BlueCross BlueShield Association

An Association of Independent
Blue Cross and Blue Shield Plans

By Electronic Mail

July 21, 2010

Honorable Sandy Praeger
Chair, Antifraud (EX) Task Force
National Association of Insurance Commissioners

Re: Uniform Fraud Reporting Form Comments

Dear Commissioner Praeger:

The National Health Care Anti-Fraud Association (NHCAA) and the Blue Cross and Blue Shield Association (BCBSA) appreciate the opportunity to submit the following comments for consideration as the NAIC examines its Online Fraud Reporting System (OFRS) and considers its suitability for meeting the directive set forth in Public Law 111-148, the Patient Protection and Affordable Care Act (PPACA), to:

> *develop a model uniform report form for private health insurance issuer seeking to refer suspected fraud and abuse to State insurance departments or other responsible State agencies for investigation.*

Our initial recommendation is to clearly discern the purpose driving the statutory language to ensure that the form resulting from this exercise meets the expectation. If the NAIC is able to define how the form, as well as the data collected using it, will be utilized, NHCAA and BCBSA may have additional comments and recommendations to offer.

Noting that both NHCAA and BCBSA operate in the health insurance industry, the current OFRS form (adopted in 2003) seems to us to be predominantly focused on property and casualty insurance. As the only national organization focused exclusively on the fight against health care fraud, NHCAA knows that health care fraud can be a very complex issue and broadly dissimilar from other types of insurance fraud. Billions of health care claims are generated in the United States every year in the public programs (e.g., Medicare and Medicaid) and through private insurance. For those looking to commit fraud this presents a broad scale opportunity, with the entire population of insured patients and the entire range of health care services and health conditions on which to base false claims. In addition, individuals seeking to perpetrate health care fraud can include: providers, patients, insureds, employees of insurers and providers, suppliers and vendors, and organized crime groups. In short, health care fraud is a broad term that can manifest in countless ways.

Therefore, in hopes of enhancing the ability of OFRS to collect more complete data relating to suspected health care fraud, we offer the following three ideas:

1. Edit, add and reorganize several fields in the current OFRS form (based on our review of the form as a Word document) to effectively collect valuable health care fraud data. Please see the specific edits we recommend listed numerically later in this letter.

2. The NAIC Antifraud Task Force is likely familiar with NHCAA's Special Investigation Resource and Intelligence System (SIRIS) database, as NHCAA has been working with the NAIC for many months to integrate SIRIS with OFRS. SIRIS collects data on health care fraud investigations and NHCAA welcomes the NAIC to consider the field data set used in SIRIS as a model from which NAIC may consider revamping the OFRS form to meet the federal request. Attached to this letter for your review and use is the list of SIRIS data input fields.
3. Devote attention to updating and reorganizing the Suspected Fraud Types list provided in the OFRS form to ensure that it reflects health care fraud in its many variations. Attached to this letter we offer a list of health care fraud types that essentially represents a merging of NHCAA SIRIS Classifications and applicable NAIC Fraud Types, which could be incorporated into the OFRS form.

To promote the usability of the form, we suggest that the NAIC employ user-friendly tools such as pop-up boxes (for instructions and definitions), prompts to "add" additional fields of data (i.e. click "Add" to provide additional state license numbers, taxpayer information numbers, etc.), "skip logic" or "branching logic" that allows a respondent to skip questions or be directed to a specific set of questions based on a previous response, as well as other functionality.

Below is a list of specific edits that NHCAA and BCBSA recommend for the existing OFRS form (comments are based on our review of the reporting form as a Word document):

1. Number the data fields—this will make the form easier to complete, follow and refer to.
2. Assuming the form will be completed primarily online, integrate the form with its instructions document so that a user can click on a field title and the corresponding instruction will appear in a pop-up box.
3. Examine the fields that have been identified as required fields (i.e. information must be provided in order for the form to be submitted successfully) and affirm that these are the appropriate ones.
4. Move the "Detailed synopsis" field to later in the form so that the user will complete the Subject Information and Case Details sections first. This will likely result in the collection of richer sortable data.
5. Move "Insurance Type" field up to be the first field following the contact information collected for the "Reporting person."
6. Unless instructions for the "detailed synopsis" field are easily available as a pop-up box (see recommendation #2 above), offer some guidance as to what could/should be included in this field (i.e. "Include predication that prompted the case to be opened and assigned and a summary of investigative results that validated the suspicion of fraud").
7. Expand the Procedure Code #'s field to include "ICD-9" and "ICD-10" as check box selections. (International Classification of Diseases, 9th revision (ICD-9) and International Classification of Diseases, 10th revision (ICD-10). ICD-9 provides for the classification of disease by diagnosis codified into six-digit numbers. The far more detailed ICD-10, which is now coming into use, provides for longer alphanumeric codes).
8. Add "estimated" together with a check box to the "Loss Amount" field.
9. Rename the "Type:" field found under the Subject Information section "Subject Type:" to alleviate any confusion with "Suspected Fraud Types" and add "(refer to Subject/Additional Party Types list)" as an instruction note directly in the field.
10. The form allows for the collection of two telephone numbers under the Subject Information section. Rename the fields "Telephone No. 1" and "Telephone No. 2" (or some variation thereof) to differentiate between them and make it clear that these fields are not duplicates.
11. Break out the field found beneath the Subject Information Section asking respondents to indicate if there are additional parties involved and if the subject in question goes by an alias (AKA) into two

separate fields in order to alleviate confusion. Repeat the “See Additional Party Involved/AKA Information Section” instruction for both fields.

