AGA BENEFIT SOLUTIONS

Fraud and Abuse Prevention Policy

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1. What Is Fraud?

Fraud refers also to abuse in this document as both are related concepts.

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

Fraud consists in submitting receipts with wrong and misleading information, modified receipts (date, claimant's name or amount) or fake receipts in order to intentionally and voluntarily deceive the group insurance plan for financial gain. It can be committed by the plan member, by the service provider (pharmacist, dentist or therapist) or by both acting in collusion. Fraud can take many forms, and fraudsters are continually improving their tactics.

Abuse consists in submitting claims for unnecessary, excessive or inappropriate care given the claimant's health condition (an excessive number of visits, exaggerated quantities of supplies, fees far exceeding reasonable and customary fees).

Fraud is an illegal act that can lead to punitive actions against the plan member or the provider, such as dismissal, criminal conviction, imprisonment, or request for refunding previously reimbursed fees or fines.

Abuse is not considered illegal, but it can lead to significant financial losses for group plans, thus having negative effects on their sustainability.

To point out the difference between fraud and abuse is not easy. Each suspicious claim must be analyzed in detail and additional information must be requested from the plan member or the service provider, in order to make a clear distinction between both and select the right approach.

The purpose of this document is to inform you about the various forms of fraud, and to raise your awareness so that you can contribute to our fraud detection process.

2. Prevention Methods

As a third-party payer, AGA is responsible for guaranteeing the sound management of the policyholders' plans.

Sound plan management means ensuring that we reimburse legitimately incurred expenses that meet the plan's eligibility criteria:

- The insured person is eligible under the plan.
- The service provider is a member in good standing of an association recognized by the insurer or by a government agency.
- The service provider's field of expertise allows them to provide the care claimed.
- The charges submitted are within the reasonable and customary fees.
- The claimant's health or medical condition justifies the purchase of supplies, or the care claimed.

The Claims Processing Team is well trained to recognize any warning sign of a potential fraud. Analysts must make sure to process any claim with vigilance. Refer to the "Indicators for Potential Fraud and Abuse" Cheat Sheet that lists the most common red flags to be aware of.

Attempted cases or confirmed cases of fraud are not passed over lightly. Any file that appears fraudulent to us is promptly handled by an analyst, who is responsible for gathering as quickly as possible all the necessary information and for taking quick action to deal with it and limiting any potential impact on the plans.

As we deal with many insurers, we must inform them of any case of fraud detected so they can give us their approval or dictate specific instructions to follow. The instructions may vary from one insurer to another: from a simple notification to the plan member to a formal request for reimbursement of all expenses paid, and even to the termination of the coverage.

Telus Santé offers its own auditing services. In addition to accrediting health providers and dentists as per certain established criteria, this service provider performs audits before and after payments. In some cases, those audits lead to cases of refusal or request for reimbursement.

3. Examples

Example 1

The plan member submits a claim for massage therapy.

The receipt shows three different visit dates, but two of them are written in different ink and the total amount appears to be modified to $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 plan member contacts our Customer Care Team after receiving a claim statement through the Members' Portal.

The plan member does not understand the nature of the dental expenses as no visit was made on the dates mentioned.

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

Example 3

The plan member submits a claim for two lumbar orthoses. We question the need for both.

The plan member confirms that they need one at home and another one to bring it to their office, to avoid carrying it from one location to the other.

Example 4

The plan member submits naturopathy expenses for them and all their 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 center offers to give the plan member nutritionist receipts for the value of their annual membership fees.

Example 6

A naturopath writes service receipts to their patient, even though the services provided were for physical training services, not considered a medical necessity.

4. Attention

Fraud should be taken seriously. We must take the time to properly evaluate each suspicious claim.

We must be able to obtain and collect all information related to the claim in question. Prior to accusing a plan member, a service supplier or both, the fraud must clearly be demonstrated, and the evidence must be tangible.

Analysts only inform that the documents provided do not allow them to justify the necessity of the care or supplies claimed, the frequency of the care and so on.

Avoid any accusatory tone in the communications and refer instead to the standards and clauses stipulated in the contract, including:

- Care services or supplies as a medical necessity and
- Care services or supplies to treat any pain, illness or injury.

5. Prevention: A Collaborative Effort

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

Policyholders and plan members must understand that the purpose of our investigations is not to inconvenience them. It is rather a strategy 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.

Here are some examples of plan member awareness-raising actions:

- 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. Plan members must carefully select their care providers by validating their membership in a credible association, not hesitate to shop around for healthcare providers and always confirm the need to receive any care before it is provided.

We also seek their assistance to report any case of fraud they may witness.

To report any case of fraud anonymously and confidentially, send an email to investigation@aga.ca or call 1-800-363-6217.