

## Blue Cross and Blue Shield of Vermont Anti-Fraud, Waste & Abuse Program

### OVERVIEW

Blue Cross and Blue Shield of Vermont (BCBSVT or the Plan) has developed a comprehensive anti-fraud, waste and abuse (FWA) program designed to prevent (minimize), detect, investigate, report and recover funds related to fraudulent, wasteful and abusive activities perpetrated by providers, members, employees, vendors or employer groups. The foundation for the program is the Plan's Fraud, Waste, Abuse and Recovery Unit, whose primary function is to manage and oversee the Plan's anti-fraud program, provider audit program and internal claim recovery programs. The unit also functions as the Plan's primary fraud investigation resource. Our anti-fraud, waste and abuse initiatives generally apply uniformly across all lines of business, including Qualified Health Plans sold over Vermont Health Connect.

#### Working definitions

**Fraud** - Intentional misrepresentation; deception; intentional act of deceit for the purpose of receiving payments that an individual or entity is not eligible to receive.

**Abuse** - 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.

The difference between fraud and abuse is that fraud is acting with knowing intent and considered criminal behavior, while abuse is regarded as similar except that the elements of a crime cannot be demonstrated, characterized or proven. Deliberate ignorance or reckless disregard of rules and procedures are often considered civil fraud.

**Waste** - Generally refers to over utilization of medical services, behaviors or practices that result in unnecessary costs, misuse of resources, 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.

**Investigation** - Careful search, systematic inquiry, gathering of information to substantiate or refute presented or known facts and/or allegations.

### PREVENTION AND DETECTION

Security over the Plan's data processing systems is critical to ensure the integrity of claim processing and member enrollment, and avoid fraud conducted via the Plan's data processing systems. The Plan has established a comprehensive security policy and program designed to prevent and detect potential unauthorized access or use of Plan data processing systems. A

detailed description of policies may be found in the BCBSVT Confidentiality and Security policy.

Pre-payment edits within the Plan's claim processing system are another key tool in the prevention of fraud, waste and abuse. Examples of such edits include eligibility validation, identification of potentially duplicate billings, high dollar claim review, automatic "bundling" of unbundled services, review of cosmetic and investigational procedures.

Numerous approaches are in place to detect potential fraud, waste and abuse, including: provider audit programs, use of data analysis and queries, employee referrals, fraud hotline, and referrals through the Blue Cross and Blue Shield Association network. Each is discussed in detail below.

## **PROVIDER AUDIT PROGRAM**

The Plan administers a comprehensive program of provider audits, utilizing a combination of outsourced vendors and internal resources to maximize efficiency and effectiveness. Ongoing provider audits are conducted by third party vendors who use proprietary algorithms to identify claims with a high likelihood of recovery due to up-coding, unsupported charges, or billing errors, payment errors and duplicative payments. Suspect claims are audited against patient medical records and/or provider contracts, and claims recovered as applicable. Each case is reviewed by the Fraud and Recovery Unit for possible patterns of fraud or abuse which may warrant further investigation. Vendor audit programs include:

- DRG audits at facilities
- Hospital Bill Accounts at facilities - reviewing for services that are unsupported (not provided or rendered to members)
- High Cost Injectable Drug - reviewing to assure pricing is correct, correct drug and dose billed, services/supplies were provided as billed
- Home Infusion
- Renal Dialysis
- A/R credit balance
- Pharmacy FWA with BCBSVT Pharmacy Benefit Manager
- COB Overpayments
- Duplicate claims
- Skilled Nursing Facility
- Observation Services
- Provider Based Billing
- Urine Drug Screening Tests

In addition, the Plan's Fraud, Waste, Abuse and Recovery Unit conducts regular reviews for duplicate payments, ineligible subscribers/dependents, and other routine "outlier" provider billing patterns.

## **FRAUD/WASTE/ABUSE DETECTION SOFTWARE**

The Plan's Fraud, Waste & Abuse detection software allows quick and easy identification and prioritization of instances of potential fraud and abuse. Potential suspects are detected by

scanning claims data for patterns indicative of known fraud/abuse schemes and/or emerging aberrant billing patterns. Examples of patterns identified by the software include:

- excessive charges, patient costs, units/hours billed;
- unusual coding patterns, which may indicate inappropriate coding, up-coding or over-utilization;
- billing for services not rendered;
- mis-matches between professional and institutional services;
- unbundling of outpatient/inpatient services;
- significant changes in billing patterns (which may indicate emerging fraud/abuse).

The software applies statistical analysis to determine the degree of deviation from “norms”. Using this information, the software generates a “hit list” of providers, ranked by score, rule violations and paid amount, allowing the user to quickly assess impact and recovery opportunity.

## **DATA ANALYSIS AND QUERIES**

The Fraud, Waste, Abuse and Recovery Unit runs both regular and ad-hoc queries in response to a specific allegation or to detect patterns of abuse. Aberrant claims or patterns are investigated, and overpayments recovered as identified, primarily through claim adjustments, or when necessary, through refund requests to providers or members.

Processes are also in place to query the United States Department of Health and Human Services’ (HHS) Healthcare Integrity and Protection Data Bank (HIPDB) for providers within the Plan’s network who may have been reported. The databank was implemented by HHS as a means to combat fraud and abuse in health insurance and healthcare delivery, and functions as a flagging system to alert users that fraud or abuse may have occurred and that a comprehensive review of a provider’s past actions may be prudent.

## **EMPLOYEE TRAINING AND REFERRAL**

Employees are in the best positions to identify potentially aberrant claims, enrollment forms or other indicators of potential fraud. As part of the Plan’s annual Standards of Business Conduct training, employees are alerted to indicators of potential fraud, and reminded of their responsibility to report any suspicions of potential fraud either directly to a member of the Fraud, Waste, Abuse and Recovery team, or anonymously through the Plan’s fraud hotline. Fraud and Recovery Unit personnel receive ongoing training through the National Health Care Anti-fraud Association, and other anti-fraud organizations to remain current on industry trends related to fraud and abuse.

## **PUBLICIZED FRAUD HOTLINE AND EMAIL ADDRESS**

Numerous BCBSVT employees, stakeholders and constituents have the opportunity to identify and report potential fraud. The primary means for receiving such referrals is through the

Plan's fraud hotline or email. Subscriber Explanation of Benefits, provider Remittance Advices and the Plan's website all contain reference to the fraud hotline phone number and email address. The Plan's website also includes potential fraud indicators, to assist stakeholders and constituents in identifying potential fraud.

The Fraud Hotline is monitored and operated by Fraud, Waste, Abuse and Recovery Unit personnel. A voice mail service records messages for after-hours and weekend calls, which are returned within forty-eight hours. Each call is logged and initially screened to determine whether a potential for fraud or abuse exists. Case files are opened for all calls with fraud potential.

#### **REFERRALS THROUGH BCBSA NETWORK**

The Blue Cross and Blue Shield Association (BCBSA) maintains a list-serve of fraud investigation contacts within each Plan. The list-serve is used to communicate information about potential fraud cases and/or schemes which may spread beyond the investigating Plan's service area. Each of these referrals is researched by the Fraud, Waste, Abuse and Recovery Unit to determine Plan impact, if any.

#### **VERMONT HEALTH CARE FRAUD ENFORCEMENT & PREVENTION TASK FORCE**

BCBSVT is a participant of the Vermont Health Care Fraud Enforcement & Prevention Task Force. The purpose of this Task Force is to exchange information between the public and private sector partners in order to be more informed and better detect, investigate, and reduce health care FWA. The Task Force also enables the members to individually share successful anti-FWA practices and effective methodologies and strategies for detecting and preventing health care FWA.

Current Task Force membership includes:

- Public sector - representatives of Federal and state health care programs such as Medicare and Medicaid programs, and other Federal or state government organizations including the U.S. Attorney's office (USAO), Medicaid Fraud and Residential Abuse Unit of the Vermont Attorney General's Office (MFRAU), and/or Program Integrity Unit of the Department of Vermont Health Access (DVHA).
- Private sector - non-governmental organizations, health insurers, delivery systems and other appropriate entities involved with FWA detection and prevention.

#### **REFERRALS THROUGH MEDICARE D NEW ENGLAND JOINT ENTERPRISE**

As a participant in the Medicare Part D New England Joint Enterprise (JE), the Fraud, Waste and Abuse Recovery Unit may receive referrals of potential pharmacy fraud in the Vermont market area from the JE Compliance committee and/or from the JE pharmacy benefit manager. Each of these referrals is reviewed and/or researched by the Fraud, Waste and Abuse Recovery Unit.

Similarly, in the course of conducting its own fraud, waste and abuse investigations, BCBSVT may surface suspicious activity which could impact the JE. These cases will be referred to the JE compliance officer (who will review and refer the case to the JE pharmacy benefit manager for investigation).

## FRAUD INVESTIGATION

### INVESTIGATION PROCESS

The Plan has identified the following as the most common types of fraud, and defined the possible actions and evidence required to pursue each.

- Falsified enrollment application
- Submission of falsified claims history for the purpose of obtaining more advantageous premium rates
- Submission of false claim or prescription - either services not provided or services misrepresented
- Provision or authorization of medically unnecessary services (for purpose of maximizing reimbursement), or intentional use of medically unnecessary services (e.g. “doctor shopping” for purpose of obtaining narcotic prescriptions)
- Waiver of co-pays (for purpose of increasing patients)
- Identity theft

Fraud and abuse investigations are conducted by the Plan’s Fraud, Waste, Abuse and Recovery Unit. Case files are used to document the fraud investigation process. Compliance with state and federal privacy laws and protection of confidential personal and financial information of members and providers is maintained during the investigation process, and is overseen by a BCBSVT attorney.

