



SIU

SPOTLIGHT



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WELCOME

Welcome to the *SIU Spotlight!*



Spring has (finally) sprung and insurance carriers continue to navigate a claims and litigation environment defined by heightened scrutiny, evolving medical billing practices, and an increasingly active plaintiffs' bar. Courts and arbitrators alike are being asked to address novel theories of recovery, expanding discovery disputes, and renewed challenges to long-standing cost-containment tools. For carriers, staying ahead of these developments is not simply a matter of compliance, but of strategic positioning.

In this issue of *SIU Spotlight*, we examine several recent decisions and trends that underscore the importance of disciplined claims handling and proactive litigation strategy.

We hope this edition serves as a useful resource for claims professionals, offering not only summaries of recent decisions, but actionable insights to support informed decision-making in the months ahead. ♦

Ariel Brownstein



Top 10 Recommendations for Addressing Fraud in NJ PIP Arbitration: A DRP's Perspective

Gary Lesser, Esq. | Roseland, NJ

New Jersey's no fault PIP system presents a unique blend of statutory requirements, arbitration procedures, and evolving fraud schemes. For carriers, counsel, and SIU professionals, navigating this landscape effectively requires more than familiarity with the rules — it demands an understanding of how Dispute Resolution Professionals (DRPs) evaluate evidence, credibility, and patterns of abuse.

Drawing on more than a decade as a Forthright PIP arbitrator and extensive experience investigating staged losses and systemic fraud, I offer ten practical recommendations for strengthening fraud detection and improving outcomes in PIP arbitration.

1. Understand the NJ PIP Landscape

New Jersey's PIP framework is unlike any other. Arbitration, not Superior Court, is the primary forum for resolving disputes, and Forthright's DRPs adjudicate cases based strictly on the evidence presented. Appreciating the procedural nuances — including timelines, evidentiary expectations, and the limits of DRP authority — is essential for building a defensible case.

2. Spot the Red Flags Early

Fraud often reveals itself in the details. Early indicators include:

- Overutilization of treatment
- Templated or boilerplate medical reports
- Conflicting timelines
- Identical documentation across unrelated claimants

Identifying these patterns at the outset allows carriers to intervene before questionable treatment escalates.

3. Investigate Policy Level Fraud

Fraud doesn't always begin with the accident. Policy level misrepresentations — such as false garaging locations, unlisted household residents, or misrepresented vehicle use — can undermine coverage entirely. Scrutinizing these issues early can support dismissal applications under the PIP rules.

4. Use the PIP Arbitration Rules to Your Advantage

Rule 35 of the New Jersey No Fault PIP Arbitration Rules provides a mechanism for pre-hearing dismissal when coverage requirements are not met. As the document notes:

“If any party contends that... there is no coverage or Forthright lacks subject matter jurisdiction, such party may apply for an Order dismissing the case prior to hearing.” ▶

A well supported dismissal application — including policy provisions, factual support, and documentation — can resolve a dispute before it reaches a hearing.

5. Analyze Treatment Records for Patterns

Fraud rarely occurs in isolation. Comparing CPT codes, treatment patterns, and provider behavior across multiple cases can reveal systemic issues. Reviewing prior arbitration awards involving the same providers can also uncover recurring credibility concerns or previously identified irregularities.

6. Use SIU Strategically

SIU involvement is most effective when timed to coincide with treatment phases and targeted to specific concerns. Preparing SIU investigators with focused questions and clear objectives enhances credibility assessments and strengthens the evidentiary record.

7. Leverage the EUO Effectively

Examinations Under Oath remain one of the most powerful tools in the investigative arsenal. Choosing between recorded statements and EUOs depends on timing and strategic goals. Records should be used to challenge inconsistencies in patient testimony and to test the reliability of the claimant's narrative.

8. Prepare Your Arbitration Submission Thoughtfully

A strong submission clearly identifies:

- The legal issues
- The evidence supporting your position
- How the facts align with your defense theory

While written submissions are important, oral hearings often make the difference. DRPs value clarity, organization, and a well articulated argument.

9. Coach Your Witnesses

Witness credibility can make or break a case. Preparing witnesses for cross-examination ensures they present confidently and consistently. DRPs evaluate demeanor, clarity, and the ability to explain complex issues without overreaching.

