

Fraud and Abuse

The Blue Cross and BlueShield Association (BCBSA) and the National Insurance Association of America (NIAA) have estimated that between 5-10% 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. A goal of the BCBSA and Regence is to preserve health care quality and affordability. To this end, we cooperate with hospitals, doctors, and law enforcement agencies to identify and stop health care fraud.

Health care fraud is the intentional, unlawful and repetitive practice of filing fraudulent or deceptive claims for reimbursement. The following practices have been identified by the BCBSA as examples of fraud:

- Billing for services not rendered
- A patient presenting a false member card
- Deliberately submitting or filing false claims
- Purposely misrepresenting a condition or the types of services provided
- Intentionally omitting information about a condition, symptoms or services provided

Inadvertent errors, such as occasionally reporting the wrong billing code, are not considered fraudulent.

Preventing Fraud

We encourage you to observe the following practices, as recommended by the BCBSA, to protect your office from intentional or inadvertent fraud:

- Verify that billing codes are accurate.
- Protect your prescription forms, which are often stolen during medical visits and used in pharmacy fraud schemes.
- Check patient histories to help prevent prescription drug fraud. Ask patients if they are seeing or have obtained prescriptions from other doctors.
- Implement procedures to ensure that information, such as the nature of services provided, is accurately communicated to your billing staff and to any third-party firms and services.

External Audit

To respond to the fraud and abuse issues, Regence has established an External Audit and Investigations Department (EAID).

The EAID is responsible for:

- Providing internal and external training
- Conducting pre and post payment reviews
- Conducting desk audits and on-site audits
- Investigating possible fraudulent and abusive billing practices
- Responding to questions and complaints from members and providers who call the fraud hotline

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 that which was actually performed. Billing for services in addition to those actually performed is also considered fraudulent (i.e., billing for 12 tests when only six were done).

Abusive billing is more subtle and, consequently, more difficult to define. However, it does fall under the Health Care False Claim Act. Of the two false billing types, abuse is by far the most prevalent. Abuse, in this context, means misuse, misapplication or false enhancement of charged services.

This includes:

- Charging for medically unnecessary services
- Submitting claims with misleading diagnostic codes in order to receive benefits for an excluded service
- Billing for a time-consuming comprehensive level of medical management when a less time-consuming straightforward medical decision code was actually provided

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

- Billing for telephone calls
- Billing members for provider write-off amounts
- Billing separately for services included within a global fee or code
- Reporting excessive costs (e.g., falsely representing the actual cost)
- A pattern of billing for services not rendered, not medically necessary, or in a manner that overstates the services rendered
- Billing members for amounts in excess of amounts determined by Regence for deductible, copayment and coinsurance
- Advertising free or discounted service, then billing Regence for additional services that may or may not be medically necessary

- Billing for services performed by another provider, practitioner or laboratory (except if there is a written coverage arrangement in place)
- Not collecting all deductible, copayment or coinsurance amounts owed by the member. These charges cannot be written off by the provider.
- 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
- A pattern of billing that includes submitting incorrect or misleading diagnostic or procedure codes, which leads to incorrect processing services
- Billing for services or treatment performed on a family member, even those with different last names (a family member is defined as the health care professional's own spouse, parent, child or eligible dependent)
- 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")

While most health care providers bill honestly and responsibly, Regence cannot ignore the impact of fraudulent and/or abusive billing. As a result, we have established a process for members and providers to report suspect billing issues through our fraud hotline at 1 (888) 207-4211 or via a link on the bottom of each page of the Regence Web site.

Provider Audits

Regence audits claims of participating physicians, facilities and other health care professionals. While many of our audits are conducted to determine whether we have been appropriately billed, we also audit for:

- Proper utilization
- Medical necessity
- Coverage of services
- Appropriateness of services
- Accuracy of claims submitted

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

Trained auditors, who are certified coders through the American Academy of Professional Coders (AAPC), cover all disciplines, including physicians, laboratories, pharmacies, durable medical equipment suppliers, hospitals and ancillary health care providers. All audits comply with federal and state regulations pertaining to the confidentiality of member records.

