Insurance
INSTITUTE OF EAST AFRICA

HEALTH INSURANCE FRAUD FUNDAMENTALS

Online Course

International Fraud
TRAINING GROUP

| Accredited |

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

- 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 Kenya
- 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

Contact us to register
Phone: +254 20 6530128 | Safaricom: +254 723 334 408 | Airtel: +254 733 812 695
E-Mail: info@iiea.co.ke or Training@iiea.co.ke

Insurance Institute of East Africa
Brunei House, 3rd Floor | Witu Road off Lusaka Road
P.O. Box 16481-00100 Nairobi, Kenya
Tel: +254 20 6530128 | 6530298
Mobile: +254 723 334 408 | 733 812 695
Email: info@iiea.co.ke | www.iiea.co.ke