards for original review of claims and PTR determinations are too conservative and whether its denial codes on the EOBs/CEOBs are adequately effective in communicating with dentists and patients.

Under Regulation R23-17.12-UR, DDRI is required to process appeals within 15 days. DDRI keeps statistics on its appeals through its appeals logs. Based on the logs, an average of 62% of appeals took longer than 15 days over 2009 and the first quarter of 2010. This was relatively worse during the second and third quarters of 2009, when DDRI was going through system conversion and experiencing customer service delays and over 80% of appeals took longer than the regulatory maximum. While some improvement was made, nearly 40% of appeals still took longer than 15 days during the first quarter 2010. It is possible that DDRI may have overstated the number of appeals that took longer than the allowed standard. The regulation permits a total of 21 days for a written response in cases where a verbal response is given within 15 days. DDRI apparently has not been tracking whether it may have provided verbal responses on a timely basis, in which case some responses that were made in written form in more than 15 days but fewer than 21 days may have been compliant with the regulation.

¹⁵ DDRI provided statistics for adverse determinations and appeals from studies of first quarter 2006 and first quarter 2007 adverse determinations. 25% of adverse determinations were appealed in the 2006 period and 36% were appealed in the 2007 period.

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Recommendation 11: DDRI should take whatever steps are necessary to process appeals within the 15 day timeframe mandated by Section 6.1.2 of Regulation R23-17.12-UR.

Summary of Utilization Review Program Issues:

Utilization review denial and appeal performance do not meet DDRI's own policy requirements and appear not to meet the requirements of Regulation R17-12-UR sections 4.0, 5.0 and 6.0. DDRI's practices:

- a. Do not include the option to submit a verbal appeal;
- b. Do not meet appeal timeframes mandated by Regulation R17-12-UR sections 6.1.2 and 6.1.3,
- c. Fail to provide effective communications with providers and members; and
- d. Fail to provide the opportunity to add to and inspect the case file before the appeal decision at the second level of appeal.

DDRI's UR processes result in delays in payment due to the lack of clear communications with the provider and/or member as to what explicit information needs to be submitted to complete the UR claim file. DDRI's communication of denials is unclear with regard to whether a denial has been made as well as the reasons for denial, e.g., benefit denial, administrative denial, contractual denial or utilization review denial. Without specific information, providers and members cannot fully understand their appeal rights.

When a denial is made by DDRI, the processing codes do not provide enough specificity as to the reason for the denial, making it difficult to know what information to provide in order to successfully appeal.

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See Recommendation 8, above: In the event of a claim or PTR denial, DDRI should provide clear communication as to the specific reason for the denial in order that the patient and/or provider is able to effectively appeal.

The utilization review process is used by DDRI to address substandard care rendered by providers. Relying on utilization review and on withholding payment as the primary mechanism to address poor quality care is not an effective or acceptable remedial action when DDRI has determined a provider is providing poor quality care to its membership.

Recommendation 12: DDRI should clearly distinguish between claims that are denied for benefit reasons, pended claims that are held for additional information and denials that are made because of medical necessity.

12. Prompt Payment of Claims

OHIC Regulation 7 Prompt Processing of Claims requires that insurers process electronic claims within 30 days of receipt and written claims within 40 days of receipt. Under the regulation, insurers are required to pay interest on claims that are not paid within the required time frames, to file claim processing reports with OHIC and to provide complete claim standards to participating providers.

We reviewed Delta's prompt processing reports since the effective date of the Prompt Processing regulation, January 1, 2007. The reports have been made on a timely basis, and are in the format required by the regulation. In general, compliance with the prompt payment requirements has been extremely good, with over 99% of claims reported as processed within the required time frame in each of the four years. There were only two months in which payment times slipped, May and June 2009, which still had processing completed on a timely basis for approximately 97% of all claims.

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There was an anomaly noted in that the company routinely reports more claims processed than received. While there could be more processed than received in some months, this is a persistent pattern. DDRI has analyzed its reports and believes that the reports are generally correct except for the total number of claims received and processed. DDRI is working on a new reporting methodology that will report the number of claims received and processed correctly.¹⁶ DDRI is developing a new reporting tool to generate the prompt pay report to OHIC.

The company also noted some difficulties it has had with properly identifying and reporting claim processing times.

- From time to time, some written claims have been mistakenly recorded as electronic.
- Some claims have been logged as subject to prompt processing that did not meet the clean claim standard.
- The company had a problem when it began processing its written claims through its outside vendor, Rocky Mountain Data Control. A batch of claims did not get properly transmitted to the vendor in February 2010, and it was not located and processed until May 2010.
- DDRI notes that it has not been set up to prepare the prompt processing reports automatically. Instead, they have had to do some manual intervention. They re-wrote the system to prepare these reports beginning in fall 2009.

The company's complete claim is defined in DDRI Policy PAY-02RI titled Complete Claim Standard approved March 7, 2005. It states that "A complete claim would be a properly submitted paper ADA dental claim form, or reasonable facsimile, or electronic claim submitted in a HIPAA compliant format, with all data filed accurately and legibly completed, accompanied by x-rays, charting, narratives or other documentation as may be specified for the procedure in question in the Delta Dental of Rhode Island Participating Dentist Manual and/or other written communications." This standard is reiterated in its

¹⁶ Email from Melissa Gennari, November 19, 2010.

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plan summary document title “How Your Plan Works” that is sent to beneficiaries and at least annually in the provider notice titled “Details”.

This standard seems too vague, in our opinion. In particular, there are occasions when the company asks for additional information on a sequential basis. For example the clean claim policy asks for “narratives” but this can be interpreted to mean many different forms of provider documentation. The provider cannot know what information DDRI needs in order to adjudicate a claim based only on the clean claim standard. This occurred both as part of the utilization review process to determine the medical necessity of care and for those claims outside of this process. It would be preferable for the company to identify the kinds of information they expect for each particular procedure. (For example, pre- and post-operative x-rays, treatment notes, etc.) It is recommended that the company prepare and file a more descriptive clean claims standard, including variation as appropriate by procedure type.

Recommendation 13: DDRI should revise its clean claims standard to provide specific detailed requirements for the information required by DDRI for adjudicating a claim or making a PTR determination.

We were not able to tell from the prompt processing reports how DDRI treats claims on which additional information is submitted. Such claims should also be in the prompt processing report. The company sometimes assigns a new claim number to a claim for which additional information is submitted, and sometimes uses the original claim number. This makes it difficult for the company to pull up the complete history of a claim, but does not affect compliance with the prompt processing regulation.

13. Analysis of Specific OHIC Complaints

We reviewed 23 specific complaints that were filed with OHIC by providers or patients between January 1, 2009 and April 4, 2011. An additional four complaints were

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reviewed that were not filed directly with OHIC, but that were submitted to DDRI by or against a provider noted in the OHIC Complaint Cases reviewed by the examiners.

a. Root canal related complaints

Of the twenty three complaints, seven related to DDRI's handling of the endodontic claims from one specific endodontist (referred to here as "Dr. B"), either directly from Dr. B as a result of DDRI's adverse determinations with regard to paying for the endodontic work, or from one of three different general dentists who had adverse determinations of crowns because of DDRI's identification of problems with the underlying root canals.

