# ***The Definition of Insurance Fraud:***

**I**nsurance **F**raud 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?***

**T**here 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.

**I**f 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 thought 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.

**I**f 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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**H**ere 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.

**A**n 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.

**N**ow 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.

# 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**