

Humana Business Entity and Employee Education Policy about False Claims Recovery

Humana Medical Plan Inc. is contracted with the Agency for Health Care Administration (AHCA), in the state of Florida, to provide health insurance to a selected number of Medicaid enrollees. Federal and state legislation are a driving force on how health plans manage their business.

Humana policy requires compliance with federal and state rules, laws, and regulations and Humana requirements by all contracted providers, subcontractors, vendors, and any other entity doing business with Humana serving its Medicaid membership.

This policy includes definitions and examples for all Humana business organizations and their employees on the topics of Federal False Claims Act, Federal Program Fraud Civil Remedies, Florida State False Claims Act, whistleblower and whistleblower protections and Humana's procedure for reporting suspected fraudulent activities.

In regard to the False Claims Act, the meaning of a claim is "the request for reimbursement that is submitted to a health plan contracted with the government or a request for reimbursement submitted directly to the government."

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Federal False Claims Act- (FCA) Title 31 United States Code (USC) 3729-3733

(a) The False Claims Act states:

Any person or entity who-

(1) Knowingly presents, or causes to be presented, to an employee of the United States government a false or fraudulent claim for payment or approval;

(2) Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the government;

(3) Conspires to defraud the government by getting a false or fraudulent claim allowed or paid;

(4) Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money to the government;

(5) Has actual knowledge of the information;

(6) Acts in deliberate ignorance of the truth or falsity of the information; or

(7) Acts in reckless disregard of the truth or falsity of the information; no proof of specific intent to defraud is required.

The False Claims Act imposes two sorts of liability: first, the submitter of the false claim or statement is liable for a civil penalty, regardless of whether the submission of a claim actually causes the government any damages and even if the claim is rejected. Secondly, the submitter of the claim is liable for damages that the government sustains because of the submission of the false claim.

In the CMS Manual it states that "Under the False Claims Act, those who knowingly submit or cause another person to submit, false claims for payment by the government are liable for three times the government's damages plus civil penalties of \$5,000 to \$10,000 per false claim."

The federal government does not consider an innocent mistake as a legitimate defense for submitting a false claim, and the violation could result in a multitude of penalties.

Examples of medical fraud:

- Submitting a bill to Humana for services never rendered to a Humana Medicaid member;
- Knowingly overcharging for services provided to a Humana Medicaid member;
- Filling a prescription at brand cost, but giving the Medicaid member the generic medication;
- Upcoding the Medicaid member's visit;
- Falsifying the Medicaid member's record noting a visit when the member did not come to the office;
- Submitting a bill to Humana for supplies never used by the Medicaid member;
- Double billing;
- Use of untrained personnel to provide services;
- Distribution of unapproved devices or drugs;
- Forgery of physicians' signatures;
- Unbundling;
- Fraudulent cost reports; and
- Use of substandard equipment.

Administrative Remedies under the False Claims Act

Program Fraud Civil Remedies Act (PFCRA) 31 USC 3801- 13

This act was enacted in 1986 as an administrative alternative to pursue false claims and statements that total under \$150,000. The standards of knowledge and burden of proof are the same as the False Claims Act, and no specific intent to defraud is required. An administrative hearing will be held to determine liability. This is considered a civil case. A potential case may be reported to the Office of Inspector General (OIG). The OIG would make the determination whether or not the case warrants additional investigation.

Florida Statute 68.081-.083 Title VI Civil Practice and Procedure

Florida False Claims Act

This act was created to serve as a deterrent to persons who might consider submitting false claims to the state government. In addition, it provides recourse for the state to obtain monetary damages and civil penalties when there is a conviction. The state false claims definitions mirror the federal definitions. However, there are some differences in what civil actions may be taken if there is a conviction for false claims. The state civil penalties of the person liable would not be less than \$5,000, but not more than \$10,000 plus three times the monetary amount of damages the state agency sustained because of the violation. No proof of specific intent to defraud is required. An innocent mistake would be considered a defense to a false claim according to the state legislation.

Whistleblower

A whistleblower is someone, such as an employee, who reports suspected misconduct that would be considered an action against company policy or federal or state rules, laws or regulations. The reporting of suspected misconduct may be related to the severity of the alleged violation. If it is low risk, then the reporting could be to a fellow co-worker or supervisor; if it is considered high risk then the employee could choose to seek legal advice or speak with law enforcement. Prior to making accusations, the whistleblower should be reporting facts and not what he or she thinks is true. This is an extremely serious situation that requires much forethought by the whistleblower prior to taking any action.

Whistleblower Protection- 31 United States Code Service (USCS) 3730 (h)

The whistleblower provision protects employees who assist the federal government in the investigation and prosecution of violations of the False Claims Act. Whistleblower protections apply only to actions taken in furtherance of a viable False Claims Act case that has been, or is about to be, filed. The

provision prevents retaliation against the employee, such as firing that individual for assisting in the investigation and prosecution. If any retaliation does occur, the employee has a right to obtain legal counsel to defend the actions he or she has taken.

