



Better Health

Aetna Health, Inc

Policy

Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	1 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	■ Texas Medicaid ■ Texas CHIP		

Purpose: The waste, abuse and fraud plan is to detail the prevention, detection, investigation, recovery, and reporting of all suspected cases of waste, abuse or fraud. The Plan also specifies the development of a Special Investigative Unit (SIU), whose primary responsibility is to prevent, detect, investigate, recover, and report cases of waste, abuse and fraud.

Policy: Aetna Better Health (Aetna) recognizes that its responsibility and commitment to detecting, preventing, investigating, recovering, and reporting of waste, abuse, and fraud for all services pertaining to the Medicaid and CHIP programs, including services provided by subcontractors. Texas Administrative Code (TAC), Title 1, Part 15, Chapter 353, Subchapter F, Rule 353.501-353.505. Texas Administrative Code (TAC), Title 1, Part 15, Chapter 370, Subchapter F, Rule 370.501-370.505 as well as Texas Government Code §§ 531.113,533.012.

Aetna Better Health (Aetna) also recognizes that it is responsible for investigating, recovering, and reporting waste, abuse or fraud related to the filing of false claims against the United States Government or failure of an MCO to provide services required under contract with the state of Texas, enrollment/marketing violations and wrongful denial of claims. Title 31 United States Code (USC) Subtitle III, Chapter 37, Subchapter III, Sections 3729 – 3733. Aetna is also subject to the administrative remedy provisions under Chapter 38 of Title 31, Texas Human Resources Code Chapter 32, Subchapter B, Section 32.039, 42 CFR § 438.608 Program Integrity requirements and 42 CFR § 455.20. Aetna is also subject to the administrative and civil remedies under Chapters 32 and 36 of this title.

Aetna Better Health (Aetna) employees must adhere to the Corporate Code of Conduct to ensure ethical behavior and actions of all employees, and participate in annual training regarding corporate policies and procedures.



Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	2 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	■ Texas Medicaid ■ Texas CHIP		

Procedures:

0.0 Special Investigative Unit (SIU)

- 0.1 The Aetna Better Health (Aetna) SIU is responsible to detect, investigate and recovery of suspected cases of fraud, waste, and abuse to be reported to the HHSC Office of Inspector General (OIG) and Office of Attorney General (OAG).
- 0.2 The Aetna Better Health (Aetna) SIU includes a dedicated Texas SIU Coordinator who is a full time employee (FTE) whose job function includes responding to OIG, OAG inquiries, assisting SIU investigators with administrative duties for potential fraud, waste, or abuse cases. The SIU Coordinator will serve as a liaison for SIU in reporting completed case findings to the Compliance Manager.
- 0.3 The SIU Coordinator will chair the Fraud, Waste, and Abuse Committee, which will meet as needed to review all cases that have been identified as potentially involving fraud, waste, or abuse. This Committee will consist of representatives from the Quality, Medical Management, Claims, Member Services, Compliance, Provider Relations, Community Outreach, and Data Management Departments.
 - 0.3.1 The SIU will investigate and provide all details to the SIU Coordinator to be reviewed during the Committee meetings.
 - 0.3.2 All Committee meeting minutes will be documented and logged by the SIU Coordinator.

1.0 Provider Fraud, Waste, and Abuse

- 2.0 Detection of Provider Fraud, Waste, and Abuse The SIU uses the following software to support fraud detection and investigation: IBM Fraud & Abuse Management System, Statistical Analysis System (SAS), Crystal Reports, MS Access, MS Excel and the Aetna Fraud & Abuse Case Tracking System, QNXT, iHealth. and McKesson Claim Check. Mechanisms available to detect potential fraud, waste, and abuse include:



Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	3 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	<input type="checkbox"/> Texas Medicaid <input type="checkbox"/> Texas CHIP		

- 2.1.1 Trending of provider complaints, billing patterns, payment history, acute care, emergency room, and pharmacy claims..
- 2.1.2 Ad Hoc reporting, custom analyses, specialty profiling and outlier detection using the QNXT and McKesson Claim Check
- 2.1.3 Claim check editing that identifies lifetime procedures, duplicate payments, and payment to specific procedures codes to gender and age
- 2.1.4 Aetna Credentialing and Provider Relations reviews HHS OIG exclusions and state license actions monthly and updates provider flags for identified, excluded/unlicensed providers. Aetna terminates provider contracts for excluded providers.
- 2.1.5 The Member/Provider Hotline will be used to report fraud, waste, and abuse. The Hotline will be communicated to the providers and members through the use of the provider manual, provider orientations, member handbooks and member and provider newsletters. The introductory message to the Hotline will state the ability to report any suspected cases of fraud, waste, or abuse using the specified function of the Hotline.
- 2.1.6 Payment review methodologies will be utilized to detect suspicious cases to include: up-coding, bundling/unbundling, and utilization patterns.
- 2.1.7 Direct reporting to the SIU department from staff, members or providers and State and Federal agencies.
- 2.1.8 In addition, upon receiving notification of a deceased provider Aetna Better Health (Aetna) will terminate the provider and ensure appropriate system updates to mitigate risk of future payments

2.2 Investigation of Provider Waste, Abuse, and Fraud The SIU will conduct a preliminary investigation within fifteen (15) working days of identification of a potential fraud, waste, or abuse case. This investigation methodology may include:



Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	4 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	<input type="checkbox"/> Texas Medicaid <input type="checkbox"/> Texas CHIP		

- 2.2.1 Previous investigations or reports of fraud, waste, and abuse by the provider with all information related to the previous investigation, the outcome of the investigation and whether the new allegation is the same or related to a previous investigation, to determine any connection with the case under review.
- 2.2.2 Provider Relations educational/visitation logs/complaint logs.
- 2.2.3 Reports of provider paid claims, denied claims, and encounter data for a minimum of three years (if available).
- 2.2.4 Internal policies and procedures, state defined policies and procedures, TMPPM, and state and federal regulations.
- 2.2.5 Letters sent to members and providers during the course of the investigation to confirm treatment was received or provided

2.3 Sample Selection and Medical Record Request

- 2.3.1 Based on the review above, the SIU will select a minimum of 50 members or 15% of the provider’s claims related to the suspected fraud, waste, or abuse within fifteen (15) working days of making the determination of possible waste, abuse or fraud.
- 2.3.2 Within fifteen (15) working days a sample is selected. The SIU will request medical records and encounter data from the provider via certified mail and return receipt requested.

