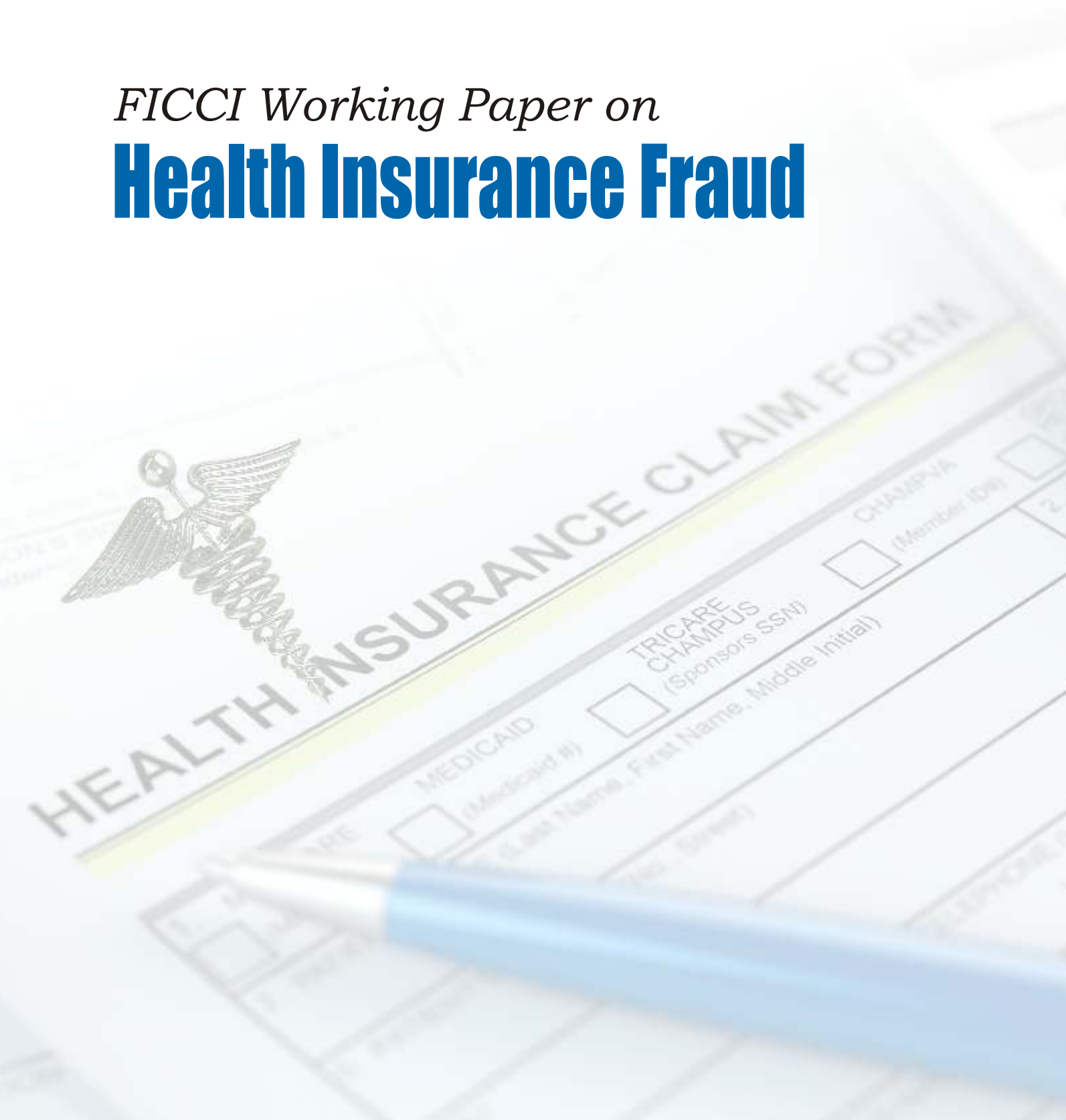




FICCI Working Paper on
Health Insurance Fraud



HEALTH INSURANCE CLAIM FORM

MEDICARE MEDICAID CHAMPUS CHAMPVS GROUP HEALTH PLAN FECA BLK LING OTHER (FOR PROGRAM IN ITEM 1)

1a. INSURED'S ID NUMBER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM : DD : YY M F SEX

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) STATE

6. PATIENT'S RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No. Street) STATE

8. PATIENT STATUS Single Married Other

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) CITY

10. IS PATIENT CONDITION RELATED TO: Employed Full-Time Student Part-Time Student

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to myself or to the party who accepts assignment. SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSONS SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

14. DATE OF CURRENT ILLNESS (First Symptom) OR INJURY (Accident or PREGNANCY) MM : DD : YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM : DD : YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM : DD : YY TO MM : DD : YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM : DD : YY TO MM : DD : YY

19a. ID. NUMBER OF REFERRING PHYSICIAN

19b. CHARGES

20. OUTSIDE LAB? YES NO

21. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

22. PRIOR AUTHORIZATION NUMBER



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8. Mr Shreeraj Deshpande, Head - Health Insurance, Future Generali India Insurance Company Ltd
9. Mr Nazeem Khan, VP, ICICI Lombard



Patient Name: _____

Physician: _____

Length of Procedure: _____

Diagnosis: _____

Procedure: _____

Site: _____



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ADDITIONAL INFORMATION
 IS NOT LEGAL, IF NOT SAFETY BLUE BACKGROUND

Handwritten notes:
 1000 mg 477 mg
 60 mg
 2x daily

Rate 1 mg

PRODUCT SELECTION PERMITTED

DISPENSE AS WRITTEN

DIAGNOSIS

692.99	Lichen Simplex Chronicus	698.3	Skin Tag	701.9
690.10	Lipoma (non-lipid)	214.1	Sunburn	692.71
692.20	Lipoma (fatty)	214.0	Tarso	709.00
434.1	Lupus Discoid	695.4	Telangiectasia	448.1
693.0	Lupus Systemic	780.0	Tinea Capitis	110.0
216(0-8)	Melanoma	173(0-8)	Tinea Corporis	110.5
692.9	Melanoma	709.00	Tinea Cruris	110.3
782.3	Molluscum Contagiosum	078.0	Tinea Pedis	110.4
695.1	Necroplasma (Ulcer Natus)	248.2	Tinea Versicolor	111.0
214.0	Oncobolus	703.8	Ulcer Leg (Venicose)	454.0
214.1	Oncobolus	110.1	Ulcer Leg	707.10 - 707.19
214(0-8)	Paronychia	681.9	Urticaria	708.0
704.8	Paronychia	695.3P	Venous Ulcer	454.1
078.19	Pigmented Lesion	216(0-8)	Verruca	078.10
695.39	Polymorphous Erythema	696.3	Vitiligo	709.01
228.01	Psoriasis (typical)	692.6	Xerosis	706.8
054.0	Psoriasis	698.9	Cutaneous burn	702.8
051.9	Psoriasis	696.1	Elastosis	701.3
709.09	Psoriasis	287.2	Cosmetics	V30
684	Pyogenic granuloma	686.1	Keratosis Pilaris	737
695.89	Rash (unspecified)	782.1	Hx. Malign. Neoplasm	V10.1
701.4	Scabies	113.0	Hx. Malign. Melanoma	V10.92
709.09	Scab	709.2		
112.0	Seborrheic Keratosis (Baldwin)	702.11		
697.0	Schwarzer Keratosis (Other)	702.19		

DISPENSE AS WRITTEN
 LIC05015486

692.9	
691.8	Keloid
705.81	Leish
694.0	Lice
692.89	Lichen planus

FICCI Health Insurance Working Group

Tackling Fraud in Health Insurance

1. Introduction

There is a growing concern among the insurance industry about the increasing incidence of abuse and fraud in health insurance. FICCI sub group on health insurance fraud was set up to deliberate upon the issue and come up with a working paper on health insurance abuse and fraud management for the practitioners within the health insurance industry and to suggest a framework of best practices. This paper is the result of sub-groups efforts and deliberations over a short period of 12 weeks.

