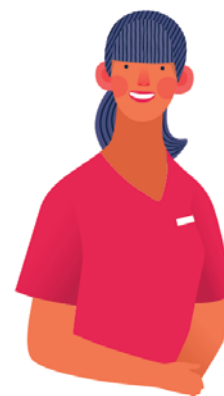




SUPPLEMENTARY HEALTH INSURANCE EXPLAINED

FOR HEALTHCARE PROVIDERS



CAOT - ACE

Canadian Association of Occupational Therapists
Association canadienne des ergothérapeutes



Association
chiropratique
canadienne



Canadian
Chiropractic
Association

CANADIAN
PSYCHOLOGICAL
ASSOCIATION



SOCIÉTÉ
CANADIENNE
DE PSYCHOLOGIE



Canadian
Physiotherapy
Association

Association
canadienne de
physiothérapie



CANADIAN ASSOCIATION OF OPTOMETRISTS
ASSOCIATION CANADIENNE DES OPTOMÉTRISTES



Dietitians of Canada
Les diététistes du Canada



CANADIAN
PHARMACISTS
ASSOCIATION

ASSOCIATION DES
PHARMACIENS
DU CANADA











CANADIAN
DENTAL
ASSOCIATION



**SAC
OAC**

Speech-Language & Audiology Canada
Orthophonie et Audiologie Canada
Communicating care | La communication à cœur

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 Section 5: Provider Eligibility <ul style="list-style-type: none"> • Eligible Providers - Regulated Professions • Eligible Providers - Non-Regulated Professions • Provisional Practice, Supervised Practice and Delegation of Duties 	 Section 6: Provider Audits <ul style="list-style-type: none"> • Purpose of Provider Audits • Authorization • Process for Provider Audits • Fraud and Abuse 	 Section 7: Other <ul style="list-style-type: none"> • Information for Orthotics and Footwear Providers 	 Section 8: Appendix

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General Overview

The delivery of healthcare services is a collective responsibility of healthcare providers, such as optometrists, psychologists, audiologists, etc., who deliver care, as well as the systems and structures that support its delivery. When it comes to the services of hundreds of thousands of Canada's healthcare providers, much is delivered in the private sector and is not funded through our public health insurance plans. Canadians often rely on supplementary healthcare coverage provided to them through employment or by purchasing individual coverage to access the services of healthcare providers working outside of publicly funded health systems.

Healthcare providers have a duty of care to their patients and are often advocates for them. In order to effectively deliver care, healthcare providers need to have a clear understanding of the healthcare environment which includes models and mechanisms of private and public health insurance. Private health insurance administration has evolved significantly over the past few years both in terms of what services are covered by private health insurance plans and the policies and procedures (e.g. electronic claims submission) for submitting and authorizing claims.

The Canadian Life and Health Insurance Association (CLHIA) is a voluntary, not-for-profit association whose members include companies that account for 99 per cent of Canada's life and health insurance business. CLHIA's mission is to serve the diverse needs of its membership and of the public in matters of health insurance. The following eleven health provider associations partnered with CLHIA in the production of this guidance document: Canadian Psychological

Association, Canadian Physiotherapy Association, Canadian Association of Occupational Therapists, Speech Language and Audiology Canada, Canadian Pharmacists Association, Dietitians of Canada, Canadian Association of Social Workers and the Canadian Chiropractic Association, Canadian Dental Association, Canadian Dental Hygienists' Association, Canadian Association of Optometrists.

This document is intended to help healthcare providers and their patients understand the private health insurance environment. Healthcare providers have a role in helping patients understand the services they receive and their insurance plan. The information provided in this document is intended to be informative but not exhaustive; it is not a legal document. It provides general information and readers are cautioned that insurance plans will vary. Patients should refer to their insurance booklet for further information.

When "patient" is referred to in this document, it may mean the plan member, typically an employee, but also any covered spouse or dependent.





Contract/Plan Wording

Supplementary healthcare insurance, also known as extended healthcare insurance was developed as an insurance offering many years ago when the coverage was meant to

be 'supplementary to' provincial public payments. Over the years as public plans have decreased coverage for certain services and supplies, or as healthcare needs and services have changed, supplementary healthcare insurance has assumed a more central role in supporting access to needed care.

The insurance contract is between the plan sponsor, typically an employer, and insurer. The choice of plan design and available coverage is determined largely by the plan sponsor and is based on the benefits that the employer wishes to provide as well as the price they are willing to pay. Insurers/benefit administrators may have a role in helping employers design a plan that meets the particular needs of their workforces and work environments.

It is most important to understand that claim adjudication (i.e. whether a benefit is paid, claim rejected, or limits imposed) is governed by the wording in contracts between the insurer/benefit administrator and the employer/plan sponsor. Different insurers/benefit administrators may offer similar coverage but due to the differences in contractual wording, adjudication results can differ.

Information Provided to Plan Members

All plan members, typically employees are provided with a benefits booklet upon initial enrolment by their employer. Plan members should review their coverage and contact the plan administrator, if necessary, to ensure they fully understand the terms and conditions. The benefits booklet will outline at a high level, the services eligible for coverage, any deductible, co-payment and the benefit maximum that may apply. It may identify if pre-approval is required. While documentation will be provided to the plan member only, family members may be covered. Eligibility is dependent on the kind of plan the plan sponsor purchased.

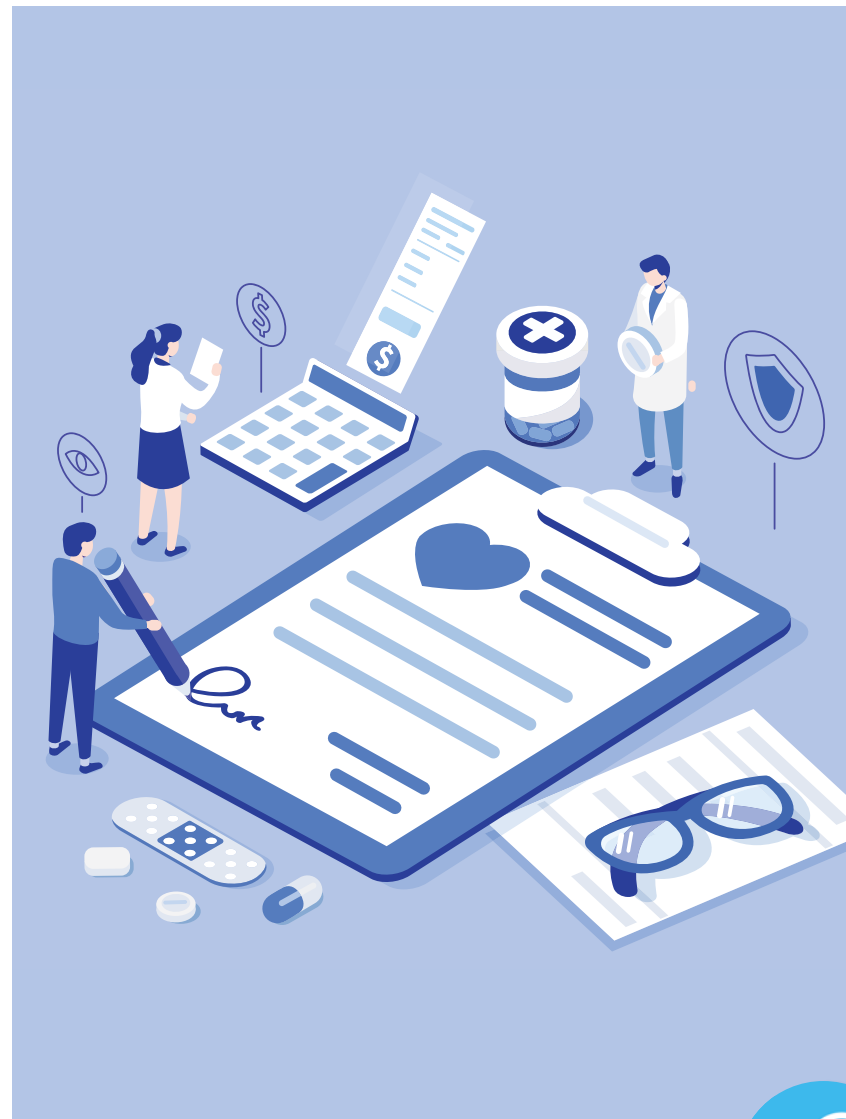
Just a few years ago, all plan member information would have been provided in print format. Now, not only is it frequently provided electronically, the plan member will usually have access to all up-to-date information at the member portal specific to their insurer/benefit administrator. This will usually include information on previously paid claims and remaining maximum amounts. Member portals can be accessed directly through a browser and are frequently downloadable as a mobile application. Insurers/benefit administrators are making it easier for plan members to access their own information real-time anytime that they need to view it. Note that only the plan member can access their information at the member portal. In addition, insurers/benefit administrators still maintain member and provider contact centres that are open extended hours. Plan members are also usually provided with an ID card that will have a plan/group number, their name and a member ID. The card may contain eligibility information for dependants. The card is normally plastic or paper but is increasingly also available on the member's mobile phone.





