DATA · ANALYTICS DECISION SUPPORT MAY 2008
ISO REVIEW
NEWS AND ANALYSIS FOR INSURANCE EXECUTIVES

Workers Compensation Fraud: Challenges and Solutions

In this Issues Forum edition of ISO Review, *Thomas Mulvey, national director of Claim and SIU Services at AISG, a division of ISO, addresses fraud fighting in the workers compensation industry.*

What are some key challenges in fighting workers compensation fraud?

Workers compensation is designed to provide medical care and lost wage benefits for injured workers. But the system is often plagued by fraud. As with any coverage, individuals who see workers comp as an easy revenue source can manipulate it to their advantage. The National Insurance Crime Bureau has estimated workers comp fraud at $5 billion annually.

One challenge in fighting this type of fraud is that the crime assumes a variety of forms. Another difficulty is that both lawmakers and insurers must provide solutions. Reversing public acceptance of insurance fraud is another important factor. According to a 2003 survey by Accenture Ltd., nearly one out of four Americans feels it's acceptable to defraud insurers. The insurance industry has a lot of work to do to change the public's tolerance of this type of crime.

What are some examples of claimant abuses?

The most well-known type of workers comp fraud is perpetrated by claimants who exaggerate or lie about injuries, collect

benefits after recovering, or receive benefits from one job while employed elsewhere. A New York City Transit Authority bus driver collected $13,000 in benefits for a shoulder injury while touring Europe as a drummer with a band. In 2007, authorities set up a sting at one of the band's concerts, where the claimant unwittingly signed CDs for the investigators who had tracked her down.

Do businesses also perpetrate workers comp fraud?

The potential for premium fraud is vast. There is a risk with every policy. According to the Washington State Department of Labor and Industries, key indicators of premium fraud include employers who operate businesses without proper licenses or registrations, employers who pay workers in cash, and employers who pay for injured employees' medical bills rather than reporting the accident to a workers comp carrier.

Premium fraud occurs when businesses reduce workers comp premiums by unscrupulous means. Some firms may not account for all employees on the payroll. Others may misrepresent employees' jobs — such as a construction company with an inordinate portion of clerical workers (low risk of injury) versus construction "on-site hard-hat" workers (higher risk of injury) — or designate workers as contract employees. Still other companies may hide a history of injuries and risk by changing their name and reorganizing.

Is there also fraud potential in the medical provider arena?

Medical providers can seize upon workers comp cases to make hefty profits. Doctors may bill for tests and procedures that never took place or prescribe extensive treatments for minor injuries. A December 2006 Workers' Compensation Fraud Report by the Washington State Department of Labor and Industries tells of an owner of a Spokane hearing aid company who was found guilty of billing the Department of Labor and Industries $132,000 for hearing aids that he never provided. He also billed for top-quality hearing aids but provided used or less expensive models.

Red flags for provider fraud include treatment regimens beyond the norm for a particular injury, professionals with repeated claim histories, "cookie cutter" medical treatments and billing records, and high incidences of prescribing numerous prescription drugs.

How are insurers addressing workers comp fraud?

Reducing workers comp fraud requires a range of initiatives. One positive development is that state insurance departments are creating more stringent regulations and increasing resources for state fraud bureaus. In many instances, the increase in resources is funded by the insurance industry.

What are some key fraud-fighting initiatives?

Opportunities for fraud are curtailed as legislators strengthen workers comp laws. Those measures should be bolstered by continuing efforts to alter the public's tolerance of insurance fraud.

In 2007, a bill was signed in New York that will help combat fraud as part of a workers comp overhaul. An investigation resulted in the arrest of ten suspects in a workers comp fraud scheme totaling more than $110,000. One former New York City Housing Authority employee began collecting benefits in 1983. He then took another construction job and illegally collected $19,365 in workers comp benefits in 2003 and 2004.

In May of 2007, California Insurance Commissioner Steve Poizner formed a blue-ribbon Advisory Task Force on Insurance Fraud. A multicounty sweep in that year netted the arrests of dozens of individuals, including the owner of a farm labor service company who failed to report and/or misclassified approximately $4 million in employee payroll, resulting in $900,000 in losses to the State Compensation Insurance Fund and approximately $500,000 in losses to the Employment Development Department.

How are insurers using technology to fight workers comp fraud?

Antifraud technology is one of the most effective ways to combat workers comp fraud in the insurance industry. The arsenal of fraud-fighting tools includes an all-claims database, as well as link analysis, data visualization, and claims scoring tools.

Underwriting, loss, and treatment data are all sources of checks and balances that should be queried to avoid lost premium and fraudulent claim payments. Fortunately, new technology enables carriers to run automated queries against such data. Insurers are using sophisticated software and databases to systematically spot employee, employer, and provider fraud, according to Neil Johnson, who investigates

workers compensation fraud for Liberty Mutual, a leading writer of that coverage. Johnson adds that knowing what to look for and where to find it protects honest claimants, policyholders, and caregivers from the negative impacts of fraud.

How is ISO contributing?

For insurers, data is the key to discovering workers comp fraud. By analyzing the claims and premium data insurers already collect, investigators can discover hidden fraud indicators and catch the individuals, businesses, and providers who perpetrate workers comp fraud.

ISO's Premium Audit Advisory Service (PAAS®) is involved in the battle against workers comp premium fraud. PAAS is developing a predictive modeling system that reviews workers comp applications, employer payrolls, employee classifications, and other factors that determine premiums. The system will generate a score that may indicate whether a business is falsifying information to reduce premiums.

ISO Claims Outcome Advisor® (COA™) also helps users manage bodily injury and workers compensation claims by producing accurate and consistent loss estimates covering a wide range of damages. For workers comp, COA helps develop the optimal return-to-work plan for each individual. COA provides data for active claims management and documents to facilitate communication among all the parties to a claim.