

Group insurance fraud and abuse

FREQUENTLY ASKED QUESTIONS



1 Are there different types of fraud?

Yes. We divide them into 3 categories: abuse, suspected fraud and confirmed fraud.

- An example of **abuse** is when a plan member uses all of their benefits every year just because their plan offers them, not because they really need them.
- An example of **suspected fraud** is when a plan member submits a claim for physiotherapy but the receipt seems to be for a gym membership.
- **Confirmed fraud** is when we have evidence that someone used deception to illegally get money or benefits. An example is when we have proof that someone has submitted a fake invoice and is trying to pass it off as authentic.

2 What happens in cases of suspected or confirmed fraud?

In cases of **abuse** or **suspected fraud**, we don't immediately suspend the payment card, but we do suspend the online and paper claims services. We send the plan member a letter asking them to pay back the amounts they weren't entitled to. Once we receive the reimbursement, we'll reactivate the online claims service¹ and process any pending paper claims. If the plan member refuses to pay us back, we suspend their payment card and transfer their file to Legal Affairs.

In cases of **confirmed fraud**, we remove the clinic or professional from our list of providers and stop covering any fees they bill. In addition, we immediately suspend the payment card and the online claims service (including claims for prior authorization and life-sustaining drugs²) and put paper claims on hold. We then send the plan member a letter asking them to pay back the amounts they weren't entitled to. Once we receive the reimbursement, we reactivate the plan member's payment card and online claims service¹ and process any pending paper claims. If the plan member refuses to pay us back, we transfer their file to Legal Affairs.

3 In cases of fraud or abuse, does the claim information remain confidential?

In cases of **abuse** and **suspected fraud**, information about the plan member and healthcare provider will remain confidential. However, for administrative services only (ASO) plans, we can share some non-medical information with authorized individuals upon request before claims are suspended.

In cases of **confirmed fraud**, we can share all the claim information with authorized individuals upon request (plan member's name, amounts in question, healthcare providers involved, etc.).

4 Do you notify the police in cases of confirmed fraud?

As a member of the Canadian Life and Health Insurance Association (CLHIA), we can confirm that Canadian insurers no longer report fraud cases to the police. The process is very long and complicated, and, as it falls under the *Criminal Code*, we would not be able to get the money back.

However, if we have to, we can:

- Use our internal investigation services
- Transfer the file to our Legal Affairs
- Report certain healthcare professionals to their professional association or order in the event of questionable practices

¹If a confirmed or suspected case of fraud is committed using online services, we will not reactivate the online claims service.

²Our pharmacology experts determine what is considered a life-sustaining drug.

5 How do I know if a healthcare provider is delisted?

We regularly audit the administrative practices of clinics and healthcare professionals. When one doesn't meet our standards, we remove them from our list of eligible providers. This means we won't cover any fees they bill.

Plan members can see which providers have been delisted by logging in to their group insurance account under **Tools and resources > Resource Centre**.

We encourage plan members to check this list *before* seeing a provider to avoid the frustration of having their claim denied.

6 How can I report fraud anonymously?

- Write to anti-fraud@dfs.ca
 - Call us toll-free at 1-866-692-7227
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