DELTA DENTAL

July 29, 2011

Herbert W. Olson
Legal Counsel
Office of the Health Insurance Commissioner
1511 Pontiac Ave, Building 69-1
Cranston, RI 02920

RE: Market Conduct Examination of Delta Dental of Rhode Island

Dear Mr. Olson:

Attached is Delta Dental of Rhode Island's written response to the Market Conduct Examination Report prepared on behalf of the Health Insurance Commissioner and dated June 24, 2011. Please contact me if you have any questions or require additional information. You can reach me by phone (401-752-6236) or via email (kshanley@deltadentalri.com).

Sincerely,

Kathryn M. Shanley

Kathryn M. Shanley
Vice President
External Affairs

CC: Christopher F. Koller, Commissioner
Joseph Torti, III
Joseph A. Nagle, President & CEO, Delta Dental of Rhode Island

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Written Response of Delta Dental of Rhode Island to the Market Conduct Examination Report Prepared on Behalf of the Office of the Health Insurance Commissioner by DeWeese Consulting Inc., Johnson and Associates and John Aloysius Cogen, Jr. dated June 24, 2011.

Delta Dental of Rhode Island (DDRI) respectfully submits this response to the Office of the Health Insurance Commissioner. We appreciate the opportunity to comment on the report and the specific recommendations contained therein. Please be advised that this Report received the highest level of attention within our organization.

As the state's largest dental insurer, we are committed to providing affordable dental plans that meet our customers' needs and budget. We also recognize our obligation to dentists to assure that claims are processed promptly and accurately, and to adequately communicate the requirements for claim submission.

Delta Dental fully cooperated in the Market Conduct Examination and regarded it as an opportunity to identify any administrative deficiencies and to improve how we serve our various constituencies. The audit was not based on a random sample of DDRI's policies or claims but was rather an examination focused on 23 specific complaints from DDRI members or providers.

In 2010, our organization processed nearly 1.6 million claims and pre-treatment estimates and issued claims payments totaling $170 million to over 30,000 providers all across the country. Approximately 50 % of our claims/payments were for services rendered by Rhode Island dentists. It is unavoidable when handling such a large volume of claims that some errors are made and it is also inevitable that some claim decisions, particularly denials, result in dissatisfied dentists and members. We strive to minimize dissatisfaction and to respond appropriately to complaints, but we can always learn from our mistakes and work to improve our performance.

We continually work to improve our communications with our members and providers and have recently made major changes to our website to provide more detailed information to our constituents. We developed tutorials to help users become familiar with the new web features and are using our website to alert users if we have system issues such as a temporary problem with our phone system or planned system maintenance of our website. We have expanded our call center hours to better serve callers from other time zones as well as local callers that prefer to call us after 5 pm. We annually hire an independent market research firm to do a telephone survey of our members and have consistently received high marks from members regarding our service. In fact, our 2010 customer satisfaction survey once again demonstrated our members' overwhelming satisfaction with both the performance of Delta Dental and our participating dentists - 93% indicated that they would recommend Delta Dental to their family and friends while 94% were satisfied or very satisfied with Delta Dental's overall performance.

Most of the Examiners' conclusions revolved around communication issues and, as you will see in our responses, we are committed to improving our communications. We did not always agree with the Examiners' conclusions in the particular cases that are noted in the report; however, we concede that each case is subject to some element of interpretation. To underscore this point, we have attached hereto three separate submissions we made to the auditors during the audit process setting forth our specific comments on the cases covered by the audit (Attachments 1-3).

What follows is our formal response to the 19 recommendations contained in the Market Conduct Examination Report. Please be advised that we have directed our Internal Audit Department to formally assure that we implement the changes noted in our responses, as applicable, and that they be monitored on a go-forward basis.

Recommendations and Responses

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.

Delta Dental of Rhode Island (DDRI) agrees to clearly define what consititutes a withdrawn complaint and to establish a consistent process for a "withdrawn" complaint. The definition and the process will be codified in our written policies, specifically QA-01RI and QA-02RI. We will complete the revisions within 60 days and submit them to the Department of Health in accordance with the Rules and Regulations for the Certification of Health Plans with a copy to the Office of the Health Insurance Commissioner.

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.

We agree that we should maintain documentation of any monitoring related to anonymous claims and should investigate serious matters, even if the complaints have been made anonymously. While we feel that we have done so in the past, we agree that our documentation did not fully reflect the scope of our investigations. We will ensure that we document complaints, including anonymous complaints, in our internal Complaint Log and have already begun to do so.

One of the challenges of the anonymous complaint is that if it is patient-specific, it is difficult to investigate as we cannot ask the dentists for patient-specific information that could reveal the individual making the complaint. However, if the nature of the complaint is serious, we will conduct an audit of the practice and include the patient who made the complaint in the audit sample in an effort to preserve anonymity while fully investigating the complaint. We track anonymous and individually identified complaints for trend in our Complaint Log. If there should be a pattern (two or more similar complaints) noted with any dentist, we will investigate the dentist. By way of example, in 2010 we received two anonymous complaints from staff members employed by a RI dentist. We acted upon those complaints and conducted an audit of the dental practice.

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.

We agree that as part of our written complaint processing policy, we will 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. As noted above, one of the challenges of the anonymous complaint is that if it is patient-specific, it is difficult to investigate as we cannot ask the dentist for patient-specific information that could reveal the individual making the complaint. However, if the nature of the complaint is serious, we will conduct an audit of the practice and include the patient who made the complaint in the audit sample in an effort to preserve anonymity while investigating the complaint.

We will define our current practice with regard to anonymous complaints by revising policies QA-01RI and QA-02RI. Within 60 days we will file said revisions with the Department of Health in accordance with the Rules and Regulations for the Certification of Health Plans with a copy to the Office of the Health Insurance Commissioner.

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

We acknowledge that we need to do a better job recording and tracking complaints, particularly those that are resolved during the initial contact. We realize that understanding why people complain provides us with an opportunity to improve our products and services. In the past, these types of complaints, while addressed, were not referred to the Quality Assurance Coordinator for inclusion in the Complaint Log.

In the past month, we have educated Customer Service Representatives and all other staff as to the importance of documenting all complaints in the patient's electronic files. We issued guidelines on what constitutes a complaint as opposed to an inquiry and have instructed staff to forward complaints, and a record of their disposition, to the Quality Assurance Coordinator for inclusion in the Complaint Log.

We will monitor the Complaint Log for trends and identify areas where we need to improve our processes and/ or enhance our communication efforts. We will take action on any findings that result

from our monitoring efforts. We will also identify areas that may require further training of internal staff, particularly front-line personnel such as Customer Service Representatives.

