Prevention and Early Detection of Health Care Fraud, Waste, and Abuse

October 30, 2009

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Senior Director Corporate & Financial Investigations Department
Independence Blue Cross
Philadelphia, Pennsylvania
Our mission

To enhance the health and wellness of the people and communities we serve by increasing access to quality health care and delivering value through our products and services.
Independence Blue Cross

- 2008 revenue: $11.4 billion
- 2008 claims incurred: $10.1 billion
- 2008 employees: 8,400
- Number of office locations: 18
Healthcare Fraud:
Estimated Losses and Actual Recoveries

- 2008 US health care expenditures: $2.6 trillion
- National Health Care Anti-Fraud Association estimates: 3% to 10% of dollars spent on health care lost to fraud
- Estimates of $78 billion in 2008
- Blue Cross Blue Shield Association Plans
  2008 fraud savings and recoveries:
  $350 million; $7 in savings for each $1 spent
Healthcare Fraud Estimated Losses

- 2008 IBC claims incurred $10.1 billion
- National Health Care Anti-Fraud Association estimate: 3% to 10% of dollars spent on health care lost to fraud
- 2008 IBC estimated fraud losses: $303 million - $1 billion
- 2008 IBC FWA recoveries: $51.7 million; $9.8 in recoveries for each $1 spent
# Corporate and Financial Investigations Department

## Fraud, Waste, and Abuse Financial Recoveries

<table>
<thead>
<tr>
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<th>2008</th>
<th>2004 - 2008</th>
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<tr>
<td><strong>Medical</strong></td>
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<tr>
<td>• Facility</td>
<td>$ 40.1 million</td>
<td>$ 149.6 million</td>
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<td>• Professional</td>
<td>$ 3.3 million</td>
<td>$ 7.2 million</td>
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<td><strong>Pharmacy</strong></td>
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<td><strong>Total Recoveries</strong></td>
<td>$ 51.7 million</td>
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### CFID Fraud Referrals and Legal Action

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Methods to Identify Fraud, Waste, and Abuse

- Software VIPS products
  - STARS
  - Sentinel
- Hotline
- Internal sources
- External sources
- Inter and intranet websites
STARS – Data Mining Software Tool

- Fraud, waste and abuse data mining tool
- Data warehouse – multiple years
- Type of data
  - Medical claims
  - Pharmacy claims
- Drug Enforcement Administration numbers – National Technical Information Services
STARS – Data Mining Software Tool (continued)

- Member enrollment and group benefits
- Provider demographics
- National Provider Identification Numbers
- Proactive identification of questionable trends, patterns, and schemes
- Claim level data detail
- Average Wholesale Price/Average Sales Price
- Early-warning fraud detection tool
- Overpayment protection software
- Rules based
- Compares peer to peer
- Compares procedure to procedure
Separate modules for professional, pharmacy, and hospital claims

- Pharmacy – drug vs. medical utilization
- Professional comparison to hospital claims
- Identifies who/what to look at
Fraud Schemes

- Intentional billing for services not rendered
- Falsifying medical diagnoses or procedures to maximize payments
- Duplicate billing
- Misrepresentation of location where service was rendered
- Identity theft
Fraud Schemes (continued)

- Rendering medical care without a license
- Conspiracy with durable medical equipment supplier to bill for unnecessary items
- Knowingly permitting someone who does not have insurance to use a covered person’s card
- Billing for more than 24 hours of service in a day
• Data mining for an “impossible day”

• Psychiatrist billed for 60 hours a day, more than 50 patients per day

• Proactive analysis indicated excessive billing, at a high level, individual psychiatric consultations

• Patients interviewed never went to psychiatrist
CFID decided to proactively perform analysis on the billing patterns of psychiatric outpatient office visits, **90801-90809**, especially higher level codes with medical evaluation.

The Summary Analysis function was performed to determine the top 25 providers billing those codes, regardless of medical specialty.

**Observe the results...**
Our most aberrant provider is not only billing the highest volume in terms of unit and billed amount, but also for the highest level code, **90809**!
Observe the results...

- Standard Analysis reporting by top procedure codes indicated that **90809**, a 75-80 minute psychiatric O/V with Medical Evaluation was not one of the top 50 procedures billed by IBC’s entire psychiatry population!
Observe the results...

Ratio Reports reveal how pervasively this provider billed this high level code across her entire patient population....

Another Red Flag

Observe the results...
Once again, despite lower Normalized Values relative to her peers, sheer patient volume puts this provider to the forefront.
## Subset Summary Report

**Report Date:** 10/27/2009 08:30:59

### Summary Field
- **Sync From Date:**
- **Subset:** 202000037 - new start claims
- **Invoice Type:** C1 - Legacy Professional Claims

### July 2001

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Fraud Scheme Behavioral Healthcare Provider

- Surveillance of office: yoga classes offered
- Undercover operation enrolled in yoga classes
- Insurance card photocopied
- CEO/treasurer owner of health care provider business signed lease for building
- Corporate owner filed medical claims to represent yoga classes as treatment for mental and substance abuse
Fraud Scheme Behavioral Healthcare Provider

- Medical claims listed licensed psychiatrist as performing provider
- Yoga class attendees had not seen psychiatrist
- Investigators determined that psychiatrist was out of the country for most of the claim dates
- Psychiatrist was confronted: Never saw patients and did not work for corporation owner
Fraud Scheme Behavioral Healthcare Provider

- Investigation referred to Federal Insurance Fraud Task Force
- Corporate owner indicted and plead guilty to health care fraud charges
- Sentence: 30 months’ incarceration, 30 months’ probation, and ordered to make restitution of $1,080,755
Enablers of Fraud, Waste, and Abuse

- State regulations pertaining to timely process and payment of a clean claim
- Resource constraints
- Law enforcement’s competing priorities
- Sharing of case information between law enforcement and private sector insurance companies
- Risk of law suites by providers
- Pay and chase is extremely costly
Blue Cross Blue Shield Association: Recommendations to Address Fraud

- Strengthen public-private partnerships
- Increase federal fraud investigation personnel
- Increase funding for federal enforcement activities
- Incorporate private health plan losses due to fraud and abuse, associated with government program and other coverage, into federal enforcement actions or negotiated settlements (e.g. Medicare Advantage, Part D, Medigap)
Blue Cross Blue Shield Association: National Anti-Fraud Strategy

- Continued close collaborations with law enforcement agencies (e.g. FBI, HHS, OIG)
- BCBSA Anti-Fraud Strike Force initiative
- Expanded consumer education initiatives
- Smart technology/data mining initiatives