# General Control Plan for ‘Materiële Controle’ and Appropriate Use 2024

## *EUCARE Insurance PCC Ltd (NL Care Cell)*

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## FOREWORD

EUCARE Insurance PCC Ltd. on behalf of its NL Care Cell (EUCARE) has a social responsibility and a legal obligation to take a prudent approach to healthcare expenditure. EUCARE uses a set of audit instruments for this purpose. One of the audit instruments available to EUCARE is ’materiële controle’. We use this plan to inform healthcare providers, insured parties, and other interested parties about how EUCARE has structured the process aimed at materiële controle and audit on appropriate use[1]. We conduct these audits in accordance with applicable laws and regulations.

This plan has been approved by the EUCARE Board and prepared in cooperation with the authorized agent Aevitae B.V. (referred to below as: 'Aevitae'). Aevitae performs the materiële controle on behalf of EUCARE.

**Scope**
This audit plan has been drawn up for all care claimed under the Healthcare Insurance Act (Zorgverzekeringswet) and supplementary insurance for insured persons of EUCARE Insurance PCC Ltd (NL Care Cell), regardless of whether this care is based on a contract with the care provider. This means that healthcare providers declare the bill via the insured party and healthcare providers with a payment agreement also fall within the scope of this general audit plan and the associated statutory frameworks.

[1] Where reference is made to ’materiële controle' alone, this should be read ’materiële controle and appropriate use'.

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# 1 GENERAL

## 1.1 Purpose of materiële controle

With this instrument, EUCARE fulfils the social task of auditing expenditure on healthcare costs on the one hand, whilst on the other it fulfils the statutory task of verifying whether the claimed care is legitimate as described in the Healthcare Insurance Regulations (Regeling Zorgverzekering), article 1u, and the 'Further regulation on the audit and administration of healthcare insurers.'

The purpose of a 'materiële controle' is to demonstrate with sufficient certainty that the care claimed was actually and correctly provided. This means that the care claimed to EUCARE has actually been provided and that this claimed care is also the most appropriate care for the patient's (EUCARE insured) state of health.

## 1.2 Definition

The set of EUCARE audit instruments to verify the legitimacy of the claimed care goes beyond a 'materiële controle' and audits on appropriate use. The regularity of the care claimed is also assured by carrying out:

- formal control (formal audits);
- fraud investigations;
- horizontal supervision;
- compliance with the terms of the contract.

These and other relevant terms are covered in this section.

*Formal control* is defined according to the Healthcare Insurance Regulations (article 1t) as 'an investigation in which the healthcare insurer verifies whether the rate charged by a healthcare provider for goods or services:

- is for care that has been provided to a person insured with that healthcare insurer;
- is for care that is included in the insured package of that person;
- is for care provided by a competent healthcare provider;
- satisfies any applicable statutory care indication conditions;
- is care that has been claimed at the correct rate;
- complies with the provisions of other legislation and regulations.

'Materiële Controle'
According to the "Regeling Zorgverzekering" (paragraph 1, under u), 'materiële controle' is defined as "an investigation in which the health insurer checks:

- whether the performance charged by the care provider has been delivered[2], and;
- if this performance was most appropriate in view of the health condition of the insured person. Therefore, controls on appropriate use[3] are aimed at checking[4] if:
  1. The care that has been claimed meets the legal indication conditions[5];
  2. The care that has been claimed complies with the state of science and practice, also known as effective care. Inappropriate use of care occurs when an effective treatment method is not used.

2 By this we mean the "actual delivery" of care.

3 Inappropriate use of care can manifest itself as under- and over-treatment and being too quick to deploy expensive treatments while this is unnecessary.

4 NZa TH_NR_006__Nadere_regel_controle_en_administratie_zorgverzekeraars_2016.

5 Indication conditions are tested through both formal and material checks. For example, a formal check is used to check whether a referral is present. On the other hand, materiële controle checks whether the referral is also in accordance with the fact that care is reasonably appropriate or complies with current state of science and practice.

- 3. The insured person is reasonably dependent on the care that has been declared, given his state of health (also referred to as medical necessity).

