2021

Periodic Audit

Report

DentaQuest of Florida, Inc.

December 2021

HealthyKids™

Qsource

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Acknowledgements, Acronyms, and Initialisms[1]

AHCA ..... Agency for Healthcare Administration
AON ..... Area of Noncompliance
CDT ..... Code on Dental Procedures and Nomenclature
CECO ..... Chief Ethics and Compliance Officer
CEO ..... Chief Executive Officer
CFR ..... *Code of Federal Regulations*
CHIP ..... Children's Health Insurance Program
CY ..... Calendar Year
DBM ..... Dental Benefit Manager
DSC ..... Dental Services Contract
EQRO ..... External Quality Review Organization
FHKC ..... Florida Healthy Kids Corporation
FPR ..... Fraud Prevention and Recovery
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
SOP.....Standard Operating Procedure
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)], 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 DentaQuest of Florida, Inc. (hereafter referred to as DentaQuest) in CY 2020. As all DBM provider financial arrangements are fee-for-service, DentaQuest 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, DentaQuest 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 DentaQuest:

- 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 DentaQuest's key claim data fields were highly complete and accurate, all exceeding 96% and 99%, respectively.

For accuracy of benefit application, the number of duplicate claims submitted was minimal (1,332). While the potential error rate was high (84.9%), more than half of the claims reported as paid actually had a paid amount of zero, indicating that they were likely denied, reducing the potential error rate to 40.7%. Paid duplicates accounted for about 1.1% of total claims submitted. For eligibility of the enrollee on the date of service, few claims for services when the enrollee was not eligible were submitted (1,197). Similar to duplicate claims, while the potential error rate was high (98.8%), most of the claims reported as paid had a paid amount of zero, indicating they were likely denied, reducing the potential error rate to 28.2%. Approximately 90.1% of the remaining claims reported as paid had service dates in January, February, and March. All ineligible claims coded as paid accounted for about 1.2% of total claims submitted.

For services within benefit scope and benefit limitations paid, the potential error rate for all 26 applicable service categories was below 5%. 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 represented a negligible percentage (0.07% or less). Factors potentially impacting these results,

but not considered in this analysis, are 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, potential error rates were below the 5% acceptable rate for topical fluoride and cleaning/prophylaxis. Potential error rates were higher for regular oral exams and bitewing X-rays, at 13.3% and 12.4% respectively. 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% to 0.2%.

The truthfulness assessment was based on an evaluation of compliance with program integrity regulatory and contractual requirements. DentaQuest's overall score on the program integrity standard was 94.4%. For this assessment, three suggestions and three areas of noncompliance (AONs) were identified, all related to updating appropriate P&Ps and other related documents to ensure appropriate documentation of requirements.

Conclusions

Based on these analyses, Qsource concludes that DentaQuest's data submission for key claim data fields enabled a confident determination that the data for these fields were mostly 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 DentaQuest. However, potential errors in claim processing accuracy accounted for a negligible percentage of total claims submitted. For the truthfulness assessment, Qsource concludes that DentaQuest demonstrated a high level of compliance with regulatory and contractual requirements related to program integrity.

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. DentaQuest should also address the issue of claims coded as paid with a zero paid amount. Also, Qsource recommends that DentaQuest 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 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. DentaQuest 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 identifications (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 DentaQuest 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 DentaQuest 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 DentaQuest. 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 DentaQuest

Field	Present	Completeness Rate	Accurate	Accuracy Rate*
	N=502,314			
Member Identification (ID)	502,314	100%	502,306	100%†
Plan ID	502,314	100%	502,314	100%
Claim Reference Number	502,314	100%	502,314	100%
Billing Date	502,314	100%	502,314	100%
Claim Paid Date	502,314	100%	502,314	100%
Procedure Code	502,314	100%	501,589	99.86%
First Date of Service	502,314	100%	502,314	100%
Financial Report Service Category	502,314	100%	502,314	100%
Treating Provider Type	502,314	100%	502,314	100%
Treating Provider National Provider Identifier (NPI)	499,195	99.38%	499,195	100%
Treating Provider Medicaid ID	484,001	96.35%	484,001	100%
Treating Provider Specialty Code	502,314	100%	502,314	100%
Billing Provider Type	502,314	100%	502,314	100%
Billing Provider NPI	498,836	99.31%	498,836	100%
Billing Provider Medicaid ID	484,001	96.35%	484,001	100%
Billing Provider Specialty Code	502,314	100%	502,314	100%
Place of Service	502,314	100%	501,533	99.84%

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

All completeness rates for key claim fields were above 96% and all accuracy rates 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 DentaQuest, 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	1,332
Total Duplicate Claims Paid	1,123
Potential Error Rate	**84.9%**
Paid Duplicates as % of Total Claims	**1.10%**

A relatively small number of duplicate claims were identified (1,332) with the majority of these coded as paid. This resulted in a very high potential error rate of 84.9%. However, detailed analysis demonstrated that 581 of these were actually claims with a header claim line status of paid ("P") with a zero amount paid, indicating these claims may actually have been denied. Taking this into account, the potential error rate dropped by more than half, to 40.7%. All duplicate claims coded as paid accounted for only 1.1% 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 DentaQuest.

Table 4. Eligibility on Date of Service	
Total Services for Which Enrollee Not Eligible on Date of Service	1,197
Ineligible Services Paid	1,182
Potential Error Rate	**98.75%**
Paid Ineligible Services as % of Total Claims	**1.15%**

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. While the potential error rate is very high (98.8%), detailed claims analysis demonstrated that the majority of claims in the "ineligible services paid" category were actually claims with a header claim line status of paid ("P") with a zero amount paid, indicating these claims may actually have been denied. Taking this into account, the potential error rate dropped significantly to 28.2%. The remaining claims with a "P" header claim line status

and positive amounts paid totaled 353. Of these, 90.1% had service dates in January, February, and March. All ineligible claims coded as paid accounted for about 1.2% of total claims submitted.

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 DentaQuest. 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	510	2	0.39%	**0%**
Cleaning/Prophylaxis	53,705	58	0.11%	**0.06%**
Topical Fluoride Application	51,045	40	0.08%	**0.04%**
Sealants	38,802	44	0.11%	**0.04%**
Space Maintainers	921	0	0%	**0%**
Initial Oral Exam	10,509	20	0.19%	**0.02%**
Periodic Oral Exam	41,508	53	0.13%	**0.05%**
Emergency Exam	6,793	22	0.32%	**0.02%**
Intraoral Periapical X-Rays	62,438	45	0.07%	**0.04%**
Bitewing X-Rays	42,621	33	0.08%	**0.03%**
Complete Set of X-Rays	17,098	71	0.42%	**0.07%**
Panoramic X-Rays	5,836	6	0.10%	**0.01%**
Amalgam Restoration (silver fillings)	20,801	29	0.14%	**0.03%**
Composite/Resin Restorations (white fillings)	5,846	12	0.21%	**0.01%**
Prefabricated Stainless Steel Crowns	3,522	13	0.37%	**0.01%**
Crowns	395	1	0.25%	**0%**
Routine Extractions	10,874	21	0.19%	**0.02%**
Biopsies	*	*	*	*
Surgical Treatment of Diseases	292	1	0.34%	**0%**

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**
Root Canal Therapy on Primary and Permanent Teeth	582	2	0.34%	**0%**
Apicoectomy, Surgery Involving the Root Surface	*	*	*	*
Gingival Curetage, Including Local Anesthesia	*	*	*	*
Gingival Flap Procedure	*	*	*	*
Scaling and Root Planing	322	1	0.31%	**0%**
Gingivectomy	*	*	*	*
Upper, Lower, or Complete Set of Dentures	*	*	*	*
Partial Dentures	*	*	*	*
Repairs, Relines, and Adjustment of Dentures	*	*	*	*
Orthodontic Services (braces)	6,943	12	0.17%	**0.01%**
Analgesia	7,809	39	0.50%	**0.04%**
Sedation – Intravenous Administration of Drugs	1,260	6	0.48%	**0.01%**
Sedation Non-Intravenous Administration of Drugs	220	2	0.91%	**0%**
General Anesthesia	1,049	1	0.10%	**0%**
Palliative Treatment	*	*	*	*
Professional Hospital Visit	322	2	0.62%	**0%**