10. Understand DRP Limitations — and Read Between the Lines

DRPs decide cases based on the evidence presented, not investigative instincts. The civil burden of proof and limited credibility assessments shape outcomes. However, award language often contains subtle cues that can guide broader fraud detection efforts. Arbitration outcomes should be treated as investigative leads, not endpoints.

Conclusion

Fraud in New Jersey PIP claims continues to evolve, and carriers must adapt accordingly. By understanding the arbitration process, identifying red flags early, and presenting well supported cases, insurers can more effectively combat fraudulent activity while ensuring legitimate claimants receive the benefits they are entitled to.

These ten recommendations reflect a DRP's perspective — one grounded in thousands of cases, systemic investigations, and a deep understanding of how fraud manifests in the PIP environment. With thoughtful preparation and strategic execution, carriers can significantly improve their ability to detect, challenge, and prevent fraudulent claims. ♦

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Evaluating “Reasonable and Necessary” PIP Charges Under Delaware Law

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When it comes to evaluating bills submitted to PIP carriers in Delaware, insureds often ask whether, pursuant to Delaware law, carriers are required to pay only those amounts billed/charged by medical practitioners that are “ordinary and customary.” Delaware law is unique when it comes to consideration of this issue.

Applicable Statute: 21 Del. C. § 2118(a)

Delaware does not have a fee schedule for first party claims submitted for payment under a policy providing personal injury protection benefits. Pursuant to 21 Del. C. § 2118(a)(2)a.:

No owner of a motor vehicle required to be registered in this State, other than a self-insurer pursuant to § 2904 of this title, shall operate or authorize any other person to operate such vehicle unless the owner has insurance on such motor vehicle providing the following minimum insurance coverage:

(2) a. Compensation to injured persons for reasonable and necessary expenses incurred within two years from the date of the accident for:

1. Medical, hospital, dental, surgical, medicine, x-ray, ambulance, prosthetic services, professional nursing and funeral services. Compensation for funeral services, including all customary charges and the cost of a burial plot for one person, shall not exceed the sum of \$5,000. Compensation may

include expenses for any nonmedical remedial care and treatment rendered in accordance with a recognized religious method of healing.

2. Net amount of lost earnings. Lost earnings shall include net lost earnings of a self-employed person.

3. Where a qualified medical practitioner shall, within two years from the date of an accident, verify in writing that surgical or dental procedures will be necessary and are then medically ascertainable but impractical or impossible to perform during that two-year period, the cost of such dental or surgical procedures, including expenses for related medical treatment, and the net amount of lost earnings lost in connection with such dental or surgical procedures shall be payable. Such lost earnings shall be limited to the period of time that is reasonably necessary to recover from such surgical or dental procedures but not to exceed 90 days. The payment of these costs shall be either at the time they are ascertained or at the time they are actually incurred, at the insurer’s option.

4. Extra expenses for personal services which would have been performed by the injured person had they not been injured.

5. “Injured person” for the purposes of this section shall include the personal representative of an estate; provided, however, that if a death occurs, the “net amount of lost earnings” shall include only ▶

that sum attributable to the period prior to the death of the person so injured.

The Insurance Commissioner, in Auto Bulletin No. 10, Amended October 15, 1998 interpreted 21 Del. C. § 2118(a)(2), as requiring insurers to pay “reasonable and necessary expenses” for PIP coverage. See attached. The commissioner noted that “[s]ome insurers are refusing to pay more than a portion of the medical, hospital, or other professional medical expenses on behalf of their insureds based upon what those carriers believe are “unreasonable” fees billed” and opined “PIP carriers must pay all of an insured’s PIP costs (less any applicable deductible) if those costs are reasonable and pertain to services that are necessarily required for the care of the insured” unless the carrier and provider have previously agreed on a price for a specified service. The commissioner went on to state “[i]f a medical provider has charged [a]n ‘unreasonable fee’ for a necessary treatment, the unreasonableness of that fee does not render the treatment ‘unnecessary.’ That portion of the fee which is not in dispute shall be paid according to relevant law. A dispute over the remaining amount of such a fee should remain a dispute between the carrier and the provider. It is expected that carriers will make good faith efforts to resolve such disputes and not expose the insured party to harassment or legal action. However, if a claim is made or legal action is filed by the provider against the insured party for the amount of the fee in dispute, the carrier must provide a defense for its insured against that claim or legal action.”

Finally, the commissioner proclaimed, “[u]nder the Delaware Unfair Practice Act, Title 18 Delaware Code, Section 2304(16), it is an unfair trade practice to attempt with such frequency as to indicate a general business practice to settle a claim for less than the insurance policy requires. The Department will vigorously enforce the rights of insured to receive the benefits to which they are contractually entitled. It will be considered a violation of 18 Delaware Code, Section 2304 if a carrier asserts that the provisions of this bulletin prohibit balance billing.”

Case law

The issue of unilateral reduction in payment of bills submitted by providers under a PIP policy has been a subject of several court cases in Delaware. In *Green v. Geico Gen. Ins. Co.*, 2018 WL 1956287 (Del. Super.), the plaintiffs sought to obtain class certification

challenging Geico’s procedure for evaluating and paying for treatment as being in violation of 21 Del. Sec. 2118. GEICO apparently evaluated utilizing two rules: the Geographic Reduction Rule (GRR) which set an arbitrary cap at the “80th percentile” of other claims submitted to GEICO within a particular geographic region and the Passive Modality Rule (PMR) under which GEICO automatically denied payment for certain “passive modalities” when treatment occurs more than eight weeks from the date of the automobile accident. The plaintiffs argued under the GRR, 20% of bills submitted to GEICO for reimbursement were automatically deemed “unreasonable,” without inquiry into the facts giving rise to the claim or any factors that could impact pricing and the GRR was, in effect, a secret cap on what GEICO will pay. The court denied class certification but also denied GEICO’s motion to dismiss, finding insufficient discovery had occurred for it to render a dispositive ruling.

A similar result had been found by the United States District Court for the District of Delaware in *Johnson v. GEICO Casualty Co.* 310 F.R.D. 246 (D. Del. 2015), *aff’d*, 672 Fed. Appx. 150 (3d Cir. 2016). In *Johnson*, the USDC initially certified a class, however, later in litigation the court reviewed and found that the plaintiffs could not maintain the class based on a damage model which required significant individual inquiries. The Delaware District Court decertified the class because “even assuming that Geico’s policies resulted in the classes’ claims being systematically denied and reduced, ... individualized inquiries would be required to determine whether each class member’s individual claim was actually medically necessary and their expenses reasonable.” *Id.* at 251. The primary fight in the regarded decertification of the class, which the court agreed with and was affirmed by the 3rd Circuit.

In Wilmington, the Pain & Rehabilitation Center instituted litigation against USAA Gen. Indem. Ins. seeking class certification and declaratory judgment that USAA’s utilization of a computerized bill review system called “Reasonable Fee Methodology,” to determine the reasonableness of medical expenses was in violation of 21 Del. C. § 2118(a). *Wilmington Pain & Rehab. Ctr. V. USAA Gen. Indem. Ins. Co.*, 2017 WL 8788707 (Del. Super.). Again, the sole issues decided by the court was class certification, which it again declined to certify. The court did not address the issue of declaratory judgment. ▶

In 2019, First State Orthopedics sought class certification arguing Liberty Mutual Insurance Company's policy of paying invoices more than 30 days after they were submitted for payment was in violation of 19 Del. C. § 2362, which mandates "[a]ll medical expenses shall be paid within 30 days after bills and documentation for said expenses are received by the employer or its insurance carrier for payment, unless the carrier or self-insured employer notifies claimant or the claimant's attorney in writing that said expenses are contested or that further verification is required." First State Orthopedics v. Liberty Mutual Ins. Co., 2020 WL 764149 (Del. Super.). The Court again denied class certification but allowed the merits to proceed.

Conclusion

In sum, this issue has yet to be presented in full to the court and a trial regarding the same has not yet been held before a fact finder in Delaware. Additionally, the Delaware Insurance Commissioner has not instituted litigation seeking a definitive determination regarding whether it is an "unfair trade practice to attempt with such frequency as to indicate a general business practice to settle a claim for less than the insurance policy requires" as is threatened in Auto Bulletin No.