Checks on the state of science and practice occur in various healthcare segments.
Regarding Medical Specialist Care and the checks on rational pharmacotherapy[6], we use published scientific articles and opinions of the National Health Care Institute. In addition, we can make use of published and substantiated insights from the professional group. Using the GRADE and EBRO methodology and the frameworks of the National Health Care Institute (ZiNL, as described in its document "Assessment of the State of Science and Practice" January 2015), we assess whether a treatment meets the current state of science and practice.

For mental health care, we base ourselves on the content of the most up-to-date Circular Therapies of Health Insurers in the Netherlands[7], which was established on the basis of an assessment of published scientific articles, care standards, generic modules of Akwa Mental Health Care and consultation of external parties. If a treatment has not yet been included in the Circular Therapies, it is possible that a Care Advice process[8] will be started. In appropriate cases we can also independently carry out this investigation.

Regarding nursing and caring, the focus is on the effectiveness of care: does the treatment policy (nursing diagnostics, care provision), given its favorable and unfavorable consequences (side effects, safety), lead to a relevant added value for the client? There is a difference between efficacy and effectiveness, which is explained in the ZiNL assessment framework. To answer the mentioned question, the principles of evidence-based practice, or EBP for short, must be followed. For EBP it is important that it is about the clinical expertise, the values and preferences of the client and the best available scientific evidence. In addition, we use insights from the professional group (V&VN), for example on the theme of 'better leave'. Of course, we also follow the specific positions of ZiNL about certain treatments, in which cases ZiNL has already made such an interpretation.

The essence of *Handreiking (MSZ*) (Guide) is the fact that hospitals themselves audit their own declarations and are accountable for them to health insurers. Health insurers then verify the audit carried out by the hospital. This provides more certainty as to the correctness of the bills. In 2024 invoiced DBC-care products and other care products that are charged to the Healthcare Insurance Act in 2023 will be checked.

*Horizontal Supervision* means that health insurers and care providers:
- jointly ensure that current and future healthcare funding is properly spent;
- jointly substantiate the social justification of this expenditure;
- jointly create certainty about this expenditure to all parties in the supply chain in an efficient, effective, and timely manner.

*Compliance with the contractual terms and conditions is verified,* which involves ascertaining whether healthcare providers comply with the contractual agreements with EUCARE.

*Fraud* can be described as committing or attempting to commit forgery, deception, prejudice to creditors or beneficiaries, and/or embezzlement. In this context, this concerns fraud by persons and organizations involved in the formation and/or performance of a healthcare insurance agreement. The performance of the contract relates to the acquisition of a benefit, payment, or service to which there is no entitlement or the acquisition of insurance cover under false pretenses. In the case of fraud, the following elements must be complied with:
- (financial) gain
- violation of laws and regulations and

[6] There are many situations and criteria in rational pharmacotherapy. These are described in the VAV method for pharmacy

[7] Circular therapies GGZ Health insurers in the Netherlands

[8] Care advisory process Health insurers in the Netherlands

- deliberate and misleading acts.

A signal is an expression, in whatever form, of (a suspicion of) an undesirable situation with possible adverse consequences for the implementation of the Zorgverzekeringswet or health insurance (TH / NR-006, Article 3.19).

## 2 STATUTORY FRAMEWORK

We conduct audits in accordance with applicable laws and regulations. The following laws and regulations provide a summary of regulations in the area of audit and administration with which health insurers and care providers must comply.

*Health Care (Market Regulation Act ('WMG')*
- Article 35: conditions for declaration and payment of (defined) goods and services
- Article 36: provision on the keeping of records with regard to agreed and delivered goods or services
- Article 68a: provisions on the cooperation of healthcare providers in audits to be carried out by healthcare insurers of claims submitted to healthcare insurers or insured persons.

*Healthcare Insurance Act ('Zvw')*
- Article 87: provisions on the provision of personal data to health insurers
- Article 88: use of surveys of insured persons.

*Healthcare Insurance Regulations ('RZv')*
- Article 1: Definitions
- Article 7: provisions for the healthcare insurer for 'materiële controle' and provisions for the healthcare insurer for signs of fraud.

*Healthcare Insurance Decree ('BZv')*
- Article 2.1, discusses the provision 'reasonably dependant on care' and compliance with the latest state of science and practice.

*Dutch Healthcare Authority (NZa) regulation*
- NR-006 Further regulation on audit and administration of health insurance companies.

