

**AMENDED ANTI-FRAUD PLAN  
FOR  
AvMed, Inc. d/b/a AvMed Health Plans  
July 2007**

AvMed, Inc. d/b/a AvMed Health Plans ("AvMed") hereby amends the Anti-Fraud Plan of its Special Investigations Unit ("SIU") to identify, investigate, and rectify instances of fraud, waste and abuse committed by participating and non-participating providers and facilities, all vendors, employees, members, and unaffiliated third parties. AvMed's Special Investigative Unit, operationally established as the Audit Services & Investigations ("AS&I") resides in the AvMed Legal Department, collaborates with and is supported by the Compliance Department, Risk Management Department, and Internal Audit Department. This Plan is also designed as an element of the AvMed Compliance Program. AvMed has a fiduciary responsibility to the broader health care community to resist criminal behavior, instances of false claims and improper billing and coding practices, and other schemes that adversely impact patient safety, the quality of health care services being delivered and that impose a tremendous financial burden on the health care system.

In addition, AvMed's Anti-Fraud Plan is in compliance with Section 626.9891(a)(b), Florida Statutes, Section 626.9891(3), Florida Statutes and Rule Chapter 69D-2.001-005, Florida Administrative Code. Likewise, as a Medicare Advantage Organization under contract with the Centers for Medicare and Medicaid Services, federal law, including but not limited to 42 C.F.R. 423.504(b)(4)(vi)(H) for Part D plan sponsors, requires that AvMed have in place a comprehensive fraud and abuse plan to detect, correct, and prevent fraud, waste and abuse.

## **MISSION STATEMENT**

AvMed will not tolerate health care fraud, waste or abuse in any of its relationships with either internal or external clientele. Furthermore, AvMed will establish and maintain internal controls designed to prevent schemes with unaffiliated third parties. AvMed will identify, resolve, report, and, when appropriate, refer for prosecution, situations in which suspected fraud, waste or abuse has occurred.

AvMed has adopted the following mission statement for its fraud and abuse program:

*The AvMed Anti-Fraud Program seeks to meet the customer's expectation that we will reimburse only for services that are medically necessary and appropriate and that the benefits will be issued only to eligible subscribers and providers. We strive toward this goal by providing a central point for the detection, investigation, and resolution of fraud, waste and/or abuse.*

## ANTI-FRAUD GOALS

AvMed's goals and priorities are key to its anti-fraud program success. Key benefits include:

- ◆ **Quality** - Improving the quality of patient care is a priority.
- ◆ **Customer Relations** - An effective anti-fraud program demonstrates the company's strong commitment to honest and responsible provider and corporate conduct.
- ◆ **Assessment of Risk** - The program will facilitate a more accurate view of risk and exposure relating to fraud and abuse.
- ◆ **Public and Legislative Compliance** - The program facilitates compliance with state and federal laws, and demonstrates an aggressive approach to fighting fraud/abuse.
- ◆ **Civic Responsibility** - Combating fraud/abuse through identifying and preventing criminal and unethical conduct is considered a public duty.
- ◆ **Financial Savings** - Through prevention, early detection and recovery, minimizing the loss to AvMed and its clients from false claims is a priority.
- ◆ **Deterrence** - Future deterrence of fraud/abuse is a priority.
- ◆ **Objective Claims Handling** - Standard, unbiased claims review is required by law and is smart business.

## ANTI-FRAUD PLAN

The components of the Anti-Fraud Plan are as follows:

- I. **Internal and External Prevention, Detection and Investigation of Insurance Fraud**
- II. **Recovery**
- III. **Reporting**
- IV. **Education and Training**
- V. **Primary Contact Persons/Organizational Chart**

### I. PREVENTION, DETECTION, INVESTIGATION OF INSURANCE FRAUD

#### A. Internal Fraud

##### **Prevention, Detection and Investigation**

AvMed has adopted fraud prevention, detection and investigation procedures. Following is a summary of AvMed's fraud, waste and abuse control procedures that serve to prevent internal fraud, waste and abuse.

##### Comprehensive Internal Compliance Program

The current AvMed Compliance Program provides, among other things, for the reporting of compliance issues. Employees report improper activity to their supervisors, the General Counsel, the Director of Internal Audit, the Director of Compliance, Director of Audit Services & Investigations, or anonymously to the Compliance Hotline 1-877-

AVM-DUTY. The Compliance Program expressly prohibits retaliation against those who, in good faith, report concerns or participate in the investigation of compliance issues. The Compliance Program provides that compliance concerns will be investigated rigorously and resolved promptly. Investigations regarding compliance program violations are conducted by General Counsel, Compliance Department, Internal Audit, AS&I, or Human Resources, depending upon the nature of the violation. Compliance and fraud and abuse training is provided to all new employees and to existing employees on an annual basis.

