Internship Training

At

VIPUL MEDCORP TPA PRIVATE. LIMITED

To Study and Analysis the Frauds during Claim processing in TPA

By

Dr. Aakesh Waghe

PG/13/081

Under the guidance of

Dr. Rashmi Yadav
Sr. Manager – Business Development
Vipul MedCorp TPA Private Limited

Dr. Anandhi Ramachandran
Professor
IIHMR, New Delhi

Post Graduate Diploma in Hospital and Health Management

2013-15

International Institute of Health Management Research

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COMPLETION OF DISSERTATION

The certificate is awarded to

Dr. Aakesh Waghe

In recognition of having successfully completed her

Internship in the department of **Marketing and Networking**

And has successfully completed his Project on

To Study and Analysis the Frauds during Claim processing in TPA

30th April 2015

VIPUL MEDCORP TPA PRIVATE LIMITED

He comes across as a committed, sincere & diligent person who has a strong drive & zeal for learning

We wish him all the best for future endeavours.

Training & Development **Zonal Head-Human Resources**

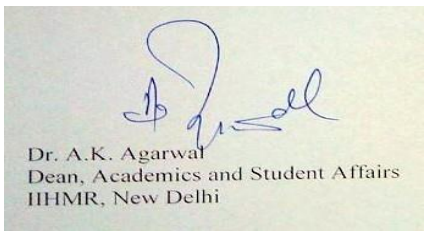
TO WHOMSOEVER IT MAY CONCERN

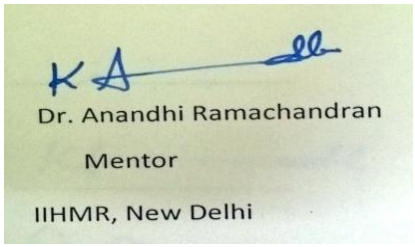
This is to certify that Dr.Aakesh Waghe student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at VIPUL MEDCORP TPA PRIVATE LIMITED from 2nd January 2015 to 30th April 2015.

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfilment of the course
requirements.

I wish him all success in all his future endeavours.





Certificate of Approval

The following dissertation titled "To Analysis Market for TPA services

And Developed Network for New branch"

at **"VIPUL MEDCORP TPA PRIVATE LIMITED"** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
_____	_____
Dr. Anandh Ramachandran	
Name	Signature

Certificate from Dissertation Advisory Committee

This is to certify that **Dr. Aakesh Waghe,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision.

He is submitting this dissertation titled

"To Study And Analysis The Frauds During Claim processing in TPA "

at "VIPUL MEDCORP TPA PRIVATE LIMITED." in partial fulfilment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management.**

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Dr. Anandhi Ramachandran	Dr. Rashmi Yadav
Professor	Sr. Manager – Business Development
IIHMR, New Delhi	Vipul MedCorp TPA Private Limited

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH,

NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "To Study and Analysis the Frauds during Claim processing in TPA "

and submitted by Dr. Aakesh Waghe

Enrolment No. PG/13/081

Under the supervision of Dr. Anandhi Ramachandran

For award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 2nd January 2015 to 30th April 2015

Embody my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Signature

FEEDBACK FORM

Name of the Student:

Dissertation Organisation:

Area of Dissertation:

Attendance:

Objectives achieved:

Deliverables:

Strengths:

Suggestions for Improvement:

Signature of the Officer-in-Charge/ Organisation Mentor (Dissertation)

Date:

Place:

To,

Dr. A.K. Agarwal

Dean, Academics and student affairs

IIHMR, New Delhi

CC: Dr. Anandhi Ramachandran

UNDERTAKING

Vipul Medcorp TPA Private Limited has asked me to sign the 1 year employment bond in lieu of signing dissertation certificate, feedback forms, using their name, data and symbol of company in dissertation report on 15th May 2015 after completion of dissertation period and signing bond was not part of initial contract of employment.

Because of personal constraints, I am unable to sign the bond hence report does not contain any dissertation certificate, Feedback form and confirm that dissertation report only include the hypothetical data and names.

Request you to please acknowledge the same.

Regards

Aakesh Waghe

Student

PG/13/081

Noted. 19/5/2015

ACKNOWLEDGEMENT

"The journey is more important than the destination. Excellence is a journey not a destination"

To traverse on the virtuous path of excellence, it required a great passion to pursue the performances of my desire and the path was illuminated by many a person of importance to whom I owe whatever I have been able to accomplish.

I would like to convey my heartfelt gratitude to **Mr. Rajan Subramanium, CEO, Vipul Med Corp TPA Pvt. Ltd** who is a visionary and it was his idea that had bloomed into this project which had been assigned to me. I would also like to thank **Ms. Rashmi Yadav, Sr. Manager Business development, Vipul Med Corp TPA Pvt. Ltd** who had been there to guide me all along the course of completion of the project.

I would also like to pay my sincere thanks to **Mr. Om Prakash, Mr. Niranjan Kulkerni,**

Mr.Swetaketu, Dr. Amit Garg who had been beside me at all times with his inspiring guidance and overwhelming support during all phases of the project.

Moreover, I'd like to thank **Dr. Sabbyasachi Muzander, Assist Manager – Corporate** and I'd like to thank the entire senior and Junior Residents of the Department of Network, Administration, HR, Accounts and all others who have contributed immensely in my project.

I would like to bow down my head in front of the Almighty for his invisible hand always behind my destiny.

Finally, I'd like to acknowledge my mentor **Dr. Anandhi Ramachandran, Assistant professor, International Institute of health Management Research, Delhi** for giving me guidance and also to my parents and family, who had been there always for me with all the support I required.

I owe this project to you all……

TABLE OF CONTENTS

Organization profile of Vipul Med Corp TPA Pvt. Ltd

Vipul Medcorp TPA Pvt. Ltd , a company promoted by Vipul group is engaged in the managed healthcare facilitation and has obtained a license from IRDA for TPA activities(health) and offers its clients a wide array of services and product in following area:

- Third Party administration (health) services (TPA)
- Claims Handling, Management & Back Office operations
- Health care Assistance services
- Outpatient health care facilitation & management
- Tailor made insurance product
- Second medical opinion
- Cost containment services
- Preferred Service Provider (PSP) Networks
- Evacuation Services

Vipul Med Corp TPA is promoted by Vipul group of India, a diversified business group having presence in Automobile Dealerships. Real Estate, Information Technologies, Smart Card related services and in Health and wellness domain.

Vipul Motors Ltd is the 3rd largest dealers of Maruti car in India with approx sales of 10,000 cars per annum and an annual turnover of approx 300 cr. It operates dealership in Faridabad, Noida, Gurgoan and Jaipur with workshop and repair centers. It has been ranked 129th amongst Indian companies in 2003, by business standard magazine (Jan 2004).

Vipul Infrastructure Developers Ltd. Is engaged in real estate development projects covering residential, commercial complexes, shopping malls and hotels. Some of the project executed / undertaken company:

- Orchid Square
- Orchid Plaza
- Orchid Agora
- Global Fortune Hotels
- Orchid Floors/ Gardens(residential schemes)

Vipul Medcorp TPA – Product Vision

- To increase medical care capacity
- To augment the existing product / service
- To provide the client with 24 hrs. Service
- To provide one stop shopping for all medical needs
- To resolve the medical problem in a fast, efficient and convenient manner(improve employee productivity)
- To combine medical services with tailor made insurance products and offer cash less services
- To render cost containment services to our client on their medical claims
- To offer total health and intermediary insurance and administrative solutions.

Promoters & Management

Promoters - Vipul Med Corp TPA Pvt. Ltd has been promoted by Vipul Group. Vipul Group consisting of Vipul motors Ltd., Vipul Infrastructure Developers Ltd is promoted by Mr.Vinit Beriwala and Mr. Punit Beriwala, third generation entrepreneurs. The promoters have a long-term vision of providing complete health and medical insurance product to the largely untapped Indian population.

Management - The company has appointed, Mr.Rajan Subramanian, a management graduate and a qualified insurance professional, as its CEO. He has wide experience in the TPA industry and is assisted by qualified professionals from the field of insurance and healthcare.

Infrastructure

Headquartered in Gurgoan with branch offices in New Delhi, Noida, Faridabad, Brindavan, Cochin, Jaipur, Mumbai, Kolkata, Bangalore, Chennai and Pune.

Medical Network of over 6000 + hospitals/Nursing Homes.

Operates a 24/7 Assistance Centre. Tailor-made software developed in-house with full web-based access for Claims Tracking, On-Line Access and Querying.

Professional manpower presenting our clients with benefits derived from our knowledge & experience of the medical network, TPA & Insurance fields.

