

# ADDRESSING WORKERS' COMPENSATION FRAUD IN LOS ANGELES COUNTY

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September 2004

**CITIZENS'  
ECONOMY  
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& COMMISSION**  
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September 14, 2004

The Honorable Don Knabe  
Chairman, Los Angeles County Board of Supervisors  
Room 822, Hahn Hall of Administration  
500 West Temple St.  
Los Angeles, CA 90012

Dear Chairman Knabe;

Over the past several years the cost of workers' compensation has become increasingly burdensome for the County. After a review of this situation it became clear that one major area in which the County can have a direct impact is in the management of fraud and abuse within the system. As a result the Commission undertook a study to identify those actions that could be taken to assist the County in minimizing fraud and abuse within the workers' compensation system. The attached report is the product of these efforts.

The Commission hopes these recommendations will provide a meaningful basis for the development of a comprehensive program to address improvements throughout the system. As always the Economy and Efficiency Commission stands ready to assist your Board and County management in the implementation of these recommendations and/or in any other manner that you would deem appropriate.

Sincerely,



Robert Philibosian  
Chairman

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## Acknowledgments

The Economy and Efficiency Commission  
would like to acknowledge the contributions made by the following individuals:

California State Senate

Senator Charles Poochigian and staff

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Mr. Alex Rossi

Los Angeles County District Attorney

Mr. Curt Livesay

Mr. Tom Higgins

Mr. John Portillo

Los Angeles County Counsel

Mr. Patrick Wu

Metropolitan Transportation Authority

Ms. Pamela Murano

## I. EXECUTIVE SUMMARY

Within California the rise of workers' compensation costs has become a major concern for both the private and public sectors of the economy. Accompanying the increase in these costs has been a corresponding increase in the opportunities for fraud and abuse within the system.

In fiscal year 2002-2003 the total County workers' compensation costs exceeded \$290 million. These costs included pay as you go payments for medical treatment, temporary and permanent disability indemnity, rehabilitation, life pensions, death benefits, salary benefits for fire and law enforcement, legal and investigative services, third party administrator's fees and all administrative costs incurred by County staff. These costs, as of December 2002, covered a total County employment of 91,588 personnel, 20,970 total open claims, 1,957 employees off duty as a result of industrial injuries and 913 employees off duty as a result of non-industrial injuries. Since that time costs have continued to increase with open claims rising to approximately 25,000.

This report considers how Los Angeles County can deter, detect, investigate and prosecute fraud and abuse in the workers' compensation system. Having reviewed the elements which comprise the system, this report makes 46 recommendations in 11 operational areas for the purpose of reducing the possibility for fraud and abuse.

### The Five Highest Priority Recommendations in this Report are that the Board of Supervisors:

- Articulate a policy addressing workers' compensation costs, including the deterrence, detection and prosecution of fraud and abuse within the program. **(Recommendation 17)**
- Consistent with the workers' compensation policy articulated by the Board, direct the County's Risk Manager to develop an anti-fraud strategy that addresses the fraud prevention needs of the County, develops program objectives that are specific, measurable, realistic, time sensitive and performance based, and ensures the effective utilization of risk management resources. **(Recommendation 18)**
- Direct the Auditor-Controller, in coordination with the Chief Administrative Officer and affected departments, to create an annual report on workers' compensation costs that:
  - a. Analyzes each of the elements of workers' compensation and delineates the County's costs by department.
  - b. Identifies the amounts expended in workers' compensation as a percent of the salary/employee benefits costs for each department in order that comparisons of these percentages can be made to other similar local, county, and state departments.
  - c. Identifies the cost changes from year to year. **(Recommendation 19)**
- Direct the County's Risk Manager to develop a database for workers' compensation claims that has as its objective the measurement of, among other things, the nature and extent of fraud and abuse in the workers' compensation system. **(Recommendation 25)**

- Direct the Chief Administrative Officer to develop a process that will enable the County actively to participate in the creation of its workers' compensation physician networks and establish criteria for the selection of health care providers. **(Recommendation 33)**

## **Listing of Recommendations for the Board of Supervisors to Address Workers' Compensation Fraud Deterrence:**

### **SOUND HIRING PRACTICES**

1. Direct that the Department of Human Resources review the County's hiring practices to ensure that all possible steps have been taken, including possible testing for illegal drugs and alcohol, to identify those applicants that may be predisposed to engage in unsafe working practices.

### **TRAINING**

2. Direct that the Department of Human Resources, in coordination with the County's Risk Manager, train all employees on the proper use and application of workers' compensation benefits, the prevention and detection of fraud and abuse in the workers' compensation system, and the impacts of fraud and abuse on the County and each County employee.
3. Direct that the Department of Human Resources, in coordination with the County's Risk Manager, expand the training of managers and supervisors on workers' compensation issues so that they can help identify and solve problems and understand how injuries decrease productivity, add to workers' compensation costs, and impact County programs.

### **COMMUNICATIONS**

4. Direct the County's Risk Manager, in coordination with the Public Affairs Office, internally to publicize the County's anti-fraud message, highlighting anti-fraud actions and convictions, using such methods as a regular segment in the County News, a special program on the County TV channel, and other appropriate communication vehicles.
5. Direct the Chief Administrative Officer to develop and implement a countywide policy that establishes when and how information on fraud related matters is to be released to the media.
6. Direct the County's Risk Manager to develop and implement measures to ensure that employees are informed of both their rights and responsibilities at the time of their injury and an explanation of the criminal, civil and administrative penalties for fraudulent or abusive claims.
7. Direct the Public Affairs Office to expand how it displays and publicizes the County's Fraud Hotline number, emphasizing the need to report the fraud and abuse of the workers' compensation system.
8. Direct the Public Affairs Office to expand how it displays and publicizes workers' compensation fraud and abuse posters.
9. Direct the Auditor-Controller, in coordination with the County's Risk Manager, on a quarterly basis, distribute workers' compensation fraud and abuse information with the payroll.
10. Direct the County Risk Manager to develop and present periodically on-site briefings with employees to discuss workers' compensation policies and procedures, emphasizing the fundamentals of the workers' compensation program, what to do when an injury occurs, and the County's policy on fraud and abuse and return to work.
11. Direct that the Department of Human Resources, in coordination with the County's Risk Manager, provide the County's workers' compensation policy to all new hires and require that they sign an acknowledgement that they have read and understood the policy. The policy should include, but not necessarily be limited to, the following:
  - a. Basic information on how the State's Workers' Compensation Program works.



- b. The procedures to be followed when treating an injured employee including, if applicable, telling injured employees which health care providers have been selected for use and why they have been chosen.
- c. A statement of how and to whom industrial injuries are to be reported.
- d. An explanation of the employee's obligations and the rules to be followed while receiving workers' compensation benefits.
- e. A policy on the return-to-work program together with a specific statement emphasizing the fact that work will be found for injured workers as soon as they can return to transitional duty.

12. Direct the County Risk Manager to publish and distribute the Workers' Compensation Policies at least annually to ensure that all employees understand the program and how it works.

13. Direct that the Auditor-Controller place a statement above the endorsement on workers' compensation checks certifying that the recipient is entitled to the disability payment.

14. Direct the County's Risk Manager to develop and implement measures to ensure that the County maintains contact and a positive relationship with the injured worker, even in situations that may seem suspicious. These measures should include a requirement that employees receiving workers' compensation benefits should also be required to periodically sign forms, in person, acknowledging that they have been informed of the rules and that they are accurately representing the facts that entitle them to the benefits that they are receiving.

#### **SAFETY**

15. Direct the Chief Administrative Officer to develop and implement a written safety program that achieves 100% safety awareness for employees and, using the approaches proposed in this program, conduct a countywide safety inspection designed to eliminate as many potential safety problems as possible.

16. Direct the Chief Administrative Officer to develop and implement countywide procedures that increase the attention being paid to any complaints or concerns over working conditions, including an employee safety hotline and insuring every effort to address these complaints in a timely manner.

#### **ANTI-FRAUD STRATEGY**

17. Articulate a policy addressing workers' compensation costs, including the deterrence, detection and prosecution of fraud and abuse within the program.

18. Consistent with the workers' compensation policy articulated by the Board, direct the County's Risk Manager to develop an anti-fraud strategy that addresses the fraud prevention needs of the County, develops program objectives that are specific, measurable, realistic, time sensitive and performance based, and ensures the effective utilization of risk management resources.

19. Direct the Auditor-Controller, in coordination with the Chief Administrative Officer and affected departments, to create an annual report on workers' compensation costs that:

- a. Analyzes each of the elements of workers' compensation and delineates the County's costs by department.
- b. Identifies the amounts expended in workers' compensation as a percent of the salary/employee benefits costs for each department in order that comparisons of these percentages can be made to other similar local, county, and state departments.
- c. Identifies the cost changes from year to year.

20. Direct the Chief Administrative Officer to analyze recently adopted state workers' compensation reforms to determine how these reforms may impact the recommendations made in this report.

21. Direct the Chief Administrative Officer to establish a special Workers' Compensation Task Force to assist the County's Risk Manager in the development of a strategy to reduce workers' compensation costs.

# **Listing of Recommendations for the Board of Supervisors to Address Workers' Compensation Fraud Detection:**

## **STAFFING**

22. Direct the County's Risk Manager to review periodically the policy, along with its implementation, that requires departments, or in some cases the Chief Administrative Office, to make an offer of light or modified duty.
23. Direct that the Department of Human Resources conduct a staffing review to consider the following:
  - a. Whether an increase in the staffing level of the Special Investigation Unit above the current 1 full-time employee and 1 part time employee would result in increased savings to the County.
  - b. Whether it would be beneficial from a cost standpoint to fund a County dedicated investigator(s) within the District Attorney's Office.
  - c. Whether it would be beneficial to join other self-insured employer's (e.g. MTA, LAUSD, the City of Los Angeles, etc) to co-fund dedicated investigators to investigate exclusively workers' compensation claims for the participating public agencies.

## **INFORMATION TECHNOLOGY**

24. Direct the County's Risk Manager to develop a database for workers' compensation claims that has as its objective the measurement of, among other things, the nature and extent of fraud and abuse in the workers' compensation system.
25. Direct the County's Risk Manager to develop uniform reporting requirements for organizations involved in workers' compensation anti-fraud activities that maximize the use of current reporting requirements in an effort to avoid duplication.
26. Direct the Chief Administrative Officer to expand upon return to work strategies using the workers' compensation claims database, along with any other information that may be available.
27. Direct that the County's Risk Manager monitor program areas such as Continuation of Pay (COP) to develop trends involving potential increases or decreases in workers' compensation program costs.
28. Direct that the County's Risk Manager utilize investigative management software to assist in the effective utilization of the Special Investigation Unit (SIU) resources.
29. Direct that the County's Risk Manager expand the analysis of the County's claims history.
30. Direct the County Counsel to investigate whether the legal right to receive State data extends to the County's anti-fraud program. If not, direct the Chief Administrative Officer to express the desire of the Board to the County Advocates to pursue legislation that would enable the workers' compensation anti-fraud program to receive such data.
31. Direct that the County's Risk Manager review the current usage of predictive modeling with the objective of understanding its application to the identification of fraud and abuse and ascertain whether such an approach would make a cost effective contribution to its anti-fraud program.
32. Direct the Chief Administrative Officer to develop a process that will enable the County actively to participate in the creation of its workers' compensation physician networks and establish criteria for the selection of health care providers.
33. Direct the Chief Administrative Officer to coordinate the group health program and the workers' compensation program.

## ACCOUNTABILITY

34. Direct the County's Risk Manager to review periodically those measurable levels of achievement that would define a successful workers' compensation fraud program and measure overall system performance, particularly data on the management and operations of available investigative resources, i.e., reduction in new claims vs. dollars spent on the program.

35. Ensure that management devotes an appropriate level of attention to the issues of workers' compensation fraud and abuse by making compliance with the overall strategy and cost reduction objectives a part of the department head's performance review.

## CASE MANAGEMENT

36. Direct that the County's Risk Manager periodically review procedures with the objective of ensuring claims are reported immediately to enable the County to reduce its workers' compensation costs.

37. Direct that the County's Risk Manager periodically review procedures with the objective of ensuring timely follow up actions on cases.

38. Direct that the County's Risk Manager to review periodically case files on all open/active claims, no matter how old, to ensure that they are being maintained.

39. Direct that the County's Risk Manager to review procedures periodically to ensure that current medical evidence is continually received so the employee may be returned to duty as soon as possible.

40. Direct the County's Risk Manager to ensure, through inspection and operational review, that Third Party Administrators have aggressive fraud units.

## INTERAGENCY COORDINATION

41. Direct the Chief Administrative Officer to pursue increased coordination among the investigative organizations of the County, the MTA, the City of Los Angeles, the District Attorney, the California Department of Insurance Fraud Bureau, and other appropriate agencies, possibly through the creation of a coordinating body, in order to maximize the effective use of scarce resources, to identify fraud detection methodologies and to seek mutual assistance.

# **Listing of Recommendations for the Board of Supervisors to Address Workers' Compensation Fraud Investigation and Prosecution:**

42. Direct the County's Risk Manager to develop a countywide protocol for the investigation of workers' compensation claims.

43. Direct County departments to investigate all accidents involving their employees using a Departmental Accident Review Team.

44. Direct the County's Risk Manager to develop a countywide protocol to ensure that there is early incident intervention for every accident.

45. Direct that the appropriate claims personnel always interview both the claimant and physician.

46. Direct the County Counsel to review the ramifications of having employees who are leaving County employment sign a Workers' Compensation Release Form, and prepare such a form, if deemed appropriate.

## II. INTRODUCTION

The California workers' compensation system is designed to limit litigation against employers by ensuring that injured workers receive the treatment reasonably necessary to cure and relieve the effects of any disability that may have been incurred on the job. The program, which is funded by employers purchasing workers' compensation insurance or paying benefits directly, provides workers with disability payments partially to replace lost wages. Those workers unable to return to work within three days are entitled to temporary disability benefits partially to replace wages lost as a result of the injury. A permanent disability, which is defined as being unable to return to the same line of work due to the incurred disability, entitles the injured worker to vocational rehabilitation and possibly to a permanent disability benefit.<sup>1</sup>

The California Workers' Compensation Institute reports that in 1999 (the most current statistics available) more than 1.6 million workers' compensation claims were filed. While the number of workers' compensation claims is down when compared to previous years, the cost of claims has dramatically increased due to increasing medical and legal costs.

The County of Los Angeles operates a self-funded workers' compensation program at a total cost of \$290 million in fiscal year 2002-2003, a significant increase over previous years. Although it is important in this environment to review and consider all of the elements of the workers' compensation system, there is one area over which the County has direct influence - fraud and abuse. It is the various means by which fraud and abuse can be minimized that this report proposes to address.

It has been alleged that employees, medical and legal providers, employers, and insurers have committed fraud and abuse in a variety of forms within the workers' compensation system. This allegation is supported by the continued successful fraud prosecutions of employees and of medical and legal providers that have been undertaken within the County. Although the levels of fraud and abuse in the system are difficult to establish with certainty, industry estimates have been published that range anywhere from 1% to 30% of claims paid. While this wide range of estimates makes it difficult definitively to establish the impact of fraud and abuse, the continued anecdotal evidence suggests that this is a serious problem within the Los Angeles County workforce. The County should minimize this impact by incorporating anti-fraud and abuse concepts and operational techniques into the County's system. This report considers the actions that deal with fraud and abuse existing within the County's workers' compensation system and arrives at a number of recommendations to improve the way they are addressed.

