

VNS HEALTH POLICY AND PROCEDURE MANUAL		SUPERCEDES: Fraud, Waste and Abuse Compliance Program
SUBJECT: Special Investigations Unit (SIU) and Fraud Waste and Abuse (FWA)		
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APPLIES TO: Compliance & the Special Investigations Unit (SIU)	Applies to Lines of Business: <input checked="" type="checkbox"/> Medicare <input checked="" type="checkbox"/> MLTC <input checked="" type="checkbox"/> SelectHealth	

1. PURPOSE:

- A.** To establish the VNS HEALTH SIU to oversee a comprehensive anti-fraud program designed to detect, investigate, resolve, correct and report incidents of suspected FWA in compliance with all applicable state and federal laws and regulations.
- B.** To ensure appropriate investigation, resolution and corrective action of all potential FWA by VNS HEALTH Directors, Officers, Employees, Contractors, Agents and others associated with VNS HEALTH 's FDRs (defined below) and providers.
- C.** To assist in supporting and enforcing VNS HEALTH compliance standards, which are clearly communicated through well-publicized disciplinary guidelines.
- D.** To ensure the appropriate referral, notification, and/or reporting of all suspected and confirmed incidents of FWA to federal and state agencies, as appropriate, and to assist state and federal investigative agencies on FWA investigations upon request.

2. SCOPE:

This policy applies to all VNS HEALTH Directors, Officers, Employees, Contractors, Agents and FDRs, who each have obligations to detect and prevent FWA. The SIU and Compliance Department are primarily responsible for implementing this policy.

3. DEFINITIONS:

- A. Abuse** is a practice that is inconsistent with accepted business, financial or medical practices or standards and that results in unnecessary cost or in reimbursement.

- B. Compliance Officer** means the VNS HEALTH Chief Compliance and Privacy Officer.
- C. FDRs** mean First Tier, Downstream and Related Entities, as defined by the Centers for Medicare & Medicaid Services (CMS) in the Medicare Managed Care Manual, which includes business partners, downstream entities and entities that perform delegated operations under state-approved management agreements.
- D. Fraud** is an intentional deception, concealment or misrepresentation made by someone with knowledge that the deception will result in benefit or financial gain.
- E. FWA** means Fraud, Waste and Abuse.
- F. SIU** means the Special Investigations Unit.
- G. VNS HEALTH** means Visiting Nurse Service Health and all its related entities.
- H. Waste** includes any practice that results in an unnecessary use or consumption of financial or medical resources. Waste does not necessarily involve personal gain, but often signifies poor management decisions, practices or controls.

4. BACKGROUND

- A.** As a licensed managed care organization that offers Medicare Advantage (MA), Managed Long-Term Care (MLTC) and Special Needs Plans, VNS HEALTH is required by law, regulations and contract to detect, investigate, report and prevent FWA and to have a SIU that is responsible for investigating cases of suspected fraudulent or abusive activity and for implementing the VNS HEALTH Fraud, Waste and Abuse Prevention Plan that has been submitted to the New York State Department of Health (DOH).
- B.** Although the SIU is VNS HEALTH 'S primary investigative unit for FWA, VNS HEALTH'S anti-fraud efforts are not limited to those designated personnel, and it will afford and make available all necessary resources that may be required to complete any investigation. The SIU assists Management in meeting compliance standards regarding FWA and serves as a liaison between VNS HEALTH , Providers, Contractors, FDRs, Federal and State agencies, and other constituents in the prevention, detection, and reporting of suspected FWA.
- C.** The objective of the SIU is to reduce the incidence of FWA through a program that includes education and training, prevention, detection, investigation and reporting, subject to the VNS HEALTH Code of Conduct and the VNS HEALTH Compliance Program Structures and Guidelines, as well as state and federal regulation. The SIU has authority for conducting inquiries and investigations of suspected FWA, and will coordinate with any and all resources deemed necessary to thoroughly conduct an investigation.

