



Workers' Compensation Insurance Fraud

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Abstract

This report provides statistics on insurance fraud, explains the various types of workers' compensation fraud schemes, and provides a list of fraud indicators. Forty-two states and the District of Columbia have set up fraud bureaus. Some bureaus have limited powers, and some states have more than one bureau to address fraud in different lines of insurance. These agencies have reported increases in referrals, tips about suspected fraud, cases opened, convictions, and court-ordered restitution.

Introduction

Fraud is the intentional perversion of truth in order to induce another to part with something of value or to surrender a legal right. Fraud in insurance may be defined as the abuse of the insurance mechanism for financial gain. Workers' compensation fraud exists when injured workers go back to work but still collect benefits; when doctors bill for services they never provided; or when employers underreport payroll to reduce their premiums. Fraud is a hidden cost of workers' compensation insurance, with an impact on both employers and injured workers. According to the National Insurance Crime Bureau (NICB), Ten percent or more of property/casualty insurance claims are fraudulent. And fraud is the second most costly white-collar crime in America behind tax evasion.

This report provides statistics on insurance fraud, explains the various types of claimant/benefits fraud and premium fraud schemes, and provides a list of fraud indicators.

The Cost of Insurance Fraud

In part, because of its hidden nature, insurance fraud has become one of the most prevalent and costly economic crimes in our society. Despite growing concern and a stepped-up effort to curb it, the magnitude of the problem has been increasing at a pace far in excess of the ability to control it - up until now. While the measurement of insurance fraud is a guess, at best, the following statistics provide some light with regard to its magnitude:

- For property/casualty insurance alone, insurance fraud is estimated to cost over \$17 billion - if it was a business, it would rank among the Fortune 500 companies.
- Approximately ten percent of claim's dollars paid out are attributable to fraud. This translates into about eight percent of all premium dollars paid by the insured.



- The United States Chamber of Commerce estimates that ten percent of the claims submitted to U.S. insurers contain some fraud.
- Estimates of the costs of fraud within the three major insurance sectors (i.e., property and casualty, health, and life) suggest that it is the second largest economic crime in America, exceeded only by tax evasion.

Background on Insurance Fraud

Insurance fraud began to get industry attention in the 1980s. The need to comply with the time requirements for paying claims imposed by fair claim practice regulations in many states made it difficult to adequately investigate suspicious claims.

In the late 1980s, insurance companies began to see the benefit of strengthening antifraud laws and more stringent enforcement as a means of controlling escalating costs. However, ongoing studies by the Insurance Research Council showed that significant numbers of Americans thought that it was all right to inflate their insurance claims to make up for all the insurance premiums they had paid in previous years when they had no claims or to pad a claim to make up for the deductible they would have to pay.

Anti-fraud activities by state fraud bureaus and special investigative units within insurance companies increased in the 1990s. Heightened antifraud activity, along with growth in funding for fraud-fighting personnel, resulted in increased prosecutions. Successful prosecution not only blocked future fraudulent activities by individuals who were repeat offenders, but news of prosecutions also acted as a deterrent to others who would be thinking about committing fraudulent acts.

Insurance companies are not law enforcement agencies and can only identify suspicious claims, withhold payment where fraud is suspected, and justify their actions by collecting the necessary evidence to use in a court. The success of the battle against insurance fraud therefore depends on two elements: the resources devoted by the insurance industry itself to detecting fraud; and the level of priority assigned by legislators, regulators, law enforcement agencies, and society as a whole to eradicating it.

Types of Workers' Compensation Fraud

Workers' compensation fraud may arise from illegitimate claims, which inflate the costs of the system, and from premium avoidance, which deprives the system of its necessary resources.

Claimant or benefits fraud is a type of workers' compensation fraud that relates to claims for benefits based on intentional misrepresentation of material facts of the injury or treatment. This type of workers' compensation fraud may involve collusion with employers, adjusters, medical providers, and lawyers in schemes to defraud the employer and its insurer.

