Seminar on Life/Non Life Insurance and Pension sector– (Institute of chartered accountants of india,ICAI) Health insurance fraud and detection

Presented by

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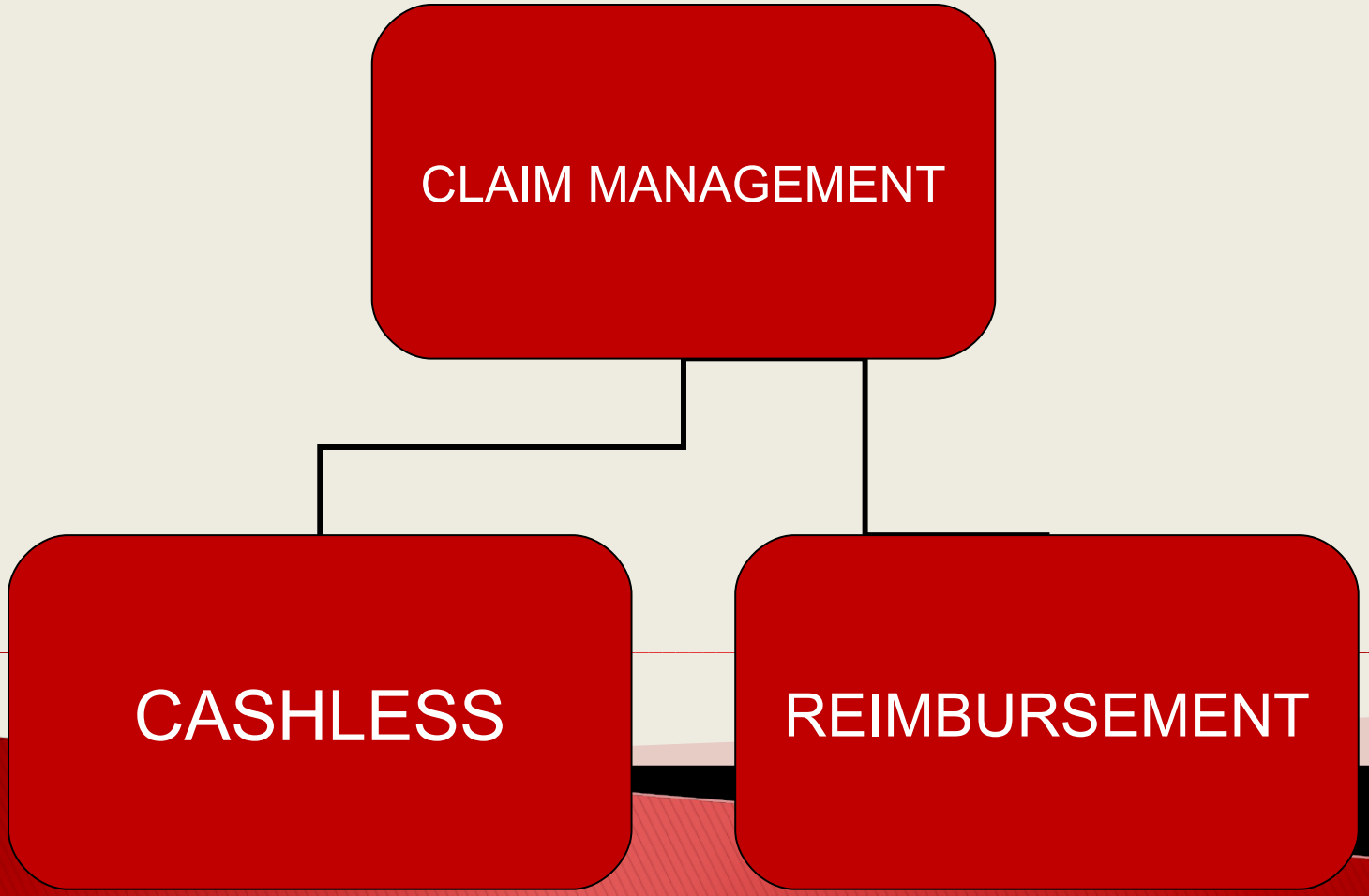
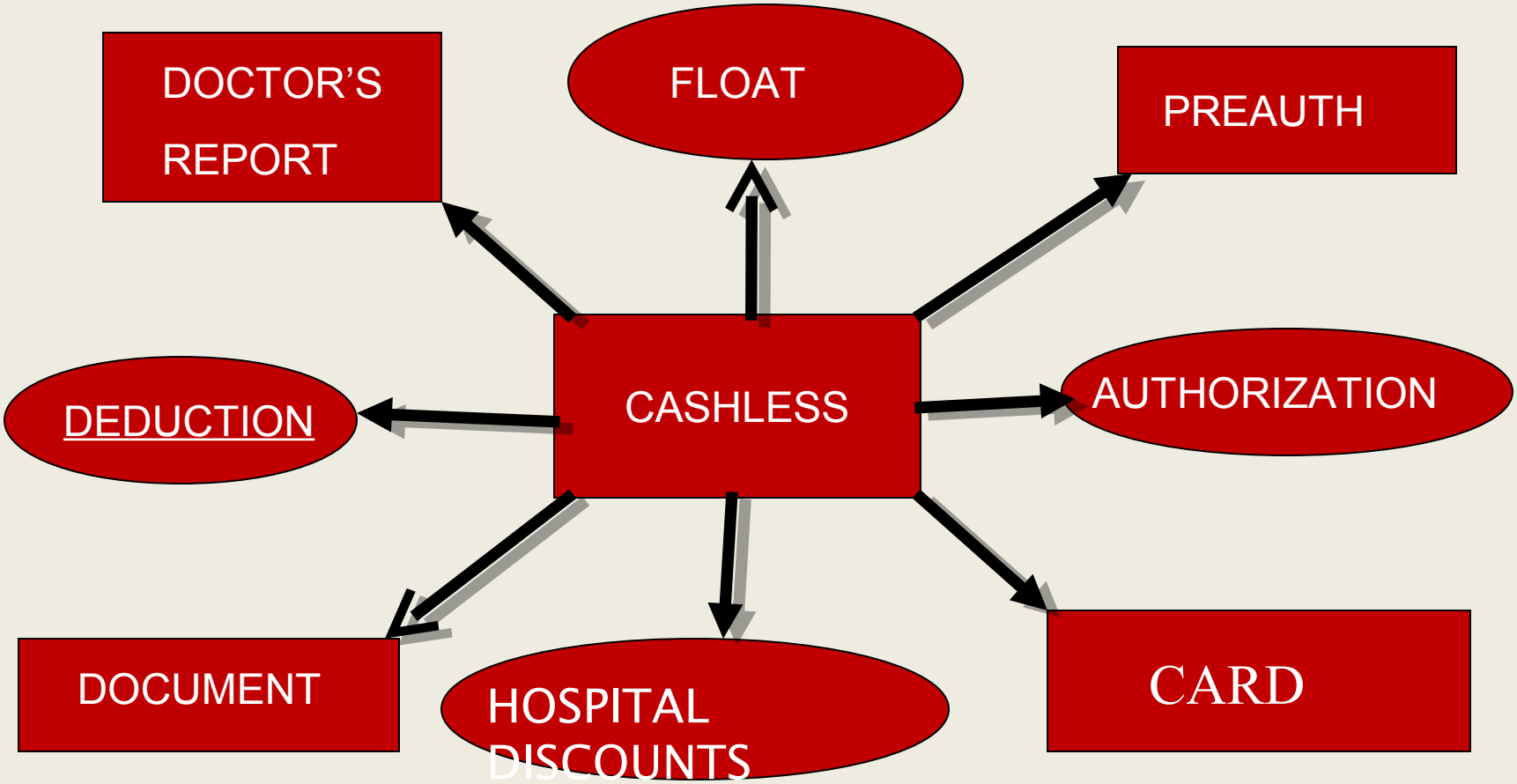
CLAIMS PAID TYPES



