FRAUD AND ABUSE POLICY

AGA
ASSURANCES
COLLECTIVES

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What is fraud?

In this document, fraud also refers to abuse.

The vast majority of claims for health and dental care are legitimate. However, a small percentage can be considered fraudulent.

Fraud consists in submitting receipts with wrong and misleading information, altered receipts (date, name of claimant, amount) or fake receipts in order to intentionally and voluntarily deceive the group insurance plan for financial gain. This type of fraud can be committed by the member, by the service provider (pharmacist, dentist, therapist) or by both acting in collusion. Fraud can take on various aspects and fraudsters keep refining their schemes.

Abuse consists in submitting claims for care that is not necessary, excessive and/or inappropriate based on the claimant's health (excessive number of visits, exaggerated quantities, fees largely exceeding customary and reasonable charges).

Fraud is an illegal act that can lead to punitive action against the member and/or the provider, such as dismissal, criminal conviction, prison term, refund of previously reimbursed fees, or fines.

Abuse is not considered illegal, but it can lead to substantial financial losses for group plans, thus affecting their sustainability.

Distinguishing between fraud and abuse is not easy; therefore, each claim that appears suspicious must be scrutinized and any additional information required must be sought by questioning the member and/or the service provider, in order to make the proper determination and select the appropriate approach.

This document is intended to make you aware of the various forms of fraud, to enable you to contribute to our fraud detection process.

Prevention methods

As a third-party payer, it is our responsibility and duty towards policyholders to guarantee the sound management of their plans.

Sound plan management consists in ensuring that we reimburse legitimately incurred expenses that meet the plan's eligibility criteria, i.e. the insured is eligible under the plan, the provider is a member in good standing of an association recognized by the insurer or by a government agency, the provider's field of expertise allows him/her to deliver the care for which a claim is presented, the expenses claimed are customary and reasonable for this type of care or supplies, the claimant's state of health or medical condition warrants purchasing the supplies or delivering the care received.

The claims processing team is alert and trained to detect the different warning signs of potential fraud that may appear on claims. If one of these signs is identified when processing a claim, the analyst will review the claim with extra care.

Here are a few examples of such signs:

- ✓ The information on the invoice has been altered, the amount claimed is very high for the type of care;
- ✓ The maximum allowed under the policy is reached with a single claim;
- ✓ Claims are submitted for all family members visiting the same service provider on the same date;
- ✓ The member provides vague answers when asked for additional information;
- ✓ The service provider refuses to submit the original document pretexting that the PDF document or photo submitted is identical, etc.

We do not take attempted or confirmed fraud lightly. Any file that appears fraudulent is promptly handled by an analyst who will gather as quickly as possible all the information required to take fast action and limit any potential impact on the plans.

As we deal with many insurers, we must inform them of any detected fraud so they can give us their approval or specific guidelines to follow. The guidelines can differ from one insurer to the other; it can go from a simple notification to the member, to a formal request for the refund of all expenses reimbursed until then, and even termination of coverage for the certificate where the fraud was discovered.

Examples of fraud and abuse

Example 1

The member submits a claim for massage therapy.

The receipt shows three different visit dates, but two of them are written in a different ink and the total amount has been altered to what appears like $275.

The analyst contacts the service provider, who confirms that a single visit was made and the amount on the receipt should be $75.

Example 2

The member contacts our Customer Service after receiving a claim statement through the Members' Portal. He does not understand the nature of the dental expenses as he did not visit his dentist recently.

Upon checking his file, we find that during his last visit to the dentist, the expenses were not reimbursed because the frequency limit had been reached.

Example 3

The member submits a claim for two lumbar orthoses. We question the need for these two orthoses. The member confirms that he needs one orthosis for the home and another one at work to avoid carrying it from one location to the other.

Example 4

The member submits naturopathy expenses for himself and all his family members. In total, four members of the same family, including an infant, were seen by the naturopathic doctor on the same dates and at the same frequency (twice a week).

Example 5

The local physical fitness centre offered to provide the member with nutritionist receipts for the value of his annual membership fees.

Prevention, a collaborative effort

In order to optimize the sound management of a plan, all the parties involved must do their share.

Policyholders and members must understand that the purpose of our investigations is not to inconvenience them. It is rather a strategy we adopt to better manage the coverage in order to reduce the impact of expenses on plan costs.

While we apply our fraud prevention procedures, we ask policyholders to support our efforts by raising employee awareness of the direct financial implications of their claims, legitimate or not.

Examples of employee awareness-raising actions include reminding them that:

- ✓ Fraud increases the costs related to their insurance premiums;
- ✓ All insurers apply fraud control procedures; the potential consequences of fraud can go as far as dismissal and criminal charges;
- ✓ They must carefully select their care providers by validating their membership in a credible association;
- ✓ They should not hesitate to shop around for healthcare providers;
- ✓ They must confirm the need to receive care or services before they are delivered.

We also seek your assistance in encouraging deterrence initiatives by inviting your employees to report any case of fraud they may witness.

Contact information for reporting any case of fraud anonymously and confidentially:

E-mail: investigation@aga.ca

Telephone: 1-800-363-6217