*Code of Conduct for the Processing of Personal Data by Health Insurers (ZN), including the 'materiële controle' protocol*
The purpose of the 'materiële controle' protocol drawn up by ZN is to contribute to further professionalization and to increase uniformity in the performance of 'materiële controle'.

*Uniform measures Health Insurers in the Netherlands ('ZN')*
Various measures, were drawn up by the ZN, to improve the uniformity of audit and administrative processes.

*Dutch Civil Code, Book 3*
- Article 310 deals with limitation periods.

*Medical Treatment Contracts Act ('WGBO')*
According to the WGBO, the healthcare provider has a duty of confidentiality with regard to his patient's medical file. According to the description of the Dutch Civil Code, Book 7, Article 457, this medical confidentiality is not absolute. Professional secrecy may be breached on the basis of a statutory provision or with the consent of the patient concerned. Article 7:454 also further explains the healthcare provider's obligation to keep records.

The most important privacy legislation in the Netherlands is the General Data Protection Regulation (GDPR) and its Implementing Act. As in the now repealed Personal Data Protection Act (Wbp), health insurers are permitted to process personal data if this is necessary for the performance of the insurance contract or if legal obligations such as the performance of 'materiële controle' and fraud investigations have to be met.

*Contract and policy conditions*
In addition to the legal framework, the contract and policy conditions are also important for the performance of the material check.

*The Dutch Healthcare Authority supervises our activities*
The Dutch Healthcare Authority (NZa) has been given the task of creating and monitoring effective healthcare markets. It does this together with the sector as a whole. The NZa is the independent healthcare supervisor. Supervision affects the behavior of care providers and health insurers in the curative and long-term care market.

Pursuant to Section 16 of the Healthcare Market Regulation Act (WMG), NZa is authorized to instruct and audit the healthcare insurer in the area of (materiële) checks.

# 3 GENERAL RISK ASSESSMENT AND PERFORMANCE OF AUDITS

Article 1y of the Healthcare Insurance Regulations defines the general risk assessment as: '*an analysis aimed at determining the data on which 'materiële controle or fraud investigation will focus*'. The input is drawn from the bottom-up signals and top-down analyses. Healthcare providers are selected for auditing on the basis of this risk assessment. In appendix 1, we explain what the most important risk programs will be in 2020 for each type of care. These risks are not limitative.

Examples of bottom-up signals include positions taken by the Netherlands Institute for Healthcare, signals from the NZA, IGJ, ZN, fellow insurers, the media, insured parties or their own organization, and analyses of risks arising from contracts.

By top-down analysis we mean data analysis, benchmarking, and reflective information, which we use to identify striking declaration behavior.

When carrying out audits, we treat privacy-sensitive information with due care. We work in accordance with the conditions laid down in legislation and regulations.

We incorporate personal data in the risk assessment (no more than necessary for the purpose). Personal data is processed by expert employees who are involved in the processing of personal data for specific purposes and under the responsibility of the medical adviser. These employees are members of the functional unit.

The overall risk assessment and the performance of formal and materiële controls are carried out by Aevitae on behalf of and under the responsibility of EUCARE. At Aevitae, the materiële controls are carried out by the staff of the Materiële Controle Department. The employees of this department are part of the functional unit.

## 3.1 Performance of formal audits

The formal audits are carried out by Aevitae's Operations Health department. Formal audits cover a mix of prior audits by means of computerized checks and subsequent checks. Furthermore it is possible that formal audits will be performed by materiële controle.

