



## **Private Health Insurance Sector Conduct Policy**

**(Fraud, Waste and Abuse)**

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## Chapter 1

### **Article (1): Introduction:**

Based on the following statutory instruments, and upon an extensive study of the private health insurance sector through an inventory and identification of challenges and lessons learned, this Policy has been developed, and the next steps are defined:

1. The Cooperative Health Insurance Law issued by Royal Decree No. (M/10), dated 1/5/1420 AH, and its Implementing Regulations approved by Ministerial Resolution No. (9/35/1/DH), dated 13/4/1435 AH.
2. The Law of Practicing Healthcare Professions issued by Royal Decree No. (M/59), dated 4/11/1426 AH, and its Implementing Regulations issued by Ministerial Resolution No. (4080489), dated 2/1/1439 AH.
3. The Anti-Forgery Law issued by Royal Decree No. (M/114), dated 26/11/1380 AH.
4. The Penal Law for Forgery Crimes issued by Royal Decree No. (M/11), dated 18/2/1435 AH.
5. The Insurance Market Conduct Regulation of the Saudi Central Bank.
6. Circulars, procedures, decisions and resolutions issued by the General Secretariat of the Council of Cooperative Health Insurance.

### **Article (2): Purpose:**

The purpose of the Policy is to establish high standards for business conduct in the private health insurance sector in a way that guarantees the right of the stakeholders' chain, starting from insurance companies to the beneficiaries, by setting the minimum procedures to which the insurance parties must adhere in order to reduce fraud, waste and abuse, and identify indicators - including but not limited to - those of fraud detection.

### **Article (3): Scope of Application:**

The provisions of this Policy shall apply to each of the following:

- A. Insurance companies qualified by the Council of Cooperative Health Insurance.
- B. Health service providers accredited by the Council of Cooperative Health Insurance.
- C. Health practitioners.
- D. The employer (policyholder).
- E. The insured (beneficiary).
- F. Claims management companies (TPAs).
- G. Revenue Cycle Management Companies (RCM).

## Chapter 2

### Article (4): Definitions:

The following terms and expressions wherever mentioned in this Policy, shall have the meanings assigned thereto unless the context requires otherwise:

<b>CCHI</b>	: The Council of Cooperative Health Insurance.
<b>General Secretariat</b>	: The General Secretariat of CCHI.
<b>Law</b>	: The Cooperative Health Insurance Law by Royal Decree No. (M/10), dated 1/5/1420 AH.
<b>Implementing regulations</b>	: The Implementing Regulations of the Cooperative Health Insurance Law issued by Ministerial Resolution No. (9/35/1/DH), dated 13/4/1435 AH.
<b>Secretary</b>	: Secretary General of CCHI.
<b>Policy</b>	: Private Health Insurance Sector Conduct Policy.
<b>SAMA</b>	: The Saudi Central Bank.
<b>Fraud</b>	: Intentional deceit by any insurance party leading to obtain benefits, funds, or privileges which exceed the allowed limits to the relevant individual or entity.
<b>Waste</b>	: Providing insurance/medical services without exercising the duly recognized reasonable amount of medical or insurance precautions that results in material or moral harm to one of the insurance parties, which would not have occurred but for the manner in which the negligent person has acted.
<b>Abuse</b>	: Practic by any insurance party that may lead to obtain benefits or advantages that are not eligible to such party who has no intention to deceit, deceive, misrepresent or distort facts in order to obtain such benefits.
<b>Health insurance</b>	: The health insurance established by the Law and its Implementing Regulations, which is practiced by cooperative insurance companies licensed to operate in the Kingdom in accordance with the Insurance Companies Control Law.

