COMPAS

WORKERS COMPENSATION AND OH&S NEWSLETTER
December 2002

A RiskNet® Group Publication
Risk Management Consultants

In this Issue

1
Federal Fraud Inquiry

2
Incidence of Fraud

4
Fraud Management

5
Doctors, employers and insurers aid and abet fraud

8
Measuring Fraud

Compo fraud.... The next crusade

In previous editions of COMPAS, issues of importance to the efficient management of the NSW workers compensation scheme have been raised. Scheme design faults have been identified and recommendations for improvement have been made.

Our goal has always been to be a catalyst of informed debate and it is pleasing to note that our cries have not always been in the wilderness. Many of the issues raised in previous editions of COMPAS have been dealt with by the regulator with generally favourable outcomes.

In this edition of COMPAS aspects of the phenomenon of workers compensation claims fraud is explored and the gauntlet thrown down again at the feet of those responsible for the regulation and management of the scheme.

Conservative politicians and employers have long recognised that claimant related workers compensation fraud is wide spread. Typically labor organisations and workers compensation health care providers have denied the existence of any fraudulent behaviour.

On 20 June 2002 Federal Minister Abbott asked the Standing Committee on Employment and Workplace Relations to inquire into various matters related to workers compensation schemes and report back to Parliament. That inquiry is ongoing and these are the terms of reference for the inquiry:

- the incidence and costs of fraudulent claims and fraudulent conduct by employees and employers and any structural factors that may encourage such behaviour;
- the methods used and costs incurred by workers' compensation schemes to detect and eliminate:
  (a) fraudulent claims; and
  (b) the failure of employers to pay the required workers' compensation premiums or otherwise fail to comply with their obligations; and
- factors that lead to different safety records and claims profiles from industry to industry, and the adequacy, appropriateness and practicability of rehabilitation programs and their benefits.

Those who have already made submissions to the Federal Inquiry include labor and employer organisations, service

(Continued on page 2)

Federal Inquiry into Aspects of workers compensation

NOTES

❶ The Inquiry's web site contains details of submissions and evidence given to the Inquiry. Click on www.aph.gov.au/house/committee/ewr/wkc/index.htm

(Continued from page 1)

provider groups' representatives, State's Governments and interested parties (including the RiskNet Group). Interestingly❶, (at the time of going to press) neither the NSW Government nor NSW WorkCover appear to have made any submission or given any evidence.

Fraud Prevalence

So that there can be no misunderstanding over the existence of widespread claims fraud, some of the evidence given to the Federal Government Inquiry should be examined.

In his opening remarks, when giving evidence to the Inquiry, Mr. Rex Hoy, Group Manager, Workplace Relations Policy and Legal Group, Department of Employment and Workplace Relations stated:

"With regard to the extent of fraud, the department considers that the incidence and cost of workers compensation fraud and non-compliance is a problem confronting all Australian workers compensation schemes. The full extent of fraud and non-compliance is difficult to measure. There is a considerable amount of anecdotal evidence, however, as well as some recent reports or studies which suggest that the problem is significant."

Mr. Mark Goodsell, Director, New South Wales, Australian Industry Group, in his evidence to the Inquiry stated in his opening remarks about fraud:

"How much of it goes on? It is very hard to say. As a guide, if you step back and look at the whole scheme across all industries in all states, you might say that five or 10 per cent of the activity that is going on could be fraudulent. If you ask an individual employer who has had one or two recent claims that they did not have a great experience with, they might say 30 or 40 per cent of claims. We would accept that there is a lot of subjectivity in the assessment of what is fraud.
The point we are really trying to make is that it does happen, and it would be naive to assume that it does not happen to the same extent that it happens in other forms of insurance or in welfare benefits and things like that."

Mr. Doug Pearce, Group Executive, Personal Injury, Health and Commercial Insurance, Insurance Australia Group in his evidence stated:

"The point to make about that (claimant fraud) *is the fact that we have hard data on the one per cent. One per cent does not seem that many but they are the ones we win and it is a strong indicator that a multiple of that is the real problem."*

Mr. Garry Brack, Chief Executive, Employers First in his evidence stated:

"I think somebody (a Committee Member) *asked the question before about how much fraud there is around. We have been debating that question for decades. Whenever you ask anybody who is in the industry, or lawyers,*

(Continued on page 3)

(Continued from page 2)

insurers or rehabilitators, they are likely to say, 'I don't think there's much fraud around, but I think there is a lot of exaggeration.' In some circumstances, if exaggeration is subconscious and somebody does not know about it, then maybe it is not fraudulent. But there is much of it, in our view, which is deliberate and conscious and therefore fraudulent, although it is described by this euphemism of 'exaggeration'."

