The Challenge:

HEALTH BENEFITS FRAUD

Health benefits fraud is becoming increasingly more sophisticated meaning detecting and shutting down fraudulent schemes involves sifting through unprecedented amounts of information and expanded levels of collusion. Fraudsters are now even more familiar with the benefits world, more technology savvy, and more innovative.

The Solution:

GREEN SHIELD CANADA'S (GSC'S) CLAIM WATCH

GSC has long been a leader in fraud prevention and detection. Claim Watch brings together all of GSC's proven fraud prevention knowledge and experience into a comprehensive and multi-layered approach that tackles fraud and abuse head on – *before* it impacts a plan sponsor's benefits spend.

gsc
green shield canada

GSC'S CLAIM WATCH

Claim Watch is a unique multi-layered strategy – the most innovative and efficient in the Canadian group benefits industry. It is a holistic approach that allows us to conduct investigations with optimal speed to shut down fraudulent activity.

Staying a step ahead

Claim Watch is built on a continuum of four foundational elements. Read on (past the illustration) for a description of each one: the National Provider Registry, the Advantage® system, artificial intelligence, and operations.

What do we mean by fraud?

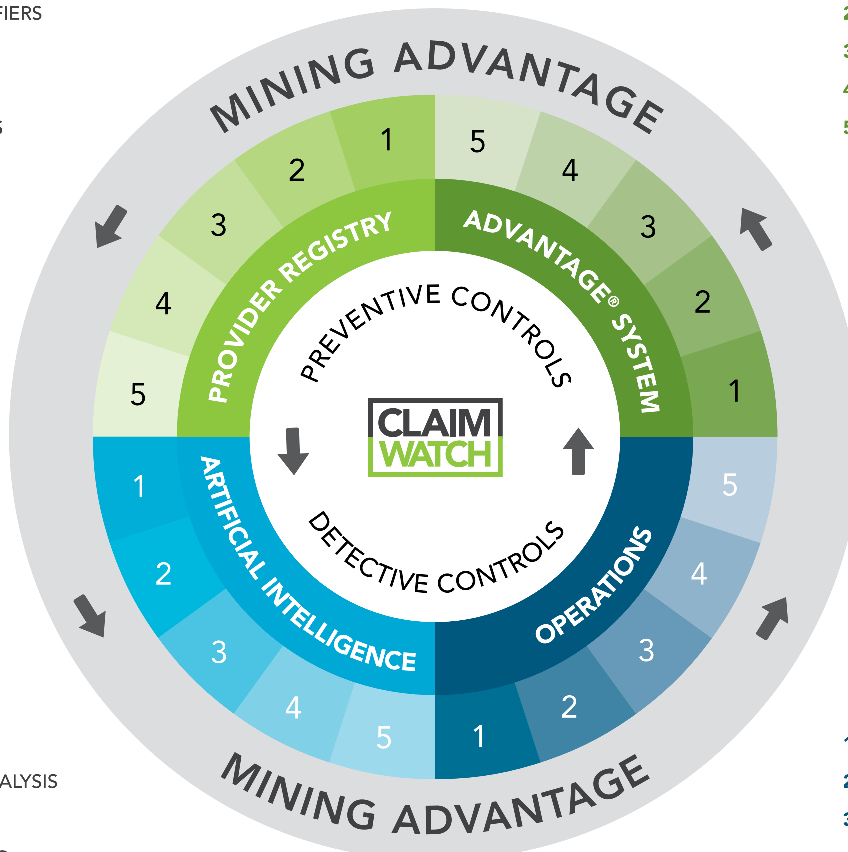
Fraud is defined as the act of deceiving or misrepresenting – and insurance fraud is any submission of false or misleading information with the intent of illegally obtaining an insurance benefit. Of all the dollars spent on health care in North America – the most recent stats indicate that **two to ten per cent** of those dollars are lost as a result of inappropriate activity.*

Fraud is often unintentional; however, whether intentional or not, abuse, misuse, and overuse of benefits plans is a reality.

* Canadian Life and Health Insurance Association, "Heathcare Anti-fraud."

