2021

Periodic Audit

Report

Argus Dental Plan

December 2021

HealthyKids™

Qsource

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List of Tables

Acknowledgements, Acronyms, and Initialisms[1]

AHCA ..... Agency for Healthcare Administration
AON ..... Area of Noncompliance
CDT..... Code on Dental Procedures and Nomenclature
CEO ..... Chief Executive Officer
CFR..... *Code of Federal Regulations*
CHIP..... Children's Health Insurance Program
COO..... Chief Operating Officer
CY ..... Calendar Year
DBM ..... Dental Benefit Manager
DSC..... Dental Services Contract
EQRO..... External Quality Review Organization
FHKC ..... Florida Healthy Kids Corporation
FDR..... Fraud Detection and Recovery / First Tier and Downstream Related
MCO..... Managed Care Organization

[1] *Other company and product names may be trademarks of the respective companies with which they are associated. The mention of such companies and product names is with due recognition and without intent to misappropriate such names or marks.*

MPI.....Medicaid Program Integrity
OIG.....Office of Inspector General
P&P..... Policy and Procedure
PAHP ..... Prepaid Ambulatory Health Plan
PIHP.....Prepaid Inpatient Health Plan
Qsource®..... a registered trademark
SAM ..... System for Award Management
SIU ..... Special Investigations Unit
SQL..... Structured Query Language

Executive Summary

Background

Pursuant to Title 42 of the *Code of Federal Regulations*, Section 438.602(e) [42 CFR § 438.602(e)], as incorporated by 42 CFR § 457.1285, Florida Healthy Kids Corporation (FHKC) "must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each MCO, PIHP or PAHP." Dental benefit managers (DBMs) are considered Prepaid Ambulatory Health Plans (PAHPs); therefore, this audit is required for them.

FHKC contracted with Qsource, an external quality review organization (EQRO), to conduct this 2021 Periodic Audit to assess the accuracy, truthfulness, and completeness of data submitted by the DBMs in calendar year (CY) 2020. This *2021 Periodic Audit Report* presents findings from an audit of claims adjudicated by Argus Dental Plan (hereafter referred to as Argus) in CY 2020. As all DBM provider financial arrangements are fee-for-service, Argus has no encounter data to report. This report also includes an assessment of compliance with federal and contractual program integrity requirements.

Methodology

Qsource obtained monthly eligibility data for Florida Healthy Kids enrollees for CY 2020 from FHKC's enrollment broker. Quarterly claim data were submitted by the DBM. In addition, Argus provided detailed provider data, including all providers for whom claims were adjudicated in CY 2020. Qsource compiled, integrated, and analyzed these data to establish the completeness and accuracy of claim data submitted by Argus:

- Completeness and Accuracy of Key Claim Data Fields Submitted
- Accuracy of Benefit Application
    - Duplicated Payments

- Eligibility on Date of Service
- Benefit Scope and Benefit Limitations
- Service Limitations

Based on the Centers for Medicare & Medicaid Services (CMS) *Protocol 5: Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan* (2019) recommendation regarding acceptable rates of accuracy and completeness, a targeted error rate below 5% was applied for completeness and accuracy analysis. As data submitted by the DBM might have deviated from the data submission guidelines and instructions, results included in this report could be different than actual DBM claim adjudication results. Therefore, a potential error rate, rather than a definitive error rate, has been identified for each analysis category.

For truthfulness of data submitted, Qsource conducted a comprehensive assessment of the DBM's compliance with federal (42 CFR § 438.608, as incorporated by 42 CFR § 457.1285) and contractual (Dental Services Contract) program integrity requirements and evidence of adequate program integrity processes in operational practice during CY 2020. To facilitate comparison across DBMs, the level of the DBM's compliance with program integrity requirements was determined according to criteria based on relative strengths and weaknesses and the extent to which they impacted the DBM's compliance with program integrity requirements.

Results, Conclusions, and Recommendations

Results

Results of the 2021 Periodic Audit demonstrated that Argus' key claim data fields were highly complete and accurate, all exceeding 99%.

For accuracy of benefit application, the number of duplicate claims submitted was minimal (1,787). The majority were denied appropriately, resulting in a low potential error rate of 1.7%. Paid duplicates accounted for a negligible percentage of total claims (0.1%). For eligibility of the enrollee on the date of service, very few claims for services when the enrollee was not eligible were submitted (183). However, the majority of the claims had a header claim line status of paid, resulting in a potential error rate of 95.1%. These paid claims accounted for a negligible percentage of total claims submitted (0.4%).

For services within benefit scope and benefit limitations paid, of the 26 applicable service categories for which benefits would typically be paid, 11 service categories (42.3%) demonstrated potential error rates over the acceptable 5% rate. For 9 categories, less than 100 services were reported and were not included in analyses. Denied claims for these services in comparison to total claims ranged from 0% to 2.5% across all categories. Factors potentially impacting these results, but not considered in this analysis, are claims with a claim line status of "D" with a positive amount paid, and the lack of tooth number and tooth surface in the current data submission layout and appropriate denial of services based on utilization review.

For services over benefit limitations paid, potential error rates were high for all four service categories. The impact of small numbers of applicable claims contributed to the high rates. In addition, for bitewing X-rays, the data submitted did not include tooth surface, which may have inflated the potential error rate. Services over limitations paid accounted for a negligible percentage of total claims, ranging from 0.3% to 0.4%.

The truthfulness assessment was based on an evaluation of compliance with program integrity regulatory and contractual requirements. Argus' overall score on the program integrity standard was 64.4%. For this assessment, two strengths were identified, related to comprehensive documentation of education and training programs for program integrity and disclosure requirements. In addition, four suggestions and 10 areas of noncompliance (AONs) were identified. The majority of suggestions and AONs were related to incomplete information included in Argus' policies and procedures (P&Ps) addressing requirements for notifying FHKC of various program integrity requirements.

Conclusions

Based on these analyses, Qsource concludes that Argus' data submission for key claim data fields enabled a confident determination that the data for these fields were highly complete and accurate. Determinations of accurate claim payments and potential error rates for duplicated payments, eligibility on date of service, benefit scope and benefit limitations, and service limitations are made with less confidence, resulting from aberrations in data submitted by Argus. However, potential errors in claim processing accuracy accounted for a negligible percentage of total claims submitted. For the truthfulness assessment, Qsource concludes that while most requirements were validated as reflected in the DBM's operational practice, updates to P&Ps and other related documents are needed to ensure appropriate documentation of requirements.

Recommendations

Qsource recommends that the DBM audit a sample of claims detail for services for which the potential error rate was above the acceptable rate of 5% to attempt to determine the cause of the results. Argus should also address the issues of claims for which the claim detail status is "D" but the amount paid is positive, and claims where line item number rows do not occur in sequential order. Also, Qsource recommends that Argus address all suggestions and AONs identified in the program integrity analysis by updating appropriate documentation. Qsource suggests FHKC consideration of the addition of tooth surface and tooth number to the claim submission data layout to allow for more accurate and complete data analysis. Qsource also suggests that FHKC provide additional clarification on the claim versioning methodology for adjustments to ensure consistency in reporting among DBMs.

Background

As administrator of the Florida Healthy Kids program, FHKC contracted with Qsource to perform federally required activities, including this Periodic Audit. Qsource meets the federal qualifications for EQROs set forth in 42 CFR § 438.354. Qsource conducted the Periodic Audit per 42 CFR § 438.602(e), as incorporated by 42 CFR § 457.1285, which requires that FHKC periodically conduct, or contract for the conduct of, an independent audit of financial data accuracy, truthfulness, and completeness for each DBM. The Periodic Audit must be conducted at least every three years.

For this audit, Qsource assessed the completeness and accuracy of claim data adjudicated by the DBM in CY 2020. Truthfulness of data was assessed through an audit of how the DBM complies with federal and contractual standards for program integrity, along with a detailed analysis of how program integrity requirements were implemented in operational practice in CY 2020.

Methodology

Completeness and Accuracy of Claim Data

Qsource obtained monthly eligibility data for CY 2020 from the FHKC enrollment broker. Claim data adjudicated in CY 2020 were provided quarterly by the DBM in the standard FHKC claim data layout, as included in Appendix A. Argus was provided specific instructions on how to report claims, including the use of versioning to consistently report adjustments. Qsource also secured detailed provider data from the DBM, including all participating and nonparticipating providers for whom claims were adjudicated in CY 2020.

Qsource used SQL [Structured Query Language] Server Management Studio to manage claim data and determine frequencies and rates in dental services data on specific fields or variables created explicitly for data validation to indicate potential concerns.

