Dominion Dental USA, Inc. and Subsidiaries

POLICY & PROCEDURE

COMPLIANCE DEPARTMENT

POLICY/PROCEDURE TITLE	**SUSPECTED CLAIM FRAUD AND ABUSE**
POLICY/PROCEDURE NUMBER	**COMPLIANCE-003D**

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I. POLICY

This policy addresses the responsibilities of various Dominion personnel for reporting and investigating suspected fraud and/or abuse, as well as the policy of Dominion regarding the recovery of overpayments, prosecution, and the release of information related to members, providers, and any other parties believed to be involved in such activities.

Provisions in Pennsylvania Act 219 of 1990 make it a felony offense to knowingly present false, incomplete or misleading information on insurance claims, to conspire to present false, incomplete, or misleading information relating to a claim, to use another person's insurance identification card, or to allow another person to use one's identification card with the intent to present a fraudulent claim. Virginia, Delaware, Maryland, Oregon, Washington and the District of Columbia have substantially similar provisions in their statutes.

These laws allow Dominion to file a civil action against such a person and to supply information to appropriate law enforcement entities, so that criminal charges may be filed against those persons who have fraudulently procured health insurance coverage or who have filed fraudulent claims. In addition to state law, various federal laws also provide civil and criminal penalties.

Definitions

Fraud

Any deliberate misrepresentation, omission of fact or other misconduct by a member, a provider, or any other party, made with the intent to induce a representative of Dominion or other party to act in reliance on the false information provided or any attempt to use Dominion for the same purpose. Examples of fraud include, but are not limited to:

- Billing for services not rendered or supplies not provided.
- Misrepresenting services rendered or supplies provided.

- Making false or misleading entries or forging signatures on enrollment applications, claim forms, medical or dental records and/or other documents required for the determination of eligibility and/or benefits; or false or misleading verbal statements in connection with the same.
- Borrowing or using another person's insurance identification card or allowing another person to use one's insurance card for the purpose of obtaining treatment or submitting a claim when the user is not a member on the contract.
- Altering a Dominion issued check or forging an endorsement on a check.

Abuse

An intentional violation of claims procedures and practices of Dominion, with the purpose of inappropriately obtaining additional compensation or coverage for services which are not medically or dentally necessary or which have been obtained for inappropriate personal benefit. Examples of abuse include, but are not limited to:

- Deliberate performance of unwarranted/non-medically or non-dentally necessary services.
- Billing for unnecessary medical or dental services.
- Excessive office visits.
- Providing care of an inferior quality.
- Improper billings in relationship to established standards of billing practice.

REPORTING AND INVESTIGATING

Dominion investigates all cases of suspected fraud and/or abuse and pends or rejects claims when there is a basis to question information included on the claim or the validity of charges. Dominion pursues the recovery of any payments made as a result of fraud. Dominion also reserves the right to release information related to fraud and/or abuse on a case-by-case basis for appropriate purposes, subject to review by the Legal Department, the Corporate Compliance Department and the Privacy Officer. Dominion reserves the right to pursue provider education and/or corrective action in lieu of payment recovery, when appropriate, or not prohibited by federal or state law or regulation.

Note: A member, provider, or other party is not guilty of fraud until convicted in a court of law. In order to minimize Dominion's potential legal liability and to maintain appropriate evidence for possibly prosecuting a case, all Dominion's employees must use extreme caution when taking any action or communicating any information (i.e., both verbally and in writing) related to enrollment, claims or the like, where fraud is suspected.

This includes not referring to a member, provider, or other party as having performed fraudulent acts. All activities related to suspected fraud cases must be coordinated and/or approved as addressed in this policy.

RESPONSIBILITIES OF DOMINION PERSONNEL

In accordance with the Code of Conduct, all employees of Dominion, in particular the Member Services Department, Claims Department and Provider Relations Department who would work directly with members and providers, are responsible for reporting suspected cases of member, provider, or other party fraud and/or abuse to their immediate supervisor, department manager, Dominion's Compliance Department or the CBC Corporate Compliance Department. Additional responsibilities for employees are explained on the following pages.

Claims Department

- Claims processing personnel are responsible for identifying claims that appear altered, or excessive, or otherwise appear to meet the definition of fraud and/or abuse and referring all pre-payment claim exceptions to their supervisor or manager.
- Claims management personnel are responsible for reviewing cases reported by claims personnel and reporting legitimate cases to the Compliance Department for logging.
- Claims processing personnel are responsible for pursuing the reimbursement of overpayments on cases referred to them.
- Claims management personnel are responsible for investigating or contributing to the investigation by others of cases of suspected fraud and/or abuse.
- Claims management personnel are responsible for developing and implementing new procedures, system edits and other techniques to facilitate the identification of suspected fraud and/or abuse.
- Claims management personnel are responsible for conducting in-depth training on detecting fraud/abuse to claims processing personnel.

