

NICB MEDICAL FRAUD SCHEME GUIDE

version 1.0



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NATIONAL INSURANCE CRIME BUREAU

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NICB Medical Fraud Scheme Guide 1.0

Medical-related fraud in the Property and Casualty insurance industry encompasses: causation of the injury, medical providers (including licensure and ownership issues), treatments, durable medical equipment, medications and billing. This quick reference guide provides brief examples in each area. More detailed information and training for the detection and investigation of fraudulent medical claims can be obtained from the National Insurance Crime Bureau (NICB) or from the National Insurance Crime Training Academy (NICTA). This guide is designed as an introductory reference document for insurance personnel processing claims involving bodily injuries.

This guide contains medical fraud schemes relating to the following:

- [Creating Fictitious Injuries/Patients](#)
- [Medical Billing Fraud](#)
- [Medical Provider/Attorney](#)
- [Treatment Specialty](#)
- [Durable Medical Equipment \(DME\)](#)
- [Alternative Medicine](#)
- [Pain Management Clinic](#)
- [Mobile Diagnostic Labs](#)
- [Diagnostic Testing](#)
- [Prescription Drug Abuse/Diversion](#)
- [Drug Compounding](#)

Unscrupulous individuals invent new medical fraud schemes frequently. If you are aware of a scheme not included in this guide, please contact the NICB's Training Department at TrainingDepartment@nicb.org.

NICB INVOLVEMENT

The NICB assists its member companies in the investigation of questionable medical claims. When a medical-related claim and/or medical provider is suspected of potentially fraudulent activity, the claim should be submitted as a questionable claim through ISO to the NICB (following your company's procedures). The NICB will review the submission and contact the insurer as appropriate.

CREATING FICTITIOUS INJURIES/PATIENTS

Caused Vehicle Accidents

Caused vehicle accidents occur when an innocent insured's vehicle is targeted. A vehicle that is likely to be insured (commercial, luxury, etc.) is identified and then a collision is caused. Collisions are caused by a variety of methods. One variation is that the perpetrators stop abruptly in front of the targeted/insured vehicle causing the insured

vehicle to rear end the perpetrators' vehicle, thus being "at fault". Then the perpetrators claim injuries and go to pre-arranged medical providers for treatment and the insurance companies are billed. Attorneys often are involved by filing bodily injury lawsuits. This scheme is often associated with organized fraud groups.

Jump-Ins

The most literal version of this scheme is where people actually "jump in" to vehicles involved in an accident and then claim to be injured. They demand money from the insurer for medical treatment. It often occurs with commercial buses where there could have been a large number of passengers. This scheme has evolved to include medical facilities assigning additional passengers to accidents involving single drivers in order to collect more money from the insurance claims. In some instances, individual insureds will try to add passengers to an accident in which they were involved. This scheme is committed by individuals and organized fraud groups.

Low Impact Soft Tissue/Minor Impact Soft Tissue (LIST/MIST) Accidents

Low/Minor impact soft tissue claims usually arise from legitimate automobile accidents where the driver takes advantage of a liability situation created when their vehicle is hit by another vehicle which is at fault for the collision. LIST/MIST claims usually feature minor damage to the vehicle where the individual claims subjective or soft tissue injuries. These types of injuries will not appear on diagnostic tests such as x-rays or MRIs; thus the doctor has to take the patient's word for the extent of the injury. These claims differ from staged/caused accidents as there is usually only one person in the car claiming injuries. The insured may not have a claims history and they are using this accident to claim injuries and obtain a settlement from the insurance company. This scheme is committed by individuals and organized fraud groups (monitoring scanners and then recruiting patients).

Medical Identity Theft

An insured's medical insurance number, Social Security number, DOB, address, etc. can be stolen by employees of hospitals or medical facilities and resold on the black market. This type of scheme usually involves at least one person at the doctor's office. Medical IDs are often stolen and sold in bulk; the stolen information is then used to submit claims to the insurance company. Often because the legitimate insured has been receiving treatment for a legitimate injury, the insurer assumes this is a continuation of legitimate care and pays the claim/bill. The stolen medical identity can be used to submit false billing in many areas including billing for treatment not rendered, fraudulent prescriptions, and providing treatment for individuals who don't have their own insurance.

Medical identity theft often involves doctors, other medical personnel or organized groups who are familiar with the process of filing insurance claims. With the identity theft victim's information, the thieves may set up fake clinics to make bogus claims against the health policies, workers comp policies, or other property/casualty policies.

Electronic Medical Records are particularly attractive to medical identity theft thieves as they are digitalized and millions can be stolen in seconds (by computer hackers) without even entering a medical facility.

Paper Accidents

A “paper accident” is an accident that never happened: it only exists on a police report (usually filed over the phone or by providing a walk-in police report) and within the claim file. Paper accidents can also include hit and runs, which occur when a perpetrator uses a previously damaged vehicle, drives it to a public location, and claims to be the victim of a hit and run. The involved parties may obtain an attorney and seek treatment for the “injuries” obtained in the accident. This scheme is committed by individuals and organized fraud groups.

