About Healthcare Fraud Shield

Healthcare Fraud Shield is a provider of dynamic fraud, waste and abuse detection software solutions that have dominated the complex financial services industry over the past fifteen years. Our suite of products introduces several new technology applications to the healthcare industry that will revolutionize cost reduction opportunities.

Healthcare Fraud Shield’s fully integrated Fraud, Waste, and Abuse software solution platform is called FWAShield™. FWAShield™ utilizes unique and proprietary data sources to maximize Return on Investment (ROI) and achieve superior results. Our platform is deployed utilizing a Software-as-a-Service model which allows us to quickly adopt new system enhancements and fraud analytics to identify and combat emerging fraud schemes. FWAShield™ integrates distinctive algorithms and an expert rules-based methodology to save time and reduce the excessive and unwanted false positives present in most other fraud detection software programs. The FWAShield™ platform consists of PreShield™, PostShield™, and CaseShield™ which are described below:

**PreShield™:** Pre-payment detection system designed to catch FWA prior to adjudication and final payment of a claim. PreShield™ allows the user to:

- Focus resources on the most viable and prospective suspicious claims using real-time data
- Tailor the daily feeds based on claim attributes, company initiatives, and regulatory alerts and guidance
- Increase Return on Investment
- Reduce dollars lost by preventing fraudulent claims to be paid
- Reduce the level of effort needed by investigators/analysts to find the fraudulent claims by reducing the excessive false positives returned by other fraud systems, allowing the staff to focus on the tangible suspicious claims/cases
- Increase the intelligence of the product over time based on prior results, strengthening the use and efficacy of predictive analytics
- Work seamlessly with the post-pay and case management system

**PostShield™:** Post-payment detection system. PreShield™ and PostShield™ are designed to work together or independently to improve the success of our FWA efforts. PostShield includes:

- Powerful algorithms producing smarter results and less false positives
- Rules uniquely designed to catch suspicious billing patterns, coding errors, policy and contract violations, collusion, ineligible providers, and ineligible members
- Improved ROI by identifying viable fraud cases
- Intuitive workflow and simple design
- Intelligence driven results continuously advancing the rules and predictive analytics incorporated into the FWAShield™ platform
- Fully customizable to adapt to your plan’s policies

**CaseShield™:** Unique case management system that works cohesively with both PreShield™ and PostShield™. CaseShield™ is designed to give management and staff an organized and easily navigable focal point, keeping track of current and historical case files, documentation storage, document template generation, case linking to external resources, medical record storage and tracking, extensive reporting capability, financial tracking in accordance with the National Health Care Anti-Fraud Association financial reporting standards, state and federal regulatory reporting requirements.

**Healthcare Fraud Shield SIU Services**

Insurance companies today face the challenge of protecting their network against fraud, waste, and abuse without adversely impacting their Medical Loss Ratio (MLR). Moreover, Special Investigation Units (SIU) are confronted with reduced budgets and increasingly strained resources. Fully outsourcing or partially outsourcing components of SIU responsibilities serve as a solution to the budgetary constraints. Healthcare Fraud Shield provides services which include the following:

**Lead Generation**
- Analyze claims data using the Healthcare Fraud Shield suite of products.
- Develop sustainable cases and provide clients with detailed referral packages.

**Identification of Plan Vulnerabilities**
- Detect systemic weaknesses and identify loopholes in the current claims processing edits.
- Review medical policies and provide recommendations.

**Case Investigation**
- Investigate cases from start to finish including lead assessment, data analysis, regulatory referrals, evidence gathering, medical record reviews, audits, interviews, settlement negotiation, recovery collection and more.

**Medical Record Reviews**
- Provide plans with full record reviews including claim line detail of discrepancies, coding inaccuracies, rationale for determinations and overpayment calculations.
Training and Support

- Provide company-wide fraud awareness training and train SIU staff on medical coding, retrospective and proactive data analysis using various tools, investigative processes, Internet research, medical record reviews and more.

For more information about Healthcare Fraud Shield, email us at info@hcfraudshield.com or give us a call at 888-333-8140.

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