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1	As part of its written complaint processing policy, DDRI should establish a clear definition of what constitutes a "withdrawn" complaint as well as a mechanism for the application of a consistent procedure.	• Clearly define what constitutes a withdrawn complaint and establish a consistent process for a "withdrawn" complaint Update written policies QA-01RI, QA-02RI. • File revisions to policies QA-01RI, QA-02RI within 60 days of the final OHIC order to the Department of Health with a copy to the Office of the Health Insurance Commissioner.	1. Verify policies QA-01RI and QA-02RI updated. 2. Verify policy revisions completed within 60 days as stated in DDRI response. 3. Verify revisions submitted to the DOH with a copy to OHIC.
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.	• Document complaints, including anonymous complaints, in an internal Complaint Log. • If the nature of a complaint is serious, conduct an audit of the provider practice and include the patient who made the complaint in the audit sample in an effort to preserve anonymity while fully investigating the complaint. • Track anonymous and individually identified complaints for trend in the Complaint Log. If there is a pattern (two or more similar complaints) noted with any dentist, investigate that dentist or practice.	1. Review Complaint Log for logging of anonymous complaints. 2. Inquire of appropriate staff if any anonymous complaints have been received and then verify they have been logged. 3. Inquire as to whether any complaints about serious matters have been received, and if so, verify that they have been logged. 4. Verify a definition of the term "serious" matters or complaints has been created and documented. 5. Inquire as to whether there have been any patterns (two or more similar complaints) noted with any dentist and confirm whether there has been an investigation of the dentist or whether an investigation is in process. 6. Review a sample of completed investigations to ensure evidence exists that supports DDRI's decision or resolution. 7. For serious complaints resulting in audits, verify that the audit sample selected includes the patient making the complaint by reviewing audit documentation.
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	• As part of the written complaint processing policy, clearly define a process for the consistent processing of anonymous complaints that includes the tracking and	1. Verify policies QA-01RI and QA-02RI have been revised to include a clearly defined process for consistent processing of anonymous complaints which includes tracking and trending procedures, and documentation requirements.

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	provider as well as the documentation of all investigative efforts.	trending of similar complaints against a provider as well as the documentation of all investigative efforts. • If the nature of the complaint is serious, conduct an audit of the provider practice and include the patient who made the complaint in the audit sample in an effort to preserve anonymity while investigating the complaint. • Define the Company's practice with regard to anonymous complaints by revising policies QA-01RI and QA-02RI. • Within 60 days of the final OHIC order file policy revisions with the Department of Health with a copy to the Office of the Health Insurance Commissioner.	2. Determine the revisions are filed with the DOH within 60 days of the response and are copied to OHIC. 3. Review a sample of investigations arising from anonymous complaints to ensure they are properly documented to support DDRI's decision or resolution.
4	DDRI should institute processes to record and act on all complaints, whether written or verbal.	• Educate Customer Service Representatives and all other staff as to the importance of documenting all complaints in the patient's electronic files. • Issue guidelines on what constitutes a complaint as opposed to an inquiry and instruct staff to forward complaints, and a record of their disposition, to the Quality Assurance Coordinator for inclusion in the complaint log. • Monitor the Complaint Log for trends with a special emphasis on looking for areas where processes and/or communications with members and providers can be improved. • Take action on any findings that result from	1. Obtain and review documentation to verify CSR's and other staff have been educated regarding documenting all complaints in patient's electronic files; that guidelines have been issued on complaints vs. inquiries; and that staff have been instructed to forward complaints and disposition to the Quality Assurance Coordinator. 2. Select a sample of CSR's and interview to determine they understand how to determine a complaint vs. an inquiry; how to document complaints; and who to report complaints to within the organization. 3. Discuss with the QA Coordinator the process of including these complaints in the Complaint Log. 4. Review Complaint Log to ensure that it is updated by the QAC periodically, and at the various stages of the complaint process.

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		the monitoring efforts. • Identify areas that may require further training of internal staff, particularly front-line personnel such as Customer Service Representatives. • Implemented a system that has the ability to record and retrieve calls to customer service..	5. Select a sample from the Complaint Log and determine that any action taken, or reason for not taking action, is documented. 6. Verify recording is in place using the voice response system. 7. Review the Complaint Procedure to ensure that it includes, but is not limited to, the following: a. How complaint is received (oral, written, or anonymous). b. Complaint log includes TYPE, PROVIDER, and COMPLAINANT. c. The Complaint Log includes the name of the person investigating the complaint, and the date the complaint was assigned to the investigator. d. The status of the complaint is documented on the Complaint Log on a regular basis. e. The Resolution of the complaint is documented and dated.
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.	• Institute processes to ensure that 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 are in fact investigated. • Identify and research each point of a complaint and maintain a record of the investigations that includes summaries of any verbal/phone conversations pertaining to the complaint as well as documentation of the research regarding the case.	1. Select a sample of complaints for review from the Complaint Log. 2. Verify that each point cited in the complaint is addressed. 3. Determine documented evidence is maintained and is adequate to show that each point has been researched and addressed. 4. Verify that investigation records include summaries of verbal/phone conversations.

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		• Institute a process that thoroughly addresses and responds to every point cited by a complainant, substantiating with documentation (i.e. case notes, attachments, statistics) when applicable.	
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.	• Supplement the current complaint-based system with a formal procedure for identifying cases of substandard dental care as part of the Dental Case Management (DCM) process. The procedure should include referring cases for further action, including counseling and, where appropriate, termination of participating provider status, • Implement a more robust Quality Management Committee function. • Within 90 days of the final OHIC order, amend Quality Assurance Policy (No. QA-02RI) to add an extra level of identification of quality of care issues. Require the dental case management analysts and dental consultants involved in the utilization review/Dental Case Management (DCM) function 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 must be structured in terms of "referrals" of potential quality of care issues, not just internal and external "complaints",	1. Verify that policy QA-02RI has been amended to include: referring cases of substandard dental care to the QA Coordinator for further action, including counseling and, where appropriate, termination of par status; a requirement that all Level 2 & 3 quality of care referrals be reviewed by the Dental Director and brought to the QMC to determine actions; requirement that the QMC will meet at least quarterly, and will formally document its review and action on each quality referral. 2. Examine QMC minutes and documentation to verify meetings are held quarterly, and that reviews and action taken on quality referrals is documented. Obtain a list of quality referrals given to the QMC and determine all have been documented. 3. Verify that revisions to policy QA-3RI include provisions for fraud referrals reviewed by senior management for remedial action after one complaint, not three. Review documentation of referrals to senior management and ensure that referrals were made after one complaint. 4. Select samples of the above types of referrals and complaints and determine compliance with policy.

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		and must provide for a key role by the DCM function in such referrals. • The policy will state that all "Level 2" and "Level 3" Quality of Care Referrals will be reviewed by the Dental Director and placed on the agenda of the Quality Management Committee for review for action, as appropriate. The policy currently provides for formal follow-up and closure on such referrals by the Dental Director, and the amendments to the Policy must further underscore the importance of counseling and potential loss of participation privileges in the range of available options for required remedial action. • The new policy must provide for the Quality Management Committee to 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. • The new policy must refer cases involving fraud to the attention of Senior Management for possible remedial action immediately This improvement, must also be formally reflected as part of the fraud/abuse policy (Policy #QA-3RI).	
7	DDRI should modify its appeals process to accept verbal appeals.	• Modify the appeals policy to state that verbal appeals will be accepted in cases of urgent care matters.	1. Obtain the documented appeals policy to verify it has been modified to state that verbal appeals will be accepted in cases of urgent care matters. Verify that the appeals policy states how verbal appeals will be documented.

