

**State of California  
Department of Industrial Relations**

**in collaboration with  
California Department of Insurance,  
Commission on Health and Safety and Workers' Compensation,  
and Division of Workers' Compensation**

**Report on Anti-Fraud Efforts  
in the California Workers' Compensation System**

**Submitted to**

**David M. Lanier, Secretary**

**Labor and Workforce Development Agency**

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**State of California  
Edmund G. Brown Jr., Governor**

## Introduction

Fraud is an ever-present problem in California's workers' compensation system, and it is perpetrated by individuals and companies from all segments of the workers' compensation community. While some associate the word "fraud" with false or exaggerated claims of injury, it also embraces service provider and premium fraud, which can be far more costly to the system and the California employers who pay for that system. Periodic reform measures have taken aim at fraud and its attendant costs by prohibiting referral and fee-sharing arrangements among attorneys and providers, placing stricter controls on medical evaluations and treatment, establishing fee schedules, requiring specific disclosures by providers, and providing funding for local prosecutors who handle workers' compensation fraud cases.

2012's historic reform measure SB 863 had the twin goals of increasing benefits for workers while controlling costs for employers. To date, it has been successful in meeting these goals, delivering increased monetary benefits and appropriate care while containing expenses across the state.<sup>1</sup> SB 863's reforms included establishing an evidence-based Independent Medical Review (IMR) system to take medical treatment decisions and disputes for accepted claims out of the litigation system; an Independent Bill Review (IBR) system to do likewise for billing disputes over accepted claims; new fee schedules to make costs more certain; and new lien-filing fees and restrictions to reduce the volume of lien claims and lien claim litigation. Along with recent technological upgrades to California's systems for managing workers' compensation claims data and adjudication,<sup>2</sup> SB 863 has also helped provide a framework for developing and implementing an empirically based, systematic strategy to confront fraudulent activity. This comes at a time when high-profile prosecutions in Southern California have shone a spotlight on provider fraud and its costs to the system. As discussed in this report, collaboration across jurisdictions and data sharing will be central to a successful approach. Success will also depend on the willingness of system participants, including parties, lawyers, and judges, to use the tools provided through legislation and technology for identifying and combating fraud.

## Stakeholder Engagement

At the direction of Labor and Workforce Development Secretary David M. Lanier, the Department of Industrial Relations (DIR) convened working groups to elicit information and evidence of fraudulent activity in the workers' compensation system. Director of Industrial Relations Christine Baker chaired the steering committee for this effort together with co-chairs Nettie Hoge and Joel Laucher, respectively the outgoing and incoming Chief Deputy Commissioners of the California Department of Insurance (CDI); George Parisotto, Acting Administrative Director of the Division of Workers' Compensation (DWC); and Eduardo Enz, Executive Officer of the Commission on Health and Safety and Workers' Compensation (CHSWC). The steering committee held a

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<sup>1</sup> See Workers Compensation Insurance Rating Bureau of California (WCIRB), *Impact of SB 863 on California Workers' Compensation Medical Costs through June 30, 2015*, released December 10, 2015. at [www.wcirb.com/sites/default/files/documents/151210\\_post\\_sb\\_863\\_medical\\_payment\\_trends\\_report.pdf](http://www.wcirb.com/sites/default/files/documents/151210_post_sb_863_medical_payment_trends_report.pdf).

<sup>2</sup> These systems are known respectively as the Workers' Compensation Information System (WCIS) and the Electronic Adjudication Management System (EAMS).

series of meetings in June 2016 with representatives of insurers, employers, labor, prosecutors, medical providers, third-party administrators, and attorneys. A plenary follow-up session was held in mid-September to discuss recommendations and next steps.

Participants offered a variety of observations on factors that facilitate fraud and strategies to combat it. Though groups met separately according to their roles in the system and have different priorities in terms of what they want that system to deliver, there was considerable consensus on what the problems are and how they might be solved. Proposed solutions included not only statutory and regulatory fixes, but also better enforcement of existing rules and procedural requirements, more information sharing and coordination among agencies, greater vigilance by insurers to identify and combat provider and premium fraud, more and better use of existing data, making examples of bad actors, greater education and transparency for the workers' compensation system and system participants, and reviewing strategies used in other health-care systems. Stakeholder input helped inform our understanding of the scope of fraud, as well as helping us to prioritize efforts, interpret results of initial findings observed in the data patterns, and formulate policy recommendations. Based on a synthesis of stakeholder input, ongoing departmental efforts to detect and deter fraud, and an independent review of best practices in other health-care systems conducted by the RAND Corporation, DIR is now pleased to present the set of recommendations detailed in this report.

## **Overview of Workers' Compensation Fraud**

Fraud within the workers' compensation system comes in many forms, including fraud by applicants (workers claiming injury), premium fraud by employers, staffing companies and professional employer organizations, claim and billing fraud by medical and ancillary service providers, and more elaborate capping and treatment or kickback schemes by providers working in collaboration with legal staff or one another.<sup>3</sup> Victims include injured workers, employers, insurers, and taxpayers. DIR has been examining all these areas, with a particular focus on provider fraud and lien abuse.

California's workers' compensation is funded through insurance premiums paid by employers to cover claim costs, plus premium surcharges, also paid by employers, to cover the public costs of administering the system.<sup>4</sup> Workers' compensation insurance premiums are calculated based on a percentage of the payroll reported for each employee, with rates varying according to occupational risk and the employer's prior claims experience. Reforms such as SB 863's cost containment measures help to lower premiums. However, premium fraud through the intentional underreporting of payroll has the opposite effect. According to a 2009 study conducted on behalf of

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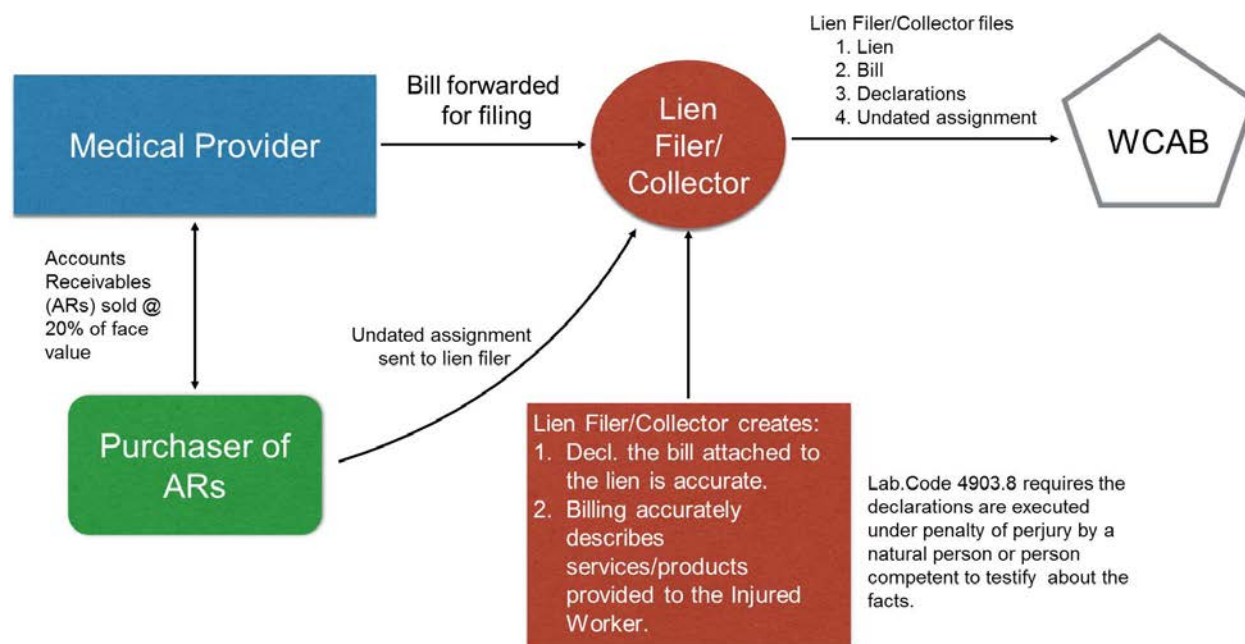
<sup>3</sup> See attached list describing various fraud types.