Completeness and Accuracy of Key Data Fields

Analyzing DBM-submitted claim data, Qsource conducted basic integrity checks to determine if key data existed, if they met expectations, and if they were of sufficient basic quality. Having no data present in one of these fields counted as an incomplete record. Within completed fields, Qsource examined data for accuracy as determined by specified accuracy checks described below. Accuracy checks reveal overall data quality issues, such as an inability to process or retain certain fields, coding limitations, or data submission issues. Qsource applied completeness and accuracy checks to claim data, verifying that key data fields contained non-missing values in the correct format and specificity, within required ranges. In addition, Qsource applied a targeted potential error rate below 5% for completeness and accuracy analysis, based on CMS EQR Protocol 5.

The validation techniques employed for analyses addressed field-specific questions:

1. Are the data available? All required data elements should be reported, and data should exist for all service types with no gaps.
2. Are the data of the type requested? Data should be of the correct type and size in relation to the data dictionary; e.g., Code on Dental Procedures and Nomenclature (CDT) procedure codes should begin with a "D" followed by four digits.
3. Compared to an external standard, are the values in the field valid and in the correct format? Values in the procedure field, for example, should be current and valid CDT codes.
4. Are FHKC's enrollee identification numbers (IDs) accurately incorporated into the DBM's information system? The appropriate enrollee ID should be the unique 10-digit FHKC enrollee number.

Accuracy of Benefit Application

The premise of this analysis holds that if the DBM accurately and completely reports claim data in the format required and according to instructions provided, accuracy of benefit application can be approximated through integration and analysis of the data files. For the accuracy of benefit application analysis, Qsource assessed the following:

- Duplicated Payments – Qsource analyzed claims data to determine the extent to which any duplicates of prior payments were paid.
- Eligibility on Date of Service – Qsource used monthly eligibility files to identify services for which enrollees were ineligible due to non-enrollment. Results were determined based on the number of services paid for which the enrollee was not eligible for benefits at the time of service.
- Benefit Scope and Benefit Limitations – Using the benefit plan for the Florida Healthy Kids program, Qsource analyzed select benefits (those that can be accurately analyzed for one calendar year of claims) for services not paid that were within the benefit scope and benefit limitations. Results were based on the number of services within the benefit scope not paid versus the total number of services reported.
- Service Limitations – Using defined benefit limitations, Qsource analyzed select benefits (those that can be accurately analyzed for one calendar year of claims) for services over limitations that were paid. Results were based on the total services over limitations that were paid versus the total services exceeding the limitation threshold.

The analysis of benefit application is based on the assumption that the DBM adhered to specific data submission guidelines and instructions when submitting claim data. However, aberrations in DBM data submission may have resulted in differences between results included in this report based on DBM-provided data and actual claim adjudication results. Due to possible deviations in the DBM's data submission, results should be interpreted with caution. As a result, Qsource has identified for each analysis category the potential error rate rather than a definitive error rate.

Truthfulness of Claim Data

Qsource conducted an analysis of program integrity to establish a level of truthfulness of claim data provided by the DBM. For this assessment, Qsource reviewed documentation submitted by Argus to demonstrate compliance with federal requirements, as codified in 42 CFR § 438.608 and incorporated by 42 CFR § 457.1285, and contractual program integrity requirements as set out in the Dental Services Contract with FHKC. In addition, Qsource conducted a virtual review, interviewing key DBM staff relative to program integrity standards to facilitate analyses and compilation of findings. Each requirement (element) was evaluated, indicating strengths, AONs, and suggestions that would strengthen compliance. The documentation review and virtual review findings were documented in a Program Integrity standard tool, developed to assess compliance with each relevant CFR and Dental Services Contract provision related to the Program Integrity standard. The tool included each requirement as a standard element, each of which was evaluated as Met or Not Met, as well as identified strengths, AONs, and suggestions where applicable. Each element was assigned a compliance score, and an overall percentage score was calculated for the entire Program Integrity standard based on the number of elements compliant out of all elements assessed. This score was used to determine the DBM's level of Program Integrity compliance, as shown in **Table 1**. Detailed results of the documentation and virtual reviews for Argus are included in the completed Program Integrity tool in Appendix B.

Table 1. Program Integrity Compliance Criteria

Level of Compliance	Criteria
High	90–100% compliance score for program integrity review
Moderate	80–89.9% compliance score for program integrity review
Low	70–79.9% compliance score for program integrity review

Qsource also requested evidence of program integrity processes applied in operational practice in CY 2020. The following documentation was obtained from the DBM and reviewed by Qsource:

1. Prospective claims system edits to prevent fraud, waste, and abuse
2. Retrospective processes for screening claims data for fraud, waste, and abuse
    a. Standard reporting and screening processes
    b. Specific investigation processes
    c. Sample screening reports
3. Follow-up on identified fraud, waste, and abuse processes
    a. Standard follow-up processes
    b. Sample report of follow-up activity results
4. Processes for flagging federally and state excluded providers for nonpayment

Results

Completeness and Accuracy of Key Data Fields

Table 2 displays completeness and accuracy rates for key claim data fields for Argus. The acceptable potential error rate is considered to be 5%, so any value less than 95% is presented in bold red text.

Table 2. Completeness and Accuracy Rates—Claim Lines Submitted by Argus

Field	Present	Completeness Rate	Accurate	Accuracy Rate*
	N=257,418			
Member Identification (ID)	257,418	100%	257,418	100%
Plan ID	257,418	100%	257,418	100%
Claim Reference Number	257,418	100%	257,418	100%
Billing Date	257,418	100%	257,160	99.90%
Claim Paid Date	257,418	100%	257,418	100%
Procedure Code	257,418	100%	257,012	99.84%
First Date of Service	257,418	100%	257,418	100%
Financial Report Service Category	257,418	100%	257,418	100%
Treating Provider Type	257,418	100%	257,418	100%
Treating Provider National Provider Identifier (NPI)	257,413	100%†	257,332	99.97%
Treating Provider Medicaid ID	257,418	100%	257,418	100%
Treating Provider Specialty Code	257,418	100%	257,418	100%
Billing Provider Type	257,418	100%	257,418	100%
Billing Provider NPI	256,438	99.62%	256,438	100%
Billing Provider Medicaid ID	256,438	99.62%	256,438	100%
Billing Provider Specialty Code	257,418	100%	257,418	100%
Place of Service	255,207	99.14%	255,111	99.96%

** Accuracy rates are those deemed accurate of records determined complete.*
† This figure was rounded to 100%.

All completeness and accuracy rates for key claim data fields were over 99%.

Accuracy of Benefit Application

As noted in the methodology description, the error rate for results of the accuracy of benefit application analysis is not definitive due to possible aberrations in DBM data submission that may have caused the results included in this report to be different than the DBM's actual adjudication results. The potential error rate rationale applies to **tables** 3, 4, 5, and 6. The acceptable potential error rate is considered to be 5%, so any potential error rate above 5% is presented in bold red text.

Table 3 displays total duplicate claims reported, total duplicate claims paid, potential error rate, and paid duplicates as a percentage of total claims for Argus, where the potential error rate indicates the percentage of duplicate claims reported that were paid according to the data submitted by the DBM.

Table 3. Duplicated Payment	
Duplicate Claims Reported	1,787
Total Duplicate Claims Paid	31
Potential Error Rate	1.73%
Paid Duplicates as % of Total Claims	**0.07%**

A relatively small number of duplicate claims were identified (1,787) with the majority of these coded as denied. This resulted in a very small potential error rate of 1.7%, within the acceptable 5% standard. In addition, these paid duplicate claims accounted for only 0.1% of total claims submitted.

Table 4 displays services for which enrollees were not eligible on the date of service, total number of these service paid, potential error rate, and ineligible services paid as a percentage of total claims for Argus.

Table 4. Eligibility on Date of Service	
Total Services for Which Enrollee Not Eligible on Date of Service	183
Ineligible Services Paid	174
Potential Error Rate	**95.08%**
Paid Ineligible Services as % of Total Claims	**0.38%**

Eligibility on the date of service was established by linking enrollee ID numbers in monthly enrollment files to dates of service in claim data submitted. Claims for services were validated as eligible for coverage based on the service date on the claim and the presence of an enrollment record for the associated month of service. Only 183 claims were submitted for ineligible dates of service. Of these, 174 indicated a paid status. This resulted in a very high potential error rate, 95.1%. However, these claims were insignificant when compared to total claims submitted, representing only 0.4%.

Table 5 displays total services within the Florida Healthy Kids benefit scope, total number of these services not paid, potential error rate, and services within benefit scope and benefit limitations that were not paid as a percentage of total claims for Argus. Due to the potential for misleading percentages as a result of small numbers, service categories with less than 100 services reported were excluded from the analyses.

