Fraud, Waste and Abuse Detection

Fraudulent claims constitute to about 3% of the healthcare insurance companies. Deriving triggers & characteristics of the fraudulent claims in healthcare on a real time basis

And segmenting customers for better detection of fraud is the need of the hour.

A Predictive model segment claims as high and low risk fraudulent claims and their characteristics.

Predicting fraudulent Claims for a US based Payer organization

Predictive solution that segments the incoming claims into high risk and low risk based on their characteristics.
Assigns a probability of fraud score to the claims and helps reduce the loss by 30% due to the fraudulent claims.