In order to understand the current workers' compensation fraud processes and the existence of any strategy that is in place, the Commission interviewed members of the Chief Administrative Officer's Risk Management Staff, the District Attorney and members of the Fraud Investigative Unit of the Metropolitan Transportation Authority as well as reviewing various County and industry documents and news articles on the

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<sup>1</sup> California Department of Industrial Relations, Division of Workers' Compensation, [The California Workers' Compensation System](http://www.dir.ca.gov/dwc/basics.htm), (web site address: <http://www.dir.ca.gov/dwc/basics.htm>).

subject. Using this information and information on the actions taken by other public and private organizations in addressing this problem, this report arrives at 46 recommendations to enhance the ability of the County to deter, detect, investigate and prosecute fraud in the workers' compensation program.

### III. OVERVIEW OF WORKERS COMPENSATION

#### State of California

##### General Background

California's first workers' compensation law was established under the Compensation Act of 1911 in which participation was voluntary for employers. A compulsory system was established two years later under the Workers' Compensation Insurance and Safety Act of 1913. This legislation required employers to provide benefits for all employees on the job (through commercially purchased insurance or internally provided "self-insurance") and generally prohibited employees from suing their employers over their injuries. The Act blocked employees from recovering money for pain and suffering or from seeking punitive damages, and called for the establishment of a competitive state insurance fund.

Reforms implemented in 1993 were intended to reduce system-wide costs and lessen litigation while, at the same time, increasing the maximum weekly benefit paid to workers. Although the cost of California's Workers' Compensation System fell from \$11.5 billion dollars in 1993 to \$8 billion in 1995, costs had begun to decline prior to the legislation. The causes for this \$3.5 billion in savings are not clear, but could include the anti-fraud efforts begun in the early 1990s, improved safety and return-to-work programs, the 1991-1994 recession, a drop in claims for disabling injuries, and the onset of Health Maintenance Organizations leading to reductions in health care costs.

The California Workers' Compensation System has been volatile in recent years. In 1995, insured employers experienced a sharp reduction in premium charges when the State passed legislation to deregulate premium rates, leading to a "premium rate war". This "war" was facilitated by large gains in investment portfolios during this period that enabled insurance companies to handle costs in excess of premium income. Large companies were able to increase market share dramatically by offering workers' compensation insurance at premium rates that were below actual losses. Ultimately, though, these competitive dynamics led to a wave of insolvencies – taking down 26 firms, including some of the largest private carriers in the California market.<sup>2</sup>

Average rates dropped from \$4.40 per \$100 of payroll in 1993 to \$2.27 in 1999, according to the Workers' Compensation Insurance Rating Bureau (WCIRB), a nonprofit

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<sup>2</sup> Saskal, Rich, Workers' Comp Safety Net - California Plans \$750M to Fix Insolvencies, The Bond Buyer Online – Regional News , July 22, 2004.

agency that serves as the statistical agent for the California Department of Insurance. But, throughout this low premium period, the WCIRB reports that benefit payouts steadily increased for both insurance companies and self-insured employers.

Workers' compensation costs per claim in California grew 10% per year over the three year period from 1997 through mid-2000, outpacing the 7% per year increase during the previous three year period, according to the Workers' Compensation Research Institute (WCRI).

### Recent History

Since the year 2000, as a result of failure on the part of some adequately to dispute medical charges, an increased level of fraud related to the economic downturn and the subsequent reduction in portfolio value, insurance companies could no longer continue subsidizing the low premiums they had been offering. As a result of these and other factors, premiums rates have increased sharply over the last several years, with the only possibility for controlling increases resting in legislative reform. The 2003 reforms did not represent a long term rollback of costs with workers' compensation costs in California still growing from \$11 billion in 1998 to \$18.8 billion in 2003 - an 80% increase. Without additional reform, costs were expected to go up an additional \$8.5 billion over the next five years - even with the recently adjusted numbers. This crisis led Governor Schwarzenegger, together with the Legislature, to enact workers' compensation reforms designed to lower the cost of premiums while improving the coverage to the injured workers.

### Legislation

Senate Bill 899 (Poochigian) was signed into law on April 19, 2004. Governor Schwarzenegger prevailed on two key provisions: insurance rates were not regulated, and injured workers were required to select doctors from a pool of doctors approved by employers and insurers. The law also tightened eligibility for permanent disability payments, capped payments for temporary disability at two years, reformed the outmoded penalty system, and permitted injured workers to seek immediate medical attention paid for by the employer. Labor and attorneys' groups criticized the law for lacking rate regulation and for not giving injured workers enough choice in choosing a doctor. Democrats quickly introduced legislation in both houses to regulate rates charged by insurance companies. These actions demonstrate the current dynamic nature of this situation, and point out that legislative actions taken, subsequent to the publication of this report, may have an impact on the recommendations that are made herein.

The legislation authored by Senator Poochigian represents a fundamental change to many aspects of the existing workers' compensation system. The regulations to implement those changes will take some time to draft and win approval, so the legislation's impact will be somewhat gradual. However, as reforms are implemented, the savings from SB 899 are expected to grow substantially over time.

With some exceptions, the changes that have been implemented affect all pending claims but do not require revising or reopening any past decisions. The following are the major highlights of the new law:

- Allows employers and insurers to contract with approved provider networks for the treatment of work-related injury and illness, thus controlling treatment indefinitely. Employees may seek second and third opinions from their choice of doctors within the network. An injured worker who is unsatisfied with network doctors' recommendations may appeal to an Independent Medical Reviewer (IMR). If the IMR agrees with the injured worker, the injured worker may seek treatment from a doctor of his or her own choosing, and the employer loses medical control. This loss of control is for the disputed treatment only. The employee will have to remain in the network for any other treatments.
- Specifies that employees may only pre-designate treating physicians who are part of the employer's health benefits plan. The situation inherent in pre-designating treating physicians is a growing County problem. The solution that was adopted in SB 899 provides employees the right to pre-designate their personal physician as their workers' compensation doctor, subject to all of the group health treatment guidelines. The physician must be a member of their group health plan and must have a history of treatment with the employee. The physician must agree to become the workers' compensation provider for the employee.
- Limits temporary disability payments to 24 months from the first payment. Certain injuries have extended temporary disability of up to 240 weeks within five years from the date of injury.
- Requires an employer/insurer to authorize medical treatment within one day of receiving an occupational injury claim, even though the claim may be delayed for up to 90 days for investigation. It limits the liability for pre-acceptance medical treatment at \$10,000.
- Refers all medical disputes regarding disability to a panel of qualified medical examiners for resolution or allows the parties to select an agreed upon medical examiner.

### Fraud Investigation

Some workers' compensation fraud investigations are conducted by the California Department of Insurance with employers being assessed roughly \$30 million annually to fund these efforts. During a recent review concerning the utilization of these funds, a

State of California audit<sup>3</sup> shows that much of this money is being used inefficiently and getting tied up in bureaucracy. It also concluded that the State Insurance and Industrial Relations Departments have failed to implement the law that cracks down on workers' compensation fraud. Additionally, the audit found that a "significant portion of its workers' compensation anti-fraud resources ... do not result in criminal prosecutions."<sup>4</sup> News articles further report that that the \$30 million collected each year in fees from employers to combat fraud hasn't made a dent in those "gaming the system".<sup>5</sup>

Currently, 40% of fraud enforcement funding goes to the California Department of Insurance (DOI) which performs investigations on cases before referring them to local District Attorneys, 40% of fraud funds are distributed directly to local District Attorneys, who often must perform their own investigations on any referrals from the state and determine whether to prosecute, and the remaining 20% is allocated to the Fraud Assessment Commission for distribution on an as needed basis. Historically, after the distribution of funds by the Commission, the actual distribution formula for fraud funds is 55% to local District Attorneys and 45% to DOI. Although it didn't make it out of committee, a bill was introduced (SB 184X) in the most recent session which was intended to grant more monies to local law enforcement, as well as proposing a reform of the process.

Even with this level of funding the state audit found that the Fraud Division spends a significant portion of its workers' compensation anti-fraud resources investigating suspected fraud referrals that do not result in criminal prosecutions by County District Attorneys. Of the referrals received by the Fraud Division between September 2001 and December 2003, 87% (7,891) were not submitted for prosecution, 3% (233) were submitted for prosecution, and 10% (946) remain open.<sup>6</sup> This data suggests, at least to some, that additional legislative action is needed to streamline workers' compensation fraud enforcement at the state level and to aggressively prosecute fraud and abuse that may be prevalent in the system. Others argue that making this comparison is like comparing every call to 911 to the number of cases that are referred to the District Attorney for prosecution.<sup>7</sup>

The private sector insurance companies have also had trouble in the fraud field. In the early 1990s, insurance companies were required to set up their own fraud investigation units and forward fraud cases to District Attorneys for prosecutions. But in the price-cutting wars unleashed by deregulation later in the decade, insurers generally cut their fraud units. There was little pressure from employers to improve them because costs were falling. By the time costs headed back up, many insurance companies were in such severe financial trouble that anti-fraud units continued to languish.<sup>8</sup>

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<sup>3</sup> California State Auditor, Bureau of State Audits, Workers' Compensation Fraud, Detection and Prevention Efforts Are Poorly Planned and Lack Accountability, Report #2002-018, April 2004.

<sup>4</sup> Antelope Valley Press, Audit Backs Chamber on Workers' Comp Fraud Unit, May 1, 2004.

<sup>5</sup> Los Angeles Daily Breeze, Skepticism about Workers' Comp, July 7, 2004.

<sup>6</sup> Derived from the California Department of Insurance, Fraud Division case management database.

<sup>7</sup> Los Angeles Daily Breeze, Workers' Comp Fraud Unit Moves Ahead, May 13, 2004.

<sup>8</sup> Los Angeles Business Journal, Prosecutors Target 'Mills' in Workers' Comp Crackdown, May 3, 2004.



## Cost Comparisons

California's workers' compensation system is currently facing one of its greatest challenges – sharply increased premium rates and an environment of rising medical costs, while at the same time providing benefit payments to injured workers at a lower level than most other states. The critical impact of this situation is the development of a non-business friendly environment in California.

The most recent state-by-state comparative on average workers' compensation insurance comes from a 2002 survey provided by the Oregon Department of Consumer & Business Services (DCBS). Even when weighted to control for industrial differences across states, it shows that California had the highest rates in the country. California employers paid \$5.23 per \$100 of payroll for their workers' compensation insurance, more than 16% higher than the \$4.50 paid by Florida employers, who had the second-highest rate. Not only was California the only state in which rates exceed \$5, Florida was the only other state with rates exceeding \$4 and just 7 additional states had rates of \$3 or higher. Arizona's average rate was \$1.63 per \$100 of payroll - less than a third of the average rate in California.<sup>9</sup> By 2004 the workers' compensation insurance for California employers topped \$6.30 per \$100 of payroll.

## System Cost Drivers

California Insurance Commissioner John Garamendi recently put forth a plan that addressed, in part, the fraud issue. He states "The current culture of California's workers' compensation system is one where abuse and fraud are widespread and serve as a cost driver in the system. This culture must change. The high premiums, low benefits, and overall inequity of the current workers' compensation system contribute to an environment that is highly vulnerable to fraud. Workers' compensation fraud includes abusive and fraudulent provider billing practices (up-coding, unbundling, prescription billing, durable equipment, and billing for services not rendered), medical-legal mills, and applicant and insider fraud. Numerous factors exacerbate and perpetuate workers' compensation fraud, including personal and business economic hardship, public acceptance of insurance fraud, and inadequate resources (manpower and funding) to investigate insurance fraud cases. Some insurance companies have also been derelict in their responsibility to fight fraud. The lack of uniform methodology and standards for assessing and reporting suspected fraud is a contributing factor."<sup>10</sup>

Other factors that help drive up costs include the rise in cost per claim including a two-week increase in temporary disability duration, higher medical payments per claim, more frequent permanent partial disability (PPD) claims, greater use of vocational rehabilitation, higher benefit delivery expenses, the lack of price limits for outpatient

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<sup>9</sup> Reinke, Derek and Manley, Mike, 2002 Oregon Workers' Compensation, Premium Rate Ranking, Oregon Department of Consumer and Business Services, January 2003.

<sup>10</sup> California Department of Insurance, The Garamendi Plan, Bridging the Gap Between Workers and Employers Completing Workers' Compensation Reform, pg. 2.

surgery centers, an increase in patient visits to health care providers, and "wild variations" in the size of permanent disability awards.

An additional factor driving higher costs in California is the adversarial nature of the system. In California 30% of workers with eight or more days out of work eventually hire an attorney to represent them – twice as many as in the next-highest state, Oregon. While attorneys provide valuable services to injured workers, workers' compensation is an administrative system intended under the original bargain to provide benefits to injured workers expeditiously while reducing litigation.

### Additional Perspectives on the Problem

Litigation within the workers' compensation system has become a source of increasing concern. Even though under the workers' compensation system workers gave up their right to sue employers for work-related injuries in exchange for compensation, a recent RAND Corporation study found that the system for handling disputes that do arise is burdened by outmoded rules and computers and a shortage of funds and staff.<sup>11</sup> Agreement on how to address this problem and reform the system is severely constrained by the involved interest groups along with their conflicting interests. These powerful groups of attorneys, unions, insurers, health care providers, and businesses have varied interests and often disagree on the solutions to the problem.

Another RAND Institute for Civil Justice study found the current workers' compensation system to be highly subjective which led to disparate treatment for injured workers. In turn, this disparity of outcomes encourages litigation.<sup>12</sup> The report found:

- While the frequency of all workers' compensation claims in California is 29% above the national average, permanent partial disability (PPD) claims are filed at nearly three times the national rate.
- California has nearly 20% more permanent partial disability claims per 100,000 workers than the next highest state. More than 40% of California workers with lost-time claims receive PPD.
- California has a higher number of PPD claims that involve attorneys compared to other states.
- California's heavily litigated PPD system is greatly influenced by "dueling doctors" reports. For example, the average PPD ratings by an applicant attorney's physician are 22% higher than the final settlement amount while employer ratings are 7% lower than the settlement amount.

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<sup>11</sup> Pace, Nicholas M., et al, Improving Dispute Resolution for California's Injured Workers: Executive Summary, Rand Institute for Civil Justice, 2003.

<sup>12</sup> Reville, Robert T., Seabury, Seth, Neuhauser, Frank, Evaluation of California's Permanent Disability Rating Schedule Interim Report, Rand Institute for Civil Justice, December, 2003.

# Los Angeles County

## General

With the exception of the State of California, the County of Los Angeles is the largest public employer in the State. In 1969 Los Angeles County moved from buying insurance to becoming a fully funded self-insured and self-administered in its workers' compensation program, after a consultant's report recommended doing so to take advantage of immediate, substantial savings estimated to be between 16% and 22%. This self-insured approach avoids the costs of underwriting incurred with insurance purchased on the commercial market, marketing, premium taxes and a profit.

Full funding for all incurred losses remained in place until the late 1970s when Proposition 13 budget impacts presented the Board of Supervisors with difficult funding choices. The Board stopped funding new monies for future reserves, but kept the trust fund (approximately \$50 million at that time) in place as a contingency reserve. In the early 1980s, this fund was appropriated by the Board of Supervisors to pay for other pressing needs and the program became completely pay-as-you-go. In 1987, the claims administration function was contracted out to private sector third-party administrators (TPA) with legal services being provided by both County Counsel and private workers' compensation defense attorneys under contract to County Counsel.

## The Magnitude of the Workers' Compensation Problem

In the fiscal year 2002-2003<sup>13</sup> total County workers' compensation costs exceeded \$290 million. These costs include pay-as-you-go payments for medical treatment, temporary and permanent disability indemnity, rehabilitation, life pensions, death benefits, salary benefits for fire and law enforcement, legal and investigative services, third party administrator's fees and all administrative costs incurred by County staff. These costs covered, as of December 2002, a total County employment of 91, 588, open claims at 20, 970, 1957 employees off duty as a result of industrial injuries and 913 employees off duty as a result of non-industrial injuries.<sup>14</sup> Los Angeles County Supervisor Zev Yaroslavsky recently commented that "The hidden costs are a new dimension to the problem. It's (workers' compensation) the single fastest growing cost in county government. It's even outpacing salaries."<sup>15</sup>

In a "normal" workers' compensation financial model, benefit costs "develop" gradually over time. Typically, for all accidents incurred in a given year, 30% of the total liability is incurred in that year; another 30% is paid in the second year; 25% is paid in the third year, and the remaining 15% is paid over the following 10 to 15 years. This last 15% is

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<sup>13</sup> Los Angeles County Chief Administrative Office, Budget and Fiscal Branch, Workers' Compensation Trust Fund Cash Balance Report, FY 2002-2003.

<sup>14</sup> Los Angeles County Chief Administrative Office, Countywide Return to Work Assessment, January 3, 2003, (Table 1 – Department Return to Work Information Summary).

<sup>15</sup> Anderson, Troy, Workers' Comp Hurting Local Government, San Gabriel Valley Tribune, June 28, 2003

generally for the long-term medical care of permanently disabled employees, for long-term salary replacement, and for “exposure” claims filed years later based upon cancers or physical infirmities blamed on working conditions or exposure to hazardous conditions during prior employment.<sup>16</sup> Further, these claims typically have hidden costs - overtime, training, and other costs to replace the injured workers - that could amount to an additional percentage of the workers’ compensation costs. Given that the net benefit expense in 2002-2003 was \$244 million, using the pay-as-you-go methodology, it is estimated that the County will face a substantial total liability of approximately \$2 billion over the next several years. It is this unfunded liability that is a major workers’ compensation problem facing Los Angeles County.

It has been proposed that existing policy and program structure has been a major factor in the creation of the workers’ compensation problem. In 2000 the Board of Supervisors directed the Auditor-Controller to review the service connected disability retirement claims filed by safety members over the previous two years. In this report the Auditor found that “...two factors are contributing to the number of service-connected disability retirements. One item pertains to the “Full Range of Duties Policy” adopted by the Sheriff and Fire Departments. The other relates to current legislation and the ease with which employees can obtain a service-connected disability retirement.”<sup>17</sup> This review recommended changes in both policies and legislation to assist in correcting this problem.

Subsequent to the Auditor’s review, the 2002-2003 Los Angeles County Grand Jury noted in it’s final report that “Without a doubt, legislation such as §4850 and §3212 (See footnote below for an explanation of these sections of the Labor Code) has a significant impact on the cost of workers’ compensation benefits. On the other hand, the Grand Jury recognizes that some higher level of costs must be associated with public safety employees”.<sup>18</sup> Since §4850 and §3212 have such an impact on costs, they certainly becomes an important consideration in any evaluation of workers’ compensation cost reduction. Specifically, the reason that §4850 and §3212 become of interest in this report results from the organizational cultural implications that have been raised in the Grand Jury Report when it pointed out that “The results of these factors and attitudes is that many sworn officers view workers’ compensation as a discretionary program to be used in anticipation of retirement”.<sup>19</sup>

It would appear based upon the contentions in these reports that the problem is being compounded by the creation of a culture of entitlement. The Commission did not attempt to validate these assertions, but if such a culture were to exist, the implementation of the recommendations that are made in this report would take a

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<sup>16</sup> The information on this financial model was obtained from the Fremont Insurance Company.

<sup>17</sup> Los Angeles County Auditor-Controller, Safety Employees, Review of Service Connected Disability Retirements, November 28, 2000

<sup>18</sup> 2002-2003 Los Angeles County Grand Jury Final Report, pg.21. Additional Note: Labor Code § 4850 provides that certain public safety employees “who sustain an injury or illness arising out of and in the course of his or her duties is entitled to a leave of absence of one year without a loss of salary in lieu of disability payments”. §3212 provides that certain injuries or illnesses of public safety employees are presumed to be work related.

<sup>19</sup> Ibid, pg. 62.

significant step toward informing employees that such a culture would be no longer tolerated.

### The Magnitude of Workers' Compensation Fraud

It is generally recognized within the industry that the extent of workers' compensation fraud and abuse is extremely difficult to quantify. This difficulty is further compounded by numerous other factors impacting the problem. For example, UCLA professor Daniel Mitchell, a business and public policy expert has pointed out that "...some workers, unhappy with the way they are treated by management, use workers' compensation as a grievance mechanism."<sup>20</sup> Additionally, any analysis covering the magnitude of the problem would also have to consider the basic question of how to distinguish between fraud and abuse. Although it is clear that determining the magnitude of the problem is certainly difficult, without some measure of the scope, effectively addressing any solutions to the problem will remain elusive.

Some statistics that have been developed by the California Department of Insurance (DOI) reveal that in fiscal year 2002-2003 the DOI received 3,544 suspected workers' compensation fraud referrals, a number that has remained steady for the past three fiscal years. More than 70% of these referrals were applicant fraud – a situation where a claimant files a false claim for an injury supposedly sustained in the workplace. Statewide in fiscal year 2002-2003 District Attorneys reported the prosecution of 660 fraud cases representing more than \$54 million in chargeable fraud.<sup>21</sup>

The California Commission on Health and Safety and Workers' Compensation stated in a recent report that "There is no generally accepted method or standard for measuring the extent of workers' compensation fraud in California. As a consequence, there are widely divergent opinions about the size of the problem and the relative importance of the issue".<sup>22</sup> Another organization, the California Farm Bureau Federation, has opined on this issue stating "Although experts are unsure about the amount of fraud in the California workers' compensation insurance system, they think it's probably about \$1 billion to \$5 billion a year".<sup>23</sup>

Various other estimates do exist with some industry experts believing that fraud has increased to a level that requires attention, accounting for between 10 and 20% of the workers' compensation claims paid. Based upon the work that they have done to date,

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<sup>20</sup> Streeter, Kurt, MTA Combats Fraud by Workers, Los Angeles Times, August 14, 2002.

<sup>21</sup> Note: Although the focus of this report is on employee fraud it is important for the reader's understanding of this problem that to recognize that in 2001 a joint study by the Department of Industrial Relations and the Employment Development Department reported that up to 25% of California's employers do not have workers' compensation insurance. In addition, the CDI found that employer fraud is one of the fastest growing areas of workers' compensation insurance. This fraud ranges from underreporting of payroll by paying cash to employees, to misclassifying employees in order to secure a lower premium.

<sup>22</sup> California Commission On Health And Safety And Workers' Compensation, Report On The Workers' Compensation Anti-Fraud Program, August 2001.

<sup>23</sup> Campbell, Kate, Report Outlines Workers' Comp Fraud Losses, California Farm Bureau Federation, May 19, 2004.

the Risk Management Division of Los Angeles County's Chief Administrative Office estimates that fraud comprises 3% of claims paid. Another source, the California Little Hoover Commission, concluded in 1993 that (1) 30% of system costs, or \$3 billion a year, are wasted in fraud, (2) 20% to 30% of employee claims are fraudulent, and (3) businesses are twice as likely to commit fraud than are injured workers.<sup>24</sup> The Insurance Services Office, Inc. estimates that the cost of fraud in the U.S. property and casualty industry is approximately \$24 billion, which represents 10% of total claims.<sup>25</sup> On the other hand, the Office of the Inspector General of the United States Department of Veterans Affairs has conducted an audit of workers' compensation claims and has found that about 4% of their employees commit fraud.<sup>26</sup> The most extreme estimate comes from the California Applicants' Attorneys Association (CAAA) which arrived at a still lower level of fraud by referring to statistics indicating that in 1998, there were 358 fraud arrests, three-quarters of which were injured workers, and that amounted to "less than one-tenth of 1% of claims".

Locally, Ms. Laura Clifford, executive director of the Southern California Employers Fraud Task Force, a coalition of employers, insurers, law enforcement officials, doctors and lawyers has stated, "We realize prosecutors are doing everything they can with the resources they have available. But you could double the resources, and still have a lot of fraud out there." She feels that only 10% of the fraud cases fit the common perception of workers faking or exaggerating injuries with the remainder coming either from employers trying to evade premium payments or from the medical-legal mills.<sup>27</sup>

Within the City of Los Angeles, workers' compensation claims are expected to cost \$142 million this year, up \$29 million from 2002-03. Although city officials have no estimate of how many of the claims are fraudulent, Councilman Dennis Zine has been quoted as saying that about 30% of claims statewide are not legitimate.<sup>28</sup>

For lack of a better measure, workers' compensation regulators generally account for fraud within the system by tracking fraud referrals and the prosecution of those referrals. This approach will only account for referred and prosecuted cases, rather than recognizing that there may exist varying amounts of fraud and abuse that may not be discovered, or if discovered not reported. Although undetected fraud and abuse clearly exist and since it cannot be quantified in other than in a highly generalized manner, it is difficult to factor it into an assessment of the extent of the problem for either California or Los Angeles County.

The Coalition Against Insurance Fraud has pointed out that the most common rationale for measuring fraud is that finding an effective solution to the problem requires knowing

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<sup>24</sup> The California Little Hoover Commission, Workers' Compensation: Containing the Costs, February, 1993

<sup>25</sup> Coalition Against Insurance Fraud, One-Fourth of Americans Say It's Acceptable To Defraud Insurance, February 12, 2003.

<sup>26</sup> The Office of the Inspector General, US Department of Veterans Affairs, Detecting Fraud and Reducing Workers' Compensation Cost: How Information Technology Can Help, PowerPoint presentation at the 1<sup>st</sup> Annual Workers' Compensation Conference and Exposition.

<sup>27</sup> Los Angeles Business Journal, Prosecutors Target 'Mills' in Workers' Comp Crackdown, May 3, 2004.

<sup>28</sup> Los Angeles Daily News, Council Votes 14-0 to Fire Workers Who Commit Fraud, April 14, 2004.

its extent. It is evident from this research that no reliable source has been able to arrive at a reasonable measure of the extent and nature of fraud, not to mention abuse, in the workers' compensation system. Instead, the industry seems to rely primarily on general anecdotal information, unscientific estimates, and descriptions of local cases involving fraud. Given these limitations, one approach the problem of estimating the financial impact of fraud and abuse is by using a range of the various fraud percentage assumptions as presented in Table 1. The reader may develop an extremely gross estimate of the impact to the County under these various potential fraud percentage scenarios.

Table 1  
Estimates of the Monetary Impact of Fraud within Los Angeles County

2002-2003 Level of Benefits	Potential Range of Fraud Percentages	Monetary Impact of Fraud
\$244M	3%	\$7.32M
	15%	\$36.6M
	25%	\$61.0M

Considering the scope of the work on measuring fraud that has been conducted to date, it is understandable that the County cannot currently establish, other than making an approximation, the extent and nature of fraud and abuse in the workers' compensation system. This inability will make it extremely difficult to determine the effectiveness of deterrent activities. Although it is clear that these difficulties exist, it is also evident that this situation would be significantly improved with the development of a centralized system(s) to track and report on the fraud that has been previously detected and by encouraging law enforcement agencies to routinely track insurance fraud crime statistics.

## IV. WORKERS' COMPENSATION BENEFIT FRAUD/ABUSE

### California Law Relating to Fraud

The California Insurance Code addresses violations of insurance fraud committed by injured employees. Section 1871.4, which is the primary charging code used by the Los Angeles County District Attorney, states in part that it is unlawful to make or cause to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining compensation. It is also unlawful to present or cause to be presented any knowingly false written or oral material statement in support of any claim

for compensation for the purpose of obtaining compensation. Additionally, charges of perjury and attempted perjury can also be filed as a result of making a false statement.

The law addressing the fraud committed by injured employees who file for workers' compensation benefits is California Penal Code §550. This section states in summary that it is unlawful to commit, or conspire with any person to knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss or injury, including payment of a loss or injury under a contract of insurance. In addition, the Legislature enacted Labor Code §3820 allowing for "...the addition of civil money penalties [to] provide necessary enforcement flexibility."

Current law provides that every person who violates §1871.4 of the Insurance Code or §550 of the Penal Code shall be punished by imprisonment in County jail for up to one year, or in the state prison for two, three, or five years, or by a fine not exceeding one hundred and fifty thousand dollars (\$150,000) or double the value of the fraud, whichever is greater, or by both imprisonment and fine. Restitution shall be ordered, including restitution for any medical evaluation or treatment services obtained or provided. The court shall determine the amount of restitution and the person or persons to whom the restitution shall be paid.

## **Definition of Fraud and Abuse**

As previously noted, one of the cost drivers within the workers' compensation system is the existence of fraud and abuse. This is an area over which the County can have a direct impact by initiating positive actions in the development, implementation and execution of its deterrence, detection, investigation and prosecution activities.

The California Department of Insurance (DOI) recognizes that within workers' compensation there should be a distinction between "abuse" and "fraud." The DOI defines abuse as using the system for one's own economic benefit, notwithstanding the purpose of the system. It is not chargeable as a crime. Fraud, on the other hand, occurs when there is clear intent to misrepresent one's injuries or to fabricate injuries.<sup>29</sup> Benefit fraud is generally classified via two types:

- Employee Fraud can be established when an employee knowingly misrepresents, either verbally or in writing, with the misrepresentation directly related to their attempt to obtain workers' compensation benefits.
- Provider Fraud is committed when a health care provider or attorney assists the worker in the commission of a fraudulent scheme, or participates in double billing or billing for services not provided

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<sup>29</sup> From the California Department of Insurance Web Site – (<http://www.insurance.ca.gov/PRS/PRS2003/fs036-03.htm>).



County Risk Management does not currently track or separate suspected fraudulent activity by category since all reports of workers' compensation fraud are investigated by the Special Investigative Unit. In spite of this lack of category tracking, it is evident that most investigations and subsequent arrests within the County do involve employee fraud, even though several medical providers have been arrested as a result of ongoing investigations.

## The County Environment

Given the potential for fraud and abuse, it is of value for the County to consider the current broad social environment that exists within this country. A survey conducted by Taylor Nelson Sofres (TNS) Intersearch which was commissioned by Accenture found that nearly one in four U.S. adults say that overstating the value of claims to insurance companies is acceptable, and more than one in 10 say that they approve of submitting insurance claims for items that were not lost or damaged or for treatments that were not provided. Eleven percent of the respondents said they knew of someone who had inflated the value of an insurance claim. Forty percent of the respondents said that they were unlikely to report someone who has committed fraud. In addition, 83% of respondents said that they believe that insurance companies are capable of identifying or preventing insurance fraud.<sup>30</sup> The results of this survey are disturbing and provide further evidence that the County must ensure that it has the proper tools and technologies in place to combat fraud and abuse. The greatest impact that the County can make upon fraud is in its prevention.

Recently, there has been a great deal of attention in the press to the existence of fraud in Los Angeles County. On March 9, 2004, it was reported in the Daily News<sup>31</sup> that fraud loss within the County was up 17,000%. This recognition and the existing prosecution of fraud acknowledge an environment within which it is clear that such activities not only **can** take place, but also **do** take place. This same article cited Mr. Tyler McCauley, the County's Auditor-Controller, as saying "...the \$250 million in losses could be reduced significantly if more safeguards were in place." Mr. McCauley correctly recognizes that systems within the County must be reviewed and revised, where appropriate, to reduce the possibility of both fraud and abuse.

The potential for fraud and abuse was also recognized in discussions presented in the June 2003 Los Angeles County Civil Grand Jury Final Report. Although the report states that "...there does not appear to be evidence of significant direct fraud involving fabricated claims" it does contend that "...the structure of the workers' compensation system that rewards time off from work and provides for disability for permanent residuals based upon the employee's objective and/or subjective complaints can contribute to claim abuse."<sup>32</sup>

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<sup>30</sup> Coalition Against Insurance Fraud, One-Fourth of Americans Say It's Acceptable To Defraud Insurance, February 12, 2003.

<sup>31</sup> Anderson, Troy, County Fraud Loss Up 17,000%, Los Angeles Daily News, March 9, 2004.