Table 5. Services within Benefit Scope and Benefit Limitations by Service Category				
Service Category	**Services Within Benefit Scope and Benefit Limitations Reported***	**Services Within Benefit Scope and Benefit Limitations Not Paid**	**Potential Error Rate**	**Services Within Benefit Scope and Benefit Limitations Not Paid as % of Total Claims**
Pre-Diagnostic Services	267	2	0.75%	**0%**
Cleaning/Prophylaxis	22,778	483	2.12%	**1.04%**
Topical Fluoride Application	22,088	471	2.13%	**1.02%**
Sealants	18,659	1,143	**6.13%**	**2.47%**
Space Maintainers	550	82	**14.91%**	**0.18%**
Initial Oral Exam	6,044	924	**15.29%**	**2.00%**
Periodic Oral Exam	16,894	361	2.14%	**0.78%**
Emergency Exam	2,622	82	3.13%	**0.18%**
Intraoral Periapical X-Rays	34,944	1,093	3.13%	**2.36%**
Bitewing X-Rays	19,379	453	2.34%	**0.98%**
Complete Set of X-Rays	952	28	2.94%	**0.06%**
Panoramic X-Rays	5,326	204	3.83%	**0.44%**
Amalgam Restoration (silver fillings)	455	11	2.42%	**0.02%**
Composite/Resin Restorations (white fillings)	12,257	749	**6.11%**	**1.62%**
Prefabricated Stainless Steel Crowns	2,030	70	3.45%	**0.15%**
Crowns	209	27	**12.92%**	**0.06%**
Routine Extractions	5,152	229	4.44%	**0.49%**
Biopsies	*	*	*	*
Surgical Treatment of Diseases	105	13	**12.38%**	**0.03%**
Root Canal Therapy on Primary and Permanent Teeth	179	32	**17.88%**	**0.07%**
Apicoectomy, Surgery Involving the Root Surface	*	*	*	*
Gingival Curetage, Including Local Anesthesia	*	*	*	*
Gingival Flap Procedure	*	*	*	*
Scaling and Root Planing	204	22	**10.78%**	**0.05%**
Gingivectomy	*	*	*	*

Table 5. Services within Benefit Scope and Benefit Limitations by Service Category				
Service Category	**Services Within Benefit Scope and Benefit Limitations Reported***	**Services Within Benefit Scope and Benefit Limitations Not Paid**	**Potential Error Rate**	**Services Within Benefit Scope and Benefit Limitations Not Paid as % of Total Claims**
Upper, Lower, or Complete Set of Dentures	*	*	*	*
Partial Dentures	*	*	*	*
Repairs, Relines, and Adjustment of Dentures	*	*	*	*
Orthodontic Services (braces)	2,873	187	**6.51%**	**0.40%**
Analgesia	4,156	198	4.76%	**0.43%**
Sedation – Intravenous Administration of Drugs	183	7	3.83%	**0.02%**
Sedation Non-Intravenous Administration of Drugs	199	0	0%	**0%**
General Anesthesia	699	36	**5.15%**	**0.08%**
Palliative Treatment	*	*	*	*
Professional Hospital Visit	132	17	**12.88%**	**0.04%**

** Less than 100 services reported*

For 9 of the 35 service categories, less than 100 services were reported and were not included in the analysis. Of the remaining 26 applicable service categories for which benefits would typically be paid, 11 services (42.3%) demonstrated potential error rates over the acceptable 5% rate. Denied claims for these services in comparison to total claims submitted ranged from 0% to 2.5% across the 26 categories. A factor impacting these results was the presence of claims coded as denied with a positive amount paid. Also potentially impacting these results, but not considered in this analysis, is appropriate denial of services based on utilization review. Last, the lack of tooth number and tooth surface in the data submissions could overstate denial rates for services for which these data fields are required for accurate claim processing.

Table 6 displays total services over limitation reported, total number of these services that were paid, potential error rate, and services over limitation that were paid as a percentage of total claims for Argus. Due to the potential for misleading percentages as a result of small numbers, service categories with less than 100 services reported were excluded from the analyses.

Table 6. Services Over Limitation by Service Category				
Service Category	**Services Over Limitation Reported**	**Services Over Limitation Paid**	**Potential Error Rate**	**Services Over Limitation Paid as % of Total Claims**
Topical Fluoride Application – One Every Six Months	202	144	**71.29%**	**0.31%**
Cleaning/Prophylaxis – One Every Six Months	170	120	**70.59%**	**0.26%**
Regular Oral Exams – One Every Six Months	305	129	**42.30%**	**0.28%**
Bitewing X-Rays – One Every Six Months	242	169	**69.83%**	**0.36%**

Potential error rates were above the acceptable 5% rate for all four service categories analyzed. Because service levels are low for all four categories, potential error rates appear high. However, each of these paid service categories accounted for less than approximately 0.4% of all total claims. The bitewing X-rays potential error rate may be overstated as there are a number of codes for bitewing X-rays based on the number of images taken. If these images are based on tooth surface, which is not included in the current claims data layout, a number of them may have been paid correctly.

Summary of Data Submission Issues Observed

In completing this analysis, the following issues were identified in Argus' claims data submissions:

- Claim Line Status is "D" with a positive amount paid.
- Certain line item number rows are missing (do not occur in sequential order).

Truthfulness of Claim Data

During the review, Qsource surveyors used the tools in Appendix B—along with personal observations and interviews with DBM staff—to facilitate analyses and compilation of findings. The results include identified performance strengths, suggestions, and AONs (Table 8).

Table 7 includes Argus' performance on the Program Integrity standard tool (review of regulatory and contractual compliance) as detailed in Appendix B. A score of 100% on an element indicates that the DBM fully met the criteria and, therefore, is in full compliance

Table 7. 2020 Program Integrity Compliance Standard Score	
Argus	64.4%

For Argus, 10 criteria were not documented across the 12 elements in the evaluation tool, resulting in an overall score of 64.4%.

Strengths, Suggestions, and Areas of Noncompliance (AONs)

Strengths indicate that the DBM demonstrated particular proficiency on a given element and can be identified regardless of compliance score; the lack of an identified strength should not be interpreted as a shortcoming on the part of the DBM. Suggestions are recommendations that are not required to meet compliance, but include possible improvements to P&Ps or processes for the DBM to consider regardless of score. AONs are identified where the DBM achieved less than 100% compliance and reflect what the DBM should do to improve performance. **Table 8** summarizes the strengths, suggestions, and AONs for Argus.

Table 8. Strengths, Suggestions, and Areas of Noncompliance

Strengths	
Element 1: Fraud, Waste, and Abuse Procedure Components – 1	Policy and Procedure (P&P) #CP_03 included a very comprehensive description of the education and training programs of the DBM.
Element 12: Disclosures	P&P #CP_15 included a comprehensive and detailed description of disclosure requirements.
Suggestions	
Element 1: Fraud, Waste, and Abuse Procedure Components – 1	The dental benefit manager (DBM) could update P&P #CP_01 to include specific references to 42 CFR 438.608, 42 CFR 4559(a)(2), and Section 409.814, Florida Statutes.
Element 3: Fraud, Waste, and Abuse Procedure Components – 3	The DBM could document in a P&P the requirement to notify Florida Healthy Kids Corporation (FHKC) of changes in provider circumstances that may affect eligibility to participate in the network.
Element 7: Fraud, Waste, and Abuse Procedure Components – 7	The DBM could update the Compliance Program to specifically state that reports of fraud to FHKC would be adequately investigated and followed up on.
Element 9: Fraud, Waste, and Abuse Procedure Components – 9	The DBM could update P&P #CP_10 to note the *Deficit Reduction Act* of 2005.
AONs	
Element 1: Fraud, Waste, and Abuse Procedure Components – 1	1. The DBM should update P&P #CP_01 to address compliance with standards under the contract. 2. The DBM should ensure and document that the Compliance Officer reports to the Chief Executive Officer. 3. The DBM should update P&P# CP_02 to include compliance with contractual requirements.
Element 3: Fraud, Waste, and Abuse Procedure Components – 3	The DBM should update the appropriate P&P to include notification to FHKC of changes in enrollee circumstances that may affect eligibility.

Table 8. Strengths, Suggestions, and Areas of Noncompliance	
Element 5: Fraud, Waste, and Abuse Procedure Components – 5	The DBM should update the Compliance Program to include the requirement to provide access to FHKC to monitor fraud and abuse prevention activities.
Element 6: Fraud, Waste, and Abuse Procedure Components – 6	The DBM should update P&P #CP_07 to include reporting information on fraud or potential fraud to FHKC.
Element 8: Fraud, Waste, and Abuse Procedure Components – 8	The DBM should update the Compliance Program to address cooperation in any investigation by FHKC or state or federal entities and any subsequent legal action.
Element 12: Disclosures	The DBM should document the requirement to report to FHKC within 60 calendar days when it has identified capitation payments or other payments in excess of amounts specified in the contract.
Element 13: Treatment of Recoveries	1. The DBM should update the Provider Agreement to include that the provider must provide a reason for an overpayment when reporting an overpayment to the DBM. 2. The DBM should update the appropriate P&P to include annual reporting of recoveries of overpayments to FHKC.