Information Provided to Healthcare Providers

Insurers/benefit administrators have built capabilities to respond to inquiries from healthcare providers. Depending on the plan member consents on file, some insurers/benefit administrators may be allowed to provide benefit coverage details to providers while others may not. If the healthcare provider cannot obtain details directly from the insurer/benefit administrator, the plan member will be able to obtain coverage details through the member portal or by calling the contact centre. Note that it may only be the plan member who can request coverage details..





While insurance companies may offer 'standard plans', plan sponsors (employers) are able to select from different types of plan design to meet the needs of plan members and their needs as a plan sponsor. This section will provide information on plan designs of traditional benefit plans, as well as typical benefit plan limitations.

Traditional Benefit Plans

Typically, traditional health benefit plans provide coverage for prescription drugs, dental care and supplementary healthcare. Supplementary healthcare is further divided into benefits by provider type (physiotherapist, chiropractor, psychologist etc.)

Flexible Benefit Plans

'Flex' plans offer plan members some choice in their coverage. The ability to change coverage levels or deductibles for certain benefits may be offered on an annual or bi-annual basis.

Healthcare Spending Accounts (HSAs)

Healthcare spending accounts are known by a few different names depending on insurer/benefit administrator. Plan sponsors provide a sum of money to be spent by the plan member on healthcare related products and services. Most insurers/benefit administrators follow the definition of eligible services and supplies provided by Canada Revenue Agency for the medical expense tax credit to determine what services or supplies may be reimbursed. HSAs are offered in addition to a traditional supplementary healthcare plan or may replace it completely.

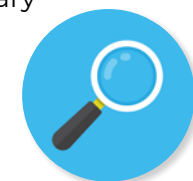
As HSAs are somewhat different than traditional benefit plans, electronic claim submission may not be as widely available for them. In addition, usually only the plan member (not their dependents) can request reimbursement from an HSA.

Benefit Plan Limitations

Almost all benefit plans have a maximum dollar amount that will be paid out each year (calendar year or some other 12-month period) for certain benefits. Typically, there is an annual maximum applied to the claims paid for a healthcare provider type – for example, a specific annual dollar amount for services delivered by a physiotherapist, a separate limit for services delivered by a chiropractor and another limit for services delivered by a psychologist. Sometimes, claims for all supplementary healthcare paramedical services are combined under one annual maximum amount. Some plans may also include a lifetime maximum per member.

Frequently, a supplementary healthcare benefit plan will reimburse a percentage of the expense claimed. As an example, this may be 80% with the plan member responsible to pay the remaining 20% out-of-pocket (called a co-payment). A plan may include an annual deductible, a dollar amount that the plan member (and sometimes each of their dependents) must pay each year before any insurance payments are made. Deductibles may be required for each individual within a family or there may be a family deductible amount to be paid.

