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First Steps to Fight Workers' Compensation Fraud†

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Abstract

One of several currently popular explanations of increasing claim costs and the consequent drain on profitability in workers' compensation (WC) is fraud. This paper explores the nuts-and-bolts aspects of the first steps in fighting insurance fraud in WC by defining and categorizing that criminal behavior called WC fraud. The necessary steps to provide for a legal system that allows for the effective prosecution of that fraudulent behavior is illustrated by means of the 1991 Massachusetts WC Reform Law provisions on insurance fraud. A variety of schemes and scams that arise in actual Massachusetts workers' compensation cases referred for investigation are discussed in relevant detail. The expected universality of the paradigm fraud cases described in the paper and the techniques used to detect and prosecute them will assist public and private efforts to fight WC fraud in other states.

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Introduction

Fraud is one of several currently popular explanations for increasing claim costs and the consequent drain on workers' compensation (WC) profitability. The Insurance Research Council (IRC) reports in its Public Attitude Monitor (PAM, 1992) that nearly one in 12 members of the general public approve of someone who was injured at home claiming that their injury was work related in order to collect WC benefits. Fortunately, only four percent deem working at another job while receiving WC wage loss benefits for total disability as acceptable behavior. Still fewer (3 percent) believe it is acceptable to file a disability claim without being injured when a layoff occurs or is likely. With public attitudes such as these, it is highly likely that WC fraud is a problem but the exact extent of that problem is unknown.

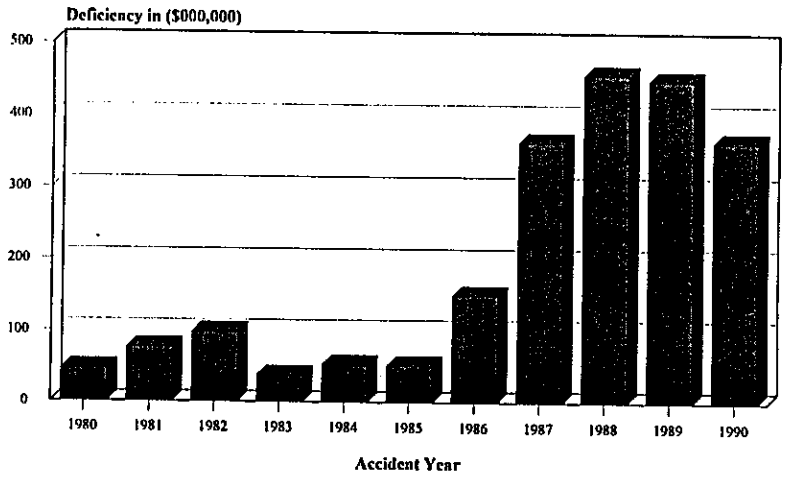
This paper explores the first steps in fighting insurance fraud in WC. It does so by defining sharply and categorizing the criminal behavior called WC fraud, by discussing the necessary steps to provide a legal system that permits effective prosecution of that fraudulent behavior, and by elaborating on the variety of schemes and scams that arise in actual Massachusetts workers' compensation cases that have been referred to the Insurance Fraud Bureau for investigation. The primary objective of this paper is to describe how those first steps have been taken in Massachusetts during the past two years. The generality of the fraud cases described in the paper and techniques to combat them can assist efforts to fight WC fraud in other states.

Fraud in workers' compensation arises from illegitimate claims that inflate the costs of the system and from premium avoidance that deprives the system of necessary resources. This paper identifies eight major categories of fraudulent activities and seven types of schemes to perpetrate those frauds. It summarizes detailed case studies of the Massachusetts experience to show the *modus operandi* of the fraud perpetrators and the nature of the efforts used by the insurance companies and fraud investigators to uncover their activities.

This paper also uses the Massachusetts Workers' Compensation Reform Act of 1991 as an example to show the essentials of shaping an effective legal structure to fight fraud. The principal steps taken by that law were:

- Establishing a central investigative *Insurance Fraud Bureau* with sufficient resources, especially access to dedicated resources from the Attorney General for prosecution of completed cases.

