Department of Health Care Services

Overview of the Medi-Cal Dental Program
Member Support Services Frequently Asked Questions

The following responses to FAQs provide additional clarification to questions asked by participants during the Member Support webinars held on September 9th and 18th of 2019. Questions are responses also include questions that were not answered during either webinar.

Complaint Process

1. Does the patient know the reason why their services were denied? Does the patient receive a TARNOT?

Yes, a Notice of Action (also referred to as a TAR NOT) is sent to the member when procedures on a Treatment Authorization Request (TAR) are denied or modified. If the member has any questions, the member can call the Telephone Service Center (TSC) 1-800-322-6384. If there are provider or member identification issues on the TAR, a TAR NOT is not generated (for example: incorrect patient information or provider information missing). When a claim is denied, no notice is issued to the member; however, the member can contact the TSC to inquire about any claims related to their record or for further clarification.

2. What's a clinical screening?

A clinical screening is an exam conducted by a Delta Screening Licensed California Dentist, in either a dental office or skilled nursing (convalescent) facility, to verify whether requested treatment is needed or if treatment rendered is adequate and is considered a second opinion. No treatment is rendered during the clinical screening exam. A screening report is completed to assist in the determination of a treatment that was requested or rendered.

3. If a member disagrees with the TAR conclusion then the member is asked to complete a new TAR? Not the provider?

No, only the provider can submit a new TAR. Members are not asked to submit TARs. However, the member can request a State Hearing through the Department of Social Services if they disagree with the denial or are unsatisfied with the results of a complaint. Alternatively, they can submit a new complaint to restart the process.

4. What can a patient do if the Dentist office will not perform requested procedures like extractions but instead the Dentist wants the patient to have other procedures that are not covered?

There could be several approaches to this situation. It could be that the member's request is not in the best interest of the member, or the dentist has not assessed the situation accurately, or the provider is not adhering to program requirements. More information would be needed to make a sound assessment. The member can call the Telephone Service Center (TSC) and explain the situation. The TSC can provide additional referrals to the member or the member can request that care coordination connect with the provider to assess the situation. In this case an access to care complaint would be opened on the member's behalf, which does not require a complaint form. The care coordination team would in turn reach out to the provider office, and possibly the member, to request additional information. Once received, care coordination will work with other departments in Delta Dental to properly assess the situation. If the requested extractions are necessary, the Delta Dental team will coordinate a different provider for treatment. If the original provider is not adhering to program's requirements, we will notify the provider accordingly. The member can also contact the Dental Board of California to file a complaint.

5. How do patients access a complaint form if patients do not have Internet access?

Members can call the Telephone Service Center (TSC) and request a complaint form be mailed to them. Additionally, TSC agents can complete the complaint form over the telephone on the member's behalf.

6. If the complaint forms are only available in English, how can a limited English proficiency member complete the form?

The complaint form is available on the Medi-Cal Dental website in the following languages: Arabic, Armenian, Cambodian, Chinese, English, Farsi, Hindi, Hmong, Japanese, Korean, Lao, Punjabi, Russian, Spanish, Tagalog, Thai, and Vietnamese. If a member who speaks a language other than these languages wants to complete the form, they would call the Telephone Service Center (TSC). The TSC agent will connect to Language Line Services and the interpreter would assist with the completion of complaint form.

7. How are complaints handled if a TAR is denied for lack of medical necessity?

The member contacts the Telephone Service Center (TSC) and explains the situation. TSC would then contact our dental policy department to handle the complaint. If a complaint about a TAR denial is received, dental policy will:

- Re-evaluate the TAR for medical necessity, if it originally included documentation about the member's medical need. This may also include a clinical screening or a phone call to the dental provider if additional details are needed.

- Support the denial, if the TAR in question was received without any documentation about a member's specific medical condition that would require special consideration
- If a member informs the TSC agent about a specific medical condition that may allow for the requested procedure, the TSC will inform Delta's dental policy staff to contact the provider to inform him/her to complete a new TAR and resubmit to the attention of the correspondence department. The TAR would receive special handling and get processed through dental policy and if necessary, be reviewed by DHCS's dental consultants for consideration.

8. Does the Department take any action regarding office conduct? Why is this beyond the authority of Delta Dental?

No, the Department does not take any action regarding office conduct. The Dental Board of California is the licensed authority to investigate these matters. Office Conduct complaints relate to a complaint regarding the behavior of non-clinical staff (not a dentist or hygienist) at a dental office: poor attitude, unprofessional approach, and unethical conduct.

