Help us prevent health care fraud

Blue Cross and Blue Shield of Kansas takes the fight against health care fraud very seriously. That's why we have an anti-fraud department dedicated to detecting and preventing fraud.

The anti-fraud department at **Blue Cross Blue Shield of Kansas** 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 fraud in our communities.

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

800-432-0216, ext. 6400 (toll-free)
785-291-6400 (in Topeka)
suspected.fraud@bcbsks.com

How to report suspected fraud:

Your assistance is vital in helping to identify, investigate, and prosecute fraud. If you think you've experienced fraud or suspect fraudulent activity, contact:

800-432-0216, ext. 6400 (toll-free)
785-291-6400 (in Topeka)
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HELP US STOP HEALTH CARE FRAUD

Partnering to detect and prevent health care fraud

What is health care fraud?

Health care fraud is not an innocent mistake, such as a key stroke error on a medical bill. Health care fraud is a deliberate and unlawful act of deceit to obtain undue health care services or payments. Health care fraud plagues the U.S. health care system, costing Americans tens of billions of dollars each year.

HOW DOES HEALTH CARE FRAUD IMPACT YOU?

Health care fraud goes well beyond financial loss alone. While you work hard to establish a good reputation with your patients and in your community, a small number of individuals are taking advantage of the health care system. Many types of fraud schemes deliberately and alarmingly threaten patients' well-being and safety. This intentional abuse of the system leads to patient distrust and hampers the reputations of honest providers.

HOW CAN YOU HELP?

We partner with providers in the battle against health care fraud. We depend on YOU, our allies at the frontlines of health care, to identify and report health care fraud. This pamphlet contains information about fraud types and tips so you can protect your patients, yourselves and our communities against health care fraud.

Types of health care fraud

Health care fraud can take many forms. The most common of these include:

NON-PROVIDER FRAUD

Masquerading as a health care professional – When an individual or group delivers health care services or equipment to a patient without a proper license.

Identity theft – When a patient uses another person's health insurance card to obtain health care services.

Doctor shopping – When a patient bounces from one practitioner to another in order to obtain multiple prescriptions for controlled substances.

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

PROVIDER FRAUD:

Phantom billing – When a provider bills for services or equipment that were never performed or delivered.

Upcoding – When a provider bills an insurer for a more expensive service such as a visit to a specialist when the patient actually saw a nurse or an intern, or for a complex office visit when only a basic procedure was performed.

Overutilization/Unnecessary care – When a provider performs or orders unnecessary tests, surgeries or other procedures on patients to receive additional payments or referral fees.

Misrepresenting services – When a provider performs uncovered services on a patient, and bills their insurer for different services that are covered under the patient's plan.

Unbundling – When a provider bills an insurer separately for procedures that are actually part of a single procedure.

Fraud case studies

Phantom billing – Marian is a nursing home resident and needed to be transported to the hospital for a minor procedure. The nursing home called for an ambulance to transport Marian to and from the hospital. When Marian reviewed her Explanation of Benefits (EOB) forms, she discovered her insurance company was billed for thirteen additional trips to the hospital that were not provided.

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.

"Free" Services – Glen received a "free" hearing test from his doctor, who was advertising his services from a booth at a local shopping mall. In order to receive the "free" hearing test, Glen was asked to complete a survey that included his health insurance information. Later, Glen reviewed his Explanation of Benefits (EOB) form from his health insurance company and discovered that his insurance plan was charged for the "free" hearing test.

Glen has never had any problems with his hearing and would not have taken the test if he had known there would be a charge for the service.