** 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. The potential error rate for the remaining 26 applicable service categories was well below the acceptable 5% rate. Denied claims for these services in comparison to total claims submitted ranged from 0% to 0.07% across the 26 categories. A factor potentially impacting these results, but not considered in this analysis, is appropriate denial of services based on utilization review. Also, 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 DentaQuest. 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	1,574	4	0.25%	**0.01%**
Cleaning/Prophylaxis – One Every Six Months	2,752	1	0.04%	**0%**
Regular Oral Exams – One Every Six Months	1,808	241	**13.33%**	**0.23%**
Bitewing X-Rays – One Every Six Months	1,505	186	**12.36%**	**0.18%**

Potential error rates for topical fluoride application and cleaning/prophylaxis were very low. Regular oral exams and bitewing X-ray potential error rates were higher. However, each of these paid service categories accounted for less than approximately 0.2% 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, a significant number of claims coded as paid with a zero amount paid were identified.

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 DentaQuest's 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	
DentaQuest	94.4%

For DentaQuest, three criteria were not documented across the 12 elements in the evaluation tool, resulting in an overall score of 94.4%.

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 DentaQuest.

Table 8. Strengths, Suggestions, and Areas of Noncompliance	
Strengths	
No strengths were identified.	
Suggestions	
Element 1: Fraud, Waste, and Abuse Procedure Components – 1	1. The dental benefit manager (DBM) could update Policy and Procedure (P&P) #HR01.03-ENT and/or the Compliance Program Description to include specific references to 42 *Code of Federal Regulations* (CFR) 438.608, 42 CFR 4559(a)(2), and Section 409.814, Florida Statutes. 2. The DBM could create a document similar to the DentaQuest of Florida Contract Compliance with the State of Florida Agency for Healthcare Administration (AHCA) to address the Florida Healthy Kids program.
Element 13: Treatment of Recoveries	The DBM could update P&P #CL02-INS to address the requirements for providers to notify the DBM of the reason for overpayment and to return an overpayment within 60 calendar days after the overpayment was identified. The DBM could update the provider manual to address the 60-calendar-day timeframe.
AONs	
Element 1: Fraud, Waste, and Abuse Procedure Components – 1	The DBM should demonstrate appropriate reporting of the Chief Ethics and Compliance Officer (CECO) to the Chief Executive Officer (CEO).
Element 3: Fraud, Waste, and Abuse Procedure Components – 3	The DBM should document prompt notification to Florida Healthy Kids Corporation (FHKC) of changes in an enrollee's circumstances that may affect the enrollee's eligibility within five business days of receipt.
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.

Review of DentaQuest's compliance documentation resulted in three AONs, including demonstration of the appropriate reporting relationship of the Chief Ethics and Compliance Officer to the Chief Executive Officer, notification to FHKC of changes in enrollee circumstances that may affect eligibility, and reporting excess capitation or other payments to FHKC. Three suggestions were identified, one specific to including appropriate regulatory citations in a P&P, creating a document similar to the DentaQuest of Florida Contract Compliance with the State of Florida Agency for Healthcare Administration to specifically address the FHKC contract requirements, and addressing provider overpayment requirements in the associated P&P, though this was demonstrated in operational practice. 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
DentaQuest Benefits Administration, Windward Claims Administration System: Restricting Fraud, Waste, and Abuse During Claim Adjudication described procedure coverage rules (based on covered benefits and benefit limitations), adjudication engine edits (including claim, provider, and service line validation), clinical edits (based on standard medical practice), crossclaim bundling edits, and procedure payment/alternative benefit edits (based on appropriate coding). Reject codes were also in place to cause manual review for continued processing.