Pedestrian Staged/Caused Accidents

Pedestrian accidents are not usually thought of as fraudulent because of the heightened risk of injury to the pedestrian. In a pedestrian staged/caused accident, the pedestrian simulates being hit by a vehicle slowing down at an intersection or that is exiting a parking space. The most important element in these types of claims is the alleged impact. Impact is either simulated by a) the pedestrian hitting the vehicle with his/her hands, or b) the vehicle striking something that the pedestrian is pushing across the street and the pedestrian will later claim injuries. In some instances, the pedestrian will just write down the license plate number of a vehicle that is likely insured. In this situation, the vehicle is often parked at a shopping mall. After the car leaves, the pedestrian calls the police and claims to have been hit by the owner’s vehicle as it left. As the owner admits to being at the mall, it is hard to prove the accident didn’t happen. This scheme is committed by individuals and organized fraud groups.

Product Liability

Product liability pertains to the responsibility of manufacturers, distributors and sellers of products to deliver products free of defects which may harm an individual as well as provide adequate instructions and warnings on their proper and safe use. When this responsibility is allegedly not fulfilled, the manufacturer, distributor or seller is often sued. Examples of fraudulent product liability claims include the individual claiming foreign objects were in food they purchased (sometimes causing illness or injury) or a product broke and caused injury during normal use. Other examples include alleging food poisoning, and any product malfunction. These types of claims are becoming more popular among organized groups.

Recruited Patients

Providers will recruit patients and create fictitious, accident-related injuries to collect on fraudulent disability, workers’ compensation and personal injury claims. These providers usually work through middlemen (runners/cappers/chasers) who recruit patients for the schemes. Patients can be recruited from: police accident reports, the scene of legitimate accidents, the workplace, and from the friends, family and neighborhood of the recruiter. The recruited patients are promised some type of monetary incentive to participate in the

treatments. The doctors often bill insurers for multiple office visits and tests, which never take place. This can occur with or without the injured person's knowledge.

Slip & Fall Claims

A slip and fall incident may occur at a supermarket, retail store, parking lot, restaurant or a private residence. The resulting claim will usually involve alleged negligence on behalf of the property owner. In fraudulent claims, claimant may intentionally trip over a broken/raised sidewalk, slip in a spilled substance, pull display or store merchandise on top of themselves and claim their injuries were caused by the negligence of the property owner. Prior or existing injuries may also be used to substantiate the claim. A common scheme involves an individual or team of people who will go into a store; one person will serve as a witness (or accomplice) while the other will put a liquid or some other type of slippery item on the floor then pretend to fall down. The next step in this process will be to submit an insurance claim and then collect money for their injuries. This scheme is committed by individuals and organized fraud groups.

Staged Accidents

Staged accidents are where the perpetrators intentionally create damage to one or more insured vehicles and physically position the vehicle (or vehicles) to appear as if it/they were in an accident. The perpetrators then call the police and report the "accident" and state they were injured by acting as if they were passengers in the vehicle at the time of the "accident". Then the perpetrators go to pre-arranged medical providers for treatment and the insurance companies are billed. Attorneys often are involved by filing bodily injury lawsuits. In staged accidents all the participants are involved in the fraud. This type of fraud is also known as "orchestrated accidents". This scheme is committed by organized fraud groups.

Workers Compensation Claims

This type of fraud usually occurs in five general categories:

- First, the employee may be injured while not working for the employer. The employee goes back to work and then reports the injury as happening at the jobsite.
- Second, the employee may exaggerate an actual injury. A minor injury will be reported as severe in order to receive more money for the claim and for the employee to be able to stay out of work longer. Malingering may also be an issue: the employee has recovered from his/her injuries but is pretending to still be injured so they may continue to treat and stay out of work. In some of these instances the employee will actually obtain other employment and work at another job while receiving workers compensation benefits.
- Third, completely fake injuries can be claimed. Employees of a company that is going out of business or downsizing may claim injuries that will result in being classified with a total disability (payment of these benefits will never run out), rather than collecting either a severance package or unemployment which will run out after a set number of weeks.

- The fourth area is where the employee was injured at work but the injury happened during some type of “horseplay” or other activity not associated with the employee’s normal duties.
- The fifth category is collusion between the medical provider and the employee. Both parties are knowingly submitting fraudulent claims/bills. This scheme is committed by individuals and organized fraud groups.

MEDICAL BILLING FRAUD

Unscrupulous medical providers often use fraudulent billing schemes to receive unmeritorious payments from insurers. These schemes include: billing for services not rendered, using improper treatment codes, and performing unnecessary and/or inappropriate exams, diagnostic testing, and treatments. Medical Billing schemes take many different forms. The schemes described below are general in nature and can be committed by any medical provider regardless of their specialty.

Billing for Alternate Days

The clinic may bill for treatment on Monday, Wednesday and Friday. Once those bills are paid, the provider will then bill for Tuesday, Thursday and even Saturday treatment. Providers are aware that “billing cross checks” are infrequently done and he/she is likely to receive payment for multiple services not rendered.

Double Dipping or Billing Multiple Carriers

The medical facility will bill all insurance plans the injured party has available. For instance, for a motor vehicle accident they will bill the injured party’s automobile insurance company as well as their healthcare company. The same scenario is seen regarding workers’ compensation: the provider or facility will bill both the workers’ comp carrier as well as the injured party’s healthcare insurance. These types of schemes are successful because many times a company’s property and casualty insurer and healthcare insurer do not communicate with each other, resulting in the provider/facility receiving payment from both carriers.