<sup>4</sup> Claim costs include monetary benefits paid to injured workers (which include fees paid to their attorneys), the cost of medical evaluations and treatment for injured workers (which are paid separately to providers and may greatly exceed the worker's monetary benefits), ancillary services such as interpreters, and all claim evaluation and adjudication costs, including the cost of the insurer's own lawyer. Public costs include assessments to fund DWC, the Workers' Compensation Appeals Board (WCAB), the Uninsured Employers and Subsequent Injuries Benefits Trust Funds, the California Insurance Guarantee Association (to pay claims against insolvent insurers), and CDI's Fraud Assessment Commission (discussed below).

CHSWC,<sup>5</sup> underreported payroll in 1997 through 2005 ranged from \$4 billion to \$15 billion annually in years of low premium rates to \$55 billion–\$68 billion annually in years of high premium rates. The inevitable consequence is higher rates for everyone, including the honest employers, so that all the risks and costs of workplace illnesses and injuries will remain covered.

Provider fraud has garnered special attention lately through high-profile criminal prosecutions of medical providers involved in referral, treatment, and kickback schemes designed to generate billings for unnecessary or sometimes nonexistent evaluations and treatment. In some schemes, workers are solicited to present dubious claims (*e.g.*, for a different body part supposedly affected by a previously resolved injury claim), then referred for evaluation and treatment outside the insurer’s Medical Provider Network and without the insurer’s knowledge, thereby eluding the Utilization Review and IMR processes and ultimately resulting in the filing of lien claims with the WCAB.<sup>6</sup> Additional liens may be filed for drugs and for ancillary services such as interpreters, and the liens may be bundled and assigned to others to file, making the service provider more difficult to identify. **Figure 1** depicts how liens have been generated, assigned, and filed despite the anti-assignment provisions of SB 863.

**Figure 1.** Schematic of Lien Generation



<sup>5</sup> Frank Neuhauser and Colleen Donovan, “Fraud in Workers’ Compensation Payroll Reporting: How Much Employer Fraud Exists? How are Honest Employers Affected?” University of California at Berkeley (2009), [www.dir.ca.gov/chswc/Reports/2011/Final\\_Report\\_FAC\\_Premium\\_Avoidance.pdf](http://www.dir.ca.gov/chswc/Reports/2011/Final_Report_FAC_Premium_Avoidance.pdf).

<sup>6</sup> Historically, California law has authorized providers of medical treatment and evaluations to file lien claims in association with an employee’s claim for workers’ compensation benefits. These are not liens against the employee’s benefits in the traditional sense, but instead are an asserted right to be paid directly by the employer or insurer for services provided to an injured worker in connection with a work-related illness or injury.

These cases also put a spotlight on lien-filing abuses that have continued despite SB 863's reforms. A lien filer's ability to get one foot inside the courthouse door creates tremendous pressure on the insurer to pay something in settlement, rather than taking on the expense of fighting or disproving a clearly invalid claim. A recent internal analysis showed that 10% of the state's lien filers were responsible for 75% of the lien claims filed between 2013 and 2015. The top 1%, comprising 68 businesses, filed more than 273,000 liens, totaling \$2.5 billion, and included five individuals who were being prosecuted or had already pled guilty to fraud. However, it remained possible to continue filing and settling liens notwithstanding fraud prosecutions and other lien-filing restrictions. A DIR [issue brief](#) written last August on this topic provides additional detail.

