BlueCross BlueShield of Illinois

# 2025 Provider Manual – Fraud and Abuse Program



Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

**Fraud and Abuse Program — Updated January 2025**

## Special Investigations Department

Each year, fraud, waste, and abuse costs the health care industry billions of dollars. FWA is a key driver of the rising cost of health care.

Blue Cross and Blue Shield of Illinois is committed to:

- Controlling the rising cost of health care;
- Identifying, investigating, and preventing health care FWA;
- Protecting the integrity of the BCBSIL Provider Network; and
- Referring individuals and/or facilities that defraud or attempt to defraud BCBSIL and its clients to law enforcement.

To honor this commitment, BCBSIL established the Special Investigations Department which has adopted an aggressive and effective healthcare FWA investigation program. The SID employs the use of various investigative techniques, the diverse skills of its staff, and its unique relationship with internal and external partners, such as the law enforcement community. The SID follows the reporting requirements mandated by law (state and federal) as well as contractual obligation.

Departmental investigators come from law enforcement, health care, and insurance backgrounds to form an effective investigative team. These investigators occasionally interview members during the course of their investigations but strive to do so in a manner that does not interfere with the Provider/Patient relationship. SID also includes a robust Data Intelligence Unit that data mines for anomalous billing, supports SID investigations and responds to demands for information from law enforcement agencies.

When no FWA is found, the case may simply be closed with no further action. If investigations reveal the existence of FWA, possible courses of action include (but are not limited to):

- Notifying and placing the Provider on Pre-Payment Review for questionable billing;
- Seeking a refund from the Provider;
- Educating the Provider about billing errors;
- Terminating the Provider from the BCBSIL Network; and
- Referring the Provider to a state regulatory and/or law enforcement agency.

BCBSIL considers fraudulent billing to include, but is not limited to, the following:

1. Deliberate misrepresentation of the service provided in order to receive payment;
2. Deliberately billing in a manner which results in reimbursement greater than what would have been received if the claim were filed in accordance with BCBSIL billing policies and guidelines; and/or
3. Billing for services which were not rendered.

## Pre-Payment Review

The SID and its internal partners may determine that it is appropriate to place a provider or specific codes on PPR to help prevent erroneous, fraudulent, or otherwise unclean claims from being paid. In this process, the

provider's claims undergo an additional layer of scrutiny to verify eligibility for reimbursement. Consistent with their contractual obligations to provide BCBSXX with access to medical, billing, and financial records, a provider must supply documentation in support of the services billed on their claims. The documentation is reviewed by medical professionals and/or coding experts to determine whether the services were medically necessary, within terms of coverage according to BCBSXX members' benefits, rendered as billed on the claim and billed in compliance with BCBSXX's reimbursement policies, including but not limited to BCBSXX's clinical payment and coding policies.

The SID employs numerous investigative techniques in its mission. These may include review of claims and supporting records, data mining, and interviews. The SID may also use a Statistical Random Sample to select a representative set (sample) of claims to evaluate the adherence to our requirements.

## Provider Responsibilities

BCBSIL Providers are responsible for:

- All statements made with any claim submitted to BCBSIL by or on behalf of the Provider; and
- The actions of staff members or agents.

Providers should be knowledgeable about BCBSIL Medical Policies, located in the Standards and Requirements/Medical Policy section of the BCBSIL Provider website.
***Note: this process does not apply to HMO members. Refer to the HMO Scope of Benefits for coverage.***

These policies serve as one set of guidelines for coverage decisions. However, Medical Policy does not constitute plan authorization, nor is it an explanation of benefits or meant to substitute for **clinician judgement.**

BCBSIL Providers should determine member benefits and eligibility prior to services, either electronically or by calling the Provider Telecommunication Center at 800-972-8088. If the Provider has a question as to whether a frequently billed service is a covered benefit under a Medical Policy, the Provider should address that question with his/her BCBSIL Provider Network Consultant. If there is a discrepancy between a Medical Policy and a member's benefit plan or contract, the benefit plan or contract will govern.

**How to Report Health Care Fraud:**
Providers who become aware of potential fraudulent or abusive billing by other Providers should report those matters to the BCBSIL Hotline at 800-543-0867. The Fraud Hotline operates 24 hours per day, seven days per week. Suspicions of fraud can be reported anonymously.