Response to HCR 119 of the 2017 Regular Legislative Session

Evaluation of an independent claims review process for dental services provided through the Medicaid managed care program

Louisiana Department of Health

Bureau of Health Services Financing

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LOUISIANA DEPARTMENT OF HEALTH

Contents

Preface

In an effort to continue to improve access and the quality of oral health services, the Louisiana Department of Health (LDH) contracted with Managed Care of North America (MCNA) to provide dental benefits for qualified Medicaid enrollees. MCNA administers all aspects of both the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) dental benefit and adult denture program. The contract was awarded for the period of July 1, 2014, through June 30, 2017, and is currently operating under a two-year extension that will end June 30, 2019.

House Bill No. 492 of the 2017 Regular Session was passed due to a recognized need for an independent, objective process for resolving disputes over Medicaid claims and medical necessity determinations under the managed care program.

Due to the unique aspects of dental benefits administration, LDH took a multifaceted approach to gathering information and engaging stakeholders for this study. A thorough assessment of the agency's policy and procedures, currently being implemented for MCO independent claims review, was used as a foundation.

In addition, because the state of Tennessee has operated a system of independent review for Medicaid dental claims since 2013, online research and contacts made directly to the Department of Commerce and Insurance Oversight Division provided information on the inclusion of dental claims in an independent review process.

Stakeholders from MCNA, the Louisiana Dental Association (LDA), the Louisiana Academy of Pediatric Dentistry, and the School of Dentistry of the Louisiana State University Health Sciences Center at New Orleans were each engaged through a series of contacts to deliver background information, gather additional input, and discuss potential approaches to implementation. A teleconference was also held, inviting all stakeholders to participate in a discussion to find common ground to resolving claims disputes.

This report is being submitted inclusive of background research and all stakeholder feedback relative to its findings and recommendations.

Section 1 – Current MCNA Provider Complaint Processes

A "complaint" in the Louisiana EPSDT dental benefit and adult denture programs is defined as a "verbal or written expression by a provider that indicates dissatisfaction or dispute with MCNA policy, procedure**, claims processing and/or payment**, or any aspect of MCNA functions." Claims categories for provider complaints are as follows:

- Denial or non-payment of claim
- Claims are not paid accurately or at contracted rate
- Claims not being processed in a timely manner
- Difficulty submitting claims online
- Difficulty speaking with claims staff to resolve claims related inquiries
- Claims staff not knowledgeable/helpful/courteous

MCNA currently operates a robust provider complaint process to resolve provider issues, including the following mechanisms:

1.1 Provider Relations

If an issue cannot be resolved by a Provider Hotline Representative, the call will be escalated to the Provider Relations Department. Upon receipt of a complaint, the Provider Relations department will review the issue and forward it to, or solicit the assistance of, the appropriate MCNA department(s). Staff thoroughly investigates each provider complaint using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties, while applying MCNA's written policies and procedures to resolve the complaint within 30 business days from the date received.

1.2 Consolidated Complaints of Multiple Claims

Providers can submit a complaint in writing involving any number of claims that share the same or similar payment or coverage issue regardless of the number of individual patients or claims included in the bundled complaint. Written complaints are processed using the following procedure:

1. The complaint is received by the Provider Relations Department.
2. A Provider Relations Representative documents receipt of the complaint and researches the claim issues.
3. The Provider Relations Representative coordinates with the Claims Reconsideration Unit to reprocess any claims if necessary.
4. The Provider Relations Representative sends the provider a letter stating MCNA's resolution of the complaint.
5. If a trend is identified related to the provider/facility, the Provider Relations Representative contacts the Provider/Facility and conducts training to correct the trend if necessary.
6. If a trend is identified related to MCNA's processing, the PR Provider Relations Representative R shares the information with the claims department for rectification.

1.3 Reconsiderations

Requests for MCNA's reconsideration of a claim may be filed when a claim has been denied for anything other than medical necessity or benefit coverage including, but not limited to, the following examples:

- Timely filing
- Duplicate
- Member and Provider eligibility
- Incorrect fee applied

1.4 Peer-to-Peer Availability

MCNA offers the availability of peer-to-peer consultations with their Dental Director and specialty clinical reviewers. Louisiana-licensed general dentists, pediatric dentists, and specialty dental providers, such as orthodontists and oral surgeons, make all clinical determinations. The peer-to-peer process enables participating providers to discuss cases and clinical issues, including medical necessity denials, with MCNA clinical reviewers. The peer-to-peer process serves as MCNA's informal reconsideration process for adverse determinations.

1.5 Medical-Necessity Denials

Concerns related to medical necessity are not addressed through the complaint system. Those concerns can be submitted through the appeal system. Utilization management uses dental policies, protocols, and industry standard guidelines to render review decisions. Licensed dentists and specialty dentists serve as clinical reviewers for the plan. All clinical requests are reviewed by an MCNA clinical reviewer who is available to discuss any decision rendered with the attending dental provider through the peer-to-peer process.

After a provider has exhausted MCNA's internal complaint process, if the provider is dissatisfied with the resolution they have the right to file a complaint directly with LDH, including any issues or decisions that are not a unique function of MCNA.

