ROLE OF AUDIT IN HEALTH CLAIM RECOVERY

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ABOUT:

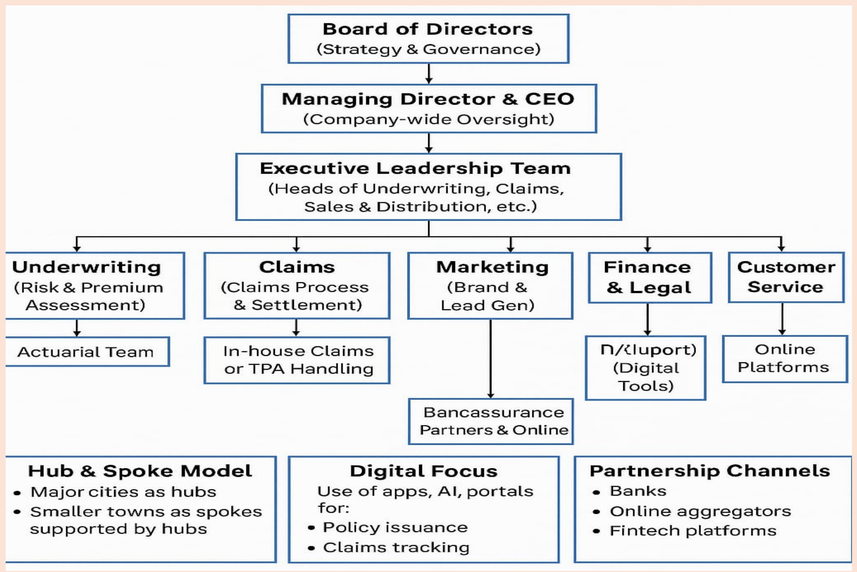
Care Health Insurance is a specialized health insurer offering products in the retail segment for Health Insurance, Top-up Coverage, Personal Accident, Maternity, International Travel Insurance and Critical Illness along with Group Health Insurance and Group Personal Accident Insurance for Corporates, Micro Insurance Products for the Rural Market and a Comprehensive Set of Wellness Services. Best Health Insurance Plan – Care Plus's at the Global Financial Planner's Summit 2024.

VISION:

Being the most preferred health service provider, which is caring, cost effective, innovative and reachable.

MISSION:

- Create value for all stakeholders.
- Extend benefits to rural and social sectors.
- Lead in customer care, products, and communication.



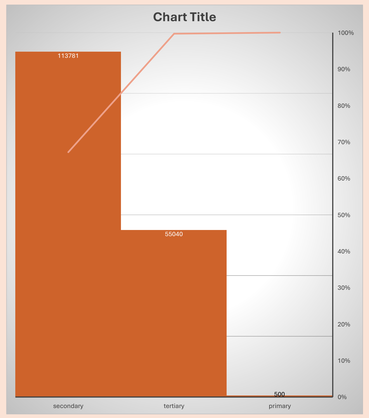
ANALYSIS AND INTERPRETATION OF DATA:

Analysis
Cashless claims show high inflation, especially in surgeries and secondary hospitals in tier 2 cities.
Audits detect overbilling, fraud, and help recover excess payouts.

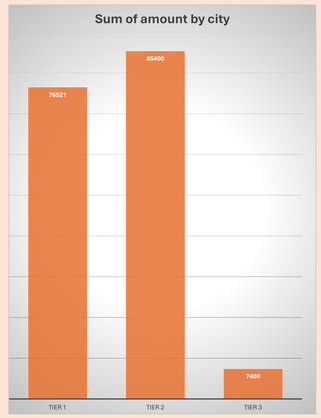
Interpretation
Audits are key to controlling costs and ensuring fair claims.
Strong collaboration is needed across stakeholders to reduce claim inflation.

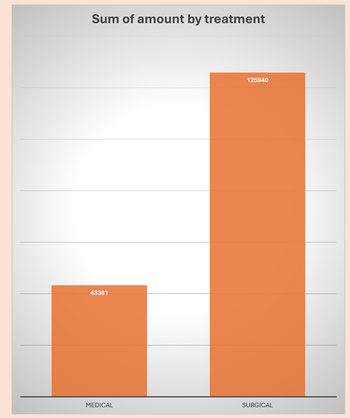
Results
In 758 cases the recovery amount was ₹113781 in secondary type hospitals, ₹85400 in tier 2 cities and ₹125940 in surgical cases.

RECOVERY ON THE BASIS OF TYPES OF HOSPITAL :



RECOVERY ON THE BASIS OF KIND OF TREATMENT IN DIFFERENT CITIES:





- **Practical Exposure at SIP (Care Health Insurance)**

Hands-on experience with real-time claims and audits.
Exposure to **actual billing patterns**, overcharging cases, and recovery processes.
Worked with **claim audit tools and internal processes** for deduction, delisting, and fraud detection.
Interacted with hospital records, insurer policies, and audit documentation.
Gained insight into **stakeholder coordination** and system limitations.

- **Theoretical Understanding at IIHMR University**

Focus on **insurance concepts**, claim types, and health systems.
Learned **regulations, pricing frameworks** (like CGHS/PM-JAY), and ethical audit principles.
Emphasis on **health economics**, policy structure, and analytical models.
Case-based understanding of audits, fraud, and reimbursement mechanisms.

- **Key Difference**

Theory provided structured knowledge and frameworks.
Practice revealed real-world challenges, decision-making gaps, and operational complexities not covered in textbooks Lead in customer care, products, and communication.

Learnings:

Gained insight into cashless claim processes and inflation factors.
Understood the critical role of audits in cost control and fraud detection.
Learned about recovery methods and hospital billing patterns.
Recognized the importance of data, policy, and stakeholder collaboration.

OBJECTIVES:

- To analyze recovery trends by hospital type, treatment, and region.
- To highlight how audits improve accuracy and prevent fraud.

METHODOLOGY:

- 758 cashless claims cases were randomly reviewed on organization software called claims live.
- The bills of cases were compared with the tariff of the hospital.
- According to the comparison excess payments were detected.

SWOT

STRENGTHS:

- Real-time access to actual claims data.
- Support from experienced audit and claims teams.
- Strong collaboration across departments.

WEAKNESSES:

- Limited access to some hospital-side documents.
- Time constraints during high-volume data periods.

THREATS:

- Resistance from hospitals during claim rejections.
- Risk of missing nuanced clinical justification without full case notes.

OPPORTUNITIES:

- Scope to influence claim cost policies.
- Future integration of AI-based cost flags.
- Building predictive models using claim history.

Challenges faced :

No standard pricing leads to billing inconsistencies.
Hospital resistance and limited audit resources hinder recovery.
Fraud is hard to detect without advanced tools.
Incomplete data and poor documentation reduce audit effectiveness
low policyholder awareness add further barriers.

Suggestions

Use AI tools for real-time claim analysis and fraud detection.
Strengthen pre-authorization and recovery workflows.
Standardize hospital communication and documentation.
Train audit teams and track repeat offender hospitals.
Improve inter-department coordination and hold regular audit reviews.
Raise policyholder awareness on claims and billing practices