When necessary, on-site audits are conducted in the offices of our providers and occur at a mutually agreed date and time within the timeframe specified in your agreement with Regence. In the event of an audit, please allow sufficient space within your office to review records and copy those records relevant to the scope of the audit.

Original records are never removed. Copies of relevant records will be removed from your office to compare with claims submitted to Regence. When this is necessary, we protect the confidential nature of the member records as required by state and federal regulations.

Federal False Claims Act

The federal False Claims Act (FCA), 31 U.S.C.A. §§ 3729 – 3733, provides a mechanism to recover fraudulent or false medical claims paid with government funds. The law impacts providers, among others, who may have been overpaid by a government program including the Federal Employee Program (FEP), Medicaid, Medicare, Medicare Advantage, Medicare Part D and TRICARE. We recommend all providers and their billing staff read the Act in its entirety at: <http://www.taf.org/federalfca.htm>. The Fraud Enforcement Recovery Act (FERA) of 2009 amended the FCA. For your convenience, some of the changes have been noted below:

- **Intent** – Formerly, the FCA required proof of intent to get a false claim paid. This provision has been revised to reflect that a person can be found liable if he or she knowingly makes, uses or causes to be made or used a false record or statement material to a false or fraudulent claim.
 - Material is defined as “having the natural tendency to influence or being capable of influencing the payment or receipt of money or property.”
 - Knowingly means that a person, with respect to information, has actual knowledge of information, acts in deliberate ignorance of the truth or falsity of information, or acts in reckless disregard of the truth or falsity of information.
- **Recipient of claim** – The FCA formerly applied only to a claim presented to an officer or employee of the government. Now, the amendment also attaches liability if a false or fraudulent claim is presented to an agent of the government or a government contractor (e.g., if a provider’s office submits a fraudulent claim to a government program such as Regence MedAdvantage or the Federal Employee Program (FEP)).

- **Obligation to repay** – The amendment obligates providers to return overpayments. It is a FCA violation if a provider knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government. An obligation includes an established duty arising from the retention of an overpayment.
- **Liability for cost of recovery** – A new provision now imposes strict liability on FCA violators for the costs incurred by the government to recover penalties and damages.
- **Expanded conspiracy provision** – The amended FCA no longer applies only to conspiracy to get a false claim paid, but now includes conspiracy to violate any substantive provision of the FCA.
- **Expanded whistleblower protection** – Whistleblower protection now extends to employees, contractors and agents attempting to stop or report an FCA violation.
- **Extends statute of limitations for the government** – If a private person brings a lawsuit for violation of the FCA, the government can intervene in that lawsuit. For statute of limitations purposes, the government’s complaint shall “relate back” to the original filing date of the lawsuit.

A person who violates the FCA could be liable to the government for \$5,000 to \$10,000 per violation, plus three times the amount of damages the government sustains because of the violation.

Medicare Fraud and Abuse compliance training

If you are a Regence MedAdvantage provider you are required to complete a Medicare compliance training once per year. We make available a Medicare Fraud and Abuse Compliance Training on our *Provider Web Site* in the Educational Tools, under Self-paced. It takes approximately 15 minutes to complete and is available for your staff. Although this training can be obtained through any source, a provider must keep a record that this required training has been completed.

Member card fraud

Health care member card fraud is an increasing problem. According to the World Privacy Forum, insurance fraud affects more than three million members every year and costs the health care industry in excess of \$68 million. Many cases of identity fraud are reported involving member cards that are misplaced, stolen or loaned to an acquaintance. Theft can also happen when someone writes down a member’s information and presents it as his or her own at the time of service.

When cases of member card fraud are discovered, Regence will seek reimbursement from providers. To protect your practice from this type of deception, we recommend taking the following precautions:

- Photocopy the front and back of each patient's (or their guardian's) member card and driver's license at every visit.
- Take a digital photo of each patient when he or she checks in for their first visit. Include it as part of his or her permanent electronic record. Then refer to the picture each time that patient checks in.

Additional information

To learn more about how to protect your office from fraudulent activities, please visit the Blue Cross and Blue Shield Association's Web site at **www.bcbs.com/antifraud**.