Most workers' compensation premium fraud involves misrepresentation by the insured, the agent, or insurance company personnel. Collusion amongst these parties may also exist. One or more of three factors may be involved in the fraud: (1) the classifications of the business operations, (2) the annual payroll associated with those classifications, and (3) the experience modification factor.



Claimant/Benefits Fraud

The following are examples of claimant/benefits fraud:

Deliberate Injury - An employee deliberately injures him/herself (usually minor) in order to get time off. The claim may develop into an opportunity for "early retirement."

Faked Injury - A claimant files for benefits and claims an injury or illness that did not occur.

Multiple Claims - A claimant files more than one claim for benefits using aliases.

Fabricated Treatment - Medical providers prescribe unnecessary treatment, bill for services not provided, or charge inflated fees.

Non-Work-Related or Prior Injury - An injury that occurs at home, or results from a sports activity, is claimed to have happened at work.

Misrepresentation of Wage Loss - The injured employee works at another job while claiming workers' compensation benefits.

Other Material Misrepresentations - Malingering complaints persist for the employee/claimant long after a doctor consents for a return-to-work.

Premium Avoidance Fraud

The other major category of workers' compensation fraud involves premium avoidance. Material (criminal) misrepresentation can arise from any or all four of the following premium determinants: (1) employee job classification; (2) amount of payroll in each classification; (3) geographic location of insured operations; and/or (4) history of past losses. Any intentional misrepresentation of these items can affect the total premium charged by an insurer for workers' compensation insurance.

A special type of premium avoidance fraud is that associated with leasing companies. Unscrupulous leasing firms can avoid legitimate premiums charged for their operations by hiding the number of client companies, (illegally) self-insuring some client companies, or passing on intentionally incorrect workers' compensation costs to their client companies.

Payroll Misrepresentation - The most common type of premium fraud is the understatement or misrepresentation of payroll. By representing the payroll to be less than it actually is, the insured is able to produce an artificially low workers' compensation premium.

Employee Misclassification - Misclassification fraud occurs when employees exposed to the operational hazards of the business are claimed by the insured to be exposed to a lower-rated operation. In most instances, the misclassified employees are identified as part of the insured's office staff, which would require a "Clerical Office Employee" classification and the low rate associated with this classification. Fraud of this nature



can be significant, particularly where the rates do not reflect a substantial operational hazard. For example, an insured falsely represents \$200,000 of carpentry payroll as clerical payroll - if the carpenter rate is \$45.07 and the clerical rate is \$0.39, the insurance carrier is defrauded out of the premium difference equal to \$89,360.

Misclassification Fraud - Temporary Help and Employee Leasing - Temporary help and employee leasing firms supply employees to businesses. Because no "Basic" classification is available to describe the operation of a personnel firm, the employees of such companies are classified, for workers' compensation premium purposes, according to the classification of the business where they work. Though some of these personnel firms specialize in renting or leasing specific classes of employees, such as office, construction, or accounting workers, most leasing firms contract with a wide variety of businesses.

Experience Modification Avoidance - In basic terms, the premium for a workers' compensation insurance policy is determined by multiplying the rates for an insured's business operations by the payroll assigned to each of the operations. The classifications associated with each business are assigned based on a set of rules established in the National Council on Compensation Insurance's *Basic Manual*.

The resultant amount is then multiplied by an experience modification factor. This "mod" factor represents the claims history of a risk compared with other businesses performing similar operations. A business that is experiencing losses that are considered average in that industry would receive a mod factor of 1.00. The experience modification for a risk with a loss history that is worse than the average risk within its class would be greater than 1.00 (a debit mod); for a risk with experience that is better than the average, the factor would be a credit mod or less than 1.00.

Material Change In Ownership - The easiest means to reduce premiums for an employer with a high debit modification is to escape from this high experience modification. The term "easiest means" is used because until a few years ago, it truly was easy. Up until that time, a material change in ownership caused an experience modification to revert to 1.00. The reasoning for this is obvious. New ownership wanted the experience rating of their business to reflect their efforts in the initiation of safety programs and risk control. For new business owners, this concept makes sense and is still the rule. However, many business owners saw this change in ownership as a means of "dumping" a high debit experience modification. The owner with such a modification merely transferred the business ownership to a spouse or child solely for the purpose of avoiding the debit modification. In the day-to-day management of the business, nothing changed.