As background, when a root canal is performed, the nerve within the tooth is removed and filling material is inserted into the canal space. The filling must completely fill the nerve chamber, or there is an increased risk of re-infection and failure of the tooth. DDRI does not ordinarily review root canals, because it has determined that they are generally performed only when dentally necessary. However, when a crown is submitted for either PTR or for claim, DDRI requires a periapical x-ray (one which shows the full root) so they can evaluate the underlying root canal prior to approving the application of the crown. DDRI may request treatment notes when the root canal fill appears incomplete, particularly because there may be anatomical reasons a fill cannot be full depth. In addition, for root canals of long standing, if they are asymptomatic, that may indicate that they are not a threat to the integrity of a subsequent restoration.

When DDRI determines, in the course of reviewing a claim or PTR for a crown, that a root canal is not completely filled, it issues an adverse determination and sends an EOB to the patient and a CEOB to the provider with the processing code 168, which means, "due to the uncertain prognosis of this tooth, benefits for major restorative services are denied."

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Some time during early 2008, DDRI became aware that a relatively large number of code 168 adverse determinations involved prior root canals performed by Dr. B¹⁷. DDRI questioned the quality of Dr. B's work and instituted a program of reviewing all his root canals effective May 1, 2008. Three of the complaints received by OHIC were from Dr. B about the number of his claims that were denied/disallowed and the appeals process in general, with the last of these complaints containing a letter of resignation as a DDRI network dentist.

In addition, three other complaints received by OHIC were from general dentists who had PTR or claims that were not approved because of underlying root canals performed by Dr. B. Each of these complaints expressed concern about the difficulty of obtaining coverage for medically necessary care and the difficulty of the appeals process.

Since January 1, 2009, DDRI reviewed 169 of Dr. B's root canals. Of those, 102 (60%) were approved by the DDRI dental analyst, while 67 (40%) were identified by the analyst as potentially inadequately filled. Each of those claims was referred to a dental consultant for review. An adverse determination can only be made by a dentist, and not by an analyst. Sixty-four of those 67 were disallowed by the dental consultant. Sixty-three of the 64 went to the first level of appeal, where 26 were approved and 37 again disallowed. Thirty-six of the 37 went to the second level of appeal, with 18 approved and 18 disallowed. Nine of the disallowed claims then went to external review. As noted earlier, in order to go to external review, the complainant must pay \$144 or half of the external review charge. If the complainant is successful, that charge is refunded by DDRI. Two of the nine claims were approved at external review. The remaining claims were confirmed as disallowed.

Ultimately, 151 of 169 (89%) teeth were approved and paid, while 18 (11%) were not.

¹⁷ While Dr. B is not the only dentist who had root canals challenged by DDRI, only about 0.33% of 48,000 crown claims resulted in a denial using code 168 during a recent one year period.

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There are several considerations raised by review of these cases:

1. Sixty-four cases were disallowed, but ultimately 46 of those cases were approved and paid (over 70%). For the cases ultimately approved, there were delays in payment and delays in subsequent restorative work while the appeals process was taking place.
2. DDRI's communication of denial of coverage/payment could lead to confusion. The description of the reason for denial of restorative work based on processing code 168 ("uncertain prognosis") does not adequately describe the appropriate course of treatment and the options for proceeding to restorative work.

Recommendation 14: When denying coverage because of an inadequately filled root canal, DDRI should explain that the crown will be approved once the root canal is fixed and that DDRI will pay for the repair to the root canal if performed properly by a different endodontist.

Placing an endodontist on full review results in delay in payment, delay of subsequent care, and additional time and expense on the part of the dentist to provide additional information and navigate the appeals process. R.I.G.L §23-17.13-3(11) requires that a health plan provide due process to a provider for any adverse decision that changes his or her privileges and that it allow the provider to contest the action or decision.

Recommendation 15: When a provider is being audited and placed on additional review or sanctioned in a way that changes the provider's ability to have claims processed in a timely fashion, DDRI should allow the provider the opportunity to review the audit information and respond to DDRI conclusions prior to the changes taking effect.

Dr. B shares responsibility for the difficulties faced by him and by his patients. He was identified for full review because of alleged poor quality work. When an inadequate root

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canal is identified by DDRI, it would be more appropriate for a provider to try to understand what DDRI would require to make the service eligible for payment and then try to meet that requirement rather than engage in a lengthy sparring match with DDRI. While a provider might view this as telling him or her how to practice, such an approach would likely resolve conflicts more quickly and benefit both the patient and the provider. However, DDRI has made such an approach difficult by the volume of their original denials and by their failure to adequately describe the reason for each denial. These two factors make a cooperative approach to resolving payment disputes more difficult. Furthermore, DDRI's denials may appear arbitrary to some providers and patients in that a relatively large percent of denials are appealed¹⁸, and over 70% of the ones that are appealed are ultimately overturned on appeal. DDRI notes that denials are based on failure to meet Utilization Review criteria. However, such a high rate of overturn implies that either DDRI is not getting adequate information to evaluate claims initially, or that they are being unduly conservative in their initial assessment of the information they have. A claims process that may appear arbitrary to the providers can generate suspicion and ill will among providers.

b. Other crown related complaints

Three other complaints came in from dentists who submitted PTR or claims for crowns that were denied by DDRI. In two of these cases, there was a dispute as to whether the tooth being reconstructed had a loss due to decay or fracture (for which a crown is covered), or to attrition or wear (for which a crown is not a covered benefit). In each case there had been a protracted process of requesting additional information, and a protracted appeals process. The third case involved rejection of a claim for a crown because DDRI initially felt the crown was "ill-fitting", although DDRI eventually paid for the crown. Some common problems to all three situations were identified by the examiners:

- a. DDRI did not adequately and clearly communicate the reason for denial.

¹⁸ As noted above, 25% of first quarter 2006 adverse determinations and 36% of first quarter 2007 adverse determinations were appealed, based on DDRI's internal studies.

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- b. DDRI did not fully evaluate the complaint and completely address all actual or potential problems that were the subject of the complaint.

In addition, DDRI had requested a photograph as supplementary evidence of tooth breakdown. There was a dispute over the picture. There is no photograph in the record. The dentist claims to have sent one, but DDRI may not have received it, or may have received it and then lost it. We saw no evidence that DDRI had investigated adequately to conclusively establish that a photograph had not been sent. DDRI's position is that the claim form did not establish that a photo had been sent. Given the importance of a photo to the resolution of the claim, it is the opinion of the examiners that DDRI should have made a specific attempt to resolve with the dentist whether a photo existed, whether or not it had not been sent with the original claim.

c. Benefit determination

Three of the complaints related to benefit matters:

1. In one case, DDRI rejected a claim for a full mouth x-ray ("FMX") series on a patient under 12 years old. DDRI disallows these claims until they are provided evidence that the FMX was actually taken. This is a fraud detection mechanism, because it is unusual for a child under 12 to have full dentition. Eventually evidence was provided and this claim was paid. This limitation is not contained in benefit descriptions provided to members. DDRI has advised us that the processing policy states that payment for an FMX under age 12 requires a narrative explaining the need for the service and a copy of the x-ray series. The processing policy code would not ordinarily be seen, however, until after the procedure had been performed.
2. In another case, a patient with dual coverage (self and spouse) sought coverage for three prophylaxis procedures in one year. The patient

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misunderstood the way co-ordination of benefits works. Each plan provides for two prophylaxis visits. Having dual coverage does not increase the eligibility for benefits. Instead it allows additional payment for eligible services that are paid at less than 100%, with a maximum total payment of 100%. DDRI eventually paid for this procedure as a periodontal cleaning, which has a separate eligibility from regular prophylaxis.

