

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 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



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