A STUDY ON BLACKLISTING OF NETWORK & NON-NETWORK HOSPITALS

Dissertation Submitted to

The IIHMR University, Jaipur

for the partial fulfilment for the award of the degree of
Master of Business Administration (MBA)
in
Hospital and Health Management
By

Dr. Samiksha Arun Rushiya

Under the Supervision and Guidance of
Tripti Bisawa
Associate Professor at IIHMR University
2023

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled *'A STUDY ON BLACKLISTING OF NETWORK & NON-NETWORK HOSPITALS*' is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

(Signature)
Name of Student
Date:

CERTIFICATE

This is to certify that Dr. Samiksha Arun Rushiya in partial fulfilment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur has successfully completed her internship at Aditya Birla Health Insurance Co. Limited during February 22- May 19, 2023.

Place:
Date:

Preceptor/Head of the Organization
Name of the Organization

CERTIFICATE

This is to certify that dissertation titled 'A STUDY ON BLACKLISTING OF NETWORK & NON-NETWORK HOSPITALS' is a record of the research work undertaken by Dr. Samiksha Arun Rushiya in partial fulfilment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and her approach to the research study has been sincere, scientific, and analytical.

Faculty Guide
IIHMR University, Jaipur

Date:

School Dean
IIHMR University, Jaipur

Date:

ABSTRACT

Introduction:

The blacklisting of network and non-network hospitals has become a widespread practice in healthcare insurance systems worldwide. This study aims to investigate the reasons behind the blacklisting of hospitals and the impact it has on patients, hospitals, and insurance providers. The study employs a quantitative data collection method. Data collection involves the analysis of hospital and insurance data. The study findings reveal that hospitals are blacklisted mainly due to issues such as non-compliance with quality standards, fraudulent practices, and high billing charges. The study also shows that blacklisting has negative impacts on both patients and hospitals, including reduced access to quality care, financial losses, and damage to reputation. Based on the findings, the study recommends that insurance providers should take a more collaborative approach with hospitals to address the root causes of blacklisting and improve the overall quality of healthcare delivery.

Rationale:

Prevention of claims from blacklisted hospitals will result in lower Average Claim Size (ACS).

Methodology:

The Purposive Non –Probability sampling is done on secondary data, the compiled data is categorized into different themes, which was then entered into Microsoft Excel for further analysis. The resulting tables and graphs provide summary of the data. Finally, conclusions were drawn based on the themes that emerged from the data analysis.

Key Results:

Over the years, the fraud hospitals have made false claims and gained rigorous amount of money in forms of both cashless and reimbursements from the insurance industry. This has weakened the insurance industry as well as the economy. The results show the trends from the past three years of these secluded hospitals which are now blacklisted to prevent further health insurance claims.

Conclusions:

Preventing financial losses and ensuring the quality of inpatient treatment and healthcare services are the ultimate goals of this fraud detection technique. It is important to note that the methods can be adjusted to suit specific conditions or address particular fraud-related issues. To reduce the prevalence of fraud, insurance companies must have an effective risk management system.

ACKNOWLEDGEMENT

My family has been patient with me and has provided me with moral support.

The success and end of this project needed a lot of guidance and assistance from a lot of individuals, and I am fortunate to have received this during the course of my work. All of what I have accomplished has been made possible by their direction and assistance, and I would want to express my gratitude to them.

Before anything else, I just want to express my gratitude to Mr. Rupesh Choubey (Head – Providers Network, ABHI) for providing me with the chance to complete my dissertation work at Aditya Birla Health Insurance, Mumbai.

I am thankful and fortunate enough to be able to request Ms. Brijeshwari Rajput's (Chief Manager - Providers Network, ABHI) unwavering assistance, advice, and guidance on a regular basis.
I would also like to thank Ms. Tripti Bisawa (Professor at IIHMR University), my college mentor, for her unwavering support and encouragement during the internship.

It will be my pleasure to include Dr. P.R. Sodani (Pro president, Dean Academics, and Dean Training - IIHMR UNIVERSITY) in my report for his unwavering support and patience in guiding me during this period.

My special thanks to our alumni Ms. Shreya Saxena (Manager-Providers Network) & Ms. Pooja Sambhalwar (Manager-Providers Network), for their encouragement and help throughout the project's Process Documentation.