<b>Insurance policy</b>	: The primary cooperative health insurance policy approved by CCHI and attached to the Regulations, which includes limitations, benefits, exclusions and general conditions. It is issued by the insurance company according to an insurance request submitted by the employer (policyholder).
<b>Insurance company</b>	: A cooperative insurance company that is authorized to operate in the Kingdom by SAMA, and is qualified to practice cooperative health insurance business by the CCHI.
<b>Claims Management Company (TPA)</b>	: A company specialized in adjusting insurance claims; it is authorized to operate in the Kingdom by SAMA, and qualified to manage cooperative health insurance claims by CCHI. TPAs are subject to the rule of insurance companies in this Policy.
<b>Revenue Cycle Management Company (RCM)</b>	: A company specialized in managing the revenue cycle, billing, medical coding, and preparing and issuing insurance claims on behalf of the service provider, which have been licensed and approved by CCHI.
<b>Service provider</b>	: A (governmental/non-governmental) health facility authorized to provide health services in the Kingdom in accordance with the relevant laws and rules, and is by CCHI. For example: hospital, diagnostic center, clinic, pharmacy, laboratory, physiotherapy center, or radiotherapy center.
<b>Insurance coverage</b>	: The basic health benefits available to the beneficiary as defined in the policy.
<b>Employer</b>	: A natural or legal person who employs one or more workers.
<b>Policyholder</b>	: A natural or legal person in whose name the policy was issued.
<b>The insured (beneficiary)</b>	: A natural person(s) for whom insurance coverage is determined according to the policy.
<b>Health practitioners</b>	: A person licensed to practice medical professions, including the following categories: Human physicians, dentists, specialist pharmacists, health technicians (radiology, nursing, anesthesiology, laboratory, pharmacy, optometry, epidemiology, prosthetics, physiotherapy, dental care and fitting,

tomography, nuclear therapy, laser devices, and operations), specialist psychologists, social workers, public health nutrition specialist, midwifery, paramedics, speech and hearing therapy, vocational rehabilitation, vocational therapy, medical physics, and other health professions that are agreed upon between the (former) Ministers of Health and Civil Service and the Saudi Commission for Health Specialties.

**Insurance parties**

: The insurance company, claims management company, revenue cycle management company, service provider, health practitioners, employer (policyholder) and the insured (beneficiary).

### Chapter 3

#### Controls and Procedures to be Followed to Reduce Fraud, Waste, and Abuse

##### Article (5): The minimum procedures to be taken by insurance parties:

##### 1. Insurance companies and claims management companies (TPAs):

- a. Develop a strategic plan that defines clear and comprehensive procedures for assessing claims, whereby the necessary steps are detailed to verify the facts and validity of claims, and check for fraud indicators to combat it. The strategic plan shall be approved by the company's board of directors.
- b. Establish an internal administration/unit specialized in combating fraud and dealing with abuse and waste cases.
- c. Provide advanced internal information systems that enable rapid response to medical approval requests.
- d. Provide procedural evidence and a clear escalation process for all claims involving suspected fraud, abuse or waste.
- e. Provide an approved clear procedural mechanism between the service provider and insurance company to ensure the exchange of information for reporting cases of fraud, abuse, or waste.
- f. Review the current policies and procedures and ensure that they conform to the required standards.
- g. Conduct specialized training courses and programs, as well as organize awareness campaigns, for the medical and administrative staff, on a regular basis to warn of the danger of fraud, waste, or abuse and their most prominent indicators.
- h. Conduct awareness campaigns for the insured and inform them of the company's policies to combat fraud, abuse or waste, and the consequences of providing false or inaccurate information.
- i. Appoint a liaison officer representing the entity, to communicate with CCHI and provide it with their information.
- j. Insurance companies shall keep detailed records of occurrences of fraud practiced by the insured, provided that the records contain the following minimum detailed information:
  - Type of fraud.
  - Technique or technology used to commit the fraud.
  - Weakness in the internal control and its procedures.
  - The file for the fraudsters and their previous background.
  - Fraud monitoring.

These records must be referred to the competent authority, upon request.

## 2. Service Providers and Revenue Cycle Management Company (RCM):

- a. Establish an internal policy for how to deal with cases of fraud, waste and abuse, in addition, to reviewing the current and ensure the required standards have been met.
- b. Provide advanced internal information systems that enable quick response to the inquiries and observations of insurance companies (if any) regarding the approval request.
- c. The CEO of the enterprise shall sign a pledge to validate all the invoices issued by his/her entity.
- d. Provide advanced internal information systems that enable the monitoring of fraud and abuse cases, and reducing waste cases.
- e. Not to provide excessive health services to patients, who do not need them, for the purpose of achieving financial gain. The services provided should be limited to what is required by the actual treatment needs, in accordance with the clinical evidence approved by CCHI.
- f. Educate and motivate practitioners not to raise claims of unnecessary health services and medical treatments for medical conditions.
- g. Provide an administrative staff with the minimum experience necessary to review and evaluate a claim before submitting it to the insurance company.
- h. Conduct specialized training courses and programs, as well as organize awareness campaigns, for the medical and administrative staff, on a regular basis to warn of the risk of tolerating or contributing to fraud, waste, or abuse.
- i. Appoint a liaison officer representing the entity, to communicate with CCHI and submit provide it with their information to it.
- j. Allow insurance companies to visit the service provider and facilitate their access to the insured files, invoices, and services provided. This procedure is important for building a complete file of suspected cases and supporting insurance companies with evidence, if any.
- k. Carry out all due diligence measures to verify the ID cards/identity of the insured before providing the service.
- l. Work on training employees to request approvals while being fully aware of the provisions of the Implementing Regulations and the companies' benefits schedules, to request covered services only and avoid requesting excluded services, to improve the customer experience and effectiveness of operation management.