The CDI Fraud Division is the lead state agency for criminal investigations of insurance fraud. CDI's Fraud Assessment Commission allocates funds collected from insurance premium surcharges (see note 5) to support workers' compensation fraud investigations by the CDI's Fraud Division as well as investigations and prosecutions of workers' compensation fraud by local district attorneys.<sup>7</sup> From an aggregate assessment of \$58.9 million for fiscal year 2016-17, the Commission allocated approximately \$24 million to the Fraud Division and \$35 million to local prosecutors who were pursuing cases of "chargeable fraud" with an estimated overall value of nearly \$900 million statewide. The program supports county prosecutors throughout the state, pursuing all forms of workers' compensation fraud, but the highest value cases involve medical provider fraud, and the district attorneys' offices in Kern, Orange, Riverside, and San Diego counties have distinguished themselves in prosecuting this type of case.

Though unsupported by premium assessments, federal prosecutors have also undertaken some major medical fraud cases against participants in the workers' compensation system, including the successful investigation and prosecution of Long Beach hospital owner Michael Drobot that was aided by the investigative work of CDI's Fraud Division and also led to the prosecution and conviction of State Senator Ron Calderon for political corruption. Another significant resource for the battle against provider fraud are the expert attorneys and research analysts within DWC who can identify and explain aberrational and illegal conduct and can use accumulated data to ascertain the scope and extent of illegal capping, referral, and treatment schemes.

## **Data Monitoring**

The EAMS and WCIS case management and data storage systems, together with the IMR and IBR systems, developed under SB 863 have greatly enhanced DIR's ability to detect fraud. By cross-referencing filings, we are now able to see patterns of behavior and billing among individual providers or groups of providers as well as relationships among providers that were not readily detectable in the past. As the ability to match data and parties across systems becomes more robust, so will the ability to detect fraud.

Data analytics helped DIR ascertain the extent of potentially fraudulent activity associated with a physician (referred to here as "Dr. X") who had been criminally charged in a kickback scheme. In 2006 through 2015, Dr. X's practice, with patients in 50 of the state's 58 counties, was found to have billed and been paid about \$46 million through the workers' compensation system. The practice had billed for more than 1.4 million services,

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<sup>7</sup> By law, at least 40% of the funds must be allocated to the Bureau of Fraud and at least 40% to district attorneys through a competitive grant program.

plus \$500,000 in physician-dispensed drugs and an additional \$160,000 in pharmacy-dispensed drugs. Claims associated with this practice were denied at three times the average rate for medical providers as a whole and included 3 times the average number of cumulative injury claims and 2.5 times the average number of claims for multiple body parts. In 2011-15, Dr. X's practice submitted over 5,000 lien claims requesting payments in excess of \$21 million (an average of \$4,200 per lien). Since 2013, 6,000 IMR requests were filed for treatments proposed by Dr. X's practice but rejected in utilization review (UR). Egregious examples like this led to the incorporation of immediate measures in AB 1244 and SB 1160 to get practitioners such as Dr. X out of the system and prevent them from litigating or collecting on liens associated with their fraudulent activity.

DIR also conducts ongoing monitoring in the following areas:

#### *Illegal Referrals*

Since 1993, physicians in the workers' compensation have been prohibited, except under very limited circumstances, from referring workers for evaluation or treatment by another office or facility in which the physician has an ownership interest. They are also prohibited from having cross-referral or referral fee arrangements and from seeking payment for any services provided in violation of these prohibitions. Using ownership information available from sources such as DWC's Qualified Medical Evaluator (QME) licensing files, other medical licensing board files, and corporate records available from the Secretary of State, and cross-checking that information against filings in the EAMS database make it possible to discern referral patterns and interrelationships among providers that are not apparent from individual claim documents, particularly when claims have been assigned to third parties for collection. DIR continually reviews the list of lien filers to determine the ownership of businesses that file liens and will expand the reviews to the IMR and IBR programs to determine whether patterns of abuse or fraud appear in those filings.

DIR will be drafting financial interest disclosure rules to improve the transparency and tracking of ownership interests and referrals. DIR will then serve as a repository of information available for use by the workers' compensation community, medical licensing boards, and other oversight agencies.

#### *Improper Billings and Unnecessary Tests*

DIR is currently looking at filing data to identify physicians who consistently overbill for certain services, including through the use of incorrect billing codes, inflating the extent of time spent on an evaluation or treatment, and the "unbundling" of combined services (i.e., making separate claims for each element of service in order to increase the total amount charged). Data analysis can also be used to determine whether physicians are performing tests that either are unnecessary or that duplicate tests already performed.

