Table of Contents

Introducing the SID ..............................................................................................................1
What is Health Care Fraud? .................................................................................................1
SID Goals .............................................................................................................................2
Investigative Process ..........................................................................................................2
Schemes ...............................................................................................................................3
Provider Checklist ...............................................................................................................4
Need More Information? .....................................................................................................5
How to Report Health Care Fraud .......................................................................................5
Introducing the SID

Each year fraud costs the health care industry over $54 billion dollars, largely contributing to the rising cost of health care for all Americans. In response to this problem, Blue Cross and Blue Shield of Illinois (BCBSIL) created the Special Investigations Department (SID), one of the most aggressive and effective health care investigation programs in the industry. The SID is committed to fighting fraud, reducing health care costs, and protecting the integrity of the BCBSIL provider network.

The SID is managed by former FBI officials who have extensive experience managing complex criminal investigations. These individuals provide valuable contacts with law enforcement, prosecutorial, and regulatory agencies throughout the United States, including the Illinois Department of Financial and Professional Regulation (IDFPR).

The SID is comprised of individuals who are drawn from a wide array of valuable professional backgrounds. These include:

- Health insurance and claims processing
- Law enforcement (including former agents of the FBI, IRS and U.S. Postal Inspector’s Office)
- Legal (former counsel to the FBI; former state prosecutor with white collar crime prosecution experience)
- Computer programming
- Data mining and analysis
- Medical (including Registered Nurses)
- Public accounting

The team environment fostered within the SID allows the department to function with a greater efficiency and intensity than any other health care anti-fraud program. This formidable team is well equipped to identify and investigate complicated fraud schemes and reduce health care costs.

What Is Health Care Fraud?

Health care fraud is a false statement knowingly made for the purpose of obtaining claim payments, health care benefits, services and other things of value from BCBSIL and its customers. An attempt to commit fraud may constitute a crime and will be vigorously investigated by the SID even if there is no apparent loss to BCBSIL and its customers. Health care fraud requires the intent to deceive and the SID is careful to screen out those situations where an honest mistake was made or the misstatement did not influence BCBSIL’s decision to pay a claim or provide health care benefits, services or other things of value.
SID Goals

The SID team works in unison to accomplish the following goals:

- Identify and investigate health care fraud
- Refer cases for criminal prosecution
- Deter others from committing health care fraud
- Recover losses due to fraud
- Use all available means to protect the assets of BCBSIL and its customers
- Protect the integrity of the BCBSIL provider network.

The SID’s primary mission is to seek the criminal prosecution and incarceration of those who defraud or attempt to defraud BCBSIL and its customers. BCBSIL’s corporate policy is to pursue criminal prosecution in lieu of resolving fraud through civil settlements. Losses due to fraud are recovered through the criminal justice system in the form of restitution or asset forfeitures and/or through civil litigation.

In cases where criminal prosecution is not an option, providers engaging in fraudulent or abusive billing practices may face other strict sanctions which include a formal demand for refund of any overpayment, civil litigation, referral to the IDFPR and/or removal from the BCBSIL provider network. A provider whose billing practices are questionable but do not rise to the level of fraud may be referred to Provider Affairs for education on the proper method for billing certain procedures.

Investigative Process

The BCBSIL SID consists of a highly qualified intelligence group and two investigative groups.

The Intelligence Group identifies health care fraud schemes using cutting-edge technology and software. Its staff consists of individuals who are highly-educated and experienced in the area of data mining and analysis.

Unlike most health care anti-fraud programs, which receive information from external technology departments, BCBSIL’s intelligence gathering function is dedicated solely to and housed within the SID in order to provide a cohesive and effective work structure.

The Investigative Groups build cases that can be referred to law enforcement for criminal prosecution. SID investigators use all available leads, resources and investigative techniques to obtain evidence and demonstrate probable cause for crimes committed against BCBSIL and its customers.

In addition, a full-time Medical Director provides valuable and timely input on current practice patterns, best practice standards regarding medical necessity, approved medical interventions and compliance with current medical policies. When requested, the Medical Director will also participate in provider interviews.
Schemes

Providers who commit fraud are usually involved in schemes affecting multiple patients and therefore produce the greatest amount of loss to BCBSIL and its customers. As a result, the SID focuses on fraud schemes involving providers. Once identified, the schemes are applied to all available claim data to determine the full scope of the fraud. The SID then works with law enforcement and other insurance companies to link private losses and losses to federal health care programs to build cases that meet the threshold for criminal prosecution.