### 3. Health practitioner:

- a. Practice the profession for the benefit of the patient's health, without giving precedence to personal interest for the purpose of achieving financial gain or for any kind of exploitation.
- b. Not to provide excessive health services or medicines to the patient who does not need them; the services provided to them should be limited to what is required by the actual treatment needs.
- c. Ensure the correctness and integrity of patient reports and that they are free from any misinformation or any type of fraud.
- d. Provide all data and information relevant to the patient's medical condition in an accurate and detailed manner, along with the latest developments in the case, and attach all reports.

### 4. The employer and policyholder, each within their competence:

- a. The employer shall explain and clarify the policy and the coverage limits for the insured (beneficiaries) through appropriate means such as brochures, direct explanations, workshops and websites. The employer shall not hide information from the insured regarding the name of the insurance company, medical network, and benefits of the policy.
- b. Educate and emphasise employees and their insured dependents to avoid acts that are considered fraud, waste, or abuse.
- c. Take the initiative and add the insured without delay, whether employees or their dependents and avoid adding those who are not legally eligible. Update, automatically and in a timely manner, the marital status of the insured.
- d. Provide insurance companies with necessary and correct information, including medical declaration forms and contact information for the insured.
- e. Appoint a liaison officer representing the entity, to communicate with CCHI and provide it with submit their information to it.

### 5. The insured (beneficiary):

- a. Comply with claiming benefits as stipulated in the coverage of the policy, or in the additional coverage obtained in accordance with Article (8) of the Law.
- b. Comply with disclosing or declaring claims resulting from work injury, occupational diseases or vehicle accidents.
- c. Not to over-request health services without the need for them, and limit them to what is required by treatment needs.
- d. Notify the employer (policyholder), immediately, of any update on the marital status.



- e. Comply with filling out the medical declaration form by adding the data correctly without concealing any.
- f. Pledge not to use the insurance for individuals other than the insured.
- g. Adhere to show the ID cards to the service provider before obtaining the service.

## Chapter 4

### Indicative Indicators

#### **Article (6): Indicative Indicators of committing fraud, waste and abuse by insurance companies and medical claims management companies (TPAs):**

- Non-compliance with the requirements for issuing the policy, addition and deletion.
- Direct Payment of the policy by the insured and not the account of the employer (policy holder).
- Issuing insurance tofor the purpose of be linked electronically with relevant authorities.
- Requiring Service Providers with an average cost for the insured.
- The company is delaying the adjustment of due claims repeatedly without clear justification.
- Repeated reports of rejections.
- The number of rejected medical approvals for emergency cases.
- The number of approvals that are canceled within a period not exceeding thirty (30) days of their approval without the service provider's request.
- An indication for the deductible amounts that the patient pays in outpatient or emergency.
- The number of medical approvals denied due to the prescription.
- Conflicts of interest among directors, team members, external companies and contractors.
- High rate of complaints.

#### **Article (7): Indicative Indicators of fraud, waste and abuse by service providers:**

- Modifying medical prescriptions, or deducting from them after diagnosis.
- Providing documents that contain wrong spelling or misuse of medical terms.
- Using incorrect identification numbers.
- The practitioner is not located in the same geographical area as the claimant.
- The presence of incorrect or conflicting diagnoses by different health service providers.
- The treatment provided to the insured does not match the diagnosis or the patient's medical record.
- The medical specialty of the practitioner is not in line with his/her issued diagnosis.
- Cooperating with another person to use the identity of the insured.
- Provision of uncovered services, for example (dental - eyeglasses).
- The results of tests or medical x-rays/scans of most medical claims are sent with the same results and from the same attending practitioner.