Dr William Marchione in his evidence stated:

"As a GP, I think that we form an important structural link between the insurers and the workplace. If a claim goes on, we have a very significant power in convincing the patient to go on or not to go on with a claim. We have a lot to give to an inquiry which is looking at trying to minimise fraud. Often the first cog in the process is to see the GP, and their attitude could be sympathetic or indifferent. For instance, with someone who does not care what the insurance company has to pay, you often find that their attitude is: 'Oh beauty, that is an insurance company; that is a $48.50 consultation instead of a $23 one.' As a GP, I have gained the impression that the level of fraud at all levels of insurance is increasing."

Mr. Dutton, Committee Member taking evidence from representatives of the NSW Labor Council New South Wales asked:

"Hear me out. I want to know on what evidence you base the statement in your submission to this committee:
'The Labor Council notes that whilst employee fraud in New South Wales is negligible …'"

In response. Ms. Mary Yaager, Occupational Health and Safety and Workers Compensation Coordinator, Labor Council New South Wales stated:

"We have not seen it; it has not been demonstrated. No evidence has been put forward of employee fraud. Define what you are talking about in terms of 'employee fraud'.
"Where is the evidence? There is plenty of evidence of employer fraud, under declaring wages or not having workers compensation policy. Time after time, the unions present this evidence to WorkCover. But, by the same token, WorkCover or the insurance companies do not bring forward these fraudulent claims. They have workers compensation claims, yet why do they not run these claims as being fraudulent?"

A search of the NSW WorkCover web site uncovered six❶ reported prosecutions for claims related fraud since 1998. Four❷ of the prosecutions involved claimants who claimed to be totally incapacitated and yet were caught working elsewhere. Penalties for these frauds ranged from a good behaviour bond to fines of $2,000. As noted by Doug Pearce (IAG) this represents a very small proportion of the actual fraudulent experience especially if fraud by exaggeration is factored in.

Regardless of an observer's philosophical or political viewpoint regarding workers compensation claimant fraud, the phenomenon is rife in NSW and needs to be effectively dealt with.

NOTES

❶ Click on www.workcover.nsw.gov.au/Media_Releases/index.asp

❷ Barry Doss, 14.8.00. Good Behaviour Bond, ordered to repay $1,655.

Grant Fuller, 4.12.01. Fined $2,000, ordered to pay costs $4,556.

Philip Foster, 11.8.99. Ordered to undertake 200 hours community service work and repay $32,000.

Adrian Polkinghorne, 10.7.98. Fined $2,000.

NOTES

[1] Professor of the Practice of Public Management and Faculty Chair of the Executive Program on Strategic Management of Regulatory and Enforcement Agencies.
He served 10 years with the British Police Service, rising to the rank of Detective Chief Inspector. He has conducted internal affairs investigations, commanded a tactical firearms unit, and has had extensive experience with criminal investigation and general police management. Recent publications include: The Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance and License to Steal: How Fraud Bleeds America's Health Care System. His research interests include regulatory and enforcement strategy, fraud control, and risk management and analysis. He is also a patent-holding inventor in the area of computerized fingerprint analysis and is dead serious at tennis. He holds an MA in mathematics from Cambridge University (England), an MPA from the Kennedy School, and a PhD in applied mathematics from the University of Kent at Canterbury

Fraud Management

Professor Malcolm Sparrow[1], is a pre-eminent fraud expert from the JFK School of Government at Harvard University. Professor Sparrow believes that the number-one obstacle to effective insurance fraud fighting is a widespread failure on the part of insurers, employers, politicians and law enforcement to understand the complex nature of fraud. He identifies six cornerstones of this complex obstacle:

1. Unless fraud is detected close to the time committed, it will probably remain undetected forever.
2. Performance indicators are highly misleading – is apparent increased fraud because of better detection, or is it a true rise in fraud incidence? Should we measure fraud prevention or measure reaction to committed fraud? Some thump their chests about recoveries; some invest more in deterrence. This results in confusion when we try to assess or compare success measures reported by different agencies, States, or companies.
3. The productivity/efficiency/fraud control balance equation generally is solved in favor of the proponents of processing efficiency. Small processing efficiencies are easily measurable and readily achieved. Large potential fraud control savings are uncertain and hard to measure. Moreover, processing efficiencies can greatly increase the vulnerability to fraud.
4. Today's controls will not detect tomorrow's fraud. The white-collar criminal is a true chameleon – ingenious in adjusting and adapting to survive in a hostile environment.
5. There is widespread misplaced emphasis on detecting and investigating committed crimes, rather than on controlling, neutralizing, and deterring future crime. Despite some progress, the probability of detection and of criminