



SOLUTION OVERVIEW

HEALTH INSURANCE FRAUD MONITORING

Health Insurance Fraud

Health Insurance Fraud can be committed at various points in the claim transaction by different parties inclusive of claimants, policyholders, third-party claimants and the professionals who provide services to claimants. Some instances of fraud include:

- Ineligible members and/or dependents
- Alterations to enrolment forms
- Concealing pre-existing conditions
- Failure to report other coverage
- Prescription drug fraud
- Failure to disclose claims that were a result of a work related injury
- Claims submitted by bogus physicians
- Billing for services not rendered
- Billing for higher level of services
- Diagnosis or treatments that are outside the scope of practice
- Alterations to claims submissions

The health insurance industry suffers tremendous losses globally and the resulting impact is higher premiums. For example, in the U.S. alone health insurance fraud was estimated to cost \$68 billion.

(National Health Care Anti-Fraud Association, 2008)

Combating Fraud

The methods being used in many health insurers lacks the sophistication to stay ahead of the threat. Relying solely on adjudicators is risky and likely to be futile resulting in greater expenditure and marginal results. Implementing software that can identify abnormal claim patterns increases the likelihood of detecting fraud significantly.

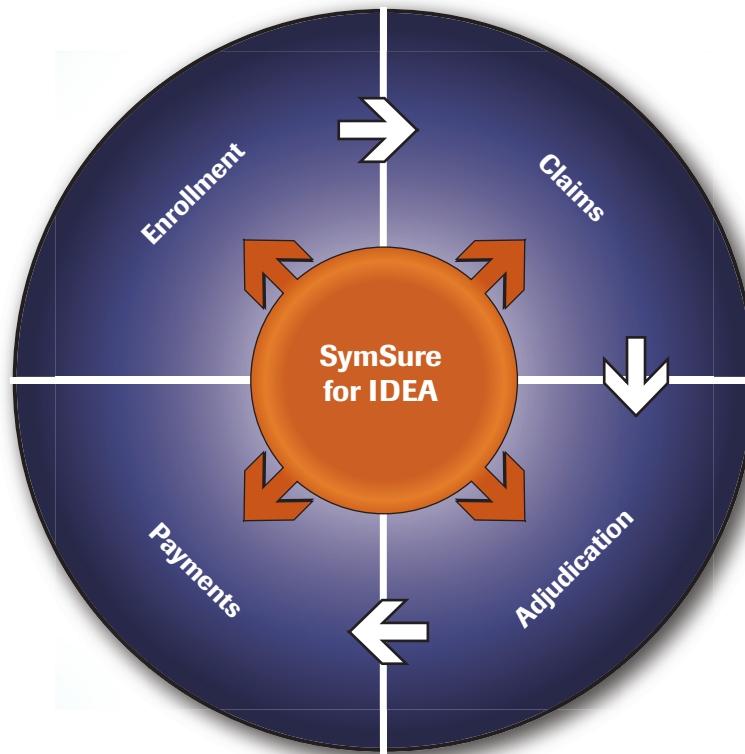
Every \$2 million invested in fighting health-care fraud returns \$17.3 million in recoveries, court-ordered judgments, plus bogus claims that weren't paid and other anti-fraud savings. (National Health Care Anti-Fraud Association, 2008)

SymSure Health Insurance Fraud Monitoring

The solution employs a combination of business rules and predictive analytics to detect fraudulent claims. SymSure for IDEA integrates seamlessly requiring no changes to existing business systems in the organization.

All claims are examined against business rules in addition to advanced analytics to detect anomalies. As depicted in Figure 1, alerts are generated and distributed to the business process owners covering all stages of the process, from enrollment to payment.

Figure 1 – Health Insurance Fraud Monitoring Process



SymSure for IDEA Workflow and Testing

When suspicious activities are detected relevant alerts are triggered and a stringent remediation process is followed to ensure that high risk activities are addressed as stipulated by the business process owners.

Other key aspects of the solution are the automation of reporting and visualization of the control environment. SymSure for IDEA automates key reporting for stakeholders, including statutory and regulatory bodies.

Standard dashboards are included in the framework:

- Trending of results across dates
- Grouping by risk ranking
- Grouping by status (new, pending, overdue, etc.)
- Comparisons across processes and users

Enrollment

Unauthorized changes to Adjudication limits.

Identify duplicated members and dependents.

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Invalid dependent(s) such as multiple spouses attached to the same member.

Claims Submission

Claims that are split to bypass adjudication Limits.

Incomplete claim information submitted but being processed for payment.

Changes in claim details after the initial claim is made.

Claims entered by unauthorized users.

Claims approved for payments that exceed thresholds.

Doctor visits exceed threshold in period.

Identify duplicated electronic, outsourced or internally keyed claims.

New claims from suspended providers.

Claims for major medical procedures within 12 months of enrollment for persons without previous coverage.

Identify claims with future dated or very old service dates (without received dates entered).

Adjudication

Identify claims for gender specific procedures and diagnoses for possible miscoding.

Identify claims for age specific procedures and diagnoses for possible miscoding.

Identify unreasonable increases in provider claims by periodic analysis.

Frequent prescriptions for legal narcotic drugs.

Identify multiple subscriber surgical claims for the same procedure.

Identify prescriptions without doctor visits.

Payments

Identify claims paid for groups with premiums owing.

Late claims approved for payment.

Identify overpayment of claim based on business rules.

Assess fee schedule items setup to determine if claims are paid in excess of the maximum amounts or percentages.

BENEFITS

BUSINESS CHALLENGE

SYMSURE FOR IDEA SOLUTION

STAKEHOLDERS' REQUIREMENTS

Escalating risk and compliance requirements

- Provide enterprise-wide definition and monitoring of controls and assurances that they are effectively implemented across all business processes

AUTOMATION

Automating control breach detection and remediation

- Detects breaches at the data source
- Distributes results across the enterprise by user-defined rules via dashboards, e-mail, SMS
- Provides workflow for remediation including automatic detection of resolution of errors
- Allows the user to define controls in multiple business processes with a consolidated view
- Increases efficiency by making analytics repeatable with the ability to adjust tolerances
- Business rules and parameters are customizable and new logic can be built by the organization
- Monitoring can also be applied to business metrics
- Issues are identified as soon as they occur

INTEGRATION

Seamless integration into existing solutions

- No changes required to underlying systems being monitored
- Non-intrusive access to data and cannot amend source data
- User and group security with LDAP support
- Strong encryption

PROCESS OPTIMIZATION

Make the process more efficient and less costly

- Issues detected more timely
- Lower recovery costs
- Greater level of automation
- Compliance and other reporting automatically generated
- Knowledge and expertise captured in the control systems and made repeatable



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