



FRAUD DETECTION AND PREVENTION

Introduction

The Unison Health Plans recognize that fraud, waste and abuse can adversely impact its operations, the health status of individuals enrolled as members in its managed care plans, and operation of the Medicare, Medical Assistance, SCHIP and other public sector programs that Unison serves. To address those adverse effects, Unison operates a plan to detect and prevent fraud, waste and abuse, comply with applicable insurance fraud laws, and provide a forum for identification of critical problems for those persons dealing with fraud, waste and abuse. Unison uses a number of avenues to educate employees, network providers, members and subcontractors as to the effects of fraud and appropriate contact persons to report suspected fraud or program waste and abuse.

The Unison Audit Section administers day-to-day operation of the Anti-Fraud Program, in conjunction with the Unison Corporate Compliance Plan and in cooperation with the Legal Affairs Department. The Audit Section, acting as the Special Investigation Unit, routinely conducts activities to detect, prevent and, where possible, remediate fraud, waste and abuse. Individual auditors assume lead responsibility for fraud, waste and abuse inquiries, based on the type of alleged misconduct at issue, availability and relevant personal expertise. The Compliance Officer takes the lead on investigations of allegations of fraud, waste and abuse by employees. Once lead responsibility for a referral is assigned, that person takes the primary role in all phases of the inquiry, including, but are not limited to, detection, review, communication and reporting obligations. This person will coordinate with all law enforcement and other involved government agencies, including responses to requests for information and assistance. Other audit personnel are available to assist on an as-needed basis. This structure permits the development of high-level expertise regarding fraud issues while still allowing flexibility to ensure that proper resources are available to pursue individual referrals. Fraud and abuse prevention activities and results are reported annually to the Unison CEO and Board of Directors.

Fraud Awareness and Training:

Unison is committed to implementing fraud, waste and abuse awareness for employees, providers, members and subcontractors through the following methods:

1. Employment offers are contingent upon successful completion of a thorough background check prior to employment. Compliance and fraud awareness training are incorporated into the new employee orientation to ensure basic entry-level health care fraud awareness. Update training is conducted periodically. See Unison Compliance Plan, Section 8, which can be viewed from the link on the Compliance page. Unison also developed an intranet-based Fraud Awareness Questionnaire for all employees. The oral presentation coupled with the questionnaire helps ensure that all employees understand the overall Unison commitment to fraud awareness.
2. Each person enrolled in a Unison managed care plan receives a Member Handbook that outlines proper use of the member identification card and prohibits use of the card by another person. Additionally, the Unison Member Services staff is extensively trained to identify and respond to inquiries related to suspected fraud, waste and abuse. Unison also includes, from

time-to-time, fraud updates in newsletters to ensure members know how they may communicate their fraud concerns, including use of the Compliance "hotline" for anonymous reporting.

3. Network Providers receive information with respect to the identification of fraud, waste and abuse, as well as the penalties for fraud, waste and abuse. This information is included in the Provider Agreement and discussed at great length during provider orientation sessions. Fraud updates are also included periodically in provider newsletters.
4. Subcontractors are informed of Unison's commitment to preventing fraud through the contracting process and instructed to report any concerns to the Compliance Department.

Fraud Detection:

Unison utilizes a comprehensive client/server based system that integrates eligibility, provider and other data to efficiently process medical and dental claims, utilization management reviews, and track case management and customer service information. The system also handles premium billing, commissions, capitation, prior payments, pre-certification and reporting needs. Additional fraud detection and prevention controls are implemented through a number of processes, such as:

- Periodic claim audits;
- Member "lock-in" programs (where permitted) to address program abuse;
- Pharmaceutical coverage controls that monitor excessive drug dosing, excessive utilization, duplicate payments, and similar indicators of Rx coverage abuse;
- Focused audit referrals;
- Utilization management controls such as prior authorization protocols; and
- Unison's Corporate Compliance Program.

Each Unison department is encouraged to provide input into improving methods to detect fraudulent behavior.