Review of Argus' compliance documentation resulted in two strengths related to the DBM's comprehensive P&Ps dealing with compliance education and training and disclosure requirements. Ten AONs were identified in Argus' compliance documentation. Three of these were related specifically to ensuring that aspects of the compliance program comply with FHKC contract requirements (in addition to regulatory requirements). Five AONs were related to notification to FHKC of potential or actual fraud, waste, and abuse information and providing access to FHKC to monitor DBM fraud and abuse prevention activities. The remaining two AONs related to addressing cooperation in fraud, waste, or abuse investigations by FHKC or state or federal entities and updating the Provider Agreement to require providers to report the reasons for overpayments. Four suggestions were identified for Argus. Two suggestions related to adding regulatory citations to support P&P documentation. While the DBM demonstrated compliance in operational practice, the remaining two suggestions involved documenting that changes in provider circumstances are communicated to FHKC and that the reports of fraud are adequately investigated and followed-up on.

Further assessment of program integrity processes in the DBM's operational practice is presented in **tables 9**, 10, 11, and 12.

Table 9. Prospective Claim System Edits
No documentation of prospective claim system edits was provided.

While prospective claims edits were evident in the claim system, documentation of these edits was not provided by the DBM.

Table 10. Retrospective Processes for Claim Screening	
Standard Reporting and Screening Processes	Policy and Procedure (P&P) #CP_06: Routine Monitoring, Auditing, and Identification of Compliance Risks described review of claim payments for potential fraud, waste, and abuse activity including provider profiling and monitoring of contracted and non-contracted providers in general.
Specific Investigation Processes	P&P #CP_06 addressed claims payment review for demonstrated patterns of falsified claims, encounters, or service reports; overstated reports or up-coding levels of services; altered, falsified, or destroyed clinical documentation; misrepresentation of clinical information to justify patient referrals; failure to provider medically necessary services; charging patients for covered services; and billing for services not rendered. It also included the process by which data analysis was used to prevent and detect fraud, waste, and abuse.
Sample Screening Reports	A claims documentation assessment detail report for Code on Dental Procedures and Nomenclature code D9920 was provided, along with criteria for documentation review.

Argus provided documentation of standard reporting and screening processes for identifying potential fraud, waste, and abuse, as well as a sample detailed claims screening report.

Table 11. Follow-Up Processes	
Standard Follow-Up Processes	Policy and Procedure (P&P) #CP_07: Procedures and System for Prompt Response to Compliance Issues described the corrective action process in response to potential violations related to payment or delivery of items or services under the contract. Written corrective action included elements of the corrective action, timeframes for specific achievements, ramifications if the entity failed to implement the corrective action satisfactorily, and reminder of any contractual language that detailed the ramifications of failing to maintain compliance or engaging in fraud, waste, or abuse, such as contract termination. Corrective actions were monitored after implementation to ensure they were effective. The dental benefit manager (DBM) enforced effective correction through disciplinary means, including contract termination, if warranted.
Sample Follow-Up Activities Conducted	The DBM indicated that no follow-up activities as a result of provider claim monitoring were required during the review period. A sample provider termination letter was submitted, but it did not address “for cause” termination.

While Argus provided a P&P documenting appropriate follow-up processes and activities based on identification of questionable billing practices, the DBM noted that no follow-up activities were required over the review period. As a result, no examples of actual follow-up processes and activities were provided.

Table 12. Claims System Flagging for Nonpayment	
Federal and State Excluded Providers	Policy and Procedure (P&P) #CR_33: Monitoring of Practitioner Sanctions described the process by which the Credentialing Specialist flagged exclusions in the appropriate dental benefit manager database(s).

Argus provided appropriate documentation of flagging of excluded providers for nonpayment.

Conclusions and Recommendations

Based on analysis of key claim data fields, Qsource concludes that these data fields were highly complete and accurate, with very low error rates for Argus. Qsource derives from the accuracy of benefit application analyses that determination of accurate payment of claims is impacted by aberrations in the data submitted by the DBM. However, potential errors in claim processing accounted for a negligible percentage of total claims submitted for most services. Finally, Qsource concludes that Argus, with a total score of 64.4%, demonstrated a lack of compliance for truthfulness of claim data based on documentation of program integrity requirements.

DBM Recommendations

Qsource recommends the actions in **Table 13** for Argus.

Table 13. Qsource Recommendations for Argus			
Category	**Data Field(s) / Service(s)**	**Issue**	**Recommendation**
Accuracy of Benefit Application	Eligibility on the Date of Service	The potential error rate was above the acceptable rate of 5%.	Audit a sample of claim detail to attempt to determine the cause of the potential errors.
Services within Benefit Scope and Benefit Limitations by Service Category	♦ Sealants ♦ Space Maintainers ♦ Initial Oral Exam ♦ Composite/Resin Restorations (white fillings) ♦ Crowns ♦ Surgical Treatment of Diseases ♦ Root Canal Therapy on Primary and Permanent Teeth ♦ Scaling and Root Planing ♦ Orthodontic Services (braces) ♦ General Anesthesia ♦ Professional Hospital Visit	The potential error rate was above the acceptable rate of 5%.	Audit a sample of claim detail to attempt to determine the cause of the potential errors.

Table 13. Qsource Recommendations for Argus			
Category	**Data Field(s) / Service(s)**	**Issue**	**Recommendation**
Services Over Limitation by Service Category	♦ Topical Fluoride Application – One Every Six Months ♦ Cleaning/Prophylaxis – One Every Six Months ♦ Regular Oral Exams – One Every Six Months ♦ Bitewing X-Rays – One Every Six Months	The potential error rate was above the acceptable rate of 5%.	Audit a sample of claim detail to attempt to determine the cause of the potential errors.
Data Submission Issues Observed	Header Claim Line	Claims with header status of "D", but a positive paid amount	Audit a sample of claim detail to attempt to determine the cause of the potential errors.
Data Submission Issues Observed	Claim Line Item Number Rows	Rows not in sequential order	Audit a sample of claim detail to attempt to determine the cause of the potential errors.
Truthfulness of Claim Data	Fraud, Waste, and Abuse Procedure Components	The policy did not address compliance with standards under the contract.	The dental benefit manager (DBM) should update Policy and Procedure (P&P) #CP_01 to address compliance with standards under the contract.
Truthfulness of Claim Data	Fraud, Waste, and Abuse Procedure Components	The policy included a requirement that the Compliance Officer report to the Chief Operating Officer, but the requirement is for the Compliance Officer to report to the Chief Executive Officer (CEO).	The DBM should ensure and document that the Compliance Officer reports to the CEO.
Truthfulness of Claim Data	Fraud, Waste, and Abuse Procedure Components	The policy did not include compliance with contractual requirements.	The DBM should update P&P# CP_02 to include compliance with contractual requirements.
Truthfulness of Claim Data	Fraud, Waste, and Abuse Procedure Components	Compliance with standards under the contract and specific references to 42 *Code of Federal Regulations* (CFR) 438.608, 42 CFR 4559(a)(2), and Section 409.814, Florida Statutes were	The DBM could update P&P #CP_01 to include specific references to 42 CFR 438.608, 42 CFR 4559(a)(2), and Section 409.814, Florida Statutes.

Table 13. Qsource Recommendations for Argus			
Category	**Data Field(s) / Service(s)**	**Issue**	**Recommendation**
		not included in the policy.	
Truthfulness of Claim Data	Fraud, Waste, and Abuse Procedure Components	No documentation of notification to FHKC of changes in enrollee circumstances was provided.	The DBM should update the appropriate P&P to include notification to FHKC of changes in enrollee circumstances that may affect eligibility.
Truthfulness of Claim Data	Fraud, Waste, and Abuse Procedure Components	No documentation of notification to FHKC of changes in provider circumstances was provided.	The DBM could document in a P&P the requirement to notify FHKC of changes in provider circumstances that may affect eligibility to participate in the network.
Truthfulness of Claim Data	Fraud, Waste, and Abuse Procedure Components	No documentation was submitted to address providing access to FHKC to monitor fraud and abuse prevention activities.	The DBM should update the Compliance Program to include the requirement to provide access to FHKC to monitor fraud and abuse prevention activities.
Truthfulness of Claim Data	Fraud, Waste, and Abuse Procedure Components	The policy addressed reporting of suspected or confirmed instances of fraud, waste, or abuse to the Office of Medicaid Program Integrity, but it did not address reporting findings to FHKC.	The DBM should update P&P #CP_07 to include reporting information on fraud or potential fraud to FHKC.
Truthfulness of Claim Data	Fraud, Waste, and Abuse Procedure Components	The Compliance Program did not specifically state that all reports of fraud for which FHKC was notified were investigated and followed up on.	The DBM could update the Compliance Program to specifically state that reports of fraud to FHKC would be adequately investigated and followed up on.
Truthfulness of Claim Data	Fraud, Waste, and Abuse Procedure Components	The Compliance Program did not address cooperation with FHKC, state or federal entities, or any subsequent legal action resulting from such an investigation.	The DBM should update the Compliance Program to address cooperation in any investigation by FHKC or state or federal entities and any subsequent legal action.