2.4 Medical Record Document Review The SIU and/or Medical Director will review the documents submitted within forty-five (45) working days of receipt in order to:

- 2.4.1 Access utilizations and quality of care.
- 2.4.2 Ensure the accuracy of encounter data submitted.



Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	5 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	<input type="checkbox"/> Texas Medicaid <input type="checkbox"/> Texas CHIP		

2.4.3 Evaluate the need for review and request additional records as necessary.

2.5 Recovery of Overpayments: The SIU may pursue fraud recovery directly from providers once an investigation confirms a verified paid loss. Provider flags may be placed by an SIU investigator (following confirmation of an allegation) which triggers pre-payment claims review and/or denial if warranted to prevent losses to fraud.

2.6 Technology of Fraud, Waste, and Abuse Services: The SIU has an internal SIU Information Technology group dedicated to anti-fraud activities. Part of its mission is to leverage technology in fraud detection, investigation, prevention and reporting. The SIU utilizes the most current versions of fraud detections systems.

3.0 Member Fraud, Waste, and Abuse

3.1 Detection of Member Fraud, Waste, and Abuse. Mechanisms will include:

3.1.1 Fraud, Waste, and Abuse Hotline

3.1.2 Review of claims data to evaluate utilization pattern to include:

3.1.2.1 Treatments and/or medications prescribed by more than one provider appearing to be duplicative, excessive or contraindicated; and

3.1.2.2 Members are using more than one physician to obtain similar treatments and/or medications; and

3.1.2.3 Providers other than the assigned Primary Care Provider (PCP) are treating the member, and there is no evidence that the member was treated by the assigned PCP for a similar or related condition or referred to a specialist; and

3.1.2.4 The member has a high volume of emergency room visits with a non-emergent diagnosis.



Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	6 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	<input type="checkbox"/> Texas Medicaid <input type="checkbox"/> Texas CHIP		

3.1.3 Use of ER utilization reports using triggers such as at least 3 visits to the ER within 6 months to detect patterns of ER abuse or overuse by the member without an emergent diagnosis.

3.1.4 Medical records review in the event that it aids to the detection if this information could not be obtained through the claims data.

3.2 Investigation of Member Fraud, Waste, and Abuse SIU conducts a preliminary investigation within fifteen (15) working days of the identification of a potential fraud, waste and/or abuse case. This investigation methodology may include:

3.2.1 Review of claims to identify any overuse or abuse in obtaining care.

3.2.2 Review of the pharmacy data to evaluate possible abuse of prescription drug usage and trending.

3.3 Member Verification of Services Aetna Better Health (Aetna) will conduct random telephonic surveys to verify with members that services billed by providers were received.

4.0 Reporting Fraud, Waste, and Abuse

4.1 All staff will be trained in reporting suspected cases of fraud, waste, and abuse to the SIU.

4.1.1 Staff will be trained to report all cases of suspected fraud and abuse within 24 hours of detection. (Attachment A and B)

4.1.2 The elements that will need to be reported to the SIU; include member/provider name, ID, date of offense, details of the situation, type of program involved (Medicaid or CHIP), any supporting documentation regarding the offense, and date that the allegation is reported to the SIU.

4.1.3 Once the detection is made, the SIU investigates the case to include any supporting elements needed to complete this investigation. The SIU



Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	7 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	<input type="checkbox"/> Texas Medicaid <input type="checkbox"/> Texas CHIP		

Coordinator convenes Fraud, Waste, and Abuse Committee to review. Feedback from the Committee will be incorporated into the completion of the investigation.

4.1.4 The SIU Coordinator will report the completed investigation to the Compliance Manager to review for completeness and accuracy of the data. The Compliance Manager will forward to the Executive Director.

4.2 The Executive Director has overall responsibility over the Fraud, Waste, and Abuse provisions.

4.3 The Aetna Better Health (Aetna) Executive Director will be accountable for reporting all information to the HHSC-OIG and OAG within thirty (30) working days of making the determination on the fraud, waste, or abuse case.

4.3.1 The Aetna Better Health (Aetna) Executive Director will use the HHSC-OIG fraud referral form located on the HHSC-OIG website to report all cases that have been determined to contain fraud, waste, or abuse. The information to be included with this form includes:

4.3.1.1 Investigative reporting identifying the allegation

4.3.1.2 Citation and/or copies of statues or regulations that have been violated

4.3.1.3 Results of the investigation of the case by the SIU

4.3.1.4 Copies of program rules and regulations that have been violated

4.3.1.5 Estimation of overpayment that has been identified, including any supporting reports or data

4.3.1.6 Summaries of interviews conducted during the investigation of the allegation



Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	8 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	■ Texas Medicaid ■ Texas CHIP		

4.3.1.7 Supporting encounter data associated with the case

4.3.1.8 Any reporting documentation used during the investigation.

4.3.2 The reporting responsibility to the HHSC-OIG and OAG lies with the Aetna Better Health (Aetna) Executive Director.

Leslie J. Young
Chief Executive Officer
Aetna Better Health (Aetna)
2777 Stemmons Freeway, Ste 300
Dallas, TX 75207
214-200-8226
800-240-1131 Fax

4.4 Expedited Referrals. All cases involving the following situations will initiate an expedited referral of the case to the HHSC-OIG and OAG.