10. Nevertheless, the language of § 2118(a) and the Insurance Commissioners interpretation in Auto Bulletin No. 10 likely support a finding that a systemic practice of doing so violates § 2118(a). The bulletin was designed (and has been amended several times) in an effort to afford the insured the protection of having his/her bills for necessary treatment paid while protecting the carrier from a physician or practice attempting to take advantage of Delaware's "dollar-for-dollar" PIP payment laws. However, it is delineated within the bulletin that it is not to be construed as authority for the carrier to engage in a repeated practice of not paying the total amount of bills submitted for payment. Therefore, it is expected that a systematic practice of not paying the total amount of bills submitted for payment without analysis on an individual basis as to the relationship of the treatment and corresponding bills to the condition being treated supported by an independent medical examination would lead to litigation that the practice violates the requirements of 21 Del. C. § 2118(a). ♦

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Florida Appellate Court Sets Record Straight on Longtime Misconception of Examinations Under Oath as Admissible Evidence

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The Florida Third District Court of Appeal recently overturned a long standing assumption regarding the admissibility of examinations under oaths (“EUOs”) as trial evidence in *Universal X Rays, Corp. v. United Auto. Ins. Co.*, 422 So. 3d 1203 (Fla. 3d DCA 2025), reh’g denied (Nov. 3, 2025). For years, a longstanding mythos existed around EUOs in Florida that they could not be used in litigation because of a multitude of reasoning: hearsay, trustworthiness, due process, creation in anticipation of litigation, among other common critiques. Such was the situation that great evidence could be potentially unearthed in an EUO, but if it could not be independently verified by other means, certain evidence as to fraudulent or denied coverage claims would never see the light of day.

In *Universal X Rays*, the assignee and insured, Miguel LaRosa-Ferrer sat for an examination under oath per his insurance policy following a car accident. The EUO was conducted via videoconference with a court reporter and the insured had an attorney present. During the required examination, the insured admitted that he had moved to a new address shortly before applying for the insurance policy but continued to list his old address on the application. This resulted in a lower premium for the insured. Two months later, United Auto sent a letter to the insured rescinding the policy, citing material misrepresentation of the garaging address, and returned the premium.

Several months later, the appellant, Universal, sued United Auto for breach of contract after it denied a medical billing reimbursement request for no-fault personal injury protection benefits. United Auto eventually moved for summary judgment on the issue of material misrepresentation with its key piece of evidence being the EUO transcript. Universal argued that the EUO transcript was inadmissible as improper hearsay, an out of court statement by a declarant offered for its truth, and that it violated section 92.33, Florida Statutes (2025) because the insurer did not provide a copy of the transcript to the insured. However, Universal offered no actual evidence disputing that the insured committed a material misrepresentation.

The lower trial court disagreed with Universal’s legal arguments and because no evidence disputing the material misrepresentation was presented, entered final judgment for United Auto. Unsurprisingly, Universal promptly appealed, as there is a history of trial courts in Florida finding EUOs to be inadmissible for numerous reasons leading to a long-fabled-belief in the industry as to the same.

For example, in *JJZ Medical Center, Inc., v. United Auto. Ins. Co.*, 32 Fla. L. Weekly Supp. 432a, (Fla. 11th Jud. Cir. Cty. 2024), a Miami-Dade trial court declined to review an examination under oath demonstrating material misrepresentation after an insured signed an affidavit to the contrary and ▶

it was submitted as evidence. The court held that the EUO could not be admissible because there was no cross-examination of the witness making it “inherently untrustworthy.” The court went on to state that an EUO transcript met no exception to hearsay exclusions under Florida law either such as former testimony or a business records exception.

Another County Court in Miami-Dade excluded an EUO transcript involving a material misrepresentation summary judgment because it was not provided to the declarant nor adopted by the declarant per § 92.33 Fla. Stat, and would be considered hearsay. *Manuel V. Feijoo, M.D., aao Andisleydis Sordo Perez v. United Auto. Ins. Co.*, 31 Fla. L. Weekly Supp. 382a (Fla. 11th Jud. Cir. Cty. 2023). In this case, the court homed in on the argument that an examination under oath, while sworn, lacks personal knowledge of the declarant because it is not provided to them, nor do they adopt it after it is transcribed. § 92.33 Fla. Stat. requires a written statement by an injured party to be provided to that individual or it may not be used in a later civil action. The court held this statute to be applicable and, thus, excluded the EUO transcript.

Both of these common lower court arguments were then brought up on appeal by Universal. They argued to the Third District Court of Appeal that the EUO was inadmissible hearsay, violating Florida Statute § 92.33, which requires a copy of a written statement to be provided to the declarant. However, Third District Court of Appeal rejected both arguments and for a reason that seemed to catch the appellant off-guard.