Table 13. Qsource Recommendations for Argus			
Category	**Data Field(s) / Service(s)**	**Issue**	**Recommendation**
Truthfulness of Claim Data	Fraud, Waste, and Abuse Procedure Components	P&P #CP_10 did not specifically note the *Deficit Reduction Act* of 2005.	The DBM could update P&P #CP_10 to note the *Deficit Reduction Act* of 2005.
Truthfulness of Claim Data	Disclosures	Documentation regarding reporting excess capitation payments was not provided.	The DBM should document the requirement to report to FHKC within 60 calendar days when it has identified capitation payments or other payments in excess of amounts specified in the contract.
Truthfulness of Claim Data	Treatment of Recoveries	The Provider Agreement did not address notifying the DBM in writing and including the reason for the overpayment.	The DBM should update the Provider Agreement to include that the provider must provide a reason for an overpayment when reporting an overpayment to the DBM.
Truthfulness of Claim Data	Treatment of Recoveries	The Provider Agreement did not document the requirement for annual reporting of overpayments and recoveries.	The DBM should update the Provider Agreement to include that the provider must provide a reason for an overpayment when reporting an overpayment to the DBM.

FHKC Recommendations

Qsource suggests consideration of the addition of tooth surface and tooth number to the claim submission data layout to allow for more accurate and complete data analysis. Qsource also suggests that FHKC provide additional clarification on the versioning methodology for claim adjustments to the DBM to ensure consistent DBM reporting.

APPENDIX A | Claim Data File Layout

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
1	Member ID	10	char	The enrollee's unique 10-digit FHKC member number.
2	Plan ID	9	char	DBM (short name) ID assigned to the plan for use in the 834 file.
3	Medicare Crossover Indicator	1	char	'M' indicates Medicare Part A Crossover, otherwise insert space.
4	Claim Type	1	char	The code used to identify the type of claim record being processed. Please see the following spreadsheet ("Claim Type") for codes and descriptions.
5	Claim Version	4	number	Indicates the claim version number, which is used if the payer adjudicates claims based on a versioning system. This is the number of times a claim as been modified or adjusted incremented each time it has been modified. Number the original claim as 1, and increment by 1 thereafter.
6	Claim Line Status	1	char	Indicates status of the claim line as reported by the payer. "P" = Paid and "D" = Denied
7	Billing Taxonomy	10	char	Please enter the Healthcare Provider Taxonomy Standard Code Set. Please see the following spreadsheet ("Taxonomy Codes") for codes and descriptions.
8	Admit Type	1	char	The code indicating the type and priority of an inpatient admission associated with the service on an intermediary submitted claim. (See spreadsheet "Admit Type Codes" for values)
9	Admit Source	1	char	The code indicating the source of the beneficiary's admission to an Inpatient facility or, for newborn admission, the type of delivery. (See spreadsheet "Admit Source Codes" for values)
10	Admit Date	8	char	Please use YYYYMMDD format. (used on hospital and long term care claims)
11	First Date of Service	8	char	Please use YYYYMMDD format.
12	Last Date of Service	8	char	Please use YYYYMMDD format. For Inpatient and Crisis Stabilization Unit services, this equals the discharge date.
13	Claim Paid Date	8	char	The payment check or warrant date. Please use YYYYMMDD format.

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
14	Total Days	3	number	Total number of days for the statement period of the encounter transaction. This includes encounters where Medicare is the primary payer. (Total Days = Last Date of Service - First Date of Service + 1)
15	Plan Covered Days	3	number	Number of days for the statement period of encounter transactions paid by the plan.
16	Claim Reference Number	25	char	The health plan's internal unique claim record identifier.
17	Patient Account Number	25	char	The hospital's unique patient identifier for an Inpatient services admission as included in Form Locator 3a on a UB-04 paper claim form.
18	Line Item Number	6	char	The line item number from the health plan's internal unique claim (Use line item number zero, '0', for header level reporting)
19	Financial Report Service Category	7	char	Please see the following spreadsheet ("Service Categories") for codes and descriptions. Input using explicit decimal points.
20	Primary Procedure Code	8	char	ICD-9, ICD-10, CPT or Healthcare Common Procedure Coding System (HCPCS) Procedure Code (for Hospital Inpatient use hospital ICD-9 only).
21	Procedure Modifier 1	2	char	2-character procedure code modifier, if applicable.
22	Procedure Modifier 2	2	char	2-character procedure code modifier, if applicable.
23	Procedure Modifier 3	2	char	2-character procedure code modifier, if applicable.
24	Procedure Modifier 4	2	char	2-character procedure code modifier, if applicable.
25	Surgical Procedure Code 2	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
26	Surgical Procedure Code 3	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
27	Surgical Procedure Code 4	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
28	Surgical Procedure Code 5	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
29	Surgical Procedure Code 6	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
30	Surgical Procedure Code 7	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
31	Surgical Procedure Code 8	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
32	Surgical Procedure Code 9	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
33	Surgical Procedure Code 10	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
34	Surgical Procedure Code 11	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
35	Surgical Procedure Code 12	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
36	Surgical Procedure Code 13	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
37	Surgical Procedure Code 14	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
38	Surgical Procedure Code 15	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
39	Surgical Procedure Code 16	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
40	Surgical Procedure Code 17	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
41	Surgical Procedure Code 18	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
42	Surgical Procedure Code 19	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
43	Surgical Procedure Code 20	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
44	Surgical Procedure Code 21	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
45	Surgical Procedure Code 22	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
46	Surgical Procedure Code 23	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
47	Surgical Procedure Code 24	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
48	Surgical Procedure Code 25	8	char	Surgical Procedure Codes (ICD-10 codes) - These should be separate from the line item procedure code so that there may be more than one per claim.
49	Revenue Code	4	char	Use only for Hospital Inpatient and Hospital Outpatient Services
50	Units of Service	10	number	Please use the units of service referenced in the appropriate Medicaid Coverage and Limitations Handbook. (For Inpatient Hospitalization, Nursing Home, or Hospice, this is the number of covered days; for Pharmacy claims this is the quantity.) **Do not format using commas.**
51	Code ICD Indicator	1	number	Indicates ICD version code. The ICD version must be consistent with codes entered on the claim. Use '0' for ICD-10. FHKC does not anticipate accepting previous version of ICD.
52	Emergency Diagnosis Code	8	char	Diagnosis code for Emergency Department services indicating the beneficiary's initial diagnosis at admission.
53	Admission Diagnosis Code	8	char	Diagnosis code on the institutional claim indicating the beneficiary's initial diagnosis at admission.
54	Admission Diagnosis POA	1	char	Present on Admission Indicator

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
55	Primary Diagnosis	8	char	Primary Diagnosis Code.
56	POA 1	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. Use the UB-04 Data Specifications Manual and the ICD-10-CM Official Guidelines for Coding and Reporting to facilitate the assignment of the POA indicator for each “primary” diagnosis and “other” diagnoses codes reported on claim forms UB-04 and 837 Institutional. See spreadsheet “POA Codes” for valid values.
57	Diagnosis 2	8	char	Additional Diagnosis Code, if applicable.
58	POA 2	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
59	Diagnosis 3	8	char	Additional Diagnosis Code, if applicable.
60	POA 3	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
61	Diagnosis 4	8	char	Additional Diagnosis Code, if applicable.
62	POA 4	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
63	Diagnosis 5	8	char	Additional Diagnosis Code, if applicable.
64	POA 5	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
65	Diagnosis 6	8	char	Additional Diagnosis Code, if applicable.
66	POA 6	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
67	Diagnosis 7	8	char	Additional Diagnosis Code, if applicable.
68	POA 7	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
				hospitals. See spreadsheet “POA Codes” for valid values.
69	Diagnosis 8	8	char	Additional Diagnosis Code, if applicable.
70	POA 8	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
71	Diagnosis 9	8	char	Additional Diagnosis Code, if applicable.
72	POA 9	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
73	Diagnosis 10	8	char	Additional Diagnosis Code, if applicable.
74	POA 10	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
75	Diagnosis 11	8	char	Additional Diagnosis Code, if applicable.
76	POA 11	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
77	Diagnosis 12	8	char	Additional Diagnosis Code, if applicable.
78	POA 12	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
79	Diagnosis 13	8	char	Additional Diagnosis Code, if applicable.
80	POA 13	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
81	Diagnosis 14	8	char	Additional Diagnosis Code, if applicable.
82	POA 14	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
83	Diagnosis 15	8	char	Additional Diagnosis Code, if applicable.
84	POA 15	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
85	Diagnosis 16	8	char	Additional Diagnosis Code, if applicable.
86	POA 16	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
87	Diagnosis 17	8	char	Additional Diagnosis Code, if applicable.
88	POA 17	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
89	Diagnosis 18	8	char	Additional Diagnosis Code, if applicable.
90	POA 18	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
91	Diagnosis 19	8	char	Additional Diagnosis Code, if applicable.
92	POA 19	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
93	Diagnosis 20	8	char	Additional Diagnosis Code, if applicable.
94	POA 20	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
95	Diagnosis 21	8	char	Additional Diagnosis Code, if applicable.
96	POA 21	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
97	Diagnosis 22	8	char	Additional Diagnosis Code, if applicable.

