

 FRASCO® training

Spotting the Signs

EFFECTIVE TACTICS FOR IDENTIFYING INSURANCE FRAUD

 APPROVED BY:
CEU Institute

Course Objectives



Distinguish between soft fraud and hard fraud



Recognize behavioral and documentation-based red flags



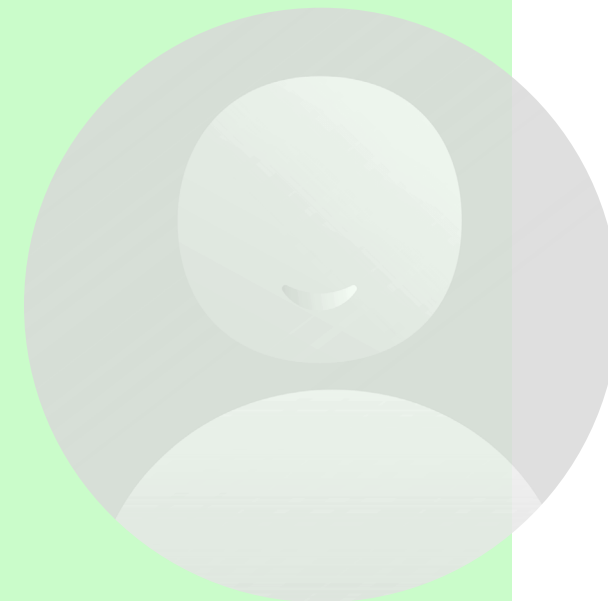
Understand jurisdictional thresholds and legal considerations



Apply investigative tools appropriately and ethically



Document claims objectively to reduce bad faith exposure



What Is Insurance Fraud?



Spotting the Signs

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Soft Fraud vs. Hard Fraud

Soft Fraud typically involves a legitimate loss that is exaggerated, prolonged, or misrepresented, such as remaining on disability longer than medically necessary.

Hard Fraud involves completely fabricated losses or incidents, such as staged accidents or fake thefts. Most fraud begins as soft fraud and escalates if unchecked.



Why Fraud Escalates

Claims may escalate due to financial stress, desire for time away from work, influence from family or legal counsel, or lack of early investigation. When inconsistencies are not addressed promptly, claimants may feel emboldened to continue misrepresentation, increasing exposure and complexity.



Fraud Dynamics

Fraud is rarely static. Behaviors change, stories evolve, and documentation patterns emerge over time. Adjusters should look for trends rather than isolated issues. Understanding how fraud develops helps adjusters identify concerns earlier and respond appropriately.



Claimant Behavior Red Flags



Witness & Documentation Red Flags

Unwitnessed injuries with questionable circumstances

No independent witnesses or unusually “perfect” witnesses

Altered, incomplete, or inconsistent documentation

Lost, unverifiable, or suspicious wage documentation



Medical & Treatment Red Flags



Subjective complaints disproportionate to objective findings



Excessive, repetitive, or unnecessary treatment



Refusal or delay of diagnostic testing



Missed or frequent changes to medical appointments



Provider Fraud Red Flags



Billing for services never



Unbundling or inflated billing practices



Referral kickbacks or collusion between providers



Billing for equipment never provided



Auto & Liability Claim Red Flags

- Claimant and insured closely connected or related
- Low-impact collisions with significant injury claims
- Immediate attorney involvement
- Vehicle ownership, damage, or repair discrepancies
- Staged accident indicators



Property & Post-Loss Red Flags



Post-disaster fraud schemes (e.g., Contractor solicitation)



Questionable timing of loss or repairs



Employment & Background Red Flags

Undisclosed employment or side

No fixed residence or use of temporary

Financial hardship indicators or credit issues

Identity discrepancies or inability to verify personal information



Legacy & Long-Term Claim Red Flags

Long-standing claims without updated review

Sudden reactivation after long inactivity

Claimant not cashing indemnity checks



Using Red Flags Effectively

Red flags should prompt questions, not conclusions. A single indicator rarely proves fraud. Multiple indicators, combined with factual inconsistencies, justify additional investigation. Objective evaluation protects both the claim and the adjuster from allegations of bias or bad faith.