FIGURE 2
Massachusetts Workers' Compensation
Accident Year Loss Deficiencies



Source: WCRIB filing for 1/1/94 rates p 569

10 percent of the (hard) fraud claims (1 percent overall) were judged to have enough evidence in the file to refer to a law enforcement agency. On a total population basis, this meant that about 600 bodily injury claims per year should receive serious consideration for further investigation and prosecution for criminal offenses. Those apparently fraudulent claims were predominantly soft tissue, strain and sprain injuries.

The Commonwealth of Massachusetts had the statutory authority to fund a fraudulent auto claims board within the Division of Insurance since the early 1970s. Since 1976, however, when the Commissioner had found that type of state agency to be unnecessary, no funding was authorized in the state budget. Acting on the results of the first auto claim study, the auto insurers proposed early in 1990 that a new type of fraud bureau be created by statute, one that would be a true public-private cooperative effort that provided for the investigation and criminal prosecution of insurance fraud cases. Chapter 338 of the Acts of 1990 created such a fraud bureau, fully funded by the auto insurers and governed by a board of governors consisting of both

insurers and public officials, including the Commissioner of Insurance.[5]

The workers' compensation reform effort took place during the same time period (1991) that the Massachusetts Insurance Fraud Bureau (IFB) was opening its doors for business. While no formal claim study of the Massachusetts WC system was available, the rapid deterioration of WC financial results and a commonality of auto and WC soft tissue injuries prompted serious concerns about WC fraud. It was natural that among the many procedural and benefit changes that were to be considered, statutory changes to enhance criminal prosecution of fraudulent practices in workers' compensation would be a prominent issue.

The Insurance Fraud Bureau

Although the IFB was initially supported completely by the auto insurers, the enabling statute allowed for the referral and investigation of fraudulent practices in all lines of insurance. Drawing upon the experiences of previously established state fraud bureaus, primarily the one established in Florida in 1976, the Massachusetts IFB statute contained several key fraud fighting elements:

- Mandatory reporting of known fraudulent insurance transactions by insurers.
- Maintenance of a toll-free telephone number for the public to report fraud (1-800-32-FRAUD).
- Confidential access to information and records, such as those within the Registry of Motor Vehicles, insurance companies, and criminal justice system.
- Immunity from civil liability for damages for IFB personnel and insurers for statements, reports, or investigations of insurance fraud, absent bad faith or malice.
- Restitution ordered when conviction on IFB cases is obtained.
- Assessment of auto insurers to be used by the Attorney General solely for the purpose of prosecuting IFB cases by at least one full-time assistant AG.

5. Chapter 338 of 1990 is quite similar to the version as amended by Section 99 of the Reform Law.

the "false pretense" clause, proving that particular fraud requires a BRD showing that the perpetrator (Harshbarger, 1992):

1) made a false statement of fact,
2) which he knew to be false,
3) intending that statement to be relied upon by the victim (insurance company), and
4) the victim did rely on that statement as true and parted with property (WC benefit payments).

If actual payments are not made because the scheme is detected early, attempted larceny can be charged. The elements of the crime of insurance fraud are similar, however, under the Massachusetts Insurance Fraud Statute (C. 266, S. 111A); reliance by the carrier (#4) is not required. The BRD standard for criminal charges clearly requires the production of:

1) a document filed in support of a claim, and
2) evidence of the *intent* to injure, defraud, or deceive the insurer.

Statutory tools that facilitate the establishment of this evidence are discussed later.