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
98	POA 22	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
99	Diagnosis 23	8	char	Additional Diagnosis Code, if applicable.
100	POA 23	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
101	Diagnosis 24	8	char	Additional Diagnosis Code, if applicable.
102	POA 24	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
103	Diagnosis 25	8	char	Additional Diagnosis Code, if applicable.
104	POA 25	1	char	Present on Admission (POA) Indicator for all claims involving inpatient admissions to general acute care hospitals. See spreadsheet “POA Codes” for valid values.
105	Treating Provider Type	2	char	Please see the following spreadsheet (“Provider Types”) for codes and descriptions. (include leading zeros)
106	Treating Provider NPI	10	char	NPI (National Provider Identifier) of the treating provider, prescribing provider or hospital
107	Treating Provider Medicaid ID	9	char	Florida Medicaid Provider ID of the treating provider, prescribing provider or hospital
108	Treating Provider Specialty Code	3	char	3-character Specialty Code of the treating Provider (include leading zeros) (See contract for Provider Network Files report for valid values.)
109	Billing Provider Type	2	char	Please see the following spreadsheet (“Provider Types”) for codes and descriptions. (include leading zeros)
110	Billing Provider NPI	10	char	NPI (National Provider Identifier) of the billing provider
111	Billing Provider Medicaid ID	9	char	Florida Medicaid Provider ID of the billing provider

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
112	Billing Provider Specialty Code	3	char	3-character Specialty Code of the billing provider (include leading zeros) (See contract for Provider Network Files report for valid values.)
113	Facility Provider Type	2	char	Please see the following spreadsheet (“Provider Types”) for codes and descriptions. (include leading zeros)
114	Facility Provider NPI	10	char	NPI (National Provider Identifier) of the facility provider
115	Facility Provider Medicaid ID	9	char	Florida Medicaid Provider ID of the facility provider
116	Place of Service	2	char	Two-digit code that specifies the place of service or treatment. See spreadsheet “Place of Service Codes” for codes.
117	TPL Amount	10	number	Third Party Liability amount paid for costs associated with the claim. Format with an explicit decimal point and two decimal places, but no explicit commas or dollar signs.
118	Billing Date	8	char	The date the claim was billed to the plan
119	Billed Amount	10	number	Billed amount for costs associated with the claim. Format with an explicit decimal point and two decimal places, but **no explicit commas or dollar signs**.
120	Patient Responsibility Amount	10	number	The amount that the recipient is responsible for paying, if any.
121	Amount Paid	10	number	Amount paid for costs of actual services associated with the claim for all Reimbursement Arrangements. Format with an explicit decimal point and two decimal places but **no explicit commas or dollar signs**. The amount paid should correspond to the amount paid type described below.
122	Amount Paid Type	1	char	“A” = Actual amount paid; “R” = Repriced to fee-for service amount; “U” = No actual or repriced amount available. It is expected that most claim amounts will be the actual amount paid, with re-priced amounts confined to sub-capitated services where the actual payment amount is unknown.
123	NDC	11	char	National Drug Code Identification number of the dispensed medication. Use only for Pharmacy services.
124	Class	3	char	Therapeutic Class Code. Use only for Pharmacy services.

2020 Data File Layout				
Field Sequence	**Field Name**	**Field Length**	**Data Type**	**Comments**
125	Prescription Number	12	char	Prescription/Service Reference number. Use only for Pharmacy services.
126	Primary Pharmacy ID	12	char	NPI number that identifies the pharmacy, chain, or Preferred Provider Organization (PPO) that the member used in order to obtain benefits. Use only for Pharmacy services.
127	Days' Supply	3	number	The number of days of medication the physician prescribed for this claim.
128	Hospital Discharge Status	2	char	Two-digit code that identifies where the patient is at the conclusion of a health care facility encounter. This should be entered for all Hospital Inpatient and Hospital Outpatient encounters. See spreadsheet "Discharge Codes" for codes.
129	Hospital Bill Type Code	4	char	Three-digit code that provides information concerning hospital bills. This should be entered for all Hospital Inpatient and Hospital Outpatient encounters. See spreadsheet "Bill Types" for codes.
130	Base APR-DRG	3	char	Three-digit APR-DRG code as determined by the health plan. This should be entered for all Hospital Inpatient and Hospital Outpatient encounters, if available.
131	APR-DRG Severity of Illness	1	number	1 = Minor; 2 = Moderate; 3 = Major; 4 = Extreme. This supplements the Base APR-DRG.
132	APR-DRG Risk of Mortality	1	number	1 = Minor; 2 = Moderate; 3 = Major; 4 = Extreme. This supplements the Base APR-DRG.
133	EAPG Code	5	char	Enter the EAPG code, based on the EAPG Core Grouping Software output, for the service(s) being rendered. Enter five digits, including the leading "0". (see spreadsheet "EAPG Codes" for codes)
134	EAPG Relative Weight	6	number	Based on the EAPG that has been entered, the weight used in the calculation. (see spreadsheet "EAPG Codes" for values)
135	Provider Policy Adjustor	6	number	Indicator of whether the provider receives an outpatient high volume adjustment in its EAPG conversion factor. If there is no adjustment, this will be set to 1 and shown as 1.0000.
136	Discounting Factor	6	number	The Final Discount Adjustment as a percentage (the combined adjustment = Bundling Adjustor x Ancillary Procedure Adjustor x Significant Procedure Adjustor x Bilateral Procedure Adjustor x Terminated Procedure Adjustor)

APPENDIX B | Argus Program Integrity Standard Tool

2021 Periodic Audit: Argus					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
1. Fraud, Waste, and Abuse Procedure Components – 1 *42 Code of Federal Regulations* (CFR) 438.608(a)(1)(i)-(iv) Dental Services Contract (DSC) 3-13-2 (A,B,J,K), Amendment 3	The dental benefit manager (DBM) must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include a compliance program that includes, at a minimum, all of the following elements: a. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable federal and state requirements, including the applicable provisions of 42 CFR 438.608, 42 CFR 4559(a)(2) and Section 409.814, Florida Statutes b. The designation of a compliance officer with sufficient experience in healthcare who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the chief executive officer and the board of directors c. The establishment of a Regulatory Compliance Committee on the board of directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract d. A system for training and education for the compliance officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract	☐ a. Written policies, procedures, and standards of conduct ☐ b. Designation of a compliance officer ☐ c. Regulatory Compliance Committee on the board of directors and at the senior management level ☑ d. System for training and education on federal and state standards and requirements under the contract ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**0.250**

2021 Periodic Audit: Argus					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
Findings	Policy and Procedure (P&P) #CP_01: Written Policies, Procedures, and Standards of Conduct described the DBM's commitment to comply with applicable federal and state standards. However, compliance with standards under the contract and specific references to 42 CFR 438.608, 42 CFR 4559(a)(2), and Section 409.814, Florida Statutes were not included. P&P #CP_02: Compliance Officer, Compliance Committee & High Level Oversight referenced the Compliance Officer, who was responsible for implementation of the Compliance Program, and had training and experience working with Medicare and Medicaid programs and regulatory authorities, and was a member of senior management. The Compliance Officer reported to the Chief Operating Officer (COO) and had direct access and authority to report to the COO and the board of directors. However, the requirement is for the Compliance Officer to report to the Chief Executive Officer (CEO). P&P #CP_02 described the Compliance Committee as a standing committee of the board of directors with general oversight responsibility for the Compliance and Ethics programs, policies, and procedures. Committee members were noted as DBM executives and managers. The P&P described that the committee ensured compliance with Medicare and Medicaid regulations, but did not mention compliance with contractual requirements. P&P #CP_03: Effective Education and Training addressed a comprehensive compliance training program that was provided for every officer, director, employee, volunteer, consultant, board member, and First Tier and Downstream Related (FDR) Entity and its associates.				
Strength	P&P #CP_03 included a very comprehensive description of the education and training programs of the DBM.				
AON	1. The DBM should update P&P #CP_01 to address compliance with standards under the contract. 2. The DBM should ensure and document that the Compliance Officer reports to the CEO. 3. The DBM should update P&P# CP_02 to include compliance with contractual requirements.				
Suggestion	The DBM could update P&P #CP_01 to include specific references to 42 CFR 438.608, 42 CFR 4559(a)(2), and Section 409.814, Florida Statutes.				
2. Fraud, Waste, and Abuse Procedure Components – 2 42 CFR 438.608(a)(1)(v)-(vii) DSC 3-13-2 (C,H,L,O), Amendment 3	The DBM must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include a compliance program that includes, at a minimum, all of the following elements: a. Effective lines of communication between the compliance officer and the organization's employees, as evidenced by some formal policy b. Enforcement of standards through well-publicized disciplinary guidelines	☑ a. Effective lines of communication between compliance officer and DBM employees ☑ b. Enforcement of standards ☑ c. Non-retaliation policies against any individual that reports violations ☑ d. Establishment and implementation of procedures and system with dedicated staff	**0.250** **0.250** **0.250** **0.250**	**1.000**	**1.000**