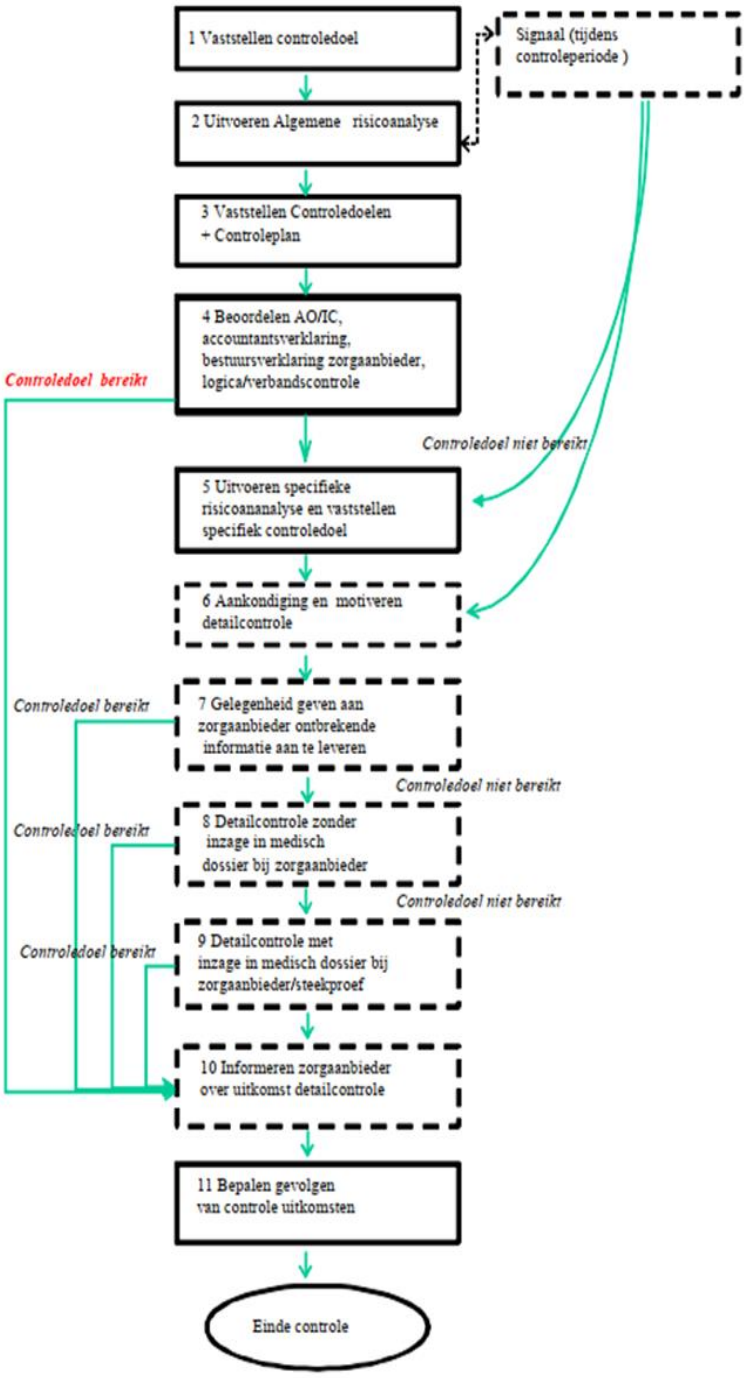
## 3.2 Performance of 'materiële controls' and checks on appropriate use

The following step-by-step plan is followed to perform the 'materiële controle'. The key points of the materiële controle are outlined below. The aim is to ensure an audit system that minimizes the burden on data subjects and privacy. These steps are a prerequisite for the use of detailed audit tools and therefore serve as a basis for the audit approach and reports.

The medical advisor has an important role in the execution of the material control. A detailed audit must be carried out under the responsibility of the medical adviser. The medical advisor is therefore involved in the steps to be followed in the context of the material control.

'Materiële controls' are carried out during the year in accordance with a pre-established schedule. This schedule differs from one audit to another: there are audits that take place continuously throughout the process, audits that are carried out only once a year, and everything in between (daily, weekly, monthly, etc.). The start and end dates may also vary from one audit to another.

*Materiële controle[9] step-by-step plan:*




1 Establish the audit objective

Signal (during audit period)

2 Perform General risk assessment

3 Determine audit objectives + audit plan

4 Assess AO/IC, audit report, management statement, care provider, logic/association audit

*Audit objective achieved*

*Audit objective not achieved*

5 Carry out specific risk assessment and establish specific audit objectives

6 Announce and give reasons for detailed audit

7 Provide the healthcare provider with the opportunity to provide missing information

8 Detailed audit without access to the medical file at the care provider's premises

9 Detailed audit with access to the medical file with the care provider/random sample

10 Inform the healthcare provider about the outcome of a detailed audit

11 Determine the consequences of audit results

End of audit

[9] Source: 'Materiële controle' protocol

*1. Establishing the audit objective*
The first step in the materiële controle process is to establish the audit objective. The audit objective corresponds to the general objective of a materiële controle as described in this general audit plan: '*Obtain sufficient assurance that there is no question of substantial illegitimacy and inefficiency in the claimed care.*'
The current standard is determined when establishing the audit objective. The materiële controle applies to the basic insurance as well as to the supplementary insurance.