- At the above places, Vipul MedCorp TPA / Vipul Group have offices / facilities that are fully geared up to provide TPA services. Apart from above all leading cities like Chandigarh, Lucknow, Pune, Ahmedabad, Hyderabad and Chennai will have resident representative / doctor retainer for servicing the insured.
- Cashless services will be given at over 200 cities all over India. Vipul MedCorp TPA is in the process of empanelling over 2000+ Medical Providers in its network, which would be the largest amongst TPAs

Products & Services

Vipul MedCorp TPA Pvt. Ltd. TPA Services:

Our service professionals deploy innovative technology and best practices to manage the administration of your health insurance policy. We endeavor to become a comprehensive and complete source for health and mediclaim

administration and management for the insured as well as the insurer. Our corporate services team have expertise in managing administration during open enrollment and throughout the plan year, notifying employees of their benefits, changes, and ensuring that related systems receive accurate data. Our in house systems team has build a full-service record keeping and administration platform tailored to suit health insurance requirements across all levels of clients. All the above can be offered online through web-based access. At the moment the following services are offered to the clients :

1. **Services:**

- Cashless medical service facilitation at network hospital up to the limit authorized by mediclaim/hospitalization Insurance
- Claim processing & reimbursement, for non-network hospitals
- Computerized Medical History records
- Online assistance to Insured during hospitalization & filing of claim documents
- Hospitals/ nursing Homes all over India

2. **Service Level Agreements:**

We at Vipul MedCorp TPA are a group of professionals dedicated to our mission of providing excellent services to our clients (Corporate as well as Retail). For deliverance of services the SLA (Service Level Agreements) are in place, which would be signed with various Insurance companies and the corporate groups. These broadly define the Turn around Time (TAT) for the deliverance of the following services:

3. **ID Cards Printing and Dispatch**

   Vipul MedCorp TPA TAT for the Delivery of cards is within seven (7) days of the receipt of the complete data of insured members and the details of the policy from the insurance company

4. **Cashless Authorization / Rejection**

   a. Cashless authorization requests are to be scrutinized and the decision of acceptance or rejection is to be conveyed to the service provider within 24 hrs. of the receipt of the Pre Hospitalization Authorization Form.

   b. In case where a query has been raised the query has to be satisfied by the concerned party and the authorization will be given within 24 hrs. of the receipt of the reply.

5. **Claims Settlement / Reimbursement**

   a. Turnaround Time (TAT) of settlement of reimbursement claims is generally upto 15 days and subject to full documentation compliance.

6. **Customer Grievance Redressal**

   a. TAT for response is max. 2 working days, for any queries or grievance raised by the client.

7. **Call Center Responses**

   a. Vipul MedCorp TPA operates a 24 * 7 / 365 days Call center to provide instant accessibility to the clients for all information required for medical services facilitation and claims status.

8. **MIS Reports**

   a. Weekly/ Monthly MIS are prepared for the following:

      i. Claims Paid /Outstanding

      ii. Premium Collection

iii. ID Cards Processed & Dispatched

iv. Special reports annually for disease wise analysis, total age wise claim incidences etc.

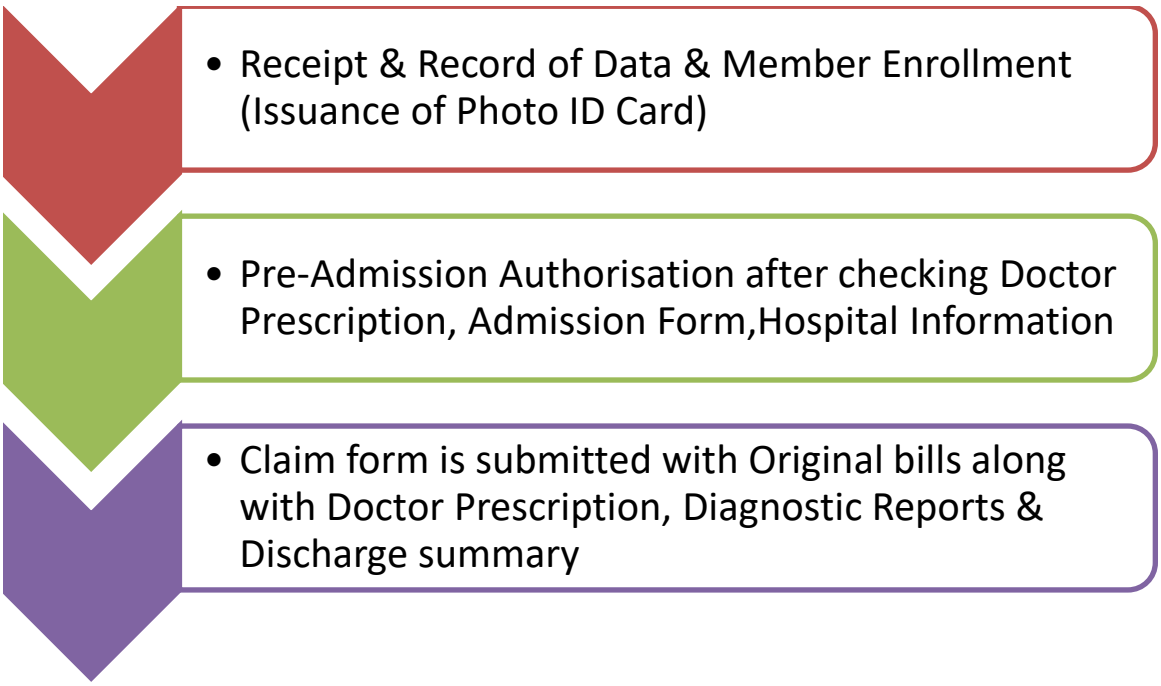
9. **Adequate Coverage of Network Hospitals**

   a. Providing a comprehensive coverage of network hospitals at all locations of client operations.

Vipul MedCorp TPA has service level agreement for all the above-defined parameters and the same can be incorporated in the client agreement.

Claim Management & Control

Cashless Facilitation Procedure



Claim Reimbursement

When Cash Less Facility is not accorded or Insured goes to a Non Network Hospital then following documents are required :

- Claim Forms
- Original bills with Diagnostic reports
- Doctor's First prescription
- Discharge summary/certificate

Claims Control

- Original Bills are verified & scrutinised against Standard Discounted Tariff
- Cost Containment by Medical procedure audit & Bill scrutiny
- 2nd Medical opinion taken for complicated cases

- Reprising done on case to case basis.

Cost Containment

Cash Less medical services lead to: :

- Bill Scrutiny before release of payment
- Discounted Rates
- Eliminates Reimbursement Frauds
- Medical Procedure Audit / Elimination of unnecessary prescriptions
- Case Management

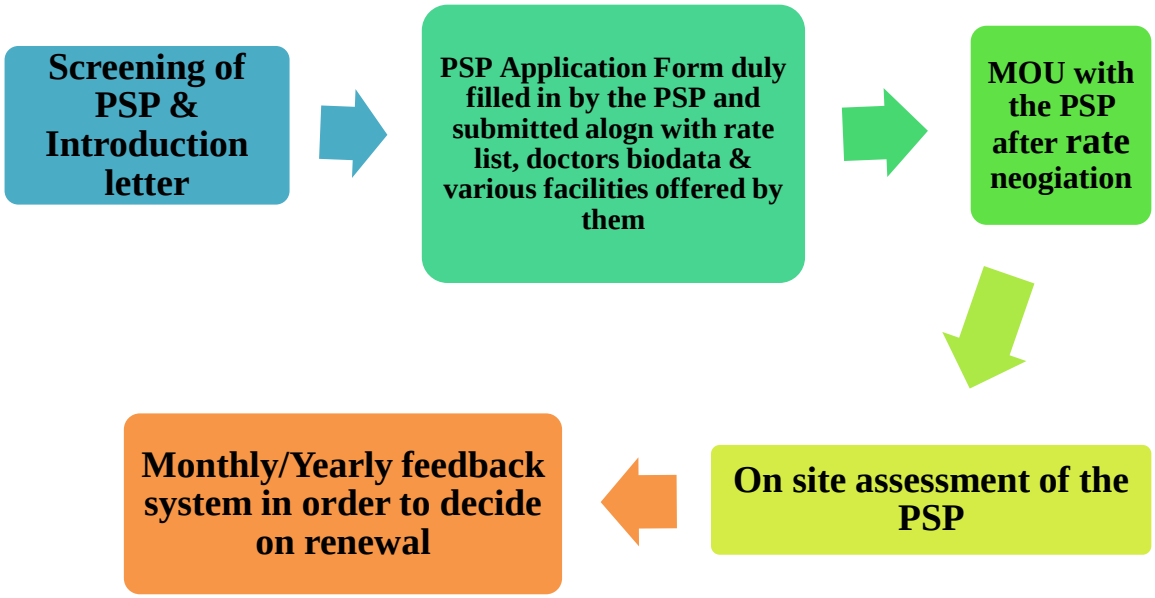
All the above leads to Cost Containment and lowering of Claims/Premium Ratio

Network Provider Accredition Norms

Vipul MedCorp TPA has shortlisted hospitals and Nursing Homes as per the minimum norms prescribed under Mediclaim Policy, that is:

- Hospital / Nursing Homes established for Indoor Care / Treatment of sickness & Injuries
- Either registered as a hospital or nursing home with local authority and under supervision of registered & qualified medical practitioners, OR, Should have at least 15 IP beds [10 beds in class C town]
- Fully equipped OT, wherever surgical procedure is carried out
- Fully qualified Nursing Staff – round the clock

The steps involved in our empanelment process are the following :



While empanelling a PSP, we also look at the following criteria :

- Infrastructure & Facilities available
- Quality of Service rendered
- Patient care background
- Bed-strength and availability
- Management background and past track record
- IT Infrastructure / Computerization

Key learning

AREA OF ENGAGEMENT

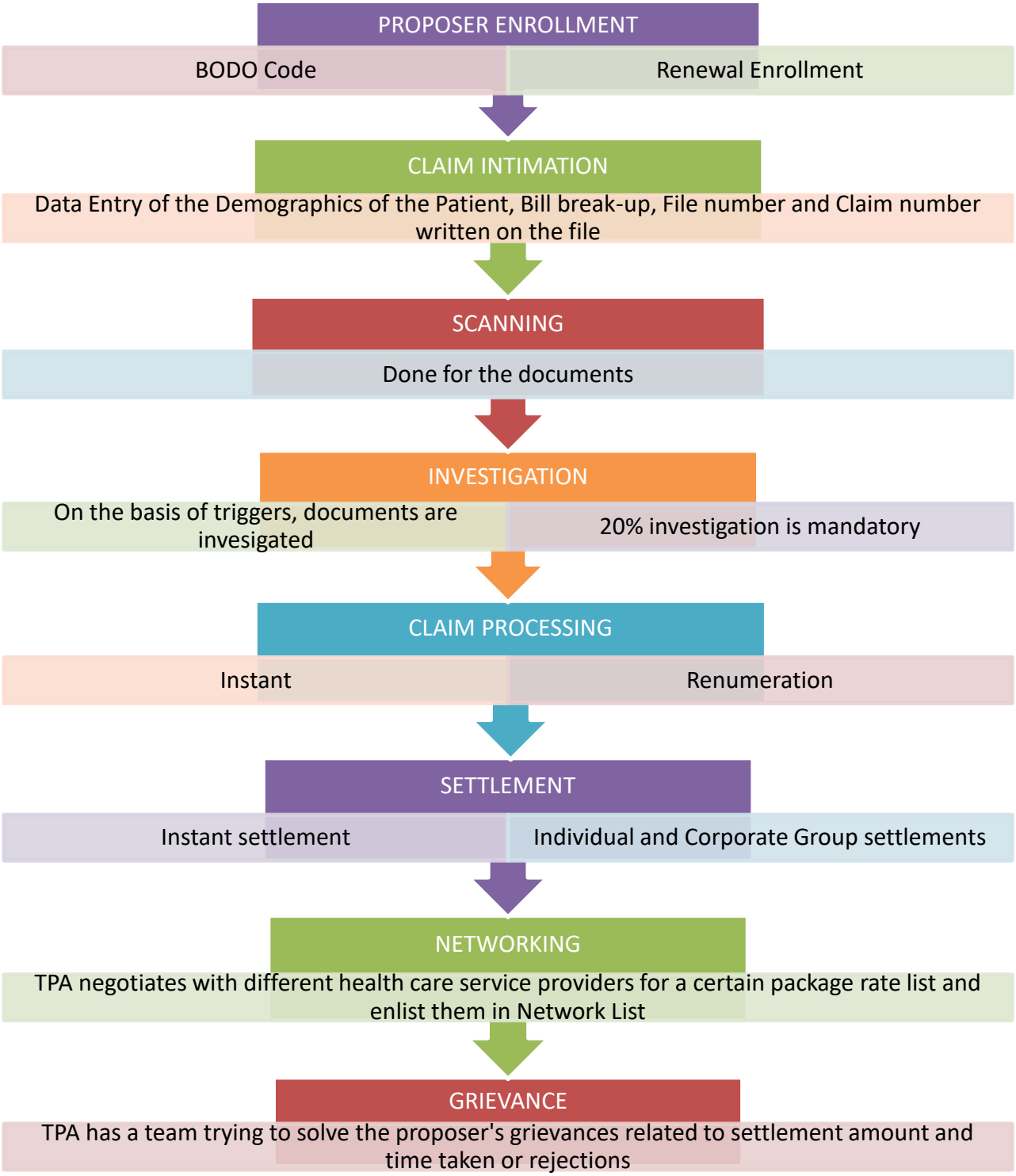
The area of engagement during the internship period was in Data analysis and network sub-department under the Operations department. The internship phase was divided in to two phases-

Undergoing training for the complete workflow:

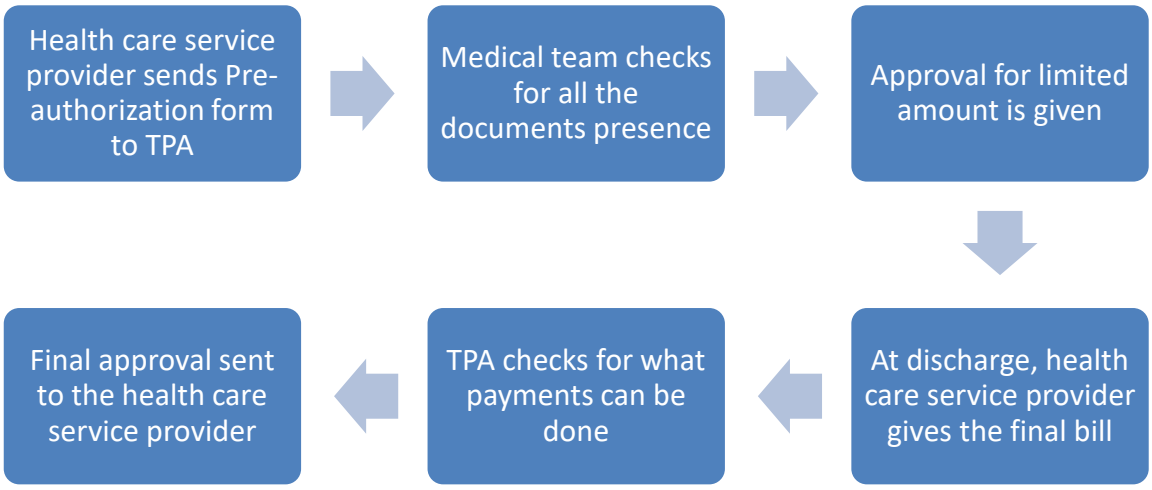
For the organization to settle all the claims on time and without disturbing the good relations with the clients there is a workflow which has to be followed by the organization employees. In the first week of the joining, training was held to get the knowledge of the complete workflow which is as follow:

a. PROPOSER ENROLLMENT
b. CLAIM INTIMATION
c. SCANNING
d. INVESTIGATION
e. CLAIM PROCESSING
f. SETTLEMENT
g. NETWORKING
h. GRIEVANCE

ORGANIZATIONAL WORKFLOW



CASHLESS FLOW CHART



ENROLLMENT PROCESS

Enrolment is the first step in the policy process.

Policies can be claimed:

1. By Executives
2. Through E-mails
3. Through courier

BODO Code: Each office has a unique code with respect to the insurance company under which the policies will be documented.

Cards are been provided to the insurers. The card numbers have different codes for each insurance company and each claim is been initialized with different codes, specified for the insurance company and the relation with the proposer.

The docket and the enrolled policy date is searched in the system.

Renewal enrolment s done with the purpose of renewing the policy before the expiry date of the policy and is extended to 15 days.

CLAIM INTIMATION

Documents are received from the hospital, in case of Instant and from the proposer, in case of Remuneration. Data entry is done which includes demographics, bill break-up where individual bills are entered in system.

Instant- Payment is directly done to the hospital.

Remuneration- Payment is done to the insured person.

SCANNING

After the intimation, documents are scanned.

Documents to be scanned:

1. Discharge Summary
2. Claim Form- for what the proposer is claiming
3. Scanned Bills
4. Payment receipt

INVESTIGATION

Usually, in Instant cases TPA are directly in contact with the health care service providers, forging is almost impossible but in the case of Remuneration cases, fraudulent cases are common.

Tariff rates in each hospital are different for insured people.

There are two types of fraudulent cases:

1. Soft- Patient is admitted and hiding his history or inflation done.
2. Hard- Patient is not admitted.

If health care service provider is non-cooperative, then it is given as non-compliance.

But there is a clause that anything, anytime documents can be asked from the health care service providers by TPA.

In case of Red flag hospitals, investigation is done at the time of inflation.

Remarks are written and discussed.

Claim Processing

Instant Claims: Photo ID, Age, Diagnosis, Payable or not are checked. If any document is missing, then query is sent. Approval is given to the hospitals and non-payable is paid by patients.

All documents that are actually payable are sent to TPA. Payment is released.

TPA PAYS ONLY FOR HOSPITALIZATION OF PATIENT.

Criteria:

- Hospital has to be registered for the functioning
- Bed criteria is seen
- **Section 4.1 Pre-existing Disease**

In Cashless, previous or first prescription that was issued to the patient is required. If in case, patient denies so, IPD records are asked for.

    - Limit of Indemnity- Insurance company will pay for those which 'insurer' are liable for.

- **Section 4.2 30 Days Exclusion**

- Except accident cases, no other cases are considered for claim payment, which is verified by going through X-Rays with the dates on them.

- **Section 4.3 Specific Waiting Period**
    - There are some diseases and cases where a specific period of time is scheduled for the claim amount to be payable.

For example,

1. Claims for calculus disease are paid only after 2 years.
2. Implants are payable only after 60 days of hospitalization.

INTIMATION SUBMISSION

Cashless cases are immediately intimated.

Intimation number is generated.

- **Arbitration Clause**- If your opinion is considered wrong by the insured person, then he will go to the Grievance Department.
- **Reasonable and Customary Expenses**-
    - With new technologies round the world, healthcare has also enhanced. If a claim comes for a robotic surgery, the claim amount is payable or not depends on the reason for the procedure to have taken place.
- **Pre-authorization Form**- Request form from hospital which has to be duly filled by the insured person with his/her details.
- **MLC form has** to be filled by the insurer in cases of drunken accidents.
- **Intentional Self Injury** involves cases with drunken drivers known to the insurer.

- **Claim Form** is filled in Remuneration cases, which has two parts-Part A, to be filled by insurer for their details and Part B, to be filled by health care service provider with the billing details and others.
- **Doctor Noting-** If disease not diagnosed earlier, but in present, then it has to be mentioned.
- **GIPSA Approval-** Claims have to be payable according to the rates the TPA has negotiated with the health care service providers, i.e., according to the package.
- **Conditional Approval-** If the health care service provider is not able to justify the increased package rate, then the patient is given the *conditional approval* to get discharged.

NETWORKING

There are 7000 hospitals in Vipul Medcorp TPA Pvt. Ltd. network.

Process of empanelment is taken in control by Networking Team.

Criteria for empanelment:

- MOU- Memorandum Of Understanding
    - Health care service provider name (with 12 articles)
- PSP Form- Preferred Service Provider Form
- Parameter Form- includes details like number of beds, type of rooms, etc.
- SOC-Schedule Of Charges , also known as Tariff or Rate List
- PAN Card copy-required for transaction
- Cancelled Cheque Copy-required for transaction

REFLECTIVE LEARNINGS

Vipul Med Corp TPA Private Limited as an organization provides an individual with the platform to learn in the tasks they are involved with. During the entire duration of internship, there has been a lot of individual learning's from the organization. Also the experience of the mentor has been very useful for knowledge transfer.

Some of the learning's during the internship are as follows:

- To create network or empanelment with Hospital for cashless facilities.
- To create network for LVGIC and Bharti Axa General insurance.
- To create network for Medhealth cliniq.
- To create network with all health insurance brokers for corporate business.
- Investigating the non networking hospital to avoid frauds during claims and reimbursement.
- To set up a new branch with the help of all legal documents and infrastructure required for the office.
- To negotiate with local vendors and brokers for purchasing office areas and office items
- To conduct weekly or monthly Health camps like Dental camps, Eye camps and Health talks session etc for corporate clients.
- To conduct help desk twice in a week for corporate clients for their health insurance query.
- To create awareness about OPD wellness services provided by our company to our providers and clients.

Introduction to Study

India's insurance and TPA industry is working toward reducing costs, one of its main focus areas to control or reduce costs is by proactively arresting fraud. Fraud is a significant issue that must be address by all insurance and TPA companies. Insurance fraud can pose a serious risk for insurance companies and may result in additional cost for their policy holder.
There is a growing concern among the insurance industry about the increasing incidence of abuse and fraud in health insurance. It is very necessary to reduce the frauds. For an TPA organization, its fraud management strategy should form part of its business strategy and be consistent with its overall mission and objectives
Fraud impacts organizations in several areas including financial, operational, and psychological. While the monetary loss owing to fraud is significant, the full impact of fraud on an organization can be staggering. The losses to reputation, goodwill, and customer relations can be devastating. As fraud can be perpetrated by any employee within an organization or by those from the outside, it is important to have an effective fraud management program in place to safeguard your organization's assets and reputation.

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 willful and deliberate, involve financial gain, done under false pretences And is illegal.

Frauds are an intentional perversion of truth for the purpose of obtaining some valuable thing or promise from another. when this happen in insurance it is also beach of trust. The international Association of Insurance Supervisors (IAIS) define frauds as an act or omission

intended to gain dishonest and unlawful advantage for a party committing the fraud or for other parties, this may example , be achieved by mean of

- Misappropriating assets
- Deliberately misrepresenting, concealing, suppressing or not disclosing one or more material facts relevant to financial decision, transaction or perception of the insurers status
- Abusing responsibility, a position of trust or a fiduciary relationship.

Type of Fraud

Parties involved in health insurance fraud and types of fraud committed by each

IRDA guidelines classify various insurance fraud as under:

- Policyholder Fraud and /or Claims Fraud - Fraud against the insurer in the purchase and/or execution of an insurance product, including fraud at the time of making a claim.
- Intermediary Fraud - Fraud perpetuated by an intermediary against the insurer and/or policyholders.
- Internal Fraud - Fraud / mis-appropriation against the insurer by a staff member.

Commonly committed fraud by a customer of health insurance relate to:

- concealing pre-existing disease (PED) / chronic ailment, manipulating pre-policy health check-up findings

- fake / fabricated documents to meet policy terms conditions,
- duplicate and inflated bills, impersonation,
- participating in fraud rings, purchasing multiple policies,
- staged accidents and fake disability claims

The agents and brokers are usually involved in fraud relating to

- providing fake policy to customer and siphoning off premium,
- manipulating pre-policy health check-up records,
- guiding customer to hide PED/material fact to obtain cover or to file claim,
- participating in fraud rings and facilitating policies in fictitious names,
- channelising customers to rouge providers
- fudging data in group health covers

Provider related fraud usually pertain to:

- Overcharging, inflated billing, billing for services not provided
- Unwarranted procedures, excessive investigations, expensive medicines,
- Unbundling and up coding
- Over utilisation, extended length of stay
- Fudging records, patient history

PROBLEM STATEMENT

- Due to frauds major Loss to insurance companies and TPA companies
- Claim processes turnaround time increase
- Burden on policy holder like increasing the policy premium.

Objective

- To keep a check on fraud case, using triggers check list, so that there is no major business loss within the organization as well as to the clients (healthcare services providers and insurance companies).
- To identify the core factor of Frauds during claims.

Research methodology

The study was conducted in Vipul MedCorp TPA Private Limited. The data collected is secondary data, enrolled by the TPA Enrollment team, which is further being updated by the team of doctors who check the claims for processing. Sampling method has been used in the study to meet the objectives

Sample Design

- Descriptive study

Data Source

- Secondary Data

Duration of Study

- 1st February to 31st April

Data Collection

- 30 days
- Data collected by interviewing investigators and doctors.

Tools use

- Interviews of the key stakeholder
- Fraud Trigger check list (Appendix A)

REVIEW OF LITERATURE

1. Article on Health insurance Fraud by FICCI,

It is a matter of concern that 'insurance fraud' is not defined under the Indian Insurance

Act. IRDA recently quoted the definition provided by 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."

Other instruments within the Indian legal system, such as the Indian Penal Code (IPC) or Indian Contract Act, also do 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. In absence of specific laws and harsh punishments, prosecution will rarely be successful and if successful, the penalty inadequate to deter others. As social health insurance grows the central and state governments will become one of the largest victims of health insurance fraud and that may be the catalyst that leads to the development of a comprehensive legal framework to tackle health insurance fraud.

2. Article on Insurance Industry Road Ahead by Shashwat Sharma.

Data Collection and Analysis

Year	Number of claims processed
2012-2013	204978
2013-2014	209354

For analysis I have collected 3 branch data that is Delhi, Mumbai, Indore.

In year 2012-2013

Branch	Cashless	Reimbursement	Total no.of claims processed
Delhi	36731	10890	47621
Mumbai	12342	8538	20880
Pune	4539	3804	8343

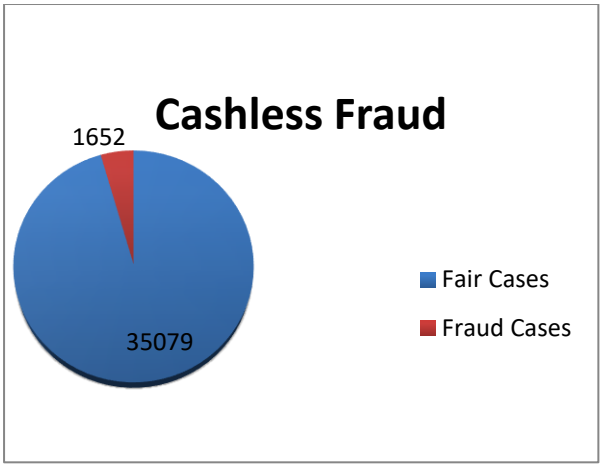
In years 2013-2014

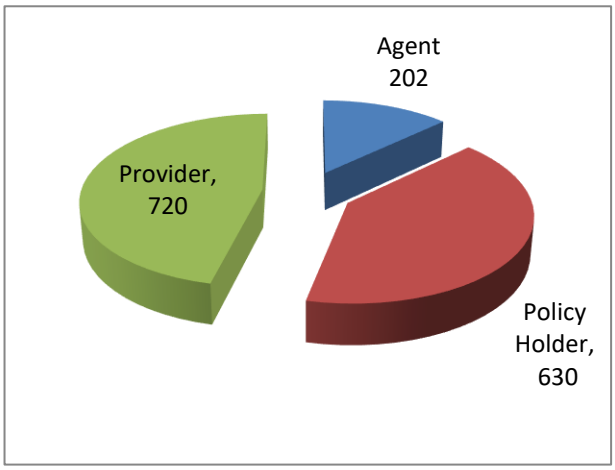
Branch	Cashless	Reimbursement	Total no.of claims processed
Delhi	38475	11158	49633
Mumbai	13453	5749	19202
Pune	5674	3249	8923

Incidence of fraud in 2012-2013 in Delhi branch.

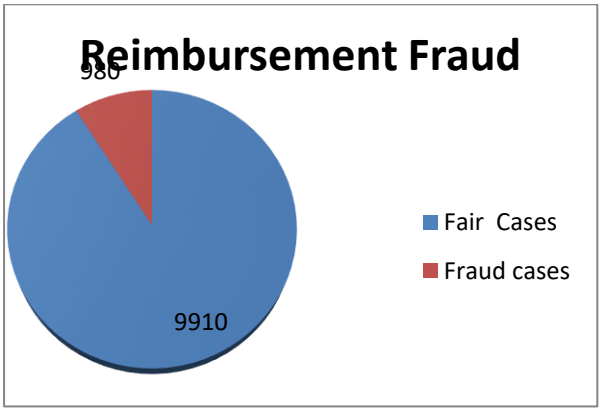
Branch	Cashless	Reimbursement	Total no.of claims processed
Delhi	36731	10890	47621

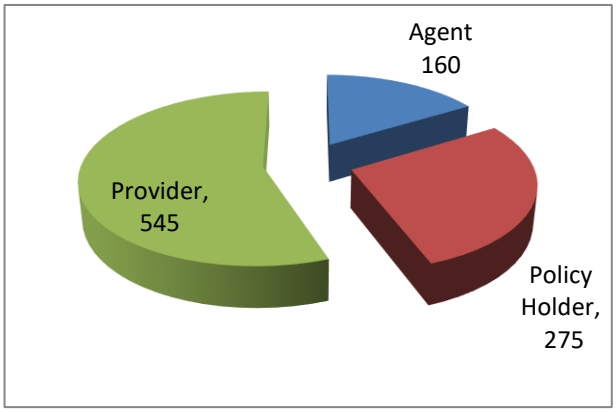
Cashless fraud in Delhi year2012-2013





Reimbursement Fraud in Delhi Year 2012-2013





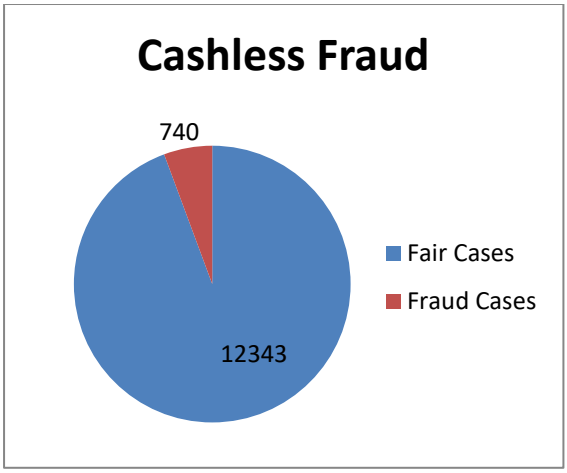
Analysis

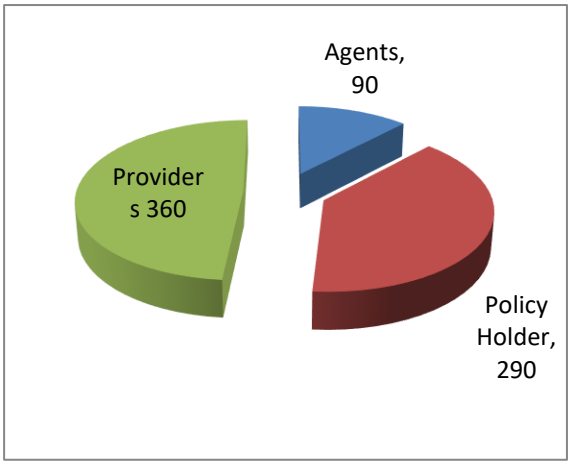
- 4.5 % fraud is deducted in cashless in the year 2012-2013.
- 9 % fraud is deducted in reimbursement in the year 2012-2013.

Incidence of fraud in 2012-2013 in Mumbai branch.

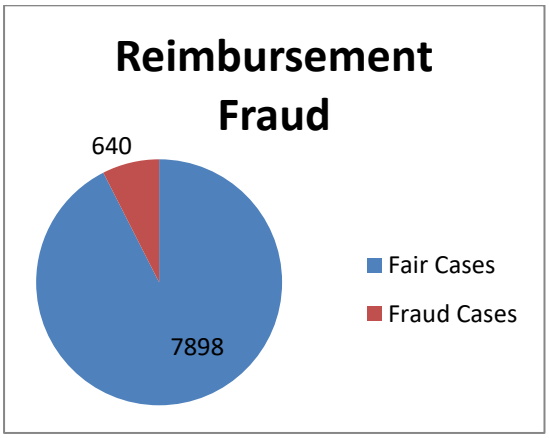
Branch	Cashless	Reimbursement	Total no.of claims processed
Mumbai	12343	8538	20880

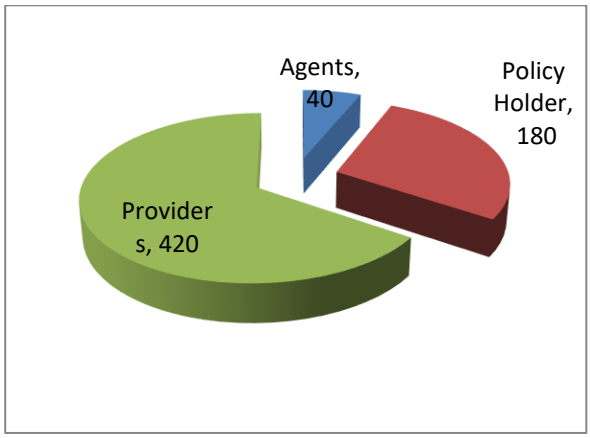
Cashless Fraud in Mumbai year 2012-2013





Reimbursement Fraud in Mumbai Year 2012-2013





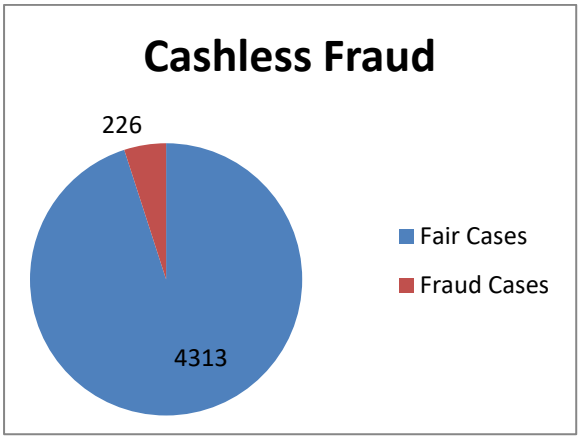
Analysis

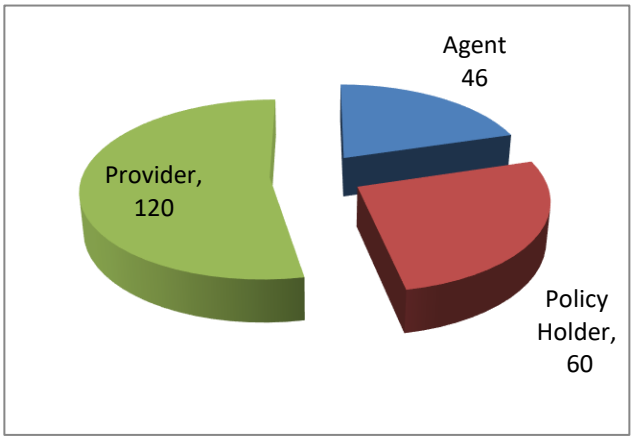
- 6 % fraud is deducted in cashless in the year 2012-2013.
- 7.5% fraud is deducted in reimbursement in the year 2012-2013.

Incidence of fraud in 2012-2013 in Indore branch

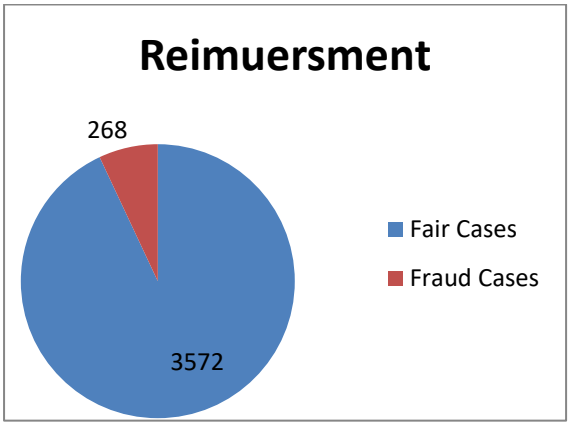
Branch	Cashless	Reimbursement	Total no.of claims processed
Indore	4539	3804	8343

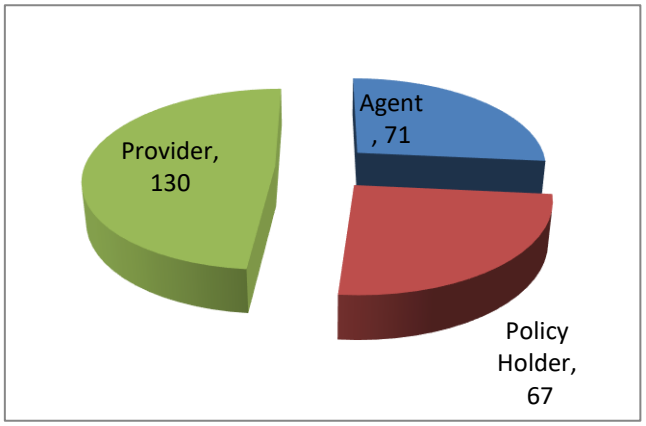
Cashless Fraud in indore Year 2012-2013





Reimbursement Fraud in indore Year 2012-2013





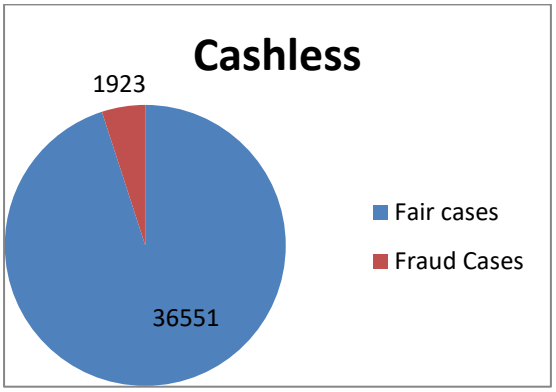
Analysis

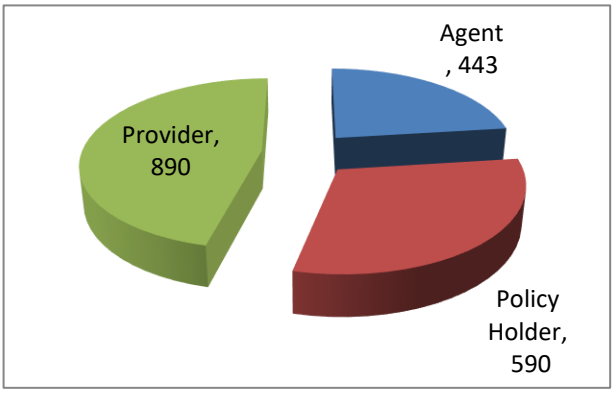
- 5 % fraud is deducted in cashless in the year 2012-2013.
- 7% fraud is deducted in reimbursement in the year 2012-2013

Incidence of fraud in 2013-2014 in delhi branch

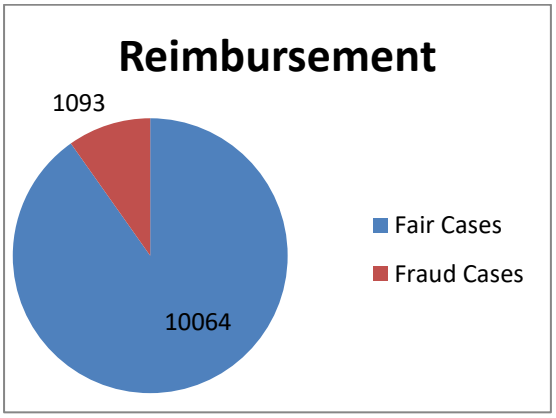
Branch	Cashless	Reimbursement	Total no.of claims processed
Delhi	38475	11158	49633

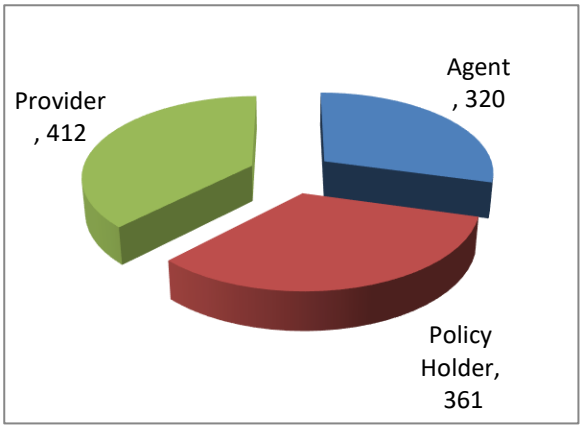
Cashless Fraud in Delhi Year 2013-2014





Reimbursement Fraud in Delhi Year 2013-2014





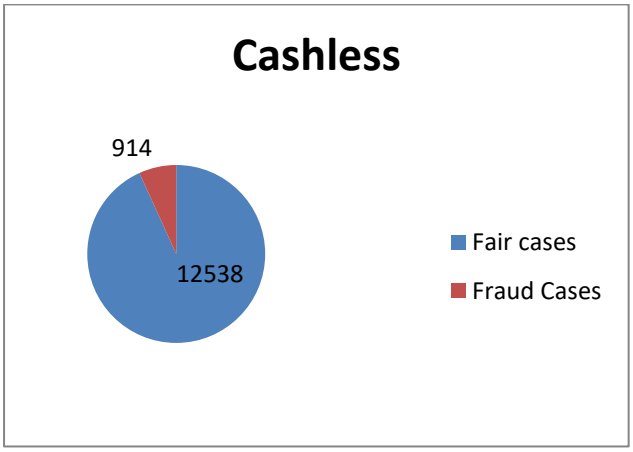
Analysis

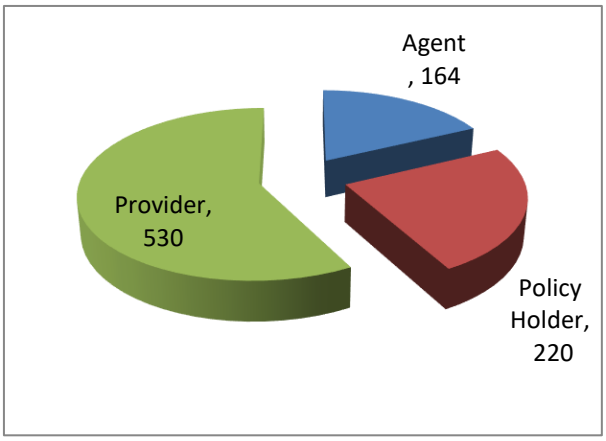
- 5 % fraud is deducted in cashless in the year 2013-2014.
- 9.8% fraud is deducted in reimbursement in the year 2013-2014

Incidence of fraud in 2013-2014 in mumbai branch

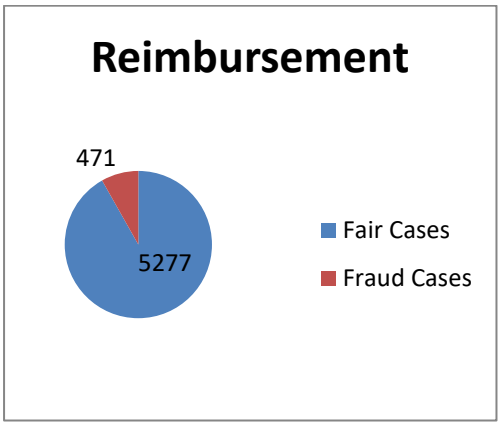
Branch	Cashless	Reimbursement	Total no.of claims processed
Mumbai	13453	5749	19202

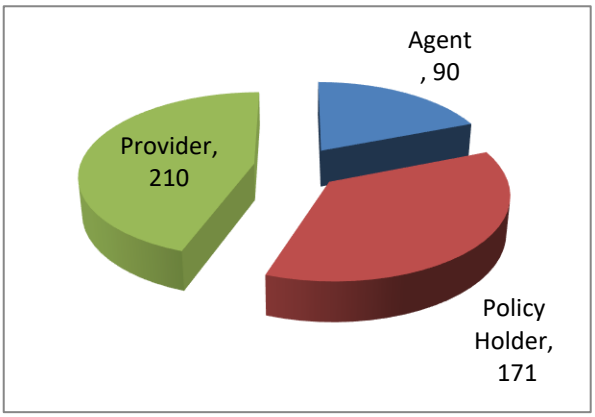
Cashless Fraud in Mumbai Year 2013-2014





Reimbursement Fraud in Mumbai Year 2013-2014





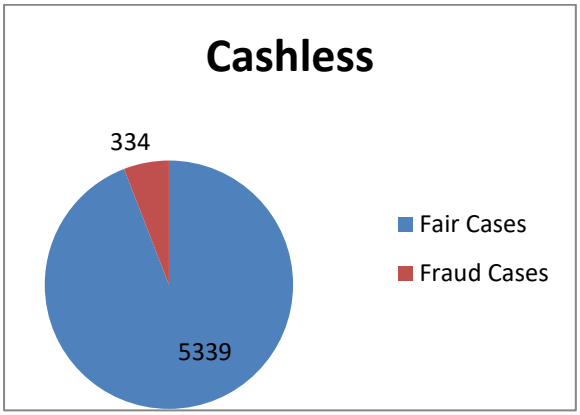
Analysis

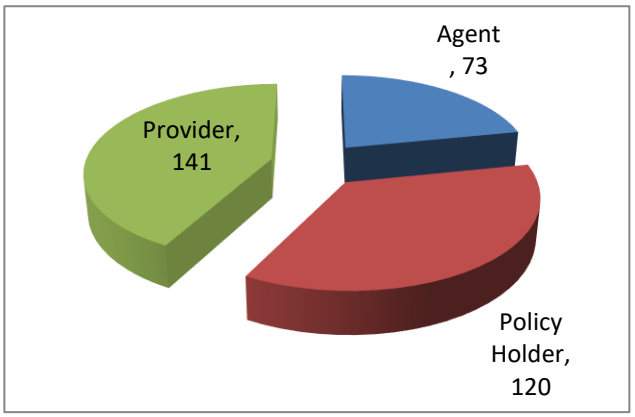
- 6.8 % fraud is deducted in cashless in the year 2013-2014.
- 8.2% fraud is deducted in reimbursement in the year 2013-2014