4.4.1 Suspected harm or death to patients

4.4.2 Loss, destruction, or alteration of valuable evidence

4.4.3 Potential for significant monetary loss that may not be recoverable

4.4.4 Hindrance of investigation or criminal prosecution of alleged offense

5.0 Member, Provider, and Staff Fraud, Waste, and Abuse Education

5.1 Member Fraud, Waste, and Abuse Education

5.1.1 Members will be provided with waste, abuse, and fraud education, such as how to report fraud, waste, and abuse and use of the Hotline to report alleged fraud, waste, and abuse. The responsibility of the member to report fraud will also be stressed. The main form of communicating the Fraud,



Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	9 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	■ Texas Medicaid ■ Texas CHIP		

Waste, and Abuse Plan will be through the Member Handbook, which is provided to all members upon eligibility

5.1.2 Periodic articles on waste, abuse and fraud will also be provided to the member through quarterly member newsletters.

5.2 Provider Waste, Abuse, and Fraud Education

5.2.1 The provider network will be educated about the Fraud, Waste, and Abuse Plan through a variety of mechanisms. Upon contracting with Aetna, Provider Relations will schedule an orientation with the provider and office staff to go over the complete plan requirements, including the Fraud, Waste, and Abuse Plan. Documentation of this is recorded on the Provider Visitation Form.

5.2.2 Details of the Fraud, Waste, and Abuse Plan are also provided to the provider network through the provider manual and the Aetna Better Health (Aetna) website. Each newly contracted provider is given a provider manual and any updates to this manual are disseminated to the network incorporating program changes. Examples of provider fraud will be included such as up-coding, billing for services not provided, and submitting false encounter data. The documentation will include identification of the source for reporting suspected cases through the use of the Hotline and indicate the responsibility of the provider and office staff to report all cases of suspected waste, abuse and fraud.

5.2.3 Periodic articles will be produced in the quarterly provider newsletters to further communicate the Fraud, Waste, and Abuse Plan.

5.3 Internal Staff Fraud, Waste, and Abuse Education

5.3.1 Annual mandatory fraud, waste, and abuse training will be provided to the Aetna Better Health (Aetna) staff. The training will incorporate the Fraud, Waste, and Abuse Plan, detailed information about the function of the SIU, detection of waste, abuse, and fraud, investigation procedures,



Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	10 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	<input type="checkbox"/> Texas Medicaid <input type="checkbox"/> Texas CHIP		

including the identification of violations to the state and Federal False Claims Acts, and Whistleblower Protection Provisions, as well as reporting all suspected cases to the SIU.

5.3.2 Included in staff education is a requirement that all advertising and marketing materials utilized by the Plan are complete and accurately reflect the information about the Plan. Marketing materials will include information targeted for members.

5.3.3 Training will be provided by use of on-line tools.

5.3.3.1 Training is developed to meet the needs of the staff in various departments throughout the health plan. Staff education, materials and presentations include: specific examples of fraud, waste, and abuse, up-coding, billing for services not rendered and submission of false encounter data.

5.3.3.2 Aetna offers an on-line fraud awareness training tool to assist staff in understanding their obligation regarding detection and prevention of fraud, waste, and abuse and the proper handling of transactions once health care fraud is suspected.

5.3.3.3 The Compliance Manager and/or SIU Coordinator will attend monthly/quarterly fraud webinars, meetings with state/federal entities, and health care alliance groups to prevent, and detect potential fraud, waste, and abuse.

5.3.4 Training will include the following elements:

5.3.4.1 Aetna Better Health (Aetna) Fraud, Waste, and Abuse Plan

5.3.4.2 State and Federal False Claim Act and Whistleblower Protections

5.3.4.3 Detection of fraud, waste, and abuse with the use of examples of provider and member fraud



Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	11 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	<input type="checkbox"/> Texas Medicaid <input type="checkbox"/> Texas CHIP		

5.3.4.4 Use of the internal and online fraud, waste, and abuse reporting form

5.3.4.5 Requirement to report all suspected cases to the SIU within 24 hours of identification.

5.3.4.6 Flow chart of the detection, investigation, and reporting process for fraud, waste, and abuse cases

5.3.5 All new employees will be trained on the Fraud, Waste, and Abuse Plan within 90 days of being hired.

5.3.6 Logs of all training sessions will be kept in the training database to include the topics covered, attendee’s names, duration of the training, and dates of the training.

5.3.7 All updates to the Fraud, Waste, and Abuse Plan or policy and procedure will be provided to members, providers and staff within twenty (20) working days of being approved.

5.4 Subcontractor Fraud, Waste, and Abuse Plan

5.4.1 Aetna Better Health (Aetna) requires all subcontractor entities to submit their fraud, waste, and abuse plan annually. All subcontractors and agents are required to provide fraud, waste, and abuse training to their staff and provider network to meet HHSC requirements

5.4.2 Aetna Better Health (Aetna) contracts with a Pharmacy Benefit Management (PBM) to administer pharmacy services to include credentialing, contracting, and education of Pharmacy Providers. The PBM coordinates with Aetna SIU to prevent, detect, investigate, recover and report suspected cases of fraud, waste, or abuse. This investigation methodology may include:



Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	12 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	■ Texas Medicaid ■ Texas CHIP		

5.4.2.1 Review of pharmacy claims that appear to be duplicative or excessive.

5.4.2.2 Use of edits or other evaluation techniques to identify possible overuse and/or abuse of controlled or non- controlled medications by members.

5.4.2.3 Analyze pharmacy claim data submitted by providers to determine if the diagnosis is appropriate for medications prescribed.

