Partnering to Detect & Prevent **Health Care Fraud**

HOW HEALTH CARE FRAUD IMPACTS YOU:

Health care fraud occurs when a person or group of people intentionally deceives the health care system in order to receive unlawful benefits or payments. The impact of health care fraud is widespread and affects providers, consumers, patients, communities and businesses within the entire health care system.

Between 4 –10% of all health care expenditures are estimated to be potentially fraudulent. This loss directly impacts providers, patients, insurers and government agencies through higher healthcare costs. Additionally, healthcare fraud often hurts patients who may be subjected to unnecessary or unsafe procedures or who may be the victims of identity theft.

Highmark takes the fight against health care fraud very seriously. That's why we have an anti-fraud department dedicated to detecting and preventing health care fraud. This department includes a staff of trained auditors, investigators and other experienced professionals who monitor millions of claims for patterns of suspicious billing activity and carefully review allegations of suspected fraud and abuse. We also work closely with local, state and federal law enforcement agencies and organizations to identify and eradicate health care fraud in our communities.

HOW YOU CAN HELP:

Highmark partners with providers in the battle against health care fraud. We depend on YOU, our allies at the frontlines, to identify and report potential health care fraud. Read the back side of this flyer for potential types of fraud and tips so you can protect your patients, yourselves and our communities against health care fraud.

Highmark Blue Shield is independent licensee of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield companies. All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

Types of Health Care Fraud

PROVIDER RELATED FRAUD:

Phantom Billing – Provider charges for services that were not performed or equipment that was not delivered.

Upcoding – Provider bills an insurer for a service that is more expensive than what was actually provided, such as billing for a specialist when the patient saw a nurse or an intern.

Overutilization/Unnecessary Care – Provider conducts or requests unnecessary tests, surgeries or other procedures in order to obtain additional payments or referral fees.

Misrepresenting Services – Provider conducts non-covered procedures on a patient and subsequently submits claims to the insurer for different services that are covered under the patient's plan.

Unbundling – Provider bills an insurer separately for parts of a single procedure.

NON-PROVIDER RELATED FRAUD:

Masquerading as a Health Care Professional – Individual or group delivers health care services or equipment to a patient without a proper license.

Identity Theft – Individual utilizes another person's health insurance or personal information to access health care services.

Doctor shopping – A patient visits multiple practitioners to get several prescriptions for controlled substances.

Falsification – An individual or group files fake claims to an insurer or alters amounts charged on claim forms or prescription receipts.

FRAUD EXAMPLES:

Phantom Billing – Marian, a nursing home resident, needed ambulance transportation to the hospital for a minor procedure. While reviewing her Explanation of Benefits (EOB), she found that her insurance was billed for thirteen extra trips that never occurred.

Identity Theft/Swapping Identity – A doctor performed surgery on a man she believed to be Mark Peters. During a post-surgical office visit, the doctor's assistant asked Mark to fill out some patient forms. Mark did not know basic personal information, such as his social security number and date of birth. The man had taken a stranger's insurance card and used it under a false identity.

Online Solicitation – Glen filled out an online form to receive free medical supplies his doctor recommended. Unscrupulous individuals used the form to create an order, which his doctor's office approved and returned. Glen then received monthly deliveries of medical equipment he neither needed nor wanted. Upon reviewing his EOB, he found his insurance was billed for these items. Despite trying to contact the company and stop the deliveries, they continued, and his insurance kept getting charged.

REPORT SUSPECTED FRAUD:

Your assistance is vital in helping to identify, investigate and prosecute health care fraud. If you suspect health care fraud and abuse that may affect you, Highmark or our members, please report the matter to our anti-fraud department immediately at:

Pennsylvania: 800-438-2478
Northeastern New York 800-314-0025