Incidence of fraud in 2013-2014 in Indore branch

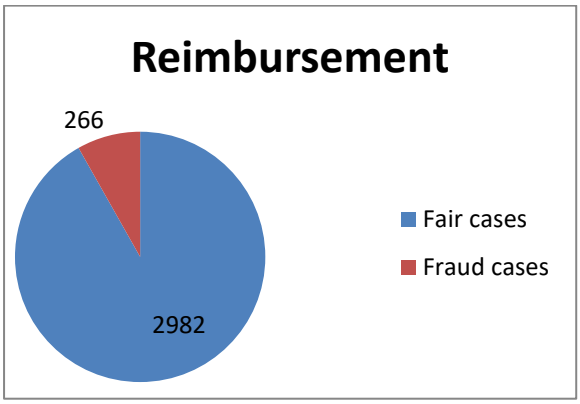
Branch	Cashless	Reimbursement	Total no.of claims processed
Indore	5674	3249	8923

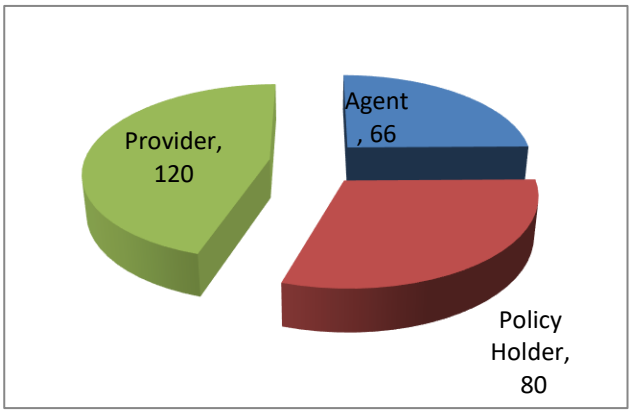
Cashless Fraud in Indore Year 2013-2014





Reimbursement Fraud in Indore Year 2013-2014





Analysis

- 5.9 % fraud is deducted in cashless in the year 2013-2014.
- 8.2% fraud is deducted in reimbursement in the year 2013-2014

Policy Holder /Customer Frauds

Sr. No	Level for Frauds	2012-2013	2013-2014
1	False history at proposal stage to hide PED And secure coverage.	35%	36%
2	Managing medical reports at proposal stage for gaining Cover or reducing premium.	25%	27%
3	Inflating bills manually for genuine treatment.	20%	22%
4	Colluding with provider (hospital) for converting OP to IP Claim.	15%	13%
5	Colluding with provider for fake claim documentation.	5%	3%

Providers

Sr. No	Level for Frauds	2012-2013	2013-2014
1	Inflation in claim cost by various methods	35%	40%
2	Hiding PED ailment	25%	27%
3	Lodging fake claim without customer knowledge based on previous card details		
4	Colluding with agent or corporate group to have a set of insured for lodging fake claims.	12%	23%
5	Offering free OPD to customers with insurance cards and later lodging fake claims on their behalf.	14%	10%

Agents Frauds

Sr. No	Level for Frauds	2012-2013	2013-2014
1	Provide fake policy to the customer and siphoning off the premium amount.	55%	60%
2	Guiding customer to hide PED for getting policy issued.	24%	25%
3	Being part of fraud ring can facilitate policies on fictitious Name and address.	21%	15%

Analysis

The comparison between two years data shows that every year number of fraud incidence increase.

Provider's frauds incidence increase every year

The top level frauds committed by Providers (Network hospital and non network hospital) every year 2% -10 % frauds incidence increase. Inflation in claim cost, Hiding PED ailment, lodging fake claim without customer knowledge based on previous card details are the major cause for frauds by the provider's level.

The second level frauds committed by policy holders / consumers /costumers. Every year 2%-8% fraud incidence increases. False history at proposal stage to hide PED, Managing medical reports at proposal stage for gaining Cover or reducing premium and secure coverage, Inflating bills manually for genuine treatment.

The third level frauds committed by Agents/ brokers. Every year 1%-5% frauds incidence increases. Provide fake policy to the customer and siphoning off the premium amount, guiding customer to hide PED for getting policy issued are the major causes for frauds by the agent/brokers level.

If the frauds cases increases the TAT time will also increase and may cause delay in claim settlement process.

Investigation of claim file

Why to investigate?

- To reduce the Fraud
- To control the claim ratio (ICR)
- To understand the behavior of hospitals in Region
- To identify the adverse claims behavior
- To identify the nexus if between any hospital and agent / client or other intermediary
- To confirm hospital eligibility as per the policy conditions
- To control prolonged hospitalizations and over-billing / over stay
- To identify good hospital who are willing to work on reasonable SOC under TPA network of hospitals
- To synchronize and educate hospitals / patients to utilize the policy in proper manner

Processes of investigation done by the TPA (Third Party Administration). The doctors manly investigated the claim file by using Triggers of investigation then they will decided the claim file is fair or fraud.

LIMITATIONS

- Few Hypothetical data has been used due to the Organization's rules and norms.
- Source for the data cannot be given due to the prior norm for confidentiality by the organization.
- Data available is secondary due to confidentiality norm.

Recommendation

Fraud investigator training program: a structured training program along with mandatory examination, as well as continuing education requirements should be developed for fraud investigators. All fraud investigators must meet a minimum skill set requirement. In addition, there should be a mechanism whereby a fraud investigator can be assessed and certified for higher skill levels. This would create a
cadre of professional and highly skilled fraud investigators. It may be desirable to ensure that these investigators are licensed by the IRDA.

Whistleblower policy (company level): develop a reporting and rewards system that will motivate individuals to alert an insurer about individual cases of fraud or systematic fraud. This can be a very attractive mechanism through which the general population can be engaged in the fight against fraud.

Intimation to insurer or TPA: the first intimation call to the insurer or TPA is a very rich source of information about the status of the policyholder at time of admission. As a result, this intelligence should be used in an optimum manner. The best practice in respect of what information should be sought at the intimation stage to mitigate fraud, should be documented and distributed.dit for stopping it.

Fraud detection tools and technology: By using data analytics processes These function as a kind of early warning system for detecting fraud.

Education: fraud can happen inadvertently and due to ignorance. It is in the industry's interest to create education and awareness collateral that creates awareness about the impact of insurance fraud and its implications.

Registration portal: This portal will be used by providers to enter their details (similar to the one in an empanelment form.) After verification of the details entered by the providers by any one TPA, their details will be added to the common database and a unique provider ID will be issued to the provider.

Autonomous anti-fraud bureau: industry, regulatory and government bodies should support the creation of an independent anti-fraud bureau. They mainly Focus activities can include anti-fraud advocacy, public awareness, dissemination of best practices, education (e.g. case studies, training), centralised services (e.g. fraud hotline, data warehousing.)

Specific laws against insurance fraud: many countries have very specific laws against insurance fraud and occasionally more specific laws pertaining to social insurance fraud.

Anti-fraud public messaging: the regulator and government can collectivelyundertake public messaging which highlights the impact (higher premiums) and consequences (legal action) of insurance fraud. Such campaigns are generally planned as ongoing initiatives which are further enforced by "name & shame"
initiatives. IRDA has run number of campaigns on policy holder education, insurance literacy. Anti-fraud awareness campaigns could form part of IRDA's consumer awareness campaigns.

Defining levels of fraud and potential responses.

Customer- occasionally the customer is the perpetrator of the fraud. Customer fraud are generally soft in nature, unless the customer is a professional claimant who regularly submits false claims.

A. Misconduct - False or suppressed history at proposal stage to hide PED and secure coverage.

Action 1 - Policy cancellation for hiding material fact , without refund of premium

Action 2 - Sharing info to industry to blacklist customer at common Database

B. Misconduct - Managing medical reports at proposal stage for gaining cover or reducing premium. (Annexure 1,2)

Action 1 - Policy cancellation for hiding material fact , without refund of premium

Action 2 - Sharing info to industry to blacklist customer at common database

C. Misconduct - Inflating bills manually for genuine treatment.

Action 1 - Policy cancellation for hiding intentional misrepresentation, without refund of premium .

Action 2 - Sharing information with industry blacklist

Action 3 - Legal remedy, such as FIR on insured

D. Misconduct - Manipulating ailment for seeking coverage not entitled to, for example an excluded ailment is masked as legitimate claim (undergoing hernia in 1st two years of exclusion phase and claiming as acute abdomen or appendectomy).

Action 1 - Policy cancellation for hiding intentional misrepresentation, without refund of premium

Action 2 - Sharing information with industry blacklist

Action 3 - Add to name and shame list

Action 4 - Legal remedy, such as FIR on both doctor and insured.