We are in the process of implementing a new Interactive Voice Response system that includes the ability to record and retrieve all calls to customer service. We expect to be fully operational in the fall of 2011.

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.

We agree that we should institute processes to ensure that we investigate 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. We believe that our past investigations have been thorough, but acknowledge that our documentation may not have fully described the details of the investigations. We will ensure that we identify and research each point of a complaint and maintain a record of our investigations that includes summaries of any verbal/phone conversations pertaining to the complaint as well as documentation of our research regarding the case.

As a result of the recommendations made by the Examiners during their investigation, we have already instituted a process in which we thoroughly address and respond to every point cited by a complainant, substantiating with documentation (i.e., case notes, attachments, statistics) when applicable. For example, if a complainant were to allege "in the past year, 30% of claims were denied by DDRI" our actuarial department will gather statistics for the specific time period so that we are able to completely and accurately address the particular issue cited.

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.

DDRI's Quality Management Program (as expressed in formal policies on file with the Department of Health as part of DDRI's Health Plan Certification) has relied to a very significant degree on complaints

generated by members or providers. Quality of care issues are often dealt with in terms of nonpayment for services, through DDRI's Utilization Review program, but the process lacks a formal mechanism for most effectively following up on those quality of care issues.

As recommended, the program is being improved by supplementing this complaint- based structure with a more formal internal procedure for identifying cases of substandard dental care as part of our Dental Case Management (DCM) process, and referring those cases for further action, including counseling and, where appropriate, termination of participating provider status. This process will be aided by a more robust Quality Management Committee function.

Specifically, within 90 days, DDRI's Quality Assurance Policy (No. QA-02RI) will be amended . The modified policy will add an extra level of identification of quality of care issues, as the dental case management analysts and dental consultants involved in DDRI's utilization review/Dental Case Management (DCM) function will be required to refer all instances of potential substandard dental care to the Quality Assurance Coordinator for assessment and further action in the same manner as "complaints" have historically been assessed and investigated under that policy. (The new policy will be structured in terms of "referrals" of potential quality of care issues - not just internal and external "complaints", and will provide for a key role by the DCM function in such referrals.)

The policy will also provide that all "Level 2" and "Level 3" Quality of Care Referrals be reviewed by the Dental Director and placed on the agenda of the Quality Management Committee for review for action, as appropriate. The policy already provides for formal follow-up and closure on such referrals by the Dental Director, and the amendments to the Policy will further underscore the importance of counseling and potential loss of participation privileges in the range of available options for required remedial action.

Also, the new policy will provide for the Quality Management Committee to now meet no less than quarterly, all as part of the "Monitoring/Trend Identification" aspect of the Policy, and to formally document its review and action on each Quality of Care Referral.

Finally, the discussion on this recommendation suggests that referrals involving fraud should be brought to the attention of Senior Management for possible remedial action immediately rather than being subject to the "three (3) or more complaints" rule in the "Monitoring/Trend Identification" section of the

Policy. This improvement, which reflects DDRI's actual recent practice, will also be formally reflected as part of the amended policy, and also as part of DDRI's fraud/abuse policy (Policy #QA-3RI).

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

DDRI respectfully requests reconsideration of this recommendation. While the recommendation that verbal "complaints" be accepted is one matter, the suggestion that formal appeals should be taken "verbally" is quite another. We respectfully disagree that the definition of "appeal" in R.I.G.L. §23-17.12-2(2) requires that "verbal" appeals be permitted. The same section not only permits – but requires – that even "complaints" be in writing, but is silent as to whether a carrier can also require that "appeals" be in writing. The statute (§ 23-17.12-9(b)(1)) gives utilization review agents significant latitude to establish the appeal procedure, and it is not unreasonable to require appeals to be in writing and to include reasons for appeal and supporting information. Appeals carry legal consequences and must usually be filed within prescribed deadlines, and in almost every context (including the regulatory context) some type of written communication affirmed by the appellant is required for an "appeal". Administration of appeals would be chaotic at best without such a requirement. Moreover, the record keeping requirements of the statute only apply to "written appeals" (R.I.G.L. §23-17.12-9(6)), strongly suggesting that "verbal" appeals are not *required* as part of the specific appeal procedure that utilization review agents are given latitude under R.I.G.L. §23-17.12-9(b)(1) to establish.

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.

We agree that in the event of a claim or pre-treatment review denial, we 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. Our primary means of communicating an adverse determination is via an Explanation of Benefits (EOB) for the subscriber and a Consolidated Explanation of Benefits (CEOB) for the dental office. EOBs and CEOBs are mailed to the provider and the subscriber. Denials are communicated using processing policy messages at the procedure code level.

Over the next 90 days we will re-examine our processing policy messages related to utilization review decisions to identify any that are confusing or unclear. We will re-write our existing policies as needed and create additional policies to make sure that the recipient understands the action we took and the

reason for it. We will then seek input from providers via our Provider Advisory Group and customers prior to finalizing the processing policies. We have already started working on revisions to the specific processing policies cited in the audit (#s 60, 168 and 219).

As a result of the recommendations made by the Examiners during their investigation, we have already instituted a change in how we communicate. In any adverse UR determination where a current processing policy message does not effectively communicate the adverse decision, or where the case is particularly complicated, a customized letter stating the Dental Consultant's rationale is written and mailed to the dentist.

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.

We agreed and have already revised and begun issuing our appeal notice entitled "Your Right to Claim Review ." We added a sentence that states *"Prior to initiating a second level of appeal, you may request to inspect the utilization review file and add information to the file."*

The Appeal notice is on our website and a printed version accompanies every EOB and CEOB that is mailed. We also include the Appeal notice with any customized communication that goes out to the provider or subscriber regarding an adverse determination (see Attachment 4.)

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.

By December 31, 2011, we will complete a new study to determine the primary reasons for denials being overturned on appeal. Our previous analyses of this aspect of the appeals process found that the primary reason for a decision being reversed on appeal is that the dentist provided additional documentation (i.e., a copy of a specialist's evaluation of the tooth) to support the treatment in question. Said information, had it accompanied the original claim submission, would have resulted in the procedure being approved upon initial submission. We believe that other recommendations by the Examiners regarding better communications will also help reduce appeals.

We do, however, disagree with the Examiners' assessment of the denial rate. The reference to the high rate of denials being overturned on appeal is taken out of context as the number of denials appealed does not equal the total number of denials issued as noted in the footnote on page 28 of the report.

