Summary of CareFirst BlueCross BlueShield Fraud and Abuse Policy

CareFirst Compliance Department

CareFirst wants to provide associates with a confidential resource to report an observed event or behavior that may be in violation of the CareFirst Code of Business Conduct & Compliance. As such, CareFirst established the Compliance and Ethics Hotline. The Hotline is a confidential, internal tool for associates who wish to report a potential or suspected violation of CareFirst’s Code of Business Conduct and Compliance. Possible violations include:

- Misuse of company resources, funds or property.
- Abuse of any accounting and financial policies and requirements.
- Disclosure of proprietary and confidential information about CareFirst or its customers.
- Conflict of interest with any business investment, financial or outside organization

Anti-Fraud and Abuse / Special Investigations:

All CareFirst associates are required to complete the Anti-fraud and Abuse Training Program. This computer based training program is designed to educate employees about fraud and abuse in the health care insurance area, and to make employees alert to fraudulent practices.

Key areas covered in the Anti-fraud and Abuse Training Program includes:

- Motivations for fraud and abuse
- Symptoms, characteristics, schemes, typical scenarios, and examples of fraud and abuse
- Steps taken if fraud and abuse is suspected:
  - Complete and attach a Phone Call form and route the claim to have a phone call made to the subscriber/provider to verify claims information. Indicate on the form "possible fraudulent claim" and the reason why the claim appears fraudulent. Note: If the claim was submitted by the subscriber, the phone call should be made to the provider. If the claim was submitted by the provider, the phone call should be made to the subscriber.
  - If services are validated, process the claim, if not, refer claim to SIU as possible fraud.

CareFirst has a Special Investigations Unit (SIU) devoted to detecting any unnecessary and inappropriate medical care costs billed by physicians and fraudulent claims submitted by subscribers. This is done through analysis of special antifraud software that identifies a physician's usage of services over and above that of his peers. SIU Investigators analyze discrepancies between services billed and those perceived as having been rendered through medical record reviews, in consultation with registered nurses and physicians. Provider/subscriber fraud concerns are also referred internally from various departments within the company and externally through law enforcement agencies and other BlueCross and BlueShield Plans.

SIU maintains a fraud hotline for people to contact (by phone or email) regarding any activities related to their health insurance which may indicate some concern of fraud and/or abuse. Such inquiries are researched and the appropriate action taken to address/resolve the concern.

SIU conducts prepayment review of claims submitted by providers and/or subscribers whose services have been identified as deviating from accepted medical practice because of inappropriate or excessive use.

- Provider is notified by certified letter of prepayment review, effective date, and issues of concern
- Provider must submit all claims via paper and attach medical records that pertain to the claim.
- A pend is placed on the provider file across all claims platforms directing the claims to SIU for review.
The investigator reviews the claim and will okay for payment, request documentation if needed to review claim, or send to the Medical Directors for review if they feel the claim should be denied.

Appeal rights are included in the notice of payment generated from the claims adjudication.

SIU is also responsible for retrospective analysis of provider practices. Generally, reviews are conducted for participating provider practices (professional or facility) or subscribers. Once an incorrect billing pattern is identified:

- The investigators contact and discuss with provider
- Conduct an expanded on site audit if appropriate
- Notify the provider of audit findings
- Initiate recoveries of identified overpayments
- Re-educate the provider on the correct billing process
- Conduct Compliance audit in 3-6 months from finalized date of the audit

In addition to the above, the following functions are in place:

- SIU conducts internal fraud refresher trainings at department staff meetings
- Confirmation program - designed to conduct both pre- and post-payment verification of services and charges on suspect claims received on behalf of members.
- A daily review of a computerized report of all claims paid to the subscriber exceeding a set dollar amount.
- Exchange of information among carriers on known fraudulent providers.
- Medical records review for suspect overseas claims.
- Cooperation with local, state and federal law enforcement agencies to assure prosecution as necessary.

Special Investigations (SI) provides new hire training for claims processors and customer service personnel, which outlines guidelines and helpful tips in spotting potential fraudulent claims.

CareFirst Associates are instructed to forward suspicious cases to Special Investigations (SI). SI is responsible for detecting, investigating, and bringing to conclusion fraudulent or abusive acts. Once tips and leads are turned over to special investigations, several steps take place:

- Auditors expand the investigations by selecting random samples of paid services.
- Auditors verify services through telephone and/or personal interviews, on site audits, and desk reviews of medical records.
- Information is compiled and a report is prepared outlining the actions taken and audit findings.
- If the information obtained indicates a discrepancy, the case is handled administratively.
- Cases involving suspected fraudulent or abusive activity are referred to the appropriate regulatory and/or law enforcement agency for further legal action.