E. Misconduct - Getting non beneficiary treated under the policy and claimed for self by customer.

Action 1 - Policy cancellation for hiding intentional misrepresentation, without refund of premium

Action 2 - Sharing information with industry blacklist

Action 3 - Add to name and shame list

Action 4 - Legal remedy, such as FIR on both doctor and insured

F. Misconduct - Colluding with provider (hospital) for converting OP to IP claim.

Action 1 - Policy cancellation for hiding intentional misrepresentation, without refund of premium

Action 2 - Sharing information with industry blacklist

Action 3 - Add too name and shame list

Action 4 - Legal remedy, such as FIR on both doctor and insured

G. Misconduct - Colluding with provider for fake claim documentation.

Action 1 - policy cancellation for hiding intentional misrepresentation, without refund of premium

Action 2 - Sharing information with industry blacklist

Action 3 - Add to name and shame list

Action 4 - Legal remedy, such as FIR on both doctor and insured

Provider frauds

Empanelled network provider are have different fraud patterns than non- network hospitals.

A. Misconduct - Inflation in claim cost by various methods

(i) Misconduct - Substituting low cost medicine with high cost brands

Action 1 - Warning with temporary suspension for 3 months from network

Action 2 - Pan-industry suspension

(ii) Misconduct - Getting unnecessary/ unwanted tests done

Action 1 - Warning with temporary suspension for 3 months from network

Action 2 - Pan-industry suspension

(iii) Misconduct - Billing extra number of physician visits

Action 1 - Warning with temporary suspension for 3 months from network

Action 2 - Pan-industry suspension

(iv) Misconduct - Unbundling of procedures and billing them separately

Action 1 - Warning with temporary suspension for 3 months from network

Action 2 - Pan-industry suspension

(v) Misconduct - Increase in length of stay, either pre or post admission, without the knowledge of the customer

Action 1 - Warning with temporary suspension for 3 months from network

Action 2 - Pan-industry suspension

(vi) Misconduct - Upgrading the accommodation category

Action 1 - Warning with temporary suspension for 3 months fromnetwork

Action 2 - Pan-industry suspension

B. Misconduct - Hiding PED ailment

Action 1 - Warning with temporary suspension for 1yr from network

Action 2 - Pan-industry suspension

C. Misconduct - Lodging fake claim without customer knowledge based on previous card details

Action 1 - Permanent de-panelment

Action 2 - Pan-industry blacklisting

Action 3 - Add to name and shame list

Action 4 - Legal remedy, such as FIR on provider

D. Misconduct - Colluding with agent or corporate group to have a set of insured for lodging fake claims.

Action 1 - Permanent dis-empanelment

Action 2 - Pan-industry blacklisting

Action 3 - Add to name and shame list

Action 4 - Legal remedy, such as FIR on provider

E. Misconduct - Offering free OPD to customers with insurance cards and later lodging fake claims on their behalf.

Action 1 - Permanent dis-empanelment

Action 2 - Pan-industry blacklisting

Action 3 - Add to name and shame list

Action 4 - Legal remedy, such as FIR on provider

Provider - non-network providers do not receive a direct payment from the insurer so fraud perpetrated by them usually involves a policy holder.

A. Misconduct - Inflated bill for genuine treatment by adding costlier medicine or increasing length of stay.

    Action 1 - Warning with temporary suspension for 6 months from industry business

    Action 2 - Pan-industry suspension

B. Misconduct - Fake and fabricated claim document on commission basis provided to customer.

    Action 1 - Permanent dis-empanelment

    Action 2 - Pan-fraudindustry blacklisting

    Action 3 - Add to name and shame list

    Action 4 - Legal remedy, such as FIR on provider

C. Misconduct - Being part of fraud ring

    Action 1 - Permanent dis-empanelment

    Action 2 - Pan-industry blacklisting

    Action 3 - Add to name and shame list

    Action 4 - Legal remedy, such as FIR on provider

Agent - are a unique link between customer and insurer and hence can defraud both customer and insurer.

A. Misconduct - Provide fake policy to the customer and siphoning off the premium amount.

   Action 1 - License cancellation

   Action 2 - Across industry blacklisting

   Action 3 - Add to name and shame list

   Action 4 - Legal remedy, such as FIR on agent

B. Misconduct - Guiding customer to hide PED for getting policy issued.

   Action 1 - warning with temporary suspension for 6 months from industry business

   Action 2 - Pan-industry suspension

   Action 3 - Add to name and shame list

C. Misconduct - Being part of fraud ring can facilitate policies on fictitious name and address.

   Action 1 - License cancellation

   Action 2 - Pan-industry blacklisting

   Action 3 - Add to name and shame list

   Action 4 - Legal remedy, such as FIR on agent

CONCLUSION

The future of the health insurance industry Isn`t entirely safe from frauds altogether. As the industry matures, the number of Frauds related risks will also augment. Majorly all the parties (Policy Holder, Agents/ Brokers, Providers) equally involved in frauds. But with the help of proper investigation and using Triggers we can reduce Frauds. It will also reduce the premium cost and reduce the claims ratio.

One of its main focus areas to control or reduce costs is by proactively arresting fraud, which can be achieved through an effective fraud risk assessment (FRA) program

Appendix

Triggers of investigation

1)Triggers from claim Documents

1	Submission of indoor case papers at the time of submission of claim with same handwriting from date of admission to discharge(including claim form)	4
2	1. there may be a lot of spelling mistakes in medical records 1. prescription papers & tampering done on it. 2. change of logo of hospital, change in format,unattested copies. 3. Visible tampering of documents like overwriting,	2
3	Treatment cost are on higher side as compared to etiology	2
4	1. treating doctor speciality not indicated, 1. variation in physician's statements(eg in claim form as well as medical record papers), 2. photocopied stationary may be used in ipd/prescription, 3. print of stationary used may not be clear, 4. papers used in claim may be thin as compared to the original papers 5. no phone no available on papers. 6. Well Made claim documents(freshly prepared)	2
5	1. X ray plate without Date & side . 2. X ray not available in documents at all.	2
6	1. Costlier investigations are more 2. investigation reports without doctor prescription	1
7	1. Diagnosis of ailment and investigations done are not related to each other 2. diagnosis like chronic disorders like cancer, paralysis, heart failure etc)pshychosomatic conditions (like peptic ulcers,irritable bowel syndrome, repetitive stress injury,fibromyalgia)	1
8	1. Supporting documentation vague/inadequate , 2. mismatch between the doctor prescription & chemist bill 3. frequent change of doctors/treatment or noncompliance of treatment 4. Injury isolated circumstances(no eye witness), no reporting(eg. Police) 5. infrastructure of hospital unsatisfactory-from the hospital information sheet and medical documents submitted.	1
9	Signature of claimant mismatched.	5
10	Death claims	1

2)Triggers from Policy

1	1. Claim within First year of coverage, 2. single person 3. single insured 4. minimum insurance 5. multiple insurance policies.	4
2	1. Multiple claim from single family 2. multiple policy from same address	3
3	Claims related to group mediclaim policy from same hospital.	4
4	1. Post policy enhancement claims 2. post endorsement claim eg. Addition of new member etc.	1

3)Triggers from Past records

1	Positive claim history of infectious diseases, acute illness	1
2	1. repeated hospitalization in same hospital within specific policy period/ end of the policy period 2. claim for the same disease in the past some times with exactly the same papers/recurrent illnesseslike calculus ,fibroid uterus etc	1
3	No pre post claim to main claim	4
4	No follow up documents available	2
5	1. Flagged Delisted/ caution 2. unregistered/unrecognised hospital	10

4)Triggers from ICP

1	poor medical history(complaints not mentioned, only diagnosis mentioned on claim documents).	1
2	Non disclosure/misrepresentation of material facts	4
3	Surgical/ anesthetic notes missing in the sugical cases.	4
4	Post operative histopathological reports are not available(surgical cases)	3

5)Triggers from Demogaphy

1	Patient residence and the hospital, chemist address, are not geographically same.	5
2	Fraud prone area	8
3	fake address of policy holder hospital doctor	1
4	return cheques	1

6)Triggers from claim submission

1	Claim intimation not given or given on the date of discharge.	1
2	Quality of submitted documents is poor with no phone numbers mentioned on it	2
3	1. claim submission on weekends(especially in case of pre auth) 2. date of loss just beyond the waiting periods.eg.hospitalization on 31st day from risk commencement	6

7)Triggers from bills

1	1. medicines bills are in serial order 2. wrong receipt no. with respect to the dates.	4
2	high value claims/ bills(doctor charges 50% of total bill)	2
3	1. bills generated on word documents 2. bills with no bill breakup	2

8)Miscellaneous Triggers

1	1. Pressure exerted for early settlement. 2. frequent & regular follow up of comparatively low value claim 3. pt could be managed on opd basis but converted into ipd	2
2	1. Abnormal knowledge of policy coverage/ claims process/terminology 2. in most of the fraud 3. the treating dr,agent and the ailment are same 4. some times hospital staff or doctor is taking treatment under ipd in their own hospital but they try to hide their relation with hospital.	2
3	1. unwillingness to meet face to face, hand deliver of cheques 2. same photograph enrolled in different u/w under different names and having claim in every u/w policy ,	1

Total score gained	

References

1. Article on Fraud in insurance by Ashvin Parek National Leader Global Financial Services Ernst & Young Pvt. Ltd.
2. Article on cost increase in health Insurance by santosh balan, Chandni Arora Bajaj Allaianza
3. Paper on Health insurance Fraud By FICCI
4. Dealing with health insurance Frauds by Dr Nayan shah