6.0 Fraud, Waste, and Abuse Procedural Flow Diagram

6.1 The fraud, waste, and abuse procedural flow diagram is included as Attachment B. This flowchart describes the process from detection, investigation, and reporting through the SIU to the Executive Director and the HHSC-OIG and OAG.

6.2 Attachment C is an organizational chart that outlines the SIU reporting arrangements.

7.0 Responding to OIG Inquiries

7.1 Aetna Better Health (Aetna) SIU Coordinator and/or Compliance Manager will be the primary contacts for all HHSC OIG records request.

7.2 Aetna Better Health (Aetna) will respond to the appropriate HHSC OIG staff member within the timeframe designated within the request

7.2.1 If Aetna Better Health (Aetna) is unable to provide all the requested information within the specified timeframe. A written extension request will be sent to the HHSC OIG within two (2) business days prior to the due date

7.2.2 All data request must include; all data fields as available. If any data field is left blank, an explanation must accompany the response.



Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	13 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	<input type="checkbox"/> Texas Medicaid <input type="checkbox"/> Texas CHIP		

- 7.2.3 The data must not include any additional data fields in the response
- 7.2.4 All requested information must be accompanied by a notarized Business Records Affidavit, unless indicated otherwise in HHSC OIG request
- 7.2.5 Aetna Better Health (Aetna) will respond to the following request in the specified timeframes.
 - 7.2.5.1 1099 data and other financial information- five (5) business days
 - 7.2.5.2 Claims data for sampling- twenty (20) business days
 - 7.2.5.3 Urgent claims data request – fifteen (15) business days
 - 7.2.5.4 Provider education information – ten (10) business days
 - 7.2.5.5 Files associated with Aetna Better Health (Aetna) investigation – fifteen (15) business days
 - 7.2.5.6 Other time sensitive information- as needed

8.0 Deliverable Reporting

- 8.1 Aetna Better Health (Aetna) will report all investigations of fraud, waste, and abuse on a monthly basis to the HHSC-OIG and OAG at OIG_MCO_Reporting@hhsc.state.tx.us on the 14 day of the month following the close of the month... The elements to be included in this deliverable are:
 - 8.1.1 The name of provider
 - 8.1.2 The provider’s NPI, Medicaid TPI and Tax ID Number (TIN)
 - 8.1.3 The detailed description of allegations
 - 8.1.4 The detailed reporting of findings



Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	14 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	<input type="checkbox"/> Texas Medicaid <input type="checkbox"/> Texas CHIP		

8.1.5 The dollar amount at risk

8.1.6 The monthly report will include all open and completed cases that

8.1.6.1 are completed within the month (“Up to 100K and over 100K”)

8.1.6.2 are not completed (“Cases Pending”)

8.1.6.3 did not result in a finding (“No Findings”)

8.1.6.4 Resulted in a recoupment of any overpayments

8.1.6.5 not accepted by OIG (“ All MCO cases not by OIG”), or

8.1.6.6 Were referred directly to OIG Sanction within the month (“Up to 100K or over 100K

8.2 A log of all incidences of suspected fraud, waste, and abuse received by the plan, regardless of the source, will be maintained in the SIU database by the SIU Coordinator. All information to support fraud, waste, and abuse cases will also be logged in the SIU database. This log will contain:

8.2.1 The subject of the violation

8.2.2 Source of the allegation

8.2.3 The date the allegation was received

8.2.4 Medicaid/CHIP ID or Provider ID

8.2.5 Status of the investigation

8.3 The log can be produced for the HHSC- OIG, OAG-MFCU, OAG-CMFD, and the HHS-OIG upon request.

8.4 The SIU database will provide investigation information such as:



Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	15 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	<input type="checkbox"/> Texas Medicaid <input type="checkbox"/> Texas CHIP		

- 8.4.1 Status of the investigation/audit
- 8.4.2 Number of audits performed
- 8.4.3 Cases resulting in no findings
- 8.4.4 Communication history with providers and members

9.0 Confidentiality and Record Retention

- 9.1 All patient information relevant to an investigation of fraud, waste, or abuse will be maintained in a confidential manner. Aetna Better Health (Aetna) SIU will develop and maintain internal procedures and controls to ensure confidentiality such as signatures on confidentiality statements, as well as utilizing secure email exchange, while adhering to HIPAA guidelines.
- 9.2 All records obtained during the investigation of a potential fraud, waste, or abuse case will be retained for a minimum of seven years or until all audit questions, appeal hearings, investigations and court cases are resolved.
- 9.3 Upon receipt of a request from a state or federal agency, all records involved with fraud, waste, or abuse investigations will be provided within 24 hours of the request.

10.0 Federal False Claims Act and Whistleblower Protections (qui tam)

- 10.1 Aetna Better Health (Aetna), its employees, and contracted providers, entities and agents are responsible for detecting and reporting any false claims against the United States Government. Under the federal False Claims Act, any person, including Aetna staff or Aetna Better Health (Aetna) Division, who:
 - 10.1.1 knowingly presents or causes to be presented to an officer or employee of the United States Government or a false or fraudulent claim for payment or approval;



Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	16 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	<input type="checkbox"/> Texas Medicaid <input type="checkbox"/> Texas CHIP		

10.1.2 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;

10.1.3 conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;

10.1.4 has possession, custody, or control of property or money used, or to be used, by the Government and intending to defraud the Government or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt;

10.1.5 authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

10.1.6 knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the government who lawfully may not sell or pledge the property; or

10.1.7 knowingly makes, uses, or causes to be made or used, a false record or statement conceal, avoid or decrease an obligation to pay or transmit money or property to the Government is liable to the U. S. Government for a civil penalty.