*2. Perform a general risk assessment*
The general risk assessment forms the basis for the audit plan. The approach to risk assessment for materiële controls includes defining risks and their impact and defining the associated internal audit measures that mitigate the risk. The overall risk analysis is formulated in collaboration with the departments Risk & Compliance, materiële controle and Operations Health department under the supervision of EUCARE. A group of organization-wide specialists periodically determine the important risks and document the associated internal audit measures. Organization-wide means that specialists from all disciplines are represented. This group of specialists evaluates the existing risks and identifies new risks as a result, among other things, of:

- signals from policyholders;
- signals from healthcare providers;
- internal staff signals (declaration processing /Care Procurement/Call center etc.);
- external signals (ZN/NZa/ZiNL/other health insurers);
- signals from the media;
- change in processes and working methods;
- changes in systems and system checks;
- changes in legislation and regulations/policy conditions/contract conditions with healthcare providers;
- developments in the sector, including 'state of science';
- others.

The specialists within the Risk & Reporting and Operations Health department determine whether something is designated as a risk. This list of risks is laid down in a comprehensive risk matrix for each type of care. This risk matrix also defines the internal audit measures and the impact of the risk.

*3. Establish audit objectives and audit plan*
The audit objectives are defined for the highest risks from the risk matrices for each type of care. These audit objectives are included in the general audit plan. It is published annually on the EUCARE site prior to the performance of the audits.

*4. Perform general audit*
The audit plan forms the basis for carrying out the materiële controle to achieve the audit objective. Aevitae observes the required proportionality and subsidiarity when carrying out the materiële controle.
This means that no heavier means are used than necessary to achieve the audit objective (proportionality), and that the processing of personal data is allowed if the audit objective can only be achieved in this way (subsidiarity).

In concrete terms, this means that Aevitae starts by examining the risks by using general audit instruments, i.e. the:

- Assessment, for example, of the Administrative Organization/Internal Control (AO/IC), the audit opinion on the financial statements, the management statement and the financial statements of the healthcare provider concerned.
- Performance of various analyses and logic/relationship audits, assuming that all forms of structural and substantial illegitimate (actual delivery) and ineffective (including non-compliance with the state of science and inappropriate use) declaration behaviour will lead to a deviation from the average. These cases are traced, audited and, if necessary, corrected by means of analysis.

If the audit objective has been achieved by carrying out the above general audit activities, the results are determined. If necessary, the healthcare provider is informed of the results and the audit is concluded.

*5. Carry out a specific risk assessment and establish specific audit objectives*
As noted above, the move to a detailed audit should only take place if the findings of the general audit plan carried out show that the audit objective has not been achieved, or that the audit objective has been achieved but that there are other signs that there is still insufficient assurance. In that case, a specific risk assessment is carried out. Based on the specific risk assessment results, Aevitae establishes a specific audit objective with an associated audit plan.

In any case, a reason for a detailed audit may arise from:
- results of the formal audit;
- results of the general audit carried out;
- signals relating to a particular healthcare provider that arise from the statistical analysis and/or association audit;
- non-compliant or incorrect application behavior;
- signal from colleagues of the healthcare provider, professional organization or inspectorate;
- signal from insured persons/patients;
- signal from other health insurance companies;
- media coverage.

The detailed audit is set out on the basis of the specific audit plan.

*6. Announcement of detailed audit*
Aevitae announces the detailed audit to the healthcare provider prior to the actual audit. Aevitae informs the care provider:
- The reason, the audit objective of the 'materiële controle' and audit points. The audit questions are derived from the audit objective.
- How the audit will be carried out
- Feedback on the results from the general/specific risk analysis.
- The period in which the findings will be made known (in accordance with the audit plan) and the possible implications (see step 11).
- What we require from the healthcare provider, for example:
    - Provide insight into the appointment calendar;
    - Providing referrals/recipes;
    - Provide care-related information at the declaration line level;
    - Providing access to (part of) files (file audit).