DentaQuest provided detailed information on its prospective claim system edits.

Table 10. Retrospective Processes for Claim Screening	
Standard Reporting and Screening Processes	Standard Operating Procedure (SOP) #FPR04-DENT-SOP: Utilization Oversight Process described the process for monitoring provider-level utilization to ensure enrollees and clients were protected from inappropriate use of allocated financial resources. The process was overseen by the Fraud Prevention and Recovery (FPR) Department, working in concert with other appropriate departments. The process was initiated when relevant complaints, grievances, or appeals regarding utilization were filed or a quality of care issue was identified. In addition, standard deviation reports indicating that a provider's utilization deviated above or below the acceptable threshold triggered an investigation.
Specific Investigation Processes	SOP #FPR04-DENT-SOP described the investigation process, including securing a significant sample of enrollee records for review by professional clinical staff to determine if services were medically necessary and appropriate and met acceptable standards of care. Remedial actions included, but were not limited to, pre-payment review, clinical audits, and behavior modification/ education. Follow-up at the end of the remediation period was conducted to determine if additional remediation action was needed.
Sample Screening Reports	DentaQuest of Florida, Inc. Benchmark Provider Report included billing activity by provider, by service code, per 100 patients.

DentaQuest 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	Standard Operating Procedure (SOP) #FPR04-DENT-SOP described how follow-up at the end of the remediation period was conducted to determine if additional remediation action was needed.
Sample Follow-Up Activities Conducted	A sample letter sent to any provider with utilization substantially deviating from acceptable thresholds was provided. It advised of increased utilization oversight and the right to conduct comprehensive review of enrollee records.

DentaQuest provided documentation of appropriate follow-up processes and activities based on identification of questionable billing practices.

Table 12. Claims System Flagging for Nonpayment	
Federal and State Excluded Providers	Policy and Procedure #PEC05-INS: Disciplinary Actions, Corrective Action Plans, and Provider Appeals described the process by which providers were screened initially and ongoing for state and federal exclusions; however, no specific documentation related to the process for ensuring nonpayment was provided.

DentaQuest did not provide specific documentation related to ensuring nonpayment.

Conclusions and Recommendations

Based on analysis of key claim data fields, Qsource concludes that these data fields were highly complete and accurate, with low potential error rates for DentaQuest. 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 DentaQuest, with a total score of 94.4%, demonstrated a high level of compliance for truthfulness of claim data based on program integrity requirements.

DBM Recommendations

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

Table 13. Qsource Recommendations for DentaQuest			
Category	**Data Field(s) / Service(s)**	**Issue**	**Recommendation**
Accuracy of Benefit Application	Duplicated Payment	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.
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.

Table 13. Qsource Recommendations for DentaQuest			
Category	**Data Field(s) / Service(s)**	**Issue**	**Recommendation**
Services Over Limitation by Service Category	♦ 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 "P", but with a zero paid amount	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	Documentation provided did not demonstrate a direct line of reporting between the Chief Ethics and Compliance Officer (CECO) and the Chief Executive Officer (CEO).	The dental benefit manager (DBM) should demonstrate appropriate reporting of the CECO to the CEO.
Truthfulness of Claim Data	Fraud, Waste, and Abuse Procedure Components	Policy and Procedure (P&P) #HR01.03-ENT: Availability of the Code of Conduct & Ethics Standards did not include specific references to 42 *Code of Federal Regulations* (CFR) 438.608, 42 CFR 4559(a)(2), or Section 409.814, Florida Statutes.	The DBM could update P&P #HR01.03-ENT and/or the Compliance Program Description to include specific references to 42 CFR 438.608, 42 CFR 4559(a)(2), and Section 409.814, Florida Statutes.
Truthfulness of Claim Data	Fraud, Waste, and Abuse Procedure Components	The DBM's documentation was not specific to the Florida Healthy Kids program.	The DBM could create a document similar to the DentaQuest of Florida Contract Compliance with the State of Florida Agency for Healthcare Administration (AHCA) to address the Florida Healthy Kids program.