<sup>32</sup> 2002-2003 Los Angeles County Grand Jury Final Report, pg. 64.

While serving as the former head deputy of the District Attorney's Workers' Compensation Division, Mr. Tom Higgins commented that although a large percentage of disability claims are valid, workers' compensation fraud is a major problem statewide. He also felt, as did the Grand Jury, that the generous benefits that have been enacted for law enforcement officers make fraudulent claims "very tempting". As a result he was of the opinion that "there's a fair amount of it (fraud)". He has also been quoted as saying that "There's almost a sense of entitlement among some people or a sense that it's a non-listed fringe benefit."

## **Recent Fraud/Abuse Prosecutions in Los Angeles County**

The Los Angeles County District Attorney has stated that "prosecutors and investigators agree that prosecution of 'high impact' cases, i.e., cases against providers, employers, or large premium fraud cases, gives the public and those working within the system a greater sense of justice and satisfaction." Since these cases have a significant economic and public impact, it is understandable that fraud committed by providers or by employers can become a major focus of any anti-fraud program. In spite of this it is important to recognize that claimant fraud should also be of concern, particularly if it were to have an immediate positive impact to workers' compensation costs being incurred by the County. The frequency of employee fraud is supported by the fact that approximately three out of four of the people convicted of workers' compensation fraud are claimants. Although to some degree, this can be explained by the fact that claimant fraud is easier to detect, investigate and prosecute, the numbers involved demonstrate that this is an area in which effective fraud prevention programs can create a positive impact. The following cases present examples of recently prosecuted fraud to support the need for the development of such programs.

### County DPSS Eligibility Worker

In January 2004, following a 3 week jury trial, L.A. County DPSS Eligibility Worker Ana Pena was found guilty of multiple counts of perjury and grand theft involving her workers' compensation claim. Ms. Pena has been off work since 1998 following an alleged psychiatric reaction to a bomb threat occurring at her work location. Following the guilty verdict Superior Court Judge Judith Champagne immediately sentenced Ms. Pena to serve 2 years in State prison for grand theft, and concurrently serve 1 year and 8 months in State prison for perjury. Ms. Pena was taken into custody, and has been transferred to the State Department of Corrections to begin serving her prison term.

Ms. Pena was also ordered to reimburse the County of Los Angeles \$110,000. Her husband had previously pled guilty to assisting her in this fraud and remains free on 5 years probation. Mr. Pena was also ordered to reimburse the County of Los Angeles \$150,000 in restitution for his part in this crime.

### Fraud Conspiracy

In August 2003 a doctor, a chiropractor, a therapist, and a former Los Angeles County employee were charged with grand theft and organizing a large workers' compensation fraud scheme that had netted them more than \$2 million since 1999. The case stems from a workers' compensation claim filed by former County-USC Medical Center welder, Leroy Jaramillo, as a result of an alleged injury he suffered in the 1980s.

On May 6, 2004, Mr. Jaramillo was sentenced to 3 years in State prison for workers' compensation fraud. In addition, he was ordered to pay \$100,000 in restitution. The others involved in this case are awaiting trial.<sup>33</sup>

### Acquittal of a Deputy Sheriff

A workers' compensation prosecution that resulted in an acquittal demonstrates the need to ensure that the information collected meets the level necessary to successfully prosecute fraud. Without sufficient information there is a highly negative impact on the individual being charged and on the system's credibility in prosecuting such cases.

This acquittal verdict resulted from a June 2003 arrest of a 14 year veteran Los Angeles County Sheriff's Deputy David Sherr. Deputy Sherr was charged with one count of felony grand theft, 5 counts of insurance fraud and one count of attempted perjury after collecting paychecks for almost 2 years while on a fraudulent disability leave. Although at the time prosecutors estimated that the cost of his fraudulent claim and subsequent investigation was at least \$135,000, the evidence that was presented did not justify a guilty verdict.<sup>34</sup>

### Fraud Scam

In April 2003, an Encino attorney and four other people were arrested and charged with one count of grand theft and conspiracy to commit workers' compensation insurance fraud that involved the theft of more than \$120,000. Mr. Sami Yasharpour, the attorney in question, was alleged to have been self-referring clients to a rehabilitation center in which he allegedly held an ownership interest. This ownership interest was allegedly concealed from the workers' compensation insurance representatives.<sup>35</sup>

### County Pharmacist

In early December 2003, Los Angeles County Pharmacist Ms. Sharon Chan entered into a guilty plea to one count of workers' compensation insurance fraud. As part of her plea agreement Ms. Chan agreed to resign from the County, revoke her pharmacy license for 5 years, dismiss all workers' compensation claims against the County, and reimburse the County \$120,000 in restitution. While on temporary disability it was

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<sup>33</sup> County News Service (CNS) at <http://www.socalnews.com>, Former County Employee Pleads Guilty in Workers' Comp Case, May 6, 2004.

<sup>34</sup> Los Angeles Daily Journal, Jurors Acquit Injured Sheriff's Deputy of Fraud Charges, April 16, 2004.

<sup>35</sup> Los Angeles County District Attorney News Release, Attorney, four others charged in Alleged Workers' Compensation Fraud Scam, April 3, 2003

discovered that Ms. Chan was employed elsewhere as a pharmacist, although she had denied undertaking any such work in a subsequent disposition.<sup>36</sup>

## **Recent Fraud/Abuse Prosecutions within the MTA**

### Alleged Job Injury

Ms. Lolita A. Hicks, a veteran MTA bus driver, was arrested in December 2003 on suspicion of workers' compensation fraud after an onboard camera showed no evidence supporting her claim of being hurt on the job. She faces up to 5 years in prison if convicted of all 16 counts of fraud.<sup>37</sup>

### Alleged Job Injury

An MTA bus driver, Gail Alcantar, claimed she twisted her ankle on stairs in the employee parking lot in 2002. In August 2002 an MTA spokesperson claimed that the MTA Special Investigation Unit had obtained videotape footage of her gardening. It is claimed that the tape shows her squatting, using stairs, bending over and using both feet to push a shovel in the ground. In a subsequent disposition taken in October 2002, Alcantar said that she had not done any gardening since her accident.<sup>38</sup>

## **V. THE MTA WORKERS' COMPENSATION FRAUD PROGRAM**

The Metropolitan Transportation Authority (MTA) has recognized the importance of developing a workers' compensation program that not only provides workers with the benefits that are necessary to respond to their medical needs, but also attempts to capitalize upon the best practices of the workers' compensation community. Several factors have been addressed in the development of this program including: influencing the corporate culture, emphasizing safety on the job, hiring outside experts to assist in the safety program, revising the organization, procedures and coordination of activities within the risk management function. The focus of this review of the MTA's efforts is on the components of their program that deal with the deterrence, detection and prosecution of workers' compensation fraud and abuse. The vital elements of the MTA program include:

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<sup>36</sup> County of Los Angeles News Advisory, County Pharmacist to Pay \$120,000 in Restitution and Resign Position, Feb 18, 2004

<sup>37</sup> Mascaro, Lisa, Veteran MTA Driver Arrested in Workers' Comp Fraud Case, Los Angeles Daily News, Dec 31, 2003

<sup>38</sup> Pierce, Meredith, MTA Arrest, County News Service (CNS), Feb 19, 2004

- Definition - Define the extent of the problem within the organization and the trends that could be identified.
- Establish Goals - The goal of reducing workers' compensation exposure and identifying solutions was given priority support from MTA Executive Staff, a requirement that is vital to the success of the program.
- Dedicated Legal Support - County Counsel dedicated two attorneys to support the MTA Special Investigations Unit (SIU).
- Liaisons Established - Liaisons have been established with the District Attorney's Office and the Department of Insurance Fraud Bureau.
- Training - An aggressive training program for workers' compensation claims examiners was developed and implemented with a pass/fail requirement.
- Employee Outreach - An employee outreach program was developed to educate employees and ensure that they understood what constituted workers' compensation fraud and abuse and the extent of the administrative, civil and criminal penalties. This program was taken to all MTA properties and to all work shifts and was presented in conjunction with the District Attorney's Office.
- Hotline - A Workers' Compensation Fraud and Abuse Hotline has been established, is widely advertised, and maintained. The Hotline allows employees and/or the general public to provide anonymous information to the Special Investigations Unit (SIU).
- Data Mining - A data mining program was implemented to complement the investigative program. This enables investigators to use data base resources to analyze claimant's industrial injury histories, identify civil litigations for non-industrial injuries, and identify information about the claimant that may assist in the investigation when the claimant is suspected of workers' compensation fraud or abuse.
- Recording Equipment - The MTA utilizes an in-bus digital video recording system (DVR) to assist in proving or disproving cases that occur on public transportation.
- Information Program - An employee and public information program is underway to advise all employees of the outcome of recent cases within the MTA (paycheck inserts on recent arrests and terminations, LA Times/Daily News and MTA Newsletter, etc.) The Fraud Deterrence Program is addressing, as a primary goal, a "change of culture" among the employees.

- Contract Oversight - The MTA provides strong oversight of contract investigative firms to maximize value for its investigative dollar and to encourage firms to provide their “best and brightest” investigators.
- Administrative Discipline - A major part of the MTA Program is strong, consistent, and timely employee discipline for workers’ compensation fraud and abuse. The MTA has terminated sixteen employees for issues relating to workers’ compensation fraud and abuse during the last eight months. Many of these cases have also been referred for criminal prosecution.
- Fraud Prosecutions - The MTA had their first arrest for workers’ compensation fraud in 2003, under the new Program, and have had three arrests so far this year. Numerous cases have been referred to the Department of Insurance and District Attorney’s Workers’ Compensation Fraud Divisions and more arrests are anticipated.

As a direct result of their efforts workers’ compensation costs have been reduced from \$58 million in 2001-2002 to \$50 million in 2002-2003. Continuing this trend, on July 27, 2004, the MTA reported that it had achieved a 25% drop in workers’ compensation claims in the fourth quarter of fiscal 2004, compared to the same quarter last year. The MTA Board chair Frank Roberts attributes this reduction to the fact that “Metro continues to aggressively pursue fraudulent claims, return injured workers back to work faster and continues to improve employee behavior and the work environment with respect to safety.”<sup>39</sup>

A direct comparison between the MTA and the County is difficult to accomplish since the MTA is an organization with a single mission, while the County assumes multiple mandates and missions. Even so, some of the elements of the anti-fraud unit that are identified in Table 2 may be applicable to the County environment.

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<sup>39</sup> CNS, MTA Comp, July 27, 2004 (located at [http://www.socalnews.com/news/?mode=1&hgl=&pr\\_id=205616](http://www.socalnews.com/news/?mode=1&hgl=&pr_id=205616)).

**Table 2**  
**Anti-Fraud Unit Program Comparison**

<b>Activity:</b>	<b>MTA*</b>	<b>County of Los Angeles**</b>
SIU / Anti-Fraud Unit Established Goals:	Reduce work comp exposures and identify solutions. Deter, detect and prosecute fraud, criminally and administratively	Arrest and prosecute criminal work comp fraud, recover damages
Dedicated Legal Support:	2 Support Attorneys (From County Counsel)	1 Support Attorney (From County Counsel)
Liaisons Established:	DA and CDI Fraud Units	DA, CDI Fraud Units, and Attorney General
Training of Examiners:	Yes (Approx 25 Examiners housed in 1 central location)	Yes (Approx 125 Examiners housed in 5 different locations)
Employee Outreach and Training:	Educate EE on what constitutes W/C fraud and how to refer to SIU	Educate Departmental EE's on red flag indicators to report to SIU
Fraud Hotline:	Dedicated Work Comp Fraud and Abuse Hotline	Countywide Fraud and Abuse Hotline to Auditor-controller & fraud reported directly to CAO
Data Mining to Capture Fraud Indicators:	Done in-house, to enhance and decrease cost of investigation.	Done in cooperation with the DA and CDI
Recording Equipment:	Video and audio equipment on buses	Does not record employees on the job
Information Program:	Paycheck inserts, news media on recent cases	News media, handouts, e-mails and press releases
Contract Oversight:	Oversees all investigation activities with the goal of quality control and cost efficiency.	Oversee all fraud investigations, monitor investigation program
Dedicated Anti-Fraud Unit Personnel / Staff:	4	1.4
Fraud Arrests (Last 2 years):	3	10
Fraud Convictions (Last 2 years):	3 Pending	5
State Prison Sentences (Last 2 years):	0 / 0	2 EE's / 5 total years
Court Ordered Restitution (Last 2 years):	\$0.00	\$592,662
Future Cost Savings on Active Work Comp Claims (Last 2 years):	\$0.00***	\$2,000,000
Employees Discharged from Employment (Last 2 years):	16	5

\* Information provided by the MTA Special Investigation Unit.

\*\* Information provided Los Angeles County Special Investigation Unit.

\*\*\* Although the MTA has the formulas established to determine "future cost savings", the system has yet to be established.

## **VI. COUNTY ORGANIZATIONAL RESPONSE TO WORKERS' COMPENSATION FRAUD**

### **CAO-Risk Management**

The County of Los Angeles' workers' compensation program has been consolidated with other risk management functions and is being administered by the Risk Management Division located within the Chief Administrative Office. It is the Risk Manager's responsibility to conduct audits and actuarial analyses of the program and to ensure that the department and claim processors are performing properly. The Risk Manager supports the departments by taking an active role in selecting and contracting for TPA claim-handling services and medical-management and bill-review services for the County's workers' compensation claims. This position also handles budgeting for the payment of claims, including the oversight of the TPA contracts, bill review vendors, medical management services, vocational rehabilitation services, computer services, fraud prevention, and return to work and other specialized cost control programs (some departments elect to run their own specialized programs). The Division also oversees all other workers' compensation program areas, including litigation and loss prevention.

One of the goals of this Division is to combat fraud through the dissemination of information regarding workers' compensation fraud. Specifically, it is their intent to inform all County departments that they are aggressively investigating and prosecuting those who choose to commit fraud within the workers' compensation program.

### **Special Investigation Unit (SIU)**

The Special Investigation Unit, which is located within the Risk Management Division, currently has one full-time Program Specialist and one part-time employee assigned to oversee the anti-fraud program. These individuals review all workers' compensation cases that have been assigned to an investigation vendor in order to determine if a more in-depth fraud investigation may be warranted. Annually, there are approximately 1,800 cases assigned out for investigation. Each of these is reviewed by the SIU to determine if potential fraudulent activity may exist. The level of open claims, which currently numbers more than 25,000, date as far back as 1969 and involve payments for lifetime medical care and, for very serious cases, life pension benefits.

The Special Investigations Unit is responsible for:

- Investigating and recommending prosecution of fraudulent claims.
- Providing departments with overall guidance on program fraud.
- Monitoring all of the investigation activities related to Los Angeles County industrial accident claims.



- Reviewing all workers' compensation cases that have been assigned to an investigation vendor in order to determine if a more in-depth fraud investigation is warranted.
- Overseeing the County's anti-fraud program.

## County Departments

Workers' compensation administration is decentralized within the County; therefore, program responsibilities are carried out within the 38 different departments of the County. Recognizing this structure the Chief Administrative Officer commented in a recent report that "Departments must play an active, not passive, role in all aspects of Workers' Compensation management...."<sup>40</sup> Each department is responsible for designating an employee to serve as the facility's workers' compensation specialist or coordinator, generally as a collateral duty.

The department, as employing agency, is responsible for:

- Reporting industrial injuries to the CAO, initiating the claim and ensuring the timely notification to the TPA personnel.

It is at this point that the workers' compensation process for the individual begins and is arguably the most important point in making and validating any claim. Since the first report of a work related injury sets the stage for all remaining actions, it is evident that it must be detailed and fact specific. For example, one could develop the analogy to an investigation of a traffic accident. Such an investigation requires that an objective party (usually a law enforcement officer, not the injured party) collect such items as detailed statements by any injured parties, witness statements, photographs, and diagrams. The department, as the "first responder", must demonstrate by their approach to this investigation the importance that it attaches to this process.

