Insurance Intelligence

Now and beyond

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Medical Fraud Detection and Prevention

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1 Introduction

Health insurance fraud is described as an intentional act of deceiving, concealing, or misrepresenting information that results in health care benefits being paid to an individual or group.

Fraud can be committed by both a member and a provider.

Member fraud consists of:

1. Ineligible members and/or dependents,
2. Alterations on enrollment forms,
3. Concealing pre-existing conditions,
4. Failure to report other coverage,
5. Prescription drug fraud, and
6. Failure to disclose claims that were a result of a work related injury.

Provider fraud consists of:

1. Claims submitted by dishonest physicians,
2. Billing for services not rendered,
3. Billing for higher level of services,
4. Diagnosis or treatments that are outside the scope of practice,
5. Alterations on claims submissions, and
6. Providing services while under suspension or when license have been revoked.

(Ref.: http://healthcarespace.blogspot.com/2010/02/frauds-in-health-insurance.html

In India, for example, statistics are also alarming. According to the survey conducted two years back by one of the leading TPA the number of false claims in the industry is estimated at around 10-15 per cent of total claims. The report suggests that the Health care industry in India is losing approximately Rs 600 crore on "false claims" every year)

2 About MFDS

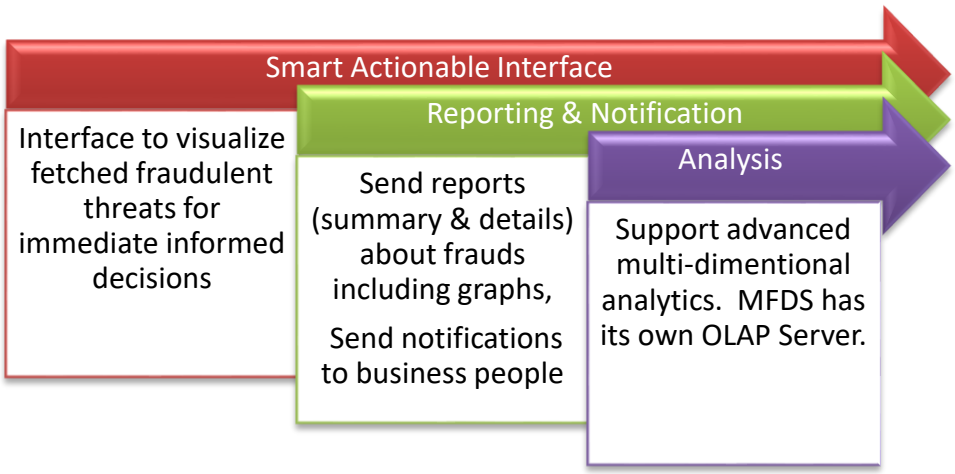
While medical claims are being submitted or even processed, the MFDS has 'Listeners' that listen to any pre-defined fraudulent Threat. If any threat is caught, it is saved in a 'Fraudulent Claims Collector' for further different actions by fraud unit. Actions include either accept or reject the claim. If a claim is rejected MDFS back updates the operations system and sends immediate notification to the fraud unit.

MFDS Support three types of fraud detection:

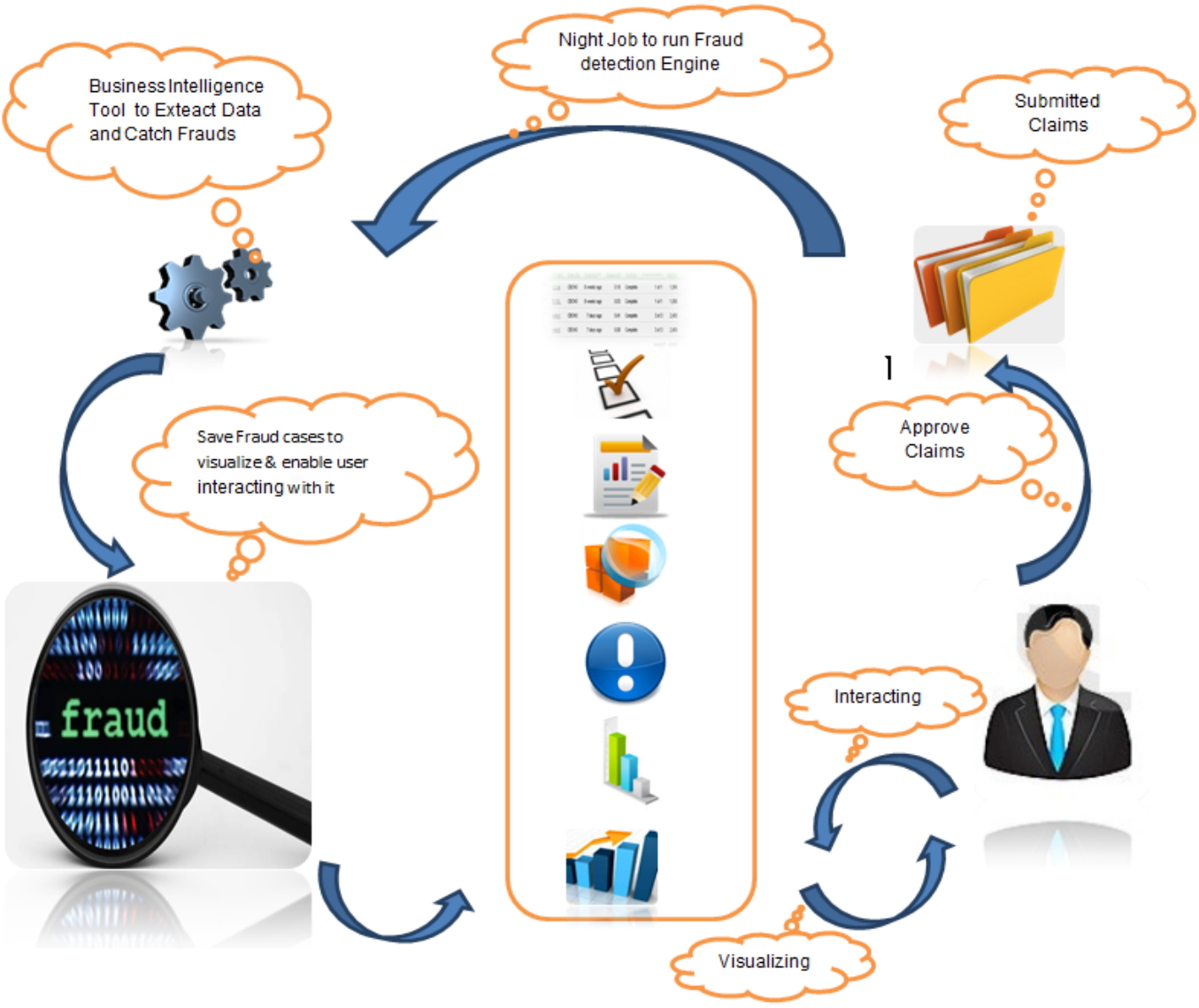
- Manual Process which allows the fraud unit processors to mark any case as a fraudulent Threat.
- Automated Process which is computer automated jobs act on submitted claims and automatically catch any Threat.
- Intelligent Process that uses the artificial intelligence to learn from historical fraud data and instantly predict whether the current claims is a fraud or not and under which Threat.

MFDS presents the detected fraud cases on various formats such as tables, reports with summary graphs or multi-dimensional cubes with slice and dice options which enable the business people to see the data from different angles

and many analytical scenarios. MFDS reports are actionable, which means the user can take immediate action on any claim as appropriate.



3 MFDS Processes



4 MFDS Architecture

MFDS is n-tier architecture with the following layers:

Presentation Layer:

The MFDS presentation is a web based thin interface that presents the caught frauds and enables user to interact with them. Also view in-line analytics about the frauds.

Business Layer:

MFDS business contains all business designated policies and Fraudulent Claim criterion.

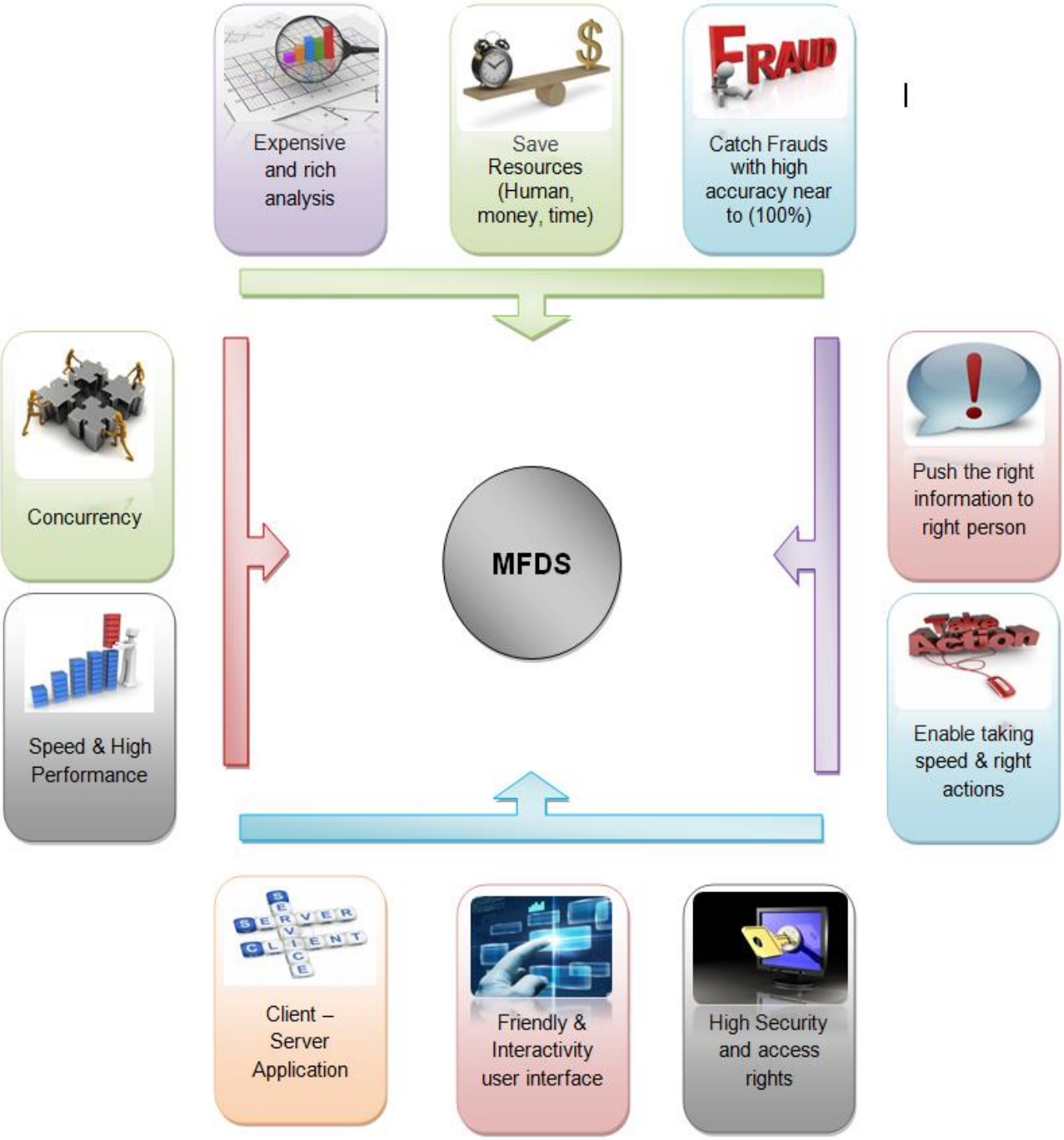
Data Layer:

A robust data warehouse with state-of-art sophisticated ETL processes.

5 The Fraud Threat Themes:

1 Billing for services not rendered *(submitted claim's services that were never provided)*
2 Billing for a non-covered service as a covered service
3 Misrepresenting dates of service *(treated the same patient on two separate days rather than one day)*
4 Misrepresenting provider of service
5 Waiving of deductibles and/or co-payments ("up-coding")
6 Overutilization of services.
7 Enrolling someone not eligible for coverage on a health plan*(divorced spouse – married daughters)*
8 Abuse Services
9 Abuse for medical unjustified visits.
10 Internal quality flags

6 Why MFDS?


Expensive and rich analysis
Save Resources (Human, money, time)
Catch Frauds with high accuracy near to (100%)
Concurrency
Speed & High Performance
MFDS
Push the right information to right person
Enable taking speed & right actions
Client – Server Application
Friendly & Interactivity user interface
High Security and access rights

7 Success Stories

Tawuniya Insurance

With a robust 'Medical Fraud Detection' system designed by 3adda, **Tawuniya** achieved a competitive edge and reduced Time and efforts to eliminate "Medical Frauds".

Fraudulent cases cost health insurance providers more than 6% of revenue. Tawuniya was the first to build such intelligent system in the Kingdom and hence saved annually millions or Saudi Riyals that were being paid to fraudulent claims.

Our unique in-house built system helped **Tawuniya** capturing fraudulent cases much more efficiently**,** and as a result, increased profitability and protected the national economics.

3adda currently has an agreement with Tawuniya to support, maintain and upgrade the Fraud Detection System.