OMNARETH

SOLUTION BRIEF

Healthcare Claims Fraud Prevention

Pay for care. Not for phantom visits.

The challenge

Healthcare fraud hides in volume: each claim looks routine, and the pattern only appears across members.

The solution

Fraudulent providers bill for visits that never happened, quote prior authorizations issued for other patients and bill the same service twice. Omnareth checks every claim against the member's coverage and history before it is paid, and recognizes the provider when it bills across many members.

12
reference rules for healthcare claims

75 ms
median fraud-checked, audited decision, lab test

8/8
reference scenario decisions correct and verified on chain

How it fits

ELEMENT	IN THIS SOLUTION	WHAT IT COVERS
The record	The member	Eligibility, the services the plan covers, the prior authorizations issued and the services already paid.
The events	Provider claims	A claim must be for an eligible member, a covered service, a verified encounter and an authorization issued for this member, once.
The memory	One provider, many members	Omnareth holds the billing provider responsible, never the members billed for, and recognizes it across members.

> **Evidence for auditors and regulators**
>
> Every decision stores the record, the request and the exact rules evaluated, with what was known about everyone involved, under a SHA-256 integrity hash anchored on the Omnareth chain. Edits, even covered-up ones, fail verification.

Next step: run the scenario with your team (`examples/healthcare-claims/demo.sh`, one command, every record verified), then scope a 90-day shadow-mode pilot. See the Pilot Program Guide.

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What it stops

RULE	WHAT OMNARETH CHECKS	DECISION
Possible Upcoding	Flag claims whose diagnosis does not support the level of service billed.	FLAG
Duplicate Billing	A service by a provider on a date is paid once.	DENY
Service Not Verified	A billed service must match a verified encounter (eligibility check, check-in or visit record).	DENY
Member Not Eligible	Claims are paid only for members with active coverage.	DENY
Prior Authorization Invalid	A prior authorization quoted on a claim must have been issued for this member.	DENY
Excluded Provider	Providers on a government exclusion list may not be paid.	DENY
Service Not Covered	The procedure must be covered by the member's plan.	DENY
Provider Across Members	Flag a provider or referrer implicated in denied claims for two or more other members in 24 hours.	FLAG
Prior Authorization Reuse	A prior authorization belongs to one member; seen on another, it is likely copied.	FLAG
Repeat Offender	Flag events involving an identity implicated in two or more denied events in the last 30 days.	FLAG
Blocked Identity	Identities blocked on the fraud watchlist may not take part in any member event.	DENY
Watched Identity	Identities under watch may proceed only with a flag for review.	FLAG

The reference scenario

#	EVENT	DECISION	FRAUD CASES
1	Genuine MRI with its prior authorization	ALLOW	
2	A clinic bills an office visit that never happened	DENY	
3	The clinic bills an MRI on another member's prior authorization	DENY	Repeat offender case; clinic watched
4	The clinic bills a therapy session already paid	DENY	One provider across three members: case opened
5	A genuine visit billed above what the diagnosis supports	FLAG	
6	A procedure the plan does not cover	DENY	
–	Analyst confirms the provider case	-	Provider blocked everywhere
7	A claims processor resubmits the clinic's claim, visit marked verified	DENY	
8	Genuine office visit	ALLOW	

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