#### *Corporate Practice of Medicine*

Reviewing ownership information for medical groups can lead to evidence of nonmedical professionals who are operating clinics and controlling medical treatment. In addition to DIR's information sources, gaining access to information collected by the Franchise Tax Board would bolster these efforts.

#### *Supplemental Job Displacement Benefits (SJDB)*

DIR has recently become aware and is investigating schemes in which the names of injured workers are sold to or

otherwise obtained by counselors and schools, who then submit SJDB voucher forms to obtain payment for services never sought by or provided to the workers.

## Recommendations

### Administrative

1. Participants need more guidance and education on the workers' compensation system, including in the following areas.
  - How to use the Medical Treatment Utilization Standards (MTUS) guidelines
  - How to bill according to the Official Medical Fee Schedule (OMFS)
  - Nuances of upcoding
  - The appropriateness of CPT billing codes such as 99080 ("Special Reports") and 99199 ("Other Medicine Services and Procedures")
  - The bundling and unbundling of liens and general medical-legal billing rules overall
  - Indications of self-referral violations prohibited by Labor Code section 139.3

Increased knowledge in these areas will enhance the ability of insurers to detect behavior patterns that should be reported. Providers should be aware of the rules associated with each element as well as the sanctions or penalties resulting from noncompliance.

*DWC has created an online physician training program that will focus on these and other topics. Additional training modules are under consideration.*

2. Workers' Compensation Judges need to be aware of and apply applicable anti-fraud provisions, as well as following protocols for reporting and referring incidents of fraud.

*Updates to the fraud protocol along with judges' training are in progress.*

3. Increase transparency in reporting of system usage by lien claimants.

*DIR continues to report on lien claimant system usage, including liens filed by or on behalf of providers who have been criminally charged or convicted of fraud in relation to the workers' compensation system or the Medi-Cal or Medicare programs.*

4. Standardize forms to increase the ability to monitor and match data across systems. Require the National Provider Identifier (NPI) number, which is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services, on all filings.

*DIR is reviewing technical options to enhance the features of EAMS for greater accuracy and speed of fraud identification, and the WCAB is in the process of revising its lien forms to correspond with recent legislation and update data requirements.*

5. Enforce threshold lien-filing requirements by rejecting incomplete or unsigned documents at the time of attempted submission.

*SB 1160 implementation appears to be addressing this issue in part. DWC will continue to monitor to see if additional reforms are necessary.*

6. Publicize the CDI's hotline (1-800-927-HELP) and website ([www.insurance.ca.gov](http://www.insurance.ca.gov)) to facilitate the reporting of workers' compensation fraud.

*This is in progress.*

7. Create an Anti-Fraud Support Unit within DIR and maintain a centralized data-intake system for transparency and expedited sharing of information among system participants. The function and purposes would be:

- Serve as DIR's central point of contact with other agencies and stakeholders on fraud issues, both for the sharing of data and information and making referrals for criminal investigation.
- Research fraud within the workers' compensation system, track data, etc.
- Coordinate and advance DIR's anti-fraud activities.

*DIR is in the process of developing this team and related program protocols.*

8. Create a data sharing process with the CDI's Fraud Division to facilitate investigation of DIR's data analysis indications.

*A new memorandum of understanding between the DIR and the CDI focuses on the sharing of information.*

#### Legislation Completed

1. Liens filed by or on behalf of medical service providers who are criminally charged (or by sworn complaint) with workers' compensation fraud, medical billing fraud, insurance fraud, or Medicare or Medi-Cal fraud, should be automatically stayed, pending disposition of the criminal case.

***Enacted through [SB 1160](#) (new Labor Code section 4615, effective 1/1/2017).***

2. Anti-assignment of lien provisions of SB 863 should be strengthened to preclude all assignments except in cases where the provider has ceased doing business and invalidate any lien assigned in violation of this provision by operation of law.