The paper begins with definition of fraud and abuse, different parties involved in various types of health insurance fraud, triggers that represent possible presence of abuse and fraud and the actions that could be considered at various levels. The paper also captures the issues concerning inadequate legal provisions and concerning code of conduct for medical practitioners. The ideas presented here can be categorised into one of three broad areas:

Category	Industry Considerations	Time-frame to yield results
Process improvements or modifications	Company specific, no industry intervention	Immediate
Industry intervention	Industry bodies endorsing, with very little regulatory or government intervention	Short/medium-term
Government or regulatory intervention	Industry intervention insufficient alone, regulatory or government intervention required	Medium/long-term

After presentation of this initial working paper and receipt of feedback from wider community of all stakeholders, the FICCI sub group will consider producing a more formal "white paper", incorporating concepts and further recommendations that are likely to emerge from expanding the dialogue to more members of the industry, consumer bodies and providers. The aim of the white paper will be to detail individual company level actions, potential industry level actions and regulatory actions which can impact health insurance fraud.

2. Defining Fraud & Abuse

It is a matter of concern that 'insurance fraud' is not defined under the Indian Insurance Act. IRDA recently quoted the definition provided by the International Association of Insurance Supervisors (IAIS) which defines fraud as "an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties."

Other instruments within the Indian legal system, such as the Indian Penal Code (IPC) or Indian Contract Act, also do not offer specific laws. Sections of the IPC which deal with issues of fraudulent act, forgery, cheating etc. are sometimes applied but none of them are specifically targeted at insurance fraud and are inadequate for purpose of acting as an effective deterrent. In absence of specific laws and harsh punishments, prosecution will rarely be successful and if successful, the penalty inadequate to deter others. As social health insurance grows the central and state governments will become one of the largest victims of health insurance fraud and that may be the catalyst that leads to the development of a comprehensive legal framework to tackle health insurance fraud.

(More information about IPC, Contract Act and state and federal laws in the USA is presented in Annexure A & B)

In simple parlance, insurance fraud can be defined as: The act of making a statement known to be false and used to induce another party to issue a contract or pay a claim. This act must be wilful and deliberate, involve financial gain, done under false pretences and is illegal.

Healthcare fraud as defined by the National Health Care Anti-Fraud Association (USA): "The deliberate submittal of false claims to private health insurance plans and/or tax-funded public health insurance programs." "Intentional deception or misrepresentation that the individual or entity makes, knowing that the misrepresentation could result in some unauthorised benefit to the individual, or the entity, or to another party."

Abuse can be defined as practices that are inconsistent with business ethics or medical practices and result in an unnecessary cost to claims.

The billing of services that may not be fraudulent, but may be of marginal utility, are inconsistent with acceptable business and/or medical practices, and are intended for the financial gain of a particular individual or corporate can be classified as abuse. Few examples of common health insurance abuse would be - excessive diagnostic tests, extended LoS, conversion of day procedure to overnight admission, admission limited to diagnostic investigations etc.

Fraud is willful and deliberate, involves financial gain, done under false pretense and is illegal. Abuse generally fails to meet one or more of these criteria, hence the subtle difference. Needless to say that the main purpose of both fraud and abuse is financial gain.

Parties involved in health insurance fraud and types of fraud committed by each

IRDA guidelines classify various insurance fraud as under:

- a) Policyholder Fraud and /or Claims Fraud - Fraud against the insurer in the purchase and/or execution of an insurance product, including fraud at the time of making a claim.
- b) Intermediary Fraud - Fraud perpetuated by an intermediary against the insurer and/or policyholders.
- c) Internal Fraud - Fraud / mis-appropriation against the insurer by a staff member.

(Select portions of IRDA circular are presented in Annexure C)

As relevant to health insurance, the type of fraud committed by customer, intermediary - agent, broker, healthcare provider either individually or jointly or in connivance with internal staff of insurance company/TPA vary in nature and modus operandi.

Commonly committed fraud by a customer of health insurance relate to:

- concealing pre-existing disease (PED) / chronic ailment, manipulating pre-policy health check-up findings
- fake / fabricated documents to meet policy terms conditions,
- duplicate and inflated bills, impersonation,
- participating in fraud rings, purchasing multiple policies,
- staged accidents and fake disability claims,

The agents and brokers are usually involved in fraud relating to

- providing fake policy to customer and siphoning off premium,
- manipulating pre-policy health check-up records,
- guiding customer to hide PED/material fact to obtain cover or to file claim,
- participating in fraud rings and facilitating policies in fictitious names,
- channelising customers to rouge providers
- fudging data in group health covers

Due to the absence of standard medical protocols, no oversight of a regulator, the provider induced fraud and abuse in India forms quite a large portion of fraudulent claims. It would be quite difficult for a customer to file a fraudulent claim or fake medical documents without connivance of treating doctor or hospital. Provider related fraud usually pertain to:

- Overcharging, inflated billing, billing for services not provided
- Unwarranted procedures, excessive investigations, expensive medicines,
- Unbundling and up coding
- Over utilisation, extended length of stay
- Fudging records, patient history

The employees of insurance company / TPA could also be involved in committing fraud by expecting receiving favours / kickbacks, colluding with other fraudsters / fraud rings, syphoning premium etc.

a) Triggers

One of the ways to control fraud is to establish triggers / red alerts for early detection and corresponding action. A list of commonly used triggers and alerts for health insurance claims are presented in Annexure D. These can be managed automatically through systems capabilities or manually detected through inspection of a physical file. It should be noted that the presence of a risk management trigger only warrants special attention and further investigation of the claim to collect evidence is required. The exercising of a trigger is not proof of fraudulent claim, only an indication of possible fraud.

3. Managing Fraud

(A) Process improvements or modifications

In this section, methods of identification, mitigation and management of fraud are considered within the context of process improvements or modifications that can be implemented by the insurer. Possible areas to consider are set out below.

- 1) **Tele-underwriting or proposal verification call:** this should ideally be a centrally controlled process to ensure that the proposal form contents reflect the policyholder's understanding and specifically including confirmation that no PEDs exist. This should be done after a proposal is received but before a policy is issued. It helps to minimise agent-led fraud and the use of recorded calls may help substantiate evidence of fraud at claims stage. In addition, this call can be utilised to confirm that the policyholder fully understands the benefits and exclusions of the policy.

Cost: low for verification call

Complexity to develop/administer: medium - agent needs to disclose policyholder's contact number

Working group output: a best practices note which insurers can utilise to create a standardised verification call process. Underwriting is complex and a very company-specific process, so no best practice or guidelines will be developed for this area

- 2) **Pre-authorisation:** this process is a vital component of the health insurance claims system. It is the first level check to curb fraud and capable of eliminating or reducing the likelihood of its occurrence. However, whether due to an insurer's processes and systems not being robust enough or lack of awareness on the part of customer or provider, this process is often not adhered to in the manner required and the key components of this process which make it effective, need to be implemented properly.
 - a. Pre-authorisation requests for scheduled surgeries must be submitted at least 24 hours before admission
 - b. Implementation of the standardised pre-authorisation, discharge summary and billing format must be fast-tracked.

- 3) Intimation to insurer or TPA:** the first intimation call to the insurer or TPA is a very rich source of information about the status of the policyholder at time of admission. As a result, this intelligence should be used in an optimum manner. The best practice in respect of what information should be sought at the intimation stage to mitigate fraud, should be documented and distributed. A sample of the type of information that can be collected at this stage is provided in Annexure E.

Cost: low

Complexity to develop/administer: low

Working group output: A best practices note which insurers can utilise to streamline processes covering claim intimation and pre-authorisation.