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ABBREVIATIONS

SERIAL NO	ABBREVIATION	FULL FORMS
1	TPA	Third Party Administrator
2	IRDAI	Insurance Regulatory & Development Authority of India
3	KYC	Know Your Customer
4	PPMC	Pre Policy – Medical Check-up
5	BMI	Body Mass Index
6	STP	Straight Through Process
7	NSTP	Non-Straight Through Process
8	CRM	Customer Relationship Management
9	TAT	Turnaround Time
10	IT	Information Technology
11	UW	Underwriting
12	TELE	Telephonic
13	MER	Medical Examination Report
14	TM	Tele-MER
15	DOB	Date Of Birth
16	MIS	Management Information System
17	VA	Value Added
18	NVA	Non-Value Added

CHAPTER 1: INTRODUCTION

This world is full of uncertainties and threats. One example of the variety of hazards that can exist is the unpredictable nature of unpleasant things happening to people's lives, well-being, resources, and property. In order to protect the interests against catastrophe and vulnerability, the Insurance Industry has evolved to cover the loss and uncertainty. It might be presented as a tool for society to lessen or get rid of the threat to people's lives and property.

With respect to protect people and their businesses from numerous potential risks, insurance makes a considerable financial contribution to the country's overall development by promoting secure contacts. Millions of people are employed by the Insurance industry, which is particularly important in nations like India where employment and savings are crucial. Unfortunately, because of all these advantages, insurance fraud is highly likely. In India in 2019, insurance fraud totalled about 45,000 crores. Fraudulent health insurance claims often range from 15% to 35%, costing insurance companies 10% to 15% of their annual revenue on average.

India is one of the biggest trading platforms in the world for insurance providers. However, it should be noted that operating in the health insurance sector in India carries several dangers due to an exceptionally high prevalence of fraud.

Fraudsters are continually enhancing their creativity. Every day, new schemes to defraud insurance companies are used. Obtaining insurance for a person who is terminally sick is the most typical method of defrauding a corporation. Indian cities prevent this from occurring. However, due to lack of infrastructures in rural India, makes it straightforward to obtain patient insurance. The term Insurance Fraud is not defined under Indian Insurance Act. According to International Association of Insurance Supervisors (IAIS), fraud is defined as “an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties.”

This can be achieved by means of:

According to the National Health Care Anti-Fraud Association (USA), healthcare fraud involves intentionally submitting false claims to private health insurance plans or tax-funded public health insurance programs, and intentional deception or misrepresentation for personal or other parties' unauthorized benefit. The insurance industry is growing increasingly concerned about the escalating cases of healthcare fraud. Such fraudulent

activities in the insurance sector can impact both the insurer and the customer, leading to a lack of trust, reduced consumer confidence, higher premiums for insurance products, and financial and reputational risks for the insurer. Misappropriation of assets, deliberate false portrayal of material facts, or abuse of fiduciary duty are a few examples of insurance fraud.

Hospitals may engage in several types of insurance fraud, including; life insurance fraud, where faking death is used to make a financial profit. Another form of fraud is healthcare insurance fraud, which involves misrepresenting information related to healthcare benefits, such as providing false medical bills, billing for a higher level of services, or submitting altered claims. Physicians are often involved in this type of fraud. Additionally, hospitals may perform unnecessary medical procedures, such as ordering blood tests for hair-related problems, which have no medical relevance, and can be considered a form of insurance fraud.

In India, insurance companies reimburse their customers for twice as much the insurance in the event of a tragic accident. Sometimes, this clause is abused to state things that are not true. Fraud is a persistent problem in the health insurance sector. In India, a lot of hospitals exist primarily to provide false paperwork for insurance claims. Before the insurance provider gets a chance to investigate what happened, the scam artists pack up and leave the area to start over somewhere else. A few of the techniques utilised to avoid fraud along the entire insurance value chain include pre-medical exams, fast renewals, KYC compliance, and improved services from the insurance industry. The Insurance Regulatory and Development Authority of India (IRDAI) has suggested that all insurance companies founded in India have an anti-fraud plan that has been formally certified by their separate boards.

The several types of health insurance fraud claims can be broadly categorized as follows:

Billing for services not rendered: This involves claiming insurance for services that were never provided, such as submitting fake bills.

