



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.

APPLIES TO:

This policy applies to all officers and employees of The Lifetime Healthcare Companies, including its subsidiaries and affiliates, and all contractors and agents of the Company.

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 company wide. It is our responsibility to our members, providers, and employees to prevent loss due to fraud and/or abuse, and to recover any loss as part of our normal company activities. Therefore, it is the policy of the Lifetime Healthcare Companies to review, investigate and document fraudulent or abusive acts with respect to claims, premium deflections, and provider billing misappropriations. The Lifetime Healthcare Companies shall comply with all applicable reporting requirements, both state and federal. The Lifetime Healthcare Companies are 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 Company encourages all personnel to internally report all potential noncompliance with state or federal laws, or the Code of Business Conduct or Compliance Program. 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 or the Compliance Officer. You may report information anonymously. Those who report wrong doing will be protected from any form of retaliation.

Employees, officers, contractors or agents of the Company 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.

You may also contact SIU Regional offices as follows:

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

or

2. The Corporate Compliance Officer at the following location and number: 344 Warren Street, Syracuse, New York 13202, telephone: 800 275 – 0170

or electronically at:

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

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

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 Lifetime Healthcare Companies’ 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 part.

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 Lifetime Healthcare Companies administers. More detail about the applicable state and federal laws is set forth in the attached 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 Deputy General Counsel-Legal Affairs, who reports to senior management. This unit 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. All Corporate rules of confidentiality and compliance will be adhered to. 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 Deputy General Counsel-Legal Affairs 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 Lifetime Healthcare Company 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.

Deputy General Counsel-Legal Affairs: It is the responsibility of the Deputy General Counsel-Legal Affairs to provide guidance, advice and counseling to the SIU concerning the legal ramifications of cases developed for prosecution. This advice includes communication concerning both criminal and civil litigation processes to insure 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.

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 Lifetime Healthcare Companies Inc. 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.

Violations of this policy may result in disciplinary action, up to and including termination.

EFFECT ON PREVIOUS POLICIES:

This policy supersedes any previously dated policy of the same subject matter, issued by The Lifetime Healthcare Companies or any subsidiary or affiliate to which this policy applies.

APPENDIX A

Summary of Federal and New York State Laws on False Claims and False Statements and Whistleblower Protections

1. Federal Laws

1.1. Federal False Claims Act [31 U.S.C. §§ 3729 - 3733]

The Federal False Claims Act allows the United States Attorney General or a private citizen to sue an individual or an entity for making certain “false claims” in connection with government business.

A person makes a false claim if he or she:

- knowingly presents a false claim for payment or approval to a federal government officer or employee;
- knowingly makes or uses a false record or statement to get a false or fraudulent claim paid by the federal government;
- conspires to defraud the federal government by getting a false claim paid;
- has property or money used by the federal government and delivers less than the amount for which he or she gets a receipt, with the intent to defraud the federal government;
- gives a receipt to the federal government without completely knowing that the information on the receipt is true, with the intent to defraud;
- knowingly buys or receives a pledge of public property from a federal government officer or employee who cannot lawfully sell the property; or
- knowingly makes or uses a false statement to conceal, avoid or decrease an obligation to pay money to the federal government.

A person can be found to have “knowingly” made a false statement if he or she acted in deliberate ignorance or reckless disregard of the truth of the statement.

A person who knowingly makes a false claim may be held liable to the federal government for a civil penalty of \$5,000 to \$10,000. He or she may also be liable for two or three times the amount of damages the federal government sustained. Whether the damages are doubled or tripled depends on whether the person cooperated with the government and other factors.

A suit for a false claim can be initiated by the United States Attorney General or by a private citizen who has independent knowledge of the facts. A private citizen wishing to bring a federal False Claims Act suit can only do so within the following time limits, whichever occurs last:

- within six years after the false claim was made; or
- within three years after the government should have become aware of the false claim, but in no event more than ten years from when the violation was committed.

A private citizen who brings a false claims suit must do so in the name of the federal government. After the private citizen (the “relator”) prepares a formal complaint and serves it on the government, along with all information that he or she has, the government may decide to take over the suit. If the government takes over the suit, it is not bound by the decisions of the relator, and the government can dismiss or settle the suit even if the relator objects. The relator may remain in the suit, or the court may limit the relator’s participation.

