

Leading the Fight Against Health Care Fraud

Excellence
with Integrity



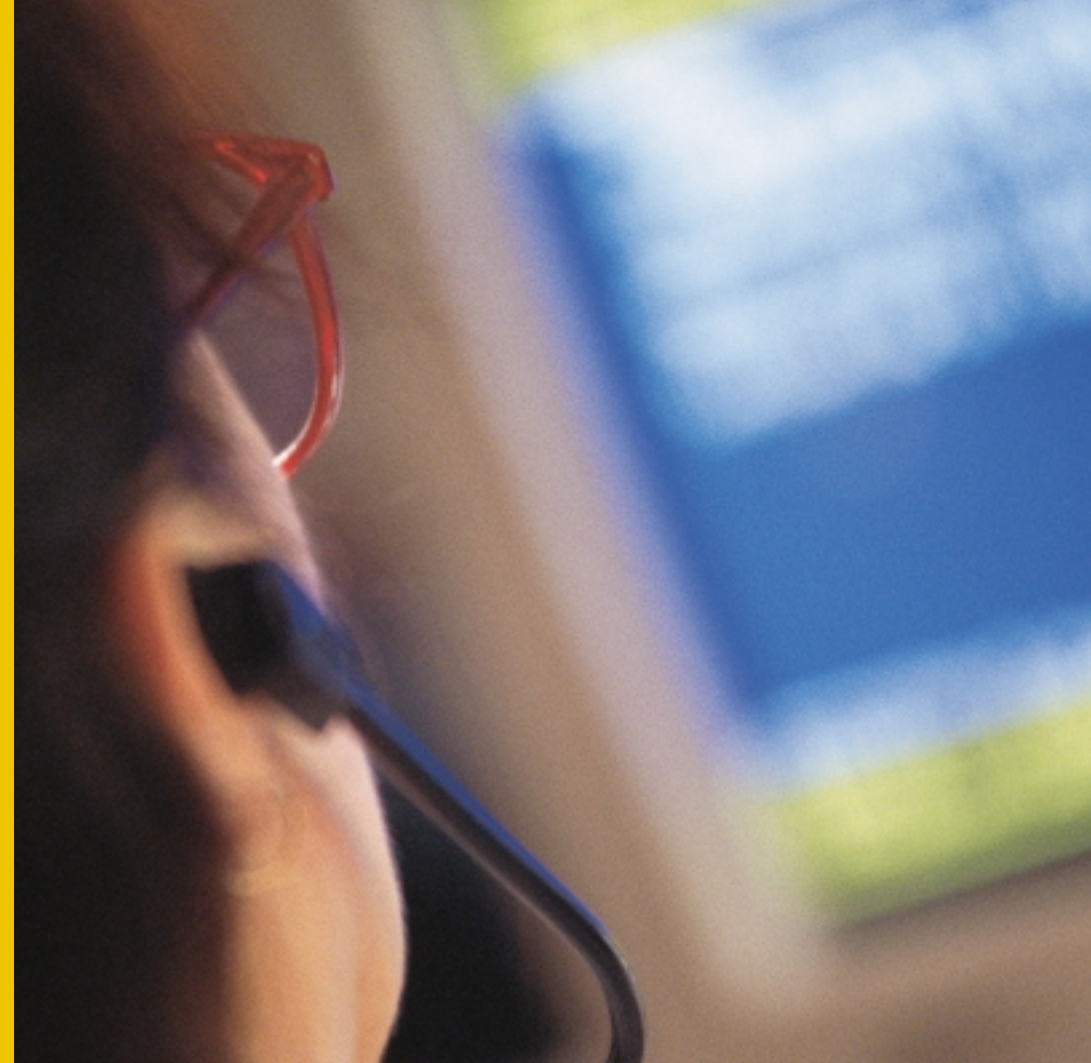
We want you to knowSM



We're fighting for our customers
and our company.

**We're fighting to
win. And we will!**

You can't always see it. It's hidden. But it's there, and it's an enormous problem — health care fraud and abuse. Billions of dollars are lost to health care fraud each year. It is diverting and wasting health care dollars, threatening America's health care system and victimizing consumers. Health care fraud is so serious a problem for the nation that it is, along with violent crime, at the top of the FBI's list of investigative priorities.



**Our goal is to detect,
deter and, ultimately,
end fraud.**



Aetna leads the way ...

**Getting tougher, getting smarter
and getting results.**

Aetna is the nation's leading health benefits company — with a commitment to Excellence with Integrity in all we do. We also are one of the top 500 companies making groundbreaking use of information technology and applying it to business needs and solutions. And we are a growing company.

We are a leader in terms of our people, our products and services, networks and overall capabilities. We are innovative ... creative ... performance driven ... and customer focused. Our strengths as a health benefits company are second to none.

As a recognized leader, we feel a responsibility to lead in the fight against fraud. Our goal is to detect, deter and, ultimately, end fraud. We haven't stopped it yet. But with the right team and the right tools, we're getting there — one win at a time!





We value integrity. We demand honesty, decency, trust and compliance in our relationships with customers, partners and each other.

Our vision lights the way ...

Creating the opportunity for all Americans to live full and healthy lives.

Aetna is creating the opportunity for all Americans to live full and healthy lives. That is our vision. Our values support our vision. We value quality and pledge to improve the quality of health care in America. We are committed to driving quality in a cost-effective manner.

