Horizon Blue Cross Blue Shield of New Jersey

FALSE CLAIMS POLICY

DOCUMENT INFORMATION

Property/Name	Value
Title	False Claims Policy
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Full Compliance Date	January 1, 2017
Owner	Timothy Susanin, Vice President, Chief Compliance and Risk Officer
Approved by (Signature) and Date	/s/ Timothy Susanin
Director Responsible For Implementation	Vice President, Chief Compliance and Risk Officer
Applies To	All Horizon BCBSNJ divisions and subsidiaries
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Recertification Date	January 1, 2018

REGULATORY, LEGAL, ACCREDITATION AND POLICY INDEX

Regulatory References	Legal References	Accreditation Reference	Policy Reference
Federal Program Fraud Civil Remedies Act, 31U.S.C. 3802 (as amended by 28 C.F.R 85.3 (a) (10-11)) 42 C.F.R. 1001.901	The Federal False Claims Act, 31 U.S.C. 3729-3733 PPACA, 42 U.S.C. 1320a-7a Social Security Act 1128A(a) New Jersey False Claims Act 2A:32C-1 N.J.S.A. 2C:21-4.2 N.J.S.A. 30:4D-17 New York False Claims Act (State Finance Law, §§187-194)		Code of Business Conduct and Ethics CO-002, Interested Party Complaint Procedures for Accounting, Auditing and Other Compliance Matters Policy CO-011, Non-Retaliation Policy

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1. PURPOSE

To ensure that Horizon Blue Cross Blue Shield of New Jersey's ("Horizon BCBSNJ" or the "Company") employees comply with federal and state false claims laws and regulations that prohibit the submission of false claims for reimbursement by the government.

2. SCOPE AND APPLICABILITY

This policy applies to any claim submitted to the state or federal government for reimbursement.

3. POLICY

3.1. General

Various federal and state laws and regulations, including the federal False Claims Act, have been enacted to recover money that was paid by the government as a result of fraud, waste, or abuse. Horizon BCBSNJ and its employees are prohibited from knowingly submitting, or causing others to submit, false claims for services that would be reimbursed by the federal or state government, including health care services reimbursed by the Medicare and Medicaid programs. No proof of intent to defraud the government is required to be held liable. All that is required is that the person or organization had knowledge, or has acted with deliberate ignorance or reckless disregard of, the truth or falsity of his or her claim.

Violation of this policy may have serious consequences for both the Company and any individual involved, including possible exclusion from participation in Medicare, Medicaid or other government health care programs, as well as substantial fines and criminal penalties.

Examples of false claims include, but are not limited to:

- falsifying medical records submitted;
- billing for services not rendered or goods not provided;
- upcoding;
- revenue-maximizing practices;
- over-utilization and under-utilization schemes;
- duplicate billing to obtain double compensation; and
- billing, certifying, or prescribing services that are medically unnecessary.

3.2. Non-Retaliation

False claims laws protect employees who come forward to report suspected fraud from retaliation by their employers. In addition, Horizon BCBSNJ's *Code of Business Conduct and Ethics* prohibits retaliation against any employee who

reports, in good faith, any violation or suspected violation of the *Code of Business Conduct and Ethics* or applicable laws and regulations.

3.3. Civil Monetary Penalties

The Social Security Act authorizes the Secretary of the Department of Health and Human Services to seek civil monetary penalties and assessments against anyone who knowingly presents or causes to be presented a claim that is improperly filed. These penalties apply to a claim:

- For a medical service or item that the person knows, or should know, was not provided as claimed, including a claim for an item or service that is based on a code that the persons knows, or should know, will result in greater reimbursement than applicable to the service provided;
- For a medical service or item and the person knows, or should know, is fraudulent or false;
- For a service that is not medically necessary;
- For a medical service or item that was provided when the provider of service was excluded from participation in the Medicare, Medicaid or other federal program to which the claim was made; or
- Presented for a physician's service by a person who knows, or should know, that the physician was not licensed as a physician; was licensed, but the license was obtained through misrepresentation; or misrepresented that the physician was certified in a medical specialty.

3.4. Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act ("PPACA") provides that overpayments by federal health care programs, such as Medicare and Medicaid, may be considered false claims. PPACA requires providers, suppliers, and health plans to report and refund an overpayment by the later of 60 days after the date on which the overpayment was identified or the date any corresponding cost report is due. The PPACA makes reporting and repaying any overpayment an obligation under the federal False Claims Act, so that failure to report and return an overpayment within the applicable deadline may in itself result in liability under the False Claims Act, including program exclusion.

The federal Anti-Kickback Statute has been amended through the PPACA to provide that claims which include items or services resulting from a violation of the Anti-Kickback Statute also constitute a false or fraudulent claim for purposes of the False Claims Act. Therefore, a violation of the Anti-Kickback Statute could subject Horizon to the penalties under the False Claims Act discussed above.

3.5 The New Jersey False Claims Act

The New Jersey False Claims Act has a wider statutory application than its federal counterpart. While the New Jersey False Claims Act includes the federal False Claims Act's language of imposing liability upon people who submit false

or fraudulent claims for payment or approval to an employee or officer of the government, the New Jersey False Claims Act also imposes liability on those who submit a false claim to an agent of the State, and to any contractor, grantee or other recipient of State funds.

In addition, while the federal False Claims Act defines "claim" as a request or demand for money or property, the New Jersey False Claims Act's definition of "claim" also includes a request for services.

3.6 Obligation to Report Violation

The Horizon BCBSNJ *Code of Business Conduct and Ethics* requires every employee to be vigilant in monitoring for fraudulent activities and to immediately report any suspected fraud, waste or abuse by hospitals, physicians, other healthcare professionals, members, subcontractors, agents, vendors and/or employees.

Any employee who knows of an actual or suspected violation of this policy or an instance of fraud, waste or abuse must immediately report the activity by contacting:

- The Compliance and Ethics Office at 973-466-7100; or
- The Company's Investigations Department at 973-466-8724.

Anonymous reports of violations can be made to:

- The Compliance Integrity Help Line at 1-800-658-6781;
- The Medicare Advantage Fraud Hotline at 1-800-624-2048
- The Part D Fraud Hotline at 1-888-889-2231
- The Medicaid Fraud Hotline at 1-855-372-8320
- The Fraud Hotline at 1-800-624-2048; or
- The Chief Security Officer or the Compliance and Ethics Office, in writing, at Riverfront Plaza, P.O. Box 200145, Newark, New Jersey 07102.

4. DEFINITIONS

A "false claim" is a falsely or fraudulently filed demand for money or property in response to which the government provides any portion of the money or property requested.

An "overpayment" is defined under the PPACA amendment as any funds received or retained under Medicare or Medicaid to which the provider, supplier, or plan is not entitled after an applicable reconciliation.

5. SANCTIONS

Any employee who violates this policy will be subject to disciplinary action, up to and including termination of employment.

6. EXCEPTIONS

There are no exceptions to this Policy. Any questions regarding this policy should be directed to the Compliance and Ethics Office, the Investigations Department or Legal Affairs.

7. APPENDICES AND ATTACHMENTS

N/A