Buying Experience Modifications - One experience modification scheme involves buying, renting, leasing, or using a favorable experience modifier belonging to another company. The company buying the modification factor pays small claims out-of-pocket and files large, serious claims through the other company. This scheme works best when two or more companies are providing similar services and one has maintained a good safety record and earned an average or credit modification.

While this type scheme has been uncovered by alert premium auditors and claims personnel using subcontractor and loss run analysis, such schemes have worked successfully for long periods of time. Settling claims and developing premium for subcontractors rely heavily on the integrity of the employer. Anonymous tips from legitimate sources, such as a disgruntled employee whose claim has not been settled satisfactorily, serve as one of the best sources for combating this type of fraud.



Other Modification Avoidance Schemes - Two other modification avoidance schemes are: (1) the establishment of a single-entity employee leasing firm, and (2) a change in geographic location to avoid the experience modification.

To effectively avoid a high, debit experience modification factor, some employers have relied on employee leasing as a means of doing business. Rather than initiate an ownership change on the existing business, such employers choose to establish a new employee leasing business. The firm is established to service one client - the other business operation. Again, nothing has changed in regard to the management or attitude toward safety of the companies involved. The leasing company merely hires all the existing business's terminated employees and leases them back to their former employer. A new business means a new experience modification.

Classification assignment for workers' compensation is based on the business of an employer within a state. The experience modification is based on this classification and the loss history of the employer. To avoid a high debit modification, the employer can either establish an employee leasing firm in another state, or the employer can cause the rating and premium to be lowered by establishing storefront locations in adjacent states. Such storefront operations are generally associated with the lower-rated states. This is apparently the reason so many truckers are based in either Tennessee or Indiana.

The following example illustrates this fraud scheme: A trucker with a 2.5 experience modification establishes a personnel office in an adjoining state. Not only are the rates for trucking lower in this state, but the insured files as a new business operation. While this storefront is established with three office workers, the operations of the trucker did not change. The trucker, in this case, is looking for a modification of 1.0 and wants the lower rates applied to the policy.

Insurance Agent Schemes

Employers and insureds are not the only players in fraud. Agents, claims adjusters, doctors, lawyers, underwriters, marketing personnel, and premium auditors have all been convicted in fraud schemes. However, the agent represents a unique position within the industry.

Independent insurance agents are independent business people. They are not employees of an insurance company, but are representatives of the companies for whom they write business. Insurers see them as spokespersons for their companies.

Insurance agents are allowed to retain any interest they earn on premiums maintained within their own bank accounts. Delays in the submission of these premium amounts to the carriers can easily account for large sums of money. From this time-value of money, numerous schemes have been devised to delay the payment to the carriers. Of course, the simplest scheme is to abscond with the money.

Misrepresentation of Payroll - Through the misrepresentation of payroll, an agent can effectively reduce the size of an insured. The carrier, unaware of the true size of the account, may forego the performance of interim audits and/or the periodic collection of premium. If the agent delays or does not forward the payment of the premiums, the carrier will not be aware of the money being collected or the money owed until the final billing. As is readily apparent, the carrier is also not aware of the true exposure of the risk for which workers'



compensation coverage is being provided.

Delaying Payment - Delaying payment involves an agent depositing premium payments into an account until the carrier threatens cancellation for non-payment. When the notice of cancellation is received, the agent pays the premium, benefiting from the time value of the money.

Making Fraud Unprofitable

Minimal risk is a big reason fraud is so common. Perpetrators usually have strong motives. In the past, there was little deterrence - if the fraud succeeded, the perpetrators collected money; if it failed, the punishment was often only a slap on the wrist.