If the government informs the court that it does *not* want to take over the suit, the private party can continue with the suit, if he or she is an original source of the information on which it is based. If the private party continues with the suit but does not prevail, the private party may have to pay the defendant’s reasonable attorney’s fees and expenses, if the court finds that the action was frivolous or was brought to harass the defendant.

If the government prosecutes the suit and prevails, the relator who brought the case to the government may receive 15% to 25% of the court award or settlement, depending on his or her contributions to the proceeding. The relator will also be awarded reasonable expenses and attorney’s fees. However, if the suit was based primarily on information from another case, a government report or the news media, the relator may be awarded no more than 10% of the award or settlement.

If the government does not take over the action and the relator prevails, the relator will receive 25%-30% of the court award or settlement plus his or her reasonable expenses and attorney’s fees. Whether or not the government proceeds with the action, however, if the relator planned or initiated the false claim in the first place, he or she may recover nothing.

An employee who is discharged, demoted, suspended, threatened, harassed or discriminated against because he or she brought or participated in a False Claims Act suit may be entitled to reinstatement, double back pay plus interest, and compensation for other damages that he or she proves. In order to seek such relief, the individual must bring a separate action in federal court.

1.2. Federal Administrative Remedies for False Claims and Statements [31 U.S.C. §§ 3801 - 3812]

In addition to a suit under the False Claims Act, the federal government (but *not* a private citizen) can seek administrative penalties against a person or entity for making false claims. An individual or entity may be subject to administrative penalties for making or submitting a claim that the person knows or has reason to know is:

- false or fraudulent;
- includes or is supported by a written statement that includes false information or omits certain material facts; or
- is for payment for property or services the person has not provided as claimed.

Any person making such a false claim may be required, after a hearing, to pay a maximum penalty of \$5,000 per claim and an assessment of up to double the amount of the claim.

1.3. Prohibitions under the Social Security Act [42 U.S.C. §§ 1320a-7a – 1320a-7b]

The Social Security Act allows the government to impose civil penalties for various offenses. Examples of these offenses include improperly submitting claims for medical services (such as false claims or medically unnecessary claims), offering kickbacks, and making payments to induce the reduction or limitation of services.

The Social Security Act sets out criminal and civil penalties for making certain kinds of false statements in connection with federal health care programs, including Medicare. False statements made by a provider of items or services may constitute a felony punishable by a fine of up to \$25,000 and five years in jail, or both. A provider found to have made false statements can also be excluded from participation in the federal health care programs. When false statements are made by someone else, the penalty may be a fine of up to \$10,000 and one year in jail, or both.

Soliciting, receiving, offering or making illegal payments, including kickbacks, bribes or illegal rebates, is a felony punishable by a fine of up to \$25,000 and up to five years in jail, or both. Knowingly and willfully making false statements to qualify an institution for which certification is required is a felony punishable by a fine of up to \$25,000 or up to five years in jail, or both. Certain “illegal patient admittance and retention practices” are also punishable by a fine of up to \$25,000 or five years in prison, or both.

1.4. Health Care Fraud [18 U.S.C. § 1347]

It is illegal to knowingly and willfully execute or attempt to execute a scheme to either defraud a health care benefit program or to obtain money or property from a health care benefit program by means of false pretenses or representations. The penalty for such actions in connection with the delivery of or payment for health care items or services may be a fine or up to ten years imprisonment, or both. If the violation results in serious bodily injury, the penalty may be a fine or imprisonment of up to 20 years, or both; if the violation results in death, the person may be fined or imprisoned for any terms of years or for life.

1.5. False Statements Relating to Health Care Matters [18 U.S.C. § 1035]

In a matter involving a health care benefit program, it is illegal for any person to knowingly and willfully falsify, conceal or cover up by a trick, scheme or device a material fact; make any materially false, fictitious or fraudulent statement or representation; or make or use a materially

false document knowing that it contains materially false statements. The penalty may be a fine or imprisonment for up to five years, or both.

1.6. Theft or Embezzlement in Connection with Health Care [18 U.S.C. § 669]

It is illegal to knowingly and willfully embezzle, steal, convert or intentionally misapply money or assets of a health care program. The penalty may be a fine or up to ten years imprisonment, or both.

1.7. Other Federal Laws Relating to False Claims and False Statements

1.7.1. Mail and Wire Fraud [18 U.S.C. § 1341]

It is illegal to engage in a scheme to defraud or to obtain money or property by means of false or fraudulent pretenses, representations or promises by using the U.S. mail or a commercial interstate carrier. Penalties may be fines or imprisonment for up to 20 years, or both.

1.7.2. Laundering of Monetary Instruments [18 U.S.C. § 1956]

The federal money-laundering statute prohibits the laundering or transportation of funds from certain illegal activities. The penalties for violation are fines and imprisonment or both.

1.7.3. Racketeer Influenced and Corrupt Organizations (“RICO”) [18 U.S.C. §§ 1961 - 1968]

The RICO law prohibits certain “racketeering activity,” including mail fraud. It is illegal to invest the profits from a pattern of racketeering activity or collection of an unlawful debt in any business which affects interstate or foreign commerce. The penalty is a fine or up to 20 years in prison (or life imprisonment, if that penalty applies to the underlying crime) or both. The defendant may also be ordered to forfeit property to the government. Any person whose business or property is injured by the violation of these provisions can seek to recover in court three times the amount of damages he or she sustained, plus reasonable attorneys’ fees and expenses.

2. New York State Laws Regarding False Claims or Statements

2.1. False Statements Relating to the Medicaid Program [Social Services Law § 145-b]

Under New York state law, it is illegal for a person, firm, or Company to knowingly obtain or attempt to obtain payment from public funds for social services, including medical services, by:

- making a false statement or representation;
- deliberately concealing a material fact; or
- a fraudulent scheme.

Any person or entity that obtains or attempts to obtain such payment may be ordered to pay damages of three times the amount that was overstated. If the false statement was non-monetary, the damages may be three times the amount of loss that the state or other governmental entity incurred. In addition, if a provider of medical services is required to refund a payment received from the state or local government, the repayment must be made with interest.

In addition to requiring repayment of improperly claimed funds, the Department of Health may impose a penalty of up \$2,000 per item or service; if the provider has been subject to another penalty within the prior five years, the maximum penalty is \$7,500 per item or service. These penalties may be imposed for:

- failing to comply with the standards of the medical assistance program;
- failing to comply with generally accepted medical practices in a substantial number of cases; or
- gross and flagrant violation of generally accepted medical standards; *if that person also* receives payment for claims when the provide knew, or had reason to know, that:
 - the care, services or supplies ordered or provided were medically improper, unnecessary or in excess of the medical needs of the patient;
 - the care, services or supplies were not provided as claimed;
 - the person who ordered or prescribed the care which was medically improper, unnecessary or in excess of the medical needs of the patient was suspended or excluded from the medical assistance program; or
 - the services or supplies were never provided to the patient.

Under New York law, actions involving false claims are brought by government officials, not by private parties. In July 2006, the New York State Legislature passed a bill regarding Medicaid fraud. Unlike the federal False Claims Act, this law does *not* allow a private citizen to bring a false claim action.

2.2. Unacceptable Practices in the Medicaid Program [18 NYCRR §§ 515.2 - 515.3]

Under Medicaid provider regulations, false claims and false statements are unacceptable practices. Sanctions that the Department of Health may impose on a provider for unacceptable practices include censure, repayment, and exclusion from participation in the Medicaid program.

Making a false claim means submitting, or inducing or seeking to induce another person to submit, a claim for:

- care, services or supplies that have not been furnished;
- care, services or supplies provided at a frequency or in an amount that is not medically necessary;
- an amount that exceeds established Medicaid rates; or
- amounts substantially in excess of the customary charges or costs to the general public.

Making a false statement means making, or inducing or seeking to induce another person to make, a false, fictitious or fraudulent statement or misrepresentation of material fact in claiming a Medicaid payment or for use in determining the right to payment.

Concealing or failing to disclose an event that affects the right to payment, with the intention that a payment be made when unauthorized or in an amount greater than the amount due, is also an unacceptable practice in the Medicaid program.

2.3. Criminal Prohibitions under New York Law

In certain circumstances, a person who makes false statements may be charged criminally under New York law. Each of the following crimes may be a misdemeanor or a felony, depending on the intent of the perpetrator. Penalties include fines or imprisonment, or both.