Recommendation 16: DDRI should investigate and evaluate its ability to communicate effectively with both patients and providers regarding benefit coverage. This should include clear communication on contract exclusions or other DDRI policies that would result in the non-payment of a dental service rendered.

3. The third case dealt with a patient who had endodontic work that exhausted his annual benefit maximum. The dentist contacted DDRI to determine when the patient would have access to additional benefits, both by telephone and on the website. DDRI was going through a period of delays in customer service and he was not able to get through to a customer service operator. Instead, he was referred to the website. Based on an assessment of the website information and subsequent conversations with customer service the dentist came to believe that the patient had a new annual maximum in effect starting September 1, 2009. The dentist then scheduled a crown for after September 1. When the claim was submitted, he was advised that it was not covered because eligibility for additional benefits did not occur until January 1. DDRI has since improved its customer service response time, and it has improved the accuracy of its website. DDRI disputes the circumstances, and asserts that the dentist knew or should have known that the patient's benefit renewed on January 1, not on September 1. However, the complaint file contains documentation of the dentist's calls with customer service and a copy of the website printout made on October 8, 2009 showing the patient with \$1200 of remaining benefits and indicating a benefit effective date of September 1. The

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maximum is referred to as an annual maximum, not as a calendar year maximum. DDRI, on the other hand, did not document any of its conversations with the dentist or any contemporaneous communications telling him that the patient's benefits were exhausted. Based on the information contained in the file, it appears that the dentist exercised appropriate diligence in attempting to determine when benefits would be available for this patient, and DDRI did not provide correct information. Based on review of the file, it appears likely that the dentist and patient would have waited until after January 1 to place the crown if DDRI had provided more complete information. It would be reasonable to require DDRI to pay for this crown.

Recommendation 17: DDRI should pay for the crown for the patient for whom DDRI did not provide correct eligibility information (OHIC tracking number 31632).

d. Full review of surgical extractions

One complaint was made by an oral surgeon, referred to here as "Dr. C", who has been subjected to full review of all his surgical extractions. For background, when teeth are extracted the dentist or oral surgeon submits them under one of seven dental procedure codes, which correspond to a regular extraction, surgical extraction, soft tissue impacted extraction, partial bony, completely bony, completely bony with complications or removal of residual roots. These codes reference increasing levels of difficulty and increasing levels of payment. In addition, general anesthesia or IV sedation may be a covered benefit in conjunction with surgical extractions.

At some point, DDRI became concerned that the proportion of extractions coded as surgical, impacted or bony impacted was higher than expected, and they suspected there might be a problem with upcoding. On or about May 31, 2009 DDRI analyzed claims

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from all oral surgeons to identify those who had the highest proportion of higher coded procedures. Dr. C was identified as one of 13 oral surgeons for audit.

DDRI then conducted an audit of Dr. C's claim activity and determined that his claims should be put on review. As part of reviewing his claims, DDRI required operative notes. However, they first disallowed coverage, then requested a narrative and ultimately requested an operative note. DDRI asserts that the dentist refused to provide operative notes, and that he then attempted to charge his patients for providing operative notes. The examiners did not see evidence supporting these assertions in the complaint file.

The following points were noted by the examiners:

1. Based on the number of teeth extracted, Dr. C's proportion of questionably coded teeth was similar to that for other providers who were not put on review. DDRI certainly has a right and responsibility to review claims carefully, particularly when they suspect irregularities, but it would be preferable to review all or none, or to have clear guidelines for why they put a dentist on review, particularly considering the implications for the dentist in terms of additional work to comply and delay of payment.
2. Dr. C was not given access to the results of the audit performed by DDRI. DDRI should give him the right to review the audit as a matter of due process, as provided for in R.I. Gen Laws § 23-17.13-3(11). In particular, given DDRI's record with appeals, under which approximately 70% of appeals ultimately result in an overturn, it seems necessary in a case like this to afford a dentist the right of response.
3. DDRI was not clear about what information was required to obtain coverage. There was substantial correspondence and delay, including adverse determination of payment, until DDRI told Dr. C they needed operative treatment notes in order to process his claims.

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See Recommendation 16, above: DDRI should investigate and evaluate its ability to communicate effectively with both patients and providers regarding benefit coverage. This should include clear communication on contract exclusions or other DDRI policies that would result in the non-payment of a dental service rendered.

e. General utilization and appeals process complaints

Four of the complaints dealt with issues related to utilization and the appeals processes although evaluation of other OHIC complaint cases revealed similar issues. Among the common themes with these complaints were:

1. DDRI did not provide a specific rationale for adverse determination.
2. Inadequate communication with regard to what information was required to process claims, thereby delaying the payment of claims.
3. Inadequate response to telephone calls in attempts to complete a claim, file a complaint or file an appeal.
4. Relying on a determination of “uncertain prognosis” in reaching an adverse determination under utilization review.
5. Delaying delivery of care and payment of claims
6. Delay in handling claims subject to utilization review and UR appeals beyond the regulatory time frames.
7. Failure to allow an appellant to inspect the file and add relevant information at the time of the second appeal.
8. Failure to investigate the full scope of a complaint.
9. Failure to isolate medical necessity in the utilization review process.
10. Use of the UR process to address quality of care and benefit issues
11. Failure to follow DDRI written UR policies and procedures

Recommendation 18: DDRI should consider providing more comprehensive explanations of denials of claims or PTR determinations. The processing codes

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included in the existing CEOBs and EOBs are sometimes confusing. In particular, denying a claim because of “uncertain prognosis” does not tell a member under what circumstances care will be authorized. We suggest a modification to add language to the effect: “consult your dentist to determine appropriate treatment options.”

One particular complaint illustrated a number of problems. The dentist, here referred to as “Dr. D”, provided a core build-up and pin retention and a crown on two separate visits. Dr. D submitted the claim for the crown on March 4, 2010. DDRI responded in a timely fashion with a request for an x-ray. Dr. D then waited until June 11 and re-submitted the claim with an accompanying panoramic x-ray, and submitted the claim for the core build-up and pin retention at the same time, also accompanied by the same x-ray. DDRI then misread the x-ray and thought the crown was being placed on a tooth with an existing root canal, instead of the actual tooth which was adjacent. DDRI therefore asked for a periapical x-ray to verify that the root canal was properly filled. Dr. D’s office called to explain the error, but was told that in order to do so, Dr. D had to file a written appeal. Dr. D declined to appeal and billed the patient. The patient then became angry with Dr. D, and called DDRI herself. DDRI (“as a courtesy¹⁹”) investigated the patient’s oral complaint and discovered the error, whereupon DDRI paid for the crown. Approximately one month later, DDRI realized it had not yet paid for the core build-up and pin retention, and did so. The patient found another dentist.

Dr. D is not blameless in this matter. Although DDRI is required to process verbal appeals and complaints, he could have followed through and made the written appeal. He should not have made this dispute the responsibility of the patient. However, Dr. D was understandably frustrated by his prior experiences with DDRI (he was a complainant in another matter earlier that involved a protracted appeals process) and by DDRI’s unwillingness to investigate a reasonable telephoned explanation that they had examined the wrong tooth. In this one case, there were several problems:

¹⁹ As contained in a document control number (“DCN”) note in the file for this claim.