Compliance Department

The Compliance Department is responsible for the oversight of the following activities:

- Providing general information company-wide on fraud/abuse.
- Receiving and logging all referred cases, both internally and externally, involving suspected fraud and/or abuse.
- Coordinating the examination of all referred cases, both internally and externally, involving suspected fraud and/or abuse.
- Coordinating all provider investigations with Dental Director, Director of Provider Relations, Director of Operations and Credentialing Supervisor prior to initiating any contact with the subject provider.

- Reporting results of internal investigations to Capital BlueCross Legal (for Commercial account matters) and/or Capital BlueCross Corporate Compliance (for Medicare-related matters) for further investigation as may be necessary. Legal and/or Corporate Compliance will report to CMS and/or law enforcement if warranted.
- Requesting provider and member claim flags, subject to the approval of the Legal Department and the Corporate Compliance Department.
- Communicating investigation results to appropriate management or to the Special Investigations Unit (Capital BlueCross) if the case was received and referred by them through the BlueCross Dental Program.
- Maintaining documentation on case investigations as dictated by federal and/or state regulations. (*Example 10 years for Medicare)*

Credentialing Supervisor

Credentialing Supervisor is responsible for:

- Upon notice by the Compliance Department of a case involving suspected fraud and/or abuse by a network provider, performing a review of internally logged complaints and querying the National Practitioner Data Bank (NPDB) and State Dental Board databases for reports of malpractice claims, adverse licensing actions and carrier terminations.

- Presenting cases of suspected fraud and/or abuse involving network providers to the Quality Assurance Committee for recommended actions.

Corporate Compliance Department (Capital BlueCross)

Corporate Compliance Officer in consultation with the legal department and government programs, is responsible for referring cases involving Medicare-related matters to CMS and/or other enforcement agencies when warranted.

Legal Department (Capital BlueCross)

Legal is responsible for reviewing and advising on actions referred to it by Compliance Department, in order to assure that the investigative actions taken are appropriate.

RELEASE OF INFORMATION

Most, if not all, claims information constitutes Protected Health Information, subject to the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Privacy Act. However, in cases involving the investigation of suspected fraud and/or abuse, Dominion may release relevant information as appropriate, and as permitted or required under law, on a case-by-case basis. Release of information to any party or person must be done in compliance with all applicable laws, including, but not limited to HIPAA and the Privacy Act. Release of such information must be coordinated with the Privacy Officer.

RECOVERY OF OVERPAYMENTS

Dominion has established no minimum dollar threshold that must be met before pursuing reimbursement for payments made for claims involving fraud and/or abuse.

CONTRACT CANCELLATION

Dominion reserves the right to terminate the contract of any individual account member involved in claim fraud and/or abuse, subject to the approval of the Legal Department.

PROVIDER AGREEMENT TERMINATION

Dominion reserves the right to terminate a provider agreement for any provider involved in claim fraud and/or abuse, subject to the approval of the Legal Department. If a provider who is being terminated is associated with a group practice, the Provider Relations Department will work with the group practice to assure that this provider is excluded from providing services to the members of Dominion. Dominion also reserves the right to terminate a group agreement for any group involved in claim fraud and/or abuse, subject to the approval of the Legal Department.

Termination of provider agreements must be coordinated with the Provider Relations Department prior to taking action.

COMMUNICATION OF INFORMATION

Dominion may communicate cases involving member and provider fraud and/or abuse when considered appropriate as described below.

GROUP NOTIFICATION

Cases of proven fraud and/or confirmed abuse involving group members are communicated by the Compliance Department to Sales who may share this with the group, on a case-by-case basis, after review by the Legal Department.

CORPORATE COMMUNICATIONS

The Compliance Department forwards information regarding providers and members convicted of fraud to the Marketing Department for a press release, based on the advice of the Legal Department.

EXCHANGE OF INFORMATION

Case information may be released to a federal, state, or local law enforcement agency for investigation or prosecution in accordance with legal requirements, after review by the Legal Department, or otherwise required by law.

OTHER COMMUNICATIONS

If a provider agreement is terminated based on the provider's involvement in claim fraud and/or abuse, the Credentialing Supervisor will report the information to the National Practitioner Data Bank and State Dental Board after review by the Legal Department.

RELATED INFORMATION/QUESTIONS

Refer all questions regarding the administration of this policy to Compliance.

Refer to the following policies for additional information:

DDS Code of Conduct

This policy is subject to revision to reflect any changes in federal or state law, regulation or agency guidance, and/or changes in internal business operations and procedures.