When a particular case is not adequately supported by standard documentation, we will continue to advise participating dentists of the advantages of submitting detailed documentation with their claim submissions via newsletters, consultant peer-to-peer phone calls, and updates to DDRI's Utilization Review Guidelines. We persist in exploring ways to effectively communicate the documentation requirements to providers. Within the last two months we have asked for e-mail addresses from our participating dentists so that we may expedite and improve our ability to communicate with the Rhode Island provider community; to date we have received email addresses from approximately 80%.

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.

DDRI is making every effort to meet the mandated 15 day timeframe by increasing Dental Consultant hours as well as creating workflow efficiencies to increase production. There are, however, some regulatory requirements that add to the turnaround times on appeals. including the requirement on first appeal to have a peer to peer call of at least two attempts to speak with the dentist prior to making an adverse decision. As dentists are often with patients, this may add 2-3 days to the process since the dentist may not be able to get to the phone and may not call us back the same day. We also follow-up the next business day and here, too, allow time for a call back if the dentist cannot come to the phone. On second appeal, in the case of claims for specialty services rendered by a specialist, a dentist of the same specialty must review the appeal; since the volume of such appeals is not significant and since specialists are not in-house, we send the case to their private office for review, which adds to the turnaround time.
We realize, however, that we must devise work processes and/or add resources that take these facts into consideration and for appeals received on or after October 1, 2011, we expect to achieve consistent compliance with the 15 day turnaround requirement.

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.

We agree that we should clearly distinguish between claims that are denied for benefit reasons and denials that are made because of medical necessity. Our claims processing system does not pend claims for additional information; if additional information is required, a claim is processed as a disallowed claim (zero payment) and the provider and member are notified via an EOB or CEOB with a processing policy that advises them that additional information is required to approve or deny the procedure(s).

As a result of the recommendations made by the Examiners during their investigation, we have already instituted changes. As noted in our answers to previous recommendations, in situations where a processing policy message does not effectively communicate an adverse decision or one that is disallowed for specific information, a customized letter stating the rationale for the decision is mailed to the dentist. Additionally, we will continue to revisit and revise processing policy messages to ensure that the message is clear to the member and provider.

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.

DDRI agrees with the recommendation and has already significantly expanded its definition of a complete claim to be much more specific. In accordance with the Prompt Pay Regulations, we are notifying providers of this definition via a newsletter that will be mailed by August 15, 2011; once that has been accomplished, we will notify the Office of the Health Insurance Commissioner of the new definition and confirm that it has been communicated to providers. We have revised our written policy PAY02-RI and will be filing it with the Department of Health with an effective date of October 1, 2011. (Attachment 5).

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.

DDRI has complied with this recommendation and effective August 1, 2011, is implementing a revised version of the processing policy for an inadequately filled root canal. We believe the following revised message addresses the concerns cited by the Examiners.

*Revised Processing Policy : **Due to the uncertain endodontic prognosis of the tooth, benefits for restorative services are denied. Once the endodontic health of the tooth has been addressed, resubmit restorative procedure for benefit consideration with PA xray showing current endodontic status of the tooth. If root canal retreatment is required, and done by the original dentist, he/she can't bill for procedure; if done by a different dentist, benefits will be provided per the patient's endodontic benefits and annual maximum.***

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.

When a provider is required to provide supporting documentation, it does not preclude claims from being processed in a timely fashion by DDRI. Also, DDRI's accounts and subscribers expect that DDRI will be an effective steward in the expenditure of premium revenues and that payment will only be made when medically necessary and in accordance with the terms of their benefit plan. Doing so also keeps dental coverage affordable.

DDRI's Participating Dentist Agreement requires that <u>all</u> dentists, as a condition to participation, agree that DDRI may exercise broad audit prerogatives, with or without prior notice. This is consistent with sound audit and review practices everywhere. Section 6 of the Participating Dentist Agreement provides, for example, in pertinent part as follows:

"6. <u>Audit Programs</u>. Delta Dental at all times reserves the right to review services rendered and fees charged by Dentists. Such review may encompass, without limitation, verification of treatment reported, the necessity of treatment, the identity of the Dentist performing the treatment, the adequacy of the standards of care employed, fees charged and collections made with respect to nonsubscriber patients, and the reimbursement for the services reviewed ... ."

DDRI's review and audit prerogatives in this regard will be critical to the more robust quality of care oversight function the Market Conduct Examination has encouraged.

In situations where DDRI's audit of a participating dentist has resulted in findings that support the need for additional review procedures, DDRI will, as recommended, modify its policy such that non-consensual "additional" reviews or sanctions that change the providers ability to have claims processed

in a timely fashion will now carry advance notice to the provider, together with the opportunity to review the audit information and respond prior to the changes taking effect. In such cases, the requirement for additional review procedures may be a requirement for continued participating status.

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.

DDRI continuously examines its methods of communication in an effort to impart both benefits or exclusions clearly to members, providers and accounts. Since the Market Conduct Examination commenced in 2010, we have enhanced our online benefit lookup application for each of these constituencies. We significantly upgraded our website to add more information on frequency limitations and developed web tutorials for accounts, members and providers that described how to access the information available on the web.

As noted previously, we have begun to address utilization review processing policy messages to better communicate the reason for denial. If a processing policy does not adequately address a reason for an adverse decision, a customized letter is crafted to precisely convey the rationale to the provider and/or member as noted in the response to Recommendation 8. We also plan on examining our Utilization Review processing polices for clarity and specificity.

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

As a good faith effort to comply with the recommendations of the Examiners, Delta Dental agrees to issue an extra contractual, administrative payment for the patient's crown described in this case.

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."

As indicated in previous responses, we too desire good communications with our subscribers and dentists. To that end we will examine and revise, as appropriate, our processing polices, particularly those that pertain to adverse determinations as indicated in our response to earlier recommendations. We will include the suggested language (consult your dentist to determine appropriate treatment options) in relevant processing policies.

As a result of the recommendations made by the Examiners during their investigation, we have already instituted changes as noted in our response to other recommendations.

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.

DDRI respectfully requests reconsideration of this recommendation. The recommendation, if implemented, would make health insurance carriers in Rhode Island the indemnitors of their subscribers with respect to financial harm, including subsequently required treatment, resulting from substandard healthcare or provider malpractice. This is not the relationship established by virtue of DDRI's agreement with its subscribers. Nor is it the relationship established by statute by and between DDRI, its providers, and its subscribers.

