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In the Spotlight: Fraud Prevention

Most of us would not turn down an investment that has a 155% return. The US Department of Health and Human Services (HHS) estimates every dollar spent on preventing improper Medicare payments saves $1.55 – quite a figure when you consider the $479 billion Medicare budget for the 40 million beneficiaries (2011 data) and error rate of almost 4% (potential $19.16 billion in improper payments). Beyond fraudulent behavior like payments made to dead physicians and falsified claims, the American College of Radiology estimates that Medicare and private insurers spend up to $16 billion a year on unnecessary imaging tests. These fraudulent payments and unnecessary tests contribute to increases in health insurance premiums that impact all of us. In short, there is a lot to be gained financially from preventing fraud, waste and abuse, both for the federal government and private insurers.

ACA and Fraud Prevention

ACA expanded HHS' authority and funding to fight Medicare fraud. Since 2010, Medicare has the authority to screen applicants for criminal backgrounds, as well as make unannounced site visits and check databases. The Medicare and Medicaid programs now require providers and suppliers to adopt compliance programs that shift some of the responsibility for ensuring the legality of activities to the organizations. ACA increases transparency by requiring drug, medical device, and supply companies to report to HHS certain information regarding any payments to physicians in an effort to deter kickbacks and better monitor relationships between these companies and doctors.

What Health Insurers are Doing

Lest one think that only the federal government is combating fraud, in July, America's Health Insurance Plans (AHIP) announced a new public-private partnership. Health insurers, like most insurers in other industries, have long been working to reduce, if not eliminate, fraud. Most insurers have special investigation units (SIUs) whose major task is to evaluate claims, perform investigations to prevent and recover improper payments resulting from healthcare fraud, waste and abuse. These units use sophisticated technology to identify questionable practices for further investigation that can result in referrals to law enforcement for criminal prosecution.

Health insurers also take pains to prevent fraud - by carefully reviewing providers prior to credentialing them to be included in their networks and by performing ongoing monitoring of providers for quality of service.

BCBSNC Views

Everyone can help to prevent healthcare fraud, waste and abuse by reporting questionable items to the BCBSNC Special Investigations Unit.

email: siu@bcbsnccom
Fraud Hotline: 1-800-324-4963
Fax: 919-765-7753
Internet: www.bcbsnc.com/inside/fraud/