An audit may be carried out without prior notice if circumstances so require and if this is relevant to the nature of the audit.

Forms of detailed audit that Aevitae uses from light to weighty:
- Ask the healthcare provider specific questions to provide missing information with regard to the insured person
- The use of surveys. There are no conditions attached to the use of surveys as a means of an audit, so they can also be used as part of a general audit. In the context of the 'materiële controle, the primary purpose of a survey is to check whether the care charged has actually been provided. For reasons of efficiency and cost, however, Aevitae only chooses the survey as an audit tool if there is no lighter audit tool that can provide sufficient insight into the legitimacy of the care provided.
- Inspection of the administration of the healthcare provider (without inspection of the medical file)
- Access to the insured's medical file.

The audit is concluded at each stage if sufficient assurance of legitimacy has been obtained. This is in line with the principle of subsidiarity: has the least intrusive alternative been used to achieve the same objective?[10]

*7. Request to provide missing information*
The notice referred to in step 6 may be accompanied by requests for additional information. With this information, the healthcare provider can answer the outstanding audit or other questions from Aevitae without providing any personal data concerning a person's health. It may also be the case that the insured person is also asked to provide additional information. Sometimes this is the only way to obtain complete information.

*8. Access to the administration of the healthcare provider (without access to the medical file)*
In the audit instrument inspection of the administration of the healthcare provider without inspection of the medical file, use is made of personal data that Aevitae does not have at its disposal. The following activities are included in the detailed audit without access to the content of the medical file:

- requesting information from the care provider, e.g. asking for an explanation of non-compliant key figures
- auditing the client's arrangements in the care provider's electronic or another system.

*9. Access to the medical file of the insured person*
When carrying out a detailed audit, a healthcare provider must provide Aevitae with access to the content of the medical file in accordance with the specific audit plan. This can be done either in individual cases or on a random basis. Aevitae is responsible for the careful performance of the detailed audit under the responsibility of a medical advisor. It should be noted that the basic principle is that access to the medical file is only possible in extreme cases. This is without prejudice to foreseeable situations in which it is clear that the specific audit objective can only be achieved by carrying out a sample, and that other tools for detailed audit cannot be used to achieve the audit objective. In that case, the other steps do not have to be taken first.

Detailed audits with access to medical records
Detailed audit with access to medical records uses personally identifiable information about a person's health. The administration of the healthcare provider should contain sufficient information (for example, recorded X-rays, ultrasounds, measurement reports, conversation reports, research reports, referrals / indications, etc.) from which it can be demonstrated that the declaration has actually been delivered and that this has also been provided and that this was also the most appropriate given the health situation of the insured.

The specialist MC selects the care providers/institutions to be audited on the basis of the analysis and extracts a partial observation. The medical posts and the selected reports are audited by the medical advisor.

The report should provide insight into:

- What the purpose of the research is;
- How the audits have been performed;
- What is the observed deviation from the declared amount per insured person/client;
- Whether the delivery of care has been effective;
- Whether the declared care has been delivered and how it has been determined; and
- What the overall impression is about the care provider.

*10. Inform the healthcare provider about the outcome of a detailed audit*
Finally, Aevitae informs the care provider of the outcome of the audits. In the context of the right to hear and be heard, the healthcare provider is given the opportunity to respond to the outcome of the detailed audit within a reasonable period of time. Aevitae determines the final outcome of the audit and notifies the healthcare provider on the basis of the healthcare provider's response.

[10] Health insurers in the Netherlands, UM-12-9-mrel1

*11. Determine the consequences of audit results*

If an audit reveals shortcomings, the consequences are determined. The interests of the insured are of course central to this. The following aspects are also taken into account:

- the extent of error/deviation;
- has the healthcare provider enriched itself?
- is there a deliberate or an inadvertent mistake?
- could the care provider have known he was making mistakes?
- have any mistakes been made on the part of the health insurance company?
- has the healthcare provider received previous warnings?
- did the care provider cooperate with the audit?
- does the care provider appear to be honest in his or her motivation?
- what is reasonable?

