2021

Periodic Audit

Report

MCNA Dental Plans

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
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
DRA ..... *Deficit Reduction Act*
DSC ..... Dental Services Contract
EOB ..... Explanation of Benefits
EQRO ..... External Quality Review Organization
FHKC ..... Florida Healthy Kids Corporation

[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.*

FDR..... Fraud Detection and Recovery / First Tier and Downstream Related
HHS..... Department of Health and Human Services
MCO..... Managed Care Organization
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)], 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 Managed Care of North America, Inc. doing business as MCNA Dental Plans (hereafter referred to as MCNA) in CY 2020. As all DBM provider financial arrangements are fee-for-service, MCNA 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, MCNA 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 MCNA:

- 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 MCNA's key claim data fields were complete and accurate, with the exception of accuracy of Treating Provider Medicaid Identification (ID) and Billing Provider Medicaid ID, both at 97.1%.

For accuracy of benefit application, of the 3,862 duplicate claims identified, only 168 were reported as paid. This resulted in a potential error rate of 4.4%, within the acceptable 5% rate. Paid duplicates accounted for a negligible percentage of total claims (0.2%). For eligibility of the enrollee on the date of service, 3,088 claims for services when the enrollee was not eligible were submitted, with 2,399 coded as paid. This resulted in a potential error rate of 77.7%. Further investigation demonstrated that the Member ID field for the vast majority of these claims was null, leading to an inability to link an associated eligibility record. Removing these claims from the analysis, the potential error rate dropped significantly to 1.5%, within the acceptable standard. All ineligible claims coded as paid accounted for about 2.9% of total claims submitted.

For services within benefit scope and benefit limitations paid, of the 25 applicable service categories for which benefits would typically be paid, 22 service categories (88.0%) demonstrated

potential error rates over the acceptable 5% rate. For 10 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 22.3%. 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 above the 5% acceptable rate for topical fluoride application, regular oral exams, and bitewing X-rays. The impact of small numbers contributed to the higher 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, all below 0.1%.

The truthfulness assessment was based on an evaluation of compliance with program integrity regulatory and contractual requirements. MCNA's overall score on the program integrity standard was 88.3%. For this assessment, one strength was identified related to comprehensive documentation of the DBM's compliance program. In addition, three suggestions and three areas of noncompliance (AONs) were identified. Most suggestions and AONs were related to incomplete information included in MCNA's policies and procedures (P&Ps) addressing requirements for notifying FHKC of various program integrity requirements.

Conclusions

Based on these analyses, Qsource concludes that MCNA'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 MCNA. However, potential errors in claim processing accuracy accounted for a negligible percentage of total claims submitted. For the truthfulness assessment, Qsource concludes that MCNA was moderately compliant with regulatory and contractual requirements related to program integrity. While most requirements were validated as reflected in 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. MCNA should also address the issue of claims with null Member ID fields. Also, Qsource recommends that MCNA 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. MCNA 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 MCNA 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 MCNA 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 MCNA. 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 MCNA

Field	Present	Completeness Rate	Accurate	Accuracy Rate*
	N=427,726			
Member Identification (ID)	409,322	95.70%	409,322	100%
Plan ID	427,726	100%	427,726	100%
Claim Reference Number	427,726	100%	427,726	100%
Billing Date	427,726	100%	427,726	100%
Claim Paid Date	427,726	100%	427,726	100%
Procedure Code	427,726	100%	427,230	99.88%
First Date of Service	427,726	100%	427,714	100%†
Financial Report Service Category	427,726	100%	427,726	100%
Treating Provider Type	427,726	100%	427,726	100%
Treating Provider National Provider Identifier (NPI)	427,726	100%	426,933	99.81%
Treating Provider Medicaid ID	426,939	99.82%	391,272	**91.65%**
Treating Provider Specialty Code	427,726	100%	427,726	100%
Billing Provider Type	427,726	100%	427,726	100%
Billing Provider NPI	427,726	100%	426,933	99.81%
Billing Provider Medicaid ID	426,939	99.82%	391,272	**91.65%**
Billing Provider Specialty Code	427,726	100%	427,726	100%
Place of Service	427,726	100%	427,443	99.93%

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

Completeness and accuracy rates were above 95% for all key claim fields, with the exception of Treating Provider Medicaid ID and Billing Provider Medicaid ID accuracy, both at 91.7%.