- Hiding essential facts, such as not explaining the cause and location of the injury (work injury - traffic or criminal accident).
- Submitting claims to the insurance companies through non-approved branches, or submitting claims for services provided in cooperation with non-accredited service providers by CCHI, such as, Laboratories, radiology, etc.
- Leakage of the insured data.
- A significant increase in the number of claims for the services provided.
- A continuous delay in providing the required records for the cases and services provided to the insurance companies and the insured.
- Delay in adding VAT to the original claim upon filing.
- Admitting the patient with no need and without medical justification.
- Excessive dispensing of medication and other medical procedures, such as blood tests and x-rays.
- Using the most expensive technical means without medical necessity.
- Issuance of new visits invoices during the free visit period.
- A continuous increase in patient deductible amounts in outpatient or emergency.
- An indication for the deductible amounts the patient paid in outpatient or emergency.
- The number of medical approvals denied due to the prescription.

**Article (8): Indicative Indicators of fraud, waste and abuse by health practitioners:**

- The health practitioner treats or prescribes medication for cases not in line with his/her medical specialty.
- The dispensed medicines do not match the diagnosed conditions.
- An excessive increase in the amount of medicines needed for the diagnosed condition.
- The health practitioner repeats the same medical diagnosis for multiple cases.
- An increase in the quantities of medicines prescribed by the health practitioner.

**Article (9): Indicative Indicators of fraud, waste and abuse by the employer (policyholder):**

- Repeated approvals and claims from the same health service provider for the same insurance policy.
- The number of the insured persons who are added long after their insurance due date.
- The presence of insurance policies without any claims.
- The insured are not provided with the benefits of the policy and the network of health service providers.
- Not filing the beneficiary's data immediately to CCHI on the date he/she becomes due for the insurance.



- Making an agreement with a health service provider to establish an in-patient clinic within the employer's facility.
- The presence of similar signatures on the medical declaration form.

**Article (10): Indicative Indicators of practices of fraud, waste and abuse by the insured (beneficiaries):**

- A continuous change of practitioners or service providers by the insured.
- The insured claims to have a disability, and at the same time he/she is an active employee in his/her work or practices sports or physical hobby.
- Fabricating additional injuries and alleging they are related to the primary injury or disease of the claim when it is about to expire.
- Alleging to be injured or sick shortly before the occurrence of an incident at the workplace (including, but not limited to, a disciplinary action, demotion, dismissal from work, refusal to work, termination of the employment contract, or reducing the number of employees).
- Requesting advice from more than one service provider for the same condition.
- Actions suggesting the insured is being impersonated.
- High drug dispensing rates, in a way not in consistent with the treatment plan and medical records.
- All (or most of) the medical invoices are issued by the same service provider, usually on the same dates.
- Changing personal data frequently, including (cellphone number - address).

## Chapter 5

### Legal Procedures to Be Taken

#### **Article (11): The legal procedures that must be taken by the insurance parties in the event of suspected fraud, waste or abuse:**

**First: If the act is characterized as a fraud by one of the insurance parties, with the exception of the health practitioner:**

- 1- After exhausting the internal communication procedures among the parties, the case is referred to the concerned authority, where it is submitted to the police station to be referred to the Public Prosecution for taking the required summoning and investigation actions in preparation for filing the case before the competent criminal court, in the event it is proven. CCHI shall be provided with a detailed copy of this complaint by filling out Form (1) and sending it via the consolidated e-mail (Supervision@cchi.gov.sa) under the subject "Fraud Complaint"; the insurance company, claims management company (TPA) and service provider shall bear the responsibility, in all cases, if one of their employees or their members commits fraud or forgery when providing the service.
- 2- In the event that the act is characterized as a forgery offense or criminally-related offense, the perpetrator of such act will be subject to accountability and punishment in accordance with the Anti-Forgery Law issued by Royal Decree No. (M/114), dated 26/11/1380 AH, and the Penal Law for Forgery Crimes issued by Royal Decree No. (M/11), dated 18/2/1435 AH. The penalties for the criminally-related offenses are as follows:
  - Any employee or person entrusted with public service or a medical or health service who issues a document, a certificate or a statement contrary to the truth and resulting in an illegal benefit or inflicting a damage upon any person, shall be liable to imprisonment for a term extending from 15 days to one year.
  - Whoever forges a seal of a non-public entity shall be punished by imprisonment for a period not exceeding three years and a fine not exceeding three hundred thousand riyals, or by one of these two penalties.
  - Whoever forges commercial, financial or bank documents or insurance certificates shall be sentenced to 1 to 5 years in prison and a fine of SR400,000..