Upcoding of services: This type of fraud involves billing for services that are more expensive than the actual services provided, such as claiming insurance for 5 days of hospitalization when the patient was admitted for only 3 days.

Upcoding of items: Here, insurance is claimed for items that are more expensive than the actual cost, such as medicines that were claimed as Rs. 5000 but cost at Rs. 1000.

Duplicate claims: This occurs when changes are made to an original bill and the same bill is submitted to the insurance company for a second time.

Unnecessary services: This involves claiming insurance for services that were not medically necessary, such as a non-cancer patient claiming insurance for chemotherapy.

Unbundling: Creating separate claims for services or supplies that should be grouped together is referred to as unbundling.

Billing for services that are not provided: This is referred to as phantom billing and entails submitting claims for healthcare services that have not been rendered as well as for medications or medical devices that have not been delivered to the patient.

Ghost employees: This involves creating fake patients on the healthcare provider's payroll that do not actually exist.

Submitting double bills: This occurs when a claim is submitted multiple times to get paid twice for the same service.

Using the wrong diagnosis: Submitting claims based on a false diagnosis, which can lead to falsely prescribing certain medicines to a patient.

Providing unnecessary care and maximizing care: Providing more healthcare than is needed to heal the patient.

Billing for services rendered by unqualified official: It happens when the person who is administering the care without the necessary training or authorization.

1.1 RESEARCH QUESTION:

WHAT IS THE PROCESS OF IDENTIFICTAION AND IMPACT OF BLACKLISTING THE HOSPITALS AT HEALTH INSURANCE INDUSTRY LEVEL?

1.2 RATIONALE:

Prevention of claims from blacklisted hospitals will result in lower Average Claim Size (ACS).

1.3 OBJECTIVES:

1. To understand the Average Claim Size of both Cashless & Reimbursements
2. To study the Fraud-Abuse claim incidences in Hospitals Pan India
3. To analyze Unwarranted Losses further leading to overall Cost Reduction

1.4 HYPOTHESIS

Prevention in claims from blacklisted hospitals will result in lower Average Claim Size.

