The Insurance Institute of Zambia (IIZA)

HEALTH INSURANCE FRAUD FUNDAMENTALS



Online Course

Introduction

Health insurance providers, managed care organizations, and other health care stakeholders are increasingly tasked with achieving more on shrinking budgets. This places a premium on strategies that combat and deter the financial effects of health care fraud. With **Healthcare Insurance Fraud Fundamentals**, you'll gain valuable expertise in detecting, deterring, and reducing health care fraud, to help you do your job even better.

Suitability

This course is suitable for:

- Agents and brokers
- Claims analysts
- Underwriters
- Health insurance provider staff
- Compliance officers
- Corporate counsel
- National regulatory personnel
- Fraud examiners
- Legal advisors
- Privacy officers
- State regulatory personnel
- Professionals working in special investigation units (SIUs)

Learning Outcomes

On completion of this course, you will be able to:

- Explore the methods investigators use to uncover and deter fraud against the health care and health insurance industries
- Compare the different ways fraud schemes work and where they often occur
- Understand how to identify fraudulent practice
- Focus on investigative methods at the organizational level, among health care consumers, and in other arenas where fraud can occur
- Navigate the legal, regulatory, and compliance issues impacting anti-fraud efforts
- Examine relevant terms, case scenarios, and key concepts

Module One: Course Overview and Insurance Fraud Statistics

What is covered

- Insurance fraud in Zambia
- Global cost of insurance fraud
- Global insurance fraud statistics

Module Two: Health Care Fraud: An Overview

What is covered

- Introduction
- Defining Fraud
  - Insurance Fraud
  - Health Care Fraud
  - Health Care Fraud vs. Health Care Abuse
- Types of Health Care Fraud
  - Provider Fraud
  - Consumer Fraud
  - Fraud by Agents, Brokers, and Insurer Employees
  - Fee-for-Service Fraud vs. Capitation Fraud
- Health care fraud red flags

Module Three: Provider Fraud and Abuse

What is covered

- False claims
- Billing Schemes
  - Upcoding
  - Unbundling
  - Billing for Noncovered Treatments
- Fraudulent Diagnoses and Unnecessary Services
  - DRG Creep
- Overutilization
- Fraudulent Dates of Service
- Waiver of Cost-Sharing Payments
- Free Medical Service Schemes and Patient Recruiting
- Kickbacks, Rebates, and Fee Splitting
- Impostors and Phantom Billing
- Pharmacy, Laboratory, and DME Fraud

  - Pharmacies
  - Online Pharmacies
  - Pharmaceutical Manufacturers
  - Laboratories
  - Medical Equipment and Supply Companies
- Provider Employees and Billing Agencies
  - Provider Employees
  - Billing Services
- Fraud Rings
- Red Flags for Health-Care Provider Fraud
  - Red Flags for Billing of Services/Treatments

Module Four: Consumer Fraud

What is covered

- Claim Fraud
  - Direct Submission
  - Assignment of Benefits
  - Medical Identity
  - Foreign Claim Fraud
  - Online Pharmacies
  - Insurance Speculation
  - Fraud Rings
- Application Fraud
  - Employer Application Fraud
- Eligibility Fraud
  - Eligibility Fraud Based on Dependent Status
  - Eligibility Fraud Based on Employment Status
- Consumer Fraud and Group Plans
  - Self-Administration and Policyholder Submission
  - Fictitious Groups
- Agent/Broker Fraud
  - Application Fraud
  - False Advertising
  - Misrepresentation of Coverage
  - Improper Replacements
  - Phony Agents
- Insurer Employee Fraud

Module Five: Managed Care Fraud

What is covered

- Capitation Fraud
- Other Provider Fraud
  - Kickbacks
  - False Diagnoses
  - Balance Billing
  - Copayment Fraud
  - Misrepresentation in Credentialing
  - Fraud by Other Health Care Providers
- Consumer Fraud
- Fee-for-Service Fraud in Managed Care

Module Six: Disability Income Insurance Fraud

What is covered

- Application Fraud
  - Misrepresentation of Disability Factors
  - Financial Misrepresentations
  - Application Fraud in Group Disability Insurance
- Claim Fraud
- Disability Misrepresentations
- Combating DI Fraud
  - Average Duration of Disability Databases
  - Requiring Continued Proof of Disability
  - Requiring Continued Proof of Loss of Income or Inability to Work
  - Requiring Medical Proof of Continued Disability
  - Surveillance
- Legal Issues
  - Subjective Disabilities
  - Physician Testimony
  - Income
  - Prompt Payments of Claims