Section 2 – Identifying Opportunities for Improvement and Reporting

MCNA's DentalTrac™ has the ability to capture, track, and report the status and resolution of all provider complaints, including all associated documentation, and whether the complaints are received by telephone, in person, or in writing. Provider complaint reports are analyzed by the Quality Improvement Committee (comprised of Executive Management and Directors) to identify any operational issues and implement intervention strategies that may include re-training and re-educating providers on policies and procedures, inter-departmental collaboration to improve internal departmental processes or implementing corrective action plans. MCNA reports the status of all provider complaints and their resolution to LDH.

Section 3 – Comparison of Claims Denial Rates by Plan

In order to effectively understand the need for an independent review process, a review of MCNA claims from State Fiscal Year 2016 was performed. Results are shown in the table below:

Health Plan	Total Denials	Total Claims	% Claims Denied
Managed Care North America Dental	410,818	3,427,326	12%

Comparing denial rates to other plans is challenging due to a lack of published data, but according to the 2011 Government Accountability Report titled Private Health Insurance Data on Application and Coverage Denials, rates on preauthorization and claims denials ranged from 11% to 24%. MCNA falls near the low end of this spectrum at 12% for the year. Rates are found to vary across states, insurers, and are affected by multiple factors such as interpretation of reporting requirements, billing errors, and eligibility issues such as a service being provided before coverage was initiated or after it was terminated.

At the time of publishing for this report, State Fiscal Year 2017 data was not yet available.

Section 4 – Tennessee's Dispute Resolution Model

Tennessee's Department of Commerce and Insurance oversees MCO dispute resolution involving the TennCare Managed Care Companies (MCCs) by administering the provider complaint and independent review process. Because Tennessee includes the Medicaid Dental Benefit Program Manager (DBPM) in the independent review process, the information below is taken into consideration as part of this study.

4.1 Types of claims eligible for Independent Review

- Claims for a TennCare Program service rendered to a TennCare enrollee and:
  - the MCC partially or totally denied or recouped the claim or
  - the MCC failed to respond to the claim by issuing a Remittance Advice within 60 calendar days and the provider requested reconsideration of the denial or recoupment in writing and 30 days have passed since the MCC received the reconsideration request.

4.2 Cost of Independent Review

- The Independent Reviewer fee is $750.00 per Independent Review Request ($450.00 if settled prior to Decision)
- If claims are "aggregated" into one Independent Review Request, there is only one fee of $750.00
- The MCCs pay the Independent Reviewers the fee amount set by the Selection Panel for TennCare Reviewers. However, if the provider loses the Independent Review, the provider is required to reimburse the MCC for the fee.

- If a losing provider does not refund the MCC the fee, the TennCare Oversight Division may prohibit that provider from future participation in the Independent Review process.

4.3 Aggregation of Multiple Claims

If the specific denial reason involves one "common" question of fact or law, claims may be aggregated into one Independent Review request.

4.4 Appealing the Independent Review Decision

Either party may file suit between the MCC and provider, but not the Independent Reviewer, in any court having jurisdiction to review the Reviewer's decision. The suit must be filed within 60 days of the Reviewer's decision.

4.5 Utilization of Independent Review Process by Oral Healthcare Providers

Since 2013, only two dental independent reviews were brought against the Tennessee DBPM, DentaQuest, which occurred in the 4th Quarter of 2014. Both decisions were resolved in favor of the provider and MCC (the Independent Reviewer found that the provider claim should be partially paid by the MCC).

Section 5 – Cost Considerations

Because dental claims are generally not as large as those paid by physical health MCOs, such as inpatient stays and durable medical equipment, considerations regarding a $750 fee are taken into account.

- Reviews can be time consuming and involve a lot of effort in terms of research and analysis of evidence submitted by providers and MCOs.
- Disputes usually involve medical necessity determination issues.
- Aggregation can result in a large number of claims being tied to a single Independent Review.
- An Independent Review process can be a timelier and less expensive alternative to litigation for resolving payment disputes.
- MCOs pay the money up front and if they win, the provider then reimburses them.
- If the decision is "split," the provider has no financial obligation to pay any of the fee. As long as the decision is made in whole or in part in favor of the provider, the MCO must pay.

Section 6 – Conclusion/Recommendations

Based on study findings contained within this report, and input of representatives from MCNA, the Louisiana Dental Association (LDA), the Louisiana Academy of Pediatric Dentistry, and the School of Dentistry of the Louisiana State University Health Sciences Center at New Orleans, LDH offers the following recommendations:

1. MCNA Dental has a robust system in place to resolve provider issues and the lowest percentage of denied claims of all managed care entities contracted with Louisiana Medicaid, but independent review would give providers an alternative to more costly litigation and arbitration.

2. Institute a mandatory requirement to exhaust all DBPM internal provider complaint processes prior to requesting an independent review.

3. An independent review process may not be widely utilized for dental claims, but outcomes could identify any operational issues and initiate intervention strategies and policy changes, thus reducing future need for independent review requests.