CASHLESS


DOCTOR'S REPORT
FLOAT
PREAUTH
DEDUCTION
CASHLESS
AUTHORIZATION
DOCUMENT
HOSPITAL DISCOUNTS
CARD

Some Important Policy wordings

- The policy shall be null and void, and no benefits shall be payable in the event of misrepresentation, misdescription or nondisclosure of any material fact/particular if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured Person or by any other person acting on his/her behalf.
- (New India Assurance Co.Ltd)
- If a claim is in any way found to be fraudulent, or if any false statement, or declaration is made or used in support of such a claim, or if any fraudulent means or devices are used by the Insured Person or any false or incorrect Disclosure to Information Norms or anyone acting on
- behalf of the Insured Person to obtain any benefit under this Policy, then this Policy shall be void and all claims being processed
- shall be forfeited for all Insured Persons and all sums paid under this Policy shall be repaid to Us by all Insured Persons who shall be jointly liable for such repayment

Insurance fraud

- Not found mention in Indian Insurance Act.
- The International Association of insurance Supervisors (IAIS) which defines fraud as "an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties.“
- Indian Penal Code (IPC) or Indian Contract Act, also does not offer specific laws. Sections of the IPC which deal with issues of fraudulent act, forgery, cheating etc. are sometimes applied but none of them are
- specifically targeted at insurance fraud and are inadequate for purpose of acting as an effective deterrent.

insurance fraud

- In simple parlance, insurance fraud can be defined as:
- The act of making a statement

- known to be false and used to induce another party to issue a contract or pay a claim.

- This act must be wilful and deliberate,
- involve financial gain,
- done under false pretences
- is illegal

Definition – Health Fraud and Abuse

Healthcare fraud as defined by the National Health Care Anti-Fraud Association (USA): "The deliberate submittal of false claims to private health insurance plans and/or tax-funded public health insurance programs." "Intentional deception or misrepresentation that the individual or entity makes, knowing that the misrepresentation could result in some unauthorised benefit to the individual, or the entity, or to another party."

Abuse can be defined as practices that are inconsistent with business ethics or medical practices and result in an unnecessary cost to claims.

excessive diagnostic tests,extended LoS, conversion of day procedure to overnight admission, admission limited to diagnostic investigations etc.

Definition – Health Fraud and Abuse

- Fraud is willful and deliberate.
- Involves financial gain.
- Done under false pretense and is illegal.
- Abuse generally fails to meet one or more of these criteria, hence the subtle difference.
- Main purpose of both fraud and abuse is financial gain.

IPC Provision

- "Section 23 and 24: deals with the term "wrongful gain" –

- Section 25:- a person is said to act fraudulently if he acts with the intent to defraud but not otherwise.

- Intent difficult to establish

IPC Provision

- Section 463: relates to forgery

- close to health insurance fraud.

- health insurance fraud. "Whoever makes any false documents or false electronic record or part of a document or electronic record, with intent to cause damage or injury, to the public or to any person,
- or to support any claim or title, or to cause any person to part with property, or to enter into any express or implied contract, or with intent to commit fraud or that fraud may be committed, commits forgery.“

IPC Provision–Section 477 A: falsification of accounts.

- relates to health insurance fraud. "Whoever, being a clerk, officer or servant or employed or acting in capacity of a clerk, officer or servant, willfully and with intent to
- defraud, destroys, alters, mutilates or falsifies any book, electronic record, paper,
- writing], valuable security or account which belongs to or is in the possession of his
- employer or has been received by him for on behalf of his employer or willfully,

Section 17 in The Indian Contract Act, 1872

- Fraud" means and includes any of the following acts committed by a party to a
- contract, or with his connivance, or by his agent, with intent to deceive another party
- thereto of his agent, or to induce him to enter into the contract:-
- the suggestion, as a fact, of that which is not true, by one who does not believe it to
- be true (across entities)
- the active concealment of a fact by one having knowledge or belief of the fact (across entities)
- a promise made without any intention of performing it (intermediary/ sales staff)
- any other act fitted to deceive (across entities)
- any such act or omission as the law specially declares to be fraudulent

Section 17 in The Indian Contract Act, 1872

- with intent to defraud, makes or abets the making of any false entry in, or omits or
- alters or abets the omission or alteration of any material particular from or in, any such

- book, electronic record, paper, writing, valuable security or account, shall be punished
- with imprisonment of either description for a term which may extend to seven years,
- or
- with fine, or with both.

Investigation and Fraud Detection

- It is a tool to control Average Claim Cost (ACC) and Frequency of claims to manage Incurred Claim Ratio(ICR)

- Fraud:

-Bogus claims

-Manipulation of medical history

Abuse:

-Over Billing

-Over Treatment

Triggers for suspicion

1	Over billing or exaggerated bill for a Particular illness
2	Pre-existing illness
3	Events leading to hospitalization
4	line of Treatment not matching
5	Questionable Claim History
6	Seeking for enhanced sum insured
7	Claim within 1st 3 years of policy
8	All documents having the same handwriting

9	Delay in sending the document with no prior intimation
10	Utilization of total Sum insured(may or may not be inclusive of CB in one go.
11	Discrepancy in the history for duration for illness
12	Continuous serial nos in medicine bill intact for all days of admission
13	Tampering of information which will affect the eligibility of the claim
14	Unexplained long duration of stay
15	Bills prepared on plain sheets with stamp
16 17 18	Claim in the first 3 years of Degenerative/chronic illness/congenital internal illness in a younger age group Single Insured person Tampering in IPD

Internal and External

Internal frauds are those made against an insurance company or its policyholders by agents or other employees.

External fraud schemes are directed against a company by individuals or entities as diverse as medical service providers, policyholders, beneficiaries, medical consumable vendors etc.

Hard and Soft fraud

Hard fraud is a deliberate attempt either to stage an event or an accident calling for hospitalization or other type of loss that would be covered under a medical insurance policy.

Soft fraud, which is sometimes called opportunity fraud, occurs when a policyholder or claimant exaggerates a legitimate claim.

Soft fraud may also occur when people purposely provide false information with regard to the pre-existing illness or other relevant information to influence the underwriting process in the favor of the applicant.

Application Fraud:

- This is committed when material misrepresentations are made on an application for insurance with the intent to defraud.
- Application fraud differs from claim fraud in that the perpetrator is not seeking to illegitimately obtain a benefit payment-
- rather the perpetrator is seeking to illegitimately obtain health insurance coverage itself.

- ✓ An applicant suppresses the truth of serious medical condition at the time of taking the policy to obtain coverage that might have been denied or excluded from the scope of coverage or to avoid additional loading of premium.
- ✓ Another case is when the consumer is having pre-existing disease, but does not declare at the time of filing a claim.
- ✓ Also, in the case of corporate changing the joining date of the employee by passing an endorsement from the insurance company with falsified records.

Eligibility Fraud

- The benefit is paid illegitimately because the beneficiary was not truly eligible to receive benefits because of non-disclosure from the insured.

- ✓ Eligibility fraud most commonly involves misrepresentations of the status of a dependent or of someone's employment status.

- ✓ For instance, a member submitting claim of his siblings/relatives/dependants, which are not covered under the policy.
- ✓ Or, a business's group health plan covers all full-time employees but not part-time workers. A part-time employee colludes with another employee in human services to falsify records so that it appears that he works full-time and is covered by the plan.

- ✓ Also, if agents and brokers create false documents and claims against genuine member's records. And, stakeholders involved in unfair trade practices to clear non-payable claims.

Provider and Consumer Fraud

Fraud can be committed both by the insured member or the provider and at times are a concerted effort of agents, brokers, insurance employees, insured member and the provider of services and other stakeholders of the healthcare system.

One of the largest single sources of fraud is the healthcare providers. They usually have the detail knowledge of the policy condition, re-imbursement process which makes it very difficult to detect such frauds.

Consumer

- ✓ With the increasing awareness of the insurance benefits, many policy holders have got involved in healthcare fraud. Consumer frauds mainly fall in three categories: claims fraud, application fraud, and eligibility fraud

Fraud Claims Trigger

- Insurance frauds usually have common profile and pattern.
- Parameters used as a trigger to detect or analyze fraudulent claims or practices.

Claims Fraud Category

- **Fraud rings**: A group comprising various players including
- consumers, agents, physicians, provider,

- making an false claim

Fraud Claims Trigger

Repeated claims of the Illness showing patterns

Antecedents of the treating doctor, agents, ailments if featuring regularly .

Patient residence and the hospital, chemist address, are not geographically same.

Early claim with high amount.

Previous fraudulent claim and suspected claims from the same Hospital.

Fraud claimers are usually short-term policy holders with lower sum insured.

Same Diagnosis for each and every claim from the hospital.

Request for sudden increase in the Sum Insured at the time of renewal for few members of the policy

Insuring only selective members of the family members instead of entire family

NABH - Standards –Quality Council of India -

- Access ,Assessment and continuity of Care(AAC)
- Care of Patients (COP)
- Patient's rights and Education (PRE)
- Hospital Infection Control (HIC)
- Continuity Quality Improvement (CQI)
- Responsibilities of Management (ROM)
- Facility Management (FMS)

Claims Investigation Report –what it should comprise….?

- Name of the Investigating Officer
- Name of the Insured
- Name of the Beneficiary
- Claim Number
- Name of the Insurer
- Policy Number
- Name and address the Hospital / Organization

Claims Investigation Guidelines

Verification with Patient:

Verification with Patient

Patient Questionnaire

Verification with Neighbors & Relatives

Provider Fraud

- Billing for services, procedures, and/or supplies that were not provided.
- Misrepresentation of what was provided; when it was provided; the condition or diagnosis; the charges involved; and/or the identity of the provider recipient.
- Providing unnecessary services or ordering unnecessary tests.

Provider Fraud

- Charging for a service that was not performed.
- Unbundling of claims: Billing separately for procedures that normally are covered by a single fee. An example would be a podiatrist who operates on three toes and submits claims for three separate operations.
- Double billing: Charging more than once for the same service.

Provider Fraud

- Upcoding: Charging for a more complex service than was performed.
- Charging for a more complex procedure than was performed
- Charging for more expensive equipment than was delivered.
- Miscoding: Using a code number that does not apply to the procedure.

Provider Fraud

- Billing for advanced life support services when basic life support was provided.
- Documentation may be falsified to indicate a patient needed oxygen —which is a key indicator for advanced life support.

- Billing for more miles than traveled for transportation.

What should you do as an Auditor ...../

Examine insurance payment reports to see whether they accurately reflect the services rendered.

Suspicious reports involving a private insurer claim should be reported to the company's fraud department.

What is gnawing ……?

- Bed/Room Charges
- Nurse's Charges
- Doctor's/Specialist's fees
- Pathological Expenses
- Non-Pathological Expenses
- Medicine
- Pre/Post Hospitalization

Case1-

- A famous B School approached an insurance company for the health insurance of its students numbering around 1500 under GMC (Tailor made) asking for waiver of PED , 30 days waiting period and also waiver of specific period exclusions for certain ailments. The cover asked for each student, was 200000/- The B School in its admission letter stated that it would charge Rs. 10 lac per student which would include tuition fee , cost of books , boarding fee , one foreign trip , library charges , seminar expenses . A claim of Rs.50000/- reported when a girl student sustained injury in the campus.
- Your comment on the admissibility of the claim

Case 2

- A patient suffered food poisoning and was admitted to a hospital. The treating charges amounted to Rs.1,50,000/- The insurance company paid the treating cost after taking into account deductibles of 2000/- and also co-pay of Rs.10%- . The sum insured was Rs.1, 00,000/- The patient filed a case against the hotelier and recovered 60,000/ from him by way of a court award. The insurance company who represented the insured under the title subrogation incurred a legal expense of Rs. 10,000/-
- How much the insurance company can keep from the award ?

Case -3

Ravi Shankar , aged 64 was admitted for eye surgery in a day care centre on 21/01/2010 and released on the same day. He had cashless insurance policy. He was diagnosed for full thickness macular hole on the right eye, membrane filling ,fluid gas . He was operated for right eye vitrectomy

- Following charges were levied by the hospital:-
- 1. Operation charge - Rs. 1500.00
- 2. Anaesthesia charges - Rs.2500.00
- 3. OT Charges -Rs.2700.00
- 4. Silcon oil - -Rs 2000.00
- 5. Disposable pack -Rs.21000.00
- 6. Hospital stay -Rs. 500.00
- 7. Doctor visit -Rs. 300.00
- 8. Blades -Rs.1000.00
- Total -Rs.45,000.00

- What are the points would you consider before settling the claim?

Case -3A

- Ravi Shankar , aged 64 was admitted on 18/02/2010 and released on the same day for eye surgery in a day care centre. He had cashless insurance policy .He was diagnosed for reopened vitrectomy hole on the right eye, membrane filling ,fluid gas . From the history of the patient, it was found that this the second incidence of vitrectomy in the same eye .

- Following charges were levied by the hospital:-
- 1. Operation charge - Rs. 9500.00
- 2. Anaesthesia charges - Rs.1500.00
- 3. OT Charges -Rs.2700.00
- 4. Gas - -Rs 2000.00
- 5. Vitrectomy (cotter) -Rs.6000.00
- 6. Hospital stay -Rs. 500.00
- 7. Doctor visit -Rs. 300.00
- 8. Iclens -Rs. 1500.00
- 9. Blades -Rs.1000.00
- Total -Rs.25,000.00

- What are points would consider for settling the above claim?