Kickbacks/Unnecessary Referrals

A medical facility/provider may refer a patient to other doctors for unnecessary visits or treatment. The referring medical facility/provider will often receive a “referral fee/kickback” from the other doctors for each patient they refer. This fee/kickback can often be illegal in addition to being medically unnecessary and fraudulent.

Medically Unnecessary Treatments and Diagnostic Tests

Even though there may not be a medical necessity for these treatments, exams or diagnostic tests, the medical provider will often provide a false diagnosis or create a medical necessity in the paperwork so that it appears the patient needs the procedures, enabling the medical facility to bill for the insurance payments associated with the procedures. Diagnostic tests include x-rays, MRIs, EEGs, EKGs, etc.

Misusing Modifiers

CPT Codes allow time for a brief history and exam. By misusing modifiers, a provider might attempt to bill for additional charges for the Evaluation and Management (E&M) of a patient. The most commonly abused modifiers are:

- *Modifier 25:* Significant, Separately Identifiable E&M Service by the Same Physician on the Same Day of a Procedure or Other Service. This modifier may only be billed if the patient's condition requires a significant separately identifiable E&M service that was above and beyond the usual pre-service and post-service work associated with the other service(s) provided.
- *Modifier 59:* (Distinct Procedural Service) should not be appended to "add-on" codes. This modifier states that a procedure is distinct or independent from other services performed on the same day. This can include a separate session or patient encounter, a different procedure, a different site, different injury. Modifier 59 should only be used when a provider bills different therapies used on the same visit.

Prescription Abuse/Drug Diversion

The provider is prescribing medications (often narcotics) in the absence of medical necessity. This can be done to support the drug addiction of individuals or to generate a supply of narcotics to be illegally sold. The insurer is billed for the medication.

Range of Motion (ROM) Testing

As a rule, these tests are only necessary when loss of strength or range of motion impairment are reported by the patient. In addition, since these tests are a part of a typical physical exam, the medical provider would have to establish that the ROM testing (above and beyond what is included in an initial or established patient office visit) is necessary and appropriate to bill separately. Billing them separately, while also billing for an exam, is a form of "unbundling".

Rent-A-Patient

People who have not been in car accidents and are otherwise healthy are used to bill the insurance company for expensive procedures and medical equipment that may not have been provided. In return for going to the clinics, the "patients" may receive cash, vacations and/or some other type of incentive. The danger in this is that sometimes the medical treatment they receive may actually injure the patients and leave them with new health complications. This is an extreme type of the "Recruited Patients" scheme.

Repeat Billing

Charging more than once for the same service, sometimes to one insurance company where the provider repeatedly submits the same bills over and over again, especially if they were denied. The provider may feel that if they continue to submit the bills the insurance company will eventually break down and provide payment.

Services Not Rendered

A medical provider may bill an insurance company for visits, diagnostic testing, treatments or prescriptions that were never actually provided to the patient. This can include billing for diagnostic testing not done, e.g., billing for a higher number of x-rays than were actually taken or more MRIs than were actually conducted.

Signing In for Multiple Days of Treatment

Patients complete sign-in sheets for multiple days on their initial visit. This documents the visits for future billing although the patient may never return to the clinic and/or never receive additional treatment. Some unscrupulous clinics may have the patient sign in for multiple treatment dates for weeks or months of treatment.

Template (Boilerplate) Billing and Narratives

Medical clinics/providers fabricate injuries and prescribe identical treatment for all patients. They then use duplicate or very similar paperwork to support the treatment. The medical provider inserts the patient's personal information in the form and the rest of the medical services are already filled in. Using "templates or boilerplate" forms is not a questionable practice (e.g. using a standard office form), but it is the entry of identical or nearly identical data and information for multiple patients that is the questionable or possibly fraudulent activity.

Treatment by Unlicensed and/or Unsupervised Personnel

In order to treat more patients without incurring the overhead of hiring additional licensed medical providers, unscrupulous providers will allow unqualified office personnel to perform treatments. A variation is where unlicensed staff can perform the treatment, but must be supervised. In these instances, the insurer is fraudulently billed as if a licensed individual performed the treatment or performed the necessary supervision.

Unbundling of Services

Billing separately for procedures that normally are covered by a single fee or CPT Code. An example of this could be charging for Range of Motion studies on each extremity for an initial evaluation. Range of Motion is part of what is customarily billed under the new patient examination CPT Codes (99201-99205). Another example includes the same provider billing separately for the administration and interpretation of tests when both functions are included in a less expensive single code. It is also unbundling to charge separately for items that can be billed collectively using a single code. An example is: billing for batteries, electrical leads, and pads, and also billing for a TENS Unit. The support items should be included in the single less expensive billing for the TENS Unit.

Upcoding (Inflated Bills)

Billing for services with a higher amount of financial compensation than the service that was actually rendered. For example, billing for a more expensive procedure when a less expensive modality was the actual treatment or billing for the exam and treatment of a higher severity than the actual injury warrants, or submitting a medical bill with a CPT Code for 45 minutes of physical therapy when the patient only received 15 minutes.