Specifically, DDRI's approved agreement with its subscribers, under the heading "Acts of Providers", specifically provides that DDRI is not liable for injuries or damages resulting from the acts or omissions of a dentist, and is not responsible if the subscriber is dissatisfied with the treatment or services the dentist provides. This is consistent with R.I.G.L. §27-20.1-3(c), DDRI's enabling statute, which provides that, "Nothing contained in this chapter or in any nonprofit dental service plan shall affect the ordinary professional relationship between the person rendering dental services under the plan and the subscriber to whom the services are rendered; and no action based upon or arising out of the relationship or relating to dental services rendered pursuant to a nonprofit dental service plan shall be maintained against the nonprofit dental service corporation operating the plan." Recommendation #19, if implemented, would dramatically change this contractual and statutory relationship between DDRI, its providers, and its members, by making DDRI responsible for financial harm to subscribers resulting from substandard dental care by providers. No such requirement applies to similarly situated health insurance carriers.

Conclusion

Once again, we have appreciated this opportunity to further improve the administrative processes through which we communicate and adjudicate matters affecting members and providers. We appreciate as well the Examiners' observation (at page 48 of the Report) that DDRI has "cooperated fully with the examination and used it to improve its customer service and provider relation practices". We thank the Examiners for their efforts. We concur with the overarching conclusion of the Report (at page 49) that "DDRI maintains adequate records and generally has good claims processing and customer service capabilities [and] prepares and submits the prompt processing, appeals and complaint reports they are required to submit." We agree as well with the corresponding observation that there are areas for improvement, and are resolute in our plan for additional improvements, all as outlined above.

Attachment 1

DELTA DENTAL

www.deltadentalri.com

Charles C. DeWeese, FSA, MAAA
DeWeese Consulting, Inc.
263 Wright Road
Canton, CT 06019

March 17, 2011

Re: (Draft) Delta Dental of Rhode Island ("DDRI")
Market Conduct Examination Report

Dear Mr. DeWeese:

Thank you for this opportunity to provide an informal response to the above. Consistent with your communication of February 17, 2011, we understand the purpose of this informal response to be to identify areas where factual errors may have been made (as opposed to responding substantively to the content of the Draft Report). In this regard, our comments are delineated on the following pages.

As always, should you have any questions or desire additional information on these issues, please do not hesitate to contact me by phone at 401-752-6236 or via email, kshanley@deltadentalri.com.

Sincerely,

Kathryn M. Shanley
Vice President, External Affairs

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5. Overview of DDRI's Business

After review of the Annual Statement filing referenced in footnote 2, this section of the report should be corrected as follows to reflect the difference between DDRI **"members"** and **"subscribers"**:

> DDRI covered approximately 306,190 members[2] enrolled in premium groups as of December 31, 2009. As of October 31, 2010, DDRI reported 287,418 members in premium groups and a total of 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]

Page 8

Paragraph 1, first complete sentence

Correction: There are approximately 600 provider/member processing codes that could appear on a CEOB.

Paragraph 2, add the following after sentence 2

The dental office determines where the billing company should send **CEOB's.**

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

Paragraph 1, first sentence

Correction: Ms. [redacted] supervises 5 Dental Claims Analysts who review and process claims and pretreatment estimates for procedures requiring clinical review based on Dental Policy and Utilization Review Guidelines.

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Footnote 8

Correction: **"Denial"**, as used above, means that the benefit is not deemed dentally necessary and appropriate, in accordance with DDRI Utilization Review Guidelines, and no benefits are provided.

First full paragraph, sentence 2

Correction: When a root canal is improperly filled, there is an increased chance of infection compromising the long term prognosis of the tooth.

To accurately reflect the true content of the processing policies, we suggest using exact wording of each rather than an abbreviated version, as follows:

PP 73: THE CONTRACT PROVIDES BENEFITS FOR CROWNS, BUILDUPS, 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.

PP 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.

PP 167: DUE TO THE UNCERTAIN PERIODONTAL PROGNOSIS OF THIS TOOTH, BENEFITS FOR MAJOR RESTORATIVE SERVICES ARE DENIED.

PP 168: DUE TO THE UNCERTAIN ENDODONTIC PROGNOSIS OF THIS TOOTH, BENEFITS FOR MAJOR RESTORATIVE SERVICES ARE DENIED.

PP 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.
PP 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 PROCEDURE DOES NOT QUALIFY FOR BENEFITS.
PP 299: THE TREATMENT PLAN SUBMITTED APPEARS TO INDICATE A COMPROMISED LONG-TERM PROGNOSIS. BASED ON THE DOCUMENTATION REVIEWED BY OUR DENTAL CONSULTANT, BENEFITS ARE DENIED.

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Paragraph 3

We acknowledge **DDRI's** complaint handling of a UR decision is incorrectly stated on page 3 of DDRI policy QA-01RI. In practice, if we receive a complaint regarding a UR decision, we do in fact follow the appropriate complaint process, as stated on page 1 of policy QA-01RI.
Also, if the dentist or member requests reconsideration of an adverse decision based on dental necessity, it is handled in accordance with Delta **Dental's** policies regarding review determinations and appeals; policy UR-03RI.

Page 12

Last statement Paragraph 1

Any employee who receives a complaint is required to complete a Customer Complaint Form with the specific details and must forward to the Quality Assurance Coordinator for evaluation, resolving and follow up.
The Complaint Log is Delta **Dental's** mechanism to ensure that the complaint is tracked and the complaint processes are fully implemented.

Page 13

Paragraph 1

The records associated with the three withdrawn complaints do in fact reveal the reason why they were withdrawn. In order to ascertain the outcome of a complaint, the complete case record must be retrieved and reviewed. The Complaint Log does not provide the complete detail, nor the resolution of the complaint.

In reference to anonymous complaints, although we record all anonymous complaints in the log, it is impossible to substantiate the validity of an anonymous complaint without providing specific patient information to the dental office. However, we do track for trend and if there should be a pattern noted with any dentist, we would investigate.

Page 14

Case 29992: The dentist stated on the initial claim form that teeth 22-27 have "**severe** attrition, decay, fracture and an unstable occlusion. " The Dental Consultant reviewed that statement on the claim during the initial review and denied with processing policy 219. The fracture was not addressed because it had no bearing on the reason for denial, attrition, which is a contractual exclusion.

Case 33435: The original complaint letter made no mention of a "**missing photograph**" . We did investigate and respond to the dentist regarding the "**missing photograph**" when it surfaced in the appeal process. Our Dental Consultant contacted the dentist on 8/25/08 to discuss the fact that we received all x-rays for the appeal, yet never received a photograph.

Case 33494: No changes.

Case 33615: The Quality Assurance **Coordinator's** response letter dated, 7/30/09, addressed delay in payment of the crown and buildup by providing a time line of all submissions and the reasons for delay. (i.e. no x-ray submitted by dentist)

Case 33813: The **Complainant's** letter simply provided a **"Notification timeline."** The Quality Assurance **Coordinator's** detailed response letter dated, 8/27/09, did in fact address the reasons for delay as well as the reason for denial.

Case 33895: The Complaint letter from the dentist does not allege that 50% of root canals from this **dentist's** office were being denied without a valid reason.

Case 33932: The Quality Assurance **Coordinator's** response letter dated, 9/11/09, specifically addressed the **dentist's** allegation with the following reply: **"The** denial or approval of a procedure is contingent upon whether or not it meets standard of care and DDRI Utilization Review Guidelines. It has absolutely nothing to do with the amount of **coverage."**

Case 34332: The Quality Assurance **Coordinator's** response letter dated, 10/21/09, specifically addressed the **dentist's** statement regarding compromising privacy with the following: **"If** a claim is received for a restorative procedure and the tooth has an existing root canal, the Dental Consultant must review the root canal to determine if the tooth will support the restorative procedure. If the root canal does not meet the standard of care, the restorative procedure is denied or disallowed. When a first level of appeal is submitted by a dentist who practices in Rhode Island and/or the member resides in Rhode Island, we are required by state law and the Rhode Island Department of Health to call the dentist if it is an adverse decision. If the reason for the denial/disallow of the restorative procedure is a result of an inadequate root canal, the Dental Consultant will discuss this with the treating dentist. However, the Consultant will **never** reveal who performed the root **canal."** The treating dentist knew who performed the root canal since it was done in that office; Delta Dental did not provide that information.

Case 34395: The Quality Assurance **Coordinator's** response letter dated, 11/10/09, did address and take responsibility for the incorrect benefit eligibility information with the following: **"We** acknowledge there were inconsistencies reflected on ***Benefit Highlights*** on Delta Dental of Rhode **Island's** website; however we are working to resolve the issue that caused this incorrect information. As an interim solution, we have removed the benefit dollars stated in the ***used*** and ***remaining balance*** section of the webpage. When a member or dentist calls the automated line or accesses the website for benefit information, they are directed to ***call customer service***. A Customer Service representative will then provide the accurate **information."**

Case 34412: The Quality Assurance **Coordinator's** response dated 10/30/09, specifically addressed this issue, as indicated in the following excerpts from her letter:

'Regarding Dr. [redacted] statement: *"Furthermore, when my patients complain about this practice to Delta Dental they are told the doctor can't charge the correct fee.*

- Dr. [redacted] can charge any amount he chooses for any procedure. However if it is a covered benefit, as a participating provider, he can only bill the member up to the allowable amount. If the procedure is covered 100%, he cannot bill the member at all.

Regarding Dr. [redacted] statement: *"Delta has been telling my patients that I have been overcharging them when, in fact, they are underpaying. Following the letter of the law, I MUST charge the difference because waiving copayment is illegal in Rhode Island.*

- It is unclear what Dr. [redacted] is referring to in this statement. If the dentist bills Delta Dental for a covered procedure and there is a coinsurance, he/she **must** bill the patient. Waiving coinsurance violates the Participating **Dentist's** Agreement and the ADA Principles of Ethics and Code of Professional **Conduct.'**

Case 35732: This complaint involved two complaint letters from Dr. [redacted] and two response letters from **DDRI's** legal counsel. Neither of his complaint letters asks for the reasons he was placed on review and/or the basis on which we had made the determination to do so. We addressed all of his cited concerns in each of our response letters.

Case 37583: The **complainant's** concerns were addressed in a letter dated 6/9/10 from our VP of External Affairs, [redacted] The closing paragraph stated the following **"We** have not mistreated Mr. C nor do we have a vendetta against Dr. [redacted] as you allege in your **letter."**

Case 38407: **Please verify the case number. We do not have a record of such file but**, we did find case number 38406, and will respond accordingly. The Quality Assurance **Coordinator's** four page response letter to the dentist dated, 9/23/10, did in fact address **"the** communication problems that resulted in a delay of **payment."** The response letter acknowledged **DDRI's** responsibility for our error and miscommunications. Also, as a courtesy, the Quality Assurance Coordinator called the patient directly on 9/15/10 and explained that, **"upon** review of her claims, we made an error and mistook tooth #4 for tooth #3. I acknowledged that it was Delta **Dental's** error and told her it was **not** Dr. [redacted] **error."** We then followed up with a letter to the member. Moreover, [redacted], Director of Program Integrity, attempted to speak with Dr. [redacted] to apologize for the errors we made. She called on September 15 and September 16, 2010; however the office was closed. Ms. [redacted] called twice on September 17, 2010 and both times left a message with the receptionist requesting that Dr. [redacted] return her call.

Page 16

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

Paragraph 2, sentence 4

Correction: **"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. "

Page 17

Paragraph 1

Quality of care complaints had been submitted against Dr. [redacted] in May 2009, July 2009 and October 2009; the final resolution of the third complaint was not complete until January 2010. In accordance with DDRI Complaint Policy, QA-02RI, **"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."**

As a result of our findings in the three complaints, Sr. Management requested an audit of his practice be conducted and said audit began on February 10, 2010.

Correction: **"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. [redacted] remained a network dentist until he resigned in May **2010."**

Bullet a: Counseling a dentist does occur in various ways. If a Dental Consultant renders an adverse decision on a first level of appeal for a RI member or RI dentist, a phone conversation must take place - peer to peer to convey the reason for the decision. In the case of Dr. [redacted] DDRI Dental Director had many conversations with the dentist regarding the quality of the work submitted and those conversations were documented in the corresponding member claim. Additionally, our Director of Professional Relations and Director of Program Integrity made contact with the dentist to explain rationales, protocols and provide direction with regard to the appeal process.

Page 19

11. Review of Denial and Appeals Process

We respectfully disagree that the definition of **"appeal"** in R.I.G.L. § 23-17.12-2(2) requires that **"verbal"** appeals be permitted and processed. The section is silent as to whether a written affirmation, statement or document can be required in connection with an appeal. Appeals carry legal consequences, and in almost every context (including the regulatory context), some type of written communication affirmed by the appellant is required for an **"appeal"**. Administration of appeals would be chaotic at best without such a requirement. Also, this same section (§ 23-17.12-2) not only permits – but requires – **"complaints"** to be in writing. Moreover, the record keeping requirements of the statute only apply to **"written appeals"** (R.I.G.L. § 23-17.12-9(6), and utilization review agents are given significant latitude to establish the appeal procedure. (R.I.G.L. § 23-17.12-9(b)(1)).

Page 20

Paragraph 1

With regard to the following statement **"Providers** and members do not appear to understand the difference between a request for additional information and a **denial."**

This is a broad statement. While we acknowledge that it could be the case for certain members, we believe that the majority of providers understand the difference.

Page 22

Paragraph 2

"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 is reversed on **appeal—suggests** that the original determination may be unduly conservative and/or that the UR process not is effectively **implemented."**

- The statement in this paragraph is misleading; in actuality, nearly 8 out of every 10 denied claims that are appealed are reversed on appeal. What is not included in this statistic, is the number of adverse decisions that never get appealed, making it appear that DDRI approves on appeal a greater percentage. A study we conducted in first quarter 2006 showed that out of 888 adverse claims, only 223 (25%) were appealed. Similarly, in first quarter 2007, out of 1388 adverse claims, 500 (36%) were appealed.

Page 27

a. Root canal related complaints

Paragraph 2

Correction: "As background, when a root canal is performed, the nerve within the tooth is removed, and filling material is placed into the canal space. The filling must completely fill the nerve chamber, or there is an increased risk of infection and failure of the tooth.

...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."

Page 28

Paragraph 1

Correction: "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, ..."

Page 30

Last statement paragraph 1

DDRI does not have an "arbitrary" denial process; any reviewable procedures that are denied are based on failure to meet Utilization Review criteria. Also, the reference to 70% of denials being overturned on appeal is taken out of context, as the number of denials appealed does not equal the total number of denials issued.

Page 31

Paragraph 1 (continued from page 30)

This is not a true statement.

The photograph issue was addressed in case # 33435, as set forth on page 2 of this document.

c. Benefit determination

Case 1

DDRI does not provide benefits under age 12 unless documentation is submitted revealing a full mouth series was actually taken. A full mouth series submitted for children under the age of 12 is a benefit limitation; typically children do not have a full dentition. Therefore, a full mouth series is not ordinarily indicated, nor the standard of care.

Also, this was implemented as a fraud detection policy.

Page 32

Paragraph 1

The following is not a true statement: **"The** website incorrectly gave him information to the effect that a new period of benefit eligibility would begin on September 1, and the dentist then scheduled a crown for after September 1."

- It appears that there is some confusion on the **patient's** part with regard to eligibility vs. yearly maximum. Refer to Atty. [redacted] 3/19/10 letter of clarification to the DBR.

d. Full review of surgical extractions

Paragraph 1

Correction: 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, 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 benefited in conjunction with surgical extractions.

Page 33

Paragraph 2

The following is not a true statement. **"However,** they first denied coverage, then requested a narrative and ultimately requested an operative note. "

- Benefits were not denied, they were disallowed. A determination could not be made with regard to the surgical extractions until the **dentists'** contemporaneous treatment notes were submitted and reviewed. This was communicated to Dr. [redacted] in Atty. [redacted] letter dated 1/19/2010.

Bullet 2

Refer to prior comments regarding adverse determination on appeal. The percentage is based on appealed adverse determinations – not all adverse determinations.

Page 35

Bullet 1

Pertaining to Dr. [redacted]'s complaint; DDRI UR Guidelines specifically state what is required for the clinical review of procedure code 2740 and 2950. (Tooth number and pre-operative periapical x-ray)

Page 36

f. Quality of Care Complaint

DDRI does take action with regard to quality of care complaints of our participating dentists as described in DDRI policy QA-02RI.

Attachment 2

Market Conduct Final report – response to second set of questions

Page 10

First full paragraph, sentence 2.

Yes, your sentence was incorrect as stated.

Decay is not a factor.

When a root canal is improperly filled there is an increased chance of re-infection that may result in the root canal treatment having to be re-done, or in the worst case, the loss of the tooth. The issue of endodontic health arises when a major restorative procedure is to be performed.

Page 14

Case 29992:

There is no decay or fractures apparent with regard to this case. The documentation supports wear as the primary reason for crown coverage. The incisal edges of these teeth are worn down due to attrition. The minor restorations present on the facial surface on teeth 22 & 27 are not extensive enough to warrant crown coverage.

Answer to questions:

If the tooth fractures are caused by attrition then the crowns are contractually excluded. All cases involving decay that is extensive enough to warrant crown coverage, despite the attrition, are eligible.

Attrition is not an automatic disqualification for coverage, yet in this case it is, because the alleged fractures are secondary to the attrition, and the extent of decay is not sufficient to warrant crown coverage.

Case 33435:

There is no indication that the dentist ever sent in a photograph with this claim. In fact, his own claim, Box 39 on the ADA claim form, stated "radiographs 1" enclosed, and the "oral images" section was blank.

After his first submission, we returned the x-rays to him, if he had submitted a photograph and we did not return it with the x-ray, we would have expected him to contact us regarding the unreturned photograph.

Also, there was NO mention of a missing photograph in his complaint. There was never any evidence of a photograph submitted with any of his documentation. And based on the conversation he had with our dental consultant, he did not challenge our assertion that DDRI never received a photograph.

Case 33932:

Those that are making the clinical decisions, Dental Consultants, are not privy to or have access to the benefit payment structure. Their decisions are based solely on clinical guidelines and not on any financial parameters.

Case 37583:

A single complaint has come to our attention since last visit; this involved our subsidiary, Altus Dental.

The case was approved on second appeal. Additionally, only two root canals have been sent in for payment to DDRI since last visit. One approved, one disallowed. It is apparent that Dr. [redacted] case load in RI has decreased. We understand that he is working more in MA.

Case 38406:
Once the mistake was discovered, we took action and the case was resolved immediately.
Also, we contacted the member and explained our error, as well as making several attempts to speak with the dentist regarding our error, but he never returned our calls. See case file for QAC notes.

Page 20

It is industry standard to communicate denials and requests for information via messaging on CEOB's. See other carrier CEOB's.

Page 30

Last statement paragraph 1
DDRI does not have an "arbitrary" claims process; any reviewable procedures that are denied are based on a failure to meet DDRI UR Guidelines. These Guidelines are available to all dentists via www.deltadentalri.com

Explanation: A high rate of overturn implies that DDRI is not getting adequate information to evaluate claims initially. The overturn on appeal can be attributed to new information submitted on the appeal along with the original documentation.

Page 31

c. Benefit determination
Case 1
DDRI is not "denying" benefits for the FMX under age 12; we are disallowing the procedure until we see evidence that a FMX was taken on a child under the age of 12. This is a fraud detection mechanism used to protect the member's benefits. The member is not penalized or harmed in any way. Once documentation is provided, benefits will be applied. If no documentation substantiates that an FMX was taken, the claim remains disallowed. This policy is located in DDRI UR Guidelines found on our website, as well as communicated to the dentist and member via CEOB and EOB.

