

Fraud and Abuse

The national Blue Cross and BlueShield Association (BCBSA) and the National Insurance Association of America (NIAA) have estimated that between five (5) and ten (10) percent of all claims nationwide are incorrectly paid due to fraudulent or abusive billing practices. Inappropriate billing for medical care inflates health insurance premiums and wastes dollars that would otherwise be available for medical services. To respond to the fraud and abuse issues, Regence BCBSO has established an External Audit and Investigations Department (EAID).

The EAID unit is responsible for: the investigation of complaints of possible fraudulent and abusive patterns; responding to questions and complaints from members and providers calling the Fraud Hot Line number listed on the Explanation of Claims Processed form; providing internal and external Fraud and Abuse Awareness training; prepayment reviews, desk audits, and on-site audits.

False claims can be divided into two categories: fraudulent and abusive. Submitting a claim for a service not rendered is considered fraud. This includes charging for a procedure different from what was actually performed. Billing for services in addition to those actually performed is also considered fraudulent (i.e., billing for twelve (12) tests when only six (6) were done). Abusive billing is more subtle and, consequently, more difficult to define. Of the two false billing types, it is by far the most prevalent. Abuse in this context means misuse, misapplication or false enhancement of charged services. These types of claims would include charging for medically unnecessary services, billing for a time-consuming comprehensive level of medical management when a less time-consuming straightforward medical decision code was the actual level of service provided, or submitting claims with misleading diagnostic codes in order to receive benefits for an excluded service.

While the vast majority of health care providers bill honestly and responsibly, Regence cannot ignore the impact of fraudulent and/or abusive billing and has established a process for members and providers to report suspect billing issues through a Fraud Hotline number and/or through the a link on the Regence web site.

To report suspected fraud and abuse, please call our Fraud Hotline at: 1(888) 207-4211. This telephone hotline may be used to anonymously report suspected fraudulent or abusive billing practices for future investigation by Regence.

When our External Audit and Investigations staff discovers a pattern of fraudulent, abusive or inappropriate billing practices, they take appropriate measures to stop such activity. Claims are denied retrospectively and refunds are requested for all charges considered to be the provider's responsibility.

The following are some examples of fraudulent, abusive or inappropriate billing for services as well as some common violations of provider/practitioner agreements and member plans.

- A pattern of billing for services not rendered, not medically necessary, or in a manner that overstates the services rendered
- A pattern of billing that includes submitting incorrect or misleading diagnostic or procedure codes, which leads to incorrect processing services
- Submitting a claim to Regence for a service or treatment at a higher rate than would be charged in the absence of third-party reimbursement
- Reporting excessive costs (e.g., falsely representing the actual cost)
- Advertising free or discounted service, then billing Regence for additional services that may or may not be medically necessary
- Billing members for provider write-off amounts
- Not collecting all deductible, copay and coinsurance amounts owed by the member. These charges cannot be written off by the provider.
- Billing members for amounts in excess of amounts determined by Regence for deductible, copay and coinsurance
- Billing for services or treatment performed on a family member, even those with different last names
- Submitting claims for charges that, in the absence of the member's insurance, there would be no obligation to pay; services provided by a family member (*It is inappropriate to bill for services that, in the absence of insurance coverage, would become "professional courtesy," e.g., group practice partners and staff or the providers immediate family.*)
- Billing for services performed by another provider, practitioner or laboratory
- Billing for telephone calls
- Billing separately for services included within a global fee or code