Workers' Compensation
Fraud Prevention Procedures

The ACWA JPIA is dedicated to consistently and cost effectively providing the broadest possible affordable coverages to its member agencies. One of the basic tenets of accomplishing this mission statement is to fairly settle all legitimate claims. This means ferreting out those claims that are illegitimate or fraudulent.

From time to time employees will claim injuries or disabilities and give obscure or vague histories. In other cases, your experience will indicate that the employee's complaints are not work related; and there may be instances in which you have reason to believe the employee's claim is not bona fide.

In all such cases, personnel who are reporting industrial injuries should take a careful chronological history from the employee, then immediately telephone the JPIA. We will arrange for investigations, medical opinions and/or medical treatment as indicated and necessary.

You need not and **should not** be drawn into arguments with employees over questionable claim situations. If questions come up that you cannot answer, advise your employees that the matter will be referred to the JPIA for immediate attention at (800) 231-5742.

SB 1218 - Fraud Legislation

Effective January 1, 1992 the Workers' Compensation Fraud Legislation SB 1218 was enacted prohibiting the following:

- Making any knowingly false material statement or material representation to obtain or deny workers' compensation benefits;
- Presenting any knowingly false material statement in support of, or in opposition to, any claim for workers' compensation benefits ("statement" includes notices, proof of injury, bills and payments for services, test results and medical/legal expense);
- Knowingly assisting persons who engage in unlawful conduct proscribed under this section; and
- Making knowingly false statements regarding entitlement to benefits with the intent to discourage an claimant from pursuing a claim.

It also includes provisions to:

- Increase penalties for "capping", prohibit misleading advertising, prohibit "kickbacks" to attorneys and doctors involved in workers' compensation insurance;
- Create the Workers' Compensation Insurance Fraud Reporting Act to:
    1) Require insurers to release relevant information to the Fraud Bureau and to report workers' compensation insurance fraud to the Fraud Bureau; and
    2) Provide civil protection for those releasing information; and
- Assess insurers and self-insured employers a surcharge to create a fund for increased investigation and prosecution of workers' compensation insurance fraud.

This anti-fraud legislation was enacted to hopefully prevent, or at least to reduce, workers' compensation insurance fraud and to assist in restoring confidence and faith in the system. In addition, workers' compensation fraud harms districts by contributing to higher costs of the program.

If fraudulent activity is suspected, the JPIA retains special investigators with law enforcement backgrounds to blend with our insurance expertise, creating a team to

attack fraud as soon as it is identified. We also retain medical professionals including physicians and case management nurses to assist in the process. They advise us if they see evidence of fraud within their specialty. The most important aspect of fraud control is early communication by the Member agencies. If you or anyone within the agency suspects fraud or observes suspicious behavior relative to a claim, the JPIA needs to know.

Workers' Compensation Fraud Key Indicators

1. The alleged injury occurred on a Monday morning or occurred late on Friday, but was not reported until the next Monday.

2. The accident occurred just prior to a strike, job termination, layoff, end of a project or at the end of seasonal work.

3. The employee (claimant) reported an injury three or four months after it allegedly occurred.

4. The claimant started work shortly before the alleged incident.

5. The loss was reported after the employee was terminated.

6. The loss was reported immediately after notice of probation or other disciplinary action.

7. The claimant was found to be employed while collecting temporary disability benefits.

8. The accident was not witnessed by any fellow employee or witness accounts conflict with one another, or differ from the claimant's version.

9. The claimant had a history of previous claims.

10. Surveillance documented activity that was inconsistent with the claimant's description of the limitations imposed by a physician.

11. The claimant was overly pushy and demanding of a quick settlement, commitment or decision.

12. The claimant was unusually familiar with the claim handling procedures, workers' compensation rules, laws and proceedings.

13. The claimant consistently failed to keep appointments and/or was generally uncooperative.

14. The claimant had no known permanent address or moved frequently.

15. The alleged injuries were all subjective; i.e. pain, headaches, nausea, inability to sleep or eat, etc.

16. Medical reports or bills appeared to have been altered, are third or fourth generation copies or were suspicious in some other way.

17. The claimant was rarely home when called and the message taker was very vague and non-committal.

Transitional Duty Note:

For an employee attempting to pursue a fraudulent claim, a well-advertised Transitional Duty Program may act as a deterrent. He or she will see that all employees continue to work in jobs suited to their physical limitations. The employee may be less likely to claim an injury fraudulently as a means to get time off work.