Special Investigation Units - The central mission of the Special Investigation Unit (SIU) is to protect the insurance company's assets from people with no legitimate claim on them. SIUs are prevalent in the insurance community and are not only relied on to identify and investigate potentially fraudulent claims, but to direct investigations in concert with State Fraud Divisions, police, and private vendors.

The SIU's mission is to help make sure that attempts at fraud succeed so seldom or become so risky that they come to be perceived as futile. SIU investigators ferret out fraud and assemble the evidence. Armed with proof, the insurance carrier can deny a claim or seek restitution. The SIU uses common law-enforcement tools: logic, technology (e.g., video cameras to record the unusual activities of "disabled" claimants, such as the claimant recorded playing goalie on a hockey team), psychology, and plain legwork. Simply checking the facts stated on a claim, such as a claimant's background with his/her neighbors, can turn up conclusive proof of a fraud.

The SIU works on referrals from claims processors, underwriters, risk control representatives, agents, and others; therefore, providing training on how to detect fraud is a part of an SIU's responsibility. Insurance company employees who suspect a claim is fraudulent should contact their SIU. The SIU will either give advice and direction or become directly involved. A second part of the SIU's mission is to train account representatives and agents - besides learning how to detect fraud, they hear how to control costs by reducing fraud and begin to work with carriers to fight it. The third major function of the SIU is the most interesting and challenging: to gather the evidence needed to defeat fraudulent claims. The SIU does the legwork that the police may be too busy or understaffed to perform.

In securing convictions for fraud, the SIU faces many obstacles that the insurance industry is trying to correct. They include laws and court decisions that do not take insurance fraud seriously. Well-publicized convictions act as deterrents to fraud, but the inconvenience to honest policyholders that result from overzealous pursuit of criminals prompts insurers to concentrate on prevention. Stopping crooks from getting any money is as effective and satisfying as putting them in jail.

New Technology to Combat Fraud

Advances in software technology are proving effective in fighting fraud. Data-mining programs, which scan many insurance claims, can uncover repetitions and anomalies and analyze links to fraudulent activities or entities. The consolidation of insurance industry claims databases has also aided investigators. Insurance Services Office's (ISO's) system, known as ClaimSearch, is the world's largest comprehensive database of



claims information. The NICB's Predictive Knowledge program collects and analyzes information that can be disseminated to insurers and law enforcement agencies. By mid-2010, insurers were able to file a single report of fraud, which would be filed with multiple state insurance departments and the National Association of Insurance Commissioners through ISO and the NICB.

Business Practices Employers Can Use to Reduce Fraud

An employer can aid in the prevention of fraud by explaining the workers' compensation system and benefits to new employees, as well as other concerns, such as disability benefits, health plans, salary continuation, and vacation. This alone can indicate an employer's desire to provide full information concerning the work environment. Other actions that can reduce the fraud problem include:

- Treat workers with respect.
- Educate managers and workers on fraud indicators and develop an anti-fraud policy.
- Establish an early return-to-work policy.
- Establish wage levels above minimums.
- Offer medical benefits to employees.
- Educate employees regularly on safety and fraud issues.
- Initiate hot lines and a system to anonymously report suspected fraud.
- Use techniques, such as exit interviews and job placement help, for terminations and layoffs.
- Use a 24-hour medical provider that is conveniently located to provide fast, quality care.
- Do not deny occurrences of on-the-job injuries, unless there is positive proof that the injury did not occur on the job. If there is a denial, it may create a potentially adversarial relationship.
- Communicate with the insurance carrier; report claims promptly, and provide all pertinent information.
- Encourage injured workers to promptly return to work and, where necessary, provide modified tasks.

Workers' Compensation Insurance Fraud Indicators

A red flag is a warning that something is not right with a claim and should lead one to take a closer look. To aid in understanding and recognizing fraudulent schemes, a set of fraud indicators is provided below. The existence of a single indicator or a combination of indicators is not necessarily conclusive proof that a fraud has been committed. However, the presence of indicators may suggest a claim deserves further investigation. The lists will help employers know what to look for when identifying possible fraudulent behaviors. Identification of any one of the following red flags does not mean that fraud exists. However, in most states, in order to submit a fraud allegation, the employer needs only to have a suspicion that fraud may have been committed. Special agents assigned to the state special investigations department will carefully collect and analyze the facts to determine whether or not fraud was committed.



Incidents of insurance fraud can be decreased once potential perpetrators realize that insurance company personnel have the skills and commitment to recognize, investigate, and prosecute fraudulent schemes. The use of the fraud indicators should be to assist in deterring fraud. It is important to recognize that these indicators are not proof of fraud, but rather factors which should be considered when evaluating potential fraud. The fraud indicators are listed in associated groups. Some of the indicators are repeated as they could promote awareness to a potential fraudulent scheme for more than one party. The list is not all-inclusive, and there are other indicators that should be considered when deciding if a situation is suspicious or fraudulent.

Underwriting/Policy Issuance Indicators

- More than one company name is listed on the correspondence or letterhead that is used to provide information for the issuance of the policy.
- Common owners are indicated on various applications.
- Multiple business operations are listed at one location.
- Requested coverages are inconsistent with the operation description(s) provided.
- The business name does not appear to be consistent with the type of work or operation of the insured.
- Insured's primary address is a post office box, suite number, or room number.
- The location provided by the producer/representative/agent is not consistent with the address provided by the insured.
- Past carrier or insurance records indicate significantly more payroll/premium.
- A significant deposit premium has been applied to the coverage to avoid interim premium audits.
- The operations do not substantiate the estimated payroll information (i.e., the expensive payroll classifications represent a low percentage of the total payroll, while the inexpensive payroll classifications account for the majority of the estimated total payroll).
- Requested coverage is for new business operations with a significant estimated payroll and/or multi-state exposures.
- Storefront or personnel locations are established in states with low rates, while the physical plants and/or operations actually take place in other states with higher rates.
- An insured's business operations are interstate operations, yet the only states of operation are those with the lower rates (e.g., a trucker who maintains facilities in Indiana and Tennessee only).
- The insured has a high experience modification factor with a relatively small premium.
- A change in the ownership of a business has occurred where the previous entity had poor loss experience and/or a high debit experience modification factor.
- A change in the ownership of a business diverts the ownership to other family members without effectively



changing control of the company.

- Several changes in name and/or ownership within the last three to five years.
- The corporate officers of a business are different from those originally listed on the submission.
- A leasing company has only its true parent as a client.
- Insured's business is depicted in initials.
- Number of employees, classification, and payroll are inconsistent.
- Number and type of claims reported are inconsistent with payroll/classification information.
- Certificates issued exceed anticipated exposure.
- Certificates issued to holders in states other than known exposures.
- Cross-outs and erasures are on applications.
- "New business" has multiple state exposures.
- A large number of endorsements to the policy.
- Minimum premium policy that adds significant payroll.

Interim Underwriting Indicators

- Requests for the issuance of a large number of endorsements to the original policy.
- Requests for certificates by the certificate holders exceed the anticipated exposure of the insured.
- Certificates issued to the holders are for states not indicated and/or for exposures not known.
- Addition of a significant amount of payroll to an estimated minimum premium policy.
- Requests to establish storefront or personnel locations in states with low rates while the physical plants and/or operations actually take place in other states with higher rates.
- The addition of multiple locations/multiple states not on the original policy is requested.

Premium Audit Indicators

- Insured's primary address is a post office box, suite number, or room number.
- Business name does not appear to be consistent with the type of work or operations of the insured.
- The estimated payroll and premium differ significantly from the prior year's audit.
- A high experience modification factor with a relatively small premium.
- Refusal by an insured to allow an audit or multiple rejections or conflicts which seriously delay the premium audit.



- Insistence by the agent/broker/representative or the insured that the audit be conducted at an off-site location.
- Insistence by the agent/broker/representative that he/she be present when the audit is being conducted.
- Business and daily financial records are always kept at a location other than where the business or audit is being conducted.
- Location visited is the same address previously visited to audit a different insured.
- No business logo, billboard, sign, or name is present at the location.
- Products, brochures, pictures, and/or trade journals displayed at the insured's location are not consistent with the insured's description of operations or the classifications indicated on the policy.
- A change in the ownership of a business has occurred where the previous entity had poor loss experience and/or a high debit experience modification factor.
- A change in the ownership of a business diverts the ownership to other family members without effectively changing control of the company.
- A leasing company with only its parent as a client.
- Letterhead bears more than one company name.
- Audit records provided are disorganized, and the volume of the records is insurmountable.
- Audit records provided are incomplete, altered, or incorrect.
- Lack of or altered Federal Form 941 or state unemployment reports, where required.
- Auditor cannot verify the accuracy of the records provided, including state and federal forms.
- Name on the policy is different from the name that appears on the federal or state forms.
- The corporate officers of a business are different from those originally listed on the submission.
- The operations do not substantiate the estimated payroll information (i.e., the expensive payroll classifications represent a low percentage of the total payroll while the inexpensive payroll classifications account for the majority of the estimated total payroll).
- Payroll for the first quarter audited exceeds the entire estimated annual payroll.
- A substantial increase in the payroll and/or premium, or conversely, a substantial decrease in the payroll and/or premium.
- Significant difference between the estimated policy payroll and the actual audited payroll.
- Certificates of insurance for the hired subcontractors appear doctored or falsified (all the certificates are through one agent and/or have sequential policy numbers or a common expiration date).



Risk Control Indicators

- Refusal by an insured to allow an inspection, or multiple rejections or conflicts, that seriously delays the risk control analysis.
- Insistence by the agent/broker/representative that he/she be present when the inspection is being conducted.
- No business logo, billboard, sign, or name is present at the location.
- Location visited is the same address previously visited for a different insured.
- Products, brochures, pictures, and/or trade journals displayed at the insured's location are not consistent with the insured's description of operations or the classifications indicated on the policy.
- Letterhead bears more than one company name.
- The operations do not substantiate the estimated payroll information (i.e., the expensive payroll classifications represent a low percentage of the total payroll while the inexpensive payroll classifications account for the majority of the estimated total payroll).
- The corporate officers of a business are different from those originally listed on the submission.
- A change in the ownership of a business has occurred where the previous entity had poor loss experience and/or a high debit experience modification factor.
- A change in the ownership of a business diverts the ownership to other family members without effectively changing control of the company.
- A leasing company with only its parent as a client.
- A high experience modification factor with a relatively small premium.
- Insured is not concerned about either the risk control analysis or the subject of employee safety.
- The OSHA Log substantially differs from the loss run data.
- Multiple business names are listed at the location.
- Number of employees is not consistent with the application.
- Classification verification is inconsistent.
- Information on the loss runs is inconsistent with the location.

Claimant/Employee Indicators

- The claimant is disgruntled, soon to retire, on probation, involved in union labor dispute, and/or facing imminent termination or layoff.



- The claimant is involved in seasonal work that is about to end.
- The claimant took unexplained/excessive time off prior to claimed injury and takes more time off than injury warrants.
- The claimant is nomadic with a history of short-term employment.
- The claimant is new on the job.
- The claimant is experiencing financial difficulties.
- The claimant recently purchased private disability policies.
- The claimant changes doctors when a release-for-work has been issued.
- The claimant has a history of reporting subjective injuries, and/or index report indicates high incidence of claims.
- The claimant is uncharacteristically familiar with workers' compensation system.
- The social security number provided does not belong to the injured worker.
- The claimant's home address is a motel/hotel or P.O. Box number.
- The claimant delays reporting injury for four weeks or more.
- The claimant cannot be reached at home telephone number.
- The claimant avoids use of the U.S. postal system.
- Phone conversations with the claimant reveal background noises that are inconsistent with home residence.
- Rehab report describes the patient/applicant as being well tanned, muscular, or inconsistent with someone off work and injured.
- The claimant protests to returning to work and never seems to improve.
- The claimant has a high absentee rate.
- Claimant had problems with fellow employees or supervisor prior to accident.
- Claimant has personal problems, such as sickness of other family member that requires someone to be home.
- Repeat claimant.
- The claimant has an extensive history of BI/PI claims.

Claims Indicators

- Number of days worked versus salary is inconsistent with occupation.



- Employee disputes average weekly wage due to additional income (i.e., cash, per diem, and/or 1099 income).
- There are cross-outs and erasures on the applications.
- Employer will not confirm wage information with documentation.
- Injury is not consistent with nature of business.
- Injured worker files for benefits in a state other than the insured's principal location.
- Injured worker is an undocumented alien.
- Employee's listed occupation is inconsistent with employer's stated business.
- Employee states his/her employer is other than what is declared on claim form.
- Neither employee nor employer can be contacted at the insured's principal location.
- The state in which the employee lives is different from the principal location of employer (other than border states).
- Employee disputes information supplied by the employer on the first report of injury notice.
- Employer refuses to cooperate in claim investigation.

Circumstances of Accident Indicators

- Accident is not witnessed by anyone, not even co-workers.
- Accident occurs late Friday afternoon or shortly after the employee arrives at work Monday morning.
- Injury rumored to not be legitimate and/or staged.
- Accident occurs in an area where employee would not normally be (e.g., office worker lifting on loading dock).
- Injury occurs at odd time (e.g., lunch hour).
- Claimant reports an accident after receiving notice of layoff, strike, job termination, or completion.
- Employer's first report of injury is different from the accident description in the medical history.
- Incident is not promptly reported, either to or by the employer.
- Details of accident are vague or inconsistent.
- Surveillance or "tip" reveals the totally disabled worker is currently employed elsewhere.
- After injury, injured worker is never home or spouse/relative answering phone states the injured worker "just stepped out."
- Return calls to residence have strange or unexpected background noises.



- No causal relationship between injuries and accident.

Medical Indicators

- Diagnosis is inconsistent with treatment.
- Physician is known for handling suspect claims.
- Medical reports are the first notice of injury/claim.
- Treatment for injuries is protracted and excessive or unnecessary, even though the accident was minor.
- Physician's medical reports are "boiler plate" or are identical to other reports from same doctor.
- Submitted medical bills and reports are photocopies and/or do not contain dates or description of office visits, and/or not signed, or stamped by treating physician.
- Treatment directed to a separate facility that is "next door" and in which the referring physician has a financial interest (especially if this is not disclosed in advance).
- Injuries are subjective (i.e., stress, headaches, nausea, inability to sleep, etc.).
- Treatment dates fall on weekends or holidays.
- Injured worker is immediately referred to multiple specialists and/or diagnostic clinics, especially when the claim is "stress."
- First notice mixes names and IRS numbers.
- Workers' compensation insurer and health care provider are billed simultaneously; payment is accepted from both.
- Amount of bill for treatment rendered is considerably higher than R.V.S. code allows.
- Injured worker does not seem to improve and protests to returning to work.
- Injured worker fails to keep doctor appointments and refuses a diagnostic procedure to confirm an injury.
- All soft tissue injuries. No objective injuries.
- Low back injury and/or soft tissue injury not conducive to surgery. There is over six months of chiropractic treatment or over thirty-nine treatments with a chiropractor or physical therapist.
- Only treated by chiropractor; never examined by medical doctor.
- Claimant flits from doctor to doctor.
- Several different doctors are involved, and no one doctor coordinates the medical treatment or takes control of the case.
- Physicians or chiropractors who will not consider claimant returning to work at any level as part of the



rehabilitation or treatment program.

- Claimant has long history of relationship with doctor, chiropractor, or attorney.
- Substantial gaps in treatment.
- Claimant has concurrent health problem that would necessitate being off work.
- Claimant has post-traumatic psychological stress-type claims.
- Location of treatment is inconsistent with home or employment locations.
- Treatment and/or diagnosis are not consistent with injuries.
- Claimant goes from treating with highly reputable, competent physician to treating with chiropractor.
- Excessive prescriptions are obtained by claimant.
- Prescriptions are from more than one pharmacy in different geographical areas which may be inconsistent with claimant's home or employment location.
- Prescribed pharmaceuticals are incidental to injury or illness.
- Disability which extends beyond the normal recovery period.
- Concurrent use of pharmaceuticals for other health problems.
- Sudden change in doctor's diagnosis.
- Copies of medical bills submitted instead of originals.

Claimant Attorney Indicators

The following issues may indicate a need for further investigation of claim activity:

- Attorney is known for handling suspicious claims.
- Attorney's lien or representation letter is dated the same day as reported incident and/or is the first notice of claim.
- Attorney and doctor are known to work as a pair.
- Applicant initially wants to settle with insurer, but then retains attorney with increased subjective complaints.
- High incidence of applications from a specific firm.
- Attorney inquires about a settlement or buy-out early in the life of the claim.
- Attorney's address is a post office box.
- Attorney's name appears on medical document prior to notice or representation.
- Multiple attorney substitutions and/or attorney constantly misses hearing/deposition appointments.
- Pattern of occupational type claims (i.e., black lung, asbestosis) for "dying" industries, wholesale claim



handling by law firms, and multiple class action suits.

- Attorney threatens further legal action unless a quick settlement is made.

Summary

This report has provided an insight into the recognition of both fraudulent schemes and premium avoidance that pervade workers' compensation insurance coverage. While this report is by no means inclusive of all the fraudulent schemes that may exist, it does provide a starting point to recognizing fraud.

Insurers alone cannot eliminate all fraud. Agents, insurers, and consumers must work together with law enforcement and other agencies in a coordinated and systematic way to close holes in the net which allow the fraud schemes to enter.

One of the most effective ways to attack the workers' compensation fraud problem is to catch the fraud criminal. Offenders need to know that people are being caught and sent to prison for this crime and are required to repay the monies that were stolen. Posters in the workplace that illustrate a worker in handcuffs, on the way to prison, serve to make some people think twice about stealing.

Review – Thirteen Key Indicators

The following may be used as general guidelines for further investigation into fraud activities:

- The alleged injury occurs late on a Friday afternoon, but is not reported until the following Monday, or the alleged injury occurs on a Monday morning.
- The accident occurs just prior to a strike, job termination, layoff, end of a project, or at the end of seasonal work.
- The accident was not witnessed by any other employees.
- Claimant has a history of previous claims.
- A substantial delay occurred in reporting the incident to the employer.
- There are differing descriptions of the accident as set forth in the medical history and the employer's first report of the claim.
- There are frequent difficulties in contacting the claimant at home when they are allegedly disabled.
- The claimant refuses a diagnostic procedure to confirm an injury or injurious condition.
- The claimant has disability policies that were recently obtained.
- The lawyer and/or treating physician are known for being involved in suspect claims.
- The claimant frequently changes physicians or medical providers.
- Claimant has received a release-for-work which is followed by the claimant changing physician or medical



provider.

- When two or more of the above indicators are present, there is a high probability of a fraudulent claim. The claim should be thoroughly evaluated and investigated.

References

1. Insurance Information Institute. "Insurance Fraud." New York, NY: III, July, 2011. <<http://www.iii.org/media/hottopics/insurance/fraud>>
2. Insurancefraud.org. Coalition Against Insurance Fraud. November 30, 2011. <<http://www.insurancefraud.org>>
3. National Insurance Crime Bureau. *Indicators of Workers' Compensation Fraud*. Des Plaines, IL: NICB, 2011. <Accessed November 30, 2011> https://www.nicb.org/theft_and_fraud_awareness.
4. ---. *Workers' Compensation and Medical Fraud, Creating Bitter Pills For Us To Swallow*. Des Plaines, IL: NICB, 2011. <Accessed November 28, 2011> https://www.nicb.org/theft_and_fraud_awareness/brochures.

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