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1. DDRI does not have a clean claims policy that specifies when an x-ray should be submitted and what kind of x-ray is required.
2. DDRI should have a process in place to investigate payment and billing errors when reported. DDRI should not require a written complaint or appeal to prompt the investigation of such errors.
3. As of June 11, DDRI had a clean claim in hand. It should not have taken over two months (for the crown) and over three months (for the core build-up and pin retention) to be evaluated and paid.
4. The patient is happy with DDRI, because DDRI apologized and paid the claim. However, DDRI bears some responsibility for the breakdown in the dentist-patient relationship which resulted, at least in part, from DDRI's failure to handle a telephoned provider contact.

f. Quality of Care Complaint

One complaint dealt with a failed crown placed by a dentist ("Dr. E") who subsequently left practice. The patient wanted a new crown, but DDRI only allows a new crown after five years, and the crown in question was too new to be replaced under DDRI's benefit plan. DDRI does have a policy that they will allow a new crown if they can recover payment for the old crown. In this case, that recovery was complicated because Dr. E was no longer seeing DDRI patients. The patient in this case tracked down Dr. E and provided contact information to DDRI. DDRI was able to recover the cost of the crown from Dr. E, and the patient did get a new crown. DDRI takes the position that it does not take financial responsibility for the quality of care provided by its network dentists.

Recommendation 19: It is appropriate for DDRI to seek repayment from a dentist who provides work that does not meet DDRI's standards for quality of care. However, a patient who uses a network dentist and receives substandard care

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should not be denied covered re-treatment because DDRI is unable to obtain repayment from that dentist. In such a circumstance, DDRI should hold the patient harmless.

g. Network membership Complaint

One complaint dealt with the terms of membership in DDRI's "Premier" provider network. DDRI has two networks, "PPO" and "Premier". PPO is a more restricted network, and the dentists in the PPO network contract at a relatively lower fee level. PPO dentists are not permitted to balance bill patients above the network fee level. Premier is a less restrictive network. Premier dentists contract with DDRI at a higher fee level than PPO. When DDRI members who are enrolled in an open access PPO plan go to a Premier dentist, DDRI pays him the same fee they pay the PPO, and he may balance bill the patient up to the Premier fee level.

DDRI differentiated the PPO and Premier categories in 2005, at which time it offered participating dentists the chance to sign a new contract for PPO membership, or be deemed not PPO dentists and be assigned instead to Premier.

One particular dentist ("Dr. F") who did not elect PPO status now finds himself unable to attract patients who have dental coverage through a large employer that is a subsidiary of an out-of-state self-insured company. The parent company of that large employer is not insured by DDRI, but instead rents DDRI's PPO network. Dr. F would like to appear as a Premier provider on the provider website associated with this employer, but the parent company only uses DDRI's PPO network and does not list Premier providers.

Dr. F wants to be included in a list of favored providers, but to also maintain the ability to balance bill higher fees. DDRI states that Dr. F elected not to be a PPO provider and should bear the consequences. However, his election was a passive one (he did not return a signed contract, but he did not actively elect the Premier status), and it is not clear that he understood the implications of the decision. For example, the explanatory material

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offered to him in 2005 specifically mentions this employer in a list of companies that accept PPO and Premier providers. Furthermore, DDRI has closed its PPO panel as of January 1, 2006, and they are not accepting new dentists except dentists who join existing PPO practices. While Dr. F's situation is unfortunate, it does not appear that DDRI has treated him in a way that violates its duty to treat providers fairly.

h. Submission of electronic digital x-rays and photos

A dentist complained because he preferred to submit electronic x-rays rather than print them and send physical copies. DDRI does not have that systems capability now, and is working on getting it. Their response was adequate.

14. Compliance with applicable laws and regulations

The examiners investigated compliance with the following laws and regulations:

- R.I. Gen. Laws § 23-17.12, the Health Care Services – Utilization Review Act
- R.I. Gen. Laws § 23-17.13, the Health Care Accessibility and Quality Assurance Act
- R.I. Gen. Laws § 27-9.1, the Unfair Claims Settlement Practices Act
- R.I. Gen. Laws § 27-29, Unfair Competition and Practices
- R.I. Gen. Laws §42-14(5), the Rhode Island Health Reform Act of 2004 – Health Insurance Oversight.
- OHIC Regulation 7, Prompt Processing of Claims
- RIDH Regulation R17-12-UR, Rules and Regulations for the Utilization Review of Health Care Services
- RIDH Regulation R17.13-CHP, Rules and Regulations for the Certification of Health Plans

The following are relevant provisions from the insurance statutes and regulations:

Unfair Claims Settlement Practices Act

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If an insurer (including Delta Dental—see R.I. Gen. Laws § 27-9.1-2(3)) commits any of the acts defined in R.I. Gen. Laws § 27-9.1-4 and does so with a frequency that indicates a general business practice to engage in that type of conduct (R.I. Gen. Laws § 27-9.1-3(2)), the insurer violates the Unfair Claims Settlement Practices Act, R.I. Gen. Laws § 27-9.1-1, *et seq.*

Relevant violations by Delta may include:

Failure to acknowledge and act with reasonable promptness upon pertinent communications with respect to claims arising under its policies (R.I. Gen. Laws § 27-9.1-4(2)) [e.g., Delta’s policy or practice to not respond to oral complaints and/or questions related to claims]

Failure to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies (R.I. Gen. Laws § 27-9.1-4(3)) [e.g., Delta’s policy or practice to not respond fully to oral complaints and/or questions related to claims, and Delta’s failure to promptly process appeals.]

Refusing to pay claims without conducting a reasonable investigation (R.I. Gen. Laws § 27-9.1-4(6))

Failure in the case of claims denials or offers of compromise settlement to promptly provide a reasonable and accurate explanation of the basis of those actions (R.I. Gen. Laws § 27-9.1-4(12))

Unfair methods of competition and unfair or deceptive acts or practices.

No insurer (including Delta Dental—see R.I. Gen. Laws § 27-29-2(4)) may engage in any trade practice that is defined as or is determined to be an unfair

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method of competition or an unfair or deceptive act or practice in the business of insurance. R.I. Gen. Laws § 27-29-3. Such acts or practices include:

Failure to maintain complaint handling procedures related to written complaints. R.I. Gen. Laws § 27-29-4(13). This includes a failure to maintain a complete record of all the complaints an insurer received since the date of its last examination. The record must indicate “the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint.” However, this statute makes clear that, for the purposes of this subsection, “‘complaint’ means any written communication primarily expressing a grievance”. Thus this section does not apply to oral complaints.

Taking this into account, we found no instances of non-compliance with R.I. Gen. Laws § 27-29, Unfair Competition and Practices.

Protecting the interests of consumers

OHIC is required to discharge its powers, among other things, to protect the interests of consumers R.I. Gen. Laws § 42-14.5-2(2); OHIC Regulation 2, Section 4(b). This includes consideration of the effectiveness of a health insurer’s consumer appeal and complaint procedures and the efforts by a health insurer to increase the effectiveness of its communications with its insureds, OHIC Regulation 2, Section 6(d)(iii) and (v).

Encouraging fair treatment of providers

OHIC is required to discharge its powers, among other things, to encourage fair treatment of health care providers. (R.I. Gen. Laws § 42-14.5-2(3); OHIC Regulation 2, Section 4(c)). This includes the policies, procedures and practices employed by a health insurer with respect to provider reimbursement, claims

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processing, and dispute resolution, OHIC Regulation 2, Section 7(d)(i), and the efforts undertaken by a health insurer to enhance communications with providers. OHIC Regulation 2, Section 7(d)(v).

Prompt processing of claims

Processing of claims. Subject to certain exceptions, health insurers (including Delta Dental—see OHIC Regulation 7, Section 3(i)) must process complete written claims within forty days of receipt and must process complete electronic claims with thirty days or receipt. OHIC Regulation 7, Section 4(a).

Reasons for denials. If a health insurer denies or pends a claim, the insurer must, with thirty days, notify the health care provider (or policyholder) in writing of any and all reasons for denying or pending the claim and what, if any, additional information is required to process the claim. OHIC Regulation 7, Section 4(b). Implicit in this standard is the requirement that the explanation be reasonably constructed so that it can be understood by the average provider or policyholder.

Complete claim standard. Health insurers must establish a written standard defining a complete claim and distribute its complete claim standard to all participating providers. OHIC Regulation 7, Section 5(a) and (b). Implicit in this standard is the requirement that the clean claims standard be reasonably constructed so that it can be understood by the average provider.

15. Context

DDRI has modified a number of its practices in the course of this examination to conform to recommendations made by the examiners. It is the opinion of the examiners that DDRI has co-operated fully with the examination and used it to improve its customer service and provider relations practices. In particular, DDRI has begun using telephone contacts more often and more effectively to resolve questions with dentists and patients.

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The examiners recognize that dental insurance is a low premium, low margin business, and that system upgrades are extremely expensive. Some of the customer service issues we found were related to inability of the current customer service system to capture recordings or documentation of customer contacts and to track them adequately. DDRI is working to enhance its systems capabilities.

DDRI presented the results of a telephone customer satisfaction survey performed on their behalf by an outside vendor. In general the results of the survey indicated a high level of customer satisfaction. A copy of the survey results is attached as Exhibit 3. The examiners did not examine the survey instrument itself or any underlying data.

16. Conclusion

DDRI maintains adequate records and generally has good claims processing and customer service capabilities. DDRI prepares and submits the prompt processing, appeals and complaint reports they are required to submit.

However, the examiners noted several areas in which DDRI needs to improve. The recommendations in the following section summarize steps DDRI should take to come into full compliance.

17. Recommendations:

The following recommendations are made for DDRI to come into compliance with applicable statutes and regulations.

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1. As part of its written complaint processing policy, DDRI should establish a clear definition of what constitutes a “withdrawn” complaint as well as a mechanism for the application of a consistent procedure.
2. DDRI should maintain documentation of any monitoring related to anonymous claims, and should investigate serious matters, even if the complaints have been made anonymously.
3. As part of its written complaint processing policy, DDRI should clearly define a process for the consistent processing of anonymous complaints that includes the tracking and trending of similar complaints against a provider as well as the documentation of all investigative efforts.
4. DDRI should institute processes to record and act on all complaints, whether written or verbal.
5. DDRI should institute processes to ensure that it investigates the full scope of each complaint, including addressing any potential issues related to the discoveries made at the initial point of contact by the complainant and in the course of any complaint investigation.
6. DDRI should modify its Quality Management Program in order to address provider specific quality problems. DDRI should discontinue use of the utilization management program as DDRI’s primary mechanism to address poor quality care. A quality management program should incorporate a process to address substandard care to protect DDRI members from providers that DDRI have identified as providing substandard quality care.
7. DDRI should modify its appeals process to accept verbal appeals.

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8. In the event of a claim or PTR denial, DDRI should provide clear communication as to the specific reason for the denial in order that the patient and/or provider is able to effectively appeal.
9. DDRI should take steps to ensure that appellants are given the opportunity to inspect the claim file and add information as necessary prior to the decision on the second level of appeal.
10. DDRI should institute a study of its claims denials to determine the reasons for the high rate of overturn on appeal. Among other possible explanations, DDRI should investigate whether its standards for original review of claims and PTR determinations are too conservative and whether its denial codes on the EOBs/CEOBs are adequately effective in communicating with dentists and patients.
11. DDRI should take whatever steps are necessary to process appeals within the 15 day timeframe mandated by Section 6.1.2 of Regulation R23-17.12-UR.
12. DDRI should clearly distinguish between claims that are denied for benefit reasons, pended claims that are held for additional information and denials that are made because of medical necessity.
13. DDRI should revise its clean claims standard to provide specific detailed requirements for the information required by DDRI for adjudicating a claim or making a PTR determination.
14. When denying coverage because of an inadequately filled root canal, DDRI should explain that the crown will be approved once the root canal is fixed and that DDRI will pay for the repair to the root canal if performed properly by a different endodontist.

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15. When a provider is being audited and placed on additional review or sanctioned in a way that changes the provider's ability to have claims processed in a timely fashion, DDRI should allow the provider the opportunity to review the audit information and respond to DDRI conclusions prior to the changes taking effect.
16. DDRI should investigate and evaluate its ability to communicate effectively with both patients and providers regarding benefit coverage. This should include clear communication on contract exclusions or other DDRI policies that would result in the non-payment of a dental service rendered.
17. DDRI should pay for the crown for the patient for whom DDRI did not provide correct eligibility information (OHIC tracking number 31632).
18. DDRI should consider providing more comprehensive explanations of denials of claims or PTR determinations. The processing codes included in the existing CEOBs and EOBs are sometimes confusing. In particular, denying a claim because of "uncertain prognosis" does not tell a member under what circumstances care will be authorized. We suggest a modification to add language to the effect: "consult your dentist to determine appropriate treatment options."
- 19. It is appropriate for DDRI to seek repayment from a dentist who provides work that does not meet DDRI's standards for quality of care. However, a patient who uses a network dentist and receives substandard care should not be denied covered re-treatment because DDRI is unable to obtain repayment from that dentist. In such a circumstance, DDRI should hold the patient harmless.**

Exhibit 1

**DELTA DENTAL OF RHODE ISLAND
POLICIES AND PROCEDURES**

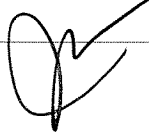
QUALITY ASSURANCE

Policy Title: Complaints

Policy Number: QA-01RI

Approved by: Joseph A. Nagle _____

Date Approved: February 18, 2010



Policy

Delta Dental of Rhode Island has a customer complaint system in place for identifying, evaluating and resolving customer complaints that encompasses every employee in the company. The complaint process is initiated in one of the following three ways -- either a phone call, written complaint or face-to-face contact with the complainant. Complaint forms (see Attachment) are available to all employees in the company. These forms detail the complainant's name, address and phone number, the date the complaint was received, and the nature/type of complaint. Anonymous complaints and those received by members who specifically request that Delta Dental not use their name are included in the tracking, evaluation, investigation, resolution and trending of all complaints.

What follows is a step-by-step review of the Customer Complaint Process:

Procedure

1. Definition of Complaint¹ -- A complaint is a contact made by a member or provider whereby he/she is not satisfied with any of the following:
 - Utilization Review Decision -- Requests for reconsideration of a procedure that was denied/reduced based on dental necessity are handled in accordance with Delta Dental's policies regarding review determinations and appeals. Refer to policy #UR-03RI. All such requests are tracked by Program Integrity in the Appeals Log and are reported as utilization review determinations.
 - Quality of Care -- All quality of care complaints are handled in accordance with Delta Dental's policies regarding quality of care complaints. Refer to policy #QA-02RI. Any concern that may be considered to be a quality of care issue should be reported immediately to the Quality Assurance Coordinator for recording and investigation. Examples include:
 - a. allegation of poor outcome of care
 - b. dissatisfaction with provider and/or provider office staff behavior and demeanor
 - c. dissatisfaction with dental facility
 - d. concerns about provider impairment
 - e. any concern regarding alleged "unprofessional conduct" by the dentist or dental hygienist as defined in the Dental Practice Act (R.I.G.L., Chapter 31.1, Section 5-31.1-10), including but not limited to incompetent, negligent or willful misconduct in the practice of dentistry or dental hygiene, which shall include the rendering of unnecessary dental services and any departure from or the failure to conform

¹According to state law, "complaint means a contact made by an enrollee or provider to the health plan whereby they are not satisfied with the following as they relate to the certified health plan, a health plan employee or the health care entity who operates the health plan:

- a) a utilization review decision;
- b) the quality of health care; and/or
- c) any activity related to the management of the delivery of health care services."

to the minimal standards of acceptable and prevailing dental or dental hygiene practice in his/her area of expertise.

- Any activity related to the management of the delivery of dental services.
 - a. access to a participating dentist (example: member cannot locate a participating dentist within what he/she considers a reasonable distance)
 - b. problems obtaining appointments in a timely manner
 - c. allegation of unprofessional or inappropriate behavior of a customer service representative or other Plan employee
 - d. dissatisfaction with response time to complaints or appeals
 - e. problems accessing member information
 - f. dissatisfaction with Plan policy
 - g. dissatisfaction with the way in which utilization review is conducted (not with the review decision as this is considered an appeal handled in accordance with Delta Dental's policies regarding review determinations and appeals. Refer to Policy #UR-03RI). Example would be a periodontist complaining that all periodontal claims are not reviewed by consultants who are periodontists.
 - Request for reconsideration of a claim that was denied/reduced based on contract provisions -- Requests for reconsideration of a claim that was denied/reduced based on contract provisions are handled in accordance with Delta Dental's policies regarding administrative appeals. Refer to policy #UR-04RI.
 - Potential Fraud & Abuse -- A complaint that suggests potential fraud and/or abuse by either a provider or subscriber is handled in accordance with Delta Dental's policies regarding fraud and abuse. See Policy #QA-03RI.
 - Privacy -- A complaint that suggests a potential violation of privacy rights granted under state or federal law, or any other privacy concern, is investigated and resolved through the Compliance department under the direction of Delta Dental of Rhode Island's Privacy Officer.
2. Identification -- The identification process occurs corporate-wide, although the majority of complaints are typically received through the Customer Service department. Any employee at any level of the company can receive a complaint from either a provider, subscriber, business customer, or member of the dental staff. Upon identification, all complaints are forwarded to the Quality Assurance Coordinator to determine whether it involves a quality of care issue.

3. Process for Complaint Resolution --

Reporting

Once a complaint is identified, employees will be instructed to follow these procedures:

- Complete a Customer Complaint Form (Attachment) by the end of the business day in which the complaint is received.
- Forward the Complaint Form to the Quality Assurance Coordinator by the end of the business day in which the complaint is received.
- The Quality Assurance Coordinator will review the complaint to determine whether it involves a quality of care issue. The Quality Assurance Coordinator will categorize the complaint and direct it to the appropriate area for investigation and resolution.

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Tracking, Evaluation and Investigation

All complaints are promptly recorded and tracked by the Quality Assurance Coordinator in the Customer Complaint Log. A complaint that has not been resolved on initial contact is reviewed and categorized, then distributed for appropriate handling as follows:

- Quality of Care Complaints – directed to the Quality Assurance Coordinator and handled in accordance with policy #QA-02RI.
- Complaints related to the management and delivery of dental services – directed to the Supervisor of Customer Service.
- Complaints Concerning a Utilization Review Decision – directed to the Appeals Coordinator and handled in accordance with policy #UR-03RI.
- Complaints Concerning a Claim that was Denied/Reduced Based on Contract Provisions – directed to the Supervisor of Customer Service and handled in accordance with policy #UR-04RI.
- Complaint Alleging Potential Fraud & Abuse – directed to the Quality Assurance Coordinator and handled in accordance with policy #QA-03RI.
- Privacy Complaint – directed to the Director of Compliance for investigation and resolution.

EXCEPTIONS:

- **Any type of complaint that is received from a regulatory agency (e.g., Department of Business Regulation, Department of Health, etc.) is directed to the Quality Assurance Coordinator for investigation and resolution.**
- **Any type of complaint that is received from a legal office is directed to the Director of Customer Service.**

For complaints concerning the management and delivery of dental services, the Supervisor of Customer Service may forward the complaint to another area responsible for investigation of the complaint as follows:

- Customer Service -- Director, Customer Service
- Participating Providers & Policy -- Director, Professional Relations
- Account Service -- Vice President, Sales
- Utilization Review Process – Director, Program Integrity
- Miscellaneous/General -- Director, Corporate Communications

Investigation by the designated department is completed no later than one (1) business day from that department's receipt and the results are communicated back to the Supervisor of Customer Service for resolution with the complainant and is then forwarded to the Quality Assurance Coordinator for closure in the Complaint Log. Resolution can be by phone or written correspondence. If the investigation cannot be completed within this time frame, then the designated department will provide a status report to the Supervisor of Customer Service. The investigation process can include phone calls to the complainant or a review of claims history records or procedural guidelines.

Resolution

Confidential. For use by Delta Dental of Rhode Island employees only.

It is expected that the majority of complaints *concerning the management and delivery of dental services* can be resolved within the initial contact. However, any such complaints that require further investigation and research we will attempt to resolve within 3 business days of the initial receipt and in all cases, no later than 60 business days. With the exception of complaints concerning utilization review decisions (refer to policy #UR-03RI for resolution timeframes), all complaint resolutions will be communicated to the complainant within 60 business days after receipt of all information necessary to complete the review. As part of the resolution, complainants are notified of their right to contact the Rhode Island Department of Health's Office of Managed Care Regulation if they are not satisfied with our internal complaint process.

Tracking and Reporting

All complaints will be entered in the Customer Complaint Log and will be included in the appropriate category in the quarterly reports to the RI Department of Health.

Monitoring/Trend Identification

Periodic reviews of all complaints will be conducted to ensure compliance with the process as outlined in this policy as well as to ensure compliance with state and federal laws, including statistical reporting requirements.

All complaints are reviewed by the Quality Management Committee in order to detect patterns of problems which may require further review or policy change. It is the role of the Quality Management Committee to recommend any revisions to policies/procedures.

Prior Versions

QA-01RI (Formerly 97-09 and QA-01) - Complaints

May 18, 2001
February 19, 2002
January 23, 2004
February 23, 2004
February 20, 2006
January 25, 2008

Delta Dental Customer Complaint Form

Date: _____

Submitted by: _____

Complainant Information:

Name: _____

Phone #: _____

Address: _____

City, State, Zip: _____

Subscriber #: _____

Group #: _____

Complainant requested to remain anonymous Yes No

Provider Information:

Name: _____

Address: _____

City, State, Zip: _____

License#: _____

Phone #: _____

Par Non-Par

Inquiry: Written _____

Call

Complaint is from:

- Dentist / Office Staff
- Subscriber / Member
- Group / Employer
- DBR
- Other State Insurance Commissioner
- Law Office
- DOH
- Other (specify) _____

Complaint Category: QAM USE ONLY

- Quality of Care
- Management/Delivery of Services
- Fraud/Abuse
- Privacy
- UR Appeal
- ADM Appeal
- Dental Policy Appeal
- Other (specify) _____

Summary of Complaint Documented in:

HDS

Summary of Complaint:

QAM USE ONLY

Is this a quality of care issue(s)? Yes No

If yes, level of severity: _____

QAC Signature: _____

Date: _____

Resolution Date: _____

Days to Resolve: _____

Exhibit 2

**DELTA DENTAL OF RHODE ISLAND
POLICIES AND PROCEDURES**

QUALITY ASSURANCE

Policy Title: Quality of Care Complaints (For RI services and/or patients) **Policy Number:** QA-02RI

Approved by: Joseph A. Nagle _____



Date Approved: February 18, 2010

Policy

Delta Dental of Rhode Island has a customer complaint system in place for identifying, evaluating and resolving customer complaints that encompasses every employee in the company. The complaint process is initiated in one of the following three ways -- either a phone call, written complaint or face-to-face contact with the complainant. Complaint forms (see Attachment) are available to all employees in the company. These forms detail the complainant's name, address and phone number, the date the complaint was received, and the nature/type of complaint. Anonymous complaints and those received by members who specifically request that Delta Dental not use their name are included in the tracking, evaluation, investigation, resolution and trending of all complaints.

This policy addresses complaints related to the quality of care received from a participating dentist or non-participating dentists that have met credentialing criteria and requested benefits be assigned. (For allegations of fraud/abuse, refer to Policy #QA-03RI.) All alleged quality of care complaints are evaluated, investigated and resolved under the direction of our Dental Director who is a practicing dentist. To assist in the oversight of these complaints, we have a Quality Assurance Coordinator who has a minimum of five years clinical experience as a dental hygienist or assistant. The Quality Assurance Coordinator manages the complaint process and reports to the Director of Program Integrity.

Procedure

1. Definition of Quality of Care Complaint -- A quality of care complaint is a contact made by a member or provider whereby he/she is not satisfied with the care received in the dental office. Categories of potential poor quality of care may relate to the following:
 - allegation of poor outcome of care
 - dissatisfaction with provider and/or provider office staff behavior and demeanor
 - dissatisfaction with dental facility
 - concerns about provider impairment
 - any concern regarding alleged "unprofessional conduct" by the dentist or dental hygienist as defined in the Dental Practice Act (R.I.G.L., Chapter 31.1, Section 5-31.1-10), including but not limited to incompetent, negligent or willful misconduct in the practice of dentistry or dental hygiene, which shall include the rendering of unnecessary dental services and any departure from or the failure to conform to the minimal standards of acceptable and prevailing dental or dental hygiene practice in his/her area of expertise.
2. Identification -- The identification of a complaint occurs corporate-wide, although the majority of complaints are typically received through the Customer Service department. Any employee at any level of the company can receive a complaint from either a provider, subscriber, business customer, or member of the dental staff; however, all complaints, including anonymous complaints, must be evaluated by the Quality Assurance Coordinator to determine whether it involves a quality of care issue.

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3. Reporting

Via Phone Call

- When someone wishes to report a potential poor quality occurrence via the phone, the call should be duly documented. The person receiving the call will encourage the caller to send the complaint in writing.
- If the caller has indicated that they will submit the complaint in writing, Delta Dental will wait until its receipt before initiating the evaluation and investigation of the complaint. If the caller does not wish to submit a written complaint, the person receiving the call will complete a Customer Complaint Form which will be forwarded promptly to the Quality Assurance Coordinator.
- The Quality Assurance Coordinator will review the complaint to determine if it should be categorized as a quality of care complaint. If so, the Quality Assurance Coordinator will attempt to contact the complainant within three (3) business days to gather more information if deemed necessary. If the complainant specifically requests that Delta Dental not use their name in the investigation of the complaint, then Delta Dental will pursue the complaint as an anonymous complaint to the best of its ability.

If the complaint does not involve a quality of care issue, then the Quality Assurance Coordinator will forward the complaint for resolution through the appropriate complaint process for non-quality of care issues.

- The complaint will be recorded for tracking purposes.
- The complaint will then be investigated.

Via Written Communication

- All written complaints should be forwarded to the Quality Assurance Coordinator within one (1) business day of receipt.
- The Quality Assurance Coordinator will review the complaint to determine if it should be categorized as a quality of care complaint. If so, the Quality Assurance Coordinator will prepare for quality of care investigation. If not, the complaint will follow the appropriate complaint process for non-quality of care issues.
- If the complainant specifically requests that Delta Dental not use their name in the investigation of the complaint, then Delta Dental will pursue the complaint as an anonymous complaint.
- The complaint will be recorded for tracking purposes.
- The complaint will then be investigated.

From An Employee within the Company Who Identifies a Potential Complaint

- Any employee who identifies a potential complaint should complete a Customer Complaint Form describing the nature of the complaint and should forward it to the Quality Assurance Coordinator within one (1) business day. (Note: Employees within the Dental Case Management area identify quality of care issues specific to submitted treatment plans. These are handled through the application of our utilization review guidelines and are separate from this process.)

- The Quality Assurance Coordinator will review the complaint to determine if it should be categorized as a quality of care complaint. If so, the Quality Assurance Coordinator will attempt to contact the complainant within three (3) business days to gather more information if deemed necessary. If the complainant specifically requests that Delta Dental not use their name in the investigation of the complaint, then Delta Dental will pursue the complaint as an anonymous complaint.

If the complaint does not involve a quality of care issue, then the Quality Assurance Coordinator will forward the complaint for resolution through the appropriate complaint process for non-quality of care issues.

- The complaint will be recorded for tracking purposes.
- The complaint will then be investigated.

Evaluation

The Quality Assurance Coordinator will review all quality of care complaints within one (1) business day to determine whether the complaint requires further investigation. A severity level will be assigned as follows:

- Level 0: No apparent problem. No corrective action needed.
- Level 1: The action is of a minor nature having no major impact on the patient's well being and is of a short duration. Examples may include an instance where the member describes their experience in the dental office as being one where they were treated rudely by either the office staff or the dentist; or they had to wait in the waiting room for a time period longer than what the standard wait time is in the office, yet the rude behavior or wait time has no impact on the outcome of the dental treatment received.
- Level 2: The action is of a minor nature but may have had an effect on the patient's outcome or persistent problems may exist despite educational efforts to correct. Examples may include a delay in treatment resulting in prolonged discomfort to the patient although not resulting in a serious problem; or allegations of over-treatment are being made, for example, the dentist appears to routinely replace fillings that are less than two years old.
- Level 3: Action requires immediate response in order to prevent serious harm/injury to the member. The action is of such a nature that in the absence of immediate attention, a prudent lay person could reasonably expect that the patient's health would be in serious jeopardy. Examples may include inappropriate treatment for symptoms presented where the patient's well-being is severely compromised; gross negligence.

Investigation

1. When assigned a severity Level 1
 - A letter is sent to the provider. The provider is asked to respond within fifteen (15) business days.
 - No formal corrective plan of action is needed.
2. When assigned a severity Level 2
 - A letter is sent to the provider. The provider is asked to respond within ten (10) business days.
 - Corrective action may or may not be appropriate. If corrective action is found necessary, it may include, but is not limited to, written communications from the Dental Director; an on-site visit/audit of the practice appropriate for the specific issue (usually 3 months after the incident reported);

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education through Professional Relations; mandatory pre-treatment estimates for certain services; probation of participation status.