9. The 2016-2017 grievance report said there were close to 4,000 complaints, but I imagine the TSC received more than 4,000 calls in the year so how do some calls get filed as complaints and others as general calls?

The Telephone Service Center asks probing questions and, depending on the feedback, determines whether the call is counted as a complaint or a general inquiry.

10. Why is a complaint form only "really necessary" for quality of care issues and not something like improper billing, language access, or discrimination?

A complaint form is only required for unsatisfactory Medi-Cal Dental services that an enrolled Medi-Cal provider has been reimbursed for. It was originally intended to be a signed document to provide authorization to the correspondence department to access PHI. This process is currently being reviewed for simplification. All the other complaints that are submitted are handled by Telephone Service Center agents initially. They document all complaint calls, attempt to locate another dental provider if needed, and forward complaint requests to appropriate departments for follow-up.

11. How many denials trigger the Department to reach out to a provider about their TARs/claims?

The trigger that results in contact with the provider is 60 claims and TARs with a 40% or greater error rate. This is a monthly system generated assessment based on providers' claim and TAR submissions.

12. Will you only send a Title 22 letter (balance billing letter) and corresponding reimbursement packet to a member if they file a formal billing complaint or will you do the same without them filing a formal complaint?

A formal complaint is not required. If a member calls the Telephone Service Center (TSC) and mentions that he/she has paid for covered services, the TSC will offer to send the member a Conlan packet and it will be mailed within five days. A Notice of Improper Billing (Title 22 letter) is mailed to the enrolled Medi-Cal provider that billed the member for procedures that are a benefit of the Medi-Cal Dental Program. The member will also receive a copy of the notice sent to the provider. Additionally, a member can call the TSC at any time and request a Conlan packet. The correspondence department will work with the member to get the packet completed and assist with recoupment. For additional Conlan reimbursement information, please visit the DHCS website.

13. Related to reimbursement, is the reimbursement the member could receive the entire amount billed/paid? Or are they only reimbursed up to the Medi-Cal reimbursement rate? What happens to the balance? Will DHCS work to ensure that the balance is also refunded to the client?

If services were provided by an enrolled Medi-Cal provider, the member will be reimbursed the total amount paid for covered procedure(s). Services that were provided by a non-Medi-Cal provider, due to member retro member eligibility, will be reimbursed the Schedule of Maximum Allowance (SMA) for the covered procedure.

The member is responsible for out-of-pocket expenses for the following:

- Member does not have retro eligibility
- Procedures are not a covered benefit
- Covered procedures did not meet the Manual of Criteria (MOC)
- Member chose to receive services from a non-Medi-Cal provider for non-emergency services

14. What's the difference between Office Conduct and Quality of Service?

Quality of Service: Complaint regarding the quality of service at a dental office, which includes office cleanliness, usage of appropriate safety measures such as wearing gloves, and procedural and technical aspects of care.

Office Conduct: Complaint regarding the behavior of non-clinical staff (not a dentist or hygienist) at a dental office.

15. I hear stories of some providers who are not aware or familiar with the restoration of adult dental benefits in Medi-Cal - would this be included in Scope of Coverage complaint? I assume this wouldn't go to the social services department?

This would not be included as a Scope of Coverage complaint. If a member calls the Telephone Service Center (TSC) about adult related benefits, the TSC agent would provide information about the benefits available. In addition, if the member advises that a dental provider denied services that would normally be available to an adult, the TSC agent will offer the member the option of three or more new referrals, and a warm transfer to a dental office and assist with scheduling an appointment. Additionally, the care

coordination team would reach out to the provider to share information about the availability of adult dental benefits. Information regarding the restoration of adult dental benefits has been broadcasted via provider bulletins, email blasts, provider seminars, outreach events and office visits.

16. Could you clarify how a member should go about resolving a billing issue with their provider? How does and can the TSC assist?

Members are encouraged to work with their dental provider first as many times for fast and real time correction. This also allows the provider an opportunity to fix an issue they are unaware of. If resolution does not occur, the member should call the Telephone Service Center to initiate a complaint. The complaint will be investigated by Delta Dental (Delta). Delta will attempt to work with the provider and member to resolve the billing issue. The member can also write a letter to the correspondence department who will research the complaint and take action to resolve it.

17. Does the TSC provide members assistance with retrieving a ledger, x-rays, arch films, narratives, and medical records for a reimbursement claim?

The Telephone Service Center would triage the call and then forward the case to Delta Dental's correspondence team. They would call the provider and request the necessary records on behalf of the member.