10.2 “Knowing” and “knowingly” means that a person, with respect to information:

10.2.1 has actual knowledge of the information;

10.2.2 acts in deliberate ignorance of the truth or falsity of the information; or

10.2.3 acts in reckless disregard of the truth or falsity of the information.

10.2.4 no proof of specific intent to defraud is required.



Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	17 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	<input type="checkbox"/> Texas Medicaid <input type="checkbox"/> Texas CHIP		

10.3 Civil Actions for False Claims – The U.S. Attorney General may bring a civil action against a person who has violated or is violating the federal False Claims Act. Additionally, a private citizen may initiate a civil action, called a *qui tam* action, in the name of the Government. The Attorney General can join the case or let the private citizen pursue the action on his or her own.

10.3.1 Aetna is also subject to the administrative remedies for false claims and statements as prescribed in Chapter 38 of Title 31. This includes potential civil penalties, investigations by various officials including the Office of Inspector General and the Office of Attorney General.

9.4 The official description of the False Claims Act as provided by the Department of Justice can be found in Attachment D of this document.

10.0 State of Texas False Claims Act and Whistleblower Protections (qui tam)

10.1 Aetna Better Health (Aetna), its employees, and contracted providers, entities and agents are responsible for detecting and reporting any false claims, or failure of an MCO to provide services required under contract with the state of Texas, enrollment/marketing violations and wrongful denial of claims.

10.1.1 “Department” means the Texas Health and Human Services Commission.

10.1.2 “Claim” means an application for payment of health care services under Title XIX of the federal Social Security Act that is submitted by a person who is under contract or provider agreement with the department.

10.1.3 “Managed care organization” means any entity or person that is authorized or otherwise permitted by law to arrange for or provide a managed care plan.

10.1.4 “Managed care plan” means a plan under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care service. A part of the plan must consist of arranging for or



Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	18 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	<input type="checkbox"/> Texas Medicaid <input type="checkbox"/> Texas CHIP		

providing health care services as distinguished from indemnification against the cost of those services on a prepaid basis through insurance or otherwise. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

10.1.5 a person “should know” or “should have known” information to be false if the person acts in deliberate ignorance of the truth or falsity of the information or in reckless disregard of the truth or falsity of the information, and proof of the person’s specific intent to defraud is not required.

10.2 Under the State of Texas False Claims Act, a person, including Aetna staff or Aetna Better Health (Aetna) Division, commits a violation if the person:

10.2.1 presents or causes to be presented to the department a claim that contains a statement or representation the person knows or should know to be false; or

10.2.2 is a managed care organization that contracts with the department to provide or arrange to provide health care benefits or services to individuals eligible for medical assistance and:

10.2.2.1 fails to provide to an individual a health care benefit or service that the organization is required to provide under the contract with the department;

10.2.2.2 fails to provide to the department information required to be provided by law, department rule, or contractual provision;

10.2.2.3 engages in a fraudulent activity in connection with the enrollment in the organization’s managed care plan of an individual eligible for medical assistance or in connection with marketing the organization’s services to an individual eligible for medical assistance; or



Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	19 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	<input type="checkbox"/> Texas Medicaid <input type="checkbox"/> Texas CHIP		

10.2.2.4 engages in actions that indicate a pattern of

10.2.2.4.1 wrongful denial of payment for a health care benefit or service that the organization is required to provide under the contract with the department; or

10.2.2.4.2 wrongful delay of at least 45 days or longer period specified in the contract with the department, not to exceed 60 days, making payment for a health benefit or service that the organization is required to provide under the contract with the department.

10.3 Aetna Better Health (Aetna) is subject to the administrative remedies for false claims and statements as prescribed in Chapter 32 of the Human Resources Code. This includes potential civil penalties, investigations by various officials including the Office of Inspector General and the Office of Attorney General.

10.4 Civil Actions for False Claims – The Texas Attorney General may bring a civil action against a person who has committed an unlawful act. Additionally, a person may bring a civil action for a violation of Section 36.002 for the person and for the state. The action may be brought in the name of the person or of the state may initiate a civil action, called a *qui tam* action, in the name of the Government.

Whistleblower Protections (qui tam)

Aetna Better Health (Aetna) staff, contracted providers, entities or agents are protected from retaliation from Medicaid Services in the event that they report suspected filing of false or fraudulent claims against the Government by Aetna.

11.1 Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of



Policy Name:	Fraud, Waste, and Abuse Plan – SIU (Special Investigative Unit)	Page	20 of 28
Department:	Administration	Policy Number:	06-13
Subsection:		Effective Date:	09/01/2006
Applies to:	■ Texas Medicaid ■ Texas CHIP		

employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under 31 USC §3730 including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under 31 USC §3730, shall be entitled to all relief necessary to make the employee whole.

Aetna Better Health (Aetna)