Many insurers/benefit administrators will apply a 'per visit' dollar maximum. Sometimes this 'per visit' maximum is based on what is considered the 'usual and customary' fee for the service. If the submitted fee is at or





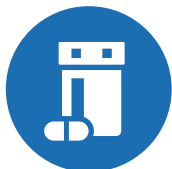
below the per visit maximum, the full fee will be considered during adjudication. If the submitted fee is higher than the maximum, the fee will be reduced to the maximum (defined as the 'eligible amount') for claim adjudication purposes. Any amount

above the maximum is fully payable by the patient. This information, as with information regarding the applicable terms and conditions of a particular plan, will be available to the plan member from the plan sponsor or the insurer/benefit administrator.

The plan's description of a service or supply, which is governed by the contract, will tell the patient whether expenses will be eligible for reimbursement. As an example, some contracts reimburse for 'Psychological Services' where others may reimburse for the 'Treatment by a Psychologist'. This may have an impact as to whether the services of other like providers (e.g. Registered Social Workers) or individuals under the direction of a psychologist will be reimbursed (see Section 4 'Provider Eligibility'). Given that it is often the plan member who submits a receipt for reimbursement for themselves or their dependants, it is important that the receipt clearly indicates the service or supply provided, for how much and by whom, especially when all or part of the service may have been delivered by someone under the regulated healthcare provider's employ. In other words, the receipt should state clearly the name of the provider who actually provided the service or supply and their registration/license number. If the person who provided the service or supply is not registered/licensed but delivered the service or supply under the supervision of a registered/licensed provider, that too should be indicated on the receipt.

In order to find out if a healthcare provider type is recognized under a particular supplementary healthcare insurance plan and the applicable benefit plan limitations, the plan member may contact the insurance company or review their benefits online, or, in some cases, the healthcare provider can contact the insurer/benefits administrator directly. If the plan does not cover services or supplies provided by a specific profession, the healthcare professional may have an ethical obligation to make the patient aware that other similar services and supplies may be covered when delivered by a different healthcare provider whose services and supplies are covered by that plan.





Authorized Health Prescribers' Referral:

Supplementary healthcare plans are designed and intended to assist in providing coverage for the expenses of medically necessary services and supplies. They are not intended to cover expenses for every service and supply not covered by the public plan. To help determine medical necessity, some supplementary healthcare plans require that, to be covered, a service or supply must be referred or prescribed by an authorized health prescriber, typically a physician. If a plan has this requirement, a current written medical referral or prescription may be required at certain frequencies, such as once every 12 months.

Plan participants are encouraged to seek clarification from their employer or plan sponsor as to whether a physician's referral is necessary to access paramedical services. If it is, the plan member should obtain the referral before any services that will be submitted to the plan for payment, are delivered.

Pre-Approval for Services

Pre-approval of coverage is suggested for appliances or devices such as braces, wheelchairs, and hearing aids as many are costly and may require documentation in addition to the prescription, such as documentation confirming make and model. In addition, some appliances may be subject to a 'usual and customary' fee limitation.

While pre-approval is generally not necessary for all healthcare services or supplies, the claim or receipt must contain sufficient information so that it can be evaluated accurately (see 'Issuing Receipts for Healthcare Services/Supplies').

Pre-approval helps to ensure that the plan member understands whether the item is covered and if they must pay any out-of-pocket amount, before incurring expenses.

Coordination of Benefits

Coordination of benefits is required when an individual is entitled to benefits under two separate benefit plans. The CLHIA developed a Guideline for the health and dental benefits industry to help promote consistency in determining the priority in which payments are made and to outline the minimum amount payable by each benefit plan. The Guideline describes the order in which benefits are determined and how to coordinate health or dental payments.

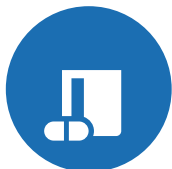
The combined payment from all plans for a particular item cannot exceed 100% of the eligible medical or dental expense. In some cases, the combined payment from all benefit plans on a particular service may be less than the submitted amount.