### CASE DISPOSITION

When the investigation of a potential fraud, waste or abuse case is complete, or has reached a point at which a sound decision can be made regarding its disposition, one or more of the following actions will be taken:

- Initiate “warnings” to providers, members or groups in response to fraud investigation findings;
- Initiate recoveries or pursue financial settlement in response fraud investigation findings;
- Perform pre-payment reviews of claims and medical notes;
- Initiate collection activities when provider/member/group is non-responsive to recovery requests;
- Refer potential fraud cases to law enforcement in response to investigation findings;
- Recommend termination of provider, member or group contracts in response to fraud investigation findings;
- Recommend legal action against provider, member or group in response to fraud investigation findings.

- Recommend changes to Plan processing guidelines or systems to better detect instances of waste and abuse.

Please see the BCBSVT Facility/Provider Audit, Sampling and Extrapolation policy for the details of our provider audit process including the use of sampling methodologies and extrapolation. A copy of the policy is attached hereto.

### **EXCLUSION PERIOD**

Members, groups and providers terminated for fraud shall be excluded from future contracts with the Plan, as follows:

- Members terminated for fraud will not be eligible for benefits under any Plan contract for a period of not less than one year, and until full restitution payment is made.
- Groups terminated for fraud shall be excluded from purchasing health benefits under any Plan contract for a period of not less than five years, and until full restitution has been made.
- Providers terminated for fraud shall be excluded from participating in the Plan's network for not less than 3 years, and until full restitution has been made.

### **INVESTIGATION OF MEDICARE PART D NEW ENGLAND JOINT ENTERPRISE FRAUD & ABUSE**

The New England Joint Enterprise has delegated fraud and abuse detection and investigation responsibilities for Medicare Part D to its pharmacy benefit manager (PBM). To the extent that a Vermont member is subject to investigation, the PBM will provide BCBSVT with its investigation results along with recommended action(s). BCBSVT must approve all actions prior to PBM implementation, including recommendations that a case be closed.

## **REPORTING**

### **HEALTHCARE INTEGRITY AND PROTECTION DATA BANK (HIPDB)**

The US Department of Health and Human Services maintains the Healthcare Integrity and Protection Data Bank (HIPDB) as a means to report instances of provider fraud, waste and abuse in health insurance and healthcare delivery system. BCBSVT providers terminated for fraud or abuse are reported to the HIPDB, or related National Practitioner Data Bank (NPDB), as required by law.

### **REFERRAL TO LAW ENFORCEMENT**

The prosecution of individuals who commit health care fraud is a strong deterrent to future fraudulent acts. Referrals may be made to any state or federal agency designated by law to investigate suspected or fraudulent insurance claims, if the Plan has a reasonable suspicion that fraud has been committed. Additionally, the Plan will fully cooperate with law enforcement agencies in the prosecution of insurance fraud cases as allowed and required by state and federal regulations.

## MEDICARE PART D NEW ENGLAND JOINT ENTERPRISE - REFERRAL TO CMS AND MEDICARE DRUG INTEGRITY CONTRACTOR (MEDIC)

Reporting of Medicare D fraud and abuse to CMS and/or CMS MEDICS is performed by the JE PBM, under its contract with the JE. As a participant in the Medicare Part D New England Joint Enterprise (JE), the Fraud, Waste and Abuse Recovery Unit may receive referrals of potential pharmacy fraud in the Vermont market area from the JE Compliance committee. Each of these referrals is researched by the Fraud and Recovery unit, with periodic status reporting to the JE Compliance committee.

If BCBSVT receives a call into the FWA Hotline that pertains to a NEJE member or prescriber, the call would be referred to CVSH for a collective decision on how to best investigate the matter. BCBSVT would also determine if there was any other information in our book of business to support the allegation.

## RECOVERY & LITIGATION

The Plan pursues recovery, restitution or both, as applicable, in all cases in which fraud is identified. Claims will typically be considered for recovery for the 12-month period immediately preceding initial identification of fraud.

In addition, the Plan may negotiate settlements when considered prudent. Settlements are negotiated by the Plan's Fraud, Waste, Abuse & Recovery Unit, in consultation with the Legal Department and/or the Plan's Provider Contracting Counsel.

The initiation of a lawsuit for purposes of restitution may occur if it is considered to be in the Plan's interest, however, no lawsuits will be initiated on the Company's behalf for fraud without approval of BCBSVT's General Counsel.

## INTERNAL FRAUD

BCBSVT's Standards of Business Conduct define the Plan's expectations for ethical conduct, compliance with law, responsibility for reporting actual or suspected violations of the Standards, and disciplinary actions which may be taken. Training on the Standards is provided annually to all employees.

All reported violations of the Standards of Business Conduct are investigated under the supervision of the Plan's General Counsel.

## PUBLIC AWARENESS

Public awareness regarding the Plan's anti-fraud, waste and abuse programs can be a deterrent to future fraud. The Plan uses a number of means to raise awareness regarding anti-fraud, waste and abuse activities, including articles in Company publications, publicizing the fraud hotline on mailings sent to members and providers, and annual employee training on fraud indicators and fraud hotline.