FRAUD/ ABUSE INDICATORS

Claims Examination

PROVIDER/ INSURED BILLING

_____ Photocopies presented (or copied over blank bill)
_____ Medical records presented with initial claim and not requested
_____ Presence of "white-out", erasures, strike-overs, alterations
_____ Mis-spelled medical terminology on bill
_____ Home-made billing statement, or PC-generated w/o letterhead
_____ Receipt only, no itemized billing
_____ Rx bills consecutively numbered
_____ Medical provider uses P.O. Box or *multiple* P.O. boxes on billing
_____ *Over-abundance of lab/diagnostic tests for diagnosis/complaint
_____ *CPT codes disguised or non-reflective of actual service ("Upcoding" or "Code Creep")
_____ *Forgiveness of co-par/waiver of deductible
_____ Services provided by several MD consultants on same day; all providers located in same clinic/facility
_____ Questionable credential of practitioner
_____ *Services not rendered (FRAUD)
_____ *Patient complaints/diagnosis not consistent with patient statement
_____ Services appear excessive / treatment portends to be very vague
_____ Uncooperative / defiant provider
_____ *Provider bills for medical treatments actually performed by other providers. (Licensing of other providers should be checked in these cases)
_____ Repetitive claims / Numerous claims within a short period of time
_____ Provider refers patient to other providers who, in turn, perform same or similar procedures (Pingponging)

*May require a telephonic interview with patient

INSURED / CLAIMANT REPRESENTATIVE

_____ Contestable investigation (*Last resort*)
_____ Benefits assigned, but claimant demands payment / Benefits not assigned when normally expected
_____ Repeatedly hand-delivered claim documentation / claim forms repeatedly faxed to claims office
_____ Multiple coverages / Probable other undisclosed insurance, denied (especially w/MVA's)
_____ Uncooperative/defiant claimant

EXCEPTIONAL MEDICAL CATEGORIES OF SERVICE

_____ Chiropractic services (over 90 days from initial visit)
_____ Physical therapy services (over 90 days from initial visit)
_____ Podiatric services (any surgery exceeding $1200.00)
_____ *Cosmetic services (especially lesion removal and nasal surgery) when provider purports treatment to be Functional in scope
_____ Flagged provider

*May require a telephonic interview with the patient

FRAUD/ ABUSE INDICATORS

Claims Examination
(Continued)

ACCIDENT / INJURY CLAIMS

_____ Accident Claims:
-Soft Tissue
-Sprains / strains
-Concussions
-Expenses exceeding $2000 on any given claim

_____ Claims of Violence:
-Falling
-Shooting
-Mugging
-Stabbing
-Poisoning

_____ Attorney representation for routine claim
_____ Attorney representation *before* initial date of service
_____ Provider billing mostly for accidents/personal injury
_____ Provider billing routinely for same services
_____ Provider billing after patient expired
_____ Possible self-inflicted injury
_____ Possible work-related injury/illness
_____ Injury just prior to layoff, strike, plant closing, job termination, company out of business, etc.

HOSPITAL CLAIMS

_____ Hospital medical bills *summarized* instead of *itemized*
_____ Hospital late charges (>5% of total billing)
_____ Watch insureds' occupation on UB-82 or UB-92 (i.e. retired, unemployed, etc.)
_____ Anesthesia charges >$500.00 per hour
_____ Provider gives inaccurate info. For hospital admission (questionable medical necessity for admission)
_____ Immediate hospitalization and treatment for injuries normally treated conservatively
_____ Assistant surgery (questionable actual necessity)
_____ Unusual number of hospital admissions by provider / High dollar inpatient admits
_____ Watch *Block #4* on UB-82 OR UB-92 where services were performed more than 3 months ago
(III – Final Bill (only bill!); 112&113 – Interim Bill; 114 – Final Bill subsequent to previous interim billings)

UNBUNDLING (Billing a medical procedure by its individual components rather than as a whole for the purpose of receiving a higher rate of reimbursement than if it was billed as a single major procedure [i.e. *surgical packs*]):

_____ 3 or more surgical CPT's on the same bill
_____ >$400.00 per day in Lab charges
_____ >$400.00 per day in conventional X-ray charges

NOTE: The foregoing list of fraudulent / abuse indicators is by no way complete. We invite you to feel free to add to this list as appropriate. We recognize that as scams come and go, so do their "fruits" or indicators. Claims examiners and SIU members are encouraged to use this list as a guideline and work-sheet for your claims examinations. Please share your added indicators with us so we may update our list.