To view the CLHIA Coordination of Benefits Guideline, [click here](#) or go to www.clhia.ca and select the 'Industry Information' section.

Preferred Provider Organizations (PPOs)*

Some insurers/benefit administrators have established contractual relationships with networks of healthcare providers. In some cases, the network is 'closed', that is, the patient must choose from among a specified network of providers or the expenses claimed will not be reimbursed. In other cases, the network is 'open', that is, the patient





can use a provider that is not part of the network however the covered amount reimbursed may be lower. As an example, the in-network claim may be reimbursed at 80% whereas the out-of-network claim may be reimbursed at 50%.

Insurers/benefit administrators put a PPO in place in order to help manage plan costs as well as out-of-pocket costs for plan members. They may also use the services of a PPO in order to provide additional benefits to plan members such as wellness programs.

If a healthcare provider would like to consider joining a PPO, he or she should contact the insurer/benefit administrator or the PPO head office for further information about whether this is an available option. If yes, it is important to understand the terms and conditions (e.g. rates of reimbursement, reporting responsibilities) of doing so.

*Not applicable in Quebec

Issuing Receipts for Healthcare Services and Supplies

CLHIA has issued a public document entitled ***'Service and Supply Provider Receipts Best Practices for Group Benefit Reimbursement'***, in order to assist healthcare providers and plan members to understand the information required to consider a claim for payment. The document can be found by [clicking here](#) or by accessing www.clhia.ca and selecting 'The Industry' tab.

A receipt should never be issued until the service or supply has been received and paid for by the patient and must always accurately reflect the details of the service or supply.

Assignment of Benefits

Assignment of benefits occurs when the plan member requests benefit reimbursement be made directly to the healthcare provider for the supplies or services delivered. Each insurance company, and even each plan sponsor, will have their own rules as to whether or not they will accept an assignment of benefits, and if so, for which benefits and for which type of healthcare provider.

Assignment of benefits may be permitted when a claim is submitted electronically from the healthcare provider to the insurer/benefit administrator. Most insurers/benefit administrators do not allow assignment in any other situation (although some may allow assignment when the claim exceeds a certain dollar amount e.g. \$1,000.00).

If the entire claim is not paid in full to the healthcare provider by the insurer/benefit administrator, the remaining amount must be collected from the plan member. If the claim is paid in error to the healthcare provider, the healthcare provider will be asked to provide a refund.

Assigning benefits does not remove any responsibility from the plan member. The plan member is still responsible to ensure that the submitted claim accurately reflects the services rendered, and it is the patient's ultimate responsibility to ensure that the healthcare provider is paid in full.

Accepting assignment does not increase the possibility that the healthcare provider will be audited by the insurer/benefit administrator. Assignment of benefits can be revoked at the discretion of the insurer/benefit administrator.





Paper Claims:

Employees can usually obtain Health & Dental claim forms from the Human Resource Department or Union Representative. Also, insurers/benefit administrators typically make claim forms available on line that can be downloaded and printed. Standard Dental Claim forms obtained from a dentist are acceptable.

To help ensure paper claims are reimbursed quickly, the claim form must be fully completed, signed and dated with receipts attached. Many insurers/benefit administrators require original receipts except in a co-ordination of benefits situation where photocopies may be acceptable. Plan members are advised to keep a copy of all information for their records. Claim forms must be signed by the actual plan member, who may or may not be the patient (i.e. could be a spouse or dependent).

Generally, plan members who submit claims on paper are responsible for completing the claim form, attaching all required information and sending the documents to the insurer/benefit administrator for reimbursement purposes although some healthcare providers, who frequently see patients from the same insurance company, may submit the claim on behalf of the member, with their consent, as a service to their patients. In this case, healthcare providers must not ask plan members to sign claim forms in advance of delivering services.

