Health Provider Fraud Detection (Damayanti Naik)

How Medicare can improve its fraud detection accuracy on claims from Health care providers by 10% building a model based on Beneficiaries' profiles, health status, Insurance details, diagnostics/procedures carried out on them and claims filed by the provider.

1 Context

Medicare, US Federal Government Health plan for ederly people receives many fraudulent claims from health care providers. This leads insurance companies to increase their premiums, making medical care highly expensive. Data based fraud detection models can discern the indulged personnels, so to improve the detection accuracy by 10% a model will be built and deployed.

2 Criteria for success

The efficiency of the prediction algorithm will be at least 95% and completed by the end of the 2021.

3 Scope of solution space

An algorithm will be developed, based on the data available and deployed in Medicare Fraud detection system.

4 Constraints within solution space

Physicians' and Health care providers' details are missing from the dataset.

5 Stakeholders to provide key insight

1. **Head of Medicare Fraud detection group**
2. **Employees in the Medicare Fraud detection group**
3. **Medicare card holders**

6 Key data sources

Datasets containing details of Medicare beneficiaries (i.e Medicare card holders), claim details, diagnosis/procedure codes, Physicians, states, races and counties.