- 4) Explanation of benefits:** in some markets, insurers send the policyholder a detailed breakdown of what benefits they have paid for. This can be very effective way to check if any impersonation or billing for services not provided had occurred.

Cost: low

Complexity to develop/administer: low

Working group output: a best practice note which insurers can utilise to design a "Benefits Explanation" letter

- 5) Fraud detection tools and technology:** insurers in advanced markets deploy robust technology and data analytics processes for detecting outlier behavior or for predictive modeling. These function as a kind of early warning system for detecting fraud. The solutions offered can work in conjunction with existing practices to create a robust framework for early detection / prevention of fraud.

Cost: medium

Complexity to develop / administer: medium

Working group output: to encourage and advocate that insurers deploy enabling technology

- 6) Whistleblower policy (company level):** develop a reporting and rewards system that will motivate individuals to alert an insurer about individual cases of fraud or systematic fraud. This can be a very attractive mechanism through which the general population can be engaged in the fight against fraud. In addition this is a mechanism for disgruntled co-conspirators to exit a risky situation whilst claiming credit for stopping it.

Cost: nil, only based on outcome

Complexity to develop/administer: low

Working group output: to encourage and advocate that insurers develop their whistleblower policy

- 7) **"Name & shame" guidelines: (company level):** publicly disclosing names of individuals and institutions involved in a confirmed case of health insurance fraud, especially when a criminal or civil case has already been filed is an effective way of raising community awareness that insurance fraud will not be tolerated. An internal media policy about how and what to disclose as well as in which situations, can provide valuable guidance as the time to take such decisions is usually short.

Cost: nil

Complexity to develop/administer: medium, proper legal review of all information released is required to avoid accusations of libel or slander

Working group output: to encourage and advocate that insurers develop their internal policies

(B) Industry Intervention

As an industry evolves, certain systematic requirements emerge. These are generally intended to organise and structure the industry and are often best implemented by the industry through a collective body, such as General Insurance Council (GIC) or through a less formal forum specifically designed for such tasks. In recent few months, General Insurance Council has taken initiative in fraud data sharing among member companies and has also looked at classification, monitoring and developing templates for data sharing; it is work-in-progress at the time of writing this paper. The data sharing should also lead to collective action for effective deterrence, either through GI Council or the recently constituted Health Insurance Forum.

Key to the success of collective action will be blacklisting / dis-empowerment by all of those entities who are proven to indulge in fraud and pursuing punitive action, recovery of money. While data sharing can be the start point, achievable in a short time, the industry level interventions need to be wide and deep for all encompassing impact. Some of the initiatives suggested below are equally easy to achieve if industry would set out the task.

- 1) Education:** fraud can happen inadvertently and due to ignorance. It is in the industry's interest to create education and awareness collateral that creates awareness about the impact of insurance fraud and its implications. This can be deployed for all levels of insurance and TPA employees. It can include content for consumer and provider education to create awareness and ensure that individuals are not inadvertently facilitating fraud. Sample messaging content is available in Annexure F.

Cost: Low

Complexity to develop/administer: Low

Working group output: initial recommendations with sample content.

- 2) Contracting:** in the absence of appropriate law on insurance fraud, the industry should develop model clauses for incorporation into policy contract, in contract with providers, in agency/broker contracts etc. The definition of what constitutes fraud, what penalties and punitive actions would follow upon confirmation of fraud could be spelt out clearly in the contract and claw back provisions for recovery of money into some of these contracts should be explored.
- 3) Deterrence guidelines:** industry recommendation on steps and processes an insurer can undertake when fraud is suspected and when it is confirmed. This would provide a common framework or best practice on how to respond. Refer to Annexure F for different types of fraud/misconduct and corresponding action to be taken.

It is to be noted that insurance industry has not made adequate use of Medical Council of India (MCI) guidelines on code of conduct and ethics for medical practitioners. The effective deterrence for medical fraternity can only come from medical regulator, in the absence of which the good offices of MCI can be utilised. Annexure H provides a list of MCI provisions which could be invoked against specific misconduct.

Cost: nil

Complexity to develop / administer: low

Working group output: sample internal deterrence guidelines and other content to assist insurers.

- 4) Benchmarks:** the industry could collaborate with IIB to create benchmarks that individual stakeholders can utilise to obtain better insight into their overall performance. A proven approach in this direction is to aggregate all industry data in

a single data warehouse and then develop various benchmarks that an individual insurer can compare itself with. Naturally, these benchmarks need to be developed carefully so that the comparison is on a like-for-like basis.

Cost: medium (one time and ongoing)

Complexity to develop/administer: medium

Working group output: a small sub-set of the working group can engage with IIB to help define those benchmarks which the industry requires and which the existing reported data supports.

- 5) **Medical protocols and treatment guidelines:** the industry should advocate for the development and dissemination of independent 3rd party evidence based standard medical protocols and treatment guidelines.
- 6) **Provider billing ID and registration portal:** a version of this control mechanism has been very effective in curbing rampant fraud amongst providers of durable medical equipment to Medicare beneficiaries in the US. The General Insurance Council or newly constituted Health Forum should build a provider registration portal. This portal will be used by providers to enter their details (similar to the one in an empanelment form.) After verification of the details entered by the providers by any one TPA, their details will be added to the common database and a unique provider ID will be issued to the provider.

For providers not currently empanelled by any TPA or insurer, their details will need to be verified before issuance of a unique ID. This unique ID (could be the same as proposed by IRDA) would also act as a billing ID and would be mandatory on all claim forms. In cases of fraud, a provider will risk losing its billing ID thus incapacitating it from lodging any claims. Naturally, the industry would need to maintain a common and accessible database which can verify all billing IDs in real time.

Individual doctors already have a registration ID and the pre-authorisation and claims forms seek this ID. The industry needs to insist that this number be provided for more active profiling of individual doctors.

Cost: low/medium

Complexity to develop/administer: low

Working group output: a small sub-set of the working group can provide guidance to the entity selected to develop the provider billing ID and registration portal

- 7) **Watch list creation and maintenance:** All TPAs and insurers maintain and share their own lists of blacklisted providers. Some insurers and TPAs share such lists of providers, refer Annexure F. A common listing of these entities by collecting this information from all TPAs and insurers would benefit the industry as a shared knowledge repository. The development of such a repository would involve a "one-time" effort to collect existing blacklists from TPAs and insurers and then compile them into user-friendly format and an "on-going" effort to maintain it.

Such a watch list would resemble a website with a secure password restricted area which would contain indexed watch lists of individuals and corporate entities which have previously defrauded or abused the insurance system. This would be a centralised resource which insurers and TPA can assess and search and update. The credibility of the data will be enhanced by replacing an ad-hoc sharing of individual lists provided between insurers.

Cost: low

Complexity to develop/administer: low/medium

Working group output: a small sub-set of the working group can provide guidance to the entity selected to develop the website

- 8) **Fraud investigator training program:** a structured training program along with mandatory examination, as well as continuing education requirements should be developed for fraud investigators. All fraud investigators must meet a minimum skill set requirement. In addition, there should be a mechanism whereby a fraud investigator can be assessed and certified for higher skill levels. This would create a cadre of professional and highly skilled fraud investigators. It may be desirable to ensure that these investigators are licensed by the IRDA.

Cost: low

Complexity to develop/administer: low/medium

Working group output: a small sub-set of the working group can liaise with IRDA or appointed institutions (e.g. NIA, III) to design the syllabus of such a training program. The full content, delivery mechanisms and examination modalities would then be developed by that institution.

- 9) **Whistleblower system & rewards:** (industry level): in case of actionable information about larger and more systematic fraud cases which span across entities, the industry (through IRDA or GIC or the newly formed Health Insurance Forum) may wish to coordinate a reward program. Modalities of reward programs initiated by insurers as well as other government entities, such as tax or customs departments, might need to be studied.