First, the court cited Florida’s revised summary judgment standard, which in 2021, aligned Florida’s Rule 1.510 with the federal summary judgment standard Rule 56. Using the full benefit of federal case law, the court held that hearsay is permissible “as long as it can” be presented in admissible form at trial—such as through live testimony. In such instances, the proper response from an opposing party is to present conflicting evidence contradicting the statement. However, in this case, Universal put forth no evidence that the insured’s garage address was not materially misrepresented, and, thus, they lost this issue.

The Third District rejected the argument that the insurer violated § 92.33 Fla. Stat., noting that the statute only requires “written statements” to be provided to an injured person. The court held that an EUO, which is a sworn transcribed statement, would not even be covered by § 92.33, and the appellant failed to provide any authority to the contrary. Given that appellant’s statutory argument did not apply and it presented no evidence to contradict the examination under oath, which could be reduced to admissible form at trial, the Third District affirmed the admissibility of the EUO in favor of the insurer.

The significance of the *Universal X Rays* opinion now means EUOs are an even stronger fraud deterrent in Florida. They can be taken with confidence and utilized to stem frivolous litigation and claims at much earlier phases than before. Rather than ignore the EUO transcript, opposing parties now must affirmatively disprove that fraud has occurred once it is admitted. ♦

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The “Inherent Risk” of Staged Collisions and the Limits of Sentencing Stipulations

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In a significant win for law enforcement and the insurance industry, the Tenth Circuit recently affirmed a 48-month sentence for a defendant who orchestrated a sophisticated, multi-year insurance fraud scheme involving staged car wrecks. The court’s ruling in *United States v. Brown*, No. 25-7026 (Dec. 30, 2025) underscores a powerful legal precedent: the act of staging an automobile collision is inherently dangerous and justifies strong sentencing enhancements, regardless of whether a particular crash resulted in actual injury.

A. Background

Defendant Sebron Dejuan Brown operated a four-year conspiracy involving odometer tampering and staged accidents. The scheme was twofold:

- **Vehicle Value Inflation:** Brown replaced or “rolled back” odometers in high-mileage vehicles to artificially inflate their market value.
- **Orchestrated Crashes:** He and his co-conspirators then deliberately crashed these vehicles—sometimes involving unsuspecting third parties—to submit fraudulent insurance claims for vehicle repairs and bodily injuries.

While the parties initially stipulated to a lower loss amount and offense level, the district court rejected the stipulated guidelines. Instead, the court applied a two-level sentencing enhancement for an offense

involving the “conscious or reckless risk of death or serious bodily injury” and imposed an 11-month upward variance, resulting in a four-year prison term.

B. The Tenth Circuit’s “Inherent Risk” Ruling

On appeal, Brown argued that the “serious bodily injury” enhancement (U.S.S.G. § 2B1.1(b)(16)(A)) was misapplied because there was no evidence that anyone was actually at risk of grave harm during his “controlled” low-speed collisions.

The Tenth Circuit rejected this “semantic and evidentiary over-demand.” The panel held that because cars are “big pieces of machinery traveling at speed,” the risk of serious injury is intrinsic in any deliberately caused accident. The court clarified that sentencing judges do not need to quantify the specific degree of risk for each individual collision; *the criminal method itself—staging wrecks—is enough to trigger the enhancement.*

Takeaways

1. The Power of “Inherent Risk” in Litigation

The most important takeaway for carriers is the judicial recognition that staged accidents are inherently dangerous. Carriers can leverage this “inherent risk” logic in civil litigation—especially in RICO or fraud counterclaims—to emphasize the egregious nature of the claimant’s conduct. By framing staged accidents as acts of reckless endangerment rather than mere ▶

paperwork fraud, carriers can more effectively push for punitive measures and deter future schemes.

2. Beware of Sentencing Stipulations

Brown highlights that courts are not bound by the stipulations between prosecutors and defendants regarding loss amounts or offense levels. Carriers, often acting as victims in these cases, should ensure their "actual loss" statements are strongly documented. Even if the parties agree to a lower loss figure for a plea deal, the carrier's impact statement can lead the court to apply enhancements or adjustments that better reflect the true scope of the harm.

