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For Distribution to Brokers/Wholesalers/Administrators Only

Agent/Broker Fraud and Abuse Training Available On-line

Market: All

Health care fraud and abuse affects everyone. CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice Inc. (BlueChoice) would like to announce that Fraud and Abuse training opportunities are now available on-line for Agents and Brokers.

Agents and Brokers can participate in training on Fraud and Abuse by logging onto the broker portal at www.carefirst.com and clicking "Fraud and Abuse" under the "Solution Center." We have also attached the training for your reference.

If you have any questions, please contact your Broker Sales Representative.



Shekar Subramaniam
Associate Vice President, Broker Sales

AGENT/BROKER FRAUD AND ABUSE TRAINING

Introduction

Health care fraud and abuse affects everyone through higher costs of health care, insurance, taxes and through reduced benefits, among other things. CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice Inc. (BlueChoice) are legally required to make available an opportunity to agents and brokers to participate in training on Fraud and Abuse. The following web-based training is available for all agents, brokers and consultants.

Objectives

Through this training program, you will learn that:

- Health care fraud is a major reason why the cost of health care in the United States continues to rise at an alarming rate;
- Providers and/or members who participate in health care fraud schemes contribute to the rising cost of health care;
- CareFirst is committed to being an industry leader in the development of a health care Anti-Fraud Program.

Perhaps most importantly, you will learn what health care fraud is, how it affects you and how to identify and handle instances of possible health care fraud.

Enforcing the Law

Health care fraud has become a multi-billion dollar problem for the health care industry. The National Health Care Anti-Fraud Association estimates that between 4 and 8 percent of all health care claims submitted nationwide are fraudulent. It is also estimated that health care fraud costs the nation \$50 billion dollars a year or about 3% of the \$1.7 trillion spent annually on health care in the United States.

Additionally, the Medicare Part D Prescription Drug Plan is estimated to add an additional \$720 billion to healthcare spending in its first 10 years, based on figures released from the White House in 2005.

Health care fraud is a material misstatement of fact knowingly made for the purpose of obtaining health care benefits, services and other things of value from Insurers, such as CareFirst, and their customers. Health care fraud requires the intent to deceive. It does not include situations where an honest mistake was made or the misstatement of fact did not influence decisions to provide health care benefits, services or other things of value.

Several states have passed legislation requiring insurance companies to educate and train associates/agents/brokers on the subject of fraud and abuse.

It is CareFirst's policy to ensure that all suspected instances of fraud and/or abuse are thoroughly investigated and brought to the appropriate resolution. In the past, CareFirst has actively pursued providers, subscribers, agents, vendors, brokers, and associates for such offenses.

Our Goal

The primary goal of CareFirst Special Investigations is to work in cooperation with all sources to:

- Identify
- Investigate
- Resolve
- Prevent Instances of fraud and/or abuse.

Legal Terms

To fully understand fraud and abuse, you will need to become familiar with a few terms.

Abuse

Any action against an insurer that is inconsistent with acceptable business and medical practices and that results in an unfair gain to the claimant; a departure from reasonable use, specifically excessive or improper utilization.

Embezzlement

The willful and secret taking of money or property by a person who has been trusted with it. This trust relationship often involves employment or other official position.

Fraud

The intentional misrepresentation of truth for the purpose of obtaining something of value by inducing another to rely upon false information.

Theft

Stealing of any kind is defined as the unauthorized possession of office supplies, equipment, software and personal possessions. In the insurance field, theft may include the providers' prescription pads, subscriber ID cards and even patient records.

Under-utilization

To deliberately under-provide medically necessary care for profit. Under-utilization of care may be construed as fraud in a managed care environment.

Schemes & Detection

Motivation

The primary motivations for those who commit fraud and abuse are:

Perceived Opportunity

- Large volume of claims submissions
- Vague contract language
- Lack of internal controls

Greed or Need

- Newer, better, bigger house, boat, car
- Financial hardship

Justification

- Dissatisfaction with services & benefits

Providers, healthcare imposters, and others who commit fraud rarely defraud only one payer at a time. Those who defraud Medicare and Medicaid also defraud private payers such as CareFirst, Kaiser Permanente, and Aetna US Healthcare to name a few.

In support of CareFirst's policy, the Special Investigations unit within CareFirst works in cooperation with all sources toward the identification, investigation, resolution, and prevention of fraud and abuse.