This approach is critical for the injured party to ensure proper and immediate treatment. It is also an important step in deterring potential fraud since the perception that the department (County) does not care is eliminated. Additionally, if a claim is fraudulent, the first story is usually not as well thought out as it would be at later stages of the process.

- Directing the injured employee to the proper treating facility.
- Making sure the treating facilities know of the department's use of a modified/transitional work program.

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<sup>40</sup> Los Angeles County Chief Administrative Office, Countywide Return to Work Assessment, January 3, 2003, pg. 1.

- Working with the injured employee and the treating facility to obtain the proper documentation on work restrictions and availability of work assignments within those restrictions.
- Assisting in return to work functions by accommodating injured workers. The purpose of this effort is to ensure that the injured worker has the right to reclaim their job within one year of the onset of wage loss and to encourage earlier transition to full duty.
- Ensuring that appropriate agency personnel, such as supervisors, understand their workers' compensation responsibilities.
- Notifying the injured employees of their rights and obligations.
- Assisting nurses and adjusters in obtaining information required to defend and process claims. On serious claims, they make personal visits to the injured employee at home or in the hospital.
- Assisting the employee in returning to work as soon as possible by providing light or modified work duties.
- Publishing guidelines and manuals for their employees regarding how and where to obtain proper medical treatment, as well as how to assist disabled workers.

All County departments, except the elected officials, are held accountable by the Board of Supervisors, which approves service contracts, audits and reports, and the program changes, and exercises settlement authority on high-value cases (over \$100,000).

## County Counsel

The County Charter provides that the County Counsel is to represent and advise the Board of Supervisors and all County officers on all matters and questions of law. The Charter also requires that the County Counsel maintain exclusive charge and control of all civil actions and proceedings in which the County or any officer is concerned.<sup>41</sup> In this role the County Counsel oversees workers' compensation litigation for the County. This office manages litigated claims with the County Counsel handling approximately 25% of the litigated claims with in-house attorneys and the remainder using outside law firms, assigning in-house attorneys to oversee the outside law firms.

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<sup>41</sup> Los Angeles County Charter, Section 21.

## District Attorney

The District Attorney considers workers' compensation fraud throughout the County as a part of the core mission of the office. In 2001, the District Attorney filed charges in 23 cases of workers' compensation fraud, increasing to 36 in 2002 and to 48 in 2003. The number of defendants increased from 30 in fiscal year 2001-2002 to 64 in fiscal year 2002-2003. It is reported by the District Attorney that, on average, more than 90% of the cases filed result in convictions. After launching a crackdown in 2003 on employers who skirt paying workers' compensation premiums, 2004 finds the District Attorney going after networks of doctors and lawyers that are widely believed to generate a major portion of the fraudulent workers' compensation claims. Unfortunately, the District Attorney has stated that he is hampered by a lack of resources to address the problem adequately.

The District Attorney's Workers' Compensation Fraud Division pursues an aggressive campaign to identify, investigate, and prosecute workers' compensation fraud. This crime – which is committed by doctors, lawyers, employers, insurance company employees and claimants – occurs in both the private and public sectors.

This Division has seen staffing levels erode over the past decade. In the mid-1990s, the unit was more than double its current size. Since this unit is funded primarily through a surcharge levied on employers' insurance premiums and a charge on self-insured employers, it has not had reductions to date.<sup>42</sup> For the current fiscal year, the Los Angeles District Attorney's share of that surcharge is \$4.5 million, enough to fund 10 investigators, 10 prosecutors and seven support staff workers. The District Attorney has stated that he intends to request \$6.7 million for the 2004-2005 fiscal year to maintain this level of staffing.<sup>43</sup>

The two primary types of fraud pursued by the District Attorney include:

- Public Sector Fraud - Fraud perpetrated upon government entities has a direct negative impact on all taxpayers. The District Attorney's Office has special prosecutors assigned who handle only those frauds committed within the public sector. This approach combines aggressive investigation and prosecution with a comprehensive prevention program. The prevention aspect involves prosecutors addressing groups of employees regarding the benefits available for work related injuries while at the same time describing the consequences of committing fraud.
- Applicant Fraud - These cases involve workers who fake an injury, lie about the extent of their injury, lie by denying filing previous claims, fail to disclose a prior injury to the same body part, claim a non-work injury is work related, or

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<sup>42</sup> Note: Los Angeles County is a self-insured employer that pays to fund this program.

<sup>43</sup> Fine, Howard, Prosecutors Target "Mills" in Workers' Comp Crackdown, Los Angeles Business Journal, May 3, 2004

illegally work while obtaining benefits. Sub rosa surveillance tapes regularly expose applicants who are committing fraud.

These types of fraud are not mutually exclusive. Most of the public sector fraud cases pursued by the District Attorney are applicant fraud. Other types of fraud that the District Attorney prosecutes are premium fraud, insider fraud, treatment fraud, medical legal mills, employer/insurance fraud (denial of benefits), and uninsured employers.

### **Third Party Administrators (TPA)**

The County currently has four Third Party Administrators (TPA) that are responsible for the administration of the benefits provided to County employees injured on the job. The County maintains contracts with the TPAs outlining provisions to which they must adhere in administering benefits to injured employees. Pursuant to these contracts the TPAs are responsible for:

- Identifying, reporting and assisting the County staff in the prosecution of workers' compensation insurance fraud.
- Maintaining their own SIU for the purposes of tracking and investigating fraudulent activity.
- Assigning representatives to work with injured employees who cannot return to work promptly after an injury.
- Referring claimants to a medical specialist for a secondary opinion examination when necessary or required for additional medical information.
- Providing vocational rehabilitation services to employees who are unable to return to work at the employing agency or in the previous job/occupation category.
- Providing and tracking medical and disability payments if the employee is unable to return to work.
- Monitoring both the worker and the provider as to the medical status of the injured employee to ensure that he/she is able to return to work as soon as possible.

There are a total of 125 claims adjusters working on County claims at the four TPAs. These claims adjusters are responsible for providing benefits to employees who are legitimately injured on the job, as well as defending the County from expenses that should not be incurred under the workers' compensation program. Claims adjusters are also trained and instructed on how to detect "red flag fraud indicators" for referral to the County's Special Investigation Unit (SIU). The County should insure that third party administrators have sufficient personnel to investigate all cases thoroughly, rather than

merely process them. It has been pointed out by the District Attorney that in a number of cases benefits have been paid without question for a long period of time before action has been taken to determine whether the claim was fraudulent.

## **VII. COUNTY ANTI-FRAUD OPERATIONS**

### **General Case Processing**

Cases in which an employee loses seven or more days of work are referred to medical management nurses. The medical managers do telephonic medical management, which includes discussing the case with the injured worker and the physician to resolve any problems or disputes. The nurses use their medical backgrounds and established treatment and disability profiles to improve the cooperation of the treating facility and the injured worker. The nurses also inform adjusters of any inappropriateness of the provider's proposed treatment plan and/or the expected length of disability. They may also recommend alternative solutions, such as a referral to a medical specialist.

Upon approval by the CAO, field case managers may be assigned to more serious injuries or complex medical issues. Field case managers visit the medical providers and injured workers and help all parties ensure that the injured worker receives all the proper treatment needed to affect the best possible recovery. Field case management is used in a small number of cases.

The TPA claims adjuster is responsible for accepting or denying the claim and, if accepted, for paying timely and accurate benefits according to the statutes. To be legally excused from paying, the adjuster must determine if the employee is working or is capable of working and has been offered modified work. The County is also excused from paying when the claim is denied because it can be reasonably determined that the accident, illness or injury was not work related.

### **Fraud Investigation**

To achieve a successful program each Department, each TPA, the CAO and the County Counsel should follow each step of the workers' compensation life cycle with special emphasis on deterrence, detection, and investigation of fraud. Prior to opening a suspected fraud case the Third Party Administrator's (TPA) claim staff oversees all of the investigation efforts. Once a fraud case is opened the Special Investigation Unit (SIU) assumes all of the investigative activities and works closely with the TPA in order to obtain all of the necessary investigative documents, as well as copies of pertinent information from the claims file.

The SIU is responsible for reviewing all potential or suspected fraudulent cases for referral to criminal investigating agencies. The Special Investigation Unit receives approximately 300 suspected fraud referrals each year from numerous sources

including: anonymous callers, co-workers of the injured employees, outside private investigation firms and various other agencies or personnel. Every referral is reviewed to determine whether or not further investigation is warranted. Approximately 25% of these 300 cases are accepted by the Special Investigation Unit for investigation. The purpose of these investigations is to determine whether or not adequate evidence exists to justify the filing of a criminal complaint. Approximately 33%, or 25 cases, meet the criteria and are subsequently referred to the California Department of Insurance and the Los Angeles County District Attorney's Office for criminal investigation.

## **Suspected Fraud Documentation**

The process of gathering all the information requested by the Department of Insurance can be time consuming and sometimes tedious. Once all of the necessary information is compiled the case is referred to local law enforcement. These cases are known as Documented Referrals by the District Attorney's Office. A Documented Referral differs from a Suspected Fraudulent Claim (SFC) as the Documented Referral contains most of the information law enforcement will need to file criminal charges. The SFC is more of a notification for the District Attorney and the Department of Insurance to add a suspect into their fraud database. Occasionally SFC referrals will also lead to criminal charges, but it takes much more time than a Documented Referral due to the lack of documentation provided with the SFC.

### Documented Referrals

A report entitled Documented Referrals Received, - fiscal year 02/03, is prepared and distributed by the District Attorney's office. This report lists all of the Documented Referrals involving insurance fraud sent to the District Attorney's Office. The report is defined by the following categories: Insurance Company, Self-Insured Employer's and Third Party Administrators. In addition to local law enforcement there were a total of 46 other entities that sent the District Attorney's Office Documented Referrals in fiscal year 02/03. The County of Los Angeles submitted the highest number of Documented Referrals during this period.

As noted in Table 3, the County's Special Investigation Unit filed seventeen Documented Referrals with the District Attorney while the next closest reporting agency filed ten. Of the other forty-six agencies listed on this report, only seven of them filed more than six Documented Referrals.

**Table 3**  
**DOCUMENTED REFERRALS RECEIVED**

FISCAL YEAR 02/03 (THROUGH JUNE 15, 2003)  
SOURCE: LOS ANGELES COUNTY DISTRICT ATTORNEY

<b>PRIVATE CARRIERS</b>		<b>SELF-INSURED</b>	
AIG	5	Adventist Health	1
Alistar	2	City of Carson	1
Clarendon	1	City of Glendale	2
Eagle	1	City of Long Beach	2
Everest National	1	City of Los Angeles	10
Fremont	2	City of Torrance	4
Golden Eagle	1	County of Los Angeles	17
Gulf	1	Dept. of Veterans Affairs	1
Hartford	1	MTA	3
Insurance Co. of the West	3	U.S. Postal Inspection	3
Intercare	2	<b>TOTAL SELF-INSURED</b>	<b>44</b>
Kemper/Lumbermens	3		
Majestic Insurance Company	3	<b>THIRD PARTY ADMINISTRATORS</b>	
Octagon Risk	1	ACE/USA	5
Republic Indemnity	8	Gallagher Bassett Services	5
Royal Sun Alliance	3	Helmsman	1
Safeco	2	Keenan & Associates	1
SCIF	7	RICOMP	1
Sedgwick	1	Southern California Risk Management	1
Springfield	9	Ward North America	1
St. Paul	1	<b>TOTAL TPA</b>	<b>19</b>
State Farm	1		
The Standard	1	<b>LOCAL LAW ENFORCEMENT</b>	
TIG	1	Local Law	8
Travelers	2	State of CA Dept. of Insurance	42
Zenith	3	<b>TOTAL LOCAL LAW ENFORC.</b>	<b>50</b>
Zurich	4		
		<b>OTHER</b>	
<b>TOTAL PRIVATE CARRIER</b>	<b>70</b>	<b>TOTAL OTHER</b>	<b>40</b>
<b>TOTAL DOCUMENTED REFERRALS RECEIVED</b>		<b>223</b>	

Suspected Fraudulent Claim Referrals

The Suspected Fraudulent Claim (SFC) Referral Received (Fiscal year 02/03) report, on Table 4, lists all agencies, including auto insurance companies that have filed SFCs with the District Attorney's Office in fiscal year 02/03. Of the sixteen employers or Third Party Administrators listed in the report the County of Los Angeles and its Special Investigation Unit have filed the most SFCs during this time period. In fact, the County of Los Angeles filed 14 Suspected Fraudulent Referrals while the next closest reporting employer or Third Party Administrator filed a total of four.

**Table 4**  
**SUSPECTED FRAUDULENT CLAIM REFERRALS RECEIVED**

FISCAL YEAR 02/03 (THROUGH JUNE 15, 2003)  
SOURCE: LOS ANGELES COUNTY DISTRICT ATTORNEY

<b>PRIVATE CARRIERS</b>			
Adventist Health	4	AIMS, Acclamation	1
Alaska National	2	American Home Assurance (AIG)	72
American Manufactures	9	American Sterling	1
Atlantic Mutual	5	California Indemnity	6
Cambridge	2	Centennial	1
Clarendon	1	C N A/RSK Co.	2
Commerce & Industry Ins. Co. (AIG)	9	Cypress	3
David Morse & Associates	1	Eagle	2
Everest National	23	Explorer Insurance Company (ICW Group)	9
Farmers	45	Fire	6
Fremont	54	Granite State (AIG)	11
Helmsman	4	Intercare	4
Kemper	7	Liberty Mutual	22
Llorente Investigations for Majestic	1	Lumbermens Mutual Casualty Co.	3
LWP Claims Administrators	1	Mercury	1
Mid-Century	77	National American	5
National Union Fires Ins. Of Pitts., PA (AIG)	22	Octagen Risk Services	2
Progressive Management Services	1	Republic	2
Royal & Sun Alliance	6	Safeco	13
SCIF	7	Springfield	7
State Farm	3	St. Paul	1
The Hartford	1	The Insurance Co. of the State of PA (AIG)	43
TIG	1	Tokio Marine	1
Travelers	3	Truck	28
Wausau	2	Zenith	3
Zurich	23	<b>TOTAL PRIVATE CARRIER</b>	<b>563</b>
<b>SELF-INSURED</b>			
City of Long Beach	1	City of Los Angeles	3
County of Los Angeles	14	Qesteral Claims Management	1
MTA	2	So. California Edison	1
United States Postal	1	<b>TOTAL SELF-INSURED</b>	<b>23</b>
<b>THIRD PARTY ADMINISTRATORS</b>			
ACE/USA	1	Crawford & Co.	2
ESIS	1	Fleming & Associates	1
Gallagher Bassett	1	Helmsman	4
Sedgwick	4	Southern California Risk Management	3
Ward Ortho America	1	<b>TOTAL TPA</b>	<b>18</b>
<b>LOCAL LAW ENFORCEMENT</b>			
Los Angeles County	2	<b>TOTAL LOCAL LAW ENFORCEMENT</b>	<b>2</b>
<b>OTHER</b>			
Other	17	<b>TOTAL OTHER</b>	<b>17</b>
<b>TOTAL SUSPECTED FRAUDULENT CLAIMS RECEIVED</b>			<b>623</b>
<b>TOTAL DOCUMENTED REFERRALS</b>			<b>223</b>
<b>TOTAL REFERRALS</b>			<b>846</b>



## VIII. WORKERS' COMPENSATION FRAUD DETERRENCE

The easiest way to prevent fraud is to prevent it from happening. To accomplish this there are a number of approaches that can be taken to minimize the possibility of fraud. For example, the Los Angeles City Council, in an attempt to address their concern over the ballooning cost of workers' compensation claims, voted on April 14, 2004 to deter the commission of fraud by disqualifying people convicted of workers' compensation fraud from working for the City, an action that was soon followed by the County of Los Angeles.

