Why Blue Cross and Blue Shield of Vermont Fights Healthcare Fraud, Waste and Abuse

BlueCross BlueShield of Vermont
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As part of our efforts to improve the healthcare system, Blue Cross and Blue Shield of Vermont has made a commitment to detecting, correcting, and preventing fraud, waste, and abuse (FWA).

Studies have determined that health care fraud is the single largest contributor to the increase in health care costs in the United States. The National Healthcare Anti-Fraud Association estimates that Fraud and Abuse equals 3-10% of all annual health care expenditures.

Financial losses incurred as a result of FWA have a direct effect upon our healthcare costs and health insurance premium. Help us control rising healthcare costs. Tips from members and healthcare providers are important in the fight against healthcare FWA.

Fraud, Waste and Abuse – How are they different?

Fraud – is intentional misrepresentation, deception, intentional act of deceit for the purpose of receiving payments that an individual or entity is not eligible to receive.

Waste – generally refers to overutilization of medical services, behaviors or practices that result in unnecessary costs, misuse of services, and that may also be inconsistent with acceptable medical guidelines. They may often be of no medical or clinical value and may be more directly related to health management.

Abuse – is deliberate ignorance or reckless disregard of the truth; conduct that goes against and is inconsistent with acceptable business and/or medical practices resulting in payments that an individual or entity is not eligible to receive.

Common Examples of Fraud, Waste and Abuse

Healthcare fraud, waste and abuse takes many forms. The most common of these forms include:

Providers

- Billing for services or supplies that were not provided or needed;
- Filing a claim for a more expensive procedure than was actually performed;
- Billing for a covered service when the true service was non-covered;
- Omitting or misrepresenting information about a condition, symptom or service performed;
- Unbundling charges – taking an overall procedure and billing each part or step separately to receive higher reimbursement;
- Accepting kickbacks for patient referrals;
- Waiving patient copays or deductibles for services that were prepaid or paid in full by the health insurer.

Members

- Using an insurance ID card that belongs to someone else;
- Adding someone to a policy who is not eligible for coverage;
- Receiving narcotic prescriptions from several physicians, through deceit;
- Forging or altering bills or receipts;
- Filing claims for services or medications not received.
- Falsifying your physical address to obtain coverage.

How to Report Fraud, Waste, and Abuse (FWA)

If you suspect fraud, waste, or abuse in the healthcare system, you should report it to Blue Cross and Blue Shield of Vermont and we will investigate. Your actions may help to improve the healthcare system and reduce costs for our members, customers, and business partners.

To report suspected fraud, waste, or abuse, you can contact Blue Cross Vermont in one of these ways:

- **Phone Blue Cross Vermont Fraud Hotline:** 1-800-337-8440

- **E-mail:** Fraud_issues@bcbsvt.com

- **Write us at:**
  Blue Cross and Blue Shield of Vermont
  PO Box 186
  Montpelier, VT 05601-0186
  Attn: Fraud, Waste, Abuse & Recovery Department

You may remain anonymous if you prefer. All information received or discovered by the Blue Cross and Blue Shield of Vermont FWA Special Investigations Unit (SIU) will be treated as confidential, and the results of investigations will be discussed only with persons having a legitimate reason to receive the information.

How Blue Cross and Blue Shield of Vermont Fights Healthcare Fraud, Waste and Abuse

At Blue Cross and Blue Shield of Vermont we take a proactive approach to detecting and investigating potential fraud, waste and abuse.

- We have a special investigative unit dedicated to preventing, detecting and investigating FWA, staffed with trained professionals who have many years of health care and health insurance experience.
- We use sophisticated software to continually analyze our healthcare claim patterns and investigate red-flag situations were provider billing exceeds normal ranges.
- We partner with industry-leading firms who specialize in identifying “outlier” claims and auditing provider’s records to ensure billings are correct.
- We maintain an active fraud hotline where our members and providers may report suspected fraud.

We recover millions of dollars in erroneous and unsupported claims every year.

How can you help?

Providers

There are several relatively easy ways for medical professionals to identify potential problems, protect themselves and help stop fraud:

- Confirm patient identification. Ask for a picture ID (and keep a copy) to ensure that the person presenting the insurance card is the actual owner of that card;
- 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;
- Verify that billing codes are accurate. Review all notes/documentation before submitting claims.

- 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;
- Report suspect FWA

Members

- Protect your insurance card as you do your social security and credit cards;
- Review your explanation of benefits or online claims history to ensure that the reported services were actually received;
- Beware of "free services" or offers to "waive" your co-payments;
- Ask questions to get a second opinion if a service or treatment seems unreasonable;
- Report suspect FWA

Tips when reviewing your Summary of Health Plan Payments (SHPP)

Help us identify potential FWA situations by reviewing your explanation of benefits or claims (available within our secure Member Resource Center) to ensure that reported services where actually received. During your review please keep these sometimes confusing scenarios in mind:

- **Some healthcare service providers bill for two components: facility and professional.** For example, if you receive laboratory, x-ray and imaging services you will likely see two separate lines on your Summary of Health Plan Payments (SHPP):
    1. Hospital where the x-ray or laboratory services were performed (facility component)
    2. Doctor who read the x-ray or laboratory service (professional component)

  It's normal and expected to see two separate provider names on your Summary of Health Plan Payments (SHPP) in these scenarios. It's not considered fraud, waste or abuse.

- **Injections/Immunizations, intravenous (IV) and blood draws fall under the type of service (TOS) category 'Surgery.'** Although these types of services aren't what typically come to mind when you think surgery, this is how they would appear on your Summary of Health Plan Payments (SHPP).