5. POLICIES:

- A.** VNS HEALTH maintains a strict policy of zero tolerance toward FWA and is committed to complying with all applicable federal and state standards on FWA.
- B.** All VNS HEALTH Directors, Officers, Employees, Contractors, Agents, Providers, FDRs and others associated with VNS HEALTH have a responsibility to detect, report and prevent FWA. All such persons report all incidents of suspected FWA, as per the VNS HEALTH Corporate Policy: Reporting Non-Compliance and Fraud, Waste and Abuse.
- C.** VNS HEALTH has created the SIU to detect, prevent, document, investigate, report, correct and deter FWA. The SIU also oversees corrective and/or disciplinary actions in cases of FWA.
- D.** The SIU reports, as required by state and federal guidelines, all suspected or confirmed incidents of FWA and, upon request, assists state and federal investigative agencies in investigating FWA.
- E.** VNS HEALTH 'S Compliance Department and other VNS HEALTH Departments refer all complaints involving suspected FWA to the SIU.
- F.** The SIU promotes the immediate reporting of suspected incidents of FWA by establishing clear lines of communications with Directors, Officers, Employees, Contractors, Agents, Providers and FDRs.
- G.** The SIU maintains written policies and procedures and adheres to standards of conduct that articulate VNS HEALTH 'S commitment to comply with all applicable federal and state standards.
- H.** VNS HEALTH is committed to detecting and deterring FWA to ensure that inappropriate payments are identified and recouped and that appropriate action is taken against perpetrators of FWA, which may include prosecution and the initiation of civil actions.
- I.** The SIU, assisted by other individuals, entities, and departments as appropriate, is responsible for the timely investigation of suspected FWA and for implementing VNS HEALTH 'S FWA prevention and reduction activities within VNS HEALTH and as to all VNS HEALTH contracted providers with the oversight of the Compliance Officer.
- J.** The SIU uses a multi-faceted approach to prevent and detect suspected or potential FWA, involving both pre-payment and post-payment strategies. The SIU uses a combination of analytical tools, clinical expertise, investigative knowledge, internal and external referrals and education and awareness training program to maximize referrals from Employees, Directors, Officers, Contractors, Agents, Providers, Members and FDRs.

- K.** The SIU is responsible for the timely investigation of allegations related to Medicare sales agent practices as defined in and according to VNS HEALTH Medicare Policy: Sales Allegation Investigations.
- L.** The SIU is responsible for the timely investigation of allegations of improper practices by VNS HEALTH MLTC and MAP marketing and enrollment representatives.
- M.** The SIU maintains training and education materials specific to FWA, in support of VNS HEALTH 'S overall Compliance Program, and assists in providing training to Employees, Directors, Officers, Contractors, Agents, Providers and FDRs.

6. RESPONSIBILITIES:

A. SIU Manager:

- i. Ensures that the SIU performs all responsibilities in compliance with applicable federal and state laws, regulations and guidelines and responds timely, thoroughly and appropriately to all allegations of FWA;
- ii. Assists with the development, implementation, and oversight of the compliance awareness, training, and education program, including continuously creating methods for communicating the compliance message throughout the organization and the appropriate and timely training of internal and external parties. Ensures appropriate tracking of compliance training as assigned;
- iii. Develops, implements, tracks progress, and reports on SIU portions of the annual Compliance Work Plan across product lines, which outlines the objectives, projects, training, timelines, and deliverables for the Compliance Program. Assists in the development and maintenance of policies and procedures. Manages day-to-day operation of the Program;
- iv. Communicates with the Claims, Network Development and Contracting and Finance Departments and/or other VNS HEALTH departments as necessary to ensure that corrective actions required to be taken against network or non-network providers as the result of substantiated allegations of FWA, including recoupment, is taken consistently and timely.
- v. Develops, assesses and improves compliance investigation processes and procedures. Ensures processes are in place to investigate and take action on compliance concerns and issues that are reported to the Compliance Committee and Board of Directors through various reporting channels. Provides guidance on the direction of investigations, identification of appropriate interviewees, interpretation of witness statements, and interpretation of evidence;
- vi. Oversees the maintenance of the Compliance Hotline and SIU case management database (the "SIU Database") containing reported compliance issues, allegations, and concerns; reviews findings as needed;

- vii. Reports to the Director of VNS HEALTH Compliance and Regulatory Affairs, who in turn reports to the VNS HEALTH Chief Compliance and Privacy Officer. The Chief Compliance and Privacy Officer reports directly to the Compliance Committee on SIU compliance matters and assists in establishing methods to reduce the VNS HEALTH'S vulnerability to violations of the Compliance Program; and
- viii. Participates in special projects and performs other duties as assigned.
- ix. Handles all investigations:
 - x. Develops investigations that involve monetary losses and sensitive issues that may meet criteria for referral to law enforcement or the imposition of administrative actions;
 - xi. Utilizes data analysis techniques to detect discrepancies in claims/billing data, and proactively seeks out and develops leads received from a variety of source;
 - xii. Conducts independent investigations resulting from the discovery of situations that potentially involve FWA;
 - xiii. Reviews information contained in standard claims processing system files to determine provider billing patterns and to detect potential fraudulent or abusive billing practices or vulnerabilities in policies;
 - xiv. Completes written referrals to law enforcement and collaborates with various operational areas to recoup overpaid monies;
 - xv. Identifies overpayments, initiating repayments, suspensions and pre- and post- payment edits.
- x. **Support Staff and Physical Resources:**
 - i. The SIU Manager has access to the Regulatory Data Validation Manager, who administers the SIU Database.
 - ii. The SIU Manager as access to registered nurses and medical personnel to review medical documentation for the purposes of FWA detection.

7. SIU Staff Qualifications

- A. In addition to meeting the qualifications above for Special Investigators, the person serving as **Compliance Officer** shall meet the following minimum qualifications:
 - i. A bachelor's degree a relevant field (a Master's in Health Care Administration or a Juris Doctorate or equivalent is preferred, but not required);
 - ii. Minimum of six years of progressively responsible leadership experience, with a minimum of three years working in health care provider/human services or managed care environment, preferably in compliance, regulatory, or policy related area;

- iii. Knowledge of best practices and criteria for effective compliance, SIU activities and ethics programs;
- iv. Demonstrated superior mentoring skills and ability to work in a highly collaborative environment;
- v. Strong knowledge of Medicare, Medicaid statutes, regulations, policies and SIU, audit and reimbursement principles and procedures related to VNS HEALTH operations;
- vi. Excellent investigative, communication and organizational skills;
- vii. Excellent presentation skills with ability to create and deliver training, informational and other types of programs;
- viii. Excellent negotiation and problem-solving skills; and
- ix. Demonstrated ability to interpret, conceptualize, analyze, and disseminate information in a readily understandable manner.

B. The SIU Manager shall meet the following minimum qualifications:

- i. A bachelor's degree in accounting, human resources, law enforcement, criminal justice, nursing or other healthcare field (a Master's in Business or Health Administration is preferred, but not required);
- ii. Minimum of five years' experience in a supervisory capacity managing compliance in a federally regulated environment, including interacting with government agencies and Medicare and Medicaid regulators;
- iii. Strong knowledge of the application of Medicare marketing guidelines and materials;
- iv. Excellent investigative, communication and organizational skills.
- v. Excellent presentation skills with ability to create and deliver training, informational and other types of programs;
- vi. Excellent negotiation and problem-solving skills; and
- vii. Demonstrated ability to interpret, conceptualize, analyze, and disseminate information in a readily understandable manner.