Table 13. Qsource Recommendations for DentaQuest			
Category	**Data Field(s) / Service(s)**	**Issue**	**Recommendation**
Truthfulness of Claim Data	Fraud, Waste, and Abuse Procedure Components	No documentation of notification to Florida Healthy Kids Corporation (FHKC) of changes in enrollee circumstances was provided.	The DBM should document prompt notification to FHKC of changes in an enrollee's circumstances that may affect the enrollee's eligibility within five business days of receipt.
Truthfulness of Claim Data	Disclosures	Documentation regarding reporting excess capitation or other 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 policy did not address the requirements for providers to notify the DBM of the reason for overpayment and to return an overpayment within 60 calendar days after the overpayment was identified, and the provider manual did not address the 60-calendar-day timeframe.	The DBM could update P&P #CL02-INS to address the requirements for providers to notify the DBM of the reason for overpayment and to return an overpayment within 60 calendar days after the overpayment was identified. The DBM could update the provider manual to address the 60-calendar-day timeframe.

FHKC Recommendations

Qsource suggests consideration of the addition of tooth surface and tooth number to the claim 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 | DentaQuest Program Integrity Standard Tool

2021 Periodic Audit: DentaQuest					
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**	**0.750**

2021 Periodic Audit: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
Findings	Policy and Procedure (P&P) #HR01.03-ENT: Availability of the Code of Conduct & Ethics Standards included the DBM's commitment to comply with applicable federal, state health plan programs, and employment law, but did not include specific references to 42 CFR 438.608, 42 CFR 4559(a)(2), or Section 409.814, Florida Statutes. P&P #HR01.03 ENT addressed the availability of the Code of Conduct on the DBM intranet for employees to review and download. The Code of Conduct & Ethics Standards included applicable requirements. P&P #COM05-ENT: Chief Ethics & Compliance Officer; Corporate Compliance Committee documented the position of the Chief Ethics and Compliance Officer (CECO), responsible for overseeing and monitoring the implementation of the Compliance Program, relating to federal and state healthcare programs, including rules and regulations of regulatory agencies. P&P #COM05-ENT noted that the CECO had direct access to the DBM's leadership and other management and legal counsel. The corporate organizational chart demonstrated that the CECO reported to the Quality and Compliance Committee of the Board of Directors with dotted line reporting to the Chief Legal Officer, who reported to the CEO. The Corporate Compliance Committee Charter Versions 2/19 and 11/20 included the committee's responsibility for oversight of the Compliance Program, which was described in the Compliance Program Description to include ensuring ongoing compliance with contractual obligations. The charter described senior management membership and addressed appropriate reporting to the Board of Directors. P&P #COM07-ENT: Training and Education included a comprehensive description of the training and education program for all employees on federal and state laws and regulations. The policy noted that the procedure outlined in the policy was modified based on unique needs of specific client/plan contracts.				
Strength	None were identified.				
AON	The DBM should demonstrate appropriate reporting of the CECO to the CEO.				
Suggestion	1. The DBM could update P&P #HR01.03-ENT and/or the Compliance Program Description to include specific references to 42 CFR 438.608, 42 CFR 4559(a)(2), and Section 409.814, Florida Statutes. 2. The DBM could create a document similar to the DentaQuest of Florida Contract Compliance with the State of Florida Agency for Healthcare Administration (AHCA) to address the Florida Healthy Kids program.				
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: DentaQuest					
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 P&P #COM06-ENT: Compliance Monitoring and Communication referenced an open line of communication between the Compliance Department and other applicable departments. Communication processes in place for employee reporting of compliance issues were described in P&P #COM09-ENT: Duty to Report Non-Compliance; Non-Retaliation. P&P #COM14-ENT: Enforcement and Discipline addressed disciplinary action as appropriate for violations of standards for employees, contractors, and vendors. P&P #COM09-ENT clearly outlined the non-retaliation policy in place. The Code of Conduct & Ethics distributed to employees included lines of communication, disciplinary guidelines, and non-retaliation policies. P&P #FPR01-INS-DENT: Fraud Prevention and Recovery Program – Dental described a dedicated Fraud Prevention and Recovery (FPR) Unit for the identification and prevention of fraud, waste, and abuse. The P&P described analysis of claims data for aberrant utilization and billing patterns and the investigation of issues identified. Florida-specific exhibits in the P&P addressed applicable federal and state laws and regulations related to fraud, waste, and abuse.