4. Although recoupments fall under the definition of adverse determination, fraud cases should not be allowed in Independent Review. Processes already exist under the Special Investigations Unit (SIU) and in connection with the Medicaid Fraud Control Unit (MFCU) and program integrity teams in Louisiana.

5. Measures should be taken to keep costs as low as possible. Options include:
    - Consider contracting with the LSU School of Dentistry for reviews. The knowledge base exists in many specialty areas.
    - Keep the number of reviewers to a minimum.

6. Selection Panel: This panel will be overseen by LDH and comprised of one representative from each Dental Benefit Manager (i.e., MCNA), one provider representative per each Dental Benefit Manager representative, one LSU School of Dentistry representative, and one LDH representative. Responsibilities will include:
    a. Approve dentists to be included in the pool of potential reviewers.
    b. Assign each claim (or bundle of aggregated claims) submitted for independent review to a reviewer selected from the pool.

7. The Reviewer Pool: A group of dentists chosen by the above mentioned selection panel and screened to meet certain criteria who have agreed to the applicable terms for compensation, confidentiality, etc. in order to be utilized as reviewers of dental claims submitted for independent review.
    a. The Reviewer Pool shall consist only of dentists who are LSU School of Dentistry faculty members and shall include:
        i. No dentists who are currently performing compensated services for a Dental Benefit Manager, whether said compensation is paid directly or through a contract with LSU School of Dentistry or other state entity, nor have received any such compensation at any time in the prior 12 months.
        ii. No dentists who have received reimbursement for dental services rendered to Medicaid patients in a private practice setting in the past 60 days. LSU School of Dentistry clinics, including LSU School of Dentistry faculty practice, shall

not be considered a private practice setting for the purposes of determining eligibility to participate in the reviewer pool.

iii. At least one dentist who has completed a Commission on Dental Accreditation (CODA)-approved residency in each of the following specialties: periodontics, endodontics, prosthodontics, and oral and maxillofacial surgery.

iv. At least two dentists who have completed a CODA-approved residency in pediatric dentistry.

b. Dentists in the Reviewer Pool shall not be eligible to submit denied Medicaid claims for independent review.

c. Reviewers shall have the option to decline to review a particular claim if they feel doing so would pose a conflict of interest.

d. Payment of reviewers shall be through a contract with the LSU School of Dentistry, which shall maintain records of payments and decisions and share the same with the Dental Benefit Manager and LDH.

8. Eligibility of claims for independent review: Essentially the same as for the Healthy Louisiana plans.

   a. While recoupments fall under the definition of adverse determination, fraud cases should not be allowed in Independent Review. Processes already exist under the Special Investigations Unit (SIU) and in connection with the Medicaid Fraud Control Unit (MFCU) and program integrity teams in Louisiana. Accordingly, it shall be expressly noted that recoupment in conjunction with program integrity audit authorized by the Office of Inspector General shall not be eligible for independent review.

   b. There shall be a mandatory requirement to exhaust all internal provider appeal/reconsideration processes with the Dental Benefit Manager prior to requesting an independent review.

   c. Denials for prior authorizations are not eligible for independent review.

9. Aggregation of claims: Claims maybe aggregated if the denial involves one common question of fact or law. The reviewer to whom the aggregated claims are assigned by the panel will first determine whether or not claims submitted in aggregate can be reviewed in aggregate and a single determination made that is applicable to all of the claims and will inform the appealing dentist and the Dental Benefit Manager. If the reviewer decides the claims are eligible to be considered in aggregate, he/she will proceed with the review. If the reviewer decides the claims cannot be reviewed in aggregate, he/she will inform the Dental Benefit Manager and the appealing dentist which claims can be aggregated and which claims must be reviewed individually.

   a. If reviewer determines claims cannot be aggregated, the appealing dentist may opt to proceed with review of all, some or none of the claims submitted. There will be one fee for all claims reviewed in aggregate and one fee for each claim reviewed individually. If, after being informed that claims submitted in aggregate cannot be

reviewed in aggregate, the appealing dentist declines to proceed with review of ANY of the claims submitted, the appealing dentist will be liable for payment of a fee not to exceed the regular fee for a single independent review.

b. Claims denied for medical necessity may be aggregated, but the reviewer must find that there is no significant clinical distinction between either the underlying condition, pathology, etc. and the treatment provided in each case to be aggregated.

10. Fee: The final fee shall be determined by rule, but shall fall roughly in the range of $150 minimum to a $400 maximum (i.e., roughly double the average payment per dental visit of $183).

    The fee for conducting an Independent Review shall be paid to the Independent Reviewer by the MCO within 30 calendar days of receipt of a bill for services. If the MCO fails to pay the bill for the Independent Reviewer's services, the reviewer may request payment directly from the department from any funds held by the state that are payable to the MCO.

    A provider shall, within 10 days of the date of the decision of the Independent Reviewer, reimburse a MCO for the fee associated with conducting an Independent Review when the decision of the MCO is upheld. If the provider fails to submit payment for the Independent Review within 10 days from the date of the decision, the MCO may withhold future payments to the provider in an amount equal to the cost of the Independent Review, and the department may prohibit that provider from future participation in the Independent Review process.

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