The Special Investigations unit also works with MEDICS (Medicare Drug Integrity Contractors) to coordinate and refer fraud and abuse involving the Medicare Drug program to law enforcement authorities. Federal guidelines also require Medi-CareFirst Blue Cross Blue Shield to have a comprehensive plan designed to detect, correct and prevent fraud and abuse. This plan also includes specialized training and education for the employees and contactors involved with the Medicare Part D product.

All agents/brokers who sell Medi-CareFirst BCBS must go through this training. If you missed this training please contact your broker representative.

Who Commits Fraud & Abuse?

Special Investigations has identified five major groups that commit fraud and abuse.

Providers

Health care providers include doctors, dentists, psychologists, pharmacists, physical therapists, labs, x-ray facilities, home health agencies, and hospitals, among others.

Methods of Provider Fraud

- Billing for services and supplies that are not rendered.
- Up-coding for more expensive services than were actually provided.
- Billing for services or supplies after subscriber's death.
- Advertising "free" services but submitting claims for reimbursement.
- Collecting payments from both the subscriber and the insurance company.
- Billing the patient's insurance company for free drugs supplied by drug manufacturer.
- Pay subscriber to submit to surgeries and other procedures that are not medically necessary.
- Conspiring with other providers and/or subscribers to create false billings.

Methods of Provider Abuse

- Providing medically unnecessary services
- Under-utilization of necessary medical care for profit.
- Providing excessive services

Subscribers

Subscribers are policyholders and their dependents.

Methods of Subscriber Fraud

- Allowing non-covered persons (family and friends) to use one's membership card.
- Submitting receipts or bills with altered dates of services or dollar amounts
- Submitting forged prescriptions
- Changing the number of refills on a legitimate prescription
- Falsifying employment status in order to receive insurance benefits
- Misrepresentation of other coverage information to avoid coordination of benefits
- Seeking non-emergency treatment in foreign countries in order to make profit via conversion of free service to U.S. levels.

Methods of Subscriber Abuse

- Shopping multiple physicians, facilities, or pharmacies in order to obtain controlled substances.
- Seeking treatment for a nonexistent illness in order to receive control substance medication.

Associates

All associates are prohibited from knowingly participating in any fraudulent or abusive activities. If an associate becomes aware of or suspects fraudulent activities, it is the

responsibility of the associate to report the activities as described in the “Reporting Misconduct” section of the Code of Business Conduct for CareFirst.

Methods of Associate Fraud

- For enrollment and billing personnel, allowing ineligible dependents to be placed on the family contract; girlfriend, boyfriend, ex-wife, or over-age child.
- Falsifying expense statements; submitting expense reports for reimbursement with higher charges than were actually encountered.
- Creating and submitting false claims for medical services in order to receive payments.
- Falsifying claims against the associate’s Flexible Spending account (FSA). Because IRS restrictions limit the allowable time for submitting a claim, employees with money left in those accounts may sometimes lose their remaining balance. This may tempt an associate to commit fraud by: 1. Altering the dates of service on prior year claims to obtain reimbursement from the FSA, or 2. Falsifying claims to access remaining balance monies.

Methods of Associate Embezzlement

- Rerouting payments to a P.O. Box or false address for personal gain.
- Creating false subscriber memberships and claims for personal gain.
- Using company property and resources for personal gain.
- Falsifying company documents to obtain payments or other personal gain.

Methods of Associate Theft

- Theft of office supplies, including software, equipment and stationery.
- Theft of personal belongings from other CareFirst associates.
- Theft of corporate proprietary information such as logos, trade secrets, and strategic plans.

Agents

Agents include, but are not limited to, brokers, employers, independent contractors, and other group representatives.

Methods of Agents Fraud

- Assisting subscribers in submitting false claims.
- Assisting persons ineligible for coverage to obtain benefits.
- Falsifying enrollment information to obtain lower rates (i.e. date of birth).

Methods of Agent Embezzlement

- Rerouting payments to a P. O. Box or false address for personal gain.
- Creating, or conspiring with others to create false subscriber memberships and claims for personal gain.
- Falsifying company documents, such as invoices, to obtain payments or other personal gain.

Others

“Others” refers to people who are neither subscribers nor directly related to the healthcare industry.

Methods of Fraud Committed by Imposter Providers

- Disguising free spa-like weight loss programs as psychiatric hospitalizations.
- Promoting free screening services, such as blood pressure and cholesterol, with the ultimate goal of obtaining insurance benefit information in order to submit false claims.
- Offering experimental treatment as a cure for terminally ill patients.

Methods of Fraud Committed by Imposter Subscribers

- Using a subscriber’s medical insurance identification card to obtain healthcare
- Misrepresenting oneself in order to redirect insurance payments from the authorized recipient for personal gain.

Schemes & Detection

Your role in detecting fraud & abuse

As a CareFirst broker/agent, you are an important part of curtailing healthcare fraud and abuse. Because abusive billing and fraudulent practices add billions of dollars to the cost of healthcare, controlling those costs is everyone’s responsibility.

Here are a few things you can do to help identify possible cases of fraud or abuse:

- Review eligibility of proposed members/applicants from group/account
- Watch for discrepancies in other insurance information.
- Identify use of different name or address on an application.

While the presence of one or more of these indicators does not confirm that fraud or abuse is present, they may indicate the need for further review. You, in your job, may see clues that trigger a decision to investigate further or notify the CareFirst Special Investigations unit by calling the appropriate number as provided below.

Common Clues to Fraud & Abuse from Providers

- Doctor and patients have the same last name and/or address.
- Provider submits claims with overlapping dates of service.
- Provider uses multiple provider numbers to submit claims for same services.
- Provider furnishes extensive claim documentation at the onset of the claim.
- Claims history shows emergency ambulance charges but no supporting medical treatment.
- Pharmacy billing history shows excessive billing of brand name drugs when generic equivalents are available.

- Pharmacy billing history shows large number of claims billed during unusual business hours such as holidays and Sundays.

Common Clues to Fraud & Abuse on Foreign Claims

- U.S. residents with terminal diagnoses (i.e. cancer) submit foreign claims.
- CareFirst will need to verify the treatment provided.
- Claims should NOT be submitted with the exchange rate. Service and Claims SOP's state claims should be submitted with bills in local currency and Accounting Services is responsible for converting the currency rates.
- Foreign claims submitted by U.S. billing agencies may be intended to disguise non-covered treatments performed outside the U.S.

Common Clues to Fraud & Abuse from Subscribers & Others

- Receipts/invoices for claim submissions appear to be altered.
- To avoid charges of postal or wire fraud, the provider or subscriber personally delivers claims to CareFirst.
- Subscriber had high dollar payments made directly to him or herself.
- Subscriber is seeing physicians of similar specialties for similar conditions, maybe in very different geographic areas.
- Pharmacy history shows excessive number of controlled substances written by multiple physicians.

Common Clues to Fraud & Abuse from Associates

- Contact information for a provider submitting claims is traced and identified as an associate's personal P. O. Box or phone number.
- An associate who has a part-time business on the side conducts business, i.e. taking phone orders or negotiating sales, on company lines during company time.

Sources of potential fraud & abuse

Some of the sources that alert CareFirst associates to fraud and abuse are:

- Audits or reviews conducted by claims examiners
- Tips from providers of services
- Tips from subscribers or calls on the Fraud Hotline
- Referrals from outside agencies
- Claims systems edits for pre- and post payment- claims submissions
- Inordinate or excessive claims submissions that are greater than the peer average
- Tips or referrals from agents/brokers

Electronic claims submission

Electronic claims are another way possible fraud and abuse can be committed. These forms are submitted and processed seamlessly. Therefore, the exposure for large losses due to fraud is greater over a shorter period of time than with paper submission.

Investigation Standard Operating Procedure (SOP)

Once tips and leads are forwarded to Special Investigations, several steps take place. Some referrals to SI may end up not requiring an extensive investigation but may actually just require a claims adjustment or provider/subscriber education.

- Investigators may expand the tip or lead by selecting random samples of paid services.
- Services are verified through telephone and/or personal interviews, on-site audits, and a review of medical records.
- Cases involving suspected fraudulent or abusive activity are referred to the appropriate regulatory and/or law enforcement agency.

Investigation outcomes

So what happens once an investigation has been initiated? Several possible investigation outcomes exist including:

- Recovery of monies
- Changes in policies and procedures
- Referral for prosecution
- Referral to regulatory agencies
- Civil suits
- Cancellation of subscriber and/or group membership
- Termination of employment
- Termination of provider participating contract
- Improved communication and training

Referral to Special Investigations

Your referral to Special Investigations should provide the following information:

- Account/company name
- Name of suspected person
- Subscriber/ Insured ID if available
- Describe the potential violation
- Your name & contact number

In order to report a suspected fraud or abuse violation, please contact the appropriate CareFirst Special Investigations unit, as provided below, or call the appropriate number.

Maryland or North Carolina areas:

Maryland Special Investigations

10455 Mill Run Circle-02-745

Owings Mills, MD 21117

Or, call (410) 998-5480

Toll Free 1-800-336-4522
FEP hotline: 1-800-337-8440

District of Columbia, Virginia or West Virginia

Washington DC Special Investigations

10455 Mill Run Circle- DC 12-16

Owings Mills, MD 21117

Or, call (202) 680-7441

Toll Free 1-800-336-4522

FEP hotline: 1-800-337-8440

Delaware area:

Delaware Special Investigations

10455 Mill Run Circle- DE

Owings Mills, MD 21117

Or, call (302) 421-3355

Closing

You are encouraged to make this training available to all your staff. After completing such training you should complete the attached attestation and forward it to Special Investigations at CareFirst.

FAX: 410 998-5323

10455 Mill Run Circle

Owings Mills, MD 21117

General Red Flags or Warning Signs

Eligibility Fraud Red Flags or Warning Signs

- Different names or addresses of dependents and primary covered person
- Use of aliases or multiple spellings of names
- Unusual number of claims on dependent children
- History of claims on a spouse with a different name
- Discrepancy in other insurance information
- No assignment of benefits, especially on large claims or billings

General Red Flags or Warning Signs - Applicable to All Types of Fraud

- Early pressure from providers or covered persons for payment
- Threats from providers or covered persons on filing complaints with State agency/attorneys or contracting the President of the company
- Misspelled medical terminology or terminology in layman's terms
- Medical treatment appears unrelated to, or inconsistent with, diagnosis
- Alteration of bills - dates, charges, diagnosis, "white-out", different color ink
- Photocopies are submitted rather than originals

Provider and Enrollee Red Flags or Warning Signs

- Claims for Providers not in the same geographical area
- Numerous claims for soft tissue injuries
- Services not matching the doctor's specialty
- Services rendered inconsistent with diagnosis
- Provider and patient with same address
- Provider and patient with the same last name
- Referring physician and provider of service at same address or professional building
- Claims on which provider is Participating and member has made several notations such as "paid in full", "pay stub", etc
- Physicians billing for frequent office visits for same patients-every two to three days
- Podiatrists billing high volume of incision and drainage procedures
- Identical claims submitted in different years for same patient

Claimant Fraud Red Flags or Warning Signs

- Alteration or fabrication of bills - dates, charges, diagnosis, "white-out", and different color ink
- Benefits are not assigned to the provider, and the medical expenses incurred appear to exceed an amount that the claimant could pay out of pocket
- Claimant threatens to go to an attorney if the claim is not settled quickly
- Claimant has an extensive claims loss ratio

- The claimant has extensive knowledge of medical terms, procedural and diagnostic codes, and insurance claims handling procedures
- Misspelled medical terminology or terminology in layman's terms
- The claimant submits photocopies rather than original documents
- Claimant refuses to answer questions related to facts surrounding the loss
- Handwritten bills or different type styles used in different areas of the bill

Customer Service Red Flags or Warning Signs

- Correspondence from the State Insurance Department advising that the insured made a complaint
- Pressure or threats from member or provider for a quick decision or payment
- Frequent calls regarding status of every claim submitted
- Constant complaints about payment determinations
- Inquiries from a lawyer, on behalf of the member, requesting immediate action on the claims
- Member requesting the re-issuance of a check that was "lost" very close to the date of issuance

Utilization Review Red Flags or Warning Signs

- Providers who exceed their peers in the following areas:
 - High dollar payments
 - High utilization of select procedures
 - High utilization for the same or small number of patients
 - Services for entire families
- Providers who bill for services not within their specialty
- Members who submit claims for the same service, dollar amounts and provider on an annual basis
- Members with high utilization of psychotherapy, prescription drugs and/or durable medical equipment
- Members who receive high dollar reimbursements

Foreign Claims Fraud Red Flags or Warning Signs

- Claims are for large amounts, such as several thousand dollars, and charges are purportedly paid out-of-pocket
- Absence of documentation or medical records
- Excessive periods of hospitalizations
- Extensive treatment for minor injuries or illnesses
- No medical follow-up in the U.S. after serious illness or injury abroad



Fraud, Waste & Abuse Training Attestation

By way of my signature below, I hereby attest to the fact that on _____(date), the _____ (Agency/Broker) completed the CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice, Inc. (BlueChoice) Fraud, Waste & Abuse Training and all materials in the training were understood.

Authorized Signature

Date

Printed Name