***Enacted through [SB 1160](#).***

3. Provide for consolidation and expedited dismissal or disposition of liens upon criminal conviction of provider for fraud involving the workers' compensation, Medicare, or Medi-Cal programs, patient abuse, and other crimes.

***Enacted through [AB 1244](#) (new Labor Code section 139.21, effective 1/1/2017).***



4. Provide for automatic suspension from the workers' compensation system of any provider upon conviction for fraud, suspension from the Medicare or Medicaid/Medi-Cal programs, or loss of professional license.

*Enacted through [AB 1244](#) (new Labor Code section 139.21, effective 1/1/2017).*

*Recommended Legislation - Significant*

1. Formalize an Anti-Fraud Support Unit within DIR (see Administrative Item No. 7 above).
2. Amend relevant provisions of the Insurance Code, Labor Code, and Unemployment Insurance Code to combat premium fraud and related issues as follows.
  - a. Require insurers at least annually to obtain copies of Employment Development Department (EDD) payroll reports and compare them to payroll reported to the insurer by the employer, with appropriate sanctions against employers who fail to supply their EDD payroll reports and insurers who fail to make the required annual comparison.
  - b. Clarify the purposes for which the Labor Commissioner has access to EDD payroll data and provide workers' compensation carriers with access to employer payroll report data (to the extent permitted by federal law) so that data can be compared to payroll data reported directly to the carriers by their policyholders.
  - c. Extend Labor Commissioner's authority to cite employers for failure to secure workers' compensation coverage to include employers who under-report payroll or misclassify workers for the purpose of reducing insurance premiums.
  - d. Create a master business application in an electronic portal that would allow businesses to quickly and easily make updates, as recommended in a [March 2015 Little Hoover Commission Report](#). Include information about employees that insurers can cross-reference with workers' compensation claims.
3. Consider changes to the statute of limitations, with appropriate exceptions, to address the proliferation of post-termination cumulative trauma claims and curb abuse.<sup>8</sup>

*Recommended Legislation - Technical*

1. Amend the new lien stay statute (Labor Code section 4615, effective 1/1/2017) to bring the definitions and coverage into alignment with the broader definitions and coverage of related lien provisions in new Labor Code section 139.21 [AB 1244] and to extend the stay of liens from the date of a conviction until the institution of lien consolidation proceedings under section 139.21.

*Other Proposed Items for Study and Follow-Up Recommendations*

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<sup>8</sup> A [December 2016 California Workers' Compensation Institute study](#) showed that a disproportionate share of cumulative trauma claims is filed in the Los Angeles Basin.

1. Have prosecutors report the filing of charges and convictions in workers' compensation fraud cases (including misdemeanors) directly to DIR and the CDI—this could be required by statute (amendment to Business & Professions Code section 803.5), by regulation in conjunction with the Fraud Assessment Commission grant program, or by interagency agreement..
2. Increase funding for fraud prosecutions and determine whether a mechanism or incentive is needed that encourages prosecutors to take on cases that are regional or statewide in scope.
3. Determine whether there are any unnecessary restrictions on the sharing of information among insurers and between insurers and enforcement agencies in cases of suspected workers' compensation fraud.
4. Examine the issues surrounding private employment organizations (PEOs) and their legal liability for workers' compensation. Acquire a better understanding of the impact of staffing companies, employee leasing arrangements, professional employer organizations, and similar types of companies and arrangements, on the workers' compensation system. Examine ways to address and clarify misclassification of employees as independent contractors, as this is the core of the confusion regarding liability among these staffing entities.
5. Prohibit the improper marketing of QME services and improve the quality control review and background checks on physicians applying for new or renewed appointments as QMEs. Review any statutory limitations on the authority to discipline QMEs for violating fee schedule and other requirements.

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## **Appendices**

- I. Types of Fraud in the Workers' Compensation System
- II. Issue Brief: Issues and Impact of Lien Filing in California Workers' Compensation System [8.19.2016]
- III. Text of Anti-Fraud Legislation (AB 1244 and SB 1160) enacted in 2016