### Sound Hiring Practices

The establishment of a sound hiring practice is the first line of defense in the fraud deterrence process. The foundation of this defense relies upon the ability and the willingness of the County to verify an employment candidates' work history, background and references carefully. Under certain circumstances it might be prudent for the County to become more proactive in the conduct of its background investigation using such things as credit checks, legal filings or criminal background checks. People who lie on applications, have financial difficulties or have criminal records may be more likely to manipulate circumstances for financial gain. Experience has shown that some workers' compensation fraudsters are professional or serial perpetrators with a history of false or exaggerated workers' compensation injury claims. These individuals can be identified via questioning and verifying gaps in employment history or frequent job changes. Using this information the County will be in a better position to determine whether a job offer should be made. Upon employment photo identification, which is currently required, ensures that an investigator looking into a potential workers' compensation fraud or abuse case covers the proper person should surveillance ever be required.

In recognition of these concepts, on May 25, 2004, Supervisor Don Knabe introduced a motion to draft an ordinance, as has the City of Los Angeles, to prohibit persons that have been convicted of filing fraudulent workers' compensation claims from employment with Los Angeles County. In his motion the Supervisor recognizes that a prior workers' compensation fraud conviction directly impacts an applicant's ability to be trusted with a job funded by the taxpayers and therefore, should be grounds for disqualification. This action is a significant step toward identifying those individuals that may be predisposed toward fraudulent activity.

It is recommended that the Board of Supervisors:

1. **Direct that the Department of Human Resources review the County's hiring practices to ensure that all possible steps have been taken, including possible testing for illegal drugs and alcohol, to identify those applicants that may be predisposed to engage in unsafe working practices.**

## Training

A study by Intracorp found that injured employees who didn't receive workers' compensation training prior to being injured were not only more likely to seek legal help, but were also out for longer periods of time than those who were informed about their benefits regarding workers' compensation. It is clear that it is not only critical that employees and management personnel understand the meaning and impact of fraud and abuse, but that they also recognize the consequences of both in applying for workers' compensation. Although there is currently some training of key personnel being conducted within the County by the risk management staff, it is important to expand this training to the employee level to ensure that everyone has an understanding of fraud and abuse within the workers' compensation system.

Warren, McVeigh & Griffin concluded in a recent report that "...improved and more detailed risk management training, under the direction of the CRM (Centralized Risk Manager), should be provided to all departments and their risk managers."<sup>44</sup> It appears upon a review of this recommendation that it was made with the objective of providing training to departmental personnel involved in the risk management program. Although the Commission would concur with the intent of the recommendation, and makes a similar recommendation to achieve the same objective, we also propose to expand upon the recommendation to ensure that all employees be trained in the area of workers' compensation and the consequences of fraud and abuse.

It is recommended that the Board of Supervisors:

2. **Direct that the Department of Human Resources, in coordination with the County's Risk Manager, train all employees on the proper use and application of workers' compensation benefits, the prevention and detection of fraud and abuse in the workers' compensation system, and the impacts of fraud and abuse on the County and each County employee.**
3. **Direct that the Department of Human Resources, in coordination with the County's Risk Manager, expand the training of managers and supervisors on workers' compensation issues so that they can help identify and solve problems and understand how injuries decrease productivity, add to workers' compensation costs, and impact County programs.**

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<sup>44</sup> Warren, McVeigh & Griffin, Inc., Evaluation of the Risk Management Role of the County Counsel's Office, November 9, 2001, Pg. 10.

## Communication

Prosecutions alone are not sufficient to deter fraud effectively, but prosecutions combined with meaningful communications concerning the prosecutions and emphasizing consequences would go a long way in deterring fraudulent activities. Communication can play an effective role in the process by raising the fear of detection and the resulting consequences. If a prosecution is necessary, an additional advantage of an effective communication program is that the County is able to demonstrate that the claimant did, in fact, have knowledge of the requirements placed on him/her.

Effectively communicating the County's fraud issues could include such items as publicizing anti-fraud news in the County's monthly newsletter and/or the development of a clearly stated policy to disseminate this information to each employee and the public. Currently, the County receives media attention whenever one of its employees is arrested and charged with fraud. This information is also disseminated to those departmental personnel involved with the workers' compensation program. This message would have an even greater impact if this information were as widely disseminated internally as it is in the local media, i.e. a regular segment in the County News or inserts included with the County paycheck. The benefits of this approach include, but are not limited to:

- Letting people who commit fraud know that the County is both serious about stopping it and that the crime has significant consequences.
- Informing employees and the public of the pervasive nature of the problem and encouraging their support in the fight against fraud and abuse.
- Educating outside organizations about fraud, the means that are available to fight it, and the benefits to be realized.

The objective of communicating effectively is to increase internal and public awareness of enforcement activities, arrests, convictions, and savings to all when fraud perpetrators are detected and punished. An additional objective of communication is to commend the efforts and results of anti-fraud activities and, where appropriate, demonstrate savings.

It may prove valuable to work with the courts to have those who have been convicted of workers' compensation fraud participate in briefings to employees on the consequences of such actions as part of their community service. These briefings might emphasize how workers' compensation costs affect the funds available to support other important programs. To prevent off-the-job accidents from being filed as workers' compensation claims, such a briefing could explain the availability of short-term disability for non job-related injuries/illnesses and how that program works. It is essential to communicate to the employee that the workers' compensation program is designed to help employees who are injured, and to fraudulently make a claim on the system by distortion or

misrepresentation for the purpose of obtaining additional benefits is a punishable felony crime.

The MTA has discovered a positive result in taking administrative action, usually termination, against those who have been found to have committed “gross misconduct” by falsifying documents in order to receive benefits. They have found that the discussions that have taken place among employees as a result of such an action have had a significant and positive effect on internally communicating the consequences of committing fraud. Several other benefits also accrue as a result of taking this type of action: a termination action is immediate and dramatic, the impact of seeing an individual lose his/her job is personal and visceral, and the consequences of committing workers’ compensation fraud are recognized by employees as being consistent in its application. Even though the MTA may concurrently file a criminal action whose consequences may be more severe, given that such filings can take months or years to resolve, the positive impact on the organization can often be diluted. An additional potential benefit that resulted was that once an individual has been terminated he/she will often withdraw any claim. Note that since the MTA deals with a number of unions they must ensure that due process is given to an individual prior to taking any administrative action. When such action is anticipated, the investigative agency works with Labor Relations to “refer for administrative action” to the appropriate department. This department holds hearings and renders a verdict. Over the past 8 months 15 hearings have been conducted, with none of those verdicts having been overturned.

Another communication technique that has been used in the workers’ compensation community is a fraud warning check endorsement. In 2000, the Coalition Against Insurance Fraud conducted a survey by mail of selected insurance companies writing workers’ compensation coverage in the United States. This survey determined that 70% of the states in which business was being conducted mandate either by law or regulation that the placement of fraud warnings on a benefit check stating that acceptance of the check for benefits to which the recipient was not entitled is a crime and could lead to prosecution. In addition, 85% agreed or strongly agreed that fraud warnings on benefit checks are a useful tool in deterring fraud. Also, 90% agreed or strongly agreed that fraud warnings on benefit checks assisted in prosecuting insurance fraud. The following is an example of the endorsement that could be included on a check:

***Possible Provider Check Endorsement Language:***

*Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers’ compensation benefits or payments is guilty of a felony. By my endorsement, I acknowledge that I have not made or caused to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining workers’ compensation benefits*

**Possible Claimant Check Endorsement Language:**

*By my endorsement, I acknowledge that while receiving workers' compensation temporary disability benefits, I must inform the County of all monies I earn from any source of employment including self-employment. I further acknowledge that acceptance of employment with another employer (including self-employment) that requires performance of activities that I have stated I cannot perform because of the injury for which I am receiving temporary disability benefits could constitute fraud and could result in criminal prosecution. Conviction could result in a loss of my rights to workers' compensation benefits and imprisonment for up to five years and a fine of up to \$50,000.00, or double the amount of the fraud, whichever is greater.*

In addition to having warnings printed on checks, employees receiving workers' compensation benefits should also be required to periodically sign forms, ***in person***, acknowledging that they have been informed of the rules and that they are accurately representing the facts that entitle them to the benefits that they are receiving, e.g. they are not working elsewhere.

Finally, a study by the Gallup Organization and sponsored by Intracorp and CIGNA shows the value of keeping in contact with injured workers. The study included in-depth interviews with more than 1,000 injured and ill workers. It found that employees who were contacted while home with an injury or illness returned to work quicker and were overall happier with the results of the event. In Los Angeles County the Chief Administrative Officer stated in a recent report that "Maintaining contact with the injured/ill employee is vital". In spite of that realization he also stated that "Department supervisors rarely contact injured employees at home to follow up on their welfare and do not use the existing Early Return to Work weekly telephone log."<sup>45</sup> As a result of these findings the CAO recommended that "Return to Work Coordinators should maintain ongoing communication with all parties impacting Workers' Compensation claims..." and that "An information brochure or letter from the department should be provided..." This report expands upon this recommendation by stating that all employees should be proactively and routinely informed in a systematic manner on all aspects of workers' compensation. This should include the consequences of fraud and abuse. This action will create a positive impact on the County and its workforce.

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<sup>45</sup> Los Angeles County Chief Administrative Office, Countywide Return to Work Assessment, January 3, 2003, pgs 13 & 5.

It is recommended that the Board of Supervisors:

4. **Direct the County's Risk Manager, in coordination with the Public Affairs Office, internally to publicize the County's anti-fraud message, highlighting anti-fraud actions and convictions, using such methods as a regular segment in the County News, a special program on the County TV channel, and other appropriate communication vehicles.**
5. **Direct the Chief Administrative Officer to develop and implement a countywide policy that establishes when and how information on fraud related matters is to be released to the media.**
6. **Direct the County's Risk Manager to develop and implement measures to ensure that employees are informed of both their rights and responsibilities at the time of their injury and an explanation of the criminal, civil and administrative penalties for fraudulent or abusive claims.**
7. **Direct the Public Affairs Office to expand how it displays and publicizes the County's Fraud Hotline number, emphasizing the need to report the fraud and abuse of the workers' compensation system.**
8. **Direct the Public Affairs Office to expand how it displays and publicizes workers' compensation fraud and abuse posters.**
9. **Direct the Auditor-Controller, in coordination with the County's Risk Manager, on a quarterly basis, distribute workers' compensation fraud and abuse information with the payroll.**
10. **Direct the County Risk Manager to develop and present periodically on-site briefings with employees to discuss workers' compensation policies and procedures, emphasizing the fundamentals of the workers' compensation program, what to do when an injury occurs, and the County's policy on fraud and abuse and return to work.**
11. **Direct that the Department of Human Resources, in coordination with the County's Risk Manager, provide the County's workers' compensation policy to all new hires and require that they sign an acknowledgement that they have read and understood the policy. The policy should include, but not necessarily be limited to, the following:**
  - a. **Basic information on how the State's Workers' Compensation Program works.**

- b. **The procedures to be followed when treating an injured employee including, if applicable, telling injured employees which health care providers have been selected for use and why they have been chosen.**
  - c. **A statement of how and to whom industrial injuries are to be reported.**
  - d. **An explanation of the employee's obligations and the rules to be followed while receiving workers' compensation benefits.**
  - e. **A policy on the return-to-work program together with a specific statement emphasizing the fact that work will be found for injured workers as soon as they can return to transitional duty.**
12. **Direct the County Risk Manager to publish and distribute the Workers' Compensation Policies at least annually to ensure that all employees understand the program and how it works.**
13. **Direct that the Auditor-Controller place a statement above the endorsement on workers' compensation checks certifying that the recipient is entitled to the disability payment.**
14. **Direct the County's Risk Manager to develop and implement measures to ensure that the County maintains contact and a positive relationship with the injured worker, even in situations that may seem suspicious. These measures should include a requirement that employees receiving workers' compensation benefits should also be required to periodically sign forms, in person, acknowledging that they have been informed of the rules and that they are accurately representing the facts that entitle them to the benefits that they are receiving.**

## Safety

Statistics have demonstrated that 90% of all occupational injuries and illnesses are the result of unsafe behaviors. In recognition of this fact the Mayor of the City of Los Angeles by executive directive requires city departments to implement the "Safety is My Job" campaign, which stresses safety training and compliance, increased safety inspections and fraud reduction. This program has been put into place in an effort to

reduce the 1.7 million employee hours – the equivalent of 834 positions – to workplace injuries.<sup>46</sup> Accordingly, loss prevention is the first step to reducing costs.<sup>47</sup>

The 2002-2003 Los Angeles County Grand Jury concurred with this assessment and stated that the “...County will continue to be responsible for their own claims, making it critical that the workers’ compensation programs be effective as possible in preventing injuries....”<sup>48</sup> With loss prevention being so important, employees need to be trained to perform clearly defined safe behaviors. If systems are put into place to show management’s commitment and active participation, the desired behavior can become the natural way that employees perform their work.

As part of an intensified safety program, consideration should be given to conducting a safety inspection by an objective third party. An example of this approach is the third party safety inspection that was conducted by the MTA using an outside consulting company that resulted in an identified success. Even though the current fiscal environment of the County might suggest that such a third party inspection might not be practical at this time, this inspection could be undertaken through the use of a “County internal third party”, i.e. an organization or agency from outside the inspected department.

If employees are going to be performing the tasks, they should be involved in helping define what is appropriate for maximizing safety. They also should be involved in assessing and measuring the results. Developing an effective way to communicate desired performance and measure outcomes is critical to any safety program’s success. But unfortunately, this is where many safety programs fall short. It is necessary to demonstrate value-added outcomes to fulfill management’s need to see that safety does have tangible and financial benefits. Employees need to see they are getting positive results and that their efforts are going to be recognized. The best way to ensure that safety goals are defined, attained and evaluated is through a written safety program.

It is recommended that the Board of Supervisors:

- 15. Direct the Chief Administrative Officer to develop and implement a written safety program that achieves 100% safety awareness for employees and, using the approaches proposed in this program, conduct a countywide safety inspection designed to eliminate as many potential safety problems as possible.**

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<sup>46</sup> County News Service (CNS), Safety Campaign, August 25, 2004, located on the web at: ([http://www.socalnews.com/news/?mode=1&hgt=&pr\\_id=210031](http://www.socalnews.com/news/?mode=1&hgt=&pr_id=210031))

<sup>47</sup> Memo to the Board of Supervisors from Tyler McCauley, Auditor-Controller, and David Janssen, Chief Administrative Officer, Evaluation of County Risk Management Program, May 30, 2001. In this memo it was recommended that the County place “Greater emphasis on collaboration with County departments to develop loss prevention programs.”

<sup>48</sup> 2002-2003 Los Angeles County Grand Jury Final Report, pg. 27.



- 16. Direct the Chief Administrative Officer to develop and implement countywide procedures that increases the attention being paid to any complaints or concerns over working conditions, including an employee safety hotline, and that makes every effort to address these complaints in a timely manner. (It has been demonstrated that the strongest predictor of fraud is a chronically disgruntled work force.)**

## Anti-Fraud Strategy

There is currently no overall strategy for how to reduce fraud within the County's workers' compensation system. The potential magnitude of the workers' compensation fraud within the County requires the Risk Management staff to design and implement a strategy to address the problem in a comprehensive manner. Warren, McViegh & Griffin arrived at the same conclusion, although more limited than the recommendation made in this report, when it concluded that "The CRM (centralized risk manager) should develop firm program goals and objectives with all parties and measure the results against these identified objectives."<sup>49</sup> The strategy proposed in this report should be of such a scope as to:

- Identify the goals and objectives of the program and link them to measurable outcomes to evaluate the effectiveness of the County's fraud prevention program.
- Establish timelines and action plans for completing each objective and allocate the available resources based on its priorities.
- Define the roles and responsibilities of all of the various participants involved in the anti-fraud activities within the County.
- Develop effective performance measures that can be effectively communicated to County departments and the public.
- Recognize the following additional responsibilities for the fraud unit:
  1. Conducting the research needed to advise the County on the resources necessary to pursue an aggressive workers' compensation fraud prevention program,
  2. Advising the risk manger on the most effective distribution of available funds to deter, detect and prosecute workers' compensation fraud, and
  3. Reporting on the impact of workers' compensation fraud and making recommendations to reduce it.