Strength None were identified.

AON None were identified.

Suggestion None were identified.

2021 Periodic Audit: DentaQuest					
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: DentaQuest					
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. P&P #PECO05-INS: Disciplinary Actions, Corrective Action Plans & Provider Appeals, Exhibit H: Florida included the provision that FHKC was notified of changes in network provider circumstances. CHIP Member Survey Results Florida Healthy Kids 2020 included results of telephone interviews of enrollees to determine if they had visited the dentist on a specific date. DentaQuest Member Satisfaction Survey Protocol for Reporting Verification of Service Findings included a description of the verification of services process, along with survey questions and reporting protocol, including investigations of non-substantiated services by the Fraud Prevention and Recovery Unit. P&P #COM10-ENT: False Claims Act Information included detailed information about the *False Claims Act*, including whistleblower protections. The P&P also addressed dissemination of its policies to contractors and agents and required they adopt these policies.				
Strength	None were identified.				
AON	The DBM should document prompt notification to FHKC of changes in an enrollee's circumstances that may affect the enrollee's eligibility within five business days of receipt.				
Suggestion	None were identified.				
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**
Findings	P&P #FPR01-INS-DENT included provisions for referral of potential fraud and abuse to the Medicaid Program Integrity (MPI) Unit within 15 business days of detection. The P&P also included suspension of payments to a provider/entity based on notification from the appropriate Medicaid agency of a credible allegation of fraud.				
Strength	None were identified.				
AON	None were identified.				

2021 Periodic Audit: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
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**	**1.000**
Findings	SFY 2020 Anti-Fraud and Abuse Compliance Plan clearly stated that FHKC had access to monitor fraud and abuse prevention activities conducted by the DBM.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				
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**	**1.000**
Findings	SFY 2020 Anti-Fraud and Abuse Compliance Plan stated that the DBM reported its findings demonstrating or indicating fraud or potential fraud by providers, subcontractors, applicants, or enrollees to FHKC.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				

2021 Periodic Audit: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
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	SFY 2020 Anti-Fraud and Abuse Compliance Plan noted that the DBM provided comprehensive reports of all investigative activity conducted by the Fraud Preventions and Recovery Department in the agreed-upon timeframe and format meeting all client-specific contractual obligations.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				
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**	**1.000**
Findings	SFY 2020 Anti-Fraud and Abuse Compliance Plan described how the DBM fully cooperated in any investigation by federal and/or state oversight agencies and any subsequent legal action resulting from an investigation.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				

2021 Periodic Audit: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
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 #COM09-ENT included a fraud and abuse policy and procedures relevant to officers, employees, independent contractors, Board members, and subcontractors regarding duty to report potential instances of non-compliance without fear or risk of retaliation. P&P #FPR04-INS: Fraud Detection, Exhibit C – Florida Laws and Statutes specifically stated that fraud and abuse policies were made available to employees, including rights to be protected as whistleblowers.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				
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	P&P #FPR01-INS-DENT addressed a dedicated FPR Unit to investigate unusual incidents and the development of corrective action plans to assist with prevention and detection of potential fraud and abuse.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				

2021 Periodic Audit: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
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 #PEC01-INS: Credentialing Guidelines indicated that, for Florida providers, a Medicaid number was required and that all providers were verified as Medicaid providers at initial and recredentialing via the AHCA electronic background screening system.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				
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 #PEC04-INS: Provider Maintenance and Ongoing Monitoring addressed provider requirements for disclosure of prohibited affiliations and information on ownership and control. Documentation regarding reporting excess capitation or other payments was not provided.				
Strength	None were identified.				
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.				