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 MCNA, 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	3,862
Total Duplicate Claims Paid	168
Potential Error Rate	4.35%
Paid Duplicates as % of Total Claims	**0.20%**

Out of 3,862 duplicate claims identified, only 168 were coded as paid. This resulted in a potential error rate of 4.4%, within the acceptable 5% standard. In addition, these paid duplicate claims accounted for only 0.2% 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 MCNA.

Table 4. Eligibility on Date of Service	
Total Services for Which Enrollee Not Eligible on Date of Service	3,088
Ineligible Services Paid	2,399
Potential Error Rate	**77.69%**
Paid Ineligible Services as % of Total Claims	**2.85%**

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 high (77.7%), detailed claims analysis demonstrated that the majority of claims in the "ineligible services paid" category were actually claims for which the Member ID field was null. This resulted in an inability to find an associated eligibility record for the claims involved. Taking this into account, the potential error rate dropped significantly to 1.5%. Total ineligible services coded as paid accounted for about 2.9% 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 MCNA. 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	305	4	1.31%	**0%**
Cleaning/Prophylaxis	40,839	4,867	**11.92%**	**5.78%**
Topical Fluoride Application	38,341	3,301	**8.61%**	**3.92%**
Sealants	28,512	3,331	**11.68%**	**3.95%**
Space Maintainers	612	164	**26.80%**	**0.19%**
Initial Oral Exam	8,233	822	**9.98%**	**0.98%**
Periodic Oral Exam	30,784	2,170	**7.05%**	**2.58%**
Emergency Exam	5,047	1,010	**20.01%**	**1.20%**
Intraoral Periapical X-Rays	55,485	18,776	**33.84%**	**22.28%**
Bitewing X-Rays	32,763	8,265	**25.23%**	**9.81%**
Complete Set of X-Rays	8,136	1,269	**15.60%**	**1.51%**
Panoramic X-Rays	7,661	6,002	**78.34%**	**7.12%**
Amalgam Restoration (silver fillings)	655	27	4.12%	**0.03%**
Composite/Resin Restorations (white fillings)	19,307	1,255	**6.50%**	**1.49%**
Prefabricated Stainless Steel Crowns	2,500	284	**11.36%**	**0.34%**
Crowns	273	42	**15.38%**	**0.05%**
Routine Extractions	8,978	1,971	**21.95%**	**2.34%**
Biopsies	*	*	*	*
Surgical Treatment of Diseases	*	*	*	*
Root Canal Therapy on Primary and Permanent Teeth	375	69	**18.40%**	**0.08%**
Apicoectomy, Surgery Involving the Root Surface	*	*	*	*
Gingival Curetage, Including Local Anesthesia	*	*	*	*
Gingival Flap Procedure	*	*	*	*

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**
Scaling and Root Planing	274	140	**51.09%**	**0.17%**
Gingivectomy	*	*	*	*
Upper, Lower, or Complete Set of Dentures	*	*	*	*
Partial Dentures	*	*	*	*
Repairs, Relines, and Adjustment of Dentures	*	*	*	*
Orthodontic Services (braces)	2,973	444	**14.93%**	**0.53%**
Analgesia	5,842	784	**13.42%**	**0.93%**
Sedation – Intravenous Administration of Drugs	1,388	170	**12.25%**	**0.20%**
Sedation Non-Intravenous Administration of Drugs	210	10	4.76%	**0.01%**
General Anesthesia	382	29	**7.59%**	**0.03%**
Palliative Treatment	*	*	*	*
Professional Hospital Visit	185	21	**11.35%**	**0.02%**

** Less than 100 services reported*

For 10 of the 35 service categories, less than 100 services were reported and were not included in the analysis. Of the remaining 25 applicable service categories for which benefits would typically be paid, 22 services (88.0%) demonstrated potential error rates over the acceptable 5% rate. Denied claims for these services in comparison to total claims submitted ranged from 0% to 22.3% of total claims submitted. 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 MCNA. 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	417	59	**14.15%**	**0.07%**
Cleaning/Prophylaxis – One Every Six Months	1,378	43	3.12%	**0.05%**
Regular Oral Exams – One Every Six Months	511	54	**10.57%**	**0.06%**
Bitewing X-Rays – One Every Six Months	437	47	**10.76%**	**0.06%**

Potential error rates were above the acceptable 5% rate for topical fluoride application, regular oral exams, and bitewing X-rays. 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 0.1% 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 Member ID data field was identified as null in 22,246 claim line records.

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 MCNA'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	
MCNA	88.3%

For MCNA, three criteria were not documented across the 12 elements in the evaluation tool, resulting in an overall score of 88.3%.

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 MCNA.

Table 8. Strengths, Suggestions, and Areas of Noncompliance

Strengths	
Element 1: Fraud, Waste, and Abuse Procedure Components – 1	The 2020–2021 Compliance and Fraud, Waste, and Abuse Program (Program) included a comprehensive, well-organized presentation of the dental benefit manager's (DBM's) compliance program.
Suggestions	
Element 1: Fraud, Waste, and Abuse Procedure Components – 1	The DBM could update the Program to include references to compliance with 42 CFR 4559(a)(2) and Section 409.814, Florida Statutes.
Element 3: Fraud, Waste, and Abuse Procedure Components – 3	The DBM could update the Program to include notification to Florida Healthy Kids Corporation (FHKC) of changes in provider circumstances.
Element 13: Treatment of Recoveries	The DBM could update the Program to specifically address notification of overpayments and recoveries to FHKC.
AONs	
Element 3: Fraud, Waste, and Abuse Procedure Components – 3	The DBM should document notification to FHKC of changes in enrollee circumstances that may affect eligibility.
Element 4: Fraud, Waste, and Abuse Procedure Components – 4	The DBM should document that payment suspensions will be put in place for a network provider for which FHKC determines there is a credible allegation of fraud.
Element 7: Fraud, Waste, and Abuse Procedure Components – 7	The DBM should update the Program to specifically note notification to FHKC of investigation and follow-up of any report notifications to FHKC of any fraud by subcontractors, applicants, or enrollees.

Review of MCNA's compliance documentation resulted in one strength related to its comprehensive and well-organized Compliance Program document. Three AONs were identified in MCNA's compliance documentation, related to notification to FHKC of changes in enrollee circumstances, investigation and follow-up on any reports on fraud, and suspension of payments

to providers for which FHKC has determined there is a credible allegation of fraud. Three suggestions were noted, one related to including appropriate regulatory citations in a P&P. The remaining two, documenting the requirement to notify FHKC of changes in provider circumstances and documenting the requirement to notify FHKC of overpayments and recoveries, were demonstrated in operational practice but not included in appropriate documentation.

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
Ineligible Codes provided a comprehensive list of ineligible codes/prospective claims edits.

MCNA provided detailed information on prospective claim system edits.

Table 10. Retrospective Processes for Claim Screening	
Standard Reporting and Screening Processes	The 2020–2021 Compliance and Fraud, Waste, and Abuse Program (Program) included the following information on standard screening and reporting: Ongoing computer-based analysis of providers (both participating and non-participating) and enrollee claims/encounter data is continual. Patterns of overutilization, exorbitant billing, or other unusual billing practices are addressed. Analysis is also performed for the monitoring of tele-dentistry including but not limited to Code on Dental Procedures and Nomenclature (CDT) codes D9995 and D9996. Additionally, proprietary system flags or edits within the claims systems automatically segregate claims with certain predetermined characteristics. Every claim is passed through a series of intelligent filters in the DentalTrac™ Management Information System for a complete profiling analysis. This includes Peer Outlier Reports that use complex algorithms to compare provider statistics against defined benchmarks. The reports compare treatment patterns using a wide range of filters, note deviations from the norms, and identify outliers. This includes calculating utilization by provider and comparing it to like providers within the same county and within the same state. Detailed claims analysis for targeted providers will include a one- to three-year service date time period (may be less depending on the provider's billing to date).
Specific Investigation Processes	The Program included detailed steps in planning and conducting investigations based on screening reports.
Sample Screening Reports	CDT Comprehensive Summary FL included standard screening reports by provider. CDT Code Summary FL Monthly provided aggregate claims by CDT code, including total claims, total line items, total billed, total allowed, total paid, total quantity, and total paid quantity. Screening reports also provided for resins billed again a year later, pulps to crowns, and surface resins.

MCNA 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	The Program addressed follow-up processes after the conclusion of the investigation, including periodic monitoring, referring suspected fraud to authorities, recoupment of overpayments, mediation or arbitration, litigation, provider education, and pursuing provider network dismissal.
Sample Follow-Up Activities Conducted	P&P #15.305: Program Integrity/Special Investigations Unit (PI/SIU) – Provider Investigations included template follow-up provider notification letters.

MCNA 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	The 2020–2021 Claims Program Description included the process by which state and federally excluded providers were flagged for nonpayment.

MCNA 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 complete and accurate for all but 2 of the 17 fields included in the analysis. 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 MCNA, with a total score of 88.3%, demonstrated moderate compliance for truthfulness of claim data based on program integrity requirements.

DBM Recommendations

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

Table 13. Qsource Recommendations for MCNA			
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	♦ Cleaning/Prophylaxis ♦ Topical Fluoride Application ♦ Sealants ♦ Space Maintainers ♦ Initial Oral Exam ♦ Periodic Oral Exam ♦ Emergency Exam ♦ Intraoral Periapical X-Rays	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 MCNA			
Category	**Data Field(s) / Service(s)**	**Issue**	**Recommendation**
	♦ Bitewing X-Rays ♦ Complete Set of X-Rays ♦ Panoramic X-Rays ♦ Composite/Resin Restorations (white fillings) ♦ Prefabricated Stainless Steel Crowns ♦ Crowns ♦ Routine Extractions ♦ Root Canal Therapy on Primary and Permanent Teeth ♦ Scaling and Root Planing ♦ Orthodontic Services (braces) ♦ Analgesia ♦ Sedation – Intravenous Administration of Drugs ♦ General Anesthesia ♦ Professional Hospital Visit		
Services Over Limitation by Service Category	♦ Topical Fluoride Application ♦ Regular Oral Exams ♦ Bitewing X-Rays	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	Member Identification (ID)	Claims with null Member ID fields	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 2020–2021 Compliance and Fraud, Waste, and Abuse Program (Program) did not specifically reference 42 *Code of Federal Regulations* (CFR) 4559(a)(2) and Section 409.814, Florida Statutes.	The dental benefit manager (DBM) could update the Program to include references to compliance with 42 CFR 4559(a)(2) and Section 409.814, Florida Statutes.

Table 13. Qsource Recommendations for MCNA			
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 notification to FHKC of changes in enrollee circumstances that may affect eligibility.
Truthfulness of Claim Data	Fraud, Waste, and Abuse Procedure Components	The Program did not address notification to FHKC of changes in provider circumstances.	The DBM could update the Program to include notification to FHKC of changes in provider circumstances.
Truthfulness of Claim Data	Fraud, Waste, and Abuse Procedure Components	The Program did not address payment suspensions as a result of FHKC determining a credible allegation of fraud exists.	The DBM should document that payment suspensions will be put in place for a network provider for which FHKC determines there is a credible allegation of fraud.
Truthfulness of Claim Data	Fraud, Waste, and Abuse Procedure Components	The Program did not specifically note notification to FHKC of investigation and follow-up of any report notifications to FHKC of any fraud by subcontractors, applicants, or enrollees	The DBM should update the Program to specifically note notification to FHKC of investigation and follow-up of any report notifications to FHKC of any fraud by subcontractors, applicants, or enrollees.
Truthfulness of Claim Data	Treatment of Recoveries	The Program did not specifically address notification of overpayments and recoveries to FHKC.	The DBM could update the Program to specifically address notification of overpayments and recoveries to FHKC.

