

Corporate Administration
Detection and Prevention of Fraud and Abuse
CP3030

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PURPOSE:

To facilitate the development of controls, which will aid in the detection and prevention of fraud and abuse against the Lifetime Healthcare Companies. To promote consistent organizational behavior regarding the detection and prevention of Fraud and Abuse. To ensure compliance with the 'Summary of Federal and New York State Laws on False Claims and False Statements and Whistleblower Protections' attached to this policy.

APPLIES TO:

This policy applies to all officers, employees and contractors of The Lifetime Healthcare Companies, including its subsidiaries and affiliates (collectively the "Corporation"), except as noted under "Exceptions."

POLICY:

The healthcare industry is a target for fraudulent and abusive billing practices. It is essential that a policy against fraud and abuse be established and understood corporate-wide. It is our responsibility to our members, providers, and employees to take appropriate steps to prevent loss due to fraud and/or abuse, and to work to recover any loss as part of our normal corporate activities. Therefore, it is the policy of the Corporation to review, investigate and document fraudulent or abusive acts with respect to enrollment, receipt of services, claims, premium deflections, provider billing misappropriations, and any other instances of fraud that are discovered. The Corporation shall comply with all applicable reporting requirements, both state and federal. The Corporation is committed to abiding by all applicable laws and regulations, including those pertaining to the state and federal programs it administers, and to assuring that its employees, contractors, and agents comply with those laws.

REPORTING:

The Corporation encourages all personnel to internally report all potential noncompliance with state or federal laws, or the Code of Business Conduct. In the event that the suspected noncompliance involves a

potential violation of any federal or state law or regulation that prohibits fraud, waste, or abuse in connection with any federal or state health care program, personnel must report such concern to the Special Investigations Unit, the Corporate Compliance Officer or Corporate Legal. Information may be reported anonymously. Those who report wrong doing will be protected from any form of retaliation.

Employees, officers, contractors or agents of the Corporation should report information regarding a potential false claim or fraud and abuse violation to:

1. The Special Investigations Unit at the following location and numbers: 165 Court Street, Rochester, New York 14647, telephone: 800-275-0170.

SIU Regional offices are as follows:

Univera	877-800-0910
Rochester	800-378-8024
CNY	800-219-8943
Utica	800-925-9154

2. The Corporate Compliance Officer at the following location and number: 165 Court Street, Rochester, New York 14647, telephone: 800-275-0170

or electronically at:

https://www.excellusbcbcs.com/guests/health_plans/about_us/preventing_fraud_and_abuse.shtml

Employees may also submit emails to the Corporate Compliance Officer at “Ethics and Compliance” through Lotus Notes.

or

3. The Corporate Legal Department can be contacted via e-tracker on Fingertips at https://www.healthcareplan.com/apps/WebEnrol/eforms/legal_tracker_contact_us_iform.jsp.

PROCESS:

Each case will be investigated on an individual basis taking into consideration the following:

- The reputations and integrity of the Corporation and its provider networks.
- The Corporation’s reputation to approach fraud and abuse seriously and conscientiously.
- Future deterrence and recovery.

FRAUD: Health care fraud is defined as an intentional deception or misrepresentation made by an individual or entity knowing that the misrepresentation may result in some unauthorized benefit to the individual, the entity or some other party.

ABUSE: Improper and excessive use of insurance, health care or long term care benefits or services, by providers, members, insureds and/ or patients. Abuse is a form of fraud which does not require intent.

The terms “fraud” and “abuse” shall also cover violations of all applicable state and federal laws and regulations pertaining to state and federal programs that the Corporation administers. More detail about the applicable state and federal laws is attached in Appendix A.

Fraud investigation will be handled by the Special Investigations Unit (SIU) under the supervision of the Corporate Director, SIU. The Corporate Director SIU, in turn, reports to the Office of Corporate Ethics and Compliance. The SIU is authorized to investigate any allegations of fraud or abusive billing pertaining to all lines of business and to include all providers, members, and group representatives, as well as, special investigations requested by management. The SIU will have unrestricted access to claims, records, reports, and all correspondence pertaining to the insured, the provider, the hospital or facility under investigation. The SIU will adhere to all Corporate rules of confidentiality and compliance. This information will be used for investigative purposes only.

The SIU will review all referrals received both by telephone and/or written communication. It is the responsibility of the SIU to detect, investigate and document possible cases of fraud or abusive activity; refer documented cases to the proper legal or regulatory authorities for criminal prosecution or other sanctions; and initiate recovery of monies identified as fraudulent or improperly paid. The Corporate Legal Department will review documented cases of fraudulent activity.

RESPONSIBILITIES:

The following are areas of responsibility related to Fraud and Abuse within the Corporation:

Senior Management: It is the responsibility of the Senior Management of the Corporation to support and stress the importance of the anti-fraud and abuse program.

Employees: It is the responsibility of every employee of the Corporation to be aware of what constitutes fraud and abuse and to report suspected situations to the SIU for further investigation. Employees may provide information anonymously via the Fraud Hotline. All details of any situation under investigation are considered confidential and no mention of any investigation is to be relayed to a provider, member, or anyone other than the SIU.

Corporate Legal: It is the responsibility of Corporate Legal to provide guidance, advice and counsel to the SIU concerning the legal ramifications of cases developed for prosecution. This advice includes communication concerning both criminal and civil litigation processes, to ensure avoidance of defamation and exposure for the Corporation.

Medical Director: It is the responsibility of the Medical Director to provide clinical interpretations and/or clarifications on issues that require the expertise of a Medical Director to determine over-utilization of services or inappropriateness of care that cannot be determined solely by the Special Investigator.

Communications: Information provided to Corporate Communications regarding the SIU's policy on fraud and abuse, and helpful information regarding awareness of fraud and abuse will be published in the appropriate publications issued to providers, members, employers, employees and brokers. The SIU will also provide Corporate Communications with information regarding criminal and civil proceedings to prepare them for any questions received from local television and radio stations.

Government Programs: It is the responsibility of Government Programs personnel to support the activity of the SIU when investigating cases of possible fraud and abuse involving government program providers or members (Medicare and Medicaid.)

Operations Division: It is the responsibility of all employees in Operations to be aware of what constitutes fraud and abuse and to follow the procedures in place regarding referrals of suspected fraud and abuse situations to the SIU for review.

VIOLATIONS:

Violation of this policy may result in disciplinary action, including termination for employees, termination of vendor, contractor or consultant contracts, or dismissal of interns and volunteers.

Additionally, individuals may be subject to loss of access privileges and/or civil or criminal prosecution

ORGANIZATION:

The Special Investigations Unit is composed of four geographic units dedicated to the identification, investigation, the pursuit of criminal prosecution, and the recovery of funds due to health care fraud and abuse. The fraud abuse teams are managed by the Corporate Director of the Special Investigations Unit. The Privacy Officer and/or Human Resources representatives may be called upon by the SIU to assist with investigations.

Additionally, the Corporation has software systems created to:

- Rebundle unbundled claims
- Flag coding errors such as inappropriate code modifiers
- Identify mutually exclusive procedures
- Flag files for review
- Use data warehousing systems coupled with data mining tools for comparisons and trends
- Identify providers that may routinely upcode procedures

EXCEPTIONS:

None.

EFFECT ON PREVIOUS POLICIES:

This policy supersedes any previous policy with respect to this subject matter approved or adopted by The Lifetime Healthcare Companies or its subsidiary or affiliates to which this policy applies.

At any time and without notice, the Corporation reserves the right to amend or establish its policies, requirements, and standards.