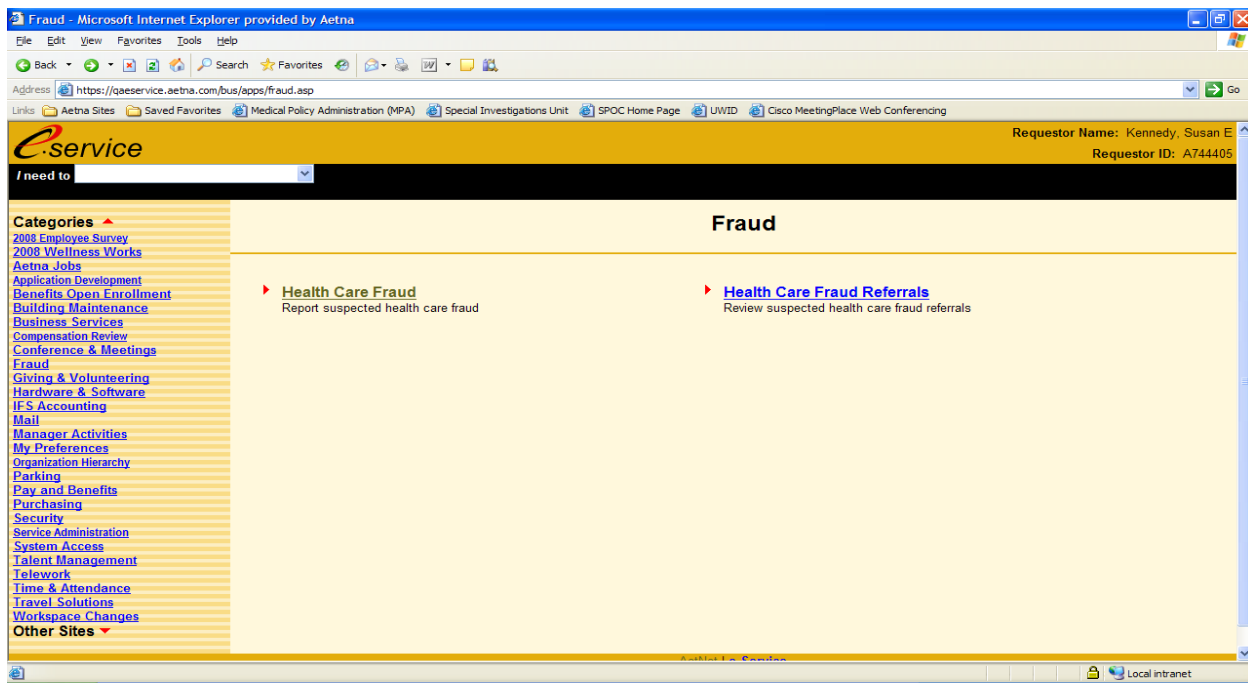
Leslie J. Young
Chief Executive Officer

Reviewed and revised: 11/01/2011
Reviewed and revised: 07/23/2010
Reviewed and revised: 04/20/2010
Reviewed and revised: 07/16/2009
Reviewed and revised: 07/17/2008
Reviewed and revised: 10/25/2007

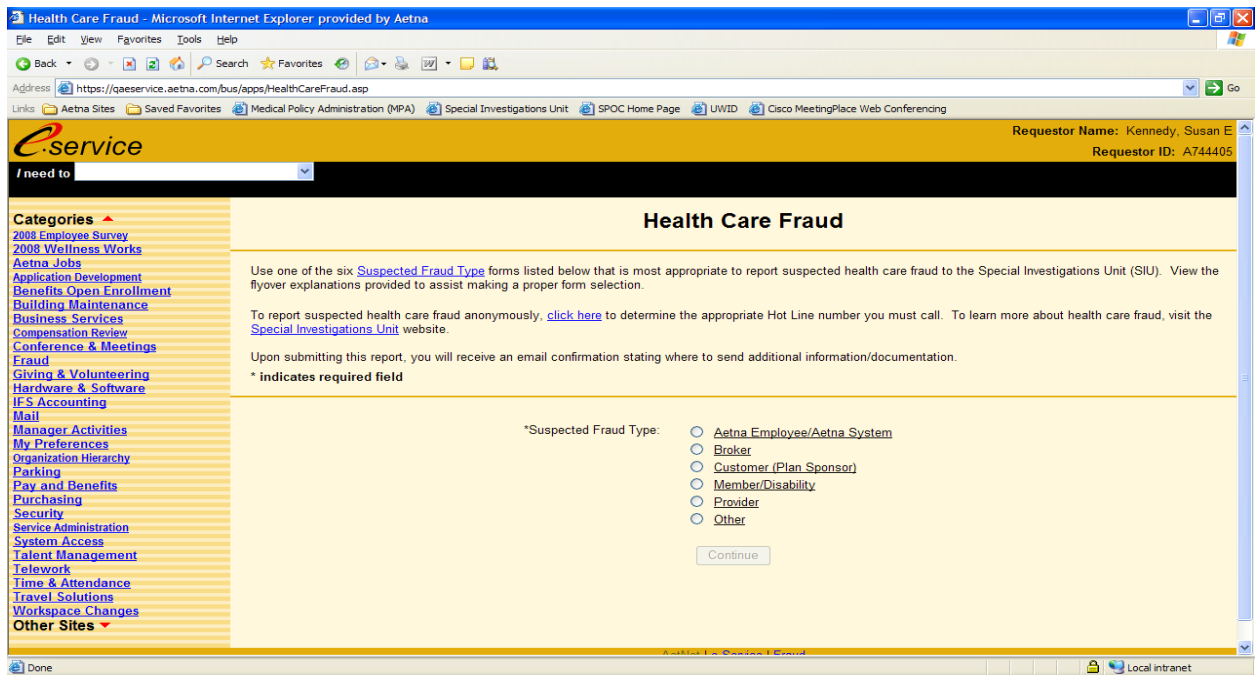
Attachment A

SIU e.Service Referrals

- From the e.Service homepage, select **Fraud**.



- Select the **Health Care Fraud** link to create/submit a referral for a new suspected fraud case.
- Health Care Fraud Referrals** link is used to manage your personal referrals, i.e. referrals you are saving for additional review prior to submitting to the SIU investigative team.
- Once you select **Health Care Fraud**, you will be presented with six choices for the suspected fraud type.



Suspected Fraud Type [SFT]: The three forms currently used in the e.Service suspected health care fraud referral workflow are:

- **Member**
Use this form to report suspected health care fraud & abuse acts by members
- **Provider**
Use this form to report suspected health care fraud & abuse acts by providers of health care services.
- **Other**
Use this form to report suspected health care fraud & abuse acts that involve circumstances that are not appropriate to communicate using any of the other forms.

