WORKERS COMP

California's latest comp reforms target fraud

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After passing reforms aimed at reducing workers compensation costs in 2012, California legislators and workers comp professionals are implementing more changes to the system, but this time they are targeting provider fraud.

Increased awareness of fraud helped prompt two anti-fraud measures last year and more action is expected.

Nationally, workers comp costs are lower than 10 years ago, but fraud remains a big problem, said Carol Murphy, Wilmette, Illinois-based managing director at Aon Risk Solutions.

In California, the high-profile prosecution of medical providers has highlighted the problem, said Vanessa Gillis, Sacramento, California-based special investigations unit manager at Sentry Insurance.

"It's been a wake-up call for people to see the exorbitant high costs of medical provider fraud within the workers compensation system. It has really captured the attention of many," Ms. Gillis said.

Many of the prosecutions were in Southern California, including a $580 million fraud involving kickbacks paid to chiropractors and doctors connected with Pacific Hospital of Long Beach (see related story). That case "was a turning point on showing how we can stop pervasive medical provider fraud in California," said Bill Zachry, San Francisco-based senior fellow at The Sedgwick Institute, a research arm of Sedgwick Claims Management Services Inc.

The current crackdown on workers comp fraud in the state is a consequence of Senate Bill 863, a workers comp reform bill enacted in 2012, experts said.

"S.B. 863, which was negotiated by labor and management to increase benefits, reduce frictional costs, and improve medical delivery, also offered the opportunity to have a more transparent system which allowed us to evaluate where there are problem areas," said Christine Baker, San Francisco-based director of California's Department of Industrial Relations.

The measure provided a framework for developing an anti-fraud strategy, said Carmichael, California-based Amanda Gualderama, West regional government affairs director at Sentry Insurance. "It was able to create the independent medical review process, the independent bill review. This is where we are getting all of the data to be able to make these connections into the fraudulent activities," said Ms. Gualderama.

In 2016, two measures targeting fraud were passed — Assembly Bill 1244 and Senate Bill 1160.

A.B. 1244 banned providers from treating patients within the workers comp system if they have been convicted and precluded from treating Medicare and Medicaid patients. The bill went into effect in January.

"There was an investigative series in early 2016 that had shone light on certain physicians who were banned from treating within the Medicare and Medicaid system and they were simply moving their practices, including some of their fraudulent practices, into the workers comp system because there was nothing that precluded them from doing that," said Ms. Gualderama.

S.B. 1160 focused on the widespread liens filed in workers comp courts. It required medical providers to cite the legal authority they relied on to file their claims and banned providers that were charged with medical fraud from collecting lien dollars until their cases were concluded.

"Prior to S.B. 1160, these fraudulent providers ... were basically taking unapproved medical care that insurers did not deem appropriate or medically necessary and, when they were denied payment, the providers would go to court and file a lien or often sold the rights to these liens to collection firms," Ms. Gualderama said.

And more action to stifle fraud in the state is expected.

In March, state Assemblyman Tom Daly, in a letter addressed to Assemblyman Al Muratsuchi, chairman of the audit committee, requested an audit for possible fraud in the state's workers comp system. Results of the audit are expected in October, according to a spokeswoman from Assemblyman Muratsuchi's office.

In the beginning of the year, the California Department of Industrial Relations made workers comp fraud a priority.

"The labor secretary has directed us to focus in on fraud and we have been making recommendations. We have been taking direct action administratively and through negotiations with the parties to really focus on anti-fraud measures. We are working closely with the department of insurance through a (memorandum of understanding) to share data back and forth and take steps in sharing information," said Ms. Baker.

NUMBER OF LIENS FILED IN CALIFORNIA

Source: The Workers' Compensation Insurance Rating Bureau of California, 2016

KICKBACK SCHEME COSTS COMP SYSTEM $580 MILLION

In 2014, Michael D. Drobot, former chief executive officer and owner of Pacific Hospital of Long Beach, pleaded guilty to charges connected to a workers compensation fraud scheme that collected hundreds of millions.

The scheme illegally referred thousands of patients for spinal surgeries and generated $580 million in fraudulent billings over a 15-year period, according to the California Department of Insurance.

Mr. Drobot and others billed workers comp insurers and the U.S. Department of Labor for hundreds of spinal surgeries and other procedures performed on patients. The medical professionals who referred them were paid illegal kickbacks of $15,000 for each lumbar fusion surgery and $10,000 for each cervical fusion surgery, the department said.

In 2015, Studio City, California-based orthopedic surgeon Philip Sobol, Las Vegas-based chiropractor Alan Ivar, Orange, California-based health care marketer Paul Richard Randall, and Irvine, California-based orthopedic surgeon Mitchell Cohen were charged in connection with the scheme.

"Health care fraud and kickback schemes burden our healthcare system, drive up insurance costs for everyone, and corrupt both the doctor-patient relationship and the medical profession

itself," said United States attorney Eileen M. Decker in a statement last year. "The members of this scheme treated injured workers and their spines as commodities, to be traded away to the highest bidder."

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SPECIAL REPORT

Claims experts use data analytics to combat workers comp fraud

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Claims fraud continues to drive workers compensation costs up, driving payers to look for new ways to combat it.

Much like on the underwriting side of the insurance business, data and the use of technology to analyze it is seen by experts as a major development in improving efficiency and detecting problems.

The use of technology to sift through massive amounts of data to spot trends and anomalies will help claims professionals spot fraud more quickly, experts say.

Given the state-based workers comp system, it's hard to get firm estimates on workers comp fraud nationally, but a figure often quoted for the whole property/casualty sector is the National Insurance Crime Bureau's estimate that it's a $30 billion annual problem in the U.S. The NICB does not provide an estimate for the workers comp sector alone.

Widely reported examples of workers comp claims fraud include false claims, working while collecting benefits, payroll and employee misclassification, malingering injuries and medical fraud.

Part of the difficulty in assessing the level of workers comp claims fraud is the limited verifiable fraud data.

"In my personal practice I see exaggerations, I see malingering, I see a lot of suspicious activity. The amount of time when that rises to the level of actionable fraud is fairly limited," said Chicago-based Rich Lenkov, attorney at Bryce Downey & Lenkov L.L.C.

However, the emergence of new technology is creating news ways to detect claims fraud. "There has always been fraud, but it's becoming more easily detectable," said Timothy Hopper, Stevens Point, Wisconsin-based special investigations unit major case manager at Sentry Insurance.

In 2016, close to 76% of insurers had integrated technology in their anti-fraud systems, with claims fraud detection leading, according to a 2016 study conducted by the Washington-based Coalition Against Insurance Fraud.

"When it comes to detecting fraud, technology is absolutely critical to the success of our program ... from a technology standpoint, data is the key — billing data, prior claim history data — so we can look at a situation where we may have a suspect claim involving a questionable medical provider. Our technology allows us to go out and look at other claims that match that same pattern. We can go out and look at other claims where that particular provider was involved, and we can compare billing patterns," said Mr. Hopper.

And technological applications can detect fraud that might not be spotted by claims professionals.

"We use various tools like predictive models and analytic rules to try to find claims that might not have come to us from a reactive level but have certain elements that make it seem like there is a potential for fraud or have similar elements we have seen on prior fraud cases," said Charlotte, North Carolina-based Eric Bushman, director of the commercial insurance special investigations unit at Liberty Mutual Insurance Co.

As a result, investigators can jump on cases based on the models rather than wait to be notified of suspicious claims, he said.

While technology has led to new ways to tackle the issue of detecting workers comp claims fraud, there are common red flags that can help identify fraud. Some of these red flags include the employee having a history of claims, no witnesses to the incident, the employee not reporting the injury or illness in a timely manner and the injury coinciding with a change in employment status, a Broadspire Services Inc. spokesman said in an emailed statement.

"Questionable or excessive medical treatment is a big red flag, a claimant that is hard to reach is suspicious, Monday morning reports of injury are always ones to scrutinize, and someone with a long history of claims inherently will be one that I look closely for suspicions of fraud," said Mr. Lenkov.

Conflicting accident histories can also signal fraud, he said.

"It shouldn't be complicated to tell your employer or medical providers how you got hurt if you legitimately got hurt," Mr. Lenkov said.

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