GMS INSURANCE

Employee Benefits
Group Retirement Plans
Pension Plans
Life Insurance
Corporate Buy-Sell Funding Arrangements

May 2014
Volume 16 Issue 3

In This Issue

Leading the Way

Fraud Prevention

Benefit plans are offered by employers to provide a tax effective way of rewarding their employees. The vast majority of employees recognize the value of such plans and are grateful to have access to one. However, there is also a small minority who feel that benefits are an entitlement and undertake to pull as much money from the plan (and employer) as they possibly can.

Often times such tactics are a simple misuse of the plan. For example, an employee may claim massage services when there is no medical need for the treatment or they may claim services more frequently than medically necessary. While such actions may not be in line with the intentions of the plan, they are not illegal and are classified as misuse.

Then there are those who go even further by falsifying or withholding information on claim forms and other documents. These actions are fraudulent and are illegal. Consequences for fraudulent behaviour are serious and can include employment reprimands, loss of job, and civil and criminal filings that may lead to fines and jail time.

Plan misuse and fraud are not tolerable behaviours. Insurance companies have invested significant resources to help protect your plan from abuse. They use state of the art technology to identify abusive/fraudulent claims and have dedicated entire departments to investigating questionable claims. However plan sponsors and plan members can take an active role in helping to reduce this problem.

For Plan Sponsors:

- Use frequency limits, deductibles, and/or co-insurance to keep plan members financially involved and encourage active management of their benefit expenditures;
- Inform employees of the costs of fraud, what it entails and what action can be taken against those found guilty;
- Foster a corporate culture that discourages or precludes such conduct;

For Plan Members:

- Keep plan information confidential;
- Verify services provided are necessary and performed by the practitioner who is billing you;
- Verify the claims listed on the explanation of benefits were actually incurred;
- Be wary of practitioners providing a set of rates for those with insurance and a lower fee for those without;
- Never sign blank forms;
- Keep all original receipts if claims were submitted electronically in case of audit;
- Report suspicious activity to Human Resources or the Fraud Prevention Hot Line at the insurance company.

6200 Dixie Road, Suite 201, Mississauga, ON L5T 2E1
Toll Free: 1-877-685-2515
25 Irvin Street, Kitchener, ON N2H 1K6
Toll Free: 1-866-536-0389
www.gmsinsurance.com

Common Sources of Fraud & Abuse

Benefit plans are susceptible to fraud and abuse from many sources.

By the Provider

Health care practitioners have legal and moral responsibilities to their patients. They are charged with providing the most appropriate care in any given situation. However, there are a few bad apples who try to circumvent the regulatory system.

Common schemes include:

- Billing for services not rendered;
- Treating outside the scope of their practice;
- Allowing unlicensed persons to use their license and/or billing number;
- Kickbacks or referral payments;
- Over treatment;

By the Consumer

Employees and/or their dependants can play an active or passive role in fraud.

They may knowingly incorrectly complete a claim or enrollment form to ensure eligibility of coverage. Similarly, issued documents (such as provider receipts) may be altered or even forged. Computer and colour printer technology has made it easier to produce such documents at home.

Plan members may try to submit claims for someone who is not an eligible dependant. They may also try to return items for which they have already received reimbursement.

Passive participation in fraud is equally detrimental. Turning a blind eye, signing blank claim forms to keep at the provider's office, and not reviewing all explanations of benefits received by the insurance company to validate claims are all examples of passive participation.

By the Plan Administrator

While administrators may not handle any claims directly, there is the potential for abuse by:

- Altering dates to ensure employee and/or dependant eligibility and to avoid late applicant restrictions;
- Changing a job title to allow an employee to participate in a different class with enhanced benefits;
- Incorrectly reporting termination dates;
- Incorrectly reporting job duties on long-term disability claim forms

Sources:
GWL GroupLine Issue 14-05

Sun Life Financial "Do you know where your benefits dollars are going?", Randy Fahr.

www.benefitscanda.com

www.chcaa.org

Quiz Corner

Put your mental mettle to the test and a $50 prize in your pocket!

How do you write the number 34 using only the number 3?

Answers can be sent to: info@gmsinsurance.com or by fax to 905-670-4146. We will draw a winner from the correct answers and announce the winner in the next newsletter.

Our March Quiz Whiz was Robyn Welfare who knew the correct answer was a cob of corn. Congratulations!