- **There are three forms to choose, select the appropriate form and click ‘Continue’**
- Depending on the form you select, specific fields will be presented for completion. Required fields will be noted with an asterisk ‘*’. Complete all required fields, and as many optional fields as possible. Use the ‘Additional Information’ section to completely describe the scenario, and reference any appropriate source documentation. Below is an example of the screen(s) for Provider fraud.

Health Care Fraud - Microsoft Internet Explorer provided by Aetna

Address: https://qaeservice.aetna.com/bus/apps/HealthCareFraud.asp?action=edit&id=

System Access
 Talent Management
 Telework
 Time & Attendance
 Travel Solutions
 Workspace Changes
 Other Sites

Continue

Customer Information

Aetna ID: A744405
 Name: Kennedy, Susan E
 Phone: 336-474-7277
 Email Address: eserviceqa@aetna.com
 Mail Location Code: F314
 Department ID: 70008
 Department Name: RB HCD Fraud & Abuse
 Organization Name: RB HCD SIU Management
 Workspace: 405002-0530
 Work at Home: Yes
 *Office Location: High Point, NC 27265 -- 4050 Piedmont Parkway
 Cost Center: 13816

Suspected Provider Health Care Fraud Details

*Suspected Fraud Location: Foreign/International Domestic/United States

*Non Individual Provider Name:

or

*Individual Provider Last Name: First Name: M.I.:

*Provider Type: Institutional Provider

*Provider ID:

*State of Practice:

Is Provider associated with a Network? Yes No

Is Provider flagged? Yes No

Health Care Fraud - Microsoft Internet Explorer provided by Aetna

Address: https://qaeservice.aetna.com/bus/apps/HealthCareFraud.asp?action=edit&id=

Is Provider associated with a Network? Yes No

Is Provider flagged? Yes No

Scheme Type:

<input type="checkbox"/> Application Fraud	<input type="checkbox"/> Ineligible Dependent	<input type="checkbox"/> Third Party Fraud
<input type="checkbox"/> Coordination Benefits	<input type="checkbox"/> Investigational/Experimental	<input type="checkbox"/> Unbundling
<input type="checkbox"/> Discount	<input type="checkbox"/> Misrepresentation	<input type="checkbox"/> Undisclosed Employment
<input type="checkbox"/> Doctor Shopping	<input type="checkbox"/> Not Medically Necessary	<input type="checkbox"/> Unlicensed Provider
<input type="checkbox"/> Forgery	<input type="checkbox"/> Over/Under Utilization	<input type="checkbox"/> Upcoding
<input type="checkbox"/> Forgiveness of Coinsurance	<input type="checkbox"/> Services Not Rendered	<input type="checkbox"/> Other
<input type="checkbox"/> Fraudulent use of Aetna Systems	<input type="checkbox"/> Submitting Increased Charges	

*Is there information on a document or system that supports this health care fraud case? Yes No

*Member ID:

System Involved: Schaller Anderson
 Schaller Anderson ~The suspected healthcare fraud report involves a Schaller Anderson product, service, or system.

*Schaller Anderson plans:

*How was case discovered?

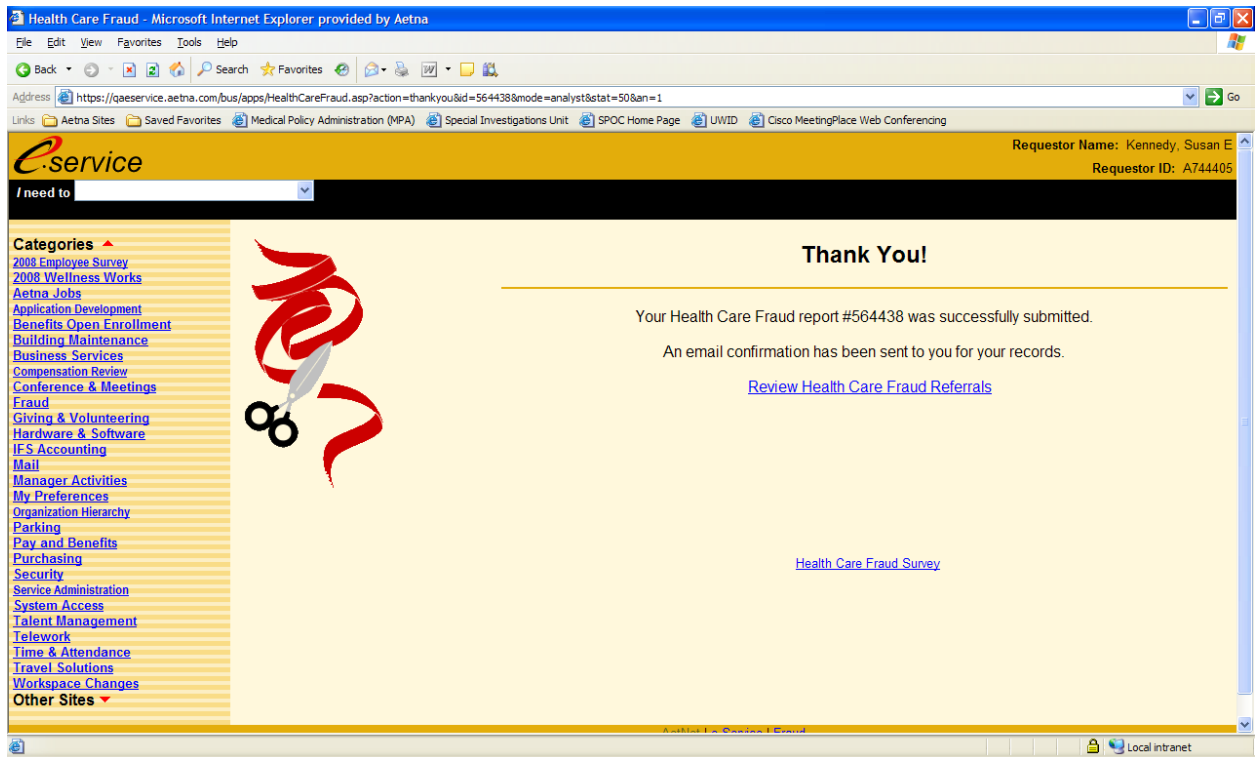
<input type="checkbox"/> Aetna Employee	<input type="checkbox"/> Provider
<input type="checkbox"/> Another Insurance	<input type="checkbox"/> Sales
<input type="checkbox"/> Audit	<input type="checkbox"/> Other
<input type="checkbox"/> Customer	<input type="checkbox"/> SIU Mailbox

*Product Type:

- Aetna Better Health - CT
- Aetna Better health - PA
- CHOC
- Delaware Physicians Care
- Maryland Physicians Care
- Missouri Care
- SAH
- Schaller Anderson Medical Administrators - Indiana
- Schaller Anderson Medical Administrators - Maine
- Schaller Anderson Medical Administrators - New Hampshire
- Texas Medicaid & Healthplan Partnership
- Unknown

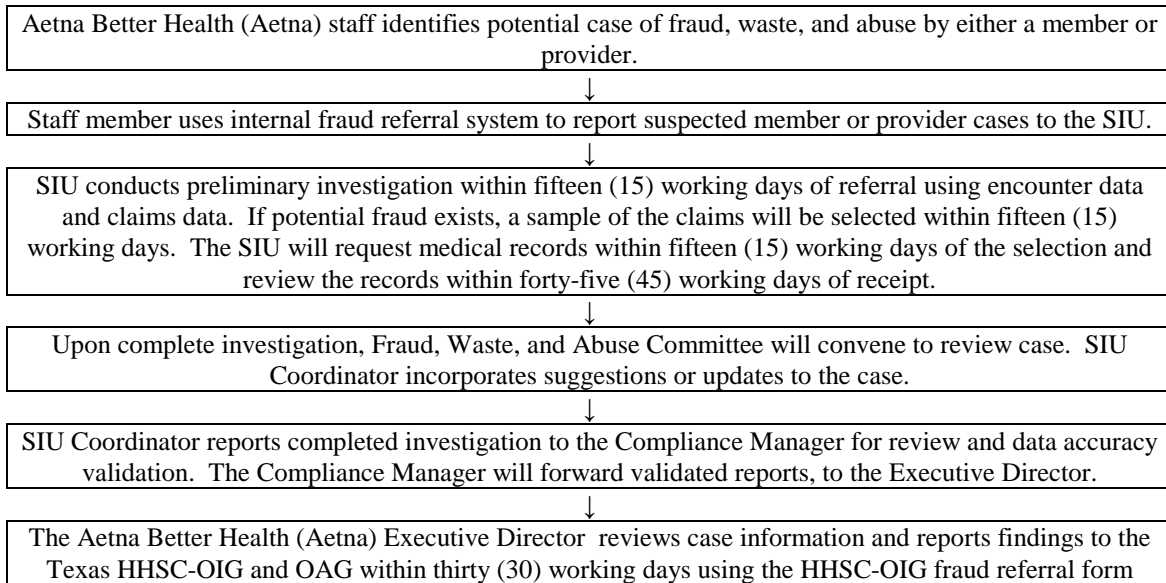
- Next you will select the System Involved: **“Schaller Anderson”**.
- Select the plan type **“Texas Medicaid & Health plan Partnership”**.
- Continue to complete all required fields, and as many optional fields as possible, then select Submit.

- When the referral is complete, and needs to go to the SIU Investigator team, select 'Submit'. The next screen will provide the tracking ID of the referral.



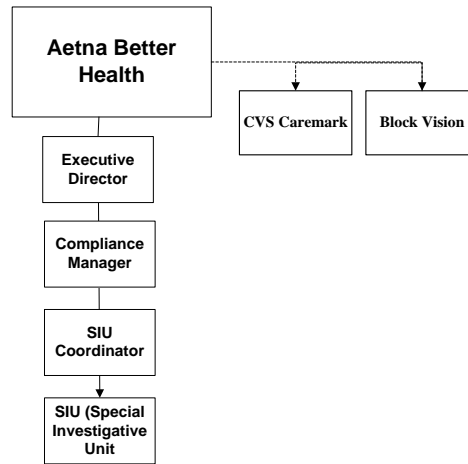
- Once the SIU completes their preliminary review of the referral, an email acknowledgement will be sent back to the originator or assigned analyst to advise the case number and investigator name, or if a case is not opened, an explanation will be provided.

Fraud, Waste, and Abuse Procedural Flowchart Attachment B



Fraud, Waste, and Abuse Reporting Organizational Chart

Attachment C



Attachment D
Aetna Better Health (Aetna)

Department of Justice, Official Description of the False Claims Act

The False Claims Act (“FCA”) provides, in pertinent part, that:

(a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States government or a member of the Armed forces of the United States 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 paid or approved by the Government;...or (7) knowingly makes, uses, or causes to be made used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to this Government,

* * *

is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages which the Government sustained because of the act of that person. . . .

(b) For purposes of this section, the terms “knowing” and “knowingly” mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729. While the False Claims Act imposes liability only when the claimant acts “knowingly,” it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information also can be found liable under the Act. 31 U.S.C. 3729(b).

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes

liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) is false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called “reverse false claim” may include a hospital who obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

In Addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. 3730 (b). These private parties, known as “*qui tam* relators,” may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a *qui tam* relator, when the Government has intervened in the lawsuit, shall receive at least 15 percent but not more than 25 percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the government does not intervene, section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.

The FCA provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys’ fees.