Johnstone's Journal

JOHNSTONE'S JOURNAL is published monthly, and designed to provide topical information of interest not only to plan administrators, but to all employees who enjoy coverage under the benefit plan. Feel free to make copies, and use as a payroll stuffer.

PHONE: 604 980-6227 or 1-800-432-9707 **www.jbenefits.com** **March 2013**

Benefits Fraud and Abuse
Do You Know What It Looks Like?

Fraud affects everyone

The cost of benefit plans is directly related to the costs of claims paid by the plan. Claim fraud and abuse, therefore, results in **increased premium costs** for everyone.

March is Fraud Prevention Month, and its motto is *Fraud: Recognize It, Report It, Stop It*. Some people consider insurance benefit fraud a victimless crime—a sort of Robin Hood act of stealing from the rich to give to the poor .In reality, benefits fraud and abuse, though perpetrated by a few, affects many. Last year the amount of health care fraud was estimated to total over five billion dollars (with some estimates reaching up to fifteen billion).

In their effort to pay only legitimate claims, insurers continue to implement increasingly **stringent claiming requirements**. More and more often, insurers are requesting supporting documents (such as a physician's letter) explaining the need for a specific purchase. Even if you've made a similar purchase previously, requirements are changing constantly.

Recognizing fraud

Fraud, or claims abuse, is committed by service providers, consumers, or both working in tandem. It is performed with or without the employee's consent.

Examples of provider fraud: Billing for services not rendered, providing unnecessary treatments, billing excessive time, billing for a service more expensive than the one performed, and falsifying or altering invoices are some methods used to defraud.

Examples of consumer fraud: Altered documents, fake claims, return products for refunds after receiving payment from the insurer, and stolen or borrowed ID cards are just some examples.

The benefits hardest hit are medical equipment and services, including orthotics, surgical stockings, and paramedical services (including physiotherapy, massage therapy, and chiropractic treatment).

Stopping fraud

Insurers have developed enhanced claims processing systems that review all types of benefit claims using sophisticated algorithms to identify fraud. Looking at such things as claiming behaviour, they can quickly identify outliers. When these systems find certain claims patterns, they will alert the insurer's fraud team to investigate further. Possible fraud alerts are built into electronic claims processing systems, which make it easy for insurers to review the majority of claims automatically and quickly.

How employees can do their part

Here are some easy ways employees can guard their benefit plans:

1. Protect all your health cards, and don't let anyone else use them. These are your identity cards and are linked to your health records. If someone else uses them, your records will be corrupted, which will affect your eligibility and insurability.

2. Check your receipts and explanation of benefits statements to make sure they accurately reflect the services you received. Report discrepancies.

3. Don't sign blank claim forms, and *do* ask for copies of claim forms you sign.

Reporting fraud

Every dollar paid out as a result of a fraudulent claim is one more dollar that is not available for the legitimate health care needs of your employees.

To keep benefit plans affordable, we all need to support programs designed to minimize fraudulent health claims. Employers need to educate employees about the many forms of benefit fraud and its implications. When fraud occurs, insurers may terminate a provider agreement, terminate the employee's coverage, or seek legal action.

Report fraud directly to your benefits carrier and the Canadian Health Care Anti-Fraud Association at: http://www.chcaa.org/report/.