2.3.1. Falsifying Business Records [New York Penal Law § 175.00 - 175.15]

Business records are defined as any writings, including computer data, that are kept or maintained by an enterprise to evidence its condition or activity. A person may be found guilty of falsifying business records if, with the intent to defraud, he or she:

- makes or causes a false entry in the business records;
- alters, erases, obliterates, deletes, removes or destroys a true entry in the business records;
- omits to make a true entry in business records when required to do so by law or his or her position; or
- prevents the making of a true entry or causes the omission of a true entry in business records.

It is a defense to a charge of falsifying business records if the person was merely an employee who, without any personal benefit, executed the orders of a supervisor.

2.3.2. Tampering with Public Records [New York Penal Law §§ 175.20 - 175.25]

A person may be found guilty of tampering with public records if he or she knowingly removes, mutilates, destroys, conceals, makes a false entry in or falsely alters any record or other written instrument filed with, deposited in, or otherwise constituting a record of a public office or public servant, when he or she knows he or she does not have the authority to do so.

2.3.3. Offering a False Instrument for Filing [New York Penal Law §§ 175.30 - 175.35]

A person may be found guilty of offering a false statement for filing if he or she, knowing that a written instrument contains false information, offers or presents it to a public office with the knowledge or belief that it will be filed with, registered or recorded in or otherwise become a part of the records of such public office.

2.4. New York Laws Prohibiting Retaliation

2.4.1. Prohibitions on Employers [New York Labor Law §§ 740]

Under New York law, an employer cannot take any retaliatory personnel action (discharge, suspension, demotion, or other adverse employment action) against an employee because the employee:

- disclosed or threatened to disclose to a supervisor or to a public body an activity of the employer that is illegal and that presents a substantial and specific danger to public health or safety;
- provides information to or testifies before a public body that is conducting an investigation or hearing into the employer's violation of law; or
- objects to or refuses to participate in the illegal activity of the employer.

A "public body" includes the U.S. Congress, the state legislature, any elected local governmental body, any federal, state or local judiciary, a grand jury or petit jury, any federal, state or local regulatory, administrative or public agency or authority, any law enforcement agency, a prosecutorial office or a police officer.

For an employee to be protected against retaliatory action for disclosing to a public body an activity of the employer that is illegal and that presents a substantial and specific danger to public health or safety, the employee must first report the violation to his or her supervisor and give the employer a reasonable opportunity to correct the activity.

If the employee is subjected to retaliation, he or she has one year from the retaliatory personnel action to bring a civil action in court. If the employee prevails in that suit, he or she may be reinstated and may receive lost wages and reasonable costs and attorney's fees. If, however, the court finds that the employee brought the suit without a basis in law or fact, the court may award the employer its costs and reasonable attorney's fees.

In any court action brought under this law, it is a defense for the employer if the personnel action was based on grounds other than the employee's exercise of protected rights.

2.4.2. Health Care Facilities [New York Labor Law § 741]

Employees who perform health care services for certain health care facilities have additional protections against retaliatory personnel actions. Health care facilities include, among others: Companies, nursing homes, and other facilities licensed under Article 28 of the Public Health Law; home care services agencies and certified home health agencies; and facilities that provide health care services under the Mental Hygiene Law. A health care facility employee covered by this statute has two years to bring suit if he or she is subject to a retaliatory personnel action for:

- disclosing to a supervisor or public body that he or she reasonably believes, in good faith, that the employer is providing “improper quality of patient care,” as defined below; or
- objecting to or refusing to participate in any practice of providing “improper quality of patient care.”

“Improper quality of patient care” means a practice or action, or a failure to act, that violates a law or regulation if the violation relates to matters that may present a substantial and specific danger to public health or safety or a significant threat to the health of a specific patient. In order to be protected against retaliation, the employee must first bring the matter to the attention of his or her supervisor and give the employer a reasonable opportunity to correct the problem, unless there is an immediate threat to health or safety and the employee reasonably believes in good faith that reporting to the supervisor will not result in corrective action.

The court may award a covered employee back pay, costs and attorneys fees and may order that he or she be reinstated. If the court finds that the employer acted in bad faith, it may assess a civil penalty of up to \$10,000, to be paid into a fund for improving quality of patient care.

In any court action brought under this law, it is a defense for the employer if the personnel action was based on grounds other than the employee's exercise of protected rights.

2.4.3. Public Employers [Civil Service Law § 75-b]

Different protections are available to employees in the public sector, such as employees of state agencies and other governmental entities.

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