1. CREDENTIAL VALIDATION
2. INDIVIDUAL IDENTIFIERS
3. PROFILING
4. RANKING
5. REAL-TIME UPDATES

1. RULES
2. ADMINISTRATIVE POLICIES
3. MOCK CLAIMS
4. PLAN DESIGN CONTROLS
5. REAL-TIME ADJUDICATION



1. PEER ANALYSIS
2. RULE BREAKING ANALYSIS
3. SOCIAL NETWORKS
4. MACHINE LEARNING
5. PREDICTIVE MODELLING

1. INTELLIGENCE DIVISION
2. INVESTIGATION DIVISION
3. FIELD OPERATIONS
4. SUBJECT MATTER EXPERTS
5. HUMAN INTELLIGENCE

National Provider Registry

GSC's Provider Services team is responsible for the administration and maintenance of the providerConnect® National Provider Registry which ensures health service providers have appropriate credentials and are registered on the GSC claims adjudication system before a claim is paid.

A specific list of criteria is verified for every provider accepted into the registry, including credentials, schooling, and address. The provider is then assigned a unique identification number that allows us to track and monitor provider claims activity at each location they may be practicing at, as well as any other provider who may be practicing at the same location.

Other controls, such as provider profiling and a provider classification system, enable ongoing monitoring of provider practices and interpretation of provider claims data to identify abnormal billing patterns, service over-utilization, and excessive fees before they escalate into larger issues.

Advantage system

A range of prevention strategies and policies is available to help deter fraud and abuse via our dynamic, rules-based, fully-integrated claims adjudication system, Advantage. Its versatility enables us to automate many of our auditing processes and apply policies and practices in real time. Through the application of rules, flagging mechanisms, or interactive messaging, Advantage does more than simply pay a claim. It can:

- → Automatically pend/flag a claim so it can be reviewed by an auditor prior to reimbursement
- → Send the adjudicator an interactive message to stop processing the claim so an auditor can undertake a review prior to payment
- → Request additional information to support the claim, such as a lab invoice or a dental x-ray – a message on the claim statement advises the plan member/provider of the need for additional information

Smart benefits plan design is key to avoiding fraud. A plan geared towards fraud prevention does not mean that the plan design needs to be restrictive – it just means having the right controls. Advantage was designed with a range of prevention strategies and policies to help deter fraud and abuse. These are optional and can be included or excluded by plan sponsors, for example:

- → Automated rules built into Advantage protect plan sponsors' benefit plans against fraudulent situations like dual benefit claiming or inappropriate billing.
- → Price monitoring practices such as our "usual and customary" pricing guidelines are established for all eligible benefits and services to prevent over-billing by service providers and, in turn, overpayment by plan sponsors' benefit plans.
- → Built-in plan-design controls encourage plan members to access appropriate and not excessive treatments.
- → Superior data-mining tools make it possible for data from every claim entered into our system to be analyzed using our sophisticated reporting tools.

Artificial intelligence (AI)

At GSC, we're inundated by data; it comes at us in a huge volume in all forms and from all directions. And it's utterly impossible for us humans to compile it all, let alone make sense of it. By contrast, our AI platform not only finds and compiles this range of data – at tremendous speeds – but also identifies patterns at a much more sophisticated level than we can.

Our AI platform also "self-educates" through machine learning, meaning the AI continuously learns as new data presents itself. And to ensure continual improvement, the results from our comprehensive investigations are fed back into the platform to establish corrective measures and enhancements. As a result, the learning curve for our AI platform is automatic and in real time, much faster and more sophisticated than possible for humans. Specifically, because it can amass such a broad range of data, at such high volumes, and perform very sophisticated analysis, it is able to unearth non-obvious connections, which is often where fraudulent claim activities lie.

Operations

Our Benefits Management and Investigation Services (BMIS) team is dedicated exclusively to claim investigation, audits, and fraud and abuse detection. The team consists of former law enforcement personnel, criminal intelligence officers, certified accountants, and individuals with backgrounds in the financial and public sectors. In addition, the BMIS team includes staff with extensive health care services backgrounds, including pharmacy and dental.

Every report of possible fraudulent activity is filtered through our intelligence division first to make sure that all of our sources of information are reviewed consistently and nothing gets missed. Files are then assigned to the investigative division to review the case and create a unique operation plan to address the concern. We also have field operations that conduct surveillance, interviews, onsite audits, and undercover investigations.

What happens when fraud is suspected/detected?

We have an established course of action for suspected fraud or abuse. Analysts strictly follow established protocols – while maintaining confidentiality – resulting in any number of outcomes:

- → For health providers: cautionary intervention, suspending or revoking billing privileges, formal complaints to regulatory agencies, or even escalation to law enforcement agencies
- → For plan members: suspending pay-direct privileges (limited or full), terminating benefits, or, in extreme cases, possible plan sponsors and/or escalation to law enforcement

Gain peace of mind over your benefits spend with GSC's Claim Watch.