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# FEHB Program Carrier Letter

## All Carriers

U.S. Office of Personnel Management  
Insurance Services Program

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**Letter No. 2003-23**

**Date:** June 18, 2003

Fee-for-service [ 22 ]    Experience-rated HMO [ 22 ]    Community-rated HMO [ 21 ]

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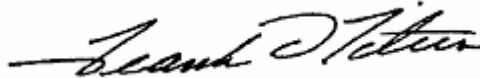
**SUBJECT: Industry Standards for Fraud & Abuse (F&A) Programs**

In this year's Call Letter, we discussed our three-pronged approach to finding ways to prevent fraud and abuse in the FEHB Program. The first phase, Raising Consumer Awareness, was implemented last year through revised consumer information pieces in our brochures, FEHB Guides, and web site. The second phase, Raising Health Plan Awareness, is being kicked off through the publication of this list of Industry Standards for health plan fraud and abuse prevention and detection programs. The Industry Standards, developed from industry research as well as information you provided us on your Fraud and Abuse Programs, will be implemented in conjunction with the third phase of this initiative, Enhancing Systematic Reporting Requirements, which involves a revision of our existing semi-annual F&A Report.

Attached is the list of Industry Standards that we would like all plans to implement as part of their F&A prevention and detection programs. We understand that some plans already have all of these F&A program components in place. However, our goal is to ensure that all plans in the FEHB Program have these Industry Standards in place. Accordingly, in the revised F&A Report that is under development for future distribution, we will include a checklist of these Industry Standards. This checklist will enable you to communicate to us where you are in terms of implementing these standards. We then will work with you in the future to implement those program components that are not in place already.

If you have any questions, please feel free to call Tanya Morrow at (202) 606-0745.

Sincerely,



Frank D. Titus  
Assistant Director  
for Insurance Services

Attachments

## **FEHB Industry Standards for Fraud and Abuse (F&A) Programs**

Based on industry research, we developed the following list of Fraud and Abuse (F&A) Program industry standards. This list represents the program components we expect FEHB plans to have in place to help address health care fraud and abuse within their organizations (for both in-house and subcontracted work). Some plans have program features in place that go beyond the practices listed below. We encourage plans to continue these practices and share them with us so that we can alert all plans to features that would further enhance fraud prevention and detection programs.

1. **Anti-Fraud Policy Statement**: Publish a policy statement providing your corporate strategy to address F&A and make it available to employees, enrollees, providers, and subcontractors.
2. **Written Plan and Procedures**: Establish written policies and procedures to be followed by all personnel for the deterrence and detection of fraud.
3. **Formal Training**: Conduct fraud awareness training for all employees, underwriting departments and subcontractors. Training should consist of an overview of specific F&A reporting requirements, and debarment policies and procedures to enable personnel to identify and handle potentially fraudulent claims submitted.
4. **Fraud Hotlines**: Establish hotlines for reporting allegations of fraud, both internally and externally. Hotlines should be available to providers, enrollees, employees and others. Compliance programs should prohibit retaliation against whistleblowers.
5. **Education**: Inform enrollees about fraudulent and abusive practices via newsletters, web sites, or other means.
6. **Technology**: Use Fraud Protection Software to analyze claims data. Software should evaluate on a prospective claim-by-claim basis and through the retrospective analysis of claim trends from either providers and/or members. See attached list of Potential Fraud Indicators by Business Unit.
7. **Security**: Put safeguards in place to protect claims, member, and provider information from unauthorized use or access.
8. **Patient Safety**: Some F&A practices turn into patient safety issues that should be addressed by your F&A programs. Patient safety issue areas might include, but not be limited to: (1) pharmaceuticals, such as altered prescriptions, illegal refills, prescription splitting, and abuse of controlled substances, (2) medical errors in both inpatient and outpatient care, resulting in unfavorable outcomes, and (3) improper settings for procedures and services that result in poor outcomes.

## **Potential Fraud Indicators By Business Unit**

We have appended to the Industry Standards this list of Potential Fraud Indicators. While this list is not exhaustive, we wanted to share with you these examples of fraudulent and abusive practices that have been used in the past and that should be watched for in the future.

### 1. Claims Processing

#### *Administrative Related*

- Claims with photocopies of receipts rather than original receipts
- Altered claims
- Claims using credit cards with multiple addresses
- Receipts submitted on white bond paper, without letterhead
- Receipts submitted inconsistent with their normal style
- Prescription claims submitted for reimbursement with consecutive Rx numbers
- Frequent address changes
- Claims processed immediately after date of service or after the claim was submitted
- Frequent submission of claims with overlapping dates of service
- Claims with requests for special mailing of checks and Explanation of Benefits
- Claims with questionable types of services rendered

#### *Provider and Enrollee Related*

- 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 the 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
- Psychiatric claims where length of sessions is outside the norm
- Identical claims submitted in different years for same patient

### 2. Customer Service

- 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

### 3. Utilization Review

- 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

#### 4. Provider/Internal Audit

- Providers with a consistent number of duplicate payments
- Providers who resubmit claims with different procedure/diagnosis codes when a claim has been rejected
- Providers who frequently call to complain about payment determinations
- Providers who consistently complain about the timeliness of payments
- Providers who request pricing information and/or a review of their profile data

#### 5. Provider Relations

- Revoked/Suspended license
- Numerous complaints against provider

#### 6. Compliance Office

- Discrepancies in T&E reporting
- Kickbacks
- Inappropriate gifts
- Inappropriate use of member/provider information
- Discrepancies in incentive reporting
- Discrepancies in financial reporting