3. Identifying the "Sophisticated Means" Red Flags

Although *Brown's* scheme was simple in its execution (crashing cars), the court noted the "repetitive and consistent nature" of the fraud for over four years as a reason for the upward variance. Carriers should look for these patterns early in the Special Investigations Unit (SIU) process:

- **Commonalities in Vehicle Acquisition:** Vehicles with high mileage that have recently "lost" significant mileage on their odometers.
- **Recruitment Patterns:** Schemes involving five or more participants often share common medical providers or legal representatives.
- **Frequency Limits:** Tracking how often the same individual appears as a passenger or "witness" across different claims.

4. Proactive Defense Strategies: Beyond Affirmative Defenses

Carriers should move beyond simple denials of claims. As seen in *Brown*, the criminal justice system is increasingly willing to treat these cases as *serious threats to public safety*. In civil court, carriers should consider:

- **Declaratory Judgment Actions:** Seeking an early court ruling that no coverage exists due to the fraudulent nature of the incident.
- **Aggressive Counterclaims:** Filing counterclaims for fraud or RICO violations rather than just asserting fraud as an affirmative defense. This shifts the burden and signals that the carrier will not settle "low-value" nuisance claims.

Accordingly, *United States v. Brown* serves as a solid reminder that the "staged accident" is not viewed by the courts as a victimless white-collar crime. By affirming that these schemes pose an inherent risk of death or serious injury, the Tenth Circuit has provided insurance carriers with a potent rhetorical and legal tool to use in the ongoing fight against organized fraud rings. ♦

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The Age of Automated Fraud: Defending Against Documentation Cloning and AI-Generated Claims

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For years, healthcare payers have treated note cloning—the practice of copying and pasting electronic health record (EHR) text—as a primary red flag in fraud, waste, and abuse (FWA) investigations. Today, as the industry races to embrace Artificial Intelligence (AI) for documentation, the threat of “cloning” is not disappearing; it is simply evolving. For insurance carriers facing healthcare fraud costs estimated to exceed \$400 billion annually in the U.S., understanding this new and evolving technological risk is paramount to effective claims denial and successful defense litigation.

The core issue with cloned documentation is its immediate challenge to the medical necessity of billed services. When medical records contain identical or near-identical entries across multiple dates of service, the documentation cannot support the premise that unique, individualized care was provided at each encounter. This practice undermines the credibility of the entire record.

Traditional copy-and-paste charting, where clinicians simply copy-forward prior entries or borrow from templates, was quickly identified by the Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) as a priority for audit and enforcement. Its misuse often results in a form of fraud known as up-coding—the insertion of false or irrelevant details to justify a higher, more expensive level of service than was actually rendered. Simply put, manufactured records support inflated billing.

Cloning 2.0: AI and the New Red Flags

The rapid adoption of AI-assisted documentation tools presents carriers with a new, but strikingly familiar, compliance pitfall. Just as a keyboard shortcut once generated a suspiciously repetitive note, a sophisticated machine learning algorithm can now produce a grammatically flawless but equally generic summary.

Insurance carriers must equip claims auditors with a new playbook for identifying these high-tech red flags:

- **Repetitive and Boilerplate Phrasing:** Like cut-and-paste, AI tools tend to reuse stock language verbatim—for instance, identical descriptions of a patient’s presentation across many different encounters. The presence of uniform, verbose, or overly formal language that clashes with an experienced auditor’s knowledge of a physician’s typical “voice” should raise suspicion. These generic statements does not reflect individual patient encounters, creates the assumption that the narrative was manufactured to support, higher E/M coding and supports the appearance of a systematic inflation by a provider, not an isolated error.
- **Overly Complete Documentation:** A hallmark red flag for potential upcoding is extreme documentation thoroughness. Unlike human clinicians, who focus

on relevant positives and negatives, AI systems frequently generate exhaustive, boilerplate reviews of systems. Such documentation can misrepresent the scope of the encounter, creating the appearance of higher-level services and automatically inflating the reported E/M code—despite no corresponding increase in clinical work. An example of this would be a patient presenting with a sore throat and congestion, but the note documents a 14-system Review of Symptoms (ROS), all marked negative. A routine upper respiratory complaint does not clinically justify a full multi-system ROS. This level of detail artificially supports a higher E/M level without corresponding medical necessity.

- **Internal Inconsistencies:** Because AI relies on patterns, it can fail to reconcile contradictory information or carry forward fabricated or outdated details. For instance, one section of an AI-generated note might state “no extremity pain,” while another later mentions “episodes of upper extremity discomfort”. These internal contradictions are destructive to a record’s credibility and are prime targets for counsel in deposition.
- **Metadata Trails:** Crucially, the technology that enables AI documentation also leaves an audit trail. Carriers must leverage the power of discovery to review system logs and timestamps that reveal when AI tools were used to generate text. This metadata can prove the extent of a provider’s reliance on automated shortcuts, flagging instances of potential overreliance.