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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.	• The 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,. • Denials are communicated using processing policy messages at the procedure code level on the EOB's and CEOB's. • 90 days after the final OHIC report re-examine the processing policy messages related to utilization review decisions to identify any that are confusing or unclear. Rewrite existing policies and create additional policies or messages for those items deemed confusing or unclear. • Seek input from providers via the Provider Advisory Group and from customers prior to finalizing the processing policies. • Where a current processing policy message does not effectively communicate the adverse decision, or where the case is particularly complicated, issue a customized letter to the dentist stating the Dental Consultant's rationale. .	1. Verify that processing policy (PP) revisions have occurred. 2. Determine input was requested and considered from Provider Advisory Group and customers; request documentation evidencing this occurred. 3. Review PP revisions for #60, 168, and 219 which were identified by OHIC and determine that the changes to the PP's were implemented. 4. Determine a new process to provide customized communication, where appropriate, is documented. 5. Determine that the right to appeal is also provided when sending customized communication. 6. Determine that the EOB/CEOB states that a separate customized communication with explanations for denials is being provided.
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.	• Utilize the revised appeal notice entitled ""Your Right to Claim Review." In which a sentence was added that states "Prior to initiating a second level of appeal, you may request to inspect the utilization review file	1. Verify that revised appeal notice "Your Right to Claim Review" has been implemented. Select a sample of appeals since the revision, and determine through documented evidence that the revised appeal notice was provided. 2. Determine old appeal notices have been destroyed and are

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		and add information to the file." • Place the Appeal notice on the Company website and mail a printed version with every EOB and CEOB. . • Include the Appeal notice with any customized communication that goes out to the provider or subscriber regarding an adverse determination.	no longer available for mailing. 3. Determine the revised notice is on the website. 4. Determine whether any appellants have requested to inspect claims files prior to DDRI's decision. Verify inspection by appellants is logged. Verify the following sentences have been added to the appeal notice entitled "Your Right to Claim Review": "Your appeal will be evaluated based on material in the file. If the file is incomplete, an incorrect decision could be reached. It is in your interest to add any information that is relevant to considering the 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.	• Complete a study timely to determine the primary reasons for denials being overturned on appeal. • In cases not adequately supported by standard documentation, 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. • Continue to explore ways to effectively communicate the documentation requirements to providers including continuing to ask for e-mail addresses from participating dentists so that communications with the Rhode Island provider community can be improved and expedited where appropriate.	1. Verify that a study of the primary reasons for claim denials being overturned on appeal has been performed and that DDRI has documented whether changes to the process are needed. 2. Verify whether DDRI has analyzed whether its denial codes on the EOBs/CEOBs are adequately effective in communicating with dentists and patients and documented its conclusions and whether changes to the process are needed.

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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.	• Make every effort to meet the mandated 15 day timeframe including looking at increasing Dental Consultant hours as well as creating workflow efficiencies to increase production. With new work processes and/or added resources it is expected that appeals received on or after October 1, 2011, will be processed within the 15 day turnaround requirement.	1. Obtain a source report of appeals received for testing 2. Select a sample and test for compliance with the 15 day turn around requirement. 3. Verify that management receives a monthly report of appeals activity. Test the report for accuracy. Verify that management has documented a plan of action and resources needed based on review of the report.
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.	• 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 will be issued to the dentist. • Continually revisit and revise processing policy messages to ensure that messages are clear to the member and provider.	1. Procedures covered under audit procedures for recommendation #8. 2. Select a sample of denied claims to ensure they are properly coded under one of the three categories (i.e., benefit reasons, denied or disallowed for additional information, or medical necessity.) 3. Select a sample of disallowed claims and determine if a customized request letter was provided to the provider and member it is was necessary.
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.	• Expand the definition of a complete claim to be more specific. • In accordance with the Prompt Pay Regulations, notify providers of the new definition via a newsletter • Notify the Office of the Health Insurance Commissioner of the new definition and how and when it was communicated to providers. • Revise policy PAY02-RI and file it with the Department of Health with an effective date of October 1, 2011.	1. Verify newsletter sent and contained expanded definition of a complete claim per Prompt Pay Regulations. Verify OHIC has been notified of the new definition and that it has been communicated to providers. 2. Verify DDRI written policy PAY02-RI and filed with the Department of Health.