Jurisdictional Considerations

Fraud investigation and prosecution vary significantly by jurisdiction and claim type. Workers' compensation, auto, property, and disability claims each have different standards. Adjusters must understand local requirements to ensure compliance and defensible decision-making.



Financial Thresholds

Many jurisdictions require significant financial exposure - often around \$10,000 - before district attorneys will pursue fraud cases. Proper documentation, timelines, and evidence collection are critical when escalation is considered.



Investigation Best Practices

Effective investigations begin with targeted, factual questioning. Adjusters should clarify inconsistencies early, request supporting documentation, and avoid accusatory or emotional language. Strong fundamentals often resolve concerns without escalation.



Investigative Tools

Investigative tools may include background research, records reviews, social media analysis, and surveillance. These tools should be used strategically, ethically, and only when justified by documented red flags.



Surveillance Insights

Surveillance is most effective when conducted over consecutive days and aligned with claimant activity patterns. Timing and planning are more valuable than duration. Surveillance should support factual findings, not replace investigation fundamentals.



Provider Fraud Indicators

Provider-related red flags include excessive or repetitive treatments, lack of measurable improvement, identical treatment plans across patients, and potential kickback arrangements. These indicators warrant careful documentation and inquiry.



Working With Medical Providers

When concerns arise, evidence should be presented objectively to medical providers. Requests for clarification or statements should remain neutral and fact-based. Professional communication helps maintain credibility and compliance.



Legal & Ethical Responsibilities

Adjusters must operate within fraud and abuse laws, maintain HIPAA compliance, and work only with licensed, ethical investigators. Proper conduct protects both the investigation and the organization.



Understanding Bad Faith

Bad faith can result from failure to investigate, delayed action, or improper conclusions. Labeling a claim as fraud without proof increases legal exposure. Process, fairness, and documentation are essential.



Documentation Best Practices

Documentation should focus on observable facts, timelines, and objective findings. Avoid definitive labels. Use language such as “red flags,” “potential concerns,” or “inconsistencies noted” to remain defensible.



Claim Types & Examples



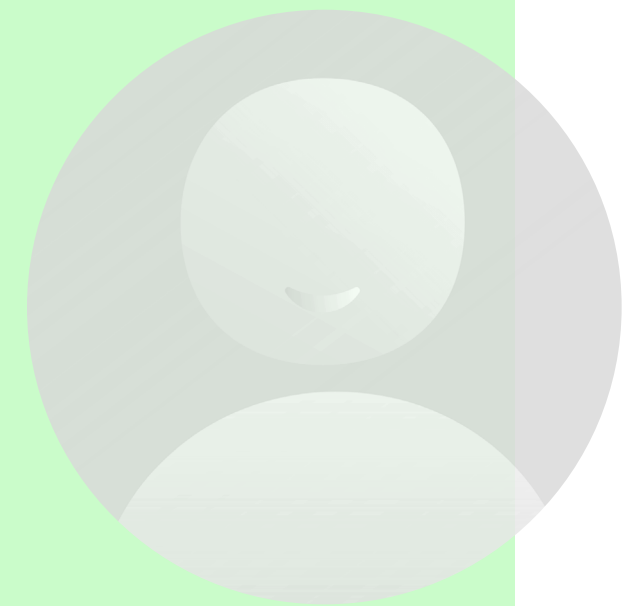
Auto claims may involve staged accidents or repair fraud.



Property claims often spike after disasters.



Legacy claims require periodic reassessment, as fraud indicators may emerge years after inception.



Importance of Periodic Reviews

Claims evolve. Updated ISO reports, new medical information, or surveillance can change claim direction. Regular reviews help identify emerging risks and reduce long-term exposure.



Team Collaboration

Successful outcomes depend on collaboration between adjusters, investigators, attorneys, and service partners. Clear communication and shared objectives strengthen investigations and improve results.



Communication & Cultural Sensitivity

Clear explanations reduce misunderstandings that can lead to soft fraud. Using interpreters when needed and maintaining cultural awareness improves cooperation and claim accuracy.



Key Takeaways

Red flags do not equal fraud. They are indicators requiring documentation, clarification, and potentially referral - not conclusions. Ethical handling, factual language, and compliance are emphasized.

- Fraud is often subtle and progressive
- Early red-flag recognition is critical
- Ethical investigations protect all parties
- Adjusters are central to fraud prevention and claim integrity