18. Where members do not receive a satisfactory resolution to issues raised with the TSC or otherwise through this process, is there a contact person within DHCS or other place where advocates should escalate cases and issues?

Yes, an email can be sent to Dental@dhcs.ca.gov and the appropriate team will follow up.

19. Who can patients in managed care be referred to?

Patients who are enrolled in a dental managed care plan can obtain their dental plan's telephone number via the Medi-Cal dental website or the DHCS website for assistance.

20. Do the public, or County CHDP or Oral Health Programs have access to how many serious complaints have come in about a local dental provider?

Complaint data about providers is not released publicly. The Dental Board of California will release a serious allegation about a local dental provider after an investigation is complete and action has been taken against the provider (i.e., license revocation or suspension, probation, etc.). Complaint data collected by the Department is published on the DHCS website.

21. Is there a certain number of quality of service complaints that could trigger some other action by DHCS? What if a particular provider received a very large number of quality of service complaints against them in a short time-- would there be any additional evaluation or determination about whether they should even continue as a Medi-Cal Dental provider?

For quality of service complaints, there are many variables that could trigger additional action, such as volume of incidents, severity of incidents, etc. If a provider received a very large number of quality service complaints, additional steps would be taken to review the complaints. After analysis, and often clinical review, Delta Dental would escalate its recommendations to DHCS to determine next steps.

For a high volume of quality of care complaints, the provider may be placed on special claims review or a prior authorization requirement prior to any treatment of members. In addition, and on a case-by-case basis, the Dental Board of California may be notified of the provider's business practice.

22. Regarding balance billing - What steps will the department take in cases where despite the balance billing letter, the provider refuses to take any action? There are many cases in which the provider does not change their course of action despite the letter. Is the Medi-Cal provider fraud unit involved?

If the provider bills the member for covered services, Delta sends the Notice of Improper Billing to the provider advising that the practice is against the law and a copy of the letter is mailed to the member.

The Medi-Cal Fraud unit is not involved in balance billing cases. If the provider does not stop the practice of improper billing, Delta Dental will advise DHCS of the provider's non-compliance with Medi-Cal requirements, state laws and regulations. The DHCS Investigations Division will determine the appropriate action on a case-by-case basis.

Care Coordination and Case Management

23. Would care coordination/case management be available for members that would need to transfer their dental care to a different dental provider in order to access anesthesia services covered by the medical plan (when the dental office does not have a contracted medical or dental anesthesiologist)?

Yes, if a member needs assistance locating a new provider or access to general anesthesia services through the medical plan, the case management unit will facilitate the coordination between the dental and medical providers. The Telephone Service Center care coordination unit can assist members who do not meet case management criteria (mental, physical or behavioral disability). Members who have mental, physical or behavioral disabilities are assisted by the case management unit.

24. Once a case management referral is completed and received, how long does it take for member to be assigned to a case manager, and start CM services and support?

Referrals emailed to the case management email box are received immediately. A case management agent is assigned and begins offering services and support within 24-48 hours, excluding holidays and weekends.

25. Will the TSC help a beneficiary who wants their dentist to fill out a case management referral, such as by calling the dentist to assist them in completing the referral over the phone?

Yes, if the member has qualifying conditions, Telephone Service Center agents contact the case management department who will then contact the provider.

26. Who can provide a referral to case management and care coordination?

Case management: A medical provider, dental provider, medical professional or case worker/social worker can submit a case management referral for members with mental, physical or behavioral disabilities. Members cannot self-refer.

Care coordination: Referrals are not needed for care coordination. Members can access care coordination services by calling the Telephone Service Center and asking for the care coordination unit for assistance with referrals, transportation or language assistance. Also, agents are trained to determine whether care coordination is sufficient or if case management services are required.

27. Case management is available to only patients in FFS?

Yes, Medi-Cal Dental case management is available for only fee-for-service members. However, the dental managed care plans and Medi-Cal managed care plans offer a similar service to their members.

28. How many beneficiaries have received case management services to date?

A total of 104 cases have been received since the implementation of the program in August 2018.

29. How many case managers do you have? What services are they providing (examples please)?

The case management unit is comprised of two staff, which is sufficient to support all existing cases. Staff are trained on handling difficult cases, coordinating healthcare and dental treatment, using language services, coordinating transportation with medical plans, coordinating dental care with multiple providers, coordinating hospital dentistry, and working with severely challenged members.

30. Do those teams coordinate with local regional centers to help members with developmental delay access the limited dental clinics that accommodate them?