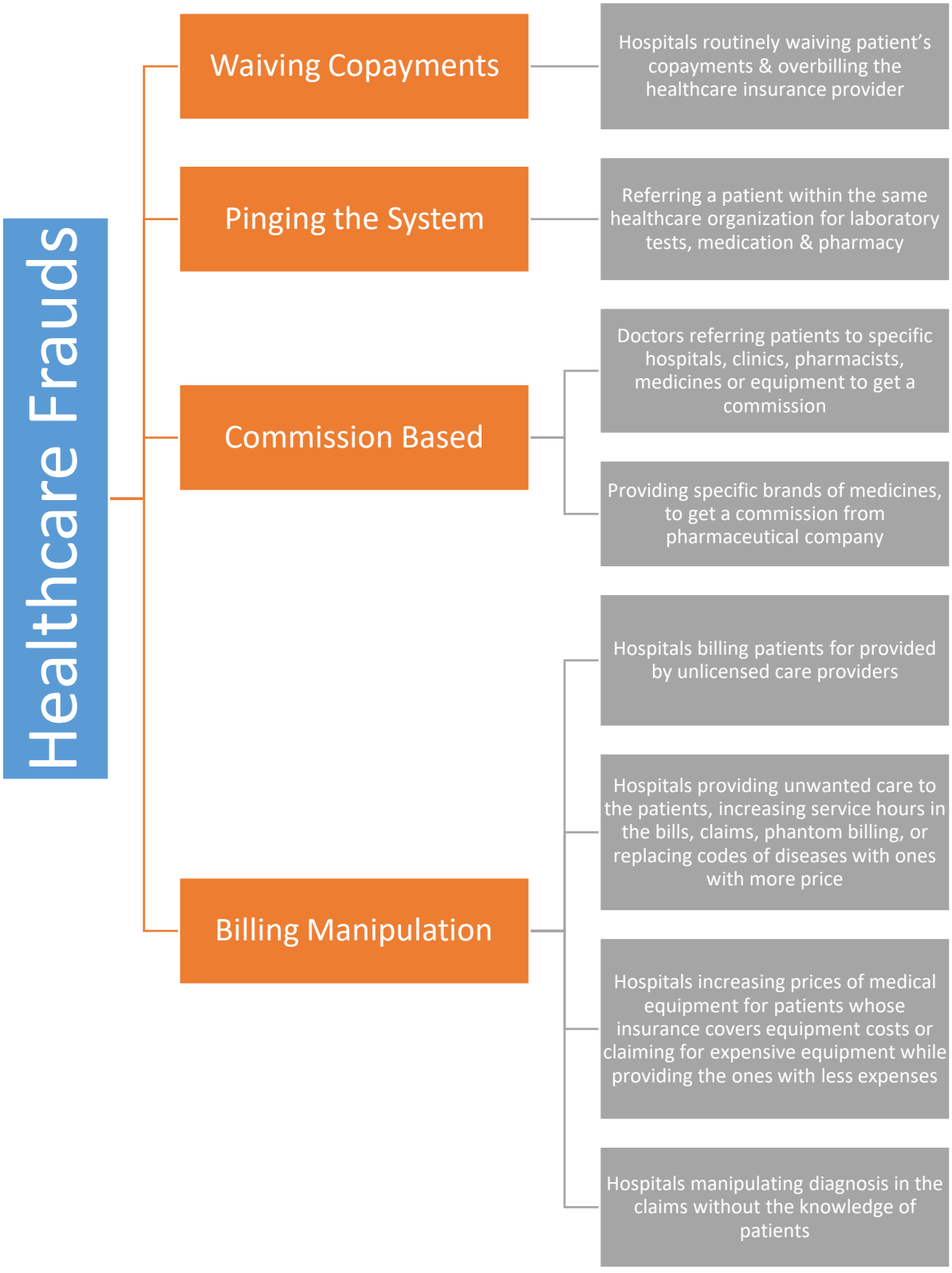

Figure 1.1 Types of Healthcare Frauds

1.5 Process Flow:

At first, Insurance companies which are listed in the healthcare industry identified the hospitals on their level, that these hospitals are suspected to do fraud or maybe there are on the verge of doing fraud. The companies then segregated the hospitals based on their claim trends and past experiences, reports by FWA (Fraud Waste and Abuse) (Fraud Waste and Abuse) team.

The industry then fixed the number of 2,916 for suspected lists of fraud hospitals & published it in the healthcare industry.

Multistage processes were done, such as Internal review and cross-checking with hospitals, to see how many of them are on every Company's network.

The team of Aditya Birla started working on this list of 2,916 Hospitals, the trend with these hospitals were reviewed again on internal level as per their claimed amount to ABHI & reimbursements made to them by ABHI, out of this, 539 hospitals were on network with ABHI. These Network hospitals were then de-empaneled by sending a temporary suspension letter. Along with it the parallel process of tagging was on going in system.

The remaining 2,377 Non network hospitals were tagged as blacklisted & the future claims made by these will be verified first as they straight away goes to verification bucket for genuineness.

For the information to customers, ABHI has also been displaying such hospitals names with their addresses, so that the customers should not fall prey to such fraudulent activities. Also, it has been mentioned on the official website that Claims coming from these hospitals will not be entertained unless it is an incident of emergency (casualty) or sudden fatality.

CHAPTER 2: REVIEW OF LITERATURE

Sr. No.	Author & Year Study	Location	Sample size	Sampling Technique	Salient features
1	Dallas Thornton, Michel Brinkhuisb, Chintan Amritb, robin Alyc (2015)	Netherland	252	Convenience Sampling	• Through a systematic assessment of published works on healthcare fraud, it seeks to examine the lessons discovered in this area thus far. • The documented categories and descriptions of healthcare fraud are given.
2	Mayur Abhyankar, Ketan Patil (2019)	Pune	Insurance Frauds in the year 2016	Purposive Sampling	• It can be used to examine fraud patterns, risk assessments, and organizational prevention strategies. • The goal of this study is to evaluate the many types of insurance fraud, the threats they pose, and the development of risk management strategies that reduce insurance fraud.
3	Andi Yaumil, Bay Thaifur, Alimin Maidnic, Andi Indalwaty sidinc, Amran Razak (2021)	Indonesia	10	Convenience Sampling	• It specifies the technique for locating fraud situations. • Secondary data tracking, information, and the employment of technology specialists are effective approaches for fraud detection. The approach to fraud detection that is most frequently utilized is secondary data tracking. • People who commit fraud are those who control medical circles and file bogus claim cases.

4	Kavita Chavali, V V Ajith Kumar, M Sudha (2015)	Bengaluru	105	Purposive Sampling	• It discusses the perception of respondents who are exposed to health insurance by having a policy on frauds and the efforts taken to stop them in the Indian health insurance business. • Another important part of the problem is the degree of regulation to prevent scams. • It has been suggested that, like the banking sector, the insurance sector's regulatory framework needs a more comprehensive approach. Hospitals, physicians, and other providers of healthcare services are not regulated by the Insurance Regulatory Development Authority, but insurance firms, agents, and brokers are.
5	Thotakura Lalitha Gayatri Tawde, Priyanka Pavate (2017)	Mumbai	All Diseases	Cluster Sampling	• A hybrid model system that combines classification and clustering. • Support Vector Machine (SVM) and Evolving Clustering Method (ECM) are selected after assessing the benefits and drawbacks of each algorithm used in classification and clustering. • The insurance firm will identify fraudulent claims and pay legitimate ones.

CHAPTER 3: METHODOLOGY

3.1 DATA COLLECTION PROCEDURE:

A group of insurers came together to tackle hospital fraud. Each insurer shared a list of excluded hospitals for this purpose. The data was collected using a system portal, and a comprehensive list of fraudulent hospitals was compiled.

Next, the collected data will undergo multistage analysis. The common responses will be coded and categorized into themes, which will be entered into Microsoft Excel for further analysis. The resulting tables and graphs will provide a summary of the data. Finally, conclusions will be drawn based on the themes that emerged from the data analysis.

3.2 RESEARCH METHODOLOGY:

- STUDY DESIGN - Correlational Quantitative Study
- SETTING - ADITYA BIRLA HEALTH INSURANCE

3.3 STUDY POPULATION:

  - INCLUSION CRITERIA - Suspected Fraud Hospitals
  - EXCLUSION CRITERIA - Non- Suspected Hospitals
  - STUDY TOOL - Secondary Data
- DURATION OF STUDY - 3 Months (22nd Feb 2023 – 21st May 2023)
- SAMPLE SIZE - Master data consists of 55,000 Hospitals, out of which 2,916 Hospitals were identified as suspected Hospitals. Conclusions are made based on suspected hospitals.

3.4 SAMPLING TECHNIQUE: Purposive Non- Probability Sampling

3.5 Limitations of Study:

1. The Hospital details which lack the Rohini ID (a thirteen digits unique number provided by IRDAI) were unable to trace in the system.
2. Repeating of Rohini ID was seen for some Hospitals, which questioned the authenticity as well as making it unable to trace in system.
3. The major difference in the addresses and pin code made it difficult to merge with the system details provided to categorize them.
4. Some Hospitals had the same name with various locations, such Hospitals were unable to analyzed.

CHAPTER 4: RESULTS

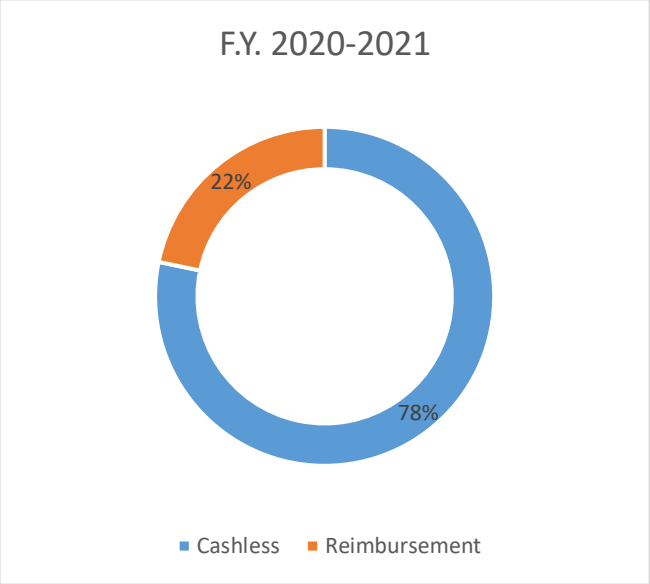

Figure 4.1 Claims distribution in the year 2020-21

- As the trend shows, out of the suspected fraud Hospitals, amount of 8,27,44,672 INR was spent through Cashless which holds a total of 78%.
- The 22% which makes around 2,29,95,856 INR was paid in terms of Reimbursement for the year 2020-2021.