8. Detection, Reporting and Referral of Potential FWA to the SIU

- A.** Potential FWA cases can be identified or received by the SIU through a variety of mechanisms, including, but not limited to:
- i. Employees, Directors, Officers, Providers, Vendors, Consultants, Members, Caregivers, FDRs, and the Public;
 - ii. via the anonymous VNS HEALTH Compliance Hotline: 1-888-634-1559, SIUmailbox@vnshealth.org,
 - iii. the EthicsPoint web portal;
 - iv. Law enforcement or regulatory agencies;
 - v. Referrals from other VNS HEALTH departments as well as third parties contracted by VNS HEALTH including:
 - Medical Management
 - Quality Management
 - Cost Containment
 - Provider Credentialing
 - Provider and Member Services
 - Grievances and Appeals
 - Pharmacy
- B.** The SIU coordinates with other VNS HEALTH departments, as appropriate, to obtain additional information, data and reports that will assist in identifying, investigating and preventing FWA.
- i. If any VNS HEALTH Employee, Director, Officer, Contractor, Agent, FDR or other person associated with VNS HEALTH receives or uncovers information that suspects FWA, such person must notify the SIU by one of the previously noted approaches. Upon receipt of this information, the SIU will log the information internally in the SIU Database, review the facts presented and open an investigation as appropriate.
 - ii. Reports of potential FWA can be made anonymously via the VNS HEALTH Compliance Hotline (1-888-634-1559) or the EthicsPoint web portal. All possible measures are to be taken to protect the anonymity and confidentiality of the reporting individual or entity, in accordance with VNS HEALTH 'S confidentiality policies. VNS HEALTH will not retaliate against or intimidate any individual who reports suspected FWA, in accordance with the VNS HEALTH Non-Retaliation and Non-Intimidation Policy.

iii. Examples of FWA and specific areas of risk and vulnerability include, but are not limited to, the following:

a. Providers:

- Billing for services not rendered;
- Deliberately filing incorrect diagnosis or procedure codes to maximize payment;
- Quality of care issues;
- Failure to maintain adequate medical records;
- Cover-ups in coordination of benefits;
- Misrepresenting services or dates of service;
- Billing non-covered services as covered services;
- An eligible provider billing for services provided by a non-eligible provider or individual;
- Providing and billing for unnecessary services; and
- Accepting or offering kickbacks and bribery.

b. Members:

- Loaning a VNS HEALTH identification card for use by another person;
- Altering the amount or date of service on a claim form or prescription receipt;
- Fabricating claims;
- “Doctor shopping” (seeing several providers to obtain frequent drug prescriptions) and excessive trips to the emergency room for narcotics; and
- Collusion with fraudulent providers.

c. Non-members:

- Using a stolen VNS HEALTH card to obtain medical services or prescriptions; and
- Engaging in impermissible sales and marketing practices to steer potential members to or from VNS HEALTH plans.

d. VNS HEALTH Employees:

- Creating claims;
- Delaying assignment of a provider to reduce costs;
- Failing to provide covered services to reduce costs;
- Engaging in impermissible sales and marketing practices, such as using unapproved promotional materials, falsifying eligibility information, enrolling individuals without their knowledge or offering inducements to members and providers to join; and
- Changing member or provider addresses to intercept payments.

10. Investigation Guidelines:

- A. The SIU conducts all FWA investigations in accordance with the Policies and Procedures set forth herein and the VNS HEALTH Corporate Policy: Investigating Compliance Issues and Corrective Action Plans.
- B. The SIU Manager logs the investigation in the SIU Database, noting the date the report was received and establishes a case file.
- C. In the case of FWA referrals from Grievance & Appeals (G&A), the G&A Department provides acknowledgment of receipt, and notice of referral to the SIU to the member or member representative.
- D. The SIU researches the validity of the report and obtains all necessary supporting documentation for the case file. The research and document collection may include, but is not limited to:
 - reviews of provider and member claims history,
 - reviews of billing and/or payment history or patterns,
 - reviews of prescribing/ordering history,
 - reviews of medical records,
 - on-site review or monitoring of a provider office,
 - interviews with providers and/or members and
 - review of provider and/or member contacts with VNS HEALTH.
- E. At any point in an investigation, the SIU may seek assistance from internal and external experts such as Physicians, Pharmacists, Certified Coders and/or Attorneys. Before engaging an external expert to assist with the investigation, the Investigator will obtain approval from the Compliance Officer in accordance with VNS HEALTH procurement standards.
- F. The SIU will investigate all instances of FWA, unless the SIU believes that law enforcement or another regulatory agency should be engaged to handle the investigation

(for example, when the FWA conduct involves bribery or stolen identity) in which case the appropriate referral is made upon the Chief Compliance Officer or VNS HEALTH'S Counsel consent.

- G. Investigations will be commenced within three (3) business days following the assignment of a case to the Special Investigator due to receipt of a report of potential FWA.
- H. The SIU promptly reviews identified issues to determine the validity and severity of every potential case. Investigations are commenced and prioritized based on the nature and potential severity of the issue, rather than by the order in which reports are received and issues are identified.
- I. The SIU Manager will make best efforts to update any investigation, if possible, every thirty (30) days of the receipt date. The SIU Manager must close all employee and sales investigations according to Compliance standards. VNS HEALTH operational areas must refer investigations to SIU promptly and within reasonable time.
- J. The SIU Manager will request medical / hospital / pharmacy records (or other patient data) for three to six patients with claims from the previous year for review. The SIU Manager will send one monthly follow-up request if the provider does not respond.
- K. If the provider of the FWA claim does not forward the requested documentation, the SIU Manager will request a refund for the undocumented claims. There will be one follow-up refund request with the final letter advising of a claim offset from future claims if the request is unanswered.
- L. The Special Investigations Unit utilizes an investigative database platform, TLOxp, to aid in its investigations of any suspected fraud, waste and abuse during the course of VNS HEALTH business. Prior to accessing TLOxp, an attestation as to the purpose and authority to utilize the investigative database platform will be undertaken. The TLOxp investigative database platform is maintained by the Special Investigations Unit Manager and overseen by the Director of Regulatory Affairs and HIPAA Privacy. The investigative database platform is to be accessed only for requests pertaining to allegations of fraud, waste and abuse during the course of an investigation. Special requests to locate individuals such as members or to confirm or dispute information can be sent to the Special Investigations Unit Manager for review and consideration. Each request initiated outside of the SIU will be memorialized on a request form to be submitted to the Special Investigations Unit. The Special Investigations Unit Manager will provide only the necessary information with respect to each request and will not provide a copy of the generated report unless approved by the Director of Regulatory Affairs & HIPAA Privacy.

11. Medicare Reporting and Cooperation:

- A. If the SIU determines that potential fraud or misconduct related to the Medicare program has occurred, the SIU will forward the referral to the VNS HEALTH 'S Counsel. Once approved by VNS HEALTH 'S Counsel, the SIU will report the conduct to the Qlarant National Benefit Integrity Medicare Drug Integrity Contractor (“MEDIC”) promptly, within seven days after the determination that a violation may have occurred.
- B. The SIU Manager reviews all allegations and determines within two weeks (14 calendar

days) of receipt by the SIU, whether a case is initiated. If the allegation cannot be addressed by the SIU (e.g., provider/member collusion cases that require undercover and/or surveillance or allegations of kickbacks or bribery) then the case file will be sent to the VNS HEALTH 'S Counsel for review. VNS HEALTH 'S Counsel will determine whether the allegations and supporting evidence support a referral to the appropriate outside regulatory agency. A case is opened in the SIU Database documenting the referral. The case is closed but any assistance required by MEDIC is quickly responded to by the SIU and is logged into the file. If MEDIC or OMIG returns the investigation the case will be reopened and handled accordingly.

12. MLTC and SelectHealth (HIV Special Needs Plan) FWA Reporting Requirements:

- A. VNS HEALTH has developed and submitted to DOH a Fraud, Waste and Abuse Prevention Plan as well as a designation of a SIU Manager, reporting up to the Compliance Officer, as the officer with responsibility for carrying out the provisions of the Fraud, Waste and Abuse Prevention Plan.