## **B. External Fraud**

### **1. Prevention and Detection**

AvMed strives to detect and prevent health care and insurance fraud, waste and abuse by receiving referrals from a variety of sources and through the use of sophisticated fraud detection technology.

AvMed seeks to detect fraud, waste and abuse through a variety of methods as follows:

#### **a. Insurance Fraud Detection Technology**

Data will be routinely and randomly analyzed by the AvMed Medical Department, Network Department, Pharmacy Department and AS&I, based upon tips from all sources, to include external vendors specific to provider, facility, member and pharmaceutical fraud, waste and abuse as well as independent research. This data analysis will be critical in the identification of repetitive fraud, waste and abuse patterns. Output reports will be used for existing cases as well as the bases for new ones.

AvMed will utilize data mining capabilities and other technological tools in preventing and detecting insurance fraud, waste and abuse as well as the advanced technological tools of external vendors.

Ongoing computer-based analysis of provider, facility, member and pharmaceutical data is important. Patterns of over-utilization, false claims, or other unusual billing practices are addressed. Additionally, proprietary system flags or edits within the claims systems automatically segregate claims with certain predetermined characteristics.

#### **b. Fraud/Suspicious Claim Referral Sources**

The identification and prevention of fraud, waste and abuse is a cooperative effort, involving all employees. All employees are required to cooperate in any investigation conducted by AvMed, its regulatory agency, or law enforcement.

The AS&I receives fraud, waste and abuse and/or suspicious claim referrals from the following sources:

- ◆ Hotline 1-877-AVM-DUTY
- ◆ Tips from enrollees, insured's, providers, other insurers and the general public received by AvMed;
- ◆ Referrals from member services staff, claims personnel, medical management, medical claim review staff, provider relations representatives, medical directors, quality assurance staff, pharmacy, utilization review personnel and provider credentialing units; other medical providers;
- ◆ Media reports;
- ◆ Through involvement in the National Health Care Anti-Fraud Association;
- ◆ Information obtained in conjunction with studies conducted by AvMed and/or its external vendors and/or;
- ◆ Office of Inspector General's (OIG) database of excluded individuals/entities;
- ◆ Referrals from law enforcement agencies such as the Florida Department of Law Enforcement, the Florida Division of Insurance Fraud, Office of Insurance Regulation, Centers for Medicare and Medicaid Services, MEDICs, the FBI, or other agencies engaged in identifying, investigating and prosecuting fraudulent activities.

## **2. Investigation**

- a. AS&I field auditors and investigators are provided with and follow AS&I's Investigation Procedures in conducting prompt investigations. The Investigations Procedure includes, but is not limited to, the following topics:
  - ◆ Information for investigators regarding general investigation guidelines; conducting interviews; report writing; information disclosure; law enforcement relations;
  - ◆ The process to be employed when a suspicious claim is identified;
  - ◆ The suspicious claim indicators;
  - ◆ The duties and functions of the AS&I.
- b. Through the course of its investigations, the AS&I Department may work with any other department within AvMed to review questionable claims and provide guidance.
- c. The quality and credibility of allegations or suspicious situations are assessed. Initial exposures and recovery potential are identified to determine if a case should be opened.
- d. Cases are prioritized pursuant to commonly accepted business practices and business objectives.
- e. An investigative action plan/timeline is developed to guide the investigation. The action plan is periodically reviewed and revised as circumstances change.

- f. Relevant claim data for the period in question is obtained and reviewed and evidence is gathered to support data analysis and allegations.
- g. An investigative summary/report is prepared which summarizes the investigative findings, displays a comprehensive understanding of the facts and financial implications and recommends a corrective action plan to include reporting as appropriate and follow-up.

## II. RECOVERY

AvMed contracts with numerous commercial client groups, as well as governmental clients including, but not limited to, the Florida Division of State Group Insurance, the U.S. Office of Personnel Management for the Federal Employee Health Benefit Program and the Centers for Medicare and Medicaid Services as a Medicare Advantage organization. AvMed acknowledges its responsibility to be a proper steward and to ensure that only eligible employees or beneficiaries are afforded coverage, only medically necessary and medically appropriate services are covered and that anti-fraud, waste and abuse programs and procedures are in place. Additionally, AvMed acknowledges its responsibility to recoup overpayments to providers, vendors or others under commercial and governmental contracts as a means of reducing unnecessary medical claims costs. To this end, the AvMed Audit Services and Investigations Department utilizes state of the art technology to detect improper billing and coding practices and employs competent nurse field auditors, data analysts and other professionals to detect, remedy and recoup overpayments due to claims unbundling and up-coding. These recovery efforts are integral to the anti-fraud, waste and abuse efforts of AvMed and supplement the other responses to such behaviors and the procedures outlined in the AvMed Compliance Program.

