NATIONAL INSURANCE CRIME BUREAU

INDICATORS OF MEDICAL FRAUD

Bills/Diagnosis/Prescription Drugs/Treatment

Detection—The First Line of Defense

PART 2 OF 2

MOST claims are legitimate, but some are fraudulent. Therefore, it is appropriate to review all claims for possible fraud. Detecting fraud is aided by familiarity with industry identified fraud indicators.

INDICATORS assist in the identification of claims which merit closer scrutiny. The presence of an indicator (or several indicators) do not prove fraud. Indicators of possible fraud are not actual evidence, they only "indicate" the need for further investigation.

SOME claims, although questionable, may be paid due to a lack of conclusive evidence of fraud. However, they should be submitted as questionable claims to NICB for further review.

DOUBLE asterisk (**) indicates the possibility of organized group activity.

For additional information on the following indicators, please see the NICB's Interactive Indicator Guide. This Guide is a software application providing the concern associated with each indicator as well as suggested resolution steps. The Interactive Indicator Guide is available from the NICB Document Download Center (nicbdocs.org).

Initial Indicators: Usually identified in the initial/early processing of the application or claim.

Subsequent Indicators: Usually identified as the application or claim processing continues. May also suggest areas of additional inquiry.

When viewed as a PDF, utilization of the bookmark function will provide the ability to choose an indicator topic or Control F can be used to rapidly locate specific key words within the indicators (e.g. address, receipts, police, etc.).

DME – Medical Bill Indicators (Initial)

- DME bill shows charges for equipment not in the doctor's order or patient's receipt.
- DME bill shows excessive rental charges for equipment (e.g. rental of equipment cannot exceed 125% of the cost to purchase equipment). **
- DME bill shows markups for equipment in excess of your state's standards for such markups.

- Invoice lists inexpensive products commonly available at local drugstores (e.g. Over the counter - OTC) such as back massagers, heat lamps or neck braces, and billed under cryptic or fictitious model names and numbers or as customized equipment.
- Mis-billing DME with multiple functions, such as hot/cold therapy units and billing as separate pieces of equipment.

DME – Medical Bill Indicators (Subsequent)

- Billing the insurer for more expensive items than those actually shipped. **
- Component parts of the DME are billed for instead of as a complete unit as provided by the manufacturer. **
- DME billed for is defective or the equipment has exceeded utilization or lifespan guidelines. **
- Duplicate orders of DME or unnecessary amounts of DME are billed for. **
- Failing to credit the insurer for DME that is returned by the patient.
- New DME is billed for when used and/or refurbished DME has been provided to the patient. **

DME – Medical Treatment Indicators (Initial)

- DME that is inappropriate and expensive is prescribed for minor injury. **
- Two types of DME items are prescribed for patients at the same time.

DME – Medical Treatment Indicators (Subsequent)

- Altering medical records to justify unnecessary DME. **
- Bags of identical DME pre-labeled with patient names seen in the medical clinic. **
- DME billed for multiple patients is the same. **
- DME given to all injured persons is the same regardless of diagnosis. **
- DME is dispensed without instructions for use. **
- Improperly licensed/certified individual(s) prescribing or providing or administering DME. **
- Information exists of patient lists being provided to the DME supplier. **
- Information exists of payments/commissions from a DME supplier to the ordering practitioner. **
- Patient denies ever receiving the DME or receiving less or different DME than the insurer is billed for.
- Patient questions the amount of DME that is prescribed.
- Prescriptions for DME are written by DME suppliers rather than the patient's physicians. **
- Provider prescribing the DME has an ownership interest in the DME company who manufacturers and ships the DME. **
- Providing false or misleading information, such as offering of "free" equipment when they are actually billing the insurer. **

- Reminder notices in doctor's office to give out DME in pre-determined sets. **
- Supplier ships DME to patients prior to obtaining a physician's order, certificate of medical necessity, or prescription. **

Diagnosis Indicators (Initial)