- B.** The VNS HEALTH Compliance Department shall file an annual report with DOH no later than the January 15 of each year, which shall describe VNS HEALTH'S experience, performance and efficiency in implementing the Fraud, Waste and Abuse Prevention Plan and proposals for improving the Fraud, Waste and Abuse Prevention Plan. VNS HEALTH shall also report at least annually the number of FWA complaints made to VNS HEALTH each year, and shall include the following information regarding confirmed cases of FWA:
- ii. The name of the individual or entity;
 - iii. The source that identified the fraud or abuse;
 - iv. The type of provider, entity or organization that allegedly committed the fraud or abuse;
 - v. A description of the fraud or abuse;
 - vi. The approximate range of dollars involved;
 - vii. The legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred; and
 - viii. Other data/information as prescribed by DOH.
- C.** The VNS HEALTH Compliance Department will also file a quarterly report with DOH no later than fifteen (15) business days after the close of each quarter that includes information about FWA complaints that warranted investigation by VNS HEALTH. VNS HEALTH will use the DOH "Quarterly Reporting Template," or such other form as directed by DOH. The quarterly reports will include the following FWA information:
- i. Number of FWA complaints received during the quarter that warranted preliminary investigation;
 - ii. A summary of the FWA issues raised during the quarter;
 - iii. For each confirmed case of FWA identified through any source:
 - a) The name of the individual or entity that committed the FWA;
 - b) The source that identified the FWA; and
 - c) The actions taken by the plan to address the FWA.
- D.** In addition, for each case of FWA confirmed by the SIU or law enforcement or other government regulatory agency, the VNS HEALTH Compliance Department shall report to the DOH on an ongoing basis.
- E.** The VNS HEALTH Compliance Department shall also, notify the New York State Office of the Medicaid Inspector General ("OMIG"), of any suspected misconduct committed by a member, provider or a contractor's employee. If during the investigation the SIU determines that potential fraud or misconduct has occurred, the SIU forwards the referral to

VNS HEALTH'S Counsel. If approved, the SIU reports the misconduct to the appropriate agency (MEDIC, DFS, OMIG, OIG or MFCU) within seven days after the determination that a violation may have occurred. The SIU will continue to work the active investigation unless instructed otherwise.

- F. When the SIU refers a potential case of fraud or abuse to OMIG, in accordance with Article V(X)(2)(h) of this Agreement, the Contractor (VNS HEALTH) may be eligible to share in the portion of the non-federal share of the recovery made by OMIG. OMIG shall determine whether the Contractor is eligible to share in the recovery, depending upon the extent to which the Contractor substantially contributed to the investigation and recovery, at a percentage to be solely determined by OMIG. Where OMIG determines that the Contractor substantially contributed to the investigation and recovery, the percentage shall be not less than one percent (1%) and not greater than ten percent (10%) of the non-federal share of the amount of Medicaid payments recovered which were received by the Provider from the Contractor. The Contractor must report its portion of the shared recovery as part of the Medicaid Managed Care Operating Report (MMCOR) reporting process. In no event shall the Contractor share in any recovery that results from the referral of a pending investigation of a credible allegation of fraud by the State to the New York State Office of the Attorney General or other law enforcement organization pursuant to 42 C.F.R. §455.23 and other pertinent authority.
- G. The SIU Manager reviews all allegations and determines within two weeks (14 calendar days) of receipt by the SIU, whether a case is initiated. If the allegation cannot be addressed by the SIU (e.g., provider/member collusion cases that require undercover and/or surveillance or allegations of kickbacks or bribery) than OMIG or another Law Enforcement Agency will be notified, and the case referred. A case is opened in the SIU Database documenting the referral. The case is closed but any assistance required by OMIG is quickly responded to by the SIU and is logged into the file. If OMIG returns the investigation the case will be reopened and handled accordingly.
- H. The annual reports submitted to DOH signed by the Compliance Officer.
- I. The VNS HEALTH Compliance Department shall file an annual Managed Care Provider Investigative report no later than January 30 of each year, to the OMIG.

14. Cooperation with New York State and Other Government Investigations:

- A. In connection with investigations or inquiries from DOH, DFS, CMS, OIG, OMIG and/or the New York State Office of the Attorney General (including the New York Medicaid Fraud Control Unit (MFCU)) or other agency, VNS HEALTH will provide access to its personnel, subcontractors and their personnel, witnesses, and enrollees and permit the above-mentioned agencies to conduct private interviews of such persons.
- B. VNS HEALTH will cooperate fully in making its personnel, subcontractors and their personnel available to the agencies for in person interviews, consultations, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process.
- C. VNS HEALTH will provide to the agencies originals and/or copies of all records and information requested, in the form requested, and allow access to the VNS HEALTH'S premises. All copies of records will be provided free of charge.