Cost: nil, only based on outcome

Complexity to develop/administer: medium

Working group output: can provide guidance on how to maintain consistency with the whistleblower policies that individual insurers are implementing

- 10) Capacity and awareness development in police and prosecution agencies:** in conjunction with building a cadre of fraud investigators, the industry will need to invest resources in training police and public prosecutors. Police officers are not familiar with intricacies of insurance processes and that can hinder progress in fraud investigations. Similarly, public prosecutors need requisite insurance knowledge to effectively prosecute offenders. A training program for police economic offence investigators and prosecutors could be conducted by the same entity tasked with training fraud investigators.
- 11) Autonomous anti-fraud bureau:** industry, regulatory and government bodies should support the creation of an independent anti-fraud bureau. Assistance to design organisational structure, charter, funding mechanisms and operations can be sought from Coalition Against Insurance Fraud (CAIF) and National Healthcare Anti-fraud Association (NHCAA). Focus activities can include anti-fraud advocacy, public awareness, dissemination of best practices, education (e.g. case studies, training), centralised services (e.g. fraud hotline, data warehousing.)

(C) Government or Regulatory Interventions

- 1) Regulatory action against licensed bodies:** IRDA's jurisdiction spans insurers, agents, brokers and TPAs. While these entities are governed by detailed guidelines, regulations and are subjected to regular inspections/audits by Regulator, the action and penalty upon confirmation of connivance or active involvement in fraudulent activity should also be clearly spelt out, leading to suspension/revocation of license.

Unfortunately there is no equivalent regulator for the supervision of providers, which puts the onus on the Health Forum to take collective action against providers indulging in health insurance fraud.

It is also necessary that MCI and Ministry of Health play an active role in bringing fraudulent hospitals and doctors to account. The Health Forum should also make a concerted effort to address these issues with members from the provider space.

- 2) **Specific laws against insurance fraud:** many countries have very specific laws against insurance fraud and occasionally more specific laws pertaining to social insurance fraud. The specific laws can contain clauses which ensure speedy resolution of cases, thus enhancing the impact of the law. Since some of the violators might be licensed entities, IRDA may also need to review its regulations.
- 3) **Introduction of claw back provisions:** insurance fraud laws which contain provisions which enable an insurer to recover payments, if fraud is proven subsequently. These have been found to be very effective in other countries. Usually such "claw back" provisions are limited to a certain time period, i.e. 3 or 5 years.
- 4) **Regulatory requirements for specific anti-fraud units and capabilities in insurers:** the licensing and inspection regulations of various insurance regulators allow them to seek detailed information about an insurer's anti-fraud capabilities. Insurers who do not demonstrate adequate safeguards may be fined. The recent guidelines by IRDA also require this (refer Annexure B)
 - a) The corporate governance guidelines mandate insurance companies to set up a risk management committee to lay down Risk Management Strategy.
 - b) Disclosing the adequacy of systems in place to safeguard the assets for preventing and detecting fraud and other irregularities on an annual basis.

Further the guidelines also mandate each insurer to have fraud control policy approved by Board, to be reviewed annually. The policy is supposed to lay framework for fraud management department, classification of potential areas of fraud, information sharing mechanism, due diligence etc.

- 5) **Anti-fraud public messaging:** the regulator and government can collectively undertake public messaging which highlights the impact (higher premiums) and consequences (legal action) of insurance fraud. Such campaigns are generally planned as ongoing initiatives which are further enforced by "name & shame" initiatives. IRDA has run number of campaigns on policy holder education, insurance literacy. Anti-fraud awareness campaigns could form part of IRDA's consumer awareness campaigns.

ANNEXURES

ANNEXURE A

Indian Penal System Code (IPC) and Indian Contract Act

- "Section 23 and 24: utilises the term "wrongful gain" - while this may seem relevant, the working group does not feel that reliance on this section is helpful
- Section 25: a person is said to act fraudulently if he acts with the intent to defraud but not otherwise. The working group feels this section is stronger than 23 and 24; however complainant should be aware that a court may ask the insurer to prove fraudulent intent, which is often very difficult. The defendant may maintain it was an oversight, they did not know it was significant, or that someone else completed the form on their behalf
- Section 463: relates to forgery and the working group feels that this is relevant for health insurance fraud. "Whoever makes any false documents or false electronic record or part of a document or electronic record, with intent to cause damage or injury, to the public or to any person, or to support any claim or title, or to cause any person to part with property, or to enter into any express or implied contract, or with intent to commit fraud or that fraud may be committed, commits forgery."
- Section 477 A: relates to falsification of accounts. This may be an applicable section in some cases of health insurance fraud. "Whoever, being a clerk, officer or servant or employed or acting in capacity of a clerk, officer or servant, wilfully and with intent to defraud, destroys, alters, mutilates or falsifies any book, electronic record, paper, writing], valuable security or account which belongs to or is in the possession of his employer or has been received by him for on behalf of his employer or wilfully, and with intent to defraud, makes or abets the making of any false entry in, or omits or alters or abets the omission or alteration of any material particular from or in, any such book, electronic record, paper, writing] valuable security or account, shall be punished with imprisonment of either description for a term which may extend to seven years, or with fine, or with both."
- Applicability of Section 17 in The Indian Contract Act, 1872
 "Fraud" means and includes any of the following acts committed by a party to a contract, or with his connivance, or by his agent, with intent to deceive another party thereto of his agent, or to induce him to enter into the contract:-
 - ❖ the suggestion, as a fact, of that which is not true, by one who does not believe it to be true (across entities)
 - ❖ the active concealment of a fact by one having knowledge or belief of the fact (across entities)
 - ❖ a promise made without any intention of performing it (intermediary/ sales staff)
 - ❖ any other act fitted to deceive (across entities)
 - ❖ any such act or omission as the law specially declares to be fraudulent

ANNEXURE B

USA Legal Framework

In the US, health insurance fraud can be prosecuted under federal laws or state laws. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) makes health care fraud a federal crime. Health care fraud occurs when anyone knowingly and willfully executes, or attempts to execute, a scheme to defraud any health care benefit program in connection with the delivery of or payment for health care benefits, or obtains any property of the health care benefit program by false representations. A person who violates the statute may be fined, imprisoned up to 10 years, or both. If the fraud results in injury to a patient, he may be imprisoned up to 20 years. If death results, he may be imprisoned for life (18 U.S.C. § 1347). The statute applies to fraud against private insurance companies and government health care programs. It also applies to any insurance program involving medical payments (e.g. health insurance, automobile insurance, workers' compensation) (18 U.S.C. § 24).

HIPAA also prohibits knowingly and willfully falsifying, concealing, or covering up a material fact; or making a false statement; or using or making any false or fraudulent document in connection with the delivery of or payment for health care benefits or services. A person who violates this law may be fined, imprisoned up to five years, or both (47 U.S.C. § 1035).

False Claims

A person who knowingly presents a fraudulent claim to the U.S. government (e.g. Medicare) is fined between \$5,000 and \$10,000 plus treble damages (three times the government's losses) under the federal False Claims Act (31 U.S.C. § 3729).

False Statements

A person who knowingly and willfully falsifies, conceals, or covers up a material fact; makes a false statement; or uses or makes a false or fraudulent statement to a government agency is fined, imprisoned up to five years, or both under the federal False Statements to a Government Agency law (18 U.S.C. § 1001).

Mail Fraud

A person who engages in a scheme to defraud any person that involves the use of the U.S. mail may be fined, imprisoned up to 20 years, or both. If the attempt to defraud affects a financial institution (e.g. bank or credit union), the person may be fined up to \$1,000,000, imprisoned up to 30 years, or both (18 U.S.C. § 1341). Mailing a fraudulent claim violates this statute.

Wire Fraud

A person who uses an interstate wire transmission (e.g. telephone, automated claim system) to carry out a fraudulent scheme may be fined, imprisoned up to 20 years, or both. If the attempt to defraud affects a financial institution (e.g., bank or credit union), the person may be fined up to \$1,000,000, imprisoned up to 30 years, or both (18 U.S.C. § 1343).

Racketeer Influenced and Corrupt Organization Act (RICO)

Under RICO, criminal charges and civil lawsuits can be brought against a person engaged in a "pattern of racketeering activity." Racketeering activity includes mail or wire fraud. Submitting a number of fraudulent insurance claims over a period of time would constitute a "pattern" of racketeering.

Criminal penalties include a fine, imprisonment up to 20 years (or more in certain circumstances), or both and forfeiture of any proceeds gained from the racketeering activity (18 U.S.C. § 1693). Civil remedies include treble damages, meaning an insurer could collect punitive damages equal to three times their actual losses, and reasonable attorney fees (18 U.S.C. § 1964).

The applicable state laws are:

Most states have statutes regarding fraud and some specifically address insurance fraud. Insurance fraud statutes generally define what constitutes fraud and what penalties or damages may be imposed. Both the National Conference of Insurance Legislators (NCOIL) and the National Association of Insurance Commissioners (NAIC) have insurance fraud model acts.

NCOIL's model act includes criminal penalties, restitution, administrative penalties, and civil remedies for insurance fraud. NAIC's model requires fraud warnings on insurance applications and claim forms, fraud reporting by insurers, the creation of fraud units within insurance departments, insurer anti-fraud initiatives, and penalties.

Usually the States define insurance fraud as a class D felony. For example, in Connecticut, a person is guilty of insurance fraud when, with the intent to injure, defraud, or deceive any insurance company, he knowingly presents false, incomplete, or misleading information in support of an insurance application, claim, or other benefit. This subjects a person to a fine up to \$5,000, up to five years imprisonment, or both (C.G.S. § 53a-215).

Larceny Penalties

Larceny Degree	Property Involved	Classification	Penalty
First	Over \$10,000	Class B felony	Up to 20 years prison; up to \$15,000 fine; or both
Second	Over \$5,000	Class C felony	Up to 10 years prison; up to \$10,000 fine; or both
Third	Over \$1,000	Class D felony	Up to 5 years prison; up to \$5,000 fine; or both
Fourth	Over \$500	Class A misdemeanor	Up to 1 year prison; up to \$2,000 fine; or both
Fifth	Over \$250	Class B misdemeanor	Up to 6 months prison; up to \$1,000 fine; or both
Sixth	\$250 or less	Class C misdemeanor	Up to 3 months prison; up to \$500 fine; or both

Source: <http://www.cga.ct.gov/2005/rpt/2005-R-0025.htm>

ANNEXURE C

Extracts from IRDA Guidelines on Fraud

Re.: Fraud Detection, Classification, Monitoring and Reporting by Insurers

The Authority has taken a number of measures to address the various risks faced by the insurance companies. Some of these include:

- The Corporate Governance guidelines mandate insurance companies to set up a Risk Management Committee to lay down Risk Management Strategy.
- As part of the Responsibility Statement which forms part of the Management Report filed with the Authority under the IRDA (Preparation of Financial Statements and Auditors' Report of Insurance Companies) Regulations, 2002, Management of the insurance company discloses the adequacy of systems in place to safeguard the assets for preventing and detecting fraud and other irregularities, on an annual basis.

The Guidelines mandate insurance companies to put in place, as part of their corporate governance structure, fraud detection and mitigation measures and submit periodic reports to the Authority in the formats prescribed herein.

1. Anti-Fraud Policy:

All insurance companies are required to have in place the Anti-Fraud Policy duly approved by the Board. The policy shall duly recognise the principle of proportionality and reflect the nature, scale and complexity of the business of specific insurers and risks to which they are exposed. It should consider relevant factors like organisational structure, insurance products offered, technology used, market conditions etc. As fraud can be perpetrated by collusion involving more than one party, insurer should adopt a holistic approach to adequately identify, measure, control and monitor fraud risk and accordingly, lay down appropriate risk management policies and procedures across the organisation.

The Board shall review the Anti-Fraud Policy on an annual basis.

The anti-fraud policy shall broadly cover the following aspects:

- i. **Fraud Monitoring Department:** Set-up a Fraud Monitoring Department (FMD) with well-defined procedures to identify, detect, investigate and report the fraud. A Compliance Officer shall be designated for this purpose, having direct access to the Board of the company.
- ii. **Potential Areas of Fraud:** Identify areas of business and the specific departments of the organisation that are potentially prone to insurance fraud and lay down a detailed area-wise/ department-wise, anti-fraud procedures, risk prevention and mitigation measures

- iii. Co-ordination with Law Enforcement Agencies: Lay down procedures to coordinate with law enforcement agencies for reporting fraud and follow-up processes thereon.
- iv. Framework for Exchange of Information: Lay down procedures for exchange of necessary information on fraud, amongst all insurers through respective councils.
- v. Due Diligence: Lay down procedures to carry out the due diligence on the personnel (management, officers and staff) before appointment.
- vi. Regular Communication Channels: Generate fraud mitigation communication within the organisation at periodic intervals and lay down appropriate framework for a strong whistle blower policy. The insurer shall formalise the information flow from/amongst the various operating departments to FMD.

2. Fraud Monitoring Department (FMD) (Role and Functions):

The FMD shall have in place reporting procedures from the various departments like underwriting, claims, information technology, investments, accounts, internal audit and intermediaries departments. All personnel shall be encouraged to report suspicious instances/ fraud to the FMD.

The FMD shall also lay down the policy framework for the training of personnel and intermediaries to sensitize them on prevention, detection, and mitigation of fraud. Suitable clause should be included in the terms of appointment of employees/intermediaries that clarifies the implications of fraud and penal provisions thereon.

The head of the FMD shall be responsible for furnishing various reports on fraud to the Authority.

3. Reports to IRDA:

Statistics on various fraudulent cases and action taken thereon along with a Compliance Certificate duly signed by the Chief Executive Officer/Managing Director shall be filed with the Authority in form FMR 1 and FMR 2 every year within 30 days of close of the financial year.

4. Reports to the Board:

FMD should lay down appropriate framework for information to be submitted to the Board. The Board shall review the same periodically.

5. Preventive mechanism:

The Insurer shall inform both potential clients and existing clients about their anti-fraud policies. The Insurer shall appropriately include necessary caution in the insurance contracts/ relevant documents, duly highlighting the consequences of submitting a false statement and/or incomplete statement, for the benefit of the policyholder, claimant and the beneficiary.

ANNEXURE D

Policy and claim history triggers

1. Claims from a policy with only one member at minimum sum insured amount
2. Multiple claims with repeated hospitalisation (under a specific policy at different hospitals or at one hospital of one member of family and different hospitals for other members of family), multiple claims towards the end of policy period, close proximity of claims
3. Claims made immediately after a policy sum insured enhancement
4. Claims from a member with history of frequent change of insurer or gap in previous insurance policy
5. Claims for policy with evidence of significant over/under insurance as compared to insured's income/life style
6. Claims from a non-traceable person or where courier/cheque have been returned from insured's documented address
7. Second claim in the same year for an acute medical illness/surgical minor illness/orthopedic minor illness in the same policy period for main claim. Young males between 25-35 years getting admitted for acute medical illness
8. Claims from members with no claim free years, i.e. regular claim history

Provider location or profile triggers

9. Claims from a hospital located far away from insured's residence, pharmacy bills away from hospital/residence
10. Claims for hospitalisation at a hospital already identified on a "watch" list or black listed hospital
11. Claims on hospital stationery without landline phone number, registration number, area pin code or doctor's qualification stated
12. Claims submitted that cause suspicion due to format or content that looks "too perfect" in order. Pharmacy bills in chronological/running serial number or claim documents with color photocopies. Perfect claim file with all criteria fulfilled with no deficiencies
13. Claims with visible tempering of documents, overwriting in diagnosis/treatment papers, discharge summary, bills etc. Same handwriting and flow in all documents from first prescription to admission to discharge. X-ray plates without date and side printed. Bills generated on a "Word" document or documents without proper signature, name and stamp.

14. Claims without supporting pre-post hospitalisation papers/bills
15. Claims with apparent discrepancy in diagnosis and line of treatment: irrelevant investigations for a particular ailment, mismatch in ICD and CPT code/ procedure description, line of treatment/procedure inconsistent with insured's profile/gender/age or season. Inconsistency between specialisation of treating doctor and illness
16. Claims with incomplete/poor medical history - complaints/presenting symptoms not mentioned, only line of treatment given, supporting documentation vague or insufficient
17. Claims without signature of the insured on pre-authorisation form
18. Reimbursement claim from a network hospital
19. Claims with missing information like post-operative histopathology reports, surgical / anaesthetist notes missing in surgical cases
20. Claims with similar format/pattern/clinical details in discharge card/bill from a particular provider

Diagnosis or surgery-specific triggers

21. Claims for hospitalisation due to chronic/life style diseases management
22. Claims with LoS far in excess of average LoS for a particular ailment
23. Claims relating to infertility, abortion, miscarriage etc.
24. Claims for medical management admission for exactly 24 hours to cover OP treatment, expensive investigations
25. Claims for acute medical illness which are uncommon e.g. encephalitis, cerebral malaria, monkey bite etc.
26. Claims for surgical conditions being treated conservatively
27. Claims for orthopedic illness being managed conservatively; accidents mandating treatment for hip, knee, ankle, shoulder, elbow and wrist joint
28. Claims for medical conditions being managed surgically in the first year of the policy - potential indication for PED. e.g. liver disorder in first year of policy
29. Claims where the clinical findings do not correlate with chief complaints or diagnosis or line of treatment; exaggeration of classical clinical findings to portray severity in acute medical illness/minor surgical conditions
30. Claims with unjustified admission in ICU or use of general anesthesia or assistant surgeon in a minor complexity or mild severity of condition

31. Claims with surgical treatment for face, nose, ear or other exposed body parts - indication of cosmetic surgery

Billing and tariff based triggers

32. Claims where the cost of treatment is much higher than expected for underlying etiology
33. Claims with a relatively high proportion of pharmacy costs or physician fees (more than 50% of the total claim value)
34. High value claim from a small hospital/nursing home, particularly in class B or C cities not consistent with ailment and/or provider profile
35. Claims with no intimation of claim till submission of claim documents; delayed pre-authorization request sent after second day of hospital admission or extraordinary delay in reporting of claim; claim intimation on weekend or public holidays especially for pre-authorization cases.

Member based triggers

36. Claims from members creating abnormal pressure to settle claim; unusually high knowledge of policy terms, claim process, medical terminology or eagerness to negotiate claim amount
37. Claims where member is unwilling to meet face to face or does not provide phone number in the claim form. Claims from members where attitude is evasive, hostile, uncooperative, complaining

ANNEXURE E

Intimation to insurer or TPA

At various stages, ranging from pre-admission to post discharge, an insurer may engage with a policyholder (or attendee) and the provider. Each of these stages provides an opportunity to solicit and capture additional information. This section details the various stages and defines what information can be captured at each stage.

- 1) Pre-Auth request regarding emergency hospitalisation from the hospital – Tele call at the time of admission (to hospital)
 - "Patient's vital statistics? i.e. pulse, BP, respiratory, saturation
 - General condition? - most would say poor; elaborate by asking using clinical language
 - What has prompted hospitalisation? - if objective parameters given such as low platelets, high WBC, dengue positive then possibility of fraud is lower; if more subjective terms used, may suspect abuse
 - Who has been treating the patient for the ailment prior to now? - if no one and this is the first hospitalisation episode, consultation, chances of fraud/ abuse high
 - Name and specialty of doctor under whom patient is to be hospitalised? - is (s)he employed by hospital or visiting consultant?
- 2) A call to patient after hospitalisation (medical)
 - Diagnosis / suspected diagnosis given
 - Room number and class of room (e.g. single, deluxe)
 - Approximate estimate given (LoS, cost of care)
- 3) A call to patient for potential surgery
 - Since when diagnosed?
 - How was the diagnosis arrived at? (e.g. X-ray, sonography, MRI, biopsy)
 - Since when were symptoms present?
 - Approximate estimate given (LoS, cost of care)?
 - Room number and class of room (e.g. single, deluxe)
- 4) A call to hospital for potential hospitalisation for surgery
 - Duration since diagnosis given?
 - How was the diagnosis arrived at? (X-ray, sonography, MRI, biopsy)
 - Since when were symptoms present?
 - Since when has the operating surgeon been treating the patient?
 - Approximate estimate given (of LoS, cost of care)?

ANNEXURE F

Education

Potential messaging for a consumer oriented "Dos" and "Don'ts" campaign

Do's

1. Always declare complete and accurate health history on proposal form
2. Any suggestion to alter history by agent or any intermediary should be reported to the insurance company or centralised fraud hotline
3. Any person offering to manage medical reports at pre-policy stage should be reported to the insurance company or centralised fraud hotline
4. Any person guiding you to forge or increase bills for genuine treatment should be reported to the insurance company or centralised fraud hotline
5. Any suggestion to alter disease in favor of claim by agent or any other intermediary or service provider should be reported to the insurance company or centralised fraud hotline
6. Any suggestion to falsify claim of health / PTD/ death / convert OPD treatment to IPD treatment by agent or any other intermediary or service provider should be reported to the insurance company or centralised fraud hotline
7. Always check your final bill when taking cashless and sign it without fail

Don't's

8. Never hide PEDs when completing proposal form
9. Do not attempt to manage medical reports at pre-policy stage
10. Never attempt to inflate bills for genuine treatment as it may lead to the entire claim being denied and result in criminal proceedings
11. Refrain from manipulating ailment in an effort to seek coverage not entitled to.
Typically intermediaries may tempt insured to mask an excluded ailment as a legitimate claim, e.g. undergoing hernia in first two years of exclusion phase and claiming as acute abdomen or appendectomy
12. Never offer your insurance card to a non-beneficiary to claim treatment under your card
13. Do not sign on blank documents, e.g. proposal form, cashless authorisation form or final bills

14. Never accept any offer to fabricate or exaggerate claims however tempting it may be

Potential content for agent education

Do's

15. Always ensure that the customer declares complete and accurate health history on proposal form

16. Any suggestion to alter history by customer or any other person should be reported to the insurance company or centralised fraud hotline

17. Any person offering to manage medical reports at pre policy stage should be reported to the insurance company or centralised fraud hotline

18. Any person asking to forge or inflate bills for genuine treatment should be reported to the insurance company or centralised fraud hotline

19. Any suggestion to alter disease in favor of claim by customer or any other intermediary or service provider should be reported to the insurance company or centralised fraud hotline

20. Any suggestion to dishonestly file claim for health, PTD, death, or convert OPD treatment to IPD treatment by customer or any other intermediary or service provider, should be reported to the insurance company or centralised fraud hotline

Dont's

21. Never hide PED or guide any insured to hide PED in proposal form

22. Never provide false duplicate policy copy to insured

23. Never facilitate any fraudulent claim

24. Never attempt to manage medical reports at pre-policy stage

Potential content for provider education

Providers are an integral part of the multi-stakeholder insurance industry and play key role across the entire business chain. Providers are empanelled with trust by the insurer and bound by a mutual and legally binding contract. However, there are cases of malpractice committed by providers which directly conflict with the insurer's interest. These sensitivities need to be understood and addressed by each provider when dealing with insured patients:

A robust code of high ethical practice needs to be followed by all providers. Areas of particular concern to insurers include:

