INTERNSHIP REPORT – 2024

At Care Health Insurance Lim. Gurugram

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EXECUTIVE SUMMARY

Introduction - An important factor in the Indian economy's ability to expand sustainably is the insurance industry. However, the rising number of fraud cases in India causes this industry to lose crores of rupees annually. As the number of insurance clients rises, insurance firms must effectively set up a strong mechanism to deal with claims fraud. The fraud control department is therefore vital to the business financially and serves as the foundation of the insurance industry.

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Aim and Objectives:- The project was carried out with a purpose to evaluate characteristics of fraud cases in health insurance company analyse role offraud control unit in detecting and preventing fraud. To identify most common types of fraud against health insurance company and to analyse the triggers and remarks given by cashless and fraud control team.

Methodology – A Study Setting was set up in Health Insurance Company in Gurugram. The Study population was 43 Cases which has been triggered for investigation and there final decisions which are carried out to reject or approve the claim filed by the patient. This retrospective study was carried out for 1 week. An observation was made and used for the purpose of study after obtaining permission from respective authorities. Information was gathered from the triggers which have been given by cashless team and final decision taken by fraud control unit. Collected data was analyzed by frequency, percentage using tools like MS excel for better interpretation.

Result – Total number of cases from trigger point as well as decision from FCU were taken into consideration and then characteristics of fraud cases and major types of fraud which occurred was analysed

Conclusion – fraud control units play a critical role in ensuring the financial stability of health insurance companies, protecting the interests of policyholders, and promoting the integrity of the insurance industry as a whole. By detecting and preventing fraudulent activities, these units help to reduce costs, mitigate risk, and maintain the trust of customers and stakeholders.

Keywords – Fraud, Investigation, Claims, Insured, Genuinity

CHAPTER 1: INTRODUCTION

TOPIC:- Evaluating the characteristics of Health Insurance fraud cases

Fraud is defined as a deliberate an intentional action to commit or try to take action to receive health insurance or obtain benefits by faking cheating or promising money or any property owned by the health insurance programme fraud in the form of up coding or encoding errors is common in a large number of patients

Healthcare insurance fraud is a pervasive issue that results in significant costs to the system. It entails purposeful deceit or misrepresentation intended to gain an unauthorized advantage. The alarming reality is that instances of health insurance fraud continue to rise annually. To prevent and uncover fraudulent activities, organizations must implement appropriate measures to investigate and detect such activities.

For the majority of insurance firms, insurance fraud poses the greatest threat. The past several years have seen an increase in insurance fraud charges for these organizations. The cost of premiums is raised by these fraudulent cases, which is extremely problematic for insurance firms as well as policyholders. Unauthorized and illegal acts are included in these insurance fraud instances. In order to combat these illicit operations, risk management is essential to the insurance sector. In order to avoid insurance fraud, insurance firms are urged to implement certain risk management strategies.

There are various type of frauds which occur in health insurance sector like providers fraud like phantom billing, in the billing for services which are not provided adding

otherwise legitimate claim charges for services which are never being performed then other is up coding charging for more expensive service suchas visit to a specialist when the patient actually saw a nurse or a intern misprintingthe diagnosis in order to support payment, or it may involve fabricating treatment plans, medical records, and certificates of medical necessity.

The most important aspect of preventing fraud in the health sector is to consistently offer comprehensive training that covers social responsibility, corporate governance, ethics, accountability, and fraud prevention. Technology should be used by health insurance firms to identify fraud.

For example, data analytics and artificial intelligence can be used to identify patterns of fraudulent behavior and flag suspicious claims and the companies should monitor high-risk providers and patients who have a history of fraudulent behavior. This can be done through audits and reviews of claims, as well as background checks on providers and patients.

The fraud control department is an essential component of any health insurance company, as it plays a critical role in preventing, detecting, and investigating fraudulent activities. Here are some of the reasons why the fraud control department is so important as it protect company's reputation and also promotes a fair and equitable healthcare system

Overall, the fraud control department is an essential component of any health insurance company. By preventing, detecting, and investigating fraudulent activities, the fraud control department can help reduce healthcare costs, protect the company's reputation, ensure compliance with regulations, improve patient outcomes, and promote a fair and equitable healthcare system.

CHAPTER 2 : AIM AND OBJECTIVES

1. To analyse role of fraud control unit in detecting and preventing fraud
2. To identify most common type of fraud against health insurance company
3. To analyse the triggers and remarks given by cashless team and fraud control unit.

CHAPTER 3 : PROCESS FLOW IN FRAUD CONTROL UNIT

- **INTIMATION**
- **REGISTRATION**
- **VERIFICATION OF DOCUMENTS**
- **Capturing Of Billing Information**
- **CODING OF CLAIMS**
- **PROCESSING OF CLAIMS**
- **TRIGGER FOR INVESTIGATION**

- **YES --- SEND FOR INVESTIGATION TO FRAUD CONTROL UNIT**
- **NO --- SETTLED AND APPROVED**

- **Investigation Required**
  - **YES -- SENT FOR INVESTIGATION**
  - **NO –**
- **REPORTS RECEIVED**
  - **Fraud Control Unit Remarks**
  - **Sent Back to Cashless Team**

CHAPTER 4: RESEARCH METHODOLOGY

A retrospective study was carried out for a duration of 60 days data was collected from 43 cases triggered for investigation and on the basis of fraud control unit remarks and decision, characteristics and major types of fraud which occurred was analysed using excel spreadsheet and through graphs and pie charts.

Study Setting:- Health Insurance Company in Gurugram, Haryana

Type of Study:- Retrospective Study

Study sampling technique:- Systematic random sampling

Sample Size:- 43 cases

Data Collection Method:- Secondary data

Inclusion Criteria:- Cashless claims

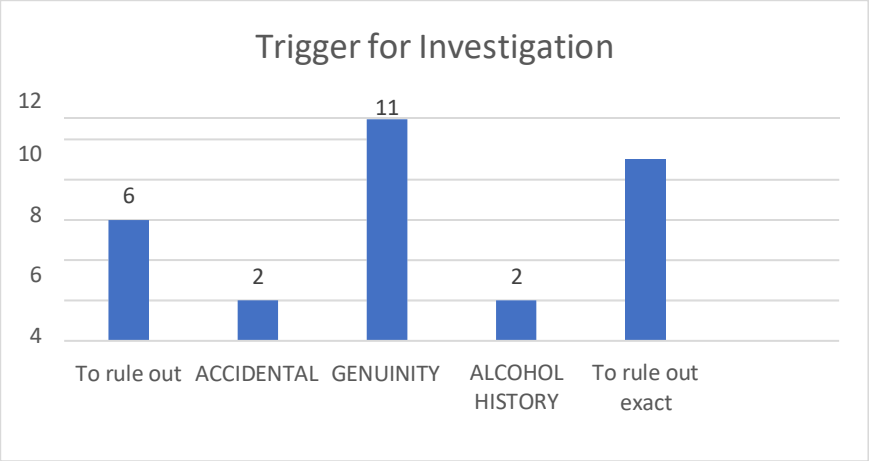
Exclusion Criteria:- Reimbursement cases

