

The Definition of Insurance Fraud:

Insurance Fraud occurs when people deceive an insurance company or agent to collect money to which they aren't entitled. It is a criminal act requiring a material and intentional misrepresentation in order to obtain a benefit, or cause a benefit due someone to be denied. Similarly, insurers and agents also can defraud consumers, or even each other.

In other words, is it really fraud or is it an exaggerated or inflated loss?

There is a difference between claim exaggeration or inflation of a claim and claim fraud. Insurance fraud as we stated needs to have a material misrepresentation in order to obtain a benefit. The misrepresentation must be intentional.

If a person receiving workers compensation payments returns to work and fails to advise the workers compensation carrier, and continues to cash the checks which are being sent to him, it clearly appears as though the system has been violated. In most cases, people may immediately believe he committed fraud, by stealing from the insurance company. In this case, insurance fraud has not necessarily been committed. It is only insurance fraud if he told an **intentional lie**, in writing or orally when questioned about his work status. If he wasn't asked or told them, fraud might not be the option here.

If a person tells a lie during the course of the claims investigation, but it is not material to the claim, they still have not committed insurance fraud. For example, a man was involved in a tractor trailer accident and advised the insurance company he was a former police officer and knew of the traffic laws and stated the adverse party was at fault. Well come to find out, this insured was never a police officer. Since this has no effect on the actual claim being paid, it is a lie, but not fraudulent because it was not material to the claim.

A person can also make a misrepresentation that is not intentional. For example, when conducting the initial loss report, the insured provides a false or wrong answer to the question asked of them. They did so because they misunderstood the question or forgot some incident or fact pertaining to the loss. This might not be an intentional misrepresentation. Here is an example: During the course of your claim investigation, you asked the subject if he can partake in any outdoor activities. He replies, "of course, I have begun to walk around the block in my neighborhood". When asked how far, he replies, "oh, just a mile". Well you later determined that his block is 1 3/10 of a mile around. This could be an **unintentional misrepresentation**. He may have estimated the distance and never measured it with an odometer. Now if you were able to get documentation of the subject running in a mini marathon or local 5K runs, then it could be perceived as an intentional misrepresentation, which has great effect on his claim.

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Here are a few examples of what fraud is and isn't: A Chiropractic clinic performs manipulations on its patients and bills the insurance company a rate of \$100.00 per visit. The customary price is \$60.00. This is a case of abuse on his billing practices. You may think they are ripping off the insurance company, but it does not necessarily constitute fraud. Now, if the Clinic billed for these services and they were never performed on the patients, then you can consider this fraud.

An insured is involved in an automobile accident and brings their vehicle to a repair shop. The adjuster meets them there and provides an estimate for \$2500.00 minus his \$500.00 deductible, to fully repair the vehicle back to the pre-accident condition. The adjuster then writes a check to the insured for \$2000.00 and goes on his way. The body shop owner then speaks with the insured and offers to fix his vehicle for \$2000.00; he'll waive the \$500.00 deductible. The shop manager tells the insured he'll fix the vehicle, and do so with his own parts, not the ones required by the adjuster. Was fraud committed, no? Insured's can take their money and do what they want with it, repair or not repair their vehicle.

Now in this same case, if the insured paid his \$500.00 deductible to the shop and told the shop to repair his vehicle utilizing the repair estimate his adjuster provided and the shop doesn't, then it can constitute fraud.

General Indicators Of Fraud

- **Physical address is not disclosed**
Uses P.O. Box, attorney's office or relative
- **Address provided is not valid**
- **Subject lives in transient housing**
- **Subject is moving around**
- **Subject uses other people's telephone numbers**
- **May call from payphone**
- **Subjects SS#, name or other pertinent info doesn't match up**
- **Receive tips or rumors from co-workers, neighbor or family**
- **Recent Claims in the family or co-workers**
- **Claim filed several days, weeks or months after alleged loss**
- **Recent increase in coverage**
- **Reduction of deductible**
- **High number or other recent claims**
- **Makes a social security disability claim as well**
- **Has multiple means of coverage for loss**

Red Flags or Indicators of Fraud

Worker's Compensation Fraud

Claim Fraud

- Poor Attendance Record
- Recent disciplinary action
- Missed a promotion or transfer
- Problems with co-workers
- Recent termination, involuntary transfer
- Upcoming layoffs
- Prior lost time claims
- New employee
- Loss occurs on Monday morning (weekend injury)
- Accident happened where subject was not to be
- Performing a task not use to doing
- No witness
- Witness is a friend
- Witness heard but did not see
- Subject resists signing authorizations
- Resist light duty offers
- Not performing job search or lacking
- Alleged restrictions out of line with injury

Premium Fraud

- Repeated injuries by new employees
- Coverage issues – under estimate of employees
- Injuries inappropriate to job classification
- Classifications or number of employees in inexpensive classifications appear out of line with type of business
- Number of exempt officers seems out of line for size of the business
- Discrepancies between employer and employee regarding wages, name of employer or type of accident
- Any discrepancies in wages reported to other entities, such as state unemployment insurance returns
- Suspicious documents, such as copies showing evidence of erasures or other changes
- Discrepancies in reports of witnesses and employer or employee
- Accident occurs in state where employer is not known to do business
- Employer's doctor are overly aggressive about dismissing employees' injury complaints
- Employer has independent contractors on staff
- Indications that employees are paid by other than reported wages, such as with rent, cash, vehicle use or unusual expenses
- Employees paid by piece work
- Employer operating without all proper licenses
- Employer pays medical bills direct without reporting loss
- Employee lives far away from employer
- Policies written under DBA's
- Employer resist or delays premium audit
- Employer is hard to reach or uncooperative
- Employer is an employee small leasing firm
- Firm low balls competitor on contract bids

Red Flags or Indicators of Fraud

Medical Provider Fraud

- Canned medical reports and notes
- Errors of an obvious nature such as subject's gender, race or age
- Diagnosis and treatment don't match
- Clinic using a P.O. Box or mail drop
- Facility with several names
- Unprofessional letterhead or stationary/photocopied
- Referral to nearby medical testing or clinics
- Answering machine
- Treatment on weekends and holidays
- Clinic diagnoses knew problems
- The work comp and health insurance are both billed
- Same treatment over and over
- Multiple subjects from same loss
- Same diagnosis for all subjects
- Clinic is a good distance from subjects home
- Inconsistency of fees for various services
- Numerous treatments on same day
- Mobile diagnostic operations
- Excessive diagnostic testing
- Subject can not identify clinic
- Subject can't explain treatment

Personal Medical

- Injuries are subjective – soft tissues, sprains, headaches, psychological issues
- Psychological claims for Stress and Anxiety
- Claim is from previous injury
- Excessive recovery time
- Excessive Chiropractic treatment
- Excessive testing – MRI-NCV
- Excessive Therapeutic treatment – massages, acupuncture
- Subject shows no interest in getting better – doesn't want tests
- Subject visit specific doctors immediately
- Subjects' vitals are good –despite alleged long term inactivity
- Subject is over dramatic when describing injury
- Conflicting medical opinions
- Medical billings are billed on holidays and weekends
- Treatment includes prescriptions for controlled substances
- Variation in description of pain