2021 Periodic Audit: Argus					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
	c. Non-retaliation policies against any individual that reports violations of the DBM's fraud and abuse policies and procedures or suspected fraud and abuse d. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence of compliance issues, and ongoing compliance with the requirements under the contract	☐ Not Applicable	**0.000**		

Findings The Standards of Conduct and Code of Ethics clearly addressed effective lines of communication between the Compliance Department and employees. Disciplinary guidelines were addressed in the Standards of Conduct and Code of Ethics as well as in P&P #CP_05: Well-Publicized Disciplinary Standards. Non-retaliation for good faith reporting of a violation of the Standards of Conduct or of a law or regulation was addressed in the Standards of Conduct and Code of Ethics and also in P&P #CP_10: Non-Retaliation and Non-Intimidation. The Argus Dental & Vision, Inc. Compliance Program 2020 (Compliance Program) included a detailed description of procedures and systems in place to monitor, audit, and respond to compliance risks, including compliance with health plan (FHKC) contract requirements.

Strength None were identified.

AON None were identified.

Suggestion None were identified.

2021 Periodic Audit: Argus					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
3. Fraud, Waste, and Abuse Procedure Components – 3 42 CFR 438.608(a)(3)(i)-(ii),(4)-(6) DSC 3-13-2(D), 3-13-2(Q)(ii)-(iii), Amendment 3	The DBM must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following: a. Provision for prompt notification to Florida Healthy Kids Corporation (FHKC) when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility within five business days of receipt of such information, including: (i) changes in the enrollee's residence; and (ii) the death of an enrollee b. Provision for notification to FHKC when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the DBM c. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis d. In the case of the DBM making or receiving annual payments under the contract of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the *False Claims Act* and other federal and state laws described in section 1902(a)(68) of the *Social Security Act*, including information about rights of employees to be protected as whistleblowers	☐ a. Provision for notification to FHKC about a change in an enrollee's circumstances affecting eligibility ☑ b. Provision for notification to FHKC about a change in a network provider's circumstances ☑ c. Provision for a method to verify services represented as delivered were received by enrollees ☑ d. Provision for written policies that provide detailed information about the *False Claims Act* and other federal and state laws ☐ Not Applicable	**0.250** **0.250** **0.250** **0.250** **0.000**	**1.000**	**0.750**

2021 Periodic Audit: Argus					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
Findings	No documentation of notification to FHKC of changes in enrollee circumstances was provided. The FHKC Reporting Grid 2020 noted the monthly reporting of provider network changes to FHKC. P&P #CP_06: Routine Monitoring, Auditing, and Identification of Compliance risks noted that processes to verify whether services billed were provided, based on member complaints and review of claims issues, including review of the clinical record, were in place. P&P #QM_17: Ongoing Monitoring – Assessing Receipt of Services addressed the monthly process of outbound calls to a sample of enrollees to verify services reported were received. P&P #CP_03 indicated that fraud, waste, and abuse training addressed the *False Claims Act* and protections for Fraud Detection and Recovery (FDR) entities and their associates who reported suspected fraud, waste, or abuse. P&P #CP_10 addressed protection for any employee, enrollee, or FDR against adverse action as a result of engaging in a statutorily protected activity.				
Strength	None were identified.				
AON	The DBM should update the appropriate P&P to include notification to FHKC of changes in enrollee circumstances that may affect eligibility.				
Suggestion	The DBM could document in a P&P the requirement to notify FHKC of changes in provider circumstances that may affect eligibility to participate in the network.				
4. Fraud, Waste, and Abuse Procedure Components – 4 42 CFR 438.608(a)(7)-(8) DSC 3-13-2(E), (Q)(iv), Amendment 3	The DBM must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following: a. Provision for the prompt referral of any potential fraud, waste, or abuse that the DBM identifies to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit b. Provision for the DBM's suspension of payments to a network provider for which FHKC or the Agency for Health Care Administration (AHCA) determines there is a credible allegation of fraud in accordance with 42 CFR 455.23	☑ a. Provision for the prompt referral of any potential fraud, waste, or abuse ☑ b. Provision for the DBM's suspension of payments to a network provider for which FHKC or AHCA determines there is a credible allegation of fraud ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**1.000**

2021 Periodic Audit: Argus					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
Findings	P&P #CP_07: Procedures and System for Prompt Response to Compliance Issues indicated that suspected or confirmed instances of fraud, waste, or abuse were reported to the Office of Medicaid Program Integrity (MPI) within 15 days of detection. P&P #CP_18: SIU Functions indicated that the DBM adhered to all requests from state/federal agencies regarding suspension of payment to network providers or termination of network providers for which the State determined there was a credible allegation of fraud.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				
5. Fraud, Waste, and Abuse Procedure Components – 5 DSC 3-13-2, Amendment 3	The DBM must provide access to FHKC to monitor fraud and abuse prevention activities conducted by the DBM.	☐ Yes ☑ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**0.000**
Findings	While the Compliance Program documented the Fraud, Waste, and Abuse Prevention Plan, no documentation was submitted to address providing access to FHKC to monitor fraud and abuse prevention activities. Attestation to FHKC that fraud, waste, and abuse procedures complied with the contract was provided, but no DBM documentation was in place.				
Strength	None were identified.				
AON	The DBM should update the Compliance Program to include the requirement to provide access to FHKC to monitor fraud and abuse prevention activities.				
Suggestion	None were identified.				

2021 Periodic Audit: Argus					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
6. Fraud, Waste, and Abuse Procedure Components – 6 DSC 3-13-2, Amendment 3	The DBM must report its findings to FHKC if it obtains information demonstrating or indicating fraud or potential fraud by providers, subcontractors, applicants, or enrollees.	☐ Yes ☑ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**0.000**
Findings	While P&P #CP_07 addressed reporting of suspected or confirmed instances of fraud, waste, or abuse to the MPI, it did not address reporting findings to FHKC. Attestation to FHKC that fraud, waste, and abuse procedures complied with the contract was provided, but no DBM documentation was in place.				
Strength	None were identified.				
AON	The DBM should update P&P #CP_07 to include reporting information on fraud or potential fraud to FHKC.				
Suggestion	None were identified.				
7. Fraud, Waste, and Abuse Procedure Components – 7 DSC 3-13-2(M), Amendment 3	The DBM's fraud and abuse compliance program must include provisions for the investigation and follow-up of any reports notification to FHKC of, including but not limited to, any fraud by subcontractors, applicants, or enrollees.	☑ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**1.000**
Findings	The Compliance Program addressed the investigation of any suspected or actual fraud, waste, and abuse by the Compliance Officer, in conjunction with the COO and Chief Legal Counsel (if applicable). However, it did not specifically state that all reports of fraud for which FHKC was notified were investigated and followed up on.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	The DBM could update the Compliance Program to specifically state that reports of fraud to FHKC would be adequately investigated and followed up on.				

2021 Periodic Audit: Argus					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
8. Fraud, Waste, and Abuse Procedure Components – 8 DSC 3-13-2(N), Amendment 3	The DBM's fraud and abuse compliance program must include cooperation in any investigation by FHKC, state, or federal entities or any subsequent legal action that may result from such an investigation.	☐ Yes ☑ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**0.000**
Findings	The Compliance Program indicated that the Compliance Department assisted law enforcement by providing information needed to develop successful prosecutions. However, it did not address cooperation with FHKC, state or federal entities, or any subsequent legal action resulting from such an investigation.				
Strength	None were identified.				
AON	The DBM should update the Compliance Program to address cooperation in any investigation by FHKC or state or federal entities and any subsequent legal action.				
Suggestion	None were identified.				
9. Fraud, Waste, and Abuse Procedure Components – 9 DSC 3-13-2(P), Amendment 3	The DBM's fraud and abuse compliance program must include distribution of written fraud and abuse policies to its employees in accordance with Section 6032 of the federal *Deficit Reduction Act* of 2005, including the rights of employees to be protected as whistleblowers.	☑ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**1.000**
Findings	P&P #CP_10 included specific provisions relative to protection of associates from retaliation or retribution for good faith reporting of potential or suspected compliance violations. It did not, however, specifically note the *Deficit Reduction Act* of 2005.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	The DBM could update P&P #CP_10 to note the *Deficit Reduction Act* of 2005.				