Ethical Consideration:- Took permission from Head of Fraud control Department

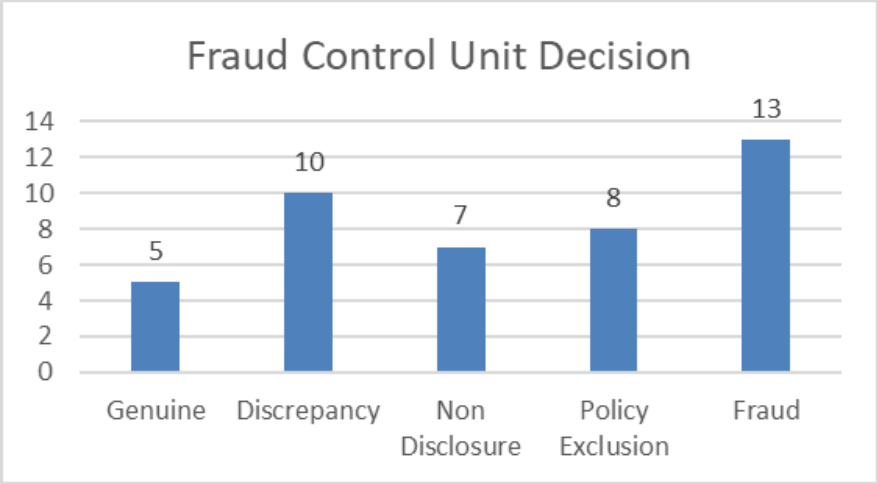
CHAPTER 5 : RESULTS AND DISCUSSION

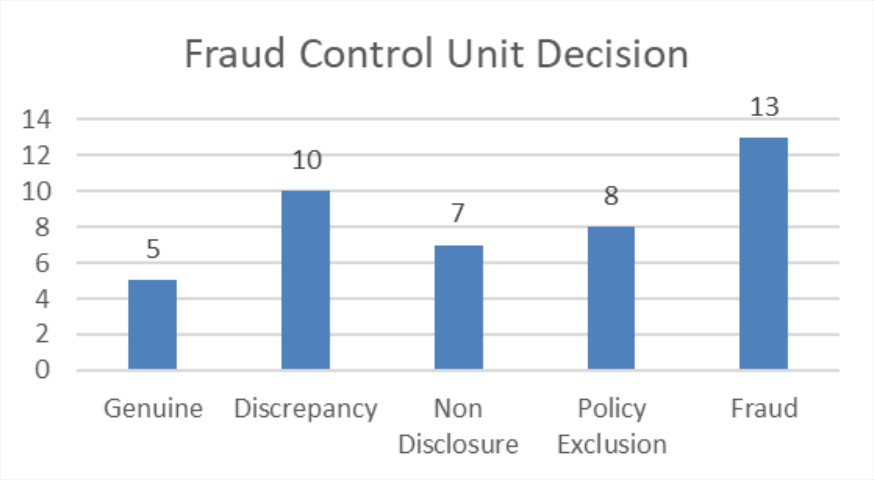
Trigger	No of cases
To rule out PED	6
Accidental Injury	2
Genuinity	11
Alcohol History	2
To rule out exactduration	9

Fraud Control Unit Decision	No of cases
Genuine	5
Discrepancy	10
Non Disclosure	7
Policy Exclusion Fraud	8 13



As from the above graph, it was inferred that the number of cases triggered for genuinity are highest(11) then to rule out exact duration of specific disease (9) like the disease which have particular waiting period followed by to rule out any pre existing disease (6) like hypertension, diabetes then the cases related to liver diseases or accidental is investigated to rule out history of alcohol or any other personal habit (2) and then cases related to injury are investigated to rule out genuinity (2) that the claim can be approved or not. So we can see that the number of fraud cases increasing and the investigation is done that is the case genuine or not.





As per the graph, it was observed that the cases of discrepancy (fraud) are highest i.e 10, then the cases of policy exclusion (8) and then the cases of non disclosure (7), the patient has not disclosed that he is suffering from an ailment while taking the policy and therefore not maintaining transparency in the system and then the least are the cases of genuinity. From this we can conclude that from 43 cases only 5 are genuine. Whereas apart from all the cases, the highest number of cases are denied as fraud which are highest in number(13). So we can see the number of frauds increasing day by day. So verification of the claim is necessary to maintain financial position of the company.

CHAPTER 6: OBSERVATIONS

1. Patients are not disclosing any ailment if they are suffering from while taking policy

2. Usually fraud happens in cases of fever where the hospitalization is not required and then also the patient is admitted

3. Patient file claim frequently for monetary benefits

4. There are some specific waiting periods for particular diseases so as soon as the waiting period gets over, patient files a claim related to it

5. Patients take treatment from there family doctor and can tell them to not disclose

any history and add things to increase the expense which is ultimately for there monetary benefits.

6. In fraud cases, impersonation is the major fraud being carried out by the public

7. Fabrication of documents, ICP is the another fraud being observed in the hospital for monetary benefits

CHAPTER 7: LIMITATIONS

1. The cases which are included in research was cashless cases, reimbursement cases were not included

2. The research was restricted to one health insurance company so the context was limited.

CHAPTER 8: RECOMMENDATIONS

1. Establish clear policies and procedures: A fraud control unit should have clear policies and procedures in place for detecting and investigating potential fraudulent activities. These policies should be communicated effectively throughout the company to ensure that all employees understand their responsibilities in preventing and reporting fraud.

2. Training should be given to employees on timely basis to identify fraud and give awareness regarding the importance and overall system of fraud control unit

3. Continuously review and improve processes: A fraud control unit should continuously review and improve its processes for detecting, investigating, and preventing fraud. This may involve regular audits of claims data, analysis of

trends and patterns, and ongoing training for employees on the latest fraud prevention techniques.

CHAPTER 9 : CONCLUSION

Overall, a fraud control unit should be viewed as a critical component of a health insurance company's operations. By taking a proactive approach to fraud prevention and detection, companies can protect their financial stability, maintain the trust of their policyholders, and promote the integrity of the insurance industry as a whole. For establishing and operating an effective fraud control unit requires a comprehensive and integrated approach, including the development of strong policies and procedures, the use of advanced technologies, the cultivation of a culture of compliance and ethical behaviour, and ongoing training and education to all employee.