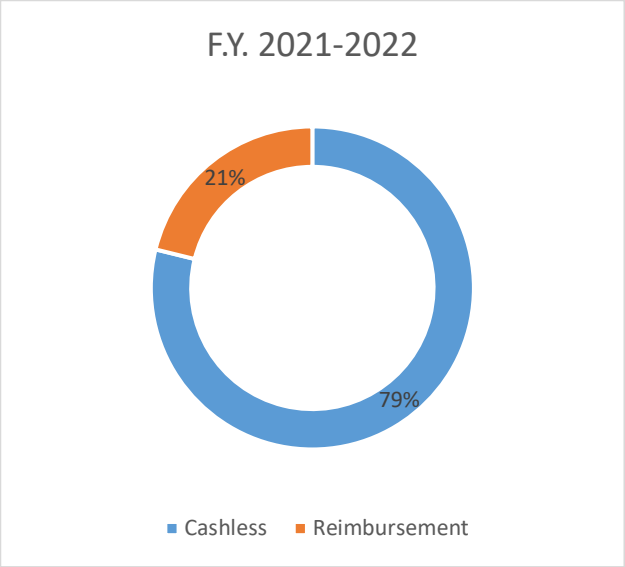

Figure 4.2 Claims distribution in the year 2021-22

- As the figure shows, out of the suspected fraud Hospitals, amount of 19,24,97,625 INR was spent through Cashless which holds a total of 79%.
- 21%, which makes around 5,16,71,725 INR was paid in terms of Reimbursement for the year 2021-2022.

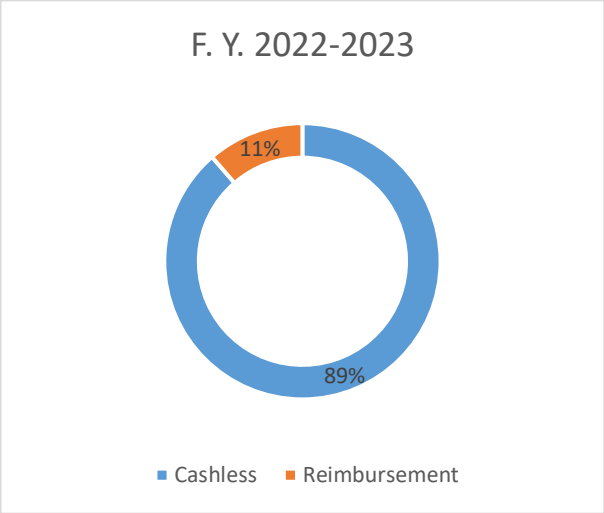

Figure 4.3 Claims distribution in the year 2022-23

- There was significant increase in the recent year in term of Cashless paybacks, out of the suspected fraud Hospitals, amount of 19,24,97,625 INR was spent which holds a total of 89%.
- The 11% which makes around 2,12,89,668 INR was paid in terms of Reimbursement for the year 2022-2023.

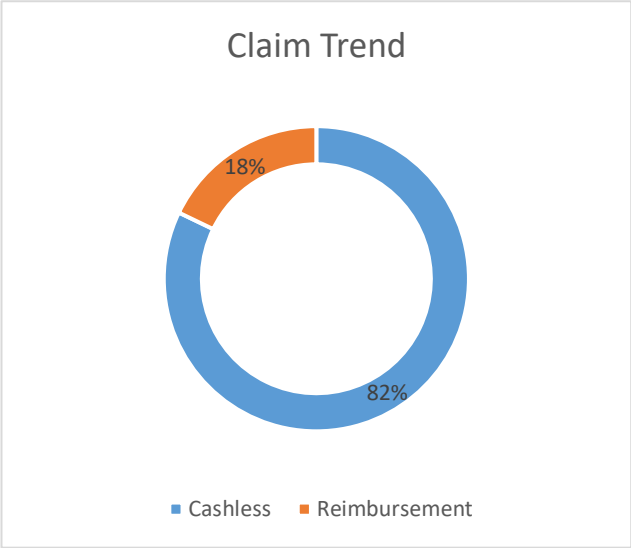

Figure4.4 Overall claim distribution 2020-23

- The above figure shows that over three years, the cashless claims were worth 44,13,02,357 INR.
- Total reimbursement claims cost 9,59,57,250 INR during the past three years.