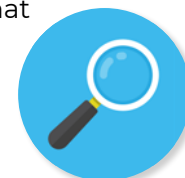
Most plans have a time submission period, for example, 12 months from the date the service was received. Claims submitted after the 12 month period may be declined. However, if an employer chooses to move from one insurer/benefit administrator to another, the claim submission period

may be shortened, for example, to 60 days. The employer is responsible for communicating the change to their employees. If a member moves to another employer, and hence changes plans, it is their responsibility to understand all the terms and conditions of the new plan coverage.

Issuing Receipts

Service providers should issue a receipt for the cost of the service or supply that they provide and for which they expect payment from the patient, regardless of whether or not a patient has access to any amount of reimbursement through insurance. For example, if a provider delivers an hour of treatment at \$50 an hour, that should be indicated on the receipt, even if the plan member's plan only reimburses 80% of that amount. The provider should not issue a receipt for any amount more than their standard rate in an effort to enable the plan member to obtain 100% reimbursement within a co-pay plan. Such a practice could result in a complaint to the healthcare provider's regulatory body.

Given that expenses for services and supplies are often paid directly by the patient and then submitted for reimbursement, it is strongly advised that receipts issued clearly identify the type of service delivered, by whom and at what rate/cost, among other required items. This will help to avoid a situation where a plan member is reimbursed expenses in error for a service that is not eligible for payment but was inaccurately described on the receipt. For example, if the receipt did not indicate that part of the service was delivered by someone other than the recognized service provider, potentially a person employed or supervised by the provider, and the plan does not cover service delivered by someone other than that provider, the insurer/benefit administrator may seek





repayment of a reimbursed claim from the recognized service provider who issued the receipt.

Receipts should clearly indicate the name of the provider who delivered the service, any relevant registration or association numbers, the address of the provider's practice location along with any other service details that would be required for insurance claiming purposes.

The CLHIA has developed guidance for healthcare providers on mandatory receipt information. Please see ['Service and Supply Provider Receipt Best Practices for Group Benefits Reimbursement'](#).

On-line (Electronic) Claims Submission:

a) Member On-line Claim Submission

Most carriers and employers allow plan members to submit certain claim types electronically through a member on-line website, while also allowing them to update certain personal information. Plan members can normally access claim forms, benefit booklets, brochures, review maximums and view their claim history at the website.

b) Healthcare Provider On-line Claim Submission

Some carriers and employers allow many healthcare providers to submit claims for services and supplies on-line. On-line claims submission may provide immediate confirmation of covered expenses. The healthcare provider may accept payment directly from the insurer/benefit

administrator, in which case the plan member is required to pay any portion of the service or supply that is not covered.

Claims may not be adjudicated on-line for a variety of reasons. Messaging displayed on the electronic claim submission system will typically indicate the reason.

When submitting claims on-line, healthcare providers need to be fully aware about how to coordinate benefits between plans (see Coordination of Benefits section of this document). Typically, if a member is covered by two plans, and both plans are with the same insurer/benefit administrator, the claim needs to be submitted just once. If the two plans are with different insurers/benefit administrators, then it is the patient's responsibility to submit the outstanding unpaid amount to the secondary plan.

On-line claim submission may not be available for all healthcare provider types. Healthcare providers are advised to check with the insurer/benefit administrator.

c) Prescription Drugs (plans that allow electronic submission)

Electronic claims submission provides the pharmacist with immediate confirmation of covered drug expenses. For most situations, the plan member is required to pay the portion of the prescription expense that is not paid.

Prescription drug claims may not be adjudicated electronically for a variety of reasons. Typically, an electronic message back to the pharmacy will indicate the reason.

d) Dental (plans that allow electronic submission)

Electronic filing of dental claims allows the dental





office to submit dental claims for plan members electronically. Depending on the plan, the dentist may or may not receive immediate confirmation of covered dental expenses.

The dentist can choose to accept payment directly from the insurer/benefit administrator (“assignment of benefits”) in which case the plan member is required to pay the portion of the dental services that is not covered. The dentist can choose to have the full payment submitted to the plan member in which case the plan member is required to pay the full amount to the dentist.

