

Reporting suspected medical care provider fraud pursuant to Labor Code section 3823

Labor Code section 3823 requires any insurer, self-insured employer, third-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person that believes a fraudulent claim has been made by any person or entity providing workers' compensation medical care, to report the apparent fraud to the administrative director of the Division of Workers' Compensation.

Labor Code section 3820 provides that it is unlawful for a medical provider to do any of the following:

- Present or cause to be presented any knowingly false or fraudulent written or oral material statement in support of, or in opposition to, any claim for compensation for the purpose of obtaining or denying any compensation, as defined in Labor Code section 3207
- Knowingly solicit, receive, offer, pay, or accept any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for soliciting or referring patients to obtain services or benefits pursuant to division four (commencing with Labor Code section 3200) unless the payment or receipt of consideration for services other than the referral of clients or patients is lawful pursuant to Business and Professions Code section 650
- Knowingly operate or participate in a service that, for profit, refers or recommends clients or patients to obtain medical or medical-legal services or benefits pursuant to division four (commencing with Labor Code section 3200)
- Knowingly assist, abet, solicit, or conspire with any person who engages in an unlawful act under this section.

For the purposes of Labor Code section 3820, the term "statement" includes, but is not limited to, any notice, proof of injury, bill for services, payment for services, hospital or doctor records, X-ray, test results, medical-legal expenses as defined in Labor Code section 4620, or other evidence of loss, expense, or payment.

What is a fraudulent claim?

The majority of medical care providers are honest and ethical professionals. Unfortunately, a small number of providers choose to try to cheat the system by committing fraud.

Fraud is an intentional deception or misrepresentation that someone makes, knowing it is false, that could result in payment to the person making the misrepresentation or to someone else. Making a fraudulent claim is a crime, regardless of whether or not any payment is ever received as a result of the claim.

In the simplest terms, fraud occurs when someone knowingly lies to obtain some benefit or advantage, or to cause some benefit that is due to be denied.

What kinds of medical provider fraud should be reported?

Medical provider fraud can include:

- Billing for visits or services never received
- Employing runners, cappers or steerers to solicit or obtain patients for the medical provider
- Billing the workers' compensation payor and the employee's health insurance for the same services
- Performing medically unnecessary treatments, examinations or diagnostic procedures in order to bill for them
- Referring the injured worker for treatment at a separate facility in which the referring physician has an undisclosed financial interest
- Unbundling of claims: Billing separately for procedures that normally are covered by a single fee
- Double billing: Charging more than once for the same service
- Upcoding: Charging for a more complex service than was performed
- Miscoding: Using a billing code that does not apply to the service or procedure
- Taking kickbacks: Receiving payment or some other benefit for making a referral
- Dispensing generic drugs while billing for brand names
- Billing for durable medical equipment that is never dispensed or selling used equipment as new.

How should a fraudulent claim by a medical provider be reported?

An insurer, self-insured employer or third-party administrator should use the Department of Insurance suspected fraudulent claim referral form (FD-1).

Any other person required to report under Labor Code section 3823 may use either use the Department of Insurance suspected fraudulent claim referral form (FD-1) or the attached report of suspected medical care provider fraud.

Can I be sued if I report a fraudulent claim?

Labor Code section 3823 provides that:

"No insurer, self-insured employer, third-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person that reports any apparent fraudulent claim under this section shall be subject to any civil liability in a cause of action of any kind when the insurer, self-insured employer, third-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person acts in good faith, without malice, and reasonably believes that the action taken was warranted by the known facts, obtained by reasonable efforts."