Unison's Audit Section acts as the liaison with other insurers and accesses a variety of sources to maintain an awareness of the ever-changing challenges of potential fraud, waste and abuse areas. Audit Section personnel may attend educational seminars related to fraud detection, investigation, round tables, fraud, waste and abuse meetings or any other industry or government meeting that will enhance Unison's ability to detect fraud and/or educate employees in fraud detection. When appropriate, the Audit Section will adapt Unison's approach to fraud detection and prevention, based on that updated information, through revisions to its investigation procedures, orientation and other fraud awareness protocols, as well as its annual training programs.

Incident Review:

The Compliance Department operates two "hotlines" [412.380.8025 or toll-free 1.877.766.3834] that allow for anonymous reporting of potential problem situations, including potential incidents of fraud, waste and abuse. See Compliance Plan, Section 5. A Compliance Incident Reporting Form is also available on the Unison website at www.unisonhealthplan.com. Unison employees can report fraud and abuse not only through these Compliance mechanisms, which are available to the general public, but can also submit a "Focused Audit Referral" or "Special Investigation Referral Form" to the Audit Section via Unison's intranet.

All employees must report suspicious or anomalous activity to their supervisor who will determine if it should be forwarded for further review. If the employee thinks the supervisor is involved in the activity they can bring their concerns directly to the Special Investigations Unit via a Special Investigation Referral Form or Focused Audit Referral, directly to the Compliance Officer or Audit Director, or through the Compliance hotline for anonymous reporting. In all instances, the identities of the individuals reporting activity will be protected to the extent possible and there will be no retaliation for reporting suspicious or anomalous activity. The non-retaliation policy does not provide immunity for individuals who voluntarily disclose their own fraud, waste and abuse; however, self-disclosure may constitute a mitigating circumstance as to the penalties or discipline, if any, assessed or imposed.

Identified cases of suspected fraud, waste and abuse are referred to the Special Investigations Unit, where the auditor assigned lead responsibility for the reviews available information to determine if the facts demonstrate a potential fraud, waste and abuse incident, including where appropriate and possible, an inquiry as to intent. Unison recognizes that not every report will result in a fraud and abuse finding - many instances that, at first blush, appear to be possible fraud may simply be a billing anomaly or a benefit being interpreted incorrectly. The Special Investigations Unit will, however, employ available resources such as additional Unison personnel or outside contractors to determine whether further action is required. A detailed record is maintained to track all reported incidents to ensure an audit trail for each case. Additionally, a log of all requests from or cases sent to law enforcement agencies is maintained.

Reporting Insurance Fraud for Criminal Prosecution or Administrative Sanctions:

The Audit Section, working with the General Counsel, coordinates activities to report program fraud, waste and abuse to the appropriate government agencies and respond to all inquiries from law enforcement agencies, including but not limited to, providing administrative, financial and medical records as requested. As a safeguard to ensure accurate reporting, the General Counsel or the Compliance Officer shall review all information relating to enrolled members or providers to ensure that a reasonable basis to suspect fraud or abuse (as opposed to mere mistake) before a report is forwarded to such government agencies. However, where such a reasonable basis exists, such reports are mandatory and will be made. Upon completion of the review, the agency's decision to decline or pursue a criminal or administrative action is recorded in the tracking system.

Recovery:

The Unison Health Plans are committed to recovering losses, whether such losses stem from program fraud, abuse or waste or result from simple billing error. Unison will initially attempt to recover losses by deducting amounts from outstanding remittance advices, unprocessed claims, etc. If Unison cannot recover the full amount of the losses by offsetting subsequent payments, appropriate legal action will occur as directed by the General Counsel. Recovery activities are coordinated, as appropriate, with criminal or administrative actions initiated by government agencies, if any, to which a report has been made as described above.

Measurement:

An annual performance report will be prepared by the Audit Section, reviewed by the General Counsel, and submitted to the Boards of Directors for the Unison Health Plans. The report will

compare activity from the prior year. The report will be submitted to the appropriate agencies (if required).

Additional Information:

Additional information on the Unison Health Plans' activities to detect and prevent program fraud, abuse and waste is available by contacting Unison's Audit Section or Compliance Department at 412.858.4000 or at 1001 Brinton Road, Pittsburgh, PA 15221.