Dental claims may not be adjudicated electronically for a variety of reasons. Typically, an electronic message back to the dental office will indicate the reason.





Eligible Providers - Regulated Professions

Supplementary health plans typically cover services performed by healthcare providers who are in professions which are regulated by provincial/territorial law. When a profession is regulated in a specific province/territory, the insurer/benefits administrator will check to see that the healthcare provider is listed in good standing with the regulatory body that governs that profession.

When a profession is regulated, it is the responsibility of the regulatory body to ensure that all healthcare providers are properly trained and qualified. When a healthcare provider is regulated, no additional investigation of training is required by the insurer/benefit administrator, except when (including but not limited to):

- there is a need to establish if the healthcare provider has taken additional special training which may not be automatic with their general license or registration or
- when concerns are raised about whether or not the healthcare provider is in fact in good standing with their regulatory body

Any concerns or complaints that an insurer/benefit administrator may have about the actions of regulated healthcare providers, including investigations about suspected fraudulent activity, may be brought to the attention of the relevant regulator.

Providers should be aware that just because they are a registered/licensed healthcare professional does not

necessarily mean that expenses for their services will automatically be covered by supplementary healthcare services plans. Contractual language normally specifies eligible provider types. Plan sponsors may choose not to include certain regulated healthcare provider types within their plans, whether it is a newly regulated profession or one that has long been regulated.

Eligible Providers - Non-Regulated Professions

Not all healthcare professions are regulated in every province/territory in Canada. As a result, some healthcare professions have organized provincially or federally and have developed associations with membership requirements that can vary significantly.

When covering the services of non-regulated healthcare providers, most insurers/benefit administrators set their own criteria. If the insurer/benefit administrator decides that the membership requirements of a particular association do not meet the coverage criteria they have established within their company, claims for services or supplies delivered by members of that association will be declined.

Similar to how complaints against a regulated healthcare provider may be made to the relevant regulatory body, complaints against a non-regulated provider may be made to the association where the individual is a member.

It is the responsibility of the plan member to check with the insurer/benefit administrator and ensure that expenses for the services or supplies from a healthcare provider are eligible for coverage before the expenses are incurred.





Insurers/benefit administrators may review the credentials of healthcare providers (regulated and un-regulated) on a periodic basis to ensure they are still valid and may also re-evaluate non-regulated providers and their associations to determine if they should

continue to be recognized. Claims paid out for the services of regulated and non-regulated healthcare providers may be subject to audits by the insurer/benefit administrator.

Provisional Practice, Supervised Practice and Delegation of Duties

Some insurers/benefit administrators may recognize services and supplies provided by provisional providers when these healthcare providers have met or are in the process of meeting the requirements of their respective regulatory/licensing body. Provisionally licensed individuals should not claim for services through their supervising healthcare provider's number but must directly invoice for services or supplies rendered. If the service or supply is invoiced by the supervisor, it must be clear that the service was provided by the provisionally licensed provider.

Services provided by students under the supervision of a licensed provider are generally not eligible for reimbursement. Healthcare providers are advised to check in advance with the insurer/benefit administrator.

Healthcare providers may have a scope of practice that includes delegation of duties to another individual (ex: speech-language pathology assistants, physiotherapy assistants, psychometrists). While insurers/benefit administrators understand that the scope of practice allows this, some plans

require that the services or supplies be delivered directly by the healthcare provider in order for the associated expense to be eligible for coverage. Healthcare providers are advised to ask the insurer/benefit administrator directly or request clarification from the patient.





In the rare instance where a provider may be subject to an audit, the information in this section will help set expectations. Most insurers/benefit administrators perform some kind of audit. Audits require the submission of information from healthcare providers and/or

may include the insurer/benefit administrator doing an audit on-site. Audits can be performed prior to benefit payment or after payment has been made.

Purpose of Provider Audits

Audits are typically routine rather than in response to a known or suspected problem and are intended to refine guidance on submitting claims. The objective of audit is to establish that the services were provided to the patient and that the claim is eligible according to the terms of the contract.