Benefits Fraud

The first type of WC insurance fraud is the claim for benefits based upon intentional misrepresentation of material facts of the injury or treatment. The AIB studies of auto insurance claims (Weisberg and Derrig, 1992) divided fraudulent claims in that line of insurance into eight categories that represented claims for auto injuries that either did not occur or were unrelated to the accident. Those eight categories are used to provide a similar taxonomy for WC fraud in Table 1. Of course, some fundamental differences exist in the motivation for and processing of fraudulent claims in the two kinds of insurance. Chief among those are the pain and suffering "pot-o'-gold" available to auto claimants but not to (most) WC claimants and the company claims adjusting and negotiating process for auto in contrast to the defined benefits/state adjudicated WC benefits awards. In any event, the analogy seems complete (Compare NJ DOI, p 5).

These types of WC benefits fraud will cover all fraudulent claims by individuals, as well as collusion with employers, adjusters, medical providers, and lawyers in schemes to defraud the employer and its insurer. Working while collecting WC benefits, a common fraud, can

involve several of the types of fraud, depending upon the circumstances of the case. Details on some IFB cases that involve these types of benefits fraud are discussed in later sections.

TABLE 1
Types of Fraud—Auto Claimant vs WC Claimant

Auto	WC
1. Staged Accident	1. Deliberate Injury
2. Claimant Not Involved in Accident	2. Faked Injury (Multiple Claimants)
3. Duplicate Claims for Same Injury	3. Multiple Claims (Aliases)
4. Bills Submitted for Treatment not Given	4. Fabricated Treatment
5. Real Injury, Unrelated to Accident	5. Non-Work Related or Prior Injury
6. Fictitious Injury	6. Faked Injury (Single Claimant)
7. Misrepresentation of Wage Loss	7. Misrepresentation of Wage Loss
8. Other Material Misrepresentations	8. Other Material Misrepresentations

Premium Avoidance

The other major categorization of WC fraud involves premium avoidance (see Table 2). According to the 1991 Internal Security Association study of premium fraud, material (criminal) misrepresentation can arise from any or all of four premium determinants.

TABLE 2
WC Premium Fraud Types of Misrepresentation

1. Employee Job Classifications
2. Amount of Payroll in Each Classification.
3. Geographic Location of Insured Operations
4. History of Past Losses

the claimant who would state under oath that he was never specifically told that he could not work while receiving workers' compensation benefits. Defenses on the intent element were also anticipated in temporary total and part-time employment situations when a claimant would feign ignorance and state his understanding that he thought he was permitted to earn the difference between the average weekly wage established as a benefit at the DIA and his salary prior to the injury.

In order to counter those defenses, company or law enforcement investigative staff would have to prove the criminal intent of the claimant by reviewing the treating health care provider's office notes and resultant medical reports in which the claimant may or may not have described his physical and/or mental disabilities and lack of employment. The claims representative would have to be contacted to show that the carrier paid medical bills submitted in reliance on the claimant's misrepresentations about his or her employment status to his or her health care professional to bolster the criminal intent element. Independent medical examinations (IME) tended to assist investigators a bit more because an IME practitioner would usually ask a claimant if they worked at all during the term of their disability. All of these sources of evidence were helpful but could not compare to the direct approach involved when a claimant personally completed and executed a document in support of his claim.

A favorable criminal statute, which had recently been amended to include workers' compensation premium evasion, was being used with success by the Florida Division of Insurance Fraud. In addition, the Florida Bureau of Workers' Compensation Fraud was created in 1990 to investigate fraud delineated in a newly amended workers' compensation statute that addressed claimants, employers, insurers, self-insurers, physicians, osteopaths, chiropractors, and other practitioners (including attorneys and "runners") who involved themselves in workers' compensation fraud (Section 817.234, Florida Statutes). As the Florida experience showed, the new workers' compensation felony language and the use of an "Employee Earnings Report" similar to the Florida statute allowed the requisite criminal intent to be established to the degree necessary for guilt beyond a reasonable doubt on each and every element of each offense charged.

