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

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. For access to the Interactive Indicator Guide, please contact NICB's Training Department.

Regarding Attorney Involvement
- Attorney is listed as the insurer on the medical bill.
- Legal representation is contacted/obtained immediately after the accident/incident is reported.
- Medical bills and narrative reports are sent from the attorney’s office.
- The same attorney appears in all BI/WC cases involving a particular medical provider.

Regarding Claim
- Damages/losses presented by one or more parties are inconsistent with facts of loss/accident (lack of injury/damage causing mechanism, etc.).

Regarding Diagnosis
- A test or series of diagnostic imaging tests is given to all patients at a clinic or medical office regardless of injury.
- Alleged injury relates to a pre-existing injury or health problem.
- Bills for diagnostic imaging are submitted without supporting documentation such as reports.
- Commonly refer patients for a “second opinion”.
- 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).
- Diagnosis in the bill is not supported by other documentation.
- 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 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.
- Discrepancies exist between the locations of diagnostic imaging testing (and other types of tests) and the person interpreting the test.
- Electrocardiograms (ECGs or EKGs) are administered to patients with no complaints or conditions.
- Evidence exists of payments/commissions from a diagnostic test provider to the ordering practitioner.
- Injuries are subjective (e.g. pain, headaches, nausea, inability to sleep, depression, dizziness and soft tissue).
Insured questions the amount of diagnostic imaging tests ordered.
Medical records do not explain excessive, expensive medical testing/treatment.
Mobile unit performs neurological or other tests, which are read at remote locations.
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.
Patient does not know the result of the diagnostic test(s).
Patient’s account of diagnosis process is inconsistent with the actual test.
Range of motion (ROM) tests are conducted frequently.
Specialized equipment is required for diagnosis but the injured person cannot describe the equipment or procedure.
Surface EMGs (SEMG) are used for diagnoses.

Regarding Facility/Operation
Claims representative receives a sudden flood of medical bills from one new center/clinic.
Clinic/Center was recently incorporated.
Contact with clinic/center is difficult.
Equipment and treating facility is out-of-date, broken or inconsistent with treatment billed.
New or unknown diagnostic clinic/center.
No request, reports, or any indication the treatment was needed or conducted prior to receiving the medical bill.
Office/building has no furniture.
Ownership of clinic is questionable.
Provider utilizes established and trusted files, members, insured, patients, and doctor’s information without their knowledge.
Telephone for the clinic/center is not listed on the medical bills.
The Tax ID number provided is real, but medical identity theft is suspected.
The building is too small to operate a clinic/center.
The clinic/center address is a P.O. Box number.
The date(s) of medical service(s) is prior to the date the clinic/center was established.
The location of the clinic/center is in a deteriorating or unsafe part of town.
The physical address of the clinic has inadequate, inconvenient, or no parking for patients and staff.
The word “Diagnostic” appears in the name of the facility submitting the medical bill.

Regarding Incident
Vehicle has numerous passengers claiming the same type of injuries.

Regarding Medical Bills
1500 Bill does not show the injury as auto accident or workplace related.
A physician bills out of multiple offices on one day (treatment time is more than possible for one day).
Amounts billed for are much more than other providers (of the same specialty) charge.
Billing and coding for cervical, thoracic, and lumbar x-rays when a full spine x-ray was performed.
Billing for daily treatment for an extended period of time.
Billing for quantitative testing but performing qualitative testing.
Billing for thermography studies.
Bills are submitted by billing or medical finance companies and not the provider.
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.
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.
Bills include high dollar additions for off-site system and surgical monitoring for surgical procedures (e.g. by doctors who are not even in the room at the time of the surgery).

CPT codes are billed for the treatment which is usually not associated with the particular diagnosis/ICD code.

Continuous billing for comfort modalities for an extended period of time.

Contradictions are revealed when comparing the bills to other documents or sources of information.

DME billed for multiple patients is the same.

Duplicate bills for same type of treatment with a different procedural name (e.g. electrical stimulation and TENS unit).

Durable medical equipment (DME) bill shows charges for equipment not in the doctor’s order or patient’s receipt.

Durable medical equipment (DME) bill shows markups for equipment in excess of your state’s standards for such markups.

Emergency services are billed by providers (providers say they provided services on a day when their office is routinely closed).

MRI bills appear early on in the treatment and repeated again in later treatment.

Medical bills accrued for the injury have a higher dollar value compared to the other providers treating patients for similar injuries.

Medical bills are not on a standard HCFA form or CMS 1500 form.

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 providers in one office all treat the patient on the same day.

Multiple time-based modalities are billed for the same treatment session, resulting in the patient being in treatment for two or more hours (including acupuncture and massage).