Commonly identified schemes involving providers include:

- **Unbundling**: providers bill separately for procedures and supplies that are considered part of a single procedure or included as part of a global fee
- **Misrepresenting services**: billing procedures under different names or CPT codes in order to obtain coverage for services, such as cosmetic or experimental procedures, which are otherwise not covered by the member’s plan
- **Upcoding**: the provider bills the health insurance company for a more expensive service, supply or piece of equipment than was actually provided
- **“Free” Screenings**: providers market tests such as hearing or allergy screenings as “free” in order to obtain a member’s insurance information. The information is then used by the providers to bill the member’s insurance company for the cost of these “free” tests and other unneeded or unwanted services
- **Durable Medical Equipment**: a DME company will use different provider numbers or business names to bill for both the rental and purchase price of the same piece of equipment or will bill for equipment or supplies never received by the member
- **Unlicensed Providers**: individuals who are unlicensed or have had their license suspended or revoked will see patients and bill the cost of their services by using the name of another health care professional or an address located in a different state
- **Kickbacks**: providers exchange money and/or other things of value for the referral of patients for services that are not medically necessary or that have no validity or diagnostic value. The providers attempt to disguise the kickbacks through improper leasing agreements and professional affiliations
- **Duplicate Billing**: a provider submits two or more claims for the same procedure, changing details such as the date of service in an attempt to get the insurance company to pay for the same procedure multiple times
- **Studies/Free Samples**: the provider bills a patient’s insurance company for the cost of drugs which the physician received at no cost in connection with a study or marketing program
- **Waiving Co-pays**: providers may violate the terms of their contract with BCBSIL and the law by failing to collect the required co-pay from a member. When a provider waves the co-pay as a matter of practice, he/she may be misrepresenting the true cost of his/her services and, as a result, filing an inaccurate claim with BCBSIL.
Providers engaging in these schemes or any other fraud risk criminal prosecution and removal from the BCBSIL network. Providers are encouraged to police their own peer groups and to use the fraud hotline to report any suspicious activity on the part of patients, health care providers and others conducting business with BCBSIL. In addition to identifying and investigating health care fraud, the SID works with providers on a proactive basis to help them avoid activities that could lead to the commission of health care fraud.

Fraud committed by BCBSIL members also contributes to the rising cost of health care and is therefore not ignored. The SID has various programs in place to identify member fraud schemes.

Commonly identified schemes involving members include:

- **Doctor Shopping**: bouncing from one doctor to another or visiting several emergency rooms in order to obtain multiple prescriptions for controlled substances
- **Identity Swapping**: instances where an insured individual allows the use of his or her insurance or pharmacy cards by an uninsured person
- **Black Market Drug Sales**: obtaining drugs from a pharmacy through the use of stolen, forged or otherwise improperly obtained prescriptions in order to resell the drugs on the black market for a significant profit.

**Provider Checklist**

Below are some simple steps you can take to help BCBSIL in its fight against fraud:

✔ **Verify patient ID**: ask for a picture ID to ensure that the person presenting the BCBSIL insurance card is the “owner” of that card

✔ **Use proper billing codes**: consult CPT, ICD-9 and HCPCS code books and other resources to verify that the codes being used are accurate and appropriate. Members of the American Medical Association (AMA) are encouraged to contact the AMA at 1-800-634-6922 for coding information and guidance.

✔ **Consult Medical Policies for benefit eligibility**: all active and pending Medical Policies are available at http://medicalpolicy.hcsc.net

✔ **Safeguard your prescription pads**: prescription pads should not be left accessible to members. Prescription forms used in pharmacy fraud schemes are often stolen from a provider’s offices during medical visits.

✔ **Police your peer group**: fraud committed by members of your peer group can adversely affect your practice in many ways and should be reported to the SID. Reporting fraud is the right thing to do and will protect the integrity of your profession and the BCBSIL network.
Spot-check/audit billing services and consulting firms: implement procedures to ensure that information, such as the nature of the services rendered, is accurately communicated to BCBSIL when using third party firms and services

Be aware of the fact that billing services may use aggressive coding and billing practices to increase your revenue and, in turn, their commissions. The use of such coding and billing practices may amount to fraud. Although the coding and billing are done by an outside service, you (the provider) may be held responsible for any fraud your billing service may commit.

Research new procedures: check to ensure that new procedures and services are recognized by the FDA and the medical community and not considered experimental or investigational

Be conscious of seminar messages: you may receive information on seminars that will teach you ways to increase your “bottom line”. Be cautious of these seminars as they often involve aggressive billing practices, referrals for procedures that are not medically necessary, tests that have no recognized value and other “enhancements” to your practice that may result in fraud. Remember, if it sounds too good to be true, it probably is and you should contact the SID.

Need More Information?
Reducing health care fraud must be a joint effort between BCBSIL, its members and its providers. In order to facilitate this joint effort, the SID provides information and training to its members and providers in an effort to educate them about the health and financial risks associated with health care fraud. Additional information about the SID and a free fraud awareness training program are available at www.bcbsil.com/sid.

How to Report Health Care Fraud

Provider Fraud Hotline: 1-877-272-9741
The Fraud Hotline operates 24 hours per day, seven days per week.

Web Site: www.bcbsil.com/sid/reporting
This web site address links to an online fraud reporting form that can be completed and sent to the SID electronically.

U.S. Mail
Blue Cross and Blue Shield of Illinois
Special Investigations Department
300 E Randolph Street, 11th Floor
Chicago, IL 60601

Suspicions of fraud can be reported to the SID anonymously.