

WORKERS' COMPENSATION INSURANCE FRAUD



**THE WORKERS' COMPENSATION FRAUD UNIT
OF THE
FRESNO COUNTY DISTRICT ATTORNEY'S
OFFICE**

WORKER'S COMPENSATION INSURANCE FRAUD

DESCRIPTION OF UNIT:

- 3 Deputy District Attorneys
- 3 District Attorney Investigators
- 1 Legal Secretary
- 1 Program Technician

We are available to talk about cases. Call us at (559) 600-6710.

We accept referrals from any source (insurance company, employer, attorney, and public)

Jurisdiction can be established if the injury takes place, the employer resides, or the fraud is committed in Fresno County; also when the compensation is paid out of, or the adjudication of the claim takes place in Fresno County. If dual jurisdiction exists, the case should be referred to the county in which prosecution is more appropriate and most convenient.

TYPES OF FRAUD WE PROSECUTE:

APPLICANT FRAUD

- AOE/COE (arising out of employment/course of employment)
- Malingering
- Denial of Previous Injury
- Other Lies

EMPLOYER FRAUD

- Premium Fraud
- Employer Misrepresentations
- No Worker's Compensation Insurance

PROVIDER FRAUD

- Double Billing
- Excessive Treatment
- Kickbacks
- Other Fraud

APPLICANT FRAUD

STATUTES:

(Insurance Fraud) California Insurance Code Section 1871.4(a)(1):

(a) It is unlawful to do any of the following:

(1) Make or cause to be made any knowingly **false or fraudulent material statement** or **material misrepresentation** for the **purpose of obtaining any compensation**, as defined in Section 3207 of the Labor Code.

- Definitions:

Material: A statement or representation is material if it concerns a subject reasonably relevant to the investigation and if a reasonable insurer would attach importance to the fact represented

Compensation: “Compensation” means compensation under the Workers’ Compensation Law of Division 4 and includes every benefit or payment conferred by Division 4 upon an injured employee, including temporary total disability payments and vocational rehabilitation.

- A false statement or misrepresentation can be made to 1) any **medical treatment provider**, 2) any **claims adjuster, investigator** or other **representative** of the insurance company, 3) any **supervisor** or other **representative** of the applicant’s place of employment, or 4) any individual that the applicant believes would have an influence on receiving his/her benefits.

(Perjury) California Penal Code Section 118(a):

(a) Every person who, having taken an oath that he or she will testify, declare, depose, or certify truly before any competent tribunal, officer, or person, in any of the cases in which the oath may by law of the State of California be administered, willfully and contrary to the oath, states as true any material matter which he or she knows to be false, and every person who testifies, declares, deposes or certifies under penalty of perjury in any of the cases in which the testimony, declarations, depositions, or certification is permitted by law of the State of California under penalty of perjury and willfully states as true any material matter which he or she knows to be false, is guilty of perjury

- Perjury charges typically arise from depositions taken of the applicant

(Grand Theft) California Penal Code 487(a):

Grand Theft is theft committed in any of the following cases:

(a) When the money, labor, or real or personal property taken is of a value exceeding four hundred dollars (**\$400**)...

- Theft by false pretence (through false representations) is theory used in prosecution

(False Claims) Penal Code 550(b)(1):

(b) It is unlawful to do, or to knowingly assist or conspire with any person to do, any of the following:

(1) Present or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(False Claims- Failure to Disclose) Penal Code 550(b)(3):

(b) It is unlawful to do, or to knowingly assist or conspire with any person to do, any of the following:

(3) Conceal, or knowingly fail to disclose the occurrence of, an event that affects any person's initial or continued right or entitlement to any insurance benefit or payment, or the amount of any benefit or payment to which the person is entitled.

- This code section is often used when an applicant is found working for a second employer while collecting disability benefits and does not report this to the insurance company

Burden of Proof

In a criminal action, the burden of proof is proof **beyond a reasonable doubt**. The verdict must be unanimous (all twelve jurors must agree). It is necessary to conduct thorough investigations and obtain sufficient evidence in order to successfully convict someone of criminal fraud.

PENALTIES:

Insurance Code 1871.4(a)(1)

- Up to one year in county jail (misdemeanor) or up to five years in State Prison (felony) **and/or**
- Fine: the greater of \$150,000 or double the value of the fraud

Penal Code 118

- Up to 4 years in State Prison

Penal Code 487

- Up to one year in the County Jail (misdemeanor) or up to 3 years in State Prison (felony)

Penal Code 550(b)(1) and 550(b)(3)

- Up to one year in the County Jail (misdemeanor) or up to 5 years in State Prison (Felony) **and/or**
- Fine: the greater of \$10,000 (misdemeanor)/ \$50,000 (felony) or double the amount of the fraud

Restitution

- Ordered once a conviction takes place in an amount determined by the court. Restitution is typically calculated from the date of the fraud. It is often collected by our office and forwarded to the victim.



INDICATORS OF APPLICANT FRAUD:

These indicators serve to assist in identifying claims which may warrant additional investigation. One or more of these indicators may also be present in legitimate claims

- There are no witnesses to the alleged injury
- The injury occurred under unusual circumstances or in an area where the applicant would not normally be
- The applicant's version of the accident is not credible
- The applicant gives differing versions of how the injury took place
- The applicant fails to report the injury timely
- The applicant's physical complaints are all subjective in nature (i.e., sore back)
- The applicant is a new hire
- The applicant has made previous workers' compensation claims
- The applicant's job is seasonal or temporary and the job is almost over
- Layoffs or firing appears imminent or the entire business will soon close
- The job's pay rate is in low to mid range
- The injury is alleged to have occurred on Monday morning, especially if the applicant does not have health insurance
- The applicant was recently demoted, reprimanded, passed over for a promotion or otherwise unhappy with his/her employer
- The applicant had new or unusual personal problems prior to the alleged injury, such as divorce, or financial difficulties
- The alleged injury relates to a preexisting injury or health problem
- Fellow employee's state alleged injury is not legitimate
- Applicant cannot be reached at home during working hours

INVESTIGATION TO ESTABLISH FRAUD:

EMPLOYER'S ROLE:

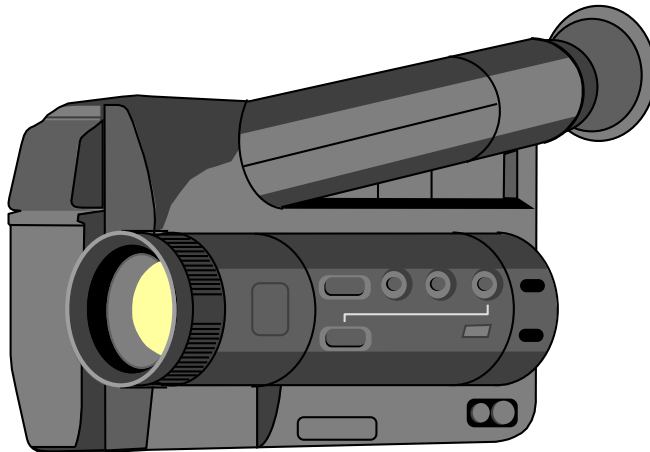
- **Thorough investigation when injury takes place:**
 - interview applicant and all witnesses. Document name of interpreter
 - take photos of scene/area where injury occurred
 - keep good records of incident (**document!**)
 - have applicant personally fill out and sign forms when possible
 - encourage employees to reveal their knowledge of incident
 - make sure all information is given to insurance carrier
- **Report to insurance company any known prior injuries, claims, and/or hobbies, etc...of applicant**
- **Business Records:**
 - Employers First Report of Injury
 - document physical requirements of the job
 - time sheets/ payroll
 - ID of applicant
 - hiring information/employment records of applicant
- **Criminal Court Proceedings:**
 - D.A. will subpoena for Preliminary Hearing (felony) and Trial
 - Custodian of Records from applicant's employer will be needed as well as any other witnesses needed to prove fraud
 - witnesses can refer to notes/file while testifying to refresh their memory
 - employers input welcome at sentencing hearings

EFFECTIVE USE OF DEPOSITIONS:

- Consider having deposition videotaped. A picture is worth a thousand words!
- Questions should be time specific, i.e. "Since the injury have you performed any yard work?" etc...
- Tie questions in with activities discovered during surveillance
- Answers like "My back hurts when I bend down" and "On bad days I can't lift 20 pounds" are not sufficient to prove perjury or fraud. Definitive and unambiguous false statements or misrepresentations are needed.
- Address applicant's abilities when on (and off) medication

EFFECTIVE USE OF SURVEILLANCE (SUB ROSA) VIDEO:

- To be effective, the video must show the applicant engaging in activities that are inconsistent with statements or representations made by the applicant regarding those activities.
- Should be taken as close in time as possible to the deposition and/or medical appointment where applicant has the opportunity to make a false statement or misrepresentation.
- The activity on video must be material and significant such as lifting heavy items or playing tennis when the applicant has claimed that he/she cannot do so. Minimal activity is often insufficient.
- Several days of film showing the applicant engaging in activities inconsistent with representations made is powerful evidence. A one day surveillance or a few minutes of activity is often insufficient.