## III. REPORTING

Pursuant to Section 626.989(6), Florida Statutes, if the Compliance Officer and General Counsel determines that a claim or case meets the minimal threshold under Florida law as defined by Section 626.989(1), Florida Statutes, information regarding suspected fraud, waste and abuse shall be reported to the Florida Department of Insurance, Division of Insurance Fraud ("Division"), CMS, MEDICs, and/or other law enforcement agencies. Reports to the Division will be via website ([www.fldfs.com/fraud](http://www.fldfs.com/fraud)) and CMS/MEDICs via the MEDIC Referral Form. All case files being referred will contain documentation that clearly defines and supports the allegation of suspicious activity, include detection and reported dates and be in compliance with 42 C.F.R. 423.504(b)(4)(vi)(H).

Pursuant to Section 626.989(1), Florida Statutes, a fraudulent insurance act is committed if a person knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer/HMO, self-insurer, agent, broker, etc., any written statement as part of, or in support of, an application for insurance, rates, claims, or any other benefit, which the person knows to contain materially false information concerning any material fact. Also, a fraudulent insurance act is

committed if the person conceals, for the purpose of misleading another, information concerning any material fact.

AvMed shall cooperate fully with the Florida Division of Insurance Fraud, CMS, MEDICs, and/or other law enforcement agencies in their prosecution or additional investigation of cases reported on behalf of AvMed.

#### **IV. EDUCATION AND TRAINING**

##### **A. Education/Fraud, Waste and Abuse Awareness Training**

Pursuant to Section 626.9891(3)(c), Florida Statutes, anti-fraud education and training of claims adjusters or other personnel is mandatory.

AvMed has initiated a Fraud Awareness Campaign. The purpose of this program is to encourage and assist AvMed's employees, members, vendors, providers and other customers to identify, detect, and report health care and insurance fraud, waste and abuse.

The corporate training program is broad in scope. The intent is to address health insurance fraud, waste and abuse and the impact that it can have on AvMed and the program is designed to be in-person training. Its objectives are to provide staff members with specific tools to detect fraud, waste and abuse, instruct them in the procedures for reporting cases of suspected fraud, waste and abuse, and create an awareness of the staggering financial and service consequences of fraud, waste and abuse. AvMed's Audit Services and Investigations, Compliance Department and Risk Management Departments collaborate in executing its Fraud Awareness Campaign.

All personnel are required to attend Fraud Awareness & Compliance Training every year. All new AvMed Staff members are provided Fraud Awareness Training as part of the orientation process. Mandatory attendance records are maintained by the Compliance Department. Non-compliance of AvMed's Compliance and or Fraud Awareness Training will result in disciplinary action. Employees that have specific responsibilities in Medicare Part D business areas should receive specialized training on issues posing compliance risks based on their job function upon initial hire and at least annually thereafter as a condition of employment. Regular fraud awareness bulletins are distributed to all employees and anti-fraud information is available on the AvMed website and eZone.

The focus will be on the critical role that each employee plays in the eradication of fraud, waste and abuse committed against AvMed and its customers. Highlights of the program include:

- ◆ Definition of fraud, waste and abuse;
- ◆ Tools for fraud, waste and abuse detection ("red flags");
- ◆ AvMed's prevention efforts;
- ◆ Reporting fraud, waste and abuse;

- ◆ Review of actual investigations;
- ◆ Current industry trends in the fraud, waste and abuse arena.
- ◆ Investigative Procedures;
- ◆ Unique Department Procedures;
- ◆ Case Management System.

## **B. Investigator Education/Training**

Upon hire, AS&I investigators complete a comprehensive fraud detection-training course that provides the new investigator with information about AvMed's Anti-Fraud Plan as well as material regarding techniques used to combat fraud, waste and abuse.

AS&I staff members receive technical fraud, waste and abuse training through attendance at the National Health Care Anti-Fraud Association's various seminars and workshops. AS&I staff members who attend participate in the sessions that relate most directly to their specialty or position.

Additional training sessions will include technical/computer training that will occur throughout the year and address various computer applications used in AS&I positions.

## **V. PRIMARY CONTACT PERSONS/ORGANIZATIONAL CHART**

In accordance with Florida Statutes Section 626.9891(3)(d), the personnel identified herein should be extended immunity from civil liability concerning the sharing of information regarding persons suspected of committing fraudulent insurance acts with Anti-Fraud personnel employed by other HMO's and/or insurers pursuant to Florida Statutes Section 626.989(4)(d).

- ◆ **Any inquiries regarding the AvMed Anti-Fraud Plan should be directed to:**

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## Audit Services & Investigations Reporting Flowchart

### AS&I Anti-Fraud Plan Flow Chart