- ii. VNS HEALTH will conduct case development and support activities for the NBMEDIC and law enforcement relating to suspected, detected or reported cases of illegal drug activity.

15. Corrective Action:

- A. Corrective action will be taken as necessary to address the findings of any investigation, to ensure compliance with regulatory requirements going forward and/or to ensure that FWA does not recur. Corrective action may include:
 - i. The development and completion of a Corrective Action Plan in accordance with the VNS HEALTH Corporate Policy: Investigating Compliance Issues and Corrective Action Plans and the VNS HEALTH Policy: Corrective Action Plans;
 - ii. A referral to criminal and/or civil law enforcement authorities having jurisdiction over such matter, or a report to state or federal agencies (see below);
 - iii. Recoupment and/or submission of any overpayments;
 - iv. Appropriate education or training, including education of FDRs and providers; and/or
 - v. Appropriate disciplinary action, including termination of FDR contract.

16. Overpayments to Providers:

- i. VNS HEALTH complies with the requirements of New York Ins. Law § 3224-b in recovering over payments made to its physician network.
- ii. VNS HEALTH shall provide two written notices to physicians every 30 days, before engaging in overpayment recovery efforts.
- iii. VNS HEALTH shall not attempt to recover payments more than twenty-four months after the original payment date, unless the recovery efforts are:
 - a) Based on a reasonable relief of fraud or other intentional misconduct;
 - b) Required by, or initiated at the request of, a self-insured plan; or
 - c) Required by a state or federal government program.

16. Training and Documentation:

- A. VNS HEALTH and its delegated FDRs, providers, vendor and others associated with VNS HEALTH and VNS HEALTH 'S FDRs, where applicable, conduct annual compliance training programs for all personnel, which includes training in identifying and evaluating instances of suspected fraud, and abuse.

- B. The SIU provides additional FWA training to VNS HEALTH employees, on an as needed basis, specific to job functions and departments.
- C. VNS HEALTH maintains all documents relating to the activities of the SIU for at least ten years.

17. Responding to Compliance Issues

- A. Prior to closure, the SIU Manager alerts the Compliance Officer.

18. Self-reporting and Referrals

- A. VNS HEALTH will voluntarily disclose matters that, in reasonable assessment, potentially violate federal or state criminal, civil, or administrative laws. The self-disclosure will follow CMS, NBI MEDIC, and OIG/OMIG Provider Self-Disclosure Protocol requirements.
- B. The SIU refers suspected, detected or reported cases of illegal drug activity, or other illegal activity, to the NBI MEDIC and/or local law enforcement.
- C. The SIU will otherwise self-report and disclose in accordance with the VNS HEALTH Self-Reporting and Self-Disclosure Policy to Governmental Agencies.

SOURCE(S) / REFERENCE(S):

VNS HEALTH Code of Conduct

VNS HEALTH Compliance Program Structure and Guidelines

VNS HEALTH Corporate Policy: Investigating Compliance Issues and Corrective Action Plans

VNS HEALTH Corporate Policy: The Detection & Prevention of Fraud, Waste and Abuse and Applicable Federal and State Laws

VNS HEALTH Corporate Policy: Self-Reporting and Self-Disclosure Policy to Governmental Agencies

VNS HEALTH Corporate Policy: Reporting Non-Compliance and Fraud, Waste and Abuse

VNS HEALTH Corporate Policy: Non-Retaliation and Non-Intimidation

VNS HEALTH Corporate Policy: Compliance Hotlines

VNS HEALTH Fraud, Waste and Abuse Prevention Plan

VNS HEALTH Medicare Policy: Sales Allegation Investigations

VNS HEALTH Policy: Corrective Action Plans

N.Y. Comp. Codes R. & Regs. title. 10, § 98-1.21

Centers for Medicare & Medicaid Services, Medicare Managed Care Manual, Chapter. 21; Medicare Prescription Drug Benefit Manual, Chapter 9

New York State Department of Health, Managed Long Term Care Partial Capitation Contract