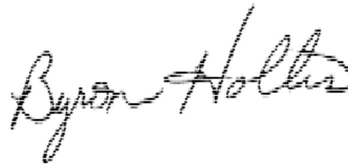
12. Rename the “Comments” field found beneath the Subject Information section “Additional Comments about Subject” (or some variation thereof) to alleviate confusion—currently as the form is laid out a respondent might think the “Comments” field relates to the Additional Party Involved/AKA Information field.
13. Case Details section is somewhat confusing. Consider moving necessary/valuable case details fields to the initial section of the form where the general information is collected (Reporting Person, contact info, etc.).
14. In the Case Details section, following the question “Is there any reason to believe that this incident is related to other suspected fraudulent activity?” add a “If yes, please explain” text box.
15. In the Case Details section, provide a field title and/or instruction note before listing the various check boxes (Statements, Proof of Loss, etc.) to clearly explain to the respondent what is being requested (note: “Other” is listed three separate times as check box selections).
16. Revamp the Suspected Fraud Types section to include Health Care Fraud as a main heading, with all the specific health care fraud types listed directly thereafter as subcategories (following the Arson example). This will give a clearer focus to health care fraud and ensure that more specific, and thus more useful, data is collected.
17. See attached for our recommendations of specific health care fraud types to be included on the form.
18. Alphabetize the Suspected Fraud Types section (exception: continue to list “Other” last).
19. Change the fraud type “Agent” to “Agent/Broker.”
20. Change the fraud type “Application fraud” to “Application fraud/Eligibility fraud.
21. Change the fraud type “Products billed are inconsistent with the products” to “Products billed are inconsistent with the products/services/supplies provided.”
22. Fraud types “Kickback/bribery” and “Received compensation for referral to health care provider or attorney” are essentially duplicative.
23. Alphabetize the Subject/Additional Party Types list or ensure that all health-related subject types are listed consecutively and in alpha order (exception: continue to list “Other” last).
24. Add the following subject types to the list of Subject/Additional Party Types: “Facility,” “Ophthalmologist,” “Psychologist,” “Psychiatrist (MD)” and “Therapist/Counselor.”
25. Change subject type “Insured” to “Insured/Member.”
26. Change subject type “Pharmacist” to “Pharmacist/Pharmacy.”
27. Change subject type “Ambulance Service Employee” to “Ambulance Service/Employee.”
28. Change subject type “Medical Clinic/Hospital” to “Medical Clinic/Out-patient facility (removing “Hospital”).
29. Create subject type “Hospital.”
30. Change subject type “False Provider” to “Nonexistent/False/Phantom Provider.”
31. For any field where multiple entries could be entered (driver’s license number, additional addresses, etc.) revamp the form to allow for a “click here to Add another” function (assuming the form is completed online). Currently, the written form instructions direct a respondent to complete an “Additional Party Involved/AKA Information” section, which may not necessarily be appropriate.
32. Update the Instructions document to provide instruction for all form fields.

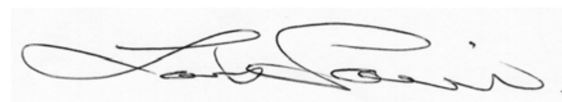
In addition to the request to develop a model uniform report form for health care fraud and abuse, we note that the Patient Protection and Affordable Care Act (PPACA) also states that the U.S. Secretary of Health and Human Services “shall request that the National Association of Insurance Commissioners develop recommendations for uniform reporting standards for such referrals [meaning referrals of suspected health care fraud and abuse].” NHCAA and BCBSA would welcome the opportunity to offer input

on this discussion as well. Ideas that could be explored include providing guidance to private insurers as to at what stage a referral should be filed (complaint stage, at the completion of the investigation, when evidence suggests potential fraud, etc.), defining the purpose of filing a referral (to collect intelligence, facilitate an investigation, etc.), defining the purpose for collecting certain types of data (i.e. settlement amounts, etc.), explaining how the data collected will be used and if it will be shared with private insurers in any capacity, etc.

Thank you for allowing NHCAA and BCBSA the opportunity to comment on the development of a model uniform report form for private health insurance issuers seeking to refer suspected fraud and abuse to State insurance departments or other responsible State agencies for investigation. If we can be of additional assistance, please let us know.

Sincerely,





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Enclosures/Attachments:

1. Data Fields from NHCAA's SIRIS Database for Adding New Investigation/Case/Provider Records
2. Proposed health care fraud types for NAIC OFRS Suspected Fraud Types list

cc: Ted Clark (Kansas Insurance Department)
Fred Nepple (Wisconsin Office of the Commissioner of Insurance)

The National Health Care Anti-Fraud Association (NHCAA) *– Established in 1985 by several private health insurers and federal and state government officials, NHCAA is the only national organization devoted exclusively to combating health care fraud. NHCAA's mission is to protect and serve the public interest by raising awareness and improving the detection, investigation, prosecution and prevention of health care fraud. Since its founding, NHCAA has remained a private-public partnership with its members comprising the nation's most prominent private health insurers as well as those Federal, state and local government law enforcement and regulatory agencies having jurisdiction over health care fraud.* www.nhcaa.org

The Blue Cross and Blue Shield Association *is made up of 39 independent, community-based and locally operated Blue Cross and Blue Shield companies that collectively provide healthcare coverage for nearly 100 million – one-in-three – Americans. For more information, go to www.bcbs.com.*