The consequences can be very diverse and, for example, result in a number of different outcomes:

- extend the audit;
- hand over the file to the fraud coordinator to carry out a fraud investigation;
- issue a warning;
- a recovery or set-off against future claims from the care provider;
- issue additional conditions to the healthcare provider;
- amend or terminate the agreement;
- inform the Healthcare Inspectorate;
- make a report to the NZa.

The above effects and actions may be combined depending on the situation.

# 4 REPORTS AND ACCOUNTABILITY

The general audit plan (for 'materiële controle' and appropriate use) is drawn up by Aevitae and then submitted to the management of EUCARE for review and approval. Aevitae periodically records the findings, the results achieved and the progress of the audits carried out (both formal and materiële controle) in a progress report. The report is shared and discussed periodically with EUCARE. This enables EUCARE to actively steer the performance of audits.

**4.1 Final report/accountability**

Aevitae documents the audits and their findings, as well as how they have been followed up in a concluding memo. This memo serves as a basis for assessing the performance of 'materiële controle' for accountability purposes and is assessed by the third line of Aevitae and EUCARE. For the external auditor and the Dutch Healthcare authority (NZa), the memo forms the basis for forming an opinion on the performance of the 'materiële control'.

The memo links the audit plan drawn up for 'materiële controle' (work planned) with the work actually carried out and the qualitative and quantitative results of the audits.

## ANNEX 1: GENERAL RISKS OF A 'MATERIËLE CONTROLE' (AUDIT OBJECTIVES)

The risks of of illegitimacy, inefficiency and inappropriate use are recognized for all types of care.

The main risks relating to 'materiële controle' are listed below for each type of care. The risks that apply to all types of care are also listed below for each type of care. This list is not exhaustive.

***Medical Specialist Care***

- Guidance on legality checks MSC 2023:
  - The risk themes follow from a nationally drawn up risk list.
  - The Guidance on legality checks 2023 applies to all hospitals (that have not yet switched to HT) and UMCs
- Horizontal Supervision (MSC)
  - The risk themes vary per hospital, there is a national theme list that health insurers use as the basis for drafting individual Control Frameworks
- In addition (among other things):
  - risk of multiple records of a Radiology examination
  - risk of U-turns
  - risk of misapplication of mutual services
  - risk of seriality
  - risk of expensive and orphan drugs - maximum quantities
  - risk of missing referrer.

***Mental healthcare***

- Horizontal Supervision (MHC)
  - the risk themes vary per mental health institution, based on a national risk list.
- In addition (among other things):
  - Risk of continuing to treat a client longer than necessary or claiming more care than actually provided.
  - Risk of a longer admission than necessary given the state of health or a longer admission than permitted under the Zvw (1095 days).
  - Risk of registering and declaring settings incorrectly
  - Declaring a setting that is not medically necessary
  - Risk that the high psychiatrist rate is wrongly charged in the independent setting.
  - Risk of incorrectly claiming physiotherapy, day care or art therapy in outpatient mental health care
  - Risk of declaring uninsured care as insured care
  - Double reimbursement of admissions across institutions and/or segments

***Pharmaceutical Care***

- risk of incorrectly declaring expensive (Appendix 2) medicines
- risk of wrongful delivery of (magistral) preparations.
- risk of Counselling Interview for New Medicines

***Medical aids***

- risk of declaring loose material in addition to the daily price
- risk of declaring more than the maximum number of items
- risk of inefficient delivery of incontinence material

***Paramedical Care***

- risk of declaring no-show
- risk of incorrect indication with the care provided

***Midwife care***

- risk of incorrect indication of the care provided

***Dental care***

- risks of upcoding
- risk of unjustified reimbursement for weekend treatments
- risk of unjustified reimbursement for retention equipment

***General practitioner and chain care***

- risk of incorrect application of additional modules
- risk of concordance between Wlz/WMO and Zvw care
- risk of incorrect declarations from chain care

***Nursing and caring***

- risk of claimed care that is not in line with the needs assessment
- risk of claims for nursing and caring during a stay in an institution
- risk of reimbursement for specialist nursing and care without the presence of a referral letter; risk of duplicate claims
- risk of concordance between Wlz/WMO and Zvw care

***Geriatric Rehabilitation Care***

- risk of incorrect indication with the care provided