We value **integrity**. We demand honesty, decency, trust and compliance in our relationships with customers, partners and each other. We are committed to doing the right thing and matching our actions to the commitments we make.

We value strong **relationships with our customers, members and providers** based on mutual respect and a shared commitment to high-quality health care, delivered in a cost-effective manner.

In keeping with our vision and values — with what we believe in — we are committed to protect our health plans, our customers and our company against health care fraud.

Our team ...

A core team of investigators. A support team of thousands.

The Special Investigations Unit (SIU), a part of Aetna's National Network, Provider & Product Services & Strategy organization, is responsible for the company's health care fraud and abuse program. The SIU is a team of professional investigators — all top notch — all experienced — with the background necessary to pursue all types of cases, from the simple to the complex. They work closely with internal marketing and financial areas, as well as outside agencies such as the FBI, and have developed extensive networks inside and outside the company.

Who refers cases to the SIU? Referrals come from law enforcement, primarily the FBI — also from the National Health Care Anti-Fraud Association, and from other health care companies. Most referrals, however, come from Aetna's claims processors and analysts, who are on the front line in our service centers across the country, and who are trained to identify potential fraud and abuse, document it and report it to the SIU for investigation.



Our program ...

A proactive, aggressive program. A philosophy of Zero Tolerance.

Our program targets all areas of health care and health care-related fraud and abuse — internal fraud, electronic transaction fraud and external fraud. Our mission is to aggressively pursue allegations of fraud and our approach is clear: Zero Tolerance. Aetna does not tolerate or passively accept health care fraud and abuse.

We rely heavily on technology. The Special Investigations Unit has its own systems capability and maintains access to Aetna's huge volume of claims data across all health products. The unit's systems professionals work with the investigators on in-depth analyses of case-related data. To help prevent fraud, they use advanced business intelligence software to identify providers whose billing, treatment or patient demographic profiles differ significantly from those of their peers.

This "built-in" systems capability, which enables systems professionals and investigators to work side by side in fighting fraud, makes our program unique in the industry.

In total, our program combines what we believe are the three most important elements: (1) a **highly professional and experienced team**; (2) an **investigative tool that employs knowledge-based technology**; and (3) **continuous training**. Our three keys to success.

Our success ...

We have recovered millions lost through fraud.

Runaway fraud is expensive. It can increase plan costs and involve huge financial loss. As part of our fight against fraud, and as part of our service to customers, we will do everything reasonably possible to pursue lost dollars. Our customers can expect this.

Thanks to the day-to-day efforts of our thousands of diligent, vigilant claims processors and analysts — and to the investigative expertise and follow-through of the Special Investigations Unit — we have been successful in recovering millions of dollars lost to fraudulent practices.

OUR THREE KEYS TO SUCCESS:

1) a highly professional and experienced team;

2) an investigative tool that employs knowledge-based technology; and

3) continuous training.



The staff also helps interpret clinical case-related data. Thanks to this highly collaborative relationship, we know how to identify fraud because we know what to look for.



What we look for ...

We look for the “red flags” of fraud. We know what they are and how to find them.

Aetna’s health delivery staff assists the Special Investigations Unit in developing a checklist of the signs and signals of fraud. The staff also helps interpret clinical case-related data. Thanks to this highly collaborative relationship, we know how to identify fraud because we know what to look for.

Medical Fraud

- Unusual provider billing practices.
- Discrepancy between the submitted diagnosis and the treatment.
- Diagnoses or treatments that are outside the practitioner’s scope of practice.
- Claims that are resubmitted with coding changes to gain benefits.
- Alterations on claim submissions.
- Pressure for quick claim payment.

Disability Fraud

- Uses a P.O. Box and is hesitant or refuses to provide a physical address.
- Either refuses to sign or alters the authorization and release of information, particularly if the alterations restrict our ability to investigate the claim properly.
- Has a history of self employment and/or is a trades person who can readily work for cash while receiving disability benefits.

- Frequently changes providers.
- Often fails to show for scheduled appointments with provider or independent medical examination.
- Has a known “issue” with the employer.
- Is disinterested in rehabilitation/ vocational services.

Dental Fraud

- Unusual provider billing practices.
- Discrepancy between the services billed and the dental records and/or X-rays submitted when requested.
- Claims that are resubmitted with coding changes to gain benefits.
- Claims that are resubmitted with dates of service changes (following a denial as outside the coverage period, or in excess of the plan year maximums), claiming an error was made initially.
- High volume or percentage of same procedures (high percentage of dollars paid, in one or two procedures).
- Pressure from provider and/or patients for rapid claim adjudication; threats of legal action; filing of complaints to state insurance departments or the Aetna Chairman.
- Alterations on claim submissions.

Member Fraud

- Misspelled or unusual terminology on claim forms.
- High dollar amount member reimbursement claims.
- High incidence of prescriptions; use of same prescription number for various family members; and prescription claims consecutively numbered even though they were purchased on different days.
- Failure to report other employer-sponsored health coverage; failure to disclose that claims submitted were a result of work-related illness or injury.
- Use of lost or stolen identification card by a third party.
- Ineligible dependents or employees.
- Pressure for a quick claim payment; filing of complaints to state insurance departments.
- Alterations on claim submissions or enrollment forms.

For more information on our fraud program, contact your local Aetna sales representative — or call the Special Investigations Unit hotline: 1-800-338-6361 or AetnaSIU@aetna.com

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