Page 35

Bullet 1
X-ray requirements are communicated via the following:

- Dentist newsletters, *Details*
- Utilization Review Guidelines
- Consolidated Explanation of Benefits

Attachment 3

Delta Dental of Rhode Island
Market Conduct Examination Report (1-1-09 to present)
Supplemental/Supportive documentation
May 5, 2011

Page 6

Paragraph 1
Addendum
DDRI's new call system implementation extended into 2011.

Page 14

Recommendation 1: DDRI should contact the member who made the third "withdrawn" complaint and ask whether the matter had been resolved to his satisfaction. If it has not, DDRI should contact the dentist and attempt to resolve the issue.

In response to recommendation 1, Quality Assurance Coordinator, [redacted], contacted the member on April 26, 2011. Member said he never followed up with [redacted] because he did not want to pursue the complaint and he still does not want [redacted] to contact [redacted] Dental; he was quite adamant. His wife joined in on the conversation and told [redacted] to forget the whole issue. He then said [redacted] refunded him "a little bit of money." When [redacted] asked how much, the member said he could not remember. [redacted] asked him for an approximation and he said $100.00. [redacted] asked him if he would send something in writing stating he does not want us to pursue the complaint and he stated "just take my word for it."

Page 15

Recommendation 3: 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.

DDRI does track anonymous complaints for trend and if there should be a pattern noted with any dentist, we investigate. Recently, we received two anonymous complaints from staff members employed by a RI dentist. We acted upon those, although anonymous, and audited the practice. Our audit findings were sent to the dentist for comment; we have received and are in the process of reviewing the dentist's comments for DDRI's final position.

Page 16

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 ~~believed~~ **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:

We believe this section needs to be clarified including the following:

There is no indication that the dentist ever sent in a photograph with this claim. In fact, the dentist's claim submitted to us for payment, (Box 39 on the ADA claim form), stated "radiographs 1" enclosed, and the "oral images" (photos) section was blank.

After the dentist's first submission, DDRI mailed the x-rays back to him. If he had submitted a photograph and we did not return it with the x-ray, it is reasonable to expect him to contact us regarding the unreturned photograph.

There was never any evidence of a photograph submitted with any of his documentation. Also, there was NO mention of a missing photograph in his complaint to us. Furthermore, based on the conversation he had with our dental consultant, he did not challenge our assertion that DDRI never received a photograph.

Page 20

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. However, DDRI did not adequately explain 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.

We disagree with the statement that "DDRI did not adequately explain 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." DDRI Dental Director and various Dental Consultants had numerous conversations with this dentist regarding the quality of the work he submitted for payment and each of those conversations were documented in the corresponding member's claim notes. For specific case details, refer to the [redacted] Log excel document; we can retrieve any case notes for the details of the Consultant phone conversations.

Additionally, Director of Professional Relations and Director of Program Integrity made contact with dentist to explain rationales, protocols and provide direction with regard to the appeal process. Also, see Dr. [redacted]'s February 24, 2010 letter to this dentist illustrating the reasons for our adverse decisions.

Page 21

Last paragraph

"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."

Quality of care complaints had been submitted against Dr. A in May 2009, July 2009 and October 2009; the final resolution of the third complaint was not complete until January 2010. We did address this issue promptly once the third complaint was resolved in the member's favor. In accordance with DDRI Complaint Policy, QA-02RI, "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." As a result of our findings of the three complaints, Sr. Management requested an audit of his practice be conducted and said audit began, February 10, 2010.

Page 22

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

> .....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 unable to secure payment for the crown until the root canal is done to ~~DDRI's satisfaction~~

We would like to revise this sentence to read: "The patient is unable to secure payment for the crown until the root canal is done in accordance with the standard of care."

Page 37

First paragraph

We saw no evidence that DDRI had investigated adequately to conclusively establish that a photograph had not been sent.

We provided the copy of the dentist's claim form that revealed there was no indication that the dentist ever sent in a photograph with this claim. In fact, the dentist's claim submitted to us for payment, (Box 39 on the ADA claim form), stated "radiographs 1" enclosed, and the "oral images" (photos) section was blank.

Page 37

Bullet 1

Because an FMX taken on a child under the age of 12, is NOT the standard of care, DDRI disallows the procedure until we see evidence that an FMX was actually taken on the child under 12. This is a fraud detection mechanism used to protect the member's benefits. The member is not penalized or harmed in any way. Once documentation is provided, benefits can be applied. If no documentation substantiates that an FMX was taken, the claim remains

disallowed. This policy is located in DDRI UR Guidelines found on our website, as well as communicated to the dentist and member via CEOB and EOB. Processing policy 60 states: *"To be considered for benefits, a complete x-ray series for a child under the age of 12 requires a narrative explaining the need for such extensive radiographs as well as a copy of the x-ray series. A participating dentist may not charge the patient for this service."*

Page 38

Last paragraph

The website printout refers to patient eligibility, "current coverage in effect since September 1, 2008." This statement does not indicate that a new maximum is available on this date.

Additionally, when Dr. [redacted] office contacted DDRI with regard to the erroneous information displayed on the website, they were merely communicating our error, as Dr. [redacted] was fully aware of exhausting the patient's benefits as he had been treating, submitting and receiving payment for services rendered prior to the office inquiry date.

Page 49

16. Recommendations

1. DDRI should contact the member who made the third "withdrawn" complaint and ask whether the matter had been resolved to his satisfaction. If it has not, DDRI should contact the dentist and attempt to resolve the issue.

In response to recommendation 1, Quality Assurance Coordinator, [redacted]., contacted the member on April 26, 2011. Member said he never followed up with [redacted] because he did not want to pursue the complaint and he still does not want [redacted] to contact [redacted] Dental; he was quite adamant. His wife joined in on the conversation and told [redacted] to forget the whole issue. He then said [redacted] refunded him "a little bit of money." When [redacted] asked how much, the member said he could not remember. [redacted] asked him for an approximation and he said $100.00. [redacted] asked him if he would send something in writing stating he does not want us to pursue the complaint and he stated "just take my word for it."

Attachment 4

DELTA DENTAL OF RHODE ISLAND

YOUR RIGHT TO CLAIM REVIEW

If you have a question about the payment or denial of a claim, call Customer Service at **401-752-6100 or 800-843-3582.** You have a right to request a full and fair review of your claim. **All claims must be received within 12 months of the date services are received to be eligible for payment.** If we cannot process a post-service claim because it is missing information, we will notify you within 30 days of what additional information is needed. (A post-service claim is a claim that is filed after dental care has been received). A participating dentist may not charge the patient for any amount that has not been paid as a result of the dentist's failure to provide the necessary information to process the claim. Under Rhode Island law, for a Rhode Island resident or for services performed by a Rhode Island dentist, your dentist has the right to request a two-way direct communication with our dental consultant (a licensed dentist) prior to us making an initial adverse determination by calling Customer Service.

TO APPEAL A CLAIM DETERMINATION

If a claim is denied, in whole or in part, you may request a review of the denied claim by sending us a written request for appeal within 180 days from the date you receive our original notice. Processing policy messages on the Explanation of Benefits or Pre-Treatment Estimate notice, explain the reason(s) for the denial, refer to any plan provisions on which the decision was based, and refer to a guideline, protocol or criteria we used to make the adverse decision (if applicable). You also have the right, on request and free of charge, to reasonable access to, and copies of, all documents relevant to the claim. Furthermore, on a written request, and free of charge, Delta Dental will provide you with a copy of any internal rule, guideline or protocol, and/or, if applicable, an explanation of the scientific or clinical judgment we used to decide the claim.

Our appeals process allows for one level of internal appeal or, in cases where an adverse determination was based on a failure to meet our utilization review guidelines, two levels of internal appeal and an opportunity for external review. The insured also has the right to bring a civil action under Section 502(a) of the ERISA Act once the applicable internal appeals process has been exhausted, except in cases where the insured is a member of a governmental plan, church plan, or a plan not established or maintained by an employer.

To initiate the first level of internal appeal, you must do so in writing within 180 calendar days of receipt of the original denial notice. You should write to the attention of ***Appeals, Delta Dental of Rhode Island, P.O. Box 1517, Providence, RI, 02901-1517.*** Your appeal should ask for reconsideration and include a copy of the Explanation of Benefits or Pre-Treatment Estimate notice, the patient's name, the subscriber identification number, the reason why you believe the claim was wrongly denied, and any other information you believe supports your claim (e.g., x-rays, narrative, charting, photos, treatment records, etc.). In cases where an adverse determination was based on a failure to meet our utilization review guidelines, a licensed dentist will review your appeal.

We will provide you with a written or electronic resolution of the appeal within 15 business days after we received the appeal. For appeals involving emergency medical conditions, a decision is made within 2 business days. If an adverse determination is issued as a result of the first internal appeal, you then have the opportunity to initiate a second internal appeal if the decision was based on a failure to meet our utilization review guidelines; otherwise, the internal appeals process is concluded. Prior to initiating a second level of appeal, you may request to inspect the utilization review file and add information to the file. Such additional information shall be forwarded in writing and shall be subject to confidentiality in accordance with applicable state and federal laws. Following conclusion of the internal appeals process, the insured has the right to bring a civil action under Section 502(a) of the ERISA Act, except in cases where the insured is a member of a governmental plan, church plan, or a plan not established or maintained by an employer.

To initiate a second internal appeal, you must do so in writing within 180 calendar days of receipt of the notice regarding the first level appeal. Prior to submitting the appeal, you have the right to inspect the utilization review file and add information to the file. Such additional information shall be forwarded in writing and shall be subject to confidentiality in accordance with applicable state and federal laws. You should write to us following the procedure outlined above under first level appeals. Another licensed dentist who was not involved in any prior determinations will review your appeal. In the case of claims for specialty services rendered by a specialist, a licensed dentist duly qualified in the specialty area in question will review the claim. We will notify you of our decision within 15 business days after we received the appeal. For appeals involving emergency medical conditions, a decision is made within 2 business days. If an adverse determination is issued as a result of the second internal appeal, the insured then has the right to bring a civil action under Section 502(a) of the ERISA Act, except in cases where the insured is a member of a governmental plan, church plan, or a plan not established or maintained by an employer. You may also have the right to an external review through an independent review agency. The second appeal concludes the internal appeals process. If you feel that we did not follow the appeals process as described in this notice, then you may notify the Rhode Island Department of Health's Office of Managed Care Regulation.

To initiate an external appeal, you must file a written request for external review with Delta Dental within 60 calendar days of receipt of the second appeal adverse determination notice. At this level of appeal, neither Delta Dental nor you can add any information to the file that will be sent to the review agency. External appeals are available only in cases where the claim was denied based on a failure to meet our utilization review guidelines. You must pay 50% of the cost of the external review. Delta Dental pays the remaining 50%. You must include with your request a check for $210.00 payable to MAXIMUS, Inc. You will be notified directly by the review agency regarding the outcome of your appeal. If the external review agency overturns Delta Dental's decision, we will reimburse you within 60 days of the notice of overturn for your half of the fee. If the claim continues to be denied, the insured has the right to bring a civil action under Section 502(a) of the ERISA Act, except in cases where the insured is a member of a governmental plan, church plan, or a plan not established or maintained by an employer.

Attachment 5

DELTA DENTAL OF RHODE ISLAND
POLICIES AND PROCEDURES

PAYMENT OF CLAIMS

Policy Title: Complete Claim Standard **Policy Number:** PAY-02RI

Approved by: Joseph A. Nagle **Date Approved:** July 21, 2011

Policy

Delta Dental of Rhode Island (Delta Dental) requires that all claims – whether electronic or paper – must be complete before they can be processed. This policy serves as Delta Dental's definition of what is meant by a "complete claim." Effective October 1, 2011, any claim received on or after this date is considered complete if the following conditions are met:

- Paper claims must be legible and on a current ADA claim form.
- Electronic claims must be in a HIPAA compliant format.
- The subscriber/patient information (name, date of birth and Delta Dental ID number) must be accurate and match Delta Dental's records for the subscriber/patient.
- Treatment must be billed using the appropriate CDT code.
- There must be a date of service for each procedure.
- The providers' charge for each procedure must be noted on the claim.
- The treating dentist and complete address of the treatment location must be indicated on the claim and match the information that Delta Dental has in its records.
- The provider's TIN and individual NPI must match the information that Delta Dental has in its records.
- If Coordination of Benefits is required, the appropriate documentation from the other carrier must be included.
- If the procedure is eligible for clinical review, the appropriate documentation must accompany the claim in accordance with the Utilization Review Guidelines as listed in the Dentist Section of the Delta Dental of Rhode Island website (www.deltadentalri.com).
- If x-rays are submitted, they must be less than 2 years old and of diagnostic quality showing the entire treatment site. They must be mounted, labeled with the patient's name, the date they were taken and if applicable, right or left must be indicated.
- Any treatment notes, narrative or charting submitted with a claim must be legible and contain no abbreviations.
- The payer has no reason to believe that the claim was submitted fraudulently or there is no material misrepresentation.

If the above conditions are not met, a claim is not considered to be a complete claim and is therefore not subject to applicable statutory/regulatory prompt pay provisions.

Prior Versions

PAY-02RI Complete Claim Standard March 7, 2005