



Bfsi

FRaud Claims Detection

Health Insurance



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**Scope and Objective of Health Insurance Fraud**

Scope of Health Insurance Fraud

Increase in number of fraudulent events in health insurance, rise in number of patients opting for health insurance, and rise in pressure to keep track of fraud & abuse in health insurance spending are projected to drive the global health insurance fraud detection market in the next few years.

Provider Fraud is one of the biggest problems facing Medicare. According to the government, the total Medicare spending increased exponentially due to frauds in Medicare claims. Healthcare fraud is an organized crime which involves peers of providers, physicians, beneficiaries acting together to make fraud claims.

The global health insurance fraud detection market is highly fragmented with major manufactures implementing various strategies to gain maximum market share in health insurance.

Healthcare fraud and abuse take many forms. Some of the most common types of frauds by providers are:

a) Billing for services that were not provided.

b) Duplicate submission of a claim for the same service.

c) Misrepresenting the service provided.

d) Charging for a more complex or expensive service than was actually provided.

e) Billing for a covered service when the service actually provided was not covered.

f) Claims made shortly after the Policy inception

g) Serious underwriting lapses observed while processing a claim

h) Insured overtly aggressive in pursuit of a quick settlement

i) Willing to accept small settlement rather than documentation all losses

j) Documents of doubtful nature

k) Insured behind in loan repayment

l) Accident un-witnessed and not promptly reported

m) Invisible injury

n) High value leakage claims without any known casualty.

According to a recent survey, it is estimated that the number of false claims in the Industry is approximately 15% of total claims. The report suggests that the Healthcare Industry in India is losing approximately Rs.600-Rs.800 crores incurred on fraudulent claims annually. Health Insurance is bleeding sector with very high claims ratio. Hence, in order to make Health Insurance a viable sector, it is essential to concentrate on elimination or minimization of fake claims.

Objective of Health Insurance Fraud

Rigorous analysis of Medicare data has yielded many physicians who indulge in fraud. They adopt ways in which an ambiguous diagnosis code is used to adopt costliest procedures and drugs. Insurance companies are the most vulnerable institutions impacted due to these bad practices. Due to this reason, insurance companies increased their insurance premiums and as result healthcare is becoming costly matter day by day.

The goal of this project is to **" predict the potentially fraudulent providers "** based on the claims filed by them. Along with this, we will also discover important variables helpful in detecting the behavior of potentially fraud providers. further, we will study fraudulent patterns in the provider's claims to understand the future behavior of providers.