Fighting Fire with Fire: The Carrier’s AI Defense

The growing sophistication of provider fraud demands that insurance carriers evolve beyond static, rules-based fraud detection to advanced analytical models. The best defense against AI-driven fraud is often the strategic use of defensive AI.

- Carriers must transition to modern FWA prevention strategies by:
- **Pre-Payment FWA Preventive Analytics:** Moving beyond traditional post-pay audits, carriers are now leveraging machine learning models to score and flag

claims for high-risk behavior before adjudication. This shift prevents the improper payment from ever being made.

- **Leveraging Natural Language Processing (NLP):** NLP is essential for analyzing the unstructured data in medical records, specifically clinical notes. These tools can scan millions of provider notes to detect the subtle anomalies that human auditors might miss, such as:

- Identification of repetitive and cloned phrases across a provider’s patient roster.
- Flagging medical codes that do not align with the narrative diagnosis or description in the note.

- **Predictive Behavioral Modeling:** AI systems can track a provider’s historical billing and documentation patterns, automatically identifying statistically significant deviations from their peers. When a provider suddenly increases their volume of complex E/M codes (a classic up-coding indicator) or exhibits unusual service combinations, the system flags the provider as a high-risk outlier for focused investigation.

- **Network Link Analysis:** Advanced analytics can uncover collusive networks of providers who might be sharing patients or services to perpetrate fraud.

In conclusion, the ultimate lesson for carriers is that documentation is not merely about filling space; it is about telling the patient’s distinctive and current story. Anything—whether a copy-paste command or a machine learning algorithm—that dilutes that unique story and creates repetitive or over-documented records is a pathway to claims failure and potential fraud. Insurance carriers must treat AI documentation with the same rigorous scrutiny once reserved for chart cloning, updating audit protocols to focus on individualized clinician attestation, customization, and metadata that reveals overreliance on automation. ♦

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Staged Accidents

Staged automobile accidents—“crash-for-cash” schemes—remain one of the boldest and most expensive forms of insurance fraud. Commercial auto carriers are hit hardest, targeted for their higher policy limits and perceived vulnerability. The result is a persistent, high stakes challenge for insurers.

Even with thorough scene investigation, these claims frequently move into litigation. When fraud indicators appear at first notice of loss, pursuing declaratory judgment can shut down coverage early and prevent claims from maturing into lawsuits. When litigation proceeds, insurers strengthen their position by asserting counterclaims against the fraud actors, shifting the posture from defense to offense and signaling zero tolerance for fraudulent conduct.

Effective defense requires a specialized, aggressive approach. Strategic discovery, targeted motion practice, and expert testimony are essential to exposing inconsistencies and undermining claimant credibility. Traditional litigation tactics rarely suffice; staged accident fraud demands a focused skillset and a proactive mindset.

To learn more about our Staged Accident practice and the strategies we deploy to combat insurance fraud, we invite you to explore additional insights from our attorneys. Please see the resources below, where our team shares their experience, analysis, and real-world perspectives on identifying and defending against staged accident claims.

"Crash & Con: Navigating Staged Accident Fraud," *AM Best Insurance Law Podcast*, May 22, 2025

"Staged Accidents, Real Consequences: Combating Crash-for-Cash Schemes in Commercial Auto," *SIU Today Magazine*, November 24, 2025


Visit our Fraud/Special Investigation Practice Group and Trucking & Transportation Practice Group to Learn More. ♦

Upcoming 2026 Events

April 8	PAMIC Claims Summit Lancaster PA
May 13 – 14	OHIO IASIU Columbus OH
June 22	NJSIA Golf Classic Knob Hill Golf Club Englishtown, NJ
September 20-23	Annual Conference Rosen Shingle Creek Resort, Orlando, Florida
October 5 – 6	OH WV Pittsburgh IASIU Pittsburgh, PA
October 19 – 21	NJSIA Annual Regional Seminar Atlantic City, NJ

Interested in training your claims professionals?

Contact Ariel Brownstein at ACBrownstein@mdwcg.com or 856.414.6075 for training opportunities in 2026 and 2027.



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