Yes. Case management works with Regional Centers throughout the state to assist members with disabilities and locate providers who can accommodate the members' healthcare needs to provide dental treatment.

31. Could advocates submit a case management referral for our clients?

Yes, advocates are considered part of the "case worker/social worker" category and can submit referrals for case management, if they are familiar with the member's medical diagnosis, dental history and dental needs.

32. What constitutes a comprehensive evaluation and treatment plan?

An evaluation by a dental provider, radiographs and treatment plans are beneficial but not required. Members with mental, physical or behavioral disabilities are often unable to withstand dental treatment in a regular dental office. A dental provider's evaluation of the patient allows case management to locate the correct type of provider and reduce unnecessary appointments that not only prolong dental care but are also difficult for members.

33. Is one way around having a provider complete a case management referral, to have the beneficiary call the TSC with a complex need that the TSC cannot resolve on its own?

No, a case management referral is required. If a member or member representative contacts the Telephone Service Center (TSC) and their dental needs surpass the scope of care coordination, the member or member representative will be directed to contact their dental provider to submit the referral form. The TSC agent can also provide a warm call to the member's dental office to direct them to the referral form on the Medi-Cal Dental website. If the provider refuses to submit the form, the TSC agent can fill out the form while the provider is on the phone or route the information to case management who will follow-up with the dental office to obtain the correct information for the referral.

Language Assistance Services

34. How can a provider assure that the language line will be available while the patient is in the office for their appointment?

Delta Dental's contract with Language Line Services requires that services be available Monday through Friday, 8:00 a.m. - 5:00 p.m., with wait times of two minutes or less. The Telephone Service Center has a dedicated provider number (800-423-0507), which a provider can call and request interpreter services from Language Line Services.

35. Does TSC offer ASL interpreting?

Yes, the member or provider can call the Telephone Service Center and set up an appointment for an American Sign Language translator to be present at the time of appointment. Please call 800-735-2922 for Teletext Typewriter assistance and have the operator call the toll-free member line at 800-322-6384.

36. Is in-person (face-to-face) interpreter services available? If so, how is this coordinated?

Face to face interpreter services is available for American Sign Language only. The Telephone Service Center (TSC) coordinates appointments with the dental provider and sign language services. For all other language requests, TSC coordinates with interpretive services over the telephone.

37. How does DHCS arrange for verbal translations if interpreters are used by Language Line - do they have access to the document/letter?

If Delta has access to the letter, Delta will read the document to the translator for real time translation. If the document is from an outside agency the member/representative would have to fax, email or USPS to Delta Dental. Once the Telephone Service Center receives the document, the member is called for translation over the telephone with the translator from Language Line Services.

38. Is it cost prohibitive to pre-schedule interpreters due to last minute cancellation? Do you have data collected (since you said it is high) on how many members, including those who need interpreters, cancel last minute or do not show up? In your outreach materials and handbook etc. to inform members about language services - are these outreach materials, handbook etc. written in the language of the member? Also are your agents trained to properly work with interpreters and limited English speaking members - there is an optimal way to do this? And finally, how do you gauge the quality and skill of the interpreters?

Yes, it is cost prohibitive to pre-schedule interpreters due to the possibility of patients missing their appointments. DHCS pays for language interpretive services and there is a charge for last minute cancellations and missed appointments. Since we do not schedule interpreters in advance, we do not have data regarding patients who cancel at the last minute or do not show for their appointment. Outreach materials such as flyers/brochures and the member handbook are available in 16 threshold languages and English. The outreach materials are available on the Medi-Cal Dental and Smile, California websites. Telephone Service Center (TSC) agents are all trained how to work with language interpretive services. Members are able to provide feedback directly to TSC as a language access complaint or can offer feedback directly to DHCS at Dental@dhcs.ca.gov. TSC agents can assist members with providing feedback to LLS. Delta Dental collects data related to missed appointments, but not specifically related to interpreter services. LLS has their own internal testing and certification process for their interpreters. Testing and training ensures staff communicates effectively and that they meet the qualifications and skills required of bilingual and interpreter staff. LLS documents their qualifications for proof of compliance with State laws and regulations.

Personal Health Information (PHI) Requests

39. Will the member always need to be on the phone with the AR?

DHCS is currently in the process of refining its AR process to better align with Health Insurance Portability and Accountability Act of 1996 requirements and Federal and State regulations. DHCS will share the AR process information as soon as it is available.

41. Will they be noted on the member's file?

The tracking of the Authorized Representative (AR) is done in a database. The Telephone Service Center agent will refer to the database to determine authority, if the member is not on the phone with the AR.