

What is Workers' Compensation Fraud?

Claim fraud can be broken down into two categories:

1. Claimant fraud
2. Provider fraud.

Claimant Fraud

Claimant fraud occurs when a worker knowingly makes a false or misleading statement for the purpose of obtaining workers' compensation benefits. The most common type of claimant fraud is when a worker exaggerates his condition in order to continue benefits relating to the work related accident they suffered. Claim fraud can also occur when an employee files a claim for an accident that did not occur, injuries that do not exist or injuries that are not work related.

Types of Claimant Fraud to be aware of:

- Malingering – when an injured worker recovers from their injuries, however, continues to receive benefits.
- Receiving benefits while employed elsewhere – an employee who files a workers' compensation claim and collects benefits while claiming they are unable to work and works another job without reporting income/work status.
- Non-work related injury – when an employee claims he/she was injured at work, however the injury occurred while not engaged in work activities.
- Non-injury claim – when an employee fakes an injury in order to collect workers' compensation benefits. This often occurs after a layoff or plant closing announcement or rumor.
- Multiple claims – an employee who files multiple workers' compensation claims for the same injury.
- Prescription drugs – when prescriptions are misused for illegally resale.

Provider Fraud

Provider fraud occurs when doctors, medical practices or medical laboratories charge excessive fees for medical services performed or charges for work never performed. Provider fraud can also occur if the provider convinces the employee to file a workers' compensation claim in lieu of unemployment benefits claiming the individual can make more money. A less obvious form of provider fraud could be unnecessary tests or treatment, even if the injury is legitimate and some form of treatment is needed.

Types of Provider Fraud to be aware of:

- False billing – when a doctor, clinic or lab bills for services not performed.
- Kickbacks – a medical provider who pays or receives compensation for a patient referral.
- Self-referrals – a medical provider who inappropriately refers patients to clinic or laboratory in which the provider has a financial interest
- Upcoding – a provider who bills for a more expensive treatment or service than what was performed
- Unbundling – a provider that performs a single service and bills it as a series of separate procedures.
- Over-utilization – a provider administers and bills for unnecessary medical services
- Product switching – a provider or pharmacy that bills for one type of product but dispenses a cheaper version.

Nine Elements of Common Law Fraud

In order to prove fraud certain requirements must be met before a prosecution can be pursued. Below are the nine elements in the Law that are necessary to prove fraud:

1. *Representation* – the simplest type of representation is an affirmative statement of a fact made directly by the person claiming the false claim. It can also be a statement that one has no knowledge of a fact or issue or an intentional understatement or overstatement of cost or value.
2. *Falsity* – to prove fraud the representation must not be true.
3. *Materiality* – a “material representation” is one that would be likely to affect the conduct of a reasonable person with regards to transaction that is subject of the claim.
4. *The Speaker’s Knowledge of Falsity or Reckless Disregard of the Truth* – the person making the statement must either know the statement was false, or be aware that they lack the knowledge as to its truth or falsity. Showing the representation was made recklessly without the knowledge of the truth or falsity can also prove fraud.
5. *Intent that Representation be Acted Upon* – the intent of the speaker must be to mislead or deceive the hearer.
6. *Hearer’s Ignorance of Falsity* - the hearer was not aware that the statement was false.
7. *Reliance* – the hearer must rely on the speaker’s representation.
8. *Hearer’s Right to Rely* – the hearer has a right to rely on the speaker’s representation.
9. *Damages* – damages are considered “general” and “punitive”. General damages are the amount paid as a result of the fraudulent representation. Punitive damages are provided by a showing of egregious conduct on the part of the defendant.

Everyone plays a role in combating fraud. Being aware of some “red flags” will help prompt additional questions and/or investigations into these issues.

These are some “Red Flag” indicators to be aware of:

- Accident occurs on a Monday morning or late on a Friday and is not reported until the following Monday. What occurred over the weekend or during days off?
- The accident occurs just prior to a strike, plant closing, layoff, job termination or end of seasonal work..
- Accident was unwitnessed by any fellow employees.
- Injured worker has a history of prior claims.
- Substantial delay between date of incident and date reported to supervisor.
- Different descriptions between employer’s accident investigation and medical provider’s report.
- Difficulties reaching injured worker at home during disability period.
- Injured worker’s attorney or medical provider is known for being involved in suspect claims.
- Injured worker switches medical providers frequently.
- After receiving a release to return to work, injured worker switches physicians.
- Injuries are minor (strain/sprain), but requires excessive treatment and lost time.
- Date of services do not correlate with the date of injury.
- Injured workers from the same insured are all using the same medical provider or attorney.

What Can You Do to Stop Fraud?

An employer is the first line of defense. Fraud prevention should be an important function of your accident investigations process. Below are some steps that can be added to your accident investigation to assist in preventing fraud:

- Immediately following an accident or incident complete a full accident investigation.
- Take statements from all witnesses.
- Have the injured worker give a written statement in his/her own words, and include the “fraud warning language” on the statement form they sign. (see sample forms is located at the end of this document)
- Keep disposable cameras available for supervisors. Photos can be very helpful for subrogation issues, safety committee meetings and the carrier’s investigations.

If any type of fraud is suspected then immediately report it to the Division of Confidential Investigations:

Albany	(518) 437-8083
Buffalo	(716) 851-2111
Endicott	(607) 741-3997
Nassua & Suffolk	(631) 756-4006
New York City	(212) 312-7302
Rochester	(585) 258-2023
Syracuse	(315) 453-6651
White Plains	(914) 997-4905

Fraud can also be reported on-line by accessing the State Insurance Fund’s web site at www.NYSIF.com or by contacting us at (914)381-5511.