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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.	• Effective August 1, 2011, issue a revised version of the processing policy for an inadequately filled root canal utilizing the following wording: *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 x-ray showing current endodontic status of the tooth. If root canal treatment 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.*	1. Verify the revised version of the PP has been implemented and the revised wording is utilized on the EOB/CEOB. 2. Select a sample of denials resulting from uncertain endodontic prognosis. Verify that the revised explanation was sent. 3. Test a sample of cases where retreatment was performed by a different dentist and verify that payment was made. 4. Determine that the revised PP is also communicated to the member.
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.	• Modify participating provider policies such that non-consensual "additional" reviews or sanctions resulting from an audit of the provider that supports the need for additional review procedures and that changes the providers ability to have claims processed in a timely fashion to state that the provider will be given advance notice, together with the opportunity to review the audit information and respond prior to the changes taking effect. The policy will also state that in such cases, the requirement for additional review procedures may be a requirement for continued participating status.	1. Verify that DDRI has modified its policy to state that non-consensual "additional" reviews or sanctions that change the provider's ability to have claims processed in a timely fashion will now carry advance notice to the changes taking effect. This applies in cases where audits of a par status dentist resulted in findings that support the need for additional review procedures. In such cases, the requirement for additional review procedures may be a requirement for continued participating status. 2. Select a sample of cases where an additional review was required and determine the advance notice was provided.

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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.	• Enhance the online benefit lookup application for members, providers and accounts. • Upgrade the website to add more information on frequency limitations and deploy web tutorials that describe how to access the information available on the web. • Address utilization review processing policy messages to better communicate the reason for denial. • In instances where a processing policy does not adequately address a reason for an adverse decision, issue a customized letter that is crafted to precisely convey the rationale to the provider and/or member. Examine the Utilization Review processing polices for clarity and specificity and modify when necessary.	1. See audit procedures for recommendation #8. 2. Confirm that the Utilization Review PP's have been reviewed for clarity and specificity as stated in the #16 response. 3. Determine if subscriber/member was notified of the exclusion citing the specific exclusion in the contract. 4. Obtain a walkthrough of enhancements made to DDRI's website. 5. Review web tutorials to ensure they provide adequate instruction on how to access information available on DDRI's website. 6. Identify communications channels in addition to web-based communications to ensure that all accounts, members and providers have access to benefit coverage standards and procedures.
17	DDRI should pay for the crown for the patient for whom DDRI did not provide correct eligibility information (OHIC tracking number 31632).	• Issue an extra contractual, administrative payment for the patient's crown described in this case.	1. Verify the payment was made.
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	• Examine and revise, where appropriate, any processing policies that are deemed to be unclear, particularly those that pertain to adverse determinations as indicated in our response to earlier recommendations. • Include the suggested OHIC language (consult your dentist to determine appropriate treatment options) in relevant processing policies.	1. Confirm the recommended language, "consult your dentist to determine appropriate treatment options" in relevant PP's has been added to EOBs. 2. Select a sample of claim denials and PTR determinations to ensure that updated EOBs and CEOBs were included.

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	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.	• Policies will be updated accordingly to state that patients who use a network dentist and receive substandard care will not be denied covered retreatment in cases where DDRI is unable to obtain repayment from that dentist.	1. Verify relevant policies are updated to state that patients who use a network dentist and receive substandard care will not be denied covered re-treatment in cases where DDRI is unable to obtain repayment from that dentist. 2. Select a sample of claims where re-treatment was performed. Ensure patient benefits were not conditioned on obtaining repayment from the dentist.