4.1 FINDINGS:

1. The ultimate goal of the fraud detection approach is to prevent the loss of financial resources as well as inpatient care and medical services.

2. To limit instances of fraud, insurance companies need to invest more in the education and training of fraud detectives.

3. By blacklisting fraud hospitals from the system, the average claim size can be reduced as the claims coming from these hospitals can be prevented.

4. A lump sum amount of approximately 53,72,59,607 INR that has been granted can be saved in the future by not engaging with these fraud hospitals.

5. This blacklisting process will help prevent unwarranted losses in the insurance industry and further assist in cost reduction planning within the organization.

CHAPTER 5: DISCUSSIONS

The healthcare industry is experiencing a growing trend of fraudulent activities, which can be hindered by privacy laws according to one of the reviewed articles. The National Health Care Anti-Fraud Association (NHCAA) has recommended key measures to tackle healthcare fraud, such as the use of predictive modelling and promoting transparency between private insurance companies and government programs. Medicare reimbursement may also lessen fraud and raise the quality standard of health treatment in underprivileged communities.

By segmenting the data into various levels or phases, this study suggests a multi-stage method for deciphering fraud. Five steps make up the approach used in this study, with the first three stages concentrating on finding fraud among providers, services, and claim numbers. The information acquired from the previous steps is combined in the fourth stage to determine the overall risk level. The decision-making process in the fifth stage, which determines whether or not the claim indicates fraud, requires computing the risk threshold value. Preventing financial losses and ensuring the calibre of inpatient treatment and healthcare services are the ultimate goals of this fraud detection technique. It is crucial to remember that the procedures can be modified to fit certain circumstances or deal with specific fraud-related problems.

Analysing the results of previous studies through a synthesis table reveals that most research has relied on secondary data to identify and analyse instances of fraud. Future researchers can thus focus on identifying the weaknesses of fraud detection methods by collecting primary data, examining the several types and rules that pertain to fraud perpetrators in different countries, and making comparisons. This information can then be used to inform the development of legal sanctions for fraud, irrespective of the job or profession of the individuals involved.

CHAPTER 6: CONCLUSION

Insurance firms are fighting extortion's negative impacts to the best of their ability, and technological advancements may help them succeed.

Organisations could help minimise the number of fraudsters by receiving legal aid from the government in the form of appropriate remedial legislation to address such crimes. To stop insurance fraud in all its manifestations, both nationally and internationally, India urgently requires legislation against it.

Sun Tzu wrote, "*Know your enemy and know yourself, find naught in fear for 100 battles. Know yourself but not your enemy, find the level of loss and victory. Know thy enemy but not yourself, wallow in defeat every time.*"

Healthcare fraud is a crime that is constantly changing, with new schemes appearing on a regular basis. In order to limit instances of fraud, insurance companies need to invest more in the education and training of fraud detectives. Increased insurance fraud cases result in higher costs for insurance companies and lead to higher premiums. To reduce the prevalence of fraud, insurance companies must have an effective risk management system. Insurance fraud is considered a low-risk task, which is why it is frequently carried out by white-collar criminals. Therefore, laws need to be changed to punish offenders rigorously.

Some types of fraud schemes receive more attention than others. The lack of investigation into healthcare fraud makes detection challenging and prevention nearly impossible. Although the fight against healthcare fraud will be ongoing, we can constantly advance the condition of the business by knowing our enemy and understanding the tools at our disposal. Methods can be modified according to the situation or issue (fraud) that is being faced.

Factors that primarily influence customers to choose a company for insurance policies include the availability of a no-claim discount and the brand equity of the company, emphasizing the importance of trust. Customer service and the premium paid are also significant considerations.