1. Billing for high cost medicine while using generic or low cost brands
2. Excessive and unwanted tests, investigations and procedures being conducted
3. Billing for extra number of physician visits not conducted or having extra visits when not required
4. Unbundling of procedures and billing them separately
5. Increase in length of stay either backwards or forwards without the knowledge of the customer
6. Upgrading the accommodation category for no reason of medical necessity. This includes keeping a medically stable patient in ICU or ICCU
7. Original and factual history of insured mis-represented and suppression of information to gain advantage
8. Refrain from putting up any claim on behalf of any customer without his knowledge for monetary benefit
9. Refrain from converting OPD treatment into IPD treatment for monetary benefit.
10. Refrain from any nexuses or collusion to produce false or artificially inflated claims

Any of the above scenarios if faced or observed in the ecosystem one should be reported to the insurance company or centralised fraud hotline

ANNEXURE G

Defining Levels of Misconduct/fraud and Potential Responses

1. Customer- occasionally the customer is the perpetrator of the fraud. Customer fraud are generally soft in nature, unless the customer is a professional claimant who regularly submits false claims.
 - (a) Misconduct - False or suppressed history at proposal stage to hide PED and secure coverage.
 - Action 1 - Policy cancellation for hiding material fact , without refund of premium
 - Action 2 - Sharing info to industry to blacklist customer at common database
 - (b) Misconduct - Managing medical reports at proposal stage for gaining cover or reducing premium.
 - Action 1 - Policy cancellation for hiding material fact , without refund of premium
 - Action 2 - Sharing info to industry to blacklist customer at common database
 - (c) Misconduct - Inflating bills manually for genuine treatment.
 - Action 1 - Policy cancellation for hiding intentional misrepresentation, without refund of premium
 - Action 2 - Sharing information with industry blacklist
 - Action 3 - Add to name and shame list
 - Action 4 - Legal remedy, such as FIR on insured
 - (d) Misconduct - Manipulating ailment for seeking coverage not entitled to, for example an excluded ailment is masked as legitimate claim (undergoing hernia in 1st two years of exclusion phase and claiming as acute abdomen or appendectomy).
 - Action 1 - Policy cancellation for hiding intentional misrepresentation, without refund of premium
 - Action 2 - Sharing information with industry blacklist
 - Action 3 - Add to name and shame list
 - Action 4 - Legal remedy, such as FIR on both doctor and insured

- (e) Misconduct
 - Getting non beneficiary treated under the policy and claimed for self by customer.
 - Action 1
 - Policy cancellation for hiding intentional misrepresentation, without refund of premium
 - Action 2
 - Sharing information with industry blacklist
 - Action 3
 - Add to name and shame list
 - Action 4
 - Legal remedy, such as FIR on both doctor and insured
- (f) Misconduct
 - Colluding with provider (hospital) for converting OP to IP claim.
 - Action 1
 - Policy cancellation for hiding intentional misrepresentation, without refund of premium
 - Action 2
 - Sharing information with industry blacklist
 - Action 3
 - Add too name and shame list
 - Action 4
 - Legal remedy, such as FIR on both doctor and insured
- (g) Misconduct
 - Colluding with provider for fake claim documentation.
 - Action 1
 - policy cancellation for hiding intentional misrepresentation, without refund of premium
 - Action 2
 - Sharing information with industry blacklist
 - Action 3
 - Add to name and shame list
 - Action 4
 - Legal remedy, such as FIR on both doctor and insured
- (h) Misconduct
 - Fake PTD claim.
 - Action 1
 - Policy cancellation for hiding intentional misrepresentation, without refund of premium
 - Action 2
 - Delist from future PA coverage eligibility
 - Action 3
 - Add to name and shame list
 - Action 4
 - Legal remedy, such as FIR on both doctor and insured
- (i) Misconduct
 - Manipulated death claim by claimant.
 - Action 1
 - Policy cancellation for hiding intentional misrepresentation, without refund of premium

- Action 2 - Delist from future PA coverage eligibility
- Action 3 - Add to name and shame list
- Action 4 - Legal remedy, such as FIR on both doctor and insured

2. Provider - empanelled network provider are have different fraud patterns than non-network hospitals. Whereas the non-network hospitals do not directly receive payments from hospitals and they may help a policy holder in lodging a false claim, the empanelled providers are direct recipients of claimed amount thus the fraud they indulge in is different.

- (a) Misconduct - Inflation in claim cost by various methods
 - (i) Misconduct - Substituting low cost medicine with high cost brands
 - Action 1 - Warning with temporary suspension for 3 months from network
 - Action 2 - Pan-industry suspension
 - (ii) Misconduct - Getting unnecessary/ unwanted tests done
 - Action 1 - Warning with temporary suspension for 3 months from network
 - Action 2 - Pan-industry suspension
 - (iii) Misconduct - Billing extra number of physician visits
 - Action 1 - Warning with temporary suspension for 3 months from network
 - Action 2 - Pan-industry suspension
- (iv) Misconduct - Unbundling of procedures and billing them separately
 - Action 1 - Warning with temporary suspension for 3 months from network
 - Action 2 - Pan-industry suspension
- (v) Misconduct - Increase in length of stay, either pre or post admission, without the knowledge of the customer
 - Action 1 - Warning with temporary suspension for 3 months from network

- Action 2 - Pan-industry suspension
 - (vi) Misconduct - Upgrading the accommodation category
 - Action 1 - Warning with temporary suspension for 3 months from network
 - Action 2 - Pan-industry suspension
 - (b) Misconduct - Hiding PED ailment
 - Action 1 - Warning with temporary suspension for 1yr from network
 - Action 2 - Pan-industry suspension
 - (c) Misconduct - Lodging fake claim without customer knowledge based on previous card details
 - Action 1 - Permanent de-panelment
 - Action 2 - Pan-industry blacklisting
 - Action 3 - Add to name and shame list
 - Action 4 - Legal remedy, such as FIR on provider
 - (d) Misconduct - Colluding with agent or corporate group to have a set of insured for lodging fake claims.
 - Action 1 - Permanent dis-empanelment
 - Action 2 - Pan-industry blacklisting
 - Action 3 - Add to name and shame list
 - Action 4 - Legal remedy, such as FIR on provider
 - (e) Misconduct - Offering free OPD to customers with insurance cards and later lodging fake claims on their behalf.
 - Action 1 - Permanent dis-empanelment
 - Action 2 - Pan-industry blacklisting
 - Action 3 - Add to name and shame list
 - Action 4 - Legal remedy, such as FIR on provider
3. Provider - non-network providers do not receive a direct payment from the insurer so fraud perpetrated by them usually involves a policy holder or a distributor.

- (a) Misconduct
 - Inflated bill for genuine treatment by adding costlier medicine or increasing length of stay.
 - Action 1
 - Warning with temporary suspension for 6 months from industry business
 - Action 2
 - Pan-industry suspension
 - (b) Misconduct
 - Fake and fabricated claim document on commission basis provided to customer.
 - Action 1
 - Permanent dis-empanelment
 - Action 2
 - Pan-fraudindustry blacklisting
 - Action 3
 - Add to name and shame list
 - Action 4
 - Legal remedy, such as FIR on provider
 - (c) Misconduct
 - Being part of fraud ring
 - Action 1
 - Permanent dis-empanelment
 - Action 2
 - Pan-industry blacklisting
 - Action 3
 - Add to name and shame list
 - Action 4
 - Legal remedy, such as FIR on provider
4. Agent - are a unique link between customer and insurer and hence can defraud both customer and insurer.
- (a) Misconduct
 - Provide fake policy to the customer and siphoning off the premium amount.
 - Action 1
 - License cancellation
 - Action 2
 - Across industry blacklisting
 - Action 3
 - Add to name and shame list
 - Action 4
 - Legal remedy, such as FIR on agent
 - (b) Misconduct
 - Guiding customer to hide PED for getting policy issued.
 - Action 1
 - warning with temporary suspension for 6 months from industry business

- Action 2 - Pan-industry suspension
- Action 3 - Add to name and shame list
- (c) Misconduct - Being part of fraud ring can facilitate policies on fictitious name and address.
 - Action 1 - License cancellation
 - Action 2 - Pan-industry blacklisting
 - Action 3 - Add to name and shame list
 - Action 4 - Legal remedy, such as FIR on agent
- (d) Misconduct - Facilitate customers to rouge providers for facilitating fraud claims on share basis.
 - Action 1 - License cancellation
 - Action 2 - Pan-industry blacklisting
 - Action 3 - Add to name and shame list
 - Action 4 - Legal remedy, such as FIR on agent

ANNEXURE H

Medical Council of India – Code of Ethics

Code of Ethics Regulations, 2002

(Published in Part III, Section 4 of the Gazette of India, dated 6th April, 2002)

(Incorporating amendments no. MCI-211(2)/2004-(Ethical) Published in Part III, Section 4 of the Gazette of India, Extraordinary dated 27th May, 2004)

Sr No	Scenario	Professional Misconduct	Potential response
1.	Refusal to share records	<p>1.3 Maintenance of medical records - 1.3.1 Every physician shall maintain the medical records pertaining to his / her indoor patients for a period of 3 years from the date of commencement of the treatment in a standard pro-forma laid down by the Medical Council of India.</p> <p>1.3.2. If any request is made for medical records either by the patients / authorised attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours.</p> <p>1.3.3 A Registered medical practitioner shall maintain a Register of Medical Certificates giving full details of certificates issued. When issuing a medical certificate he / she shall always enter the identification marks of the patient and keep a copy of the certificate. He / She shall not omit to record the signature and/or thumb mark, address and at least one identification mark of the patient on the medical certificates or report.</p> <p>1.3.4 Efforts shall be made to computerise medical records for quick retrieval.</p>	Legal letter; intimate medical council
2.	Treating doctor registration number not on any document	<p>1.4 Display of registration numbers - 1.4.1 Every physician shall display the registration number accorded to him by the State Medical Council / Medical Council of India in his clinic and in all his prescriptions, certificates, money receipts given to his patients.</p>	Legal letter; intimate medical council

Sr No	Scenario	Professional Misconduct	Potential response
3.	Insurer knowing of a fraud perpetrated by one provider, with knowledge of another one	1.7 Exposure of Unethical Conduct: (whistle blowing) - A Physician should expose, without fear or favour, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession.	One-to-one talk, if not opening up
UNETHICAL ACTS - A physician shall not aid or abet or commit any of the following acts which shall be construed as unethical-			
4.	Selling drugs without license OR drug license in doctor's name	6.3 Running an open shop (Dispensing of Drugs and Appliances by Physicians): A physician should not run an open shop for sale of medicine for dispensing prescriptions prescribed by doctors other than himself or for sale of medical or surgical appliances. It is not unethical for a physician to prescribe or supply drugs, remedies or appliances as long as there is no exploitation of the patient. Drugs prescribed by a physician or brought from the market for a patient should explicitly state the proprietary formulae as well as generic name of the drug.	Legal letter; intimate medical council
PROFESSIONAL MISCONDUCT - The following acts of commission or omission on the part of a physician shall constitute professional misconduct rendering him/her liable for disciplinary action.			
5.	Documentary evidence of not abiding by code of ethics	<p>7.1 Violation of the Regulations: If he/she commits any violation of these Regulations.</p> <p>7.2 If he/she does not maintain the medical records of his/her indoor patients for a period of three years as per regulation 1.3 and refuses to provide the same within 72 hours when the patient or his/her authorised representative makes a request for it as per the regulation 1.3.2.</p> <p>7.3 If he/she does not display the registration number accorded to him/her by the State Medical Council or the Medical Council of India in his clinic, prescriptions and certificates etc. issued by him or violates the provisions of regulation 1.4.2.</p>	Legal letter; intimate medical

Sr No	Scenario	Professional Misconduct	Potential response
7.	Notifiable conditions like Cholera, Plague, Cases of Meningitis & now Tuberculosis not intimated to authorities	<p>7.14 The registered medical practitioner shall not disclose the secrets of a patient that have been learnt in the exercise of his / her profession except-</p> <ul style="list-style-type: none"> • in a court of law under orders of the Presiding Judge • in circumstances where there is a serious and identified risk to a specific person and / or community; and • notifiable diseases <p>In case of communicable / notifiable diseases, concerned public health authorities should be informed immediately.</p>	Legal letter; intimate medical council
8.	Self-explanatory	7.20 A Physician shall not claim to be specialist unless he has a special qualification in that branch.	Legal letter; intimate medical council

ANNEXURE I

Legal letter sample

WITHOUT PREJUDICE AND CONFIDENTIAL

The Medical Superintendent,

Name of the Hospital/Nursing Home,

Respected Dr. **** *

Sub: Regarding Health Insurance Claim pertaining to the treatment taken from & given at your ABC Hospital, <location>.

This is with reference to a health insurance claim received by us from one of our policy holder who has taken treatment from your ABC hospital over a period of time. The details of the claimant are as under:

Details: (i.e.: name of LA ; policy number; claim number; date of admission; date of discharge)

Information about diagnosis & line of treatment: (i.e.: case ofyear old, M/F, presenting complaints with duration, diagnosed with, treated by)

We need to carefully examine such claim(s) in the light of the claim documents submitted by the policy holder. Having regard to the illness suffered by our policy holder vis-à-vis the documents submitted to us, we need some additional information to assess the claim.

The following inconsistencies in the documents submitted to us have been found:

Information / observations pertaining to clinical treatment: (i.e.: queries regarding ventilator & tracheostomy or regarding ARF or regarding administration of antibiotics or miscellaneous queries regarding treatment given or blood investigations or ICU staff and other physicians/ surgeons involved in treatment etc).

Information / observations pertaining to case management: (i.e.: since the patient was in ICU for 49 days, was on ventilator, underwent tracheostomy and reported to be in acute renal failure; please share the names/ qualifications/ registered numbers of other doctors/ specialists of other disciplines / intensivists who were involved in patient's treatment covering critical issues in multiple clinical disciplines. We observe that on most of the occasions, there is only one person's handwriting while treatment of this nature generally shows multiple hand writings from various doctors who were treating the patient).

If the admission involves a FIR: (i.e.: we appreciate your action of informing the police on admission (MLC H35). But that time we are certain it would be a NC as there was no way of knowing that it would be such a long drawn course of Rx. As you must be aware that, as per Section 320, IPC "Any hurt which endangers life, or which causes the sufferer to be, during

the space of twenty days, in severe bodily pain or unable to flow his daily routine" becomes a grievous hurt. Thus in this case FIR should have been lodged. Kindly provide the details thereof).

II. Those pertaining to Medical Record Documentation:

ICPs and Nursing record or Cash Memo: (i.e.: we request you to kindly clarify on all the above issues and provide us the relevant details and documents so as to enable us to assess the claim properly. We solicit your earnest cooperation in this regard. Further, there is a possibility that the matter may lead to some litigation in which case we bank on your support. We, therefore request you to kindly preserve all the original records and documents as per the MCI Code of professional Conduct. The relevant code is quoted below for your ready reference).

1. CODE OF MEDICAL ETHICS

1.3 Maintenance of medical records:

1.3.2. If any request is made for medical records either by the patients / authorised attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours.

1.3.3 A Registered medical practitioner shall maintain a Register of Medical Certificates giving full details of certificates issued. When issuing a medical certificate he / she shall always enter the identification marks of the patient and keep a copy of the certificate. He / She shall not omit to record the signature and/or thumb mark, address and at least one identification mark of the patient on the medical certificates or report. The medical certificate shall be prepared as in Appendix 2.

Your information will prove instrumental in helping us in the rational claim adjudication of the above cases. Kindly do the needful and if you need any clarifications, please do get in touch with us.