2021 Periodic Audit: Argus					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
10. Fraud, Waste, and Abuse Procedure Components – 10 DSC 3-13-2(G), Amendment 3	The DBM must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include policies and procedures to maintain adequate staffing and resources to investigate unusual incidents and to develop corrective action plans to assist the DBM with preventing and detecting potential fraud and abuse.	☑ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**1.000**
Findings	The Compliance Program noted that a program evaluation was conducted annually to determine if resources were sufficient to meet overall program goals and requirements. It also specifically addressed development of corrective action plans and monitoring of implementation for effectiveness.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				
11. Provider Screening and Enrollment Requirements 42 CFR 438.608(b)	The DBM must ensure that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of CFR chapter 42, subparts B and E.	☑ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**1.000**
Findings	P&P #CR_24: Credentialing/Recredentialing indicated that the DBM verified providers' Medicaid eligibility through the AHCA electronic background screening system.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				

2021 Periodic Audit: Argus					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
12. Disclosures 42 CFR 438.608(c)(1)-(3) DSC 3-23-1, Amendment 3	The DBM must: a. provide written disclosure of any prohibited affiliation under 42 CFR 438.610; b. provide written disclosures of information on ownership and control required under 42 CFR 455.104; and c. report to FHKC within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the contract.	☑ a. Provided written disclosure of any prohibited affiliation ☑ b. Provided written disclosures of information on ownership and control ☐ c. Reported to FHKC within 60 calendar days when the DBM identified the capitation payments or other payments in excess ☐ Not Applicable	**0.333** **0.333** **0.333** **0.000**	**1.000**	**0.667**
Findings	P&P #CP_15: OIG Excluded and SAM Sanctions addressed disclosure of prohibited affiliations and information on ownership and control. Documentation regarding reporting excess capitation payments was not provided.				
Strength	P&P #CP_15 included a comprehensive and detailed description of disclosure requirements.				
AON	The DBM should document the requirement to report to FHKC within 60 calendar days when it has identified capitation payments or other payments in excess of amounts specified in the contract.				
Suggestion	None were identified.				
13. Treatment of Recoveries 42 CFR 438.608(d)(2)-(3) DSC 3-13-2(Q)(i), Amendment 3	The DBM must: a. have a mechanism for a network provider to report in writing to the DBM when it has received an overpayment, to return the overpayment to the DBM within 60 calendar days after the date on which the overpayment was identified, and to notify the DBM in writing of the reason for the overpayment; and b. report annually to FHKC on the DBM's recoveries of overpayments.	☐ a. Mechanism for network provider to report to DBM receipt of overpayment and to return overpayment to DBM within 60 calendar days ☐ b. Reported annually to FHKC on the DBM's recoveries of overpayments ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**0.000**
Findings	The Provider Agreement included a provision requiring providers who received an overpayment to refund the overpayment within 10 days of the discovery of the overpayment. However, notifying the DBM in writing and including the reason for the overpayment was not addressed. In addition, the requirement for annual reporting of overpayments and recoveries was not documented.				

2021 Periodic Audit: Argus					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
Strength	None were identified.				
AON	1. The DBM should update the Provider Agreement to include that the provider must provide a reason for an overpayment when reporting an overpayment to the DBM. 2. The DBM should update the appropriate P&P to include annual reporting of recoveries of overpayments to FHKC.				
Suggestion	None were identified.				
14. Prohibited Affiliations – 1 42 CFR 438.610(a)(1)-(2) DSC 3-23-1(A)-(B)	The DBM must not knowingly have with the following a relationship of the type described in 42 CFR 438.610(c)—including a director, officer, or partner of the DBM; a subcontractor of the DBM as governed by 42 CFR 438.230; a person with beneficial ownership of five percent or more of the DBM's equity; and a network provider or person with an employment, consulting, or other arrangement with the DBM for the provision of items and services that are significant and material to the DBM's obligations under its contract with FHKC: a. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 b. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in 42 CFR 438.610(a)	☑ a. An individual or entity that was debarred, suspended, or otherwise excluded from participating in procurement and nonprocurement activities ☑ b. An individual or entity who is an affiliate ☐ Not Applicable	**0.500** **0.500** **0.000**	**1.000**	**1.000**
Findings	P&P #CR_33: Monitoring of Practitioner Sanctions described querying of the General Services Administration System for Award Management (SAM) for network provider exclusions at credentialing, recredentialing, and monthly as part of ongoing monitoring efforts. P&P #CP_15 addressed querying of SAM for all associates, contractors, and/or FDR entities.				
Strength	None were identified.				
AON	None were identified.				

2021 Periodic Audit: Argus					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
Suggestion	None were identified.				
15. Prohibited Affiliations – 2 42 CFR 438.610(b) DSC 3-23-1(B)(4), Amendment 3	The DBM must not have a relationship with an individual or entity that is excluded from participation in any federal healthcare program under section 1128 or 1128A of the *Social Security Act*.	☑ Yes ☐ No ☐ Not Applicable	**1.000** **0.000** **0.000**	**1.000**	**1.000**
Findings	P&P #CR_33 addressed queries of the Office of Inspector General (OIG) federal exclusions database at initial credentialing, recredentialing, and during in-between cycle monitoring.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				
Program Integrity for Periodic Audit			**64.4%**	**15.000**	**9.667**

APPENDIX C | Response to Periodic Audit Draft

Relevant responses from the DBM are included in this appendix of the final *2021 Periodic Audit Report* to reflect any comments or feedback following the DBM's review of the draft report. Qsource reviewed the DBM's feedback before compiling this final report. A description of Qsource's response to the DBM's feedback, if applicable, is also included. Responses were not altered from the original plan submission.

MCO Name: Argus Dental & Vision, Inc.
Date of Response: 12/15/2021

Listed errors were reviewed against Argus's claim processing system and information in that system at the time of processing.

Claim review of potential errors was conducted on PA Detail Data Samples_Argus.xlxs

All claims reported with status "D", indicative of being denied, had line items on the same claim that issued payment. Our conclusion is that the line item denied, however on a claim level service were paid, hence the potential errors for payment on a denied service may not have reported factually.

Standard	Element #	MCO Response
Table 4	Eligibility on Date of Service	Argus analyzed the data sample provided by Qsource and found that the 174 claims paid were for eligible enrollees, not ineligible enrollees. Eligibility on the date of service was reviewed based on the processing date and the 95.08% potential error rate appears to be incorrect. Per meeting on 11/18/2021, Qsource was to re-evaluate and provide data samples by 11/23/2021. Those were not posted, and our analysis is based on the report initially posted 11/1/2021 and prior to the meeting. All were eligible on the DOS.
Table 5	Services within Benefit Scope and Benefit	Argus analyzed all claims listed on the PA Detail Data Sample provided on all tabs. Please see comments on the spreadsheet. T5 Orthodontics T5 General Anesthesia

	Limitations by Service Category	T5 Prof Hosp Visit
Table 6	Services Over Limitation by Service Category	Argus analyzed all claims listed on the PA Detail Data Sample report. Please see comments on the spreadsheet. T6 Topical Fluoride T6 Cleaning/Prophylaxis T6 Regular Oral Exams T6 Bitewings Due to COVID changes in dental office protocols, availability of appointments, access to care, and family hardships in obtaining routine dental care during this state of emergency, Argus elected to override the definitive frequency limitation to avoid undue burden on the enrollees and provider office and to promote better dental health outcomes.
Items listed below were updated after ACA Site visit		
Fraud, Waste, and Abuse Procedure Components	**1**	P&P_01 and _02 have ben updated to meet 1 and 3. Documentation also updated to show CCO reporting in Compliance Program.
Fraud, Waste, and Abuse Procedure Components	**3**	Program updated to add verbiage to include access to FWA activities. This activity has been a routine process when a provider FWA issue is founded, and action taken by Argus.
Fraud, Waste, and Abuse Procedure Components	**5**	Compliance Program updated
Fraud, Waste, and Abuse Procedure Components	**6**	CP_07 verbiage updated for reporting fraud or potential fraud.
Fraud, Waste, and Abuse Procedure Components	**8**	Compliance Program updated
Disclosures	**12**	Argus does not issue any capitated payments or have capitated dental providers for FHKC. Added requirement

		of reporting capitation payments in excess of the contacted amount.
Treatment of Recoveries	**13**	Provider agreement updated. Argus' recoupment process restructure is underway.

Argus also reviewed a sample of claims examined by Qsource and provided feedback in an Excel spreadsheet. In future analyses, Qsource will continue to work with Argus to ensure data are accurately captured.