REASONS FOR REJECTING FRAUD REFERRALS:

NO FALSE STATEMENTS OR MISREPRESENTATIONS

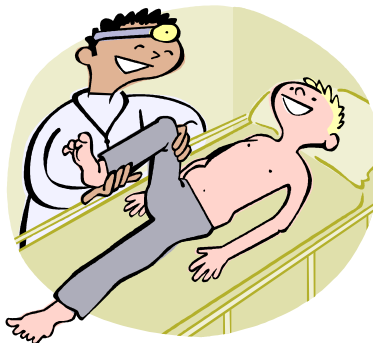
- Violating a medical provider's limitations is not sufficient; applicant must lie about it
- Medical provider's opinion that applicant is malingering or could have returned to regular duty is insufficient unless it is based on applicant's misrepresentations or false statements
- Medical Provider's lack of objective findings is insufficient
- Medical Provider's opinion that applicant, as seen in surveillance video, is not in discomfort or pain is insufficient

STATEMENTS DIFFICULT TO PROVE FALSE

- Complaints of pain "in general" are not enough
- Ambivalence when answering questions during deposition
- Vague and ambiguous statements
- Language problems/barriers. Interpreters will be needed to prove that applicant made statement and there is was no issue with interpretation of such statement
- Applicant is inconsistent; i.e. admitting to one doctor about a prior injury and either denying or failing to mention such injury to another doctor

MISCELLANEOUS

- Dueling doctor's opinions create reasonable doubt
- False statement or misrepresentations that are not **material**
- Insufficient AOE/COE investigations when injury is questioned
- Inability to prove prior injury/claim



EMPLOYER FRAUD

PREMIUM FRAUD STATUTES:

California Insurance Code Section 11880(a):

(a) It is unlawful to make or cause to be made any knowingly **false or fraudulent statement**, whether made orally or in writing, of any fact material to the determination of the premium, rate, or cost of any policy of workers' compensation insurance issued or administered by the *State Compensation Insurance Fund* for the **purpose of reducing the premium, rate, or cost of the insurance.**

California Insurance Code Section 11760(a):

(a) It is unlawful to make or cause to be made any knowingly **false or fraudulent statement**, whether made orally or in writing, of any fact material to the determination of the premium, rate, or cost of any policy of workers' compensation insurance, for the **purpose of reducing the premium, rate, or cost of the insurance.**

TYPES OF PREMIUM FRAUD:

- Cash Payroll
- Misclassification of work performed
- Failure to report injuries or reporting them as first aid
- Purchasing insurance under a new name when there is no change in the control group

IMPACT OF PREMIUM FRAUD:

- Premium rates go up
- Creates unfair competition
- Usually not paying other payroll costs

EMPLOYER MISREPRESENTATIONS:

Insurance Code Section 1871.4(a)(4)

(Example) Employer lies to employee for the purpose of discouraging employee from filing a Worker's Compensation Claim

EMPLOYER'S FAILURE TO OBTAIN WORKERS' COMPENSATION INSURANCE:

Labor Code Section 3700.5(a):

(a) The failure to secure the payment of compensation as required by this article by one who knew, or because of his or her knowledge or experience should be reasonably expected to have known, of the obligation to secure the payment of compensation, is a misdemeanor...

PENALTIES:

Insurance Code Section 11880

- Up to one year in the county jail (misdemeanor) or up to 5 years in State Prison (felony) **and/or**
- Fine: the greater of \$50,000 or double the value of the fraud

Insurance Code Section 11760

- Up to one year in the county jail (misdemeanor) or up to 5 years in State Prison (felony) **and/or**
- Fine: the greater of \$50,000 or double the value of the fraud

Labor Code Section 3700.5:

- Up to one year in the county jail **and/or**
- Fine: the greater of \$10,000 or double the amount of the premium

PROVIDER FRAUD

STATUTES:

Business and Professions Code Section 650:

(a) ...the offer, delivery, receipt, or acceptance by any person licensed under this division or the Chiropractic Initiative Act of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, irrespective of any membership, proprietary interest, or co-ownership in or with any person to whom these patients, clients, or customers are referred is unlawful.

Penal Code Section 487:

(Example) Double Billing for service rendered.

PENALTIES:

Business and Professions Code Section 650

- Up to 12 months in the county jail (misdemeanor) or up to 3 years in State Prison (felony) **and/or**
- Fines: Up to \$50,000