- Whoever forges or grants (subject to their competence) an untrue medical report or certificate, while being aware of it, shall be punished by imprisonment for a period not exceeding a year and a fine not exceeding one hundred thousand riyals, or by one of these two penalties.
  - Every private establishment operating in the Kingdom, whose manager or one of whose employees was proven to have committed one of the offenses stipulated in the Penal Law for Forgery Crimes in his/her own interest and with his/her knowledge, shall be punished by a fine not exceeding ten million riyals, and he/she shall be deprived of contracting with any public authority for between two and five years, without prejudice to any penalty stipulated in this Law against a natural person who committed the offense.
  - Whoever participates - by agreement, incitement, or assistance - in committing any of the crimes stipulated in the Penal Law for Forgery Crimes shall be punished with the same penalty prescribed for that crime.
- 3- Once the case is proved and referred to CCHI, fraud is deemed a material breach of the terms of the contractual relationship between the insurance company and the service provider. Therefore, the affected party has the right to terminate the contract of health services, taking into account the specified warning period and the termination provisions stipulated in the contract concluded between the parties.

**Second: If the case is abuse or waste by one of the insurance parties, with the exception of the health practitioner:**

- 1- The case shall be referred to the General Secretariat of CCHI to investigate it, and in the event it is proven, and according to its seriousness, the following actions shall be taken:
  - In the event that the abuse or waste is emanated by a service provider, CCHI may suspend or cancel the accreditation, taking into account the recurrence of the violation.
  - In the event that the abuse or waste is emanated by the insurance company, CCHI may suspend or cancel the qualification, taking into account the recurrence of the violation.
  - In the event that abuse or waste is emanated by the insured (beneficiary), CCHI may address the employer (policyholder) with a request to conduct an investigation and submit its findings to CCHI. In the event of

non-cooperation by the employer, the case will be escalated to the Ministry of Human Resources and Social Development and the Police.

- 2- CCHI may inform the Private Health Institutions' Violations Consideration Committee of the Ministry of Health when documented information about proven violations against any of the accredited service providers becomes available.
- 3- For violations committed by the insurance company or healthcare provider, CCHI has the right to suspend them from practicing cooperative health insurance activities for a specific period of time.
- 4- CCHI has the right to take all necessary measures to ensure the protection of the insurance parties.

**Third: If the act is characterized as suspected fraud, abuse, or waste by the health practitioner:**

- 1- In the event that the act is characterized as suspected fraud, the case is referred to the police station and submitted to the Public Prosecution to take the required summoning and investigation actions, at the same time as providing CCHI with a detailed copy of this complaint by filling out Form (1) and sending it via the consolidated e-mail (Supervision@cchi.gov.sa) under the subject "Fraud Complaint".
- 2- In the event that the act is characterized as a criminal offense, the perpetrator of the act shall be subject to accountability and punishment in accordance with the Law of Practicing Healthcare Professions issued by Royal Decree No. (M/59) of 4/11/1426 AH, and the Council of Ministers' Resolution No. 276 of 3/11/1426 AH and its Implementing Regulations issued by the Ministerial Resolution No. (4080489), dated 2/1/1439 AH. The penalties for criminally-related offenses related are as follows: without prejudice to any severe punishment stipulated in other laws, the perpetrator shall be punished by imprisonment for a period not exceeding six months and a fine of no more than one hundred thousand SAR, or by either one of these two penalties.
- 3- In the event that the act is characterized as abuse or waste, the health practitioner shall be subject to disciplinary accountability in case of violating one of his/her duties stipulated in the Law of Practicing Healthcare Professions according to Article (31) and Article (32) thereof.

**Fourth:** Insurance parties shall ensure that all dealings carried out between them are authentic and accurate, in accordance with the provisions of the relevant laws and regulations.

**Fifth:** Insurance companies and service providers shall be liable for any fraud, abuse or forgery committed by their employees upon providing service.



## Chapter 6

### **Article (12): Effectiveness of adoption and amendment of the Policy:**

- 1- This Policy enters into force as of the date of its approval by the Secretary General, and no amendment or addition may be made to it except upon a decision issued by the Secretary General.
- 2- The Policy shall be reviewed every three years by the General Secretariat, or as needed, and the comments and recommendations for updating it shall be submitted to the Secretary for consideration and approval.

Form (1)

**Parties' Information**

Complainant Name: \_\_\_\_\_ ID No.: \_\_\_\_\_ Contact No.: \_\_\_\_\_ Region: \_\_\_\_\_

Other Party Information: \_\_\_\_\_ Contact No.: \_\_\_\_\_ Region: \_\_\_\_\_

**Subject of the Complaint**

**Complaint Details**

Signature: \_\_\_\_\_