2021 Periodic Audit: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
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**	**1.000**

Findings	P&P #CL02-INS: Claims Payment addressed provider-identified overpayments, requiring immediate reporting and sending of a check for repayment with a letter, Explanation of Benefits, or the provider's own form. The provider manual included a provision that the provider notified the DBM of an overpayment and the reason for the overpayment and returned the full amount of the overpayment within 60 days after the date the overpayment was identified. Referral of Waste Recoveries Quarterly 2020 included identified and recovered payments by category.
Strength	None were identified.
AON	None were identified.
Suggestion	The DBM could update P&P #CL02-INS to address the requirements for providers to notify the DBM of the reason for overpayment and to return an overpayment within 60 calendar days after the overpayment was identified. The DBM could update the provider manual to address the 60-calendar-day timeframe.

2021 Periodic Audit: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
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 #PEC01-INS described that at initial and recredentialing, all providers, any disclosing entity, its owners, and managing employees were screened against the General Systems Administration, System of Award Management (SAM). P&P #PEC04-INS described the monthly monitoring of all providers and entities against the General Systems Administration SAM.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				

2021 Periodic Audit: DentaQuest					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
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 #PEC01-INS described that at initial and recredentialing, all providers, any disclosing entity, its owners, and managing employees were screened against state and federal exclusion lists. P&P #PEC04-INS described the monthly monitoring of all providers and entities against state and federal exclusion lists.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				
Program Integrity for Periodic Audit			**94.4%**	**15.000**	**14.167**

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.

The P and P discusses the Compliance Officer reference. The CEO is a member of the Quality and Compliance Committee of the Board of Directors, to which the CECO has direct reporting. Thus, the CECO does report directly to the CEO. To connect it, the Charter document for the Quality and Compliance Committee of the Board of Directors, which indicates on Page 1 ("Meetings") that meetings can be called at the request of the CEO. This establishes the CEO's connection with the Board, to which the CECO reports.

See updated documents submitted here.

COM05-ENT-Chief Ethics & Compliance (

ELEMENT #1_DentaQuest Qualit

Appendix B Element 3

This is an enhancement to our system will occur in 2022. We have added this information to our Fraud and Abuse Compliance Plan, see page 9 of the embedded document below.

SFY 2021 Fraud and Abuse Compliance Pla

Potential Risk Item	Description	Action Plan	Responsible Department(s)	Business Owner(s)	Anticipated Resolution Date
Change in Enrollee Circumstances Reporting	CMS requires that DentaQuest has processes to identify and report instances where an enrollee change in circumstances may affect their eligibility. DentaQuest does not have a process to capture a change in circumstance and report it back to the state.	Correspondence has created text rules to add to the return mail address to the existing double window coversheets to help Intake identify the health plan for tracking purposes. Intake is collecting undeliverable items to track the volume of undeliverable mail by market.	Intake CS Correspondence	Tenhaken Schmidt Schrank	2022

Appendix B Element 12

Capitation payments, we have a self- remit process in place with FHKC and this is our industry standard for all lines of business, of a +/-5% of expected payment threshold. We trend this for each quarter and we have not had any outstanding variances to report for FHKC. Attached is the policy.

FIN02-ENT-SOP-State and Health Plans Invo

Table 3 Duplicate Claims:

Our Claims Auditor and Encounter Team reviewed the list of claims. Both Teams did not see any duplication. The Claims are for different teeth with the same amount. The Provider should be including all teeth on 1 claim instead of breaking them out into 2 claims. The last two claims are for different members and not duplicates.

Table 4 Eligibility on DOS:

We reviewed the sample data on tab 4 and we are not seeing ineligible services were paid.

Table 6 Services over limitations:

We reviewed the sample data on tab 6 and we do not see where services were paid over limitations. Our system is set up to deny any services that have a limitation around them.

Since we do not see the same findings that your data shows from Tables 3, 4 and 6 we want to know if it would be beneficial to set up a meeting and preform a live showing and walk through? We are not sure where your data differs from what we are seeing.