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 | MCNA Program Integrity Standard Tool

2021 Periodic Audit: MCNA					
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**	**1.000**

2021 Periodic Audit: MCNA					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
Findings	The 2020–2021 Compliance and Fraud, Waste, and Abuse Program (Program) described written business policies and procedures as a component of the Program in accordance with 42 CFR 438.608. Specific reference to 42 CFR 4559(a)(2) and Section 409.814, Florida Statutes was not included. The Program referred to the Standards of Conduct, reviewed and updated by the Compliance Officer annually to ensure continued relevance in providing guidance to management and employees. The Program noted that the DBM has a designated Compliance Officer, responsible for implementing the Program with the assistance of a Compliance Committee, and who reported directly to the Chief Executive Officer (CEO) and board of directors. The Compliance Committee was described in the Program as a multidisciplinary subcommittee of the board of directors, with membership from the senior management level and responsibility for oversight of the Program. Effective training and education and verifying compliance with training were also addressed in the Program. Policy and Procedure (P&P) #7.311: Compliance and Fraud and Abuse Programs indicated that the Compliance and Fraud and Abuse program complied with all applicable requirements and standards under the applicable State agency contracts and 42 CFR 438.608 and 42 CFR455(a)(2).				
Strength	The Program included a comprehensive, well-organized presentation of the DBM's compliance program.				
AON	None were identified.				
Suggestion	The DBM could update the Program to include references to compliance with 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: MCNA					
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 Program described effective lines of communication for reporting suspected violations of regulatory compliance requirements, via a Compliance "Hotline." The Program also noted that employees, contractors, and agents could discuss issues with the Compliance Officer or CEO. The Program included a detailed discussion of enforcing standards through well-publicized disciplinary guidelines, including disciplinary actions for employees, delegates, and contractors. The Program noted that these guidelines were included in the training and education program. The Program included multiple and comprehensive references to non-retaliation policies. The Program included a detailed description of the Special Investigations Unit (SIU), including P&Ps and a dedicated staff for detecting, investigating, and reporting suspected and/or confirmed cases of fraud, waste, abuse, and/or overpayment.
Strength	None were identified.
AON	None were identified.
Suggestion	None were identified.

2021 Periodic Audit: MCNA					
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: MCNA					
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 Program included a description of notification to the Department of Health and Human Services (HHS) Office of Inspector General (OIG) with a copy to Medicaid Program Integrity (MPI) of changes in provider circumstances that may limit the ability of a provider to participate in the DBM's network. However, notification to FHKC was not addressed. The Florida Healthy Kids Provider Additions and Terminations Report from November 2020 demonstrated compliance with notification to FHKC of changes in provider circumstances. The Program described the process in place for verifying whether services billed by providers were received, using a monthly random sampling of a predetermined percentage of enrollees. Verification was conducted by enrollee phone interviews or sending the enrollee a copy of their Explanation of Benefits (EOB). The Program noted that the DBM strictly prohibited retaliation against an employee who, in good faith, seeks help or reports known or suspected violations and that compliance training included the topic of the *False Claims Act* and whistleblower protections.				
Strength	None were identified.				
AON	The DBM should document notification to FHKC of changes in enrollee circumstances that may affect eligibility.				
Suggestion	The DBM could update the Program to include notification to FHKC of changes in provider circumstances.				
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**	**0.500**

2021 Periodic Audit: MCNA					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
Findings	The Program noted that, upon completion of the preliminary investigation, if there is suspected or confirmed fraud or abuse, the SIU Investigator would report the instance within 15 days of discovery to the MPI. The Program described that the DBM would place a provider on payment hold when OIG or MPI discovers there is credible evidence of willful misrepresentation or fraud. However, FHKC was not addressed.				
Strength	None were identified.				
AON	The DBM should document that payment suspensions will be put in place for a network provider for which FHKC determines there is a credible allegation of fraud.				
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	The Program addressed access to financial and enrollee records relating to the delivery of services for which Medicaid monies are expended, upon request, to authorized federal and State oversight agencies.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				

2021 Periodic Audit: MCNA					
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**	**1.000**
Findings	The SIU Workflow provided in the Program addressed notification of findings of fraud or potential fraud to the applicable State agency.				
Strength	None were identified.				
AON	None were identified.				
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**	**0.000**
Findings	The Program specified the investigation process and follow-up notification to MPI for any fraud, waste, or abuse instances. However, notification to FHKC was not addressed.				
Strength	None were identified.				
AON	The DBM should update the Program to specifically note notification to FHKC of investigation and follow-up of any report notifications to FHKC of any fraud by subcontractors, applicants, or enrollees.				
Suggestion	None were identified.				