Intermediate frauds and claim frauds stand out when it comes to health insurance fraud vulnerabilities. It is advised that the healthcare insurance industry implement several measures to stop these fraudulent actions. Preauthorization requests can be checked, proposal calls can be verified, fraud charges can be responded to quickly, and harsh steps like blacklisting fraudulent hospitals can be taken. Furthermore, regular

assessments are essential for lowering the risk of fraud. These steps can reduce losses brought on by fraudulent activity, benefiting both the industry and policyholders.

The scope of regulation is a further crucial issue that needs to be addressed. As the primary regulator of the insurance industry, the Insurance Regulatory and Development Authority (IRDA) now has authority over businesses, agents, and brokers. Hospitals, physicians, and other healthcare service providers are not, however, covered by the rules. The insurance regulatory system needs to take a more coordinated strategy to address this issue, much like the banking sector does. With the help of tighter controls on fraud and the release of fraud-related data among multiple parties, this strategy would increase the scope of monitoring and control.

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ANNEXURES

Annexure I: Declaration by ABHI on the official website regarding Fraud Hospitals

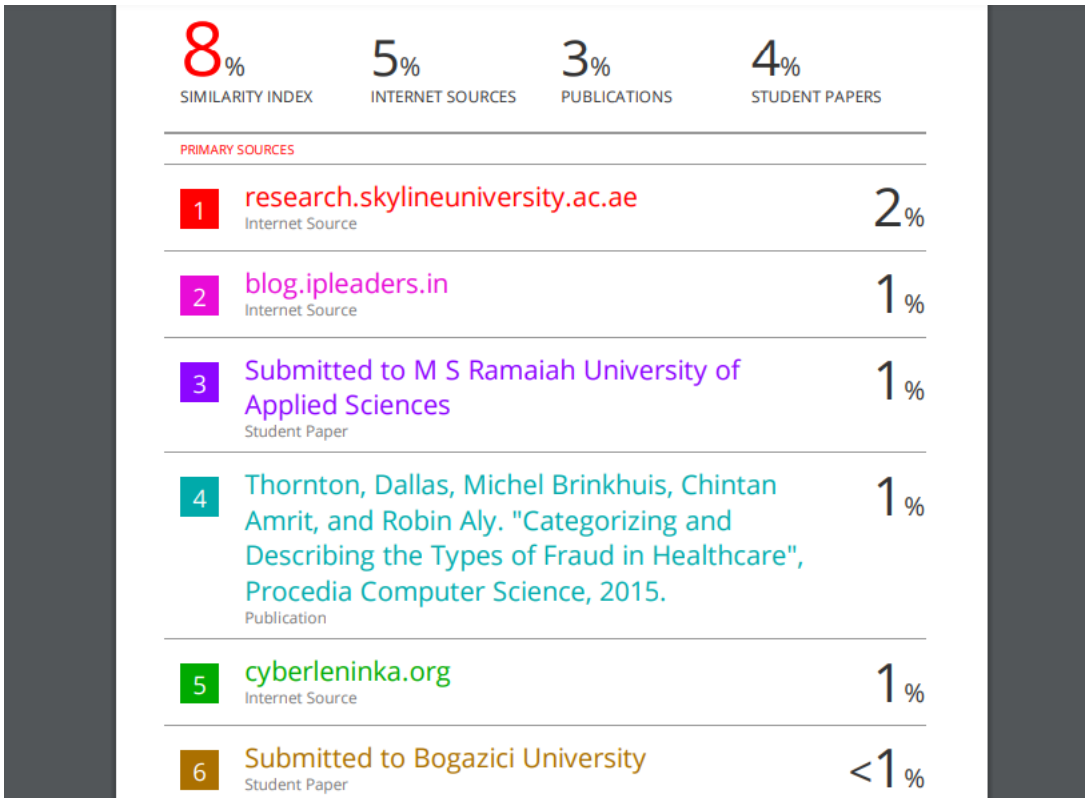
Aditya Birla Health Insurance Co. Ltd.
(A part of Aditya Birla Capital Ltd.)

ADITYA BIRLA CAPITAL

Excluded/Delisted Hospitals

Please Note: Expenses incurred towards treatment in any hospital or by any medical practitioner or any other provider specifically excluded by the Insurer and disclosed on its website/notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

Annexure II: Declaration by ABHI on the official website regarding Fraud Hospitals



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