Fraud Prevention FAQs

What Every Provider Should Know

Insurers and healthcare professionals share a common goal: protecting patients while ensuring the sustainability of benefit programs. By working together, we can prevent benefits fraud and abuse, support patient care, and safeguard employee benefits for the long term.

This document offers general guidance and is not a substitute for insurer-specific policies, plan provisions or applicable regulatory requirements.



Working Together—Best Practices

- **Submit Accurate Claims:** Provide clear detailed invoices that reflect the actual services and supplies delivered with an accurate date of service. Maintain thorough records and submit claims honestly so insurers can determine coverage under the patient's plan.
- **Guide Patients on Coverage:** Encourage patients to understand their plan-specific details. Remind them that benefits vary, and they should confirm eligibility and limits before incurring expenses.
- **Collaborate During Audits:** Respond promptly to audit requests. Work cooperatively to validate billing and acknowledge any errors found.
- **Promote Responsible Benefit Use:** Avoid "use it or lose it" messaging, which can inadvertently encourage unnecessary or inappropriate use of benefits.



Frequently Asked Questions for Healthcare Providers

Question	Answer
Is it okay to adjust service dates to help patients maximize coverage?	Service dates must always reflect the actual date the treatment was provided or supply was dispensed. Backdating or future-dating claims may be considered misrepresentation and could result in action by the insurer.
Is it acceptable to invoice for one type of treatment or supply while providing or dispensing something different?	No, invoices must accurately reflect the treatment provided, or the supply dispensed. Misrepresenting services or products may be considered improper claiming and could result in action by the insurer.
Can I use coverage from other family members to increase reimbursement?	No, using another family member's coverage inappropriately to increase reimbursement is not permitted. Coordination of benefits must follow insurer rules and the patient's plan terms. Improper use could result in an audit or further actions by the insurer.
Is it okay to hide tax on non-prescription items?	No, taxes must be applied accurately and transparently to all applicable items, including non-prescription products, in accordance with tax regulations.
Is unbundling services to increase claim amounts standard practice?	Practices such as unbundling services to increase reimbursement are not permitted.
What happens if I make an honest mistake?	Mistakes happen. Insurers generally work with providers to correct errors; they're not automatically considered as fraud. Transparency and prompt correction is key.
Can I split invoices, so patients get more coverage?	No, invoices must accurately reflect the services provided. Splitting invoices to increase coverage is not permitted, as claims must remain transparent.

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Is it okay to submit claims for prepaid or future services?	No, claims must be submitted only after the service has been provided and must reflect the correct date of service.
How should I handle audits?	Audits are a standard part of benefit plan administration and do not imply wrongdoing. View them as an opportunity to review processes, validate billing practices, acknowledge any errors, and work collaboratively with the insurer to resolve any issues.
What happens if I commit health or dental benefits fraud?	Committing health or dental benefits fraud can have serious consequences. These may include repayment of funds, loss of provider eligibility, regulatory or professional college action, reputational harm and in severe cases, legal consequences.
What does "delisting" mean?	Delisting means that, for a specific insurer, the services and supplies you provide will no longer be eligible for reimbursement under that insurer's benefits plans.
Can I be delisted for a simple administrative error?	Delisting is not a decision taken lightly. Insurers generally work with providers to correct errors. Delisting typically occurs only when there is clear evidence of improper claiming, repeated non-compliance, or serious administrative practices.
If I'm delisted, what should I do?	Contact the insurer directly.
How can I make sure my patient's claims get paid?	Submit claims exactly as performed and the insurer will determine eligibility based on the patient's plan.
Can I give patients discounts?	Yes, ensure the discount is shown clearly on the invoice or receipt. Claims must be submitted based on the discounted rate.

Have Questions? Email info@clhia.ca