Module Seven: Dental Benefits Fraud

What is covered

- The Insurance Products
  - What Is Dental Insurance?
  - Types of Dental Insurance
  - What Is Managed Dental Care?
  - Indemnity Plans
  - Dental PPOs
  - Dental HMOs (DHMOs)
- Features of Dental Coverage
  - Who Buys Dental Insurance?
  - What Does Dental Insurance Cover?
  - What Does Dental Insurance *Not* Cover?
  - Other Policy Provisions Concerning Payment
- Fraud Schemes
  - Provider Fraud and Abuse
  - Red Flags for Dental Insurance Fraud and Abuse—Providers
- Consumer Fraud
  - Red Flags for Dental Insurance Fraud and Abuse—Consumers
- Foreign Claims
- Other Problem Areas
  - Dates of Service
  - Managed Dental Care Fraud Issues
- Combating Dental Insurance Fraud
  - Information
  - Education
  - Sharing Information and Resources
- Other Issues
  - Medical Versus Dental
  - Dental Policy Exclusions and Limitations
  - Variations in Professional Practice
  - Provider Alienation

Module Eight: Prescription Drug Fraud

What is covered

- Prescription Drug Coverage
  - The Pharmacy Benefits Manager (PBM)
  - Other Drug Coverage

- Features of Prescription Drug Coverage
  - Cost-Sharing
  - Limits on Benefits
  - Drugs Covered
  - Brand-Name and Generic Drugs
  - The Drug Formulary
  - The Average Wholesale Price (AWP)
  - Rebates
- Fraud Schemes
  - Pharmacist Fraud
  - Physician Fraud
  - Consumer Fraud
  - Drug Manufacturers' Fraud
  - Red Flags for Prescription Drug Fraud
- Combating Prescription Drug Fraud
  - The Pharmacy Benefits Manager
  - Data Mining
  - Adequate Formularies
  - Protection of the Prescription Drug Identification Card

Module Nine: The Insurer Anti-Fraud Program

What is covered

- The Anti-Fraud Program
  - The Anti-Fraud Policy Statement, the Anti-Fraud Plan, and Corporate Culture
  - Training and Anti-Fraud Procedures
  - Interdepartmental Cooperation
  - Cooperation with Government Agencies and Other Insurers
  - Consumer and Provider Education
- Pursuing a Fraud Case: Detection, Investigation, and Litigation
- Anti-Fraud Activities of Insurer Departments
  - The Customer Service Department
  - The Underwriting and Actuarial Departments
  - Information Systems
  - The Public Affairs Department
  - The Legal Department
  - The Medical Department
  - Provider Relations Department
- Considerations in Designing an Anti-Fraud Program

Module Ten: The Detection of Fraud

What is covered

- Manual Detection
- Electronic Claim Processing and Fraud
- Anti-Fraud Technology
  - Edit Systems
  - Provider Profiling Systems
  - Aggregate Analysis Theory
  - Advanced-Data Analysis
- Emerging Technologies
  - Data-Driven Analytics
  - Artificial Intelligence and Fuzzy Logic
  - Link Analysis
  - Neural Networks (Pattern Recognition)
  - Genetic Algorithms
- Other Ways of Detecting Fraud
  - Claimant Behavior
  - Medical Review
  - Post-Payment Claim Audits
- Detection—The Sooner the Better

Module Eleven: Investigation: Review of Files and Records

What is covered

- Files and Records Examined
- Insurer Files and Records
  - Claim Files
  - Files of Previous Investigations
  - Insurance Application Files
  - Payment Histories and TIN Histories
  - Files and Records of Other Insurers
- Other Records
  - Medical Records of Insureds
  - Provider Licensure Records
  - Financial Records
  - Records of Public Offices and Agencies
  - Other Miscellaneous Records and Information
- Background Information

Module Twelve: Investigation: Interviews and Surveillance

What is covered

- Planning and Conducting Interviews
  - A Face-to-Face, Telephone, or Written Interview?
  - The Order of Interviews
  - Other Considerations
- Recording Interviews
- Signed Statements and Affidavits
- Surveillance
  - Recording Conversations
  - Undercover Operations

Module Thirteen: Investigation: Evidence and Reporting

What is covered

- What Is Evidence?
- Maintaining the Integrity of Evidence
  - Evidence Procedures
- Other Considerations Related to Evidence
  - The Best Evidence Rule
  - Customer Contacts
  - Email
  - Automated Claims
- The Investigative Report
- Standards of Proof

Module Fourteen: The Detection and Investigation of Managed Care Fraud

What is covered

- Contractual Arrangements
- Red Flags in Managed Care
  - Red Flags Indicating Underutilization
  - Other Red Flags
- The Provider Credentialing File

Module Fifteen: The Detection and Investigation of Disability Fraud

What is covered

- Red Flags
- Interviews
- Surveillance

Module Sixteen: Collaborative Anti-Fraud Efforts

What is covered

- Consumers and Providers
  - Promoting Fraud Awareness
  - Fraud Warnings
  - Explanation of Benefits (EOB)
  - Hotlines
- Collaboration with Government Agencies and with Other Insurers
- Commercial Investigative Services
- Summary and what insurers can do



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