3. When assigned a severity Level 3

- The Dental Director or Dental Consultant is notified immediately of any complaint assigned a severity Level 3.
- The Dental Director or Dental Consultant will investigate the complaint immediately.
- A letter will be sent to the provider from the Dental Director or Dental Consultant. The provider is asked to respond within five (5) business days.
- The Dental Director and/or the Dental Consultant will review the response and suggest a corrective plan of action to include specific timeframes for improvements. The Dental Director may call a special meeting of the Quality Management Committee to consult with the members to determine an appropriate corrective action plan. The provider will promptly implement the plan upon written notification from the Dental Director. If the provider fails to do so, the Dental Director may recommend the provider be terminated from the network.
- The Dental Director is responsible for updating the Quality Management Committee of any Level 3 situations and any actions that have occurred or will occur.

Failure to Respond to Inquiries

Participating providers are required to respond to all inquiries in accordance with Delta Dental of Rhode Island Rules and Regulations for Participating Dentists. If the provider does not respond within the amount of time stated in the letter, a second letter is sent to the provider stating that he/she must respond within 5 business days or a decision will be rendered based upon the information at hand. .

Resolution

All quality of care complaints where the complainant has identified him/herself will be closed with a resolution letter signed by the Dental Director. All resolution letters will include an identification of the specific information considered and an explanation of the basis of the decision. In addition, all resolution letters will reference the Rhode Island Dental Association's (RIDA) Peer Review Committee and the Rhode Island Board of Examiners in Dentistry, and/or the Rhode Island Department of Health's Office of Managed Care Regulation as additional sources of recourse for the complainant.

- When assigned a severity Level 0: the resolution letter will acknowledge the complaint and advise that a determination was made from the Office of the Dental Director that no investigation was needed. The complaint will be kept on file.
- When assigned a severity Level 1: a resolution letter will be sent. Upon request, a copy of the provider's response will be shared.
- When assigned a severity Level 2 or 3: a resolution letter will be sent. Upon request, a copy of the provider's response and a copy of the plan for corrective action, if found applicable, will be shared.

Resolution is made no later than sixty (60) business days from receipt of the complaint. Resolution is tracked for reporting and trending purposes.

Failure to Respond to Need for Corrective Action

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If a provider fails to respond within the required timeframes noted above to a letter issued from the Office of the Dental Director regarding a quality of care complaint, a reminder letter will be sent by certified mail.

If no response is made to the certified reminder letter within five (5) business days, the Quality Assurance Coordinator will employ next steps based upon the type of corrective action requested. This may include a phone call to the provider or recoupment of monies. If necessary, the case is immediately presented to the Dental Director for consultation with the Vice President of External Affairs and legal counsel, as appropriate, to form an action plan. An action plan will be formulated before the sixty (60) business day resolution timeframe has expired.

The provider and complainant are sent written notification of the decision by certified mail.

Note: The Dental Director is responsible for reporting incidents of adverse actions taken upon a provider's participation status to the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, and to the Board of Examiners in Dentistry within 15 days following the conclusion of any applicable appeal process. This is true whether the action is through formal action or a voluntary agreement.

Review and Filing of Corrective Action Plans

All corrective action plans issued from the Office of the Dental Director are subsequently reviewed by the Quality Management Committee and filed with the individual provider's credentialing records. Corrective action plans are reviewed for compliance at the time of re-credentialing and during any on-site visits/audits.

Monitoring/Trend Identification

Periodic reviews of all quality of care complaints will be conducted to ensure compliance with the process as outlined in this policy as well as to ensure compliance with state and federal laws, including statistical reporting requirements.

Reports of all quality of care complaints are reviewed by the Quality Management Committee in order to detect patterns of problems which may require further review or action. The reports on complaints shall include the number of quality complaints issued per dentist. Any dentist that acquires three (3) or more complaints regarding the same or a similar issue will be brought to the attention of Senior Management for possible remedial action. In addition to being reviewed by the Office of the Dental Director, all quality of care complaints determined to be of a substantive nature (i.e., Level 3 severity) are referred to our Quality Management Committee or to the appropriate state regulatory agency, such as the Board of Examiners in Dentistry or the Attorney General's Office.

Tracking and Reporting

All quality of care complaints will be tracked and will be included in the appropriate category in the quarterly reports to the RI Department of Health.

Prior Versions

QA-02R1 (Formerly QA-02) - Quality of Care Complaints (For RI services and/or patients)

May 18, 2001
February 19, 2002
January 23, 2004
February 20, 2006
January 25, 2008

Delta Dental Customer Complaint Form

Date: _____

Submitted by: _____

Complainant Information:

Name: _____

Phone #: _____

Address: _____

City, State, Zip: _____

Subscriber #: _____

Group #: _____

Complainant requested to remain anonymous Yes No

Provider Information:

Name: _____

Address: _____

City, State, Zip: _____

License#: _____

Phone #: _____

Par Non-Par

Inquiry: Written _____

Call

Complaint is from:

- Dentist / Office Staff
- Subscriber / Member
- Group / Employer
- DBR
- Other State Insurance Commissioner
- Law Office
- DOH
- Other (specify) _____

Complaint Category: QAM USE ONLY
<input type="checkbox"/> Quality of Care
<input type="checkbox"/> Management/Delivery of Services
<input type="checkbox"/> Fraud/Abuse
<input type="checkbox"/> Privacy
<input type="checkbox"/> UR Appeal
<input type="checkbox"/> ADM Appeal
<input type="checkbox"/> Dental Policy Appeal
<input type="checkbox"/> Other (specify) _____

Summary of Complaint Documented in:

HDS

Summary of Complaint:

QAM USE ONLY	
Is this a quality of care issue(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, level of severity: _____
QAC Signature: _____	Date: _____
Resolution Date: _____	Days to Resolve: _____

Exhibit 3



Customer Satisfaction Survey

(Based on 401 telephone surveys conducted in November 2010)

Please rate your satisfaction with the following:	Very Satisfied / Satisfied		Dissatisfied	Don't Know	
1. The availability of Delta Dental dentists in your area?	97%		2%	1%	
2. The promptness of Delta Dental's claims payments?	88%		2%	9%	
3. The clearness of the forms Delta Dental sends to explain what was paid or not paid?	87%		6%	7%	
4. The length of time it took to schedule your last dentist appointment?	98%		2%	0%	
5. The quality of the dental treatment you received at your last dentist visit?	98%		1%	0%	
6. The general appearance of the dental office at your last visit?	99%		1%	0%	
	Yes	No	Don't Know		
7. Does your dentist participate with Delta Dental?	97%	2%	<1%		
	Yes	No	Some Knowledge		
8. Do you know what your Delta Dental plan covers?	46%	15%	39%		
	Yes	No	Don't Know		
9. Do you think having dental insurance increases your likelihood of going to the dentist?	89%	11%	1%		
10. Have you called Delta Dental's Customer Service department in the past 12 months?	11%	88%	1%		
11. Have you ever visited the Delta Dental website?	20%	80%	0%		
12. Were you aware that members can access all of their benefit information on the Delta website?	60%	40%	1%		
	<1x	1x	2x	3x	4x
13. How many times a year do you visit your dentist?	<1%	4%	78%	9%	8%
	Very Good	Good	Fair	Poor	
14. How would you rate your overall dental health?	55%	39%	5%	1%	
	Very Satisfied / Satisfied		Dissatisfied	Don't Know	
15. How satisfied are you with Delta Dental's overall performance?	96%		4%	1%	
	Yes	No	Don't Know	Refused	
16. Would you recommend Delta Dental to a friend or family member?	93%	5%	1%	0%	

Please note: Due to rounding, some totals may not equal 100%.