Humana's Anti-Fraud Plan

Humana's Special Investigations Unit (SIU) is responsible for detection, prevention, and recommendation of process improvement for health insurance and prescription Part D fraud, waste, and abuse. In an effort to facilitate proper business practices and preserve reasonable premium rates, the SIU staff investigates and works with appropriate law enforcement agencies when dealing with insurance fraud by providers, the insured, agents, employer groups, company associates, business entities, and other individuals. Humana's health care insurance products and lines of business include medical, dental, pharmacy, commercial, Medicaid and Medicare (including Parts A, B, C, and D-Prescription Drug Plan). Life and disability insurance fraud are also investigated by the SIU.

All information received or discovered by the SIU will be treated as confidential, and the results of investigations will only be discussed with persons having a legitimate reason to receive the information (i.e., state and federal authorities, Humana corporate law department, market medical directors, or senior management). Individuals providing information to or receiving information from the SIU may be instructed to refrain from discussing facts, suspicions, and allegations with anyone outside the SIU, unless directed to do so by the SIU, or as required pursuant to government action or court order.

Humana's SIU utilizes a software tool for data mining that aids in the detection and prevention of health care claims fraud and assists in the investigation process. In addition, the tool is used in the detection and investigation of prescription fraud.

Tracking Suspected Fraud

Humana's SIU records all cases of suspected insurance fraud, waste, and abuse using a computer software program. All aspects of an investigation are recorded detailing the following information:

- A description of the allegations and how the referral was received
- Information on the suspect(s)
- Any phone calls made or received relative to the case
- Claims and medical records that are reviewed
- Correspondence with state, federal, or regulatory agencies
- Any letters or correspondence sent or received
- The decision on what action is to be taken on the case
- Any other activity or information regarding the case

The SIU and its investigators should have unrestricted access to all Humana records and facilities, and authority to examine, copy and/or remove items within the scope of an investigation. The SIU maintains reports and spreadsheets to track various activities, such as requests and subpoenas received from law enforcement agencies and cases that are referred to state and federal agencies, including CMS and the Medicare Drug Integrity Contractor (MEDIC). The SIU issues reports on a need-to-know basis to the appropriate senior management upon completion of an investigation.

Reporting of Fraud-related data to the Insurance Commissioner

The SIU reports cases of suspected fraudulent insurance activity to the state's Department of Insurance (DOI) as required, or other appropriate state, federal, or regulatory agency. The SIU reports such activity

to the state at the time that it has been determined or reasonably suspected that a fraudulent insurance act has been committed. The SIU conducts an in-depth review of the suspect(s), which involves various means of investigation, including telephone interviews, claims and medical records review, review of various reports, working with other departments, insurance companies, and law enforcement agencies, along with many other techniques, to reach the determination of suspected fraud, waste or abuse.

The SIU complies with any time frames set by the state for reporting fraudulent activity. The SIU reports to the state's DOI through the National Association of Insurance Commissioners (NAIC), or through the state's DOI Web site.

Special requests for data are forwarded to the SIU and given priority handling upon receipt of a specific written request for information. Data are compiled and submitted to the appropriate law enforcement agency.

Referral of Fraud Cases to Law Enforcement Authorities

Humana is committed to aggressively investigating and when appropriate, referring cases of fraud to law enforcement authorities for possible prosecution by members, providers, agents, business entities, employer groups, company employees, and other individuals. The SIU is responsible for the coordination of referrals to law enforcement and government authorities. SIU works with the appropriate departments within the company to provide the maximum possible assistance to law enforcement and government agencies, including CMS and MEDIC officials in compliance with state and federal laws.

Referrals may be made to state fraud bureaus, the U.S. Postal Inspectors, FBI, U.S. Department of Health and Human Services, MEDICs, state medical licensing and disciplinary boards, state insurance commissioners, federal, state and county attorneys, local police departments, Immigration and Naturalization Service, Internal Revenue Service, or any other appropriate authority. The SIU reports fraud, waste and abuse for all products and lines of business, including medical, dental, life, pharmacy, commercial, Medicare and Medicaid. Suspected fraud for Medicare (Parts A, B and C) is reported to CMS through the Department of Health and Human Services (HHS)-Office of Inspector General (OIG). Suspected Medicaid fraud, waste, and abuse are reported to the Medicaid Integrity Program Administrator, Agency for Health Care Administration (AHCA), or appropriate Medicaid Agency. Suspected fraud, waste, and abuse activities for Medicare Part D are reported to the appropriate MEDIC.

Suspected violations should be reported to Humana's Special Investigation Unit:

HUMANA

Special Investigations Unit

1100 Employers Blvd.

Green Bay, WI 54344

Phone Number: 1-800-558-4444 ext. 8187

Fax Number- 1-920-617-1594

Website - siureferrals@humana.com

Or you may call Humana's toll-free Ethics Help Line: **1-877-584-3539**

You may remain anonymous. The Help Line staff members are not Humana employees.