- Additional injuries are diagnosed by the medical provider which are more extensive than the insured/claimant initially reported. **
- Bills for diagnostic imaging are submitted without supporting documentation such as reports. **
- Comparison diagnostic tests are ordered by provider (e.g., performing a diagnostic test on an uninjured joint so the results can be "compared" to the diagnostic test results from the injured joint). **
- Computer Topography (CT or CAT) scans with multiple views when single view ordered.
- Diagnosed injuries are inconsistent with the collision (e.g. extensive injuries with very low speed impact). **
- Diagnosed injuries are subjective (e.g. pain, headaches, nausea, inability to sleep, depression, dizziness and soft tissue). **
- Diagnosed injuries are to the neck, shoulder, back or knee.
- Diagnosed injuries claimed are inconsistent with the description of the loss/accident (e.g. the injured person claims the vehicle was moving at an excessive rate of speed yet only soft tissue injuries claimed). **
- Diagnosis in the bill is not supported by other documentation. **
- Diagnosis is inconsistent with treatment. **
- Diagnostic imaging is not consistent with the nature of the injury or treatment. **
- Diagnostic imaging is performed on several separate visits rather than one. **
- Diagnostic test ordered not normally associated with the reported injury (soft tissue injury with hair analysis, allergy testing, saliva testing, balance testing, etc.). **
- Diagnostic testing (X-rays, EMG testing, MRIs, etc.) is performed often and early in the treatment. **
- Diagnostic testing is billed repeatedly without a report of a worsening condition in objective findings or a report of a new injury. **
- Digital analysis of plain film radiography. **
- Electrocardiograms (ECGs or EKGs) are administered to patients with no complaints or conditions. **
- Equipment is required for diagnosis is specialized, but the injured person cannot describe the equipment or procedure.
- Experimental testing - (Surface Electromyography (sEMG), Quantitative Sensory Testing (QST), Current Perception Threshold (CPT), Voltage Actuated SensoryNerve Conduction Threshold (VsNCT). **
- MRI bills appear early on in the treatment and repeated again in later treatment.

- Multiple diagnoses are indicated.
- Multiple diagnostic procedures are billed with separate CPT codes when there is a CPT code that includes all of the billed procedures. **
- New or unknown diagnostic clinic/center. **
- Non-diagnostic quality tests - (e.g. full spine x-rays, poor quality ultrasound, EMG poor technique). **
- Ordering nerve tests (e.g. Electromyography - EMG, Nerve Conduction Velocity - NCV) in the absence of clinical evidence of nerve injury or disease. **
- Second opinions concerning the patient's condition are commonly asked (referred)for by the provider. **
- Soft tissue injuries (often the same or similar) are diagnosed for all parties involved. **
- Surface EMGs (SEMG) are used for diagnoses. **
- Ultrasound of entire abdomen scan when quadrant scans ordered. **

Diagnosis Indicators (Subsequent)

- Diagnosis process, as described by the patient, is inconsistent with the actual test.
- Diagnostic test(s) results are not known by the patient. **
- Diagnostic tests performed but not read or interpreted by qualified medical personnel.**
- Discrepancies exist between the locations of diagnostic imaging testing (and other types of tests) and the person interpreting the test. **
- Equipment (e.g. an x-ray machine) required for the billed diagnostic CPT code is not located at the provider's facility although the test was allegedly performed there. **
- Equipment that is very technical, such as MRIs and X-ray machines show no indication they are maintained and calibrated. **
- Injury claimed relates to a pre-existing injury or health problem.
- Mobile imaging used when fixed higher quality centers locally available. **
- Mobile unit performs neurological or other tests, which are read at remote locations.**
- Prior similar injuries and or claims not disclosed when asked.
- Test or series of diagnostic imaging tests is given to all patients at a clinic or medical office regardless of injury. **

Medical Bill Indicators – General (Initial)

- All or nearly all the injured individuals submit medical bills from the same doctor or medical facility and/or use same attorney. **
- Bills are submitted in "bulk" just before the time deadline. **
- Bills are submitted months after treatment is rendered. **
- Bills are submitted without appropriate supporting documentation (e.g., PT worksheets or diagnostic imaging reports). **
- Bills are templates or prepared forms that do not document the actual facts of a patient's case. **

- Clinic billing done by outside service. **
- Contradictions are revealed when comparing the bills to other documents or sources of information.
- Emergency services are billed by providers (providers say they administered services on a day when their office is routinely closed). **
- Form/Bill does not show the injury as auto accident or workplace related.
- Large number of medical bills suddenly received from a new center/clinic. **
- Medical bills are not on a standard form or on the standard no- fault forms used in no-fault states. **
- Medical bills are supplied by the insured/claimant instead of being obtained from the provider. **
- Medical bills submitted are photocopies of originals. **
- Name of the facility submitting the medical bill includes the word "Diagnostic". **
- No request, reports, or any indication the treatment was needed or conducted prior to receiving the medical bill. **
- Past experience demonstrates that the physician's bill and report, regardless of the varying accident circumstances is always, or nearly always, the same in terms of duration and type of therapy. **
- Phone number for the clinic is not listed on the medical bills. **
- Significant lapse between when the alleged service was provided and when the medical bill is received. **
- Summary medical bills are submitted without dates and descriptions of office visits and treatments, or treatment extends for a lengthy period without any interim bills. **
- Weekends, holidays or other days the facility would not be normally open are shown as routine treatment dates on the medical bills. **

Medical Bill Indicators – General (Subsequent)

- Date(s) on the bill for medical service(s) is prior to the date the clinic/center was established. *
- Emergency Room diagnostic tests were administered (CT scans, MRIs etc.), but then no other treatment is provided to the claimant. **
- High dollar additions for off-site system and surgical monitoring for surgical procedures are included in the bill (e.g. by doctors who are not even in the room at the time of the surgery). **
- MRI facility bills for 3D imaging and the reading of the 3D film when the facility does not have the appropriate computer program to create or read it. **
- MRI imaging center billing, writing report, but not performing unique exam. Modifying the DICOM data files. **
- Medical bills accrued for the injury have a higher dollar value compared to the other providers treating patients for similar injuries. **

- Medical bills submitted appear altered and/or a claim file review of prior claims reveal the bills have been submitted in prior claims by the same claimant or suspected organized group. **
- Medical provider is associated with multiple locations and bills indicate regular or frequent treatment at one location. **
- Physician bills out of multiple offices on one day (treatment time is more than possible for one day). **
- Physician's bill and report, regardless of the varying accident circumstances is always or nearly always the same. **
- Provider is non-compliant with state licensing requirements.
- Rehabilitation or physical therapy bills are not supported by worksheets showing the who, what, when, where, effectiveness of the treatment program, and/or modification if not successful. **
- Workers compensation insurer and health carrier are billed simultaneously; payment is accepted from both (especially if worker is at the age of Medicare when they are injured). **

Medical Bill Inflation Indicators (Initial)

- Bills for E&M provide little or no detail but the CPT code billed reflects an office visit of high complexity, comprehensive history/exam, etc. **
- CPT codes appear "inflated" or "up-coded". **
- CPT codes unbundled. **
- Consultation (99241-5) billed for own patient.
- Davis Series (72052) charge with fewer than seven images or reports.
- Dollar amounts billed for are much more than other providers (of the same specialty) charge. **
- E&M codes, complex/severe (992x4-5) billed for every visit until discharge (especially if diagnosis is low severity). **
- E&M new patient code (99201-5) billed for by provider in the same medical group where the patient has previously received treatment within the past three years.
- E&M, new patient code (99201-5) billed every visit.
- Interpretation hours (90887) billed with little detail in report.
- Medical provider bills for new patient visit, but insured/claimant advised that the doctor only spent a few minutes with them or they didn't see the doctor. **
- Multiple treatment procedures are billed using separate CPT codes when there is a CPT code that includes all of the billed procedures. **
- Neuromuscular re-education (97112) billed in connection with a soft-tissue injury without nerve damage.
- Office visits daily for more than five consecutive days or continue for more than one week. **

- Patient is seen multiple days in a row. **
- Psychological testing (96101) report is without detail.
- Reports for initial exams, follow-ups, consultations, etc. provide little or no detail, but the CPT code billed reflects high complexity, comprehensive history/exam, etc. **
- TENS unit bills are very expensive (often billing for more advanced units without attempting treatment with basic, less expensive units first). **
- TENS unit bills include frequently billed supplies such as electrodes and batteries (charges may also be excessive). **
- Technical (TC) or Professional (PC) component modifier used with a diagnostic procedure CPT code billed in conjunction with the applicable global diagnostic CPT code. **
- Thermography studies billed for. **
- Time-based modalities (multiple) are billed for the same treatment session, resulting in the patient being in treatment for two or more hours (including acupuncture and massage). **

Medical Bill Inflation Indicators (Subsequent)

- Changes in treatment plan are not made after several treatment sessions have been rendered and extensive diagnostic testing (EMG, NCV, MRI etc.) is performed.**
- Clinic has continued billing or treatment irregularities. **
- Comfort modalities (pain management only) administered continuously (and the insured billed) for an extended period of time. **
- Community reintegration training (97537) billed repeatedly. **
- Digital analysis of electroencephalogram (97957) routine appearance on bills. **
- Duplicate billing with the provider billing global codes then later billing separately for the technical or professional component of the diagnostic test. **
- Duplicate bills for same type of treatment with a different procedural name(e.g. electrical stimulation and TENS unit). **
- Equipment and treating facility is out-of-date, broken or inconsistent with treatment billed. **
- Injury progression is atypical and seems to require extended treatment (often extending beyond estimated "discharge date").
- Narrative reports submitted appear to be templates containing the same information for multiple patients. **
- Provider bills a referral fee for medical services that were never rendered. **
- Provider bills cancellation charges for office visits that were not originally scheduled. **
- Provider bills for medical supplies that were not used. **
- Provider bills for office visits that were not made. **
- Provider bills for treatment, tests or evaluations that were not provided. **
- Provider repeatedly uses x-rays, ultrasounds, nerve conduction tests, or spinal video fluoroscopy to check treatment progress. **

- Quantitative testing billed for, but performing qualitative testing.
- Range of motion (ROM) tests are conducted frequently.
- Repeated billing by the medical provider for extensive established patient visits (e.g. repeated bills for manipulations on a soft tissue injury). **
- Signature of patient appears several times on the same clinic sign in sheet. **
- Treatment continues with no changes in plan. **
- Treatment plan exceeds 90 days with no evaluations during the 90-day period. **
- Treatments are administered daily and the insurer billed for an extended period of time. **
- X-Ray billing and coding for cervical, thoracic, and lumbar x-rays when a full spine x-ray was performed. **
- X-Ray of full spine on each and every patient on the initial exam and then again at the reevaluation. **

Medical Treatment Indicators (Initial)

- Date treatment begins is prior to the accident date. **
- MUA (22505 - Manipulation Under Anesthesia) billed by a chiropractor (may also bill for assistant surgeons and standby assistant), especially if billed early in the treatment and/or in conjunction with 23700 and 27194.
- Medical records do not explain excessive, expensive medical testing/treatment. **
- Passive treatment modalities are used exclusively without encouraging use of a home program of exercises/activity.
- Therapeutic activities (97530) billed in conjunction with 97112.
- Travels extensive distances to receive medical treatment. **
- Treatment administered to the patient by multiple providers in one office on the same day. **
- Treatment at the scene was refused. **
- Treatment dates on the bill indicate the start of treatment is delayed by more than four weeks from the loss date. **
- Treatment is extensive or unnecessary for minor, subjective injuries. **
- Treatment is from a medical provider identified in multiple previous questionable claims. **
- Treatment is not sought or received immediately for the injuries sustained in the accident, often waiting a day or two before going to the emergency room or other medical facility. **
- Treatment provided is not usually associated with this type of injury. **
- Treatment shows more than three therapy modalities in a single treatment session.
- Treatment which is usually not associated with the particular diagnosis/ICD code.

