

Healthcare Fraud Analytics Market is anticipated to surpass US\$5.989 billion by 2028 at a CAGR of 20.47%

The healthcare fraud analytics market is expected to grow at a CAGR of 20.47% from US\$1.626 billion in 2021 to US\$5.989 billion in 2028.



NOIDA, UTTAR PARDESH, INDIA, November 15, 2023 /EINPresswire.com/ -- According to a new study published by Knowledge Sourcing Intelligence, the [healthcare fraud analytics market](#) is projected to grow at a CAGR of 20.47% between 2021 and 2028 to reach US\$5.989 billion by 2028.

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The expanding number of individuals with health insurance, along with the rising prevalence of fraud in the medical profession, is driving the expansion of this market. Among the scams, those involving pharmaceutical claims have become a significant source of worry for insurance companies, healthcare providers, and governments. Furthermore, the increased prevalence of bribery and overcharging in the settlement of health insurance claims, as well as the expanding use of the prepayment review model, create a significant need for such analytics services and software. Furthermore, rising literacy rates across the

world, as well as high health-care costs, are encouraging consumers to get insurance. As a result, the industry is being driven by the demand for technologies that can lower the likelihood of fraud.

The application of data analysis and complex algorithms to identify, mitigate, and detect fraudulent actions in the healthcare business is known as healthcare fraud analytics. This specialized discipline analyzes huge volumes of healthcare data, such as claims, billing records, and patient information, using techniques like predictive modeling, anomaly detection, and [machine learning](#). Using these analytics technologies, healthcare companies and insurers may detect abnormal patterns, unexpected behaviors, or discrepancies that could suggest fraudulent activities such as false claims, billing problems, or identity theft. The objective is to improve the

accuracy and efficiency of fraud detection, resulting in reduced financial losses and improved overall healthcare system integrity.

The market is witnessing multiple collaborations and technological advancements, for instance, Luma Health has announced a collaboration with Change Healthcare to develop innovative patient engagement technologies that seamlessly integrate every touchpoint throughout the patient experience in May 2022. The two businesses will collaborate to create solutions to fulfil health systems' desire for faster, unified clinical, operational, and financial journeys. The firms will take a patient-first, interoperability-focused strategy to address fragmentation in healthcare and provide a more purposeful, unified patient experience.

Access sample report or view details: <https://www.knowledge-sourcing.com/report/healthcare-fraud-analytics-market>

Based on components the global healthcare fraud analytics market is divided into software and services. Among these, the software category captured the major market share and is likely to dominate over the forecast period. The bulk of medical companies utilize software-based fraud detection tools. The segment's market expansion is being driven by the adoption of newly created technologies based on machine learning and artificial intelligence eventually boosting segmental growth.

Based on deployment the global healthcare fraud analytics market is divided into on-premises and cloud-based. The on-premise category had the biggest revenue share due to the ease of access to data being on-site, i.e., hospitals, etc., which has resulted in improved record management as well as data monitoring, among other things. The on-premises solution is dependable and secure, and it enables organizations to maintain a level of control and ease of access to data, allowing for better record-keeping and information monitoring. Furthermore, insurance companies have increasingly adopted the on-premises arrangement to deal with massive datasets that hospitals hold, which include patient history, diagnostic and prescription records, as well as payment and insurance information. Furthermore, businesses are adopting this deployment strategy because it gives full ownership and control over software and data.

Based on application the global healthcare fraud analytics market is divided into insurance claims review, payment integrity, [identity and access management](#), and others. Based on application, the insurance claims review category is expected to have a lion's share of the market, and it will continue to do so in the future. The expanding number of patients seeking health insurance, the rising number of fraudulent claims, and the growing acceptance of the prepayment review model are projected to fuel the expansion of this market in the future years.

Based on end users the global healthcare fraud analytics market is divided into healthcare payers, healthcare providers, government agencies, and others. Among these, the government agencies led the healthcare fraud analytics industry in terms of end-users. The main reasons for

the substantial percentage include a larger volume of patients in government hospitals and the high susceptibility of government institutions to fraudulent operations owing to a lack of technologically updated infrastructure, particularly in developing countries.

Based on Geography North America has the largest market share in healthcare fraud analytics. This may be attributed to several factors, including the region's stringent regulatory structure, high healthcare spending, and an increase in healthcare fraud cases. Additionally, North America has a well-established healthcare system that prioritizes fraud prevention and compliance. The region's concentration on avoiding healthcare fraud, as well as the implementation of advanced analytics technologies, is the foundation of its market leadership in Healthcare Fraud Analytics.

As a part of the report, the major players operating in the global healthcare fraud analytics market, that have been covered are IBM Corporation, Sas Institute Inc., Optum (A Part Of Unitedhealth Group), Fairwarning (Acquired By Imprivata), Exl Service Holdings, Inc., Pondera Solutions (Acquired By Thomson Reuters), Cotiviti Holdings, Inc., Change Healthcare, Wipro Limited, Fico (Fair Isaac Corporation).

The market analytics report segments the global healthcare fraud analytics market using the following criteria:

- BY COMPONENT

- o Software
- o Services

- BY DEPLOYMENT

- o On-Premises
- o Cloud-Based

- BY APPLICATION

- o Insurance Claims Review
- o Payment Integrity
- o Identity and Access Management
- o Others

- BY END-USER

- o Healthcare Payers
- o Healthcare Providers
- o Government Agencies
- o Others

- BY GEOGRAPHY

- o North America

- United States
- Canada
- Mexico

- o South America

- Brazil
- Argentina
- Others

- o Europe

- Germany
- France
- United Kingdom
- Spain
- Italy
- Others

- o Middle East and Africa

- Saudi Arabia
- UAE
- Others

- o Asia Pacific

- China
- Japan
- South Korea
- India
- Indonesia
- Taiwan
- Others

Companies Profiled:

- Ibm Corporation

- Sas Institute Inc.
- Optum (A Part Of Unitedhealth Group)
- Fairwarning (Acquired By Imprivata)
- Exl Service Holdings, Inc.
- Pondera Solutions (Acquired By Thomson Reuters)
- Cotiviti Holdings, Inc.
- Change Healthcare
- Wipro Limited
- Fico (Fair Isaac Corporation)

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