Patient cannot describe the physical aspects of items appearing on the bill (e.g. ROM test exercises).

Patient indicates the provider listed on the bill is not the same person providing treatment.

Patient is quoted a treatment price but the bill shows a much higher amount.

Patient refutes charges.

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 an examination and treatment when in fact no treatment was provided.

Provider bills for medical supplies that were not used.

Provider bills for medical tests or evaluations that were not conducted.

Provider bills for office visits that were not made.

Provider bills for treatment that was not provided.

Provider bills global codes then later billing separately for the technical or professional component.

Provider bills global diagnostic CPT code without the necessary diagnostic equipment (e.g. an x-ray machine) located at the provider’s facility.

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.

Repeated billing by the medical provider for extensive established patient visits (e.g. repeated bills for X-rays on a soft tissue injury).

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.

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).

The physician’s bill and report, regardless of the varying accident circumstances, is always the same.
- The treatment requires a licensed medical professional, but the provider is not licensed.
- Use of a Technical (TC) or Professional (PC) component modifier with a diagnostic procedure CPT code billed in conjunction with the applicable global diagnostic CPT code.

**Regarding Medical Fraud/Claim Inflation**
- Boilerplate and matching reports from providers are present in claim file during review.
- CPT codes appear "inflated" or "up-coded".
- Clinic has continued billing or treatment irregularities.
- Clinic/Medical facility does not have patient sign-in sheets or patient signatures appear to be signed all at one time.
- Doctor’s notes contain no indication of checking the patient’s treatment progress/improvement of symptoms.
- Injured party’s address is located unusually far from the clinic/center.
- Medical bills indicate routine treatment being provided on Sundays, holidays, or other days that facilities would not normally be open.
- Minor accident produces major medical costs and often lost wages, household help, transportation and unusually expensive demands for pain and suffering.
- Narrative reports submitted appear to be templates.
- No changes in treatment plan after several treatment sessions have been rendered and extensive diagnostic testing (EMG, NCV, MRI etc.) is performed.
- Office visits extend daily for more than five consecutive days or continue for more than one week.
- Patients are at or near the age of eligibility for Medicare when they are first injured and begin treating.
- Patient is unable to describe the doctor or office location.
- Patient’s residence is not near treatment facility.
- 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.
- Same treatment prescribed for all patients in spite of different accident facts.
- Significant lapse between when the alleged service was provided and when the medical bill is received.
- The date(s) the medical service(s) was provided is on a weekend or holiday or during hours the clinic is not open.
- The patient decides to go back to work on their own despite the doctor classifying them with a total disability.
- The patient’s signature appears several times on the same sign in sheet.
- Treatment extends for a lengthy period without interim bills.

**Regarding Medical Treatment**
- Chiropractic treatment extends beyond the typical number of visits (approx. 30-34) for simple soft tissue injuries.
- Claimant is receiving treatment from a “known” medical provider.
- Clinic treats injured family members on different days.
- Clinic treats several or all of the claimants on same day.
- Doctor’s initial exam reports are “fill in the blank” boilerplate reports.
- Durable medical equipment (DME) given to all injured persons is the same regardless of diagnosis.
- Durable medical equipment (DME) is dispensed without instructions for use.
- Evidence that all patients see a neurologist (or other specialty) regardless of diagnosis.
- Injury progression is atypical and seems to require extended treatment (often extending beyond estimated “discharge date”).
- Medical treatment is given by receptionists or other non-medical personnel.
- Minor injury results in a network of treatment providers, diagnostic procedures, and treatments.
- Multiple treatment procedures are billed using separate CPT codes when there is a CPT code that includes all of the billed procedures.
No referral is made to another specialist for evaluation when no progress is made after four weeks of treatment.

Pain management protocol is not modified (treatment is continued) even when not effective.

Passive treatment modalities are used exclusively without encouraging use of a home program of exercises/activity.

Patient is seen multiple days in a row.

Patient's account of the treatment process is inconsistent with bill.

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.).

Patients who are members of the same family are treated on different days.

Pharmaceutical bills indicate repackaging or compounding on the part of the treating provider.

Provider only treats patients that are represented by an attorney.

Provider repeatedly uses x-rays, ultrasounds, nerve conduction tests, or spinal video fluoroscopy to check treatment progress.

Same type of treatment is given to children and adults.

The employee/individual is unaware of or has no recollection of receiving the medical treatment being billed for.

The frequency or number of therapy modalities does not decrease after four weeks of treatment.

The treatment plan does not change over time (especially if additional diagnostic tests have been done).

Time dependent procedures don’t match what was billed (more treatments than possible in a 24 hour day).

Treatment begins prior to the accident date.

Treatment continues with no changes in plan.

Treatment dates on the bill indicate the start of treatment is delayed by more than four weeks from the loss date.

Treatment is ended when the policy’s monetary limits are reached.

Treatment is extended, without re-evaluation or outcome assessment.

Treatment is not consistent with usual standards of care.

Treatment plan exceeds 90 days with no evaluations during the 90-day period.

Treatment prescribed for the various injuries resulting from differing accidents is always the same in terms of duration and type of therapy.

Treatment provided is not usually associated with this type of injury.

Treatment requires specialized equipment, but the injured person cannot describe the equipment or procedure.

Treatment shows more than three therapy modalities in a single treatment session.

Regarding Professional Issues

Attorney/Medical provider is not located near the claimant/insured’s residence.

Business/Contractors/Cleaning company are not licensed or are newly licensed.

Clinician has multiple locations and bills indicate regular or frequent treatment at one location.

Evidence of a D.C./M.D. collusion to provide unnecessary pain management/prescriptions (e.g. compounded topical pain management cream).

Provider/Clinic doesn’t allow a clinic inspection to be conducted or makes scheduling an inspection appointment very difficult.

Regarding Slip & Falls or Food Products Liability

Emergency medical responders were not called to the scene of the slip and fall.

The claimant did not receive medical treatment at an emergency room after the slip and fall.
Regarding Specific CPT Codes

- Acupuncture, first 15 minutes (97810 or 97813) billed numerous times per visit.
- Acupuncture, subsequent 15 minutes (97811 or 97814) billed more than twice per visit.
- Biofeedback (90901) is performed on all of a provider's patients.
- 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).
- Community reintegration training (97537) billed repeatedly.
- Consultation (99241-5) billed for own patient.
- Davis series (72052) charge with fewer than seven images or reports.
- Digital analysis of electroencephalogram (97957) routine appearance on bills.
- E&M codes, complex/severe (992x4-5) billed for every visit until discharge.
- E&M codes, complex/severe (992x4-5) billed for problem of relatively low severity.
- E&M new patient (99201-5) billed every visit.
- E&M, new patient (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, prolonged services (99358), routine appearance on bills.
- ESI (62310 or 62311) separate charge for drug and supplies (e.g. syringes, gloves, alcohol, etc.).
- ESI (62310 or 62311) billed more than three times in one calendar year.
- Electric stim (97014) with modifier -50.
- Interpretation hours (90887), billed with little detail in report.
- MUA (22505) manipulation under anesthesia billed by a chiropractor (may also bill for assistant surgeons and standby assistant).
- MUA (22505) manipulation under anesthesia in conjunction with (23700 and 27194).
- MUA (22505) manipulation under anesthesia performed early in treatment.
- Manual therapy (97140) routine appearance of charge.
- Mechanized traction (97012), routine appearance of charge.
- Modifier -51, routine appearance on bills.
- Modifier -52, routine appearance on bills.
- Modifiers - frequent use.
- Muscle testing (95831) billed for each muscle rather than each extremity.
- Muscle testing (95831) billed in conjunction with E&M codes (e.g. 99201-5).
- Needle EMG (95860 single extremity) multiple times per visit.
- Needle EMG (95864) all four extremities (without justification documentation).
- Nerve conduction (*95907 and *95913) testing on the same bill for the same nerve (95913 includes 95907).
- Nerve conduction tests (*95907 and *95913) billed multiple times for the same nerve.
- Nerve conduction tests (*95907 and *95913) show the same results across patients.
- Neuromuscular re-education (97112) billed in connection with a soft-tissue injury without nerve damage.
- PDD (62287, Percutaneous disk decompression), routine appearance on bills.
- Psychological test interpretation time (90887) is billed along with administration time (96101) without supporting documentation.
- Psychological testing (96101) report is without detail.
- Range of motion testing (95832) frequent.
- Range of motion testing (95832) is billed for each muscle tested.
- Range of motion testing (95832) is billed in conjunction with 95831.
- Range of motion testing (95832) is billed in conjunction with E&M (e.g. 99201-5).
- Self-care/home management training (97535) billed repeatedly.
- Subcortical/cortical mapping (95961 and 95962), routine appearance on bills.
- Therapeutic activities (97530) billed in conjunction with 97112.
- Therapeutic procedure with- 51modifier.
Unbundling of CPT Codes.
Unlisted codes (ending in 99).
Unlisted modality (97039) routine appearance on bills.
Unlisted procedure (97139) routine appearance on bills.
Unlisted rehab (97799) routine appearance on bills.

Regarding Vehicle and/or Vessel
Vehicle driven by the insured person is an old “clunker” with minimal coverage.