Notice of an audit is not an indication that there is a suspicion of an inappropriate claim submission. However, some audits may be performed because the insurer/benefit administrator has identified concerns with the claim(s) made by a specific claimant or with the claiming patterns of a specific healthcare provider. If claimant-related concerns have been identified, the healthcare provider may be asked to confirm what services or supplies have been provided to a specific patient and the dates on which the services or supplies were provided. A healthcare provider may be asked to provide details from patient records that confirm the need for treatment or supplies and the date on which treatment or supplies were provided to the patient. It is understood that the healthcare provider will need the patient's authorization to release information about his or her care.

Authorization

To process claim submissions in an effective and efficient manner the insurer/benefit administrator always requires plan members to authorize the release and exchange of information between a healthcare provider and the insurer/benefit administrator. This authorization may be in several formats, including:

- Indicated and signed-off on a paper claim form, if the plan member submitted their reimbursement request on paper;
- Signed and retained in the healthcare provider's office, if the provider submitted the claim electronically on their patient's behalf; and
- Completed on line at the insurer/benefit administrator's website, if the plan member submitted their reimbursement request electronically.

The insurer/benefit administrator is responsible for ensuring that the appropriate authorization from the claimant is obtained and retained on file, as well as provided to and confirmed by the healthcare provider, so that she or he can release patient records to the insurer/benefit administrator if so requested. For some health professions, practice may require that the record be released to the patient who in turn may release it to the insurer/benefit administrator.

Process for Provider Audits

The insurer/benefit administrator asking for the information from the healthcare provider for the purposes of





an audit will typically request that the information be provided within a specific time frame, so that the audit can be resolved in a timely manner. A typical time frame given would be for the requested documents to be returned in 3 weeks. The

information requested will generally be the patient's file or treatment record for the service or supply in question but may include other documentation such as physician's referral (if required), appointment book entry or any other documentation related to the service or supply provided.

Audits may take the form of a written request for information, a telephonic request for clarification/ information or an on-site inspection of information where the auditor(s) from the insurer/benefit administrator will present at the healthcare provider's location. Typically, the healthcare provider will receive advance notice and flexibility as to date.

Failure to respond to a request to provide information for audit purposes may result in:

- delays in the processing of future claim submissions;
- requests for detailed documentation to support future claims;
- refusal to reimburse expenses claimed.

As noted elsewhere in this document, there are some practices, particularly around invoicing, that may be subject to audit and potentially require repayment to the insurer/ benefit administrator and a report to a regulatory or credentialing body.

Some examples of practices that might signal an audit and/ or demand for repayment include:

- invoicing for an amount that includes a co-payment that the healthcare provider does not intend to collect from the patient;
- invoicing for a service that wasn't provided directly by the recognized healthcare provider without indicating that the service wasn't provided by the recognized provider (e.g. when the service was provided by someone under the recognized provider's employ or supervision); and
- having a patient sign a claim form in advance of receiving a service or supply.

Fraud and Abuse

Insurers/benefit administrators, employers, healthcare regulators, health provider associations and healthcare providers agree that there is no place for fraud and abuse of plan benefits. Fraud and abuse increase the costs of healthcare plans and can lead to employers re-considering funding supplementary health treatment costs.





Information for Orthotics and Footwear Providers

A reference document has been developed by CLHIA member companies to assist healthcare providers, plan members and employers by providing some general guidance on:

- the terminology commonly used in describing footwear and orthotics, and -
- the information that may typically be required by insurers/benefit plan administrators in order to assess footwear and orthotic claims.

The document can be found by [clicking here](#) or by accessing www.clhia.ca and selecting 'The Industry' tab.





Links to Documents

- [A Guide to the Coordination of Benefits](#)
- [Glossary of Insurance Terms](#)
- [A Guide to Supplementary Health Insurance](#)
- [Service and Supply Provider Receipt Best Practices for Group Benefit Reimbursement](#)
- [Healthcare Anti- Fraud](#)
- [Orthotics Reference Document](#)