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<sup>49</sup> Warren, McVeigh & Griffin, Inc., Evaluation of the Risk Management Role of the County Counsel's Office, Recommendation #34, November 9, 2001, pg. 10.

To facilitate this effort it would be of value to create a workers' compensation task force to identify cost saving possibilities within the program. This group can also take a role in identifying the elements needed to develop and maintain effective case management and to develop policies and procedures that can significantly aid in reducing workers' compensation costs. The task force could establish the mechanism for sharing of information among departments. It could also assist in the resolution of complex cases and other workers' compensation issues.

It is recommended that the Board of Supervisors:

- 17. Articulate a policy addressing workers' compensation costs, including the deterrence, detection and prosecution of fraud and abuse within the program.**
- 18. Consistent with the workers' compensation policy established by the Board, direct the County's Risk Manager to develop an anti-fraud strategy that addresses the fraud prevention needs of the County, develops program objectives that are specific, measurable, realistic, time sensitive and performance based, and ensures the effective utilization of risk management resources.**
- 19. Direct the Auditor-Controller, in coordination with the Chief Administrative Officer and affected departments, to create an annual report on workers' compensation costs that:**
  - a. Analyzes each of the elements of workers' compensation and delineates the County's costs by department.**
  - b. Identifies the amounts expended in workers' compensation as a percent of the salary/employee benefits costs for each department in order that comparisons of these percentages can be made to other similar local, County, and state departments.**
  - c. Identifies the cost changes from year to year.**
- 20. Direct the Chief Administrative Officer to analyze recently adopted state workers' compensation reforms to determine how these reforms may impact the recommendations made in this report.**
- 21. Direct the Chief Administrative Officer to establish a special Workers' Compensation Task Force to assist the County's Risk Manager in the development of a strategy to reduce workers' compensation costs.**

## IX. WORKERS' COMPENSATION FRAUD DETECTION

An effective detection program is important not only because it helps discover fraud and abuse, but also because the knowledge that such a program is in place helps limit potential fraud and abuse within the system.

### Staffing

It is valuable to consider the impact of injuries to employees on the continuing staffing levels of a department. A study conducted by the Chief Administrative Officer found that "Temporary modified duty is being offered to injured employees."<sup>50</sup> This process is important for a number of reasons, particularly since it is clear from industry studies that the longer an employee is off from work the harder it is to get them to return. Transitional duty also assists in shortening an employee's time off due to injuries or illness. Because of the importance of this process all cases should be monitored closely for the purpose of determining if light or modified duty is a viable option. In addition, the process should be reviewed periodically to ensure that it continues to be effective.

Work level comparisons should be undertaken of other criminal agencies that investigate insurance fraud including the District Attorney's Office and the California Department of Insurance. These investigative organizations normally assign 6 to 8 active cases to each investigator. County Risk Management SIU routinely has a minimum of 50 to 60 open cases or more. In comparing the County SIU to other organizations within the workers' compensation industry it should be noted that the County of Los Angeles has the second largest workers' compensation program in the State of California - only the State Compensation Insurance Fund (SCIF) is larger.

It is recommended that the Board of Supervisors:

- 22. Direct the County's Risk Manager to review periodically the policy, along with its implementation, that requires departments, or in some cases the Chief Administrative Office, to make an offer of light or modified duty.**
- 23. Direct that the Department of Human Resources conduct a staffing review to consider the following:**
  - a. Whether an increase in the staffing level of the Special Investigation Unit above the current one full-time employee and one part-time employee would result in increased savings to the County.**

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<sup>50</sup> Los Angeles County Chief Administrative Office, Countywide Return to Work Assessment, January 3, 2003, pg. 3.

- b. **Whether it would be beneficial from a cost standpoint to fund a County dedicated investigator(s) within the District Attorney's Office.**
- c. **Whether it would be beneficial to join other self-insured employer's (e.g. MTA, LAUSD, the City of Los Angeles, etc.) to co-fund dedicated investigators to investigate exclusively workers' compensation claims for the participating public agencies.**

## **Information Technology**

### Data Systems Development

The California Commission on Health and Safety and Workers' Compensation has stated that "It is undeniable that the more information is shared among those who collect it; the more likely it is that major fraudulent schemes will be detected, adequately investigated and successfully prosecuted".<sup>51</sup> The California Workers' Compensation Institute has stated that "A collaborative, multi-payer transactional data warehouse increases the potential of detecting true fraud and abuse 'signals' while discounting singular or aberrant anecdotes that distract special investigations."

Clearly the County could facilitate more informed decisions by adjusters and more consistent settlements by increasing its involvement in obtaining and providing claims-level data that track how claims are being resolved.<sup>52</sup> This data would expand the data available to provide feedback about historical patterns in claims resolution and could guide decision-making and help set reasonable expectations about resolving new claims. The availability of these types of data would help ensure a more informed and consistent set of practices and resolutions under the workers' compensation system. This need has been recognized by the County in its finding that "Overall, a significant need exists to implement an improved record keeping system (databases, case logs, etc.)". In addition, it was found that "Few departmental manual logs or electronic databases are maintained to track injured employees off duty or on modified duty with work restrictions, or type of benefit notices received."<sup>53</sup> As a result, this report in recommendation #8 stated that "All departments should follow a standardized recommendation process..." This recommendation followed upon a recommendation of Warren, McVeigh & Griffin, Inc. which proposed the replacement of "...the current

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<sup>51</sup> California Commission On Health And Safety And Workers' Compensation, Report On The Workers' Compensation Anti-Fraud Program, August 2001.

<sup>52</sup> Memo to the Board of Supervisors from Tyler McCauley, Auditor-Controller and David Janssen, Chief Administrative Officer, Evaluation of County Risk Management Program, May 30, 2001. In this memo it was recommended the data be made available through the "Inclusion of the County's workers' compensation incident and claim records within the new Risk Management Information System (RMIS) recently approved by the Board."

<sup>53</sup> County of Los Angeles Chief Administrative Office, Countywide Return to Work Assessment, January 31, 2003, pg. 6.

workers' compensation information technology (IT) system or upgrade the existing system to one that is fully functional and integrated with the liability system so that standardized and integrated loss control and claim-analysis reporting may be accomplished using the latest data warehousing technology."<sup>54</sup> Commenting on the preceding recommendation the Los Angeles County Auditor-Controller stated that "We agree that the current Workers' Compensation information technology system should be replaced."<sup>55</sup>

A database with this type of information, preferably one that is shared with other workers' compensation fraud organizations, is also a valuable tool for fraud detection purposes since it provides administrators with the capability to conduct statistical analysis to uncover suspicious patterns, to run queries on existing data, and to undertake analysis of claimant data. Although the County currently accesses a tremendous amount of "claims level data" the use of such a database would greatly encourage and facilitate the detection of fraud patterns.

The County currently utilizes a number of data mining tools to evaluate a claimant for prior workers' compensation claims and civil litigation, but the procedures being used are primarily a paper file system with little computer enhanced software or programming. With more fraud cases being tracked, the SIU could be enhanced by using a file tracking software program similar to *Gencomp* which is widely utilized within the workers' compensation program community.<sup>56</sup> The improved tracking of incidents would enable a meaningful study of existing County injury incident records and analyze incidents and claims by worker, position, job type, location, training and length of service, equipment type, and any other factors relevant to controlling accident claims.<sup>57</sup> The County would be able to draw upon information contained in a wage loss study as well as a possible follow-up study of claimants to improve the understanding of the rate of return to work of injured workers and whether they experience episodic periods of employment and unemployment after their return.

The County does presently provide the Fraud Interdiction Program with data to assist in the prosecution of medical providers for tax evasion. This is a promising strategy implemented by the County of Los Angeles District Attorney's Office. This data is also shared with the Department of Insurance to assist in potential provider fraud identification.

Another application in data systems development is in the pre-designation of physicians. Prior to the passage of SB 899, the fastest growing area of fraud and abuse

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<sup>54</sup> Warren, McVeigh & Griffin, Inc., Evaluation of the Risk Management Role of the County Counsel's Office, November 9, 2001, pg. 4.

<sup>55</sup> Memo from Lloyd Pellman, Los Angeles County Counsel to Tyler McCauley, Los Angeles County Auditor-Controller, Evaluation of the Risk Management Role of the County Counsel's Office, December 13, 2001.

<sup>56</sup> Similar observations and recommendations were made by Warren, McVeigh & Griffin, Inc. in their report to the County of Los Angeles County entitled Evaluation of County of Los Angeles Risk Management Program, May 22, 2001, pgs 31-32.

<sup>57</sup> *Ibid.* pg. 31 - Warren, McVeigh & Griffin also recommended "Enhancing the reporting system for both standardized and ad hoc reports."

in the County workers' compensation system was in the pre-designation of physicians. Employees were more likely to pre-designate if they were in organizations that had developed over the years underlying incentives to make claims. SB 899 modifies this right to pre-designate significantly. Now, an employee will be only able to pre-designate if the employer offers group health, which Los Angeles County does, the physician is the primary care physician of that employee, the group health physician agrees to be the workers' compensation provider, and treatment is subject to the terms and conditions of the group health program. While SB 899 will do much to limit the impact of the potential for abuse by pre-designating physicians, it may result in employees going outside of the workers' compensation doctor networks. This potential for abuse could be limited by coordinating the group health program and the workers' compensation program. If this is not undertaken, the system will have the potential for considerable leakage.

### Legislative Impact on Data Management

In recent legislation AB 1099<sup>58</sup> enables investigators of the Department of Insurance, among other governmental agencies, to receive Employment Development Department (EDD) data for the purpose of investigating a potentially fraudulent workers' compensation claim. If an injured worker, who is disabled from performing his/her usual and customary County job, is working for another employer, he/she could be committing workers' compensation fraud, depending on the circumstances of their injuries. EDD data could present a powerful tool to aid in the identification of potentially fraudulent workers' compensation claims. An additional benefit of using such a database would be to potentially enable the establishment of performance measures against which to evaluate the effectiveness of current and future anti-fraud activities.

As an example of how such common databases may be used, consider that a medical provider could claim that he/she delivered services to hundreds of claimants a day, even though it is not possible to provide this level of services. Because the provider's bills would be processed by numerous insurance carriers and self-insured employers, the magnitude of the provider's claims would not be apparent to any single insurer. In addition, the database may identify an employee who has a history of frequent accidents or injuries with no witnesses. Through query of the database, possibly using an employee's social security number, employees with a history of workers' compensation claims and/or current multiple claims can be identified. These measures can be developed through an analyses of the data that may be available from State departments engaged in employment-related activities, such as the Industrial Relations and the Employment Development Departments.

Further, AB 1099 does not make a provision to guarantee that non-credible medical professionals who promote costly and/or unneeded treatments will be kept out of the new, employer chosen health networks. It appears that the law anticipates the employer, in this case the County, must somehow identify if unqualified or unethical

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<sup>58</sup> AB 1099 - An act to amend Sections 1877.1 and 1877.3 of the Insurance Code, relating to insurance fraud, California Legislature, 2003-04 Regular Session, February 20, 2003.

medical professionals are in a network when choosing one. The problem becomes one of identifying these individuals whom the state of California, with all its resources, has chronically failed to identify.<sup>59</sup>

Since the County now becomes responsible for the identification of non-credible medical professionals it becomes incumbent upon the County to actively participate in the creation of its workers' compensation physician networks. It becomes increasingly critical to the success of the system that the workers' compensation physician networks have quality doctors that will treat patients efficiently and effectively. If the system administrator fails to utilize the capabilities of an effective database to screen healthcare providers in the network, it is possible that former applicant attorney doctors will be treating the County's patients. The County should make the creation of a quality network a number one priority. This will be one of the single most effective actions that can be taken to reduce fraud and abuse.

### Modeling Workers' Compensation Fraud

The County's anti-fraud program currently utilizes a rules based (or red-flag) model to detect workers' compensation fraud. This approach is used by most insurance companies and self-insured employers, including the MTA. The County anti-fraud program is exploring utilizing predictive models to enhance the detection of workers' compensation fraud. These models are relatively new in the workers' compensation arena and appear costly.<sup>60</sup> Even so, predictive modeling tools can help pick up what an adjuster might miss from time to time.

Other organizations throughout the nation have been trying predictive modeling to identify fraud and abuse. "The use of technology to combat fraud is still in its infancy," is the conviction of Laki Balaji, vice president of property and casualty predictive software solutions for San Rafael, California-based Fair, Isaac & Co., a developer of predictive modeling, decision analysis and intelligence management systems. The Hartford, Connecticut based Travelers Property Casualty Corporation is using technology that was first developed to address bodily injury claims stemming from auto accidents to address workers' compensation fraud. In the past, 90% of workers' compensation fraud at Travelers was detected up front, meaning that fraud was detected as the claim was submitted, but now it is able to identify fraud in the medical indemnity part of the claim. At this point, it is evident that technology alone cannot be the total solution when coping with fraud, but it is also evident that the effort should

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<sup>59</sup> Stewart, Jill, The Monster's Loose: Will Workers' Comp Reform be a Friend or a Benevolent Beast-or Eat Us Alive, Ventura County Reporter, April 29, 2004.

<sup>60</sup> An example of a predictive model currently in use is available through Workers' Compensation Fund of Utah (WCF-Utah) which uses HNC Insurance Solution's VeriComp Fraud Manager, predictive software designed to detect fraud and abuse in Workers' Compensation claims. In one case VeriComp's early detection of double-dipping resulted in a \$284,000 savings for WCF-Utah. Magnify Inc., a Chicago-based fraud technology vendor, has also focused on predictive modeling technology that runs claims through ISO's ClaimSearch comprehensive database (Jersey City, N.J). In addition, the Computer Science Corporation (CSC) claims that its predictive model, the @First® system, can detect suspicious claims as early as the first notice of loss.

include technology in synergy with human fraud detection competencies to address fully the problem.<sup>61</sup>

It is recommended that the Board of Supervisors:

- 24. Direct the County's Risk Manager to develop a database for workers' compensation claims that has as its objective the measurement of, among other things, the nature and extent of fraud and abuse in the workers' compensation system.**
- 25. Direct the County's Risk Manager to develop uniform reporting requirements for organizations involved in workers' compensation anti-fraud activities that maximize the use of current reporting requirements in an effort to avoid duplication.**
- 26. Direct the Chief Administrative Officer to expand upon return to work strategies using the workers' compensation claims database, along with any other information that may be available.**
- 27. Direct that the County's Risk Manager monitor program areas such as Continuation of Pay (COP) to develop trends involving potential increases or decreases in workers' compensation program costs.**
- 28. Direct that the County's Risk Manager utilize investigative management software to assist in the effective utilization of the Special Investigation Unit (SIU) resources.**
- 29. Direct that the County's Risk Manager expand the analysis of the County's claims history.**
- 30. Direct the County Counsel to investigate whether the legal right to receive State data extends to the County's anti-fraud program. If not, direct the Chief Administrative Officer to express the desire of the Board to the County Advocates to pursue legislation that would enable the workers' compensation anti-fraud program to receive such data.**
- 31. Direct that the County's Risk Manager review the current usage of predictive modeling with the objective of understanding its application to the identification of fraud and abuse and ascertain whether such an approach would make a cost effective contribution to its anti-fraud program.**

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<sup>61</sup> Dwyer, Steve, [Much Insurance Fraud Occurs Stealthily – Flying Below the Radar](#), Insurance Networking News, November 2002, Vol. 6, Issue 5.