MEDICAL PROVIDER/ATTORNEY SCHEMES

Medical Provider/Attorney schemes address licensing and clinic ownership issues separately from the medical billing schemes as well as unscrupulous relationships between medical providers and attorneys. The unscrupulous medical provider often has a relationship with an unscrupulous injury attorney for patient referrals and perhaps a portion of the patient's bodily injury settlement. In other instances, the attorney advertises and/or recruits clients and then refers them to the medical clinic for unnecessary treatment and billing. The medical expenses are then used to increase settlements in bodily injury lawsuits the attorney initiates.

Fraudulent/Expired/Revoked Physician License

The medical provider forges his/her license or is working under a license that is expired/revoked. Little to no medical treatment is rendered at the office but the facility/provider bills the insurance company for medical treatments. A variation of this is where multiple people use the legitimate license of a single provider. The clinics where the illegitimate providers work may or may not know the provider is operating illegally.

Doc In A Box

This scheme is associated with medical clinics submitting fraudulent billings. The name of this scheme alludes to the fact that the doctor who owns the clinic is a "figurehead" facility owner and is only "taken out of the box" when his/her medical license number is required. Otherwise, the doctor "stays on the shelf" in their box. The facility is technically and legally owned by the doctor but a management company or layperson controls all of the monetary aspects of the facility. The doctor is often paid a monthly fee for the use of his/her license. The doctor who owns the facility is rarely at the facility and rarely provides exams or treatments. The doctor's primary function is to provide a legitimate Tax Identification Number (TIN) for billing. In some states, medical clinics must be owned by a medical provider; the "Doc in a Box" scheme allows the facility to be legally licensed but illegally controlled by the layperson. Runners are used to obtain patients and are often paid for each patient they bring into the facility. The facility will bill the insurance company for a battery of unnecessary or fictitious visits, high priced tests, and a multitude of treatment modalities and procedures for these "patients". Boilerplate billing and narratives are often used; diagnostic tests are ordered; findings are exaggerated, and the severity of the injuries and the treatment plan are created to obtain the most payout from the insurance company. The clinics can use false patient information and these patients sign in for weeks of treatments that were never provided. Some clinics also forge prescriptions and provide fake invoices for medical supplies.

The Doc in a Box scheme often includes enlisting the services of various types of professionals to work with the clinic. These professionals often work as independent contractors and typically "rent space" out of the clinic and operate under a separate TIN from the medical clinic. They work under an agreement with the medical facility as to the days and hours that they will work at the facility. The patients are referred back and

forth between primary physician and the independent contractors for unnecessary treatments, and the insurer is fraudulently billed.

Independent contractors found at medical facilities can include:

- Acupuncturists
- Chiropractors
- Neurologists
- Psychologists
- Physical Therapists

Medical Mills

This term refers to medical clinics that operate solely to submit fraudulent billings to insurers. They are often created for this purpose and often are associated with unscrupulous attorneys. The mills create or recruit patients who receive unnecessary exams, diagnostics and treatments. The patients are referred back and forth between other unscrupulous providers and the law firms.

Unscrupulous Attorneys

Unethical attorneys refer patients to corrupt doctors or knowingly represent accident victims who are filing false or padded insurance claims. In some instances they advertise and recruit potential patients and convince them to receive medical treatment. Participants in the fraud often include other employees of the law office. Attorneys who are involved in organized medical mills profit by getting kickbacks from clinics. There may just be one law firm or attorney or there may be several. In a ring situation, they may also take part in the ordering of medical tests and by suing the insurer. This is known as “attorney directed care”. The attorney will stop ordering medical treatments and tests when the policy limits for medical care are reached.

Kickbacks

A common “behind-the-scenes-scheme” between medical clinics, diagnostic testing centers, attorneys and body shops involves kickbacks between all involved. A kickback is defined as a payment of money, favors, or some other valuable to another individual to perform a certain desired action. In the injury claim realm, this usually means referrals between medical facilities, law firms and body shops. Another example of a kickback could be where a doctor refers a patient to a facility where he has either a stake in ownership or a financial interest in the facility. Kickbacks and referrals to a facility where the referring provider has a financial interest are often illegal.

Sober Homes

These are a version of “medical mills” specializing in addiction recovery. While largely a healthcare problem, it is anticipated some form which will impact the property and casualty industry will arise. The scheme begins with a person being diagnosed as addicted and requiring therapy in a “safe location” – a Sober Home. There have been cases where homeless people were set up with insurance policies and then reported that the individual was in treatment. Once at the “sober home,” treatment and testing is billed

for which can amount to more than \$100,000 per patient. Fraudulent billings are submitted for services not rendered, unnecessary exams, diagnostics, and treatments. The scheme often continues even after the patient is discharged. Unscrupulous medical providers will diagnose a relapse and prescribe additional sober home therapy. This scheme is very organized and dangerous as it involves those with a drug history, criminal history, physical abuse and even death.

Sober home schemes include kickbacks for referrals, failure to collect deductibles, procurement of insurance for out-of-state clients, obtaining insurance under false pretenses, falsely indicating that patients were in treatment, and patient brokering. Instances where the patients are paid to provide their urine for testing and then paid to be an “addict” have been discovered. If the patient has a “good” policy (unlimited coverage) then the patients can be traded between sober homes and treatment centers.

FRAUD SCHEMES BY TREATMENT SPECIALTY

The schemes below are associated with a specific type of treatment specialty. In instances where the described scheme has been addressed in the Medical Billing Fraud Scheme section, additional specific information pertaining to the specialty is provided.

Acupuncture

Acupuncture is a form of Chinese medicine that has been practiced for centuries. It's based on the theory that energy, called Chi, flows through and around the body along pathways called meridians. Acupuncturists believe that illness occurs when something blocks or unbalances Chi. Acupuncture is a way to unblock or influence Chi and help it flow back into balance.

Acupuncture is done by inserting needles into the skin at certain points on the body to influence the energy flow. Sometimes heat, pressure, or mild electrical current is used along with needles. In most cases treatment lasts for 15 minutes to an hour.

Acupuncture schemes include:

- **Percutaneous Electrical Nerve Stimulations (PENS)**
Instead of billing for acupuncture services, the facility will bill for PENS under the “Unlisted Procedure” CPT Code which may mean a larger payout than the traditional acupuncture CPT Codes. In PENS, needle electrodes are implanted into an area of muscle tissue close to the pain site, this differs from acupuncture where needles are inserted into meridians.
- **Reinsertion**
The AMA states that for proper reinsertion, one set of needles must be removed from the patient and another set of new needles are inserted. The “Clean Needle Technique” is violated if the old needles are removed and reinserted into the patient again. Clinics will bill for reinsertion because extra money is paid by the

insurance company for the additional 15 minutes of contact with the patient. Overhead cost is reduced by using the old needles.

- Unbundling
The acupuncture facility will bill both the acupuncture CPT Code and the Electrical Stimulation CPT Codes on the same date. Billing separately for needle insertion and electrical stimulation adds up to a bill for higher payment from the insurance company. Another example is the facility billing for multiple units of acupuncture on one day. For example, if CPT Code 97810 or CPT Code 97814 are billed on the same date of service, the facility may be over billing. Acupuncture CPT Codes include the use of multiple needles in one 15 minute time-frame.

Chiropractic

Chiropractic treatment involves a spinal manipulation or adjustment that places pressure on the joints of the spine in order to relieve pain, increase movement in the joint, and relax the muscles. The manipulation may be done by hand or by the use of an activator that applies mechanical force on a joint. Heat, electrical stimulation, or ultrasound may be used to help relax the muscles before doing spinal manipulation. Chiropractic treatment is conservative and does not promote the use of drugs or surgery.

Chiropractic schemes include:

- Excessive Treatments
The chiropractor will bill the insurance company for an excessive number of treatments over an extended period of care when the injury doesn't warrant it.
- Extra-Spinal Manipulation
This procedure involves the shoulder, wrist, elbow, knee or ankle. Providers bill this code in addition to regular spinal manipulation charges claiming justification by stating the spinal injury is adversely affecting another area of the body.
- Therapeutic Magnetic Resonance Services
Also known as Transcutaneous Electrical Nerve Stimulation (TENS), therapeutic magnetic resonance services can be billed under a non-specific code for higher reimbursement, while TENS treatment is billed under a physical therapy code at a much cheaper rate. TENS units are often involved in DME schemes.

Dentistry

Dentistry is a branch of medicine that is involved in the study, diagnosis, prevention, and treatment of diseases, disorders and conditions of the oral cavity, commonly in the dentition but also the oral mucosa, and of adjacent and related structures and tissues, particularly in the maxillofacial (jaw and facial) area.

Dentistry schemes include:

- **TMJ Treatments**
One of the most common dental diagnoses found in questionable claims is Temporomandibular Joint disorder (TMJ) which in essence means that the ligaments and muscles connecting the upper and lower jaw are not working properly. This type of injury is most often due to repeated stress on the joint due to clenching, arthritis in the jaw, or an injury to the jaw, head or neck. Symptoms include pain, locking, clicking or popping of the jaw when opening or closing the mouth. TMJ injuries often resolve on their own in a few weeks. Other treatment may include moist heat, ice, a soft diet, and over-the-counter pain medications. TMJ is a dental version of using a soft tissue injury to submit fraudulent bills.
- **Custom Fit Mouth Guards**
Often dentists will prescribe mouth guards for individuals who are suffering from TMJ or who grind their teeth when they sleep. Most times, a generic mouth guard can be adjusted to fit a patient's mouth, but there are times when the dentist orders a "custom fit mouth guard" which involves taking a mold of the patient's teeth and sending the mold to another company to create the guard. Fraud is involved when all patients receive custom fit mouth guards regardless of real injury.
- **Billing for Multiple X-Rays**
According to the American Dental Association, most people need full mouth x-rays once every two years. Unscrupulous dentists may bill for x-rays at every visit stating they are "monitoring the patient's progress".

Neurology

A neurologist treats disorders that affect the brain, spinal cord, and nervous system. Symptoms that commonly require a neurologist include coordination problems, muscle weakness, numbness or tingling in the extremities, confusion and dizziness. The neurologist may recommend a patient go for electro diagnostic testing or MRI to diagnose the injury. (These tests are explained in detail in the diagnostic testing section of this guide.)

Physical Therapy

Physical therapy is the treatment of disease, injury, or deformity by physical methods such as massage, heat treatment, and exercise rather than by drugs or surgery. The goal of physical therapy is to make daily tasks and activities easier. Physical therapy may be used alone or with other treatments.

A typical physical therapy treatment plan may include manual therapy, education, and techniques such as heat, cold, hydrotherapy (water therapy), ultrasound, and electrical stimulation. Physical therapy almost always includes exercise that includes stretching, core exercises, weight lifting, and walking. The patient may also be given an exercise plan to do at home.

Physical Therapy schemes include:

- Individual vs. Group Sessions
The insurer is billed for a higher reimbursement “one on one” therapy session when the therapy was actually performed with a lower reimbursement group session.
- Experimental/Investigational Treatments
Billing for treatments that have not been proven to have a medical benefit. The provider submits these treatments for payment anticipating the insurer will not know they are considered experimental/investigational and issue payment.
- Aquamed Therapy
Water-related therapy, also known as hydrotherapy, hydromassage, aquamassage, or water massage, is often considered experimental and investigational because there is insufficient scientific evidence on the effectiveness of this type of therapy. The patient will sit or lay down on top of a waterproof barrier that contains interior jets. The jets rotate, pulsate and spray streams of pressurized heated water providing a massage to the patient. It is intended to relieve pain and increase blood circulation, Range of Motion (ROM), and decrease the need for other therapies by combining the effects of hydrotherapy, massage therapy, acupressure, thermotherapy, soft tissue manipulation, and trigger point therapy.
- Kinetic Taping
Kinesiology Tape was invented in the late 1970s and is used to support the muscles and ligaments of various parts of the body. The tape has a bit of “give” similar to an Ace Bandage and is designed to be worn for 3-5 days. It is designed to reduce inflammation, support strains/sprains and other soft tissue injuries. The muscles and ligaments are supported but the joint(s) is not immobilized. There is currently no CPT Code directly associated with Kinesio Taping and the American Medical Association (AMA) states that it is not appropriate to use CPT Code 97110 or CPT Code 97112 if Kinesio Taping is the only work being performed. The only appropriate code to report for Kinesio Taping application, in addition to therapy service rendered, would be the supply code for the tape itself, either A4450 Tape (non-waterproof, per 18 sq. inch) or A4452 Tape (waterproof, per 18 sq. inch).

Psychology

Psychotherapy refers to a range of treatments that can help with mental health problems, emotional challenges, and some psychiatric disorders. It aims to enable patients, or clients, to understand their feelings, and what makes them feel positive, anxious, or depressed. This can equip them to cope with difficult situations in a more adaptive way.

Some forms of psychotherapy last only a few sessions, while others are long-term, lasting for months or years. Sessions are usually for one hour, once a week and they follow a carefully structured process.

Psychology billing schemes include:

- Unverified and Excessive Testing
The insurer is billed for testing that can't be verified by the patient. The provider states the testing was administered during the office visit and the patient wasn't necessarily aware that the questions and resulting conversation constituted a test. The interpretation of the test is also billed for, as well as the report preparation.

DURABLE MEDICAL EQUIPMENT (DME) SCHEMES

Durable Medical Equipment is prescribed to the patient by a physician. Types of supplies include custom fit items such as knee braces, back braces and mouth guards. Off the shelf items such as TENS units, cervical pillows and neck braces are also included in DME. As a rule, DME must meet the following criteria:

- Durable (long-lasting)
- Used for a medical reason
- Not usually useful to someone who isn't sick or injured
- Used in your home
- Has an expected lifetime of at least 3 years

Durable Medical Equipment schemes include:

- DME for Everyone
Providing the same DME equipment to every injured party regardless of the injuries. Supplies are often provided by the receptionist and there is little if any training on the use of the equipment.
- Phantom Supplies
Insurance company is billed for many supplies throughout the claim, yet only a few (or sometimes none) of the items are received by the injured party.
- Phantom Supply Company
The supply company exists in name only so that the clinic can receive a higher reimbursement for the supply issued. If the medical facility issues the supply they will get reimbursed at the cost of the supply, but if a medical supply company is involved the supply company will be reimbursed at a cost higher than the wholesale invoice price. In many cases, the supply company is reimbursed at 150% of the amount listed on the wholesale invoice.
- Luxury-or-Else
The patient is prescribed a top of the line DME item when a more generic item is sufficient for the diagnosed injury. The doctor may receive a kickback from the supplier for ordering the more expensive supply. A supply company may facilitate this scheme by providing the clinic and/or doctor with proprietary prescription pads that limit the choice to the supply company's higher end products. In some instances, the "luxury item" is billed for, but the generic item is provided to the injured person.

- Altered DME Invoice
The DME supplier may alter/falsify the dollar amounts on the wholesale invoice or even create their own wholesale invoices in order to support the higher prices they are charging for the supplies.
- Duplicate DME Invoice
The supply company may use the same invoice over and over to support the billing. Invoices with the same number may be submitted for all claims from the supplier.
- Altered or Fake Prescription
Additional supplies will be written in on a legitimate prescription in order to collect more money from the insurance company. The supply company may also alter the prescription by extending duration of patient need for the supply; this process can extend the use of such items as electrodes, alcohol wipes and batteries.
- Fake Patients
The supply company will create names of patients and then bill the insurance company with falsified bills and information.
- Selling Patient Lists
The medical facility will sell the names of their patients and provide blank prescription pads to a DME supply company for billing. Two or more DME suppliers may share patient names and submit bills to an insurance company.
- Generic Product for Custom Fit Price
Most DME products are off-the-shelf, but some, like knee braces, back braces and dental night guards must be custom fitted specifically for the patient needs. There is usually a measurement process or casting that goes with the supplies. These custom fit products do not have a set wholesale price and therefore the amount billed is at the discretion of the supply company. The DME suppliers will provide an off-the-shelf item but bill for an item that they claim was custom fit to the injured party.
- Rent or Buy
The DME supplier will charge a high price for the rental of the item and after a few months the prescription is altered to indicate the patient will need to use the unit indefinitely. The DME Company will charge the insurance company the full price of unit in addition to the rental charges. DME companies may also provide inexpensive or inferior medical equipment and charge the insurance company the cost of renting/buying a higher quality item.
- Free Toaster
To encourage patients to return to the clinic for additional treatment, the provider may offer patients non-medical products such as blenders, mixers, sheets,

comforters, coffee makers, video game systems or iPods, as an incentive. The cost of these items are offset by charging the insurance company for DME items that were never prescribed.

ALTERNATIVE MEDICINE

Merriam-Webster Dictionary defines alternative medicine as: “any of various systems of healing or treating disease (as homeopathy, chiropractic, naturopathy, Ayurveda, or faith healing) that are not included in the traditional curricula taught in medical schools of the United States and Britain.” Many of these alternative medicines have been around for thousands of years. However, the modern medical community often doesn’t recognize the effectiveness or medical/therapeutic value of some of these treatments. This raises the question; are these legitimate treatments or are they being used as a means for the clinics to submit additional bills to the insurance company.

The “scheme” involving alternative medicine treatments is routinely providing and billing for these treatments when there is no documented medical benefit to the patient. The bills from medical providers using these treatments on a regular basis should be closely scrutinized.

Alternative Medicine Treatment examples (not all inclusive):

- Acupressure
Acupressure is similar in practice to acupuncture; only no needles are involved. Practitioners use their hands, elbows, or feet to apply pressure to specific points along the body’s “meridians.” According to the theory behind acupressure, meridians are channels that carry life energy (Qi or Chi) throughout the body. The reasoning holds that illness can occur when one of these meridians is blocked or out of balance; acupressure is thought to relieve blockages so energy can flow freely again, restoring wellness.
- Aromatherapy
Aromatherapy uses essential oils (concentrated extracts from the roots, leaves, seeds, or blossoms of plants) to promote healing. The oils can be inhaled, massaged into the skin or (in rare cases) taken by mouth, and each has a specific purpose. Some are used to treat inflammation or infection while others are used to promote relaxation.
- Biofeedback
Biofeedback techniques allow people to control bodily processes that normally happen involuntarily—such as heart rate, blood pressure, muscle tension, and skin temperature. Bodily functions are measured and the patient is taught to alter these functions through relaxation or imagery, deep breathing, meditation, and muscle relaxation techniques. Biofeedback must be monitored by a psychologist, physician or qualified healthcare provider. Biofeedback is designed to help patients treat their own health problems like tension, chronic pain, migraines and high blood pressure

- Homeopathy
Homeopathy functions in much the same way as a vaccine: It's based on the principle of treating "like with like," meaning a substance that causes adverse reactions when taken in large doses can be used—in small amounts—to treat those same symptoms.
- Reflexology
Reflexology involves applying pressure to specific areas on the feet, hands, or ears. The theory is that these points correspond to different body organs and systems; pressing them is believed to positively affect these organs and a person's overall health. (For example, applying pressure to a spot on the arch of the foot is believed to benefit bladder function.)

PAIN MANAGEMENT CLINICS

According to the AMA, Pain Management Clinics specialize in the evaluation, diagnosis, and treatment of many different types of pain. Pain is actually a wide spectrum of disorders including acute pain, chronic pain, and cancer pain, and sometimes a combination of these. Pain can also arise from many different reasons such as surgery, injury, nerve damage, and metabolic problems such as diabetes. Occasionally, pain can even be the problem all by itself, without any obvious cause.

The scheme involving pain management clinics revolves around a referral of the patient by the primary medical provider. The referral may involve kickbacks, or the medical provider may have a financial interest in the clinic. In some cases, the patients are recruited by "runners" from legitimate accidents. Once the referral is made, extensive and often not medically necessary or beneficial treatment plans are prescribed and the insurer billed. The schemes used to bill the insurer can be any of those described in this document.

MOBILE DIAGNOSTIC LABS

Mobile diagnostic labs perform x-rays, ultrasounds, echocardiograms and nerve conduction studies. The mobile diagnostic lab may be any large non-medically equipped vehicle with an individual that travels from clinic to clinic with portable equipment to perform the tests. The vehicle may not be properly outfitted with safety equipment or protective procedures (such as lead lining to protect workers from x-rays) and/or not being properly equipped to perform the diagnostic tests. In addition, the person performing the tests may not be qualified to do so. In fraudulent situations, the medical provider may be receiving kickbacks from the mobile diagnostic lab owners. Circumstances where there is a "brick and mortar" diagnostic facility (providing high quality diagnostics) close to the medical provider's (who is using the mobile lab providing low quality diagnostics) location should be closely scrutinized.

Mobile Diagnostic Labs can utilize any of the schemes listed in the diagnostic testing section below.

DIAGNOSTIC TESTING SCHEMES

Diagnostic testing is a necessary and beneficial step in the successful medical treatment of injured and ill patients. However, unnecessary and excessive diagnostic testing can be used to generate fraudulent medical billing. Diagnostic tests include a wide range of physical motion, blood and urine samples, and imaging tests including MRIs, X-Rays, Range of Motion, and Nerve Conduction Tests.

Diagnostic testing schemes include:

- Testing Not Performed
Billing for medical tests or evaluations that were not conducted or billing for more tests than were actually conducted.
- Double Billing
Billing for global codes and then later billing separately for the technical or professional component.
- Double Billing with a Modifier
Using a Technical (TC) or Professional (PC) component modifier with a diagnostic procedure CPT Code billed in conjunction with the applicable global diagnostic CPT code.
- Excessive Diagnostics
Multiple diagnostic tests or extensive, i.e., EMG, NCV, MRI, etc., tests have been rendered without changes in the treatment plan.
- Unqualified Personnel
Diagnostic tests performed but not read or interpreted by qualified medical personnel.
- Falsified Test Results
The diagnostic test results are falsified to create a condition justifying extensive treatment and billing.
- Unbundling
Billing for diagnostic tests that are included in the office exam which is billed using an Evaluation and Management CPT Code.

PRESCRIPTION DRUG ABUSE/DIVERSION SCHEMES

Prescription drug abuse (drug diversion) can be defined as utilizing prescription medication (prescribed or not) for reasons beyond the physician's intention for a patient's pain relief. The medication is fraudulently prescribed and/or obtained for an individual's illicit use or for illegal sale. Painkillers are the most commonly abused prescription. These fraudulent prescriptions are often billed to the insurer.

Prescription drug abuse/diversion schemes include:

- Drug Diversion
Obtaining legitimate pharmaceuticals for illicit purposes. Drugs are obtained by submitting fraudulent insurance claims for phantom patients, phantom injuries, and other schemes. Diversion can be perpetrated by pharmacists, pharmacy employees, nurses, and doctors. The drugs are then often sold.
- Pill Mill
A doctor, clinic or pharmacy is prescribing and/or dispensing powerful narcotics inappropriately or for non-medical reasons. The provider may be receiving an “under the table” payment for the prescription as well as billing the insurers. Many pill mills appear on the surface to be pain management clinics and often attract large volumes of patients. To avoid law enforcement attention, they often “open and close” within a short period of time.

Schemes by Individuals:

- Doctor Shopping to Obtain Drug Prescriptions
This is an individual person’s scheme to obtain the drugs. The doctors usually have no idea that the patient has already visited other physicians or even hospitals to obtain the same or other drugs (usually pain killers). The cost of the doctor or emergency room visits are quickly paid back to the patient when they fill the prescriptions and sell some or all of the drugs on the street.
- Stolen Prescription Pads
Some patients, or even medical facility employees, steal a doctor’s paper prescription pads to forge prescriptions and provider signatures. These pads are then used to create prescriptions filled at local pharmacies.
- Changing the Quantity or Number of Refills
Changes are made to the quantity of pills prescribed and/or the number of authorized refills on paper prescriptions. Some states have passed laws that only electronic prescriptions from providers to pharmacists are allowed for certain classifications of drugs.

DRUG COMPOUNDING SCHEMES

Drug compounding is the art and science of preparing personalized medications for patients. This is usually done when a patient can’t use an “off-the-shelf” remedy or product due to an allergic reaction or non-effectiveness. Compounded medications are made based on a practitioner’s prescription in which individual ingredients are mixed together in the exact strength and dosage form required by the patient. This method allows the compounding pharmacist to work with the patient and the prescriber to customize a medication to meet the patient’s specific needs. The compounded drugs can be pills, injections, infusions or topical creams.

Drug compounding schemes include:

- Template Diagnoses/Drug Compounding Prescriptions Across a Patient Population
All patients receive the same drug compounding prescription although the purpose of drug compounding is to meet the specific pain relief needs of individual patients.
- Unnecessary Compounded Drug Prescription
Compounded drugs are prescribed without documentation of medical necessity and/or documentation of the lack of medical benefit from other standard medications.
- Excessively Expensive Ingredients
Compounders use expensive commercial items (e.g. commercially available pills and costly base creams) to create very expensive topical ointments that offer no clinical improvement over more affordable products available.
- Compounding Facilities Not Properly Licensed or Registered
Unlicensed and/or unregistered providers and pharmacies preparing and dispensing compound drugs.
- No Prescription
Adding compound drugs to the bill without a prescription to document medical necessity.

**NICB MEDICAL FRAUD
SCHEME GUIDE 1.0**

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