

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.