Medical Treatment Indicators (Subsequent)

- Chiropractic manipulation (98940-5) routinely billed in conjunction with an E&M visit without documentation of a separate office visit where treatment was required beyond normal pre and post manipulation assessment (should be billed with a -25 modifier).
- Chiropractic treatment extends beyond the typical number of visits (approx. 30-34) for simple soft tissue injuries. **
- Clinic treats several or all of the claimants on same day. **
- Description of medical treatment received can't be given. **
- E&M code 99358 (Prolonged Services), routine appearance on bills. **
- Family members are treated on different days. **
- Frequency or number of therapy modalities does not decrease after four weeks of treatment.
- Minor injury results in a network of treatment providers, diagnostic procedures, and treatments. **
- Pain management protocol is not modified (treatment is continued) even when not effective. **
- Patients are seen only by a chiropractor on the initial visit, yet proceed to get treatment and multiple modalities (acupuncturist, physical therapist, neurologist, etc.) before seeing a medical doctor. **
- Patients in one claim all receive the same treatment (same treatment dates, same examination/progress reports, etc.). **
- Referral is not made to another specialist for evaluation when no progress is made after four weeks of treatment.
- Time dependent procedures don't match what was billed (e.g. more treatments than possible in a 24 hour day). **
- Treatment being billed for is not remembered by the patient. **
- Treatment billed outside the normal standards of care without documentation or explanation (e.g. alternative medicine or multiple treatments of the same type during the same visit, frequent use of modifiers, frequent use of unlisted CPT codes or the same treatment given to every patient regardless of the injury). **
- Treatment directed to a separate facility in which the referring physician has a financial interest (especially if this is not disclosed in advance). **
- Treatment extends for a lengthy period without interim bills. **
- Treatment for extensive injuries is protracted although the accident was minor. **
- Treatment given to children and adults is the same type. **
- Treatment is ended when the policy's monetary limits are reached. **
- Treatment is extended, without re-evaluation or outcome assessment.
- Treatment is given by receptionists or other non-medical personnel.**
- Treatment is sought from a hospital far away from the parties involved home or place of employment. **
- Treatment plan does not change over time (especially if additional diagnostic tests have been done). **

- Treatment prescribed by the medical provider for the various injuries resulting from differing accidents is always the same or nearly always in terms of duration and type of therapy. **
- Treatment prescribed for all or nearly all patients is the same in spite of different accident facts. **
- Treatment requires a licensed medical professional, but the provider is not licensed.
- Treatment requires specialized equipment, but the injured person cannot describe the equipment or procedure.

Prescription Drug Fraud Indicators (Initial)

- Compound medication is billed for however the compound ingredients are identical to a less expensive over the counter drug. **
- Compounded medications are prescribed (especially if containing unknown ingredients). **
- Dosage for the prescription is high compared to the recommended starting dose for the medication.
- Drugs are being prescribed without any accompanying therapeutic modality.
- Exam results and medical records in claim file do not support the need for the prescription.
- Medical records do not indicate a physical exam was performed prior to medications being prescribed.
- Research reveals there is an interaction between the medications dispensed.

Prescription Drug Fraud Indicators (Subsequent)

- Drug testing results indicate the patient is not taking any medications, however the provider is submitting bills for prescriptions.
- Highly addictive drugs are the only drugs prescribed by the provider. **
- More than one pharmacy billing for exact same prescription. **
- More than one provider billing for the same medication. **
- Patient indicates the prescription drug does not reduce their pain.
- Patient is receiving prescriptions for both compounded drugs and oral drugs which may duplicate ingredients.
- Patient not given an option to fill prescription at a pharmacy of their choice. **
- Pharmacy bills insurance company for medication never provided. **
- Prescription/Medication and/or dosage does not change over the course of the treatment plan.
- Prescriptions/treatment continue for an unusually long period of time.
- Provider alters medical records to justify unnecessary prescriptions. **
- Provider does not offer the patient other options as an alternative to the prescription medication.

- Provider uses the same or nearly the same prescription treatment plan for all patients. **
- Records do not indicate a change in diagnosis, treatment plan, medication or prognosis after a prolonged period.
- Refills are automatically refilled regardless of doctor/patient request or necessity.**