2021 Periodic Audit: MCNA					
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**	**1.000**
Findings	The Program specifically stated that the DBM would cooperate fully in any investigation by federal and State oversight agencies and any subsequent legal action that may result from such an investigation.				
Strength	None were identified.				
AON	None were identified.				
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	The Program included a summary of the *Deficit Reduction Act* (DRA), effective January 1, 2007, including the rights of employees to be protected as whistleblowers. The Program also indicated that employee training and education includes Section 6032 of the DRA.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				

2021 Periodic Audit: MCNA					
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 Program described dedicated SIU staff and resources to investigate unusual incidents and the development of provider corrective actions plans to assist with preventing and detecting potential fraud and abuse.				
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	The Program specifically addressed that the DBM would review the Agency's list of suspended and terminated providers to ensure that non-Medicaid-eligible providers were not included in the network. It also addressed that Credentialing was responsible for verifying provider Medicaid eligibility on the Agency for Healthcare Administration (AHCA) website.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				

2021 Periodic Audit: MCNA					
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**	**1.000**
Findings	The Program included a detailed section on required written disclosures to HHS OIG with a copy to MPI. P&P #14.102: Rate Adjustments and Reconciliations addressed reporting excess capitation or other payments to FHKC within 60 calendar days.				
Strength	None were identified.				
AON	None were identified.				
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**	**1.000**
Findings	The provider manual described the responsibility of the provider to notify the DBM of an overpayment and the reason for the overpayment within 60 calendar days of the date on which the overpayment was identified. The Program included that the SIU Director would submit annual reports of overpayments and recoveries to MPI. However, notification to FHKC was not addressed. The FHKC annual overpayment report template from September 2020 included overpayments identified and recovered.				

2021 Periodic Audit: MCNA					
Evaluation Elements	**Criteria**	**Criteria Met**	**Criteria Value**	**Element**	
				Value	**Score**
Program Integrity					
Strength	None were identified.				
AON	None were identified.				
Suggestion	The DBM could update the Program to specifically address notification of overpayments and recoveries to FHKC.				
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	The Program described that the DBM prohibits hiring or entering into contracts with individuals who have been debarred, suspended, or otherwise excluded from participating in procurement activities under the federal acquisition regulation. P&P #16.202: Review of Office of Inspector General (OIG) and Systems for Award Management (SAM) addressed both individuals who have been debarred, suspended, or otherwise excluded from participating in procurement activities under the federal acquisition regulation and affiliates of those individuals or entities.				
Strength	None were identified.				
AON	None were identified.				

2021 Periodic Audit: MCNA					
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	The Program specifically stated that the DBM would not engage the services of an entity that is excluded from participation in federal healthcare programs under section 1128 or 1128A of the *Social Security Act*.				
Strength	None were identified.				
AON	None were identified.				
Suggestion	None were identified.				
Program Integrity for Periodic Audit			**88.3%**	**15.000**	**13.250**

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.

Periodic Audit Response for MCNA

Please see our comments below:

The report mentions 2.85% total claims paid for members who were not enrolled on the DOS. We reviewed the ones provided in your spreadsheet and our system does show them active on the date of service.

Many of the potential errors mentioned in Table 5 make reference to entries that we denied. We noticed a couple of examples where we paid a 1208 within a month of a 1206 and they were counted as an error. We also saw some incongruence in other tabs such as in the T6 Reg Oral Exams. QSource referenced claim 1160465335247 where we paid D0150 $48.35 but in reality we denied the D0150 and paid D1110 and D1206 for $48.35.

Best Regards,

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