The Reform Law Changes Dealing with Fraud

The Reform Law provided for several distinct changes that enhance the fraud fighting activities of WC insurers and state law enforcement

personnel. Various sections of the Reform Law deal with extending the scope of the IFB to include workers' compensation (s.99); barring employees from collecting benefits for prior undisclosed injuries (s.51A); providing for specific language for criminal activity of law firms, health care providers, and leasing companies (s.38); and increasing the administrative penalties available to DIA for false and misleading claims (s.36, 37). All of these revisions taken together with the experience acquired by the IFB in its first year of existence greatly enhanced the set of tools available to fight WC fraud. Some of these changes are described more specifically below.

Administrative Changes An Employee Earnings Report is now mandated by statute and used in proceedings before the DIA. It requires a claimant to state on demand, but not more often than every 26 weeks, whether he or she had earned income from self or other employment during the time he or she was receiving workers' compensation benefits. The form is signed under the penalties of perjury. The Earnings Report is available upon request from the authors.

If an attorney or expert medical witness engages in illegal or fraudulent conduct in proceedings before the DIA, the DIA must report the matter to the IFB. As a consequence, if fraud is suspected and some evidence can be shown to support that allegation,[12] the Senior Administrative Law Judge can order an expedited hearing within 14 days. When fraudulent activity by the claimant is found, an administrative penalty, the cost of the proceedings with attorneys' fees, and a penalty equal to six times the average weekly wage in the Commonwealth, approximately six times $570 in 1992, shall be paid to the aggrieved insurer or employer. If fraud is found in the administrative proceeding, the case is also referred to the IFB.

The criminal provision applicable to workers' compensation fraud is now a felony. Also, any firm or health care establishment that encourages or coerces individuals to file workers' compensation claims (or hires "runners") is subject to the same felony provision: imprisonment in the state prison for up to five years, or by imprisonment in jail for a six month to two and one half year period or a fine of between $1,000 and $10,000 dollars or by both fine and imprisonment.

12. In the administrative context of DIA proceedings, the preponderance-of-the-evidence standard is used rather than the beyond-a-reasonable-doubt standard of criminal proceedings.

employer have been simpler to show intent to defraud because of the presence of a false signed form, just as the Reform Law intended. This enhances prosecution efforts because perjury can be brought in addition to the fraud and larceny and because courts are more likely to consider harsher penalties (jail time) when perjury is involved.

Finally, in some cases of claimant fraud that extend over many years (IFB has one extending 4 years and one 12 years), the original injury can be real (a fracture) or false, but the administrative system before the Reform Law allowed inordinate delays often running into years between DIA actions. That system encouraged those who would otherwise return to work, or at worst malinger, to obtain employment under their own name or under aliases hidden from the WC system.

One such case involves a worker who slipped and fell six days after being hired under an assumed name with a phony social security number. Incredibly, upon being injured, he filed for temporary total benefits and began a second job within 10 days under his own name. Unaware of the second job, the insurer disputed the claim but agreed 10 months later to a $10,000 lump sum settlement in addition to $4,000 in medical fees. With the first settlement in hand, our claimant slipped and fell again, and, of course, signed up with a new (third) employer. What made this case different from the first is the multiple fraudulent claims perpetrated by the claimant. With multiple fraudulent claims there is no reason to believe that the criminal activity is restricted to WC; rather the entire insurance system is at risk. Details of cross coverage fraud in one IFB case are contained in a "link chart" (Appendix) that shows *six* identities for one individual who filed auto injury claims and unemployment benefit claims in addition to his WC claims. All the illegal activities were uncovered by IFB during the investigation of an auto insurance ring; the WC activities surfaced in a report of an old WC claim from the Central Index Bureau.

Claimant/Adjuster Fraud

In addition to claimants defrauding the WC system by themselves, the adjusters on the inside of an insurance company operation can also perpetrate fraud. It is difficult, but not impossible for an adjuster to create phony claimants and collect (small) payments that they themselves authorize. The more likely case, however, is for an adjuster to agree to increase benefits to an existing claimant for a "kickback" of part of the increase. In one such scheme, a low level WC claims adjuster

used the discretion he had in settling scheduled benefits for disfigurement due to scarring to boost settlements in return for kickback payments. In this particular case, the adjuster grew bolder with each additional inflated claim, even going so far as to recommend oversized lump sum settlements to his company. The scheme was discovered, as so many are, by a tip to the insurance carrier from a claimant's relative. The carrier's internal security unit then established the facts of the case. The IFB investigation secured proof of the criminal case by obtaining the bank photographic record of the adjuster and claimants cashing the award checks together.

Claimant/Employer Fraud

One other claimant fraud can arise, even from a legitimate injury, when WC benefits are extended over multiple years. Unscrupulous employers can use the WC system to supplement the wages paid to injured employees who can legitimately return to work. One IFB case concerns an employer who conspired with an employee to return to work, collect his WC benefits, and collect the difference in pay from his employer. As with the other claimant cases, surveillance, ordered by the carrier after an IME suggests the claimant can return to work, can reveal more than just the physical condition of the claimant, it can uncover the details of the scam. The insurance company SIU investigation in this case called for an employee earnings report to be filed. Once filed, criminal intent had been established, benefits could be terminated, and prosecution could be sought.

Claimant/Provider Ring

The most insidious of the schemes to defraud the WC system are those perpetrated by the doctors and lawyers who are involved with the WC system as professionals. Schemes in which unnecessary medical treatment is provided have the unwanted consequence of driving up the costs of the system (Grasso, 1992). Massachusetts WC *appears* to have avoided wholesale inflated treatments (unlike Massachusetts auto insurance) because of the low medical proportion of total benefits paid.[16]

16. In Massachusetts only 20.8 percent of total claim payments are for medical payments versus 41.1 percent for workers' compensation outside of Massachusetts (NCCI, 1993).

IFB are instructive, if only for a relative frequency of the types of WC fraud that are suspected by insurance companies and the public at large (WCRIB, 1993).

Table 3 shows referral and IFB evaluation data by line of insurance and by source for the 4,016 referrals as of November 5, 1993. The data demonstrate the difference in the types of referrals between the 1,646 hotline referrals and the 2,370 referrals from insurance companies and other agencies (mostly DIA). For example, 52 percent of the hotline calls were about WC versus 21 percent of the company and agency referrals. This difference is a reflection of the growing awareness on the part of the public of WC fraud that can be pursued

TABLE 3
Fraud Bureau Referral and Evaluation
May, 1991 to November, 1993

Line of Insurance	Accepted for Investigation	Declined for Investigation	Referred to Other Agencies	Evaluation Pending	Total Line of Insurance
		All Sources			
Auto	1366	667	64	136	2233
WC	364	740	67	183	1354
Other	113	252	25	39	429
All	1843	1659	156	358	4016
	46%	41%	4%	9%	
		Company and Agency Sources			
Auto	1337	321	8	37	1703
WC	258	201	10	28	497
Other	92	73	0	5	170
All	1687	595	18	70	2370
	71%	25%	1%	3%	
		Hotline Referrals from Public			
Auto	29	346	56	99	530
WC	106	539	57	155	857
Other	21	179	25	34	259
All	156	1064	138	288	1646
	9%	65%	8%	17%	

Source: Insurance Fraud Bureau of Massachusetts

TABLE 4
Workers' Compensation Referrals by Type of Fraud Ranked by Number of Referrals—May, 1991 to November, 1993

Referrals Submitted for Evaluation

Percentage	Number of Referrals	Type of Fraud	Total Loss Value	Average Non-Zero Loss Value*
39%	527	Working While Collecting	$9,996,514	$59,503
16%	220	Malingering	$420,885	$42,089
15%	199	Staged Accident	$3,231,872	$31,999
9%	116	Professional Claimant	$1,347,572	$23,642
6%	84	False Loss Statement	$1,687,227	$44,401
3%	43	No Policy	0	0
3%	37	Prior Injury	$263,869	$23,998
3%	37	Undefined	$416,388	$27,759
2%	32	Premium Avoidance	$19,285,152	$3,214,192
2%	29	Not Work-Related Injury	$318,526	$35,392
2%	21	Fraud by a Professional (MD/Att/Chiro/etc)	$296,644	$37,081
	5	Multiple	$92,485	$18,497
	4	Agent Thefts	$900,000	$900,000
	1,354	TOTAL	$38,257,132	$89,177

Referrals Accepted for Investigation

Percentage	Number of Referrals	Type of Fraud	Total Loss Value	Average Non-Zero Loss Value*
46%	168	Working While Collecting	$6,062,576	$62,500
25%	90	Staged Accident	$2,110,555	$32,470
6%	21	Professional Claimant	$368,908	$30,742
5%	20	False Loss Statement	$831,992	$48,941
3%	12	Malingering	$131,622	$65,811
3%	11	Not Work-Related Injury	$316,900	$45,271
3%	10	Premium Avoidance	$19,280,717	$3,856,143
3%	10	Undefined	$47,289	$11,822
2%	9	Prior Injury	$80,899	$26,966
2%	6	Fraud by a Professional (MD/Att/Chiro/etc)	$108,200	$36,067
1%	4	Multiple	$25,110	$6,278
1%	2	Agent Thefts	$900,000	$900,000
	1	No Policy		
	364	TOTAL	$30,264,768	$137,567

* Referrals with indeterminate loss values are assigned a zero dollar value.
Source: Insurance Fraud Bureau of Massachusetts

progress, as opposed to deterrence value, will be measured in terms of cases referred to the IFB and those successfully prosecuted. If the point can be reached where there is a reasonably high probability that *fraud perpetrated will be fraud prosecuted*, then claimants, employers, insurers, and regulators alike will be assured that the WC resources are being applied precisely where they are needed.

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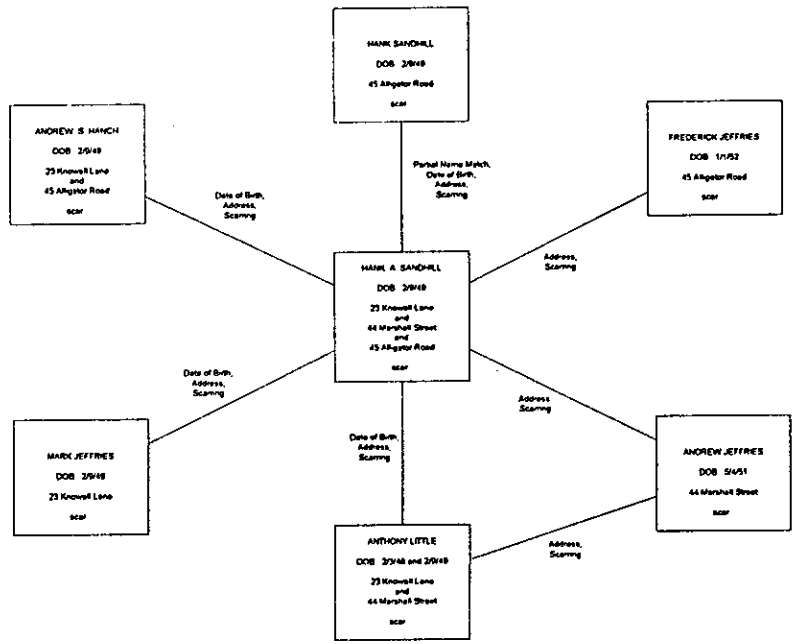
APPENDIX
First Steps to Fight Workers' Compensation Fraud
An Example of Link Chart Analyses

ALIAS INDENTIFICATION CHART
SIX POSSIBLE ALIAS IDENTITIES USED BY THE CENTRAL TRUE IDENTITY



NOTE: This chart shows possible alias indentities connected to a single identity. Alias identifications are based on common dates of birth, addresses, partial names and/or distinguishing physical characteristics. Conclusive proof is provided by handwriting analysis, eyewitness testimony and/or banking transactions.

SOURCE: Insurance Fraud Bureau of Massachusetts