A medical diagnosis is required to understand the cause of a health claim (and thus to manage health insurance), yet often this essential piece of information is either missing or unclear. There are two common reasons for this. First, health care providers often report symptoms (e.g. fever, headache, cough), not diagnoses (e.g. malaria, hypertension, pneumonia). Second, providers use a variety of terms when describing diagnoses and symptoms, making it difficult to aggregate the data.

VimoSEWA in India found large inconsistencies in how claims were reported by hospitals. For example, malaria was documented in the claims data using 16 or more terms such as fever, acute malaria, viral fever, etc., creating a challenge to obtain a comprehensive count of admissions for this illness. VimoSEWA invested significant resources to map related data terms to better understand which types of claims were driving the product’s performance.

In more developed health care delivery environments, standard codes and definitions, such as those found in the International Classification of Diseases (ICD-10) diagnosis and procedure codes, are frequently used. In the absence of such standards, or more consistent data, an insurer needs to evaluate the costs and benefits to improve source data, or seek other ways to understand the drivers of claims costs.

For more on claims data and VimoSEWA, click here [1].

For more on ICD-10, click here [2].