**32. Direct the Chief Administrative Officer to develop a process that will enable the County actively to participate in the creation of its workers' compensation physician networks and establish criteria for the selection of health care providers.**

**33. Direct the Chief Administrative Officer to coordinate the group health program and the workers' compensation program.**

## **Accountability**

Government accountability requires informing citizens and their elected officials about measurable results; that is, how much an agency has spent, what the spending was for, and how effectively and efficiently those funds were used. The basic characteristics of accountability information are understandability, relevance, reliability, and comparability. In addition, the cost of providing accountability information should not exceed the expected benefit.

County management needs to know about performance results to assess its effectiveness in providing services. Specifically, the basic elements in the development of an approach to program accountability should include the following:

- Establishing a set of measurable goals, and responsibilities.
- Developing a plan to determine what needs to be done to achieve the established goals.
- Accomplishing the work and monitoring its progress.
- Reporting on the results.
- Evaluating the results and providing feedback.

To ensure that any such approach to establishing accountability is fully understood and agreed to it should be prepared by those who have been assigned operational responsibility. Any plans should state results to be achieved, actions to be taken and by whom, estimated costs and performance targets. The completion of these elements would make it possible to measure systematically and periodically the performance of the anti-fraud program. Using the collected data would enhance the effectiveness of the program and result in reduced fraud in the workers' compensation system.

The data that is currently collected identifies the number of investigations, arrests, convictions, and restitution amounts. This approach is designed to identify those that have committed fraud and have been punished (see Table 1), not, as mentioned above, whether performance has been evaluated relative to established and measurable goals or whether any results have been evaluated and revised in accordance with a plan to improve performance.

It appears that a system(s) needs to be implemented to collect data on basic aspects of program performance, such as average time to first payment, average length of temporary total disability (TTD) duration, and time from filing to resolution of disputes. In other words, a system(s) should be available to enable the County to determine whether the current program impacts the prosecution of fraud and abuse.

Such a system(s) should be prepared in consultation with the State Department of Insurance and the District Attorney to determine what "meaningful" measures are needed and/or are realistic to assess. For example, developing a measure of the rate of new claims vs. the amount spent on the workers' compensation program (deterrence, detection, investigation and prosecution) would provide a valuable measure of the effectiveness of the program.

It is recommended that the Board of Supervisors:

- 34. Direct the County's Risk Manager to review periodically those measurable levels of achievement that would define a successful workers' compensation fraud program and measure overall system performance, particularly data on the management and operations of available investigative resources, i.e., reduction in new claims vs. dollars spent on the program.**
- 35. Ensure that management devotes an appropriate level of attention to the issues of workers' compensation fraud and abuse by making compliance with the overall strategy and cost reduction objectives a part of the department head's performance review.**

## Case Management

The most important factor for effective case management and fraud detection is providing adequate program resources. The amount of resources needed to manage cases will vary depending on the number of claims. It has been shown that workers' compensation specialists should challenge questionable medical reports, assessments, and bills. Injured employees or doctors may submit medical bills unrelated to injury for payment and receive payment if not questioned. Additionally, treating physicians may not be specific about amount and type of work that an injured employee can do if not asked. Someone with a medical/clinical background generally has a better understanding of medical terminology and would be more likely to challenge questionable medical information. Having someone with a medical background available for the program can significantly aid in reducing workers' compensation costs. The County has recognized this need by establishing protocols for medical bill review, utilization review, and medical case management.

A study by the Hartford Insurance Company conducted in 2000 of more than 53,000 permanent partial disability and temporary total disability claims indicated the following when compared with claims reported within a week of occurrence:

- a. 1-2 weeks after occurrence - 18% more expensive
- b. 3-4 weeks after occurrence - 30% more expensive
- c. Greater than 1 month after occurrence - 45% more expensive

Based upon the Hartford experience, it appears that as time passes and as discussion are held events that caused the injury can be distorted. This also correlates to the recommendations made in this document dealing with the immediate reporting and investigation of accidents.

It is recommended that the Board of Supervisors:

- 36. Direct that the County's Risk Manager periodically review procedures with the objective of ensuring claims are reported immediately to enable the County to reduce its workers' compensation costs.**
- 37. Direct that the County's Risk Manager periodically review procedures with the objective of ensuring timely follow up actions on cases.**
- 38. Direct that the County's Risk Manager to review periodically case files on all open/active claims, no matter how old, to ensure that they are being maintained.**
- 39. Direct that the County's Risk Manager to review procedures periodically to ensure that current medical evidence is continually received so the employee may be returned to duty as soon as possible.**
- 40. Direct the County's Risk Manager to ensure, through inspection and operational review, that Third Party Administrators have aggressive fraud units.**

## Interagency Coordination

The California Commission on Health and Safety and Workers' Compensation has stated "In addition to sharing of information, some have suggested that there should be greater interaction between public agency employees (primarily in DWC) and those investigating and prosecuting workers' compensation fraud.<sup>62</sup> It is clear that a great

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<sup>62</sup> California Commission on Health and Safety and Workers' Compensation, Report On The Workers' Compensation Anti-Fraud Program, August 2001.

deal could be gained from developing increased organizational cooperation among the agencies that deal with workers' compensation fraud in the Los Angeles Area. Common problems could be more easily discussed and solutions identified. In addition, this cooperation may well identify areas in which these agencies could provide mutual assistance, thereby improving the utilization of the scarce resources devoted to this function.

The establishment of such a coordinating body would enable its members to become increasingly focused on reducing workers' compensation fraud by contributing information that would be generally available for fraud analysis. It could serve as a communications vehicle to inform other members of the means used in addressing fraud, and it could provide a basis for allocating resources among organizations to ensure their maximum effectiveness. This body could meet regularly in an open forum to increase public awareness of fraud and to provide accountability of the process.

It is recommended that the Board of Supervisors:

- 41. Direct the Chief Administrative Officer to pursue increased coordination among the investigative organizations of the County, the MTA, the City of Los Angeles, the District Attorney, the California Department of Insurance Fraud Bureau, and other appropriate agencies, possibly through the creation of a coordinating body, in order to maximize the effective use of scarce resources, to identify fraud detection methodologies and to seek mutual assistance.**

## **X. WORKERS' COMPENSATION FRAUD INVESTIGATION AND PROSECUTION**

It is accepted within the industry that an effective fraud referral system is important to the effective utilization of fraud investigation resources. The quality of the investigations undertaken is dependent on the number and quality of referrals received by that unit. For example, the data presented in Table 5 indicates that prior to FY 2001-2002 little emphasis was placed on the prosecution of workers' compensation fraud within the County. From FY 2000-2001 to FY 2002-2003 the number of cases reviewed by the anti-fraud team rose 1800% (from 102 to 1844). During the same period, although the number of suspected fraud cases referred to the District Attorney rose by 600% (5 cases to 31 cases), as a percentage of the number of cases reviewed (102 cases to 1844 cases) the percentage referred has dropped from 4.9% to 1.7%. If the fraud referral percentage was the same as it was in FY 2000-2001, 88 cases would have been referred in FY 2002-2003.

Although there has obviously been a measureable increase in the number of cases referred to the District Attorney, without work measurement criteria in place and priorities for the investigation function established, it is difficult, if not impossible, to determine whether this performance is achieving the desired goals. Without a set of criteria that has been approved by management it is possible that a special investigations unit could place its emphasis on reviewing the largest number of cases possible, even though management may feel that the emphasis should be placed on completing investigations that result in referrals to the District Attorney. To ensure that appropriate goals are being addressed, management must ensure that goals are established, understood and used in the measurement of unit performance.

**Table 5**  
**Pursuit of Workers' Compensation Fraud**  
**within Los Angeles County**

	<b>97-98</b>	<b>98-99</b>	<b>99-00</b>	<b>00-01</b>	<b>01-02</b>	<b>02-03</b>
Total County Employment	77,420	80,366	83,940	86,477	89,939	88,206
Total Claims Inventory						20,000
Total Number of New Claims	11,486	11,767	12,247	12,204	12,394	12,213
New Claims Per 100 Employees	14.835	14.641	14.59	14.112	13.78	13.84
# of Approved Claims	10,616	11,054	11,443	11,180	10,965	10,669
# of Injury Claim Investigations	1,172	1,130	1,206	1,390	1,746	1,473
# of Injury Claim Denied	870	713	804	1,024	1,429	1,544
# of Cases Reviewed by Anti-Fraud Team	87	71	80	102	864	1,844
# of Suspected Fraud Cases Referred to the D.A.	3	1	4	5	25	31
# of Criminal Arrests	0	0	0	0	1	9
# of Criminal Prosecutions	0	0	0	0	1	1
Amount of Restitution Ordered by Criminal Court	0	0	0	0	\$2,886	\$600,000
Amount of Restitution Collected	0	0	0	0	\$2,886	0

Note that the current workers' compensation anti-fraud program was launched in January 2002. The above table lists the activity before the current program was put into effect, and as well as following its inception. Although the figures for fiscal year 2003-2004 are not yet available the "restitution collected" went from \$0 in 2002-2003 to \$120,000 so far in 2003-2004. The amount of "restitution ordered" by the criminal

courts has increased to \$442,662. In addition, the County had 4 additional convictions, and terminated 5 employees convicted of fraud.

When an actual criminal investigation is undertaken the Special Investigation Unit dedicates numerous hours in assisting these criminal investigators in preparing fraudulent cases for criminal prosecution. The Special Investigation Unit also provides assistance to the District Attorney. Once a case is submitted to law enforcement agencies, it is reviewed by both the District Attorney and the Department of Insurance. A determination is made as to whether or not a particular case warrants criminal investigation. The County of Los Angeles is then formally notified of this decision. The County of Los Angeles may on occasion dispute the decision not to criminally investigate a case. If this dispute occurs, a meeting is held to ultimately settle the matter.

In several recent instances, the suspected fraudulent case was referred to the authorities as far back as 1999. However, the perpetrators were not arrested until 2003. The time from referral to arrest can be explained by many factors including lack of cooperation by witnesses, fiscal considerations, extensive evidence and required research material, investigator re-assignments and reduced staffing at the criminal investigative agencies. The County's Special Investigation Unit has developed a working relationship with the California Department of Insurance and the Los Angeles County's District Attorney's Office to help with this situation. Both of these agencies have instituted a task force for the purpose of investigating and prosecuting fraud committed against public agencies.

Since nearly every accident is preventable, accident investigation becomes a critical activity. Unfortunately, the Chief Administrative Officer has found that "Very few department supervisors conduct investigations at the time of the reported injury." As a result of these findings the CAO made a recommendation to "Require supervisory investigation of every reported injury and provide investigative tools and guidelines for use by supervisory personnel."<sup>63</sup> This study concurs with that recommendation and reaffirms it with a similar recommendation.

Accident investigation and reporting not only requires immediate attention, but also requires the investigation be conducted using a systematic approach to identify accident causation factors and to implement corrective action - it is impossible to prevent future accidents if it is not clear how they occurred. This approach proposes the investigation of personal injuries, property damage and all incidents which had produced or had the potential to produce injury or property damage, no matter how minor. It is clear that there are numerous practical reasons to investigate accidents including:

- a. Using the knowledge from the investigation to identify and control future accidents by developing plans to eliminate exposure and thus, costs

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<sup>63</sup> County of Los Angeles Chief Administrative Office, Countywide Return to Work Assessment, January 3, 2003, pgs 5 & 11.

- b. Improving operational procedures to maximize safety
- c. Communicating management support of the safety process
- d. Aiding in improved injury management and assisting in spotting potential fraud or opportunities for subrogation.<sup>64</sup>
- e. Determining additional training needs

The preparation of an accident report should not be completed by checking boxes on a form, but rather the completion of a narrative by an objective and disinterested third party explaining the nature of the accident, the circumstances involved, a statement by the injured party, statements of witnesses, and any other information that would assist in the support and validation of the claim. Even though this approach has the possibility of being the most productive, the County found that “There are no published guidelines or checklists for investigating work related injuries.”<sup>65</sup> It appears clear that this process would be facilitated by the implementation of a standardized reporting format that would demonstrate the County’s commitment to establishing exactly what happened by means of a written statement at an early point in the process, deter fraud by making it easier to detect, and demonstrate the County’s commitment to an anti-fraud program in a substantial manner. During the implementation of such a protocol consideration should be given to formalizing the following:

- a. The development of a standardized reporting format.
- b. The establishment of a methodology that ensures that the report preparation and submission is timely and accurate.
- c. The development of a standardized methodology for taking an accident report.
- d. The creation of an accident review team - one dedicated to a particular department that reviews all accidents that occur within a department. This team could be made up of the workers’ compensation coordinator, the designated safety officer, an occupational health representative and a management representative. The County, in the course of integrating and applying the principle of early intervention, should train and drill the accident review team on the procedure for quick response to injury cases. As part of this immediate response, this team should evaluate the circumstances and the area where the accident occurred to determine what could be done to

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<sup>64</sup> California Labor Code Section 3752 makes it abundantly clear that the County is not entitled to any offset against its payment of workers’ compensation benefits unless the Labor Code specifically prescribed. The Section states “Liability for compensation shall not be reduced or affected by any insurance, contribution or other benefit whatsoever due to or received by the person entitled to such compensation, except as otherwise provided by this division.”

<sup>65</sup> County of Los Angeles Chief Administrative Office, Countywide Return to Work Assessment, January 3, 2003, pg. 6.

improve the situation and prevent a recurrence. This report would then be forwarded to the Risk Management Division for determination if further action is required.

It is recommended that the Board of Supervisors:

- 42. Direct the County's Risk Manager to develop a countywide protocol for the investigation of workers' compensation claims.**
- 43. Direct County departments to investigate all accidents involving their employees using a Departmental Accident Review Team.**
- 44. Direct the County's Risk Manager to develop a countywide protocol to ensure that there is early incident intervention for every accident.**
- 45. Direct that the appropriate claims personnel always interview both the claimant and physician.**
- 46. Direct the County Counsel to review the ramifications of having employees who are leaving County employment sign a Workers' Compensation Release Form, and prepare such a form, if deemed appropriate.**

## XI. CONCLUSION

The Commission believes that these recommendations can produce general and shared benefits not only within the County, but also across the broad expanse of communities interested in preventing fraud and abuse within the California workers' compensation system. Historically, workers' compensation in California has been highly politicized, with changes often more a matter of coalescence of several interest groups who impose a decision upon others. The recommendations made in this report suggest a means of producing a more efficient, appropriate, and rational system that will improve the treatment of workers who have injuries, improve the operation of the workers' compensation system and provide benefits that might be shared among parties who, although adversaries in individual cases, share common interests in a fairer and less costly system. The discussions that we have held with system participants and stakeholders suggest there is a willingness to consider the reforms we have suggested to achieve the possible benefits.

Implementing the recommendations made in this report will achieve a significant improvement in a wide variety of issues and operations, and will also result in a reduction in the cost of workers' compensation in the County. Additionally, the approaches that have been suggested will improve relations between the County and its employees and assist in obtaining a strong commitment to safety and a commitment from the County to its employees through prompt and continued personal contacts with injured workers to ensure their well being. Where organizational change or system



change is needed, ownership of the change by employees, workers' representatives, and the County is crucial. To achieve success, it is clear that County employee cooperation does not have to be based on altruism but on the clear recognition that mutual self-interest would improve the condition of both parties.

It is the sincere hope of the Commission that the recommendations made in this report will assist the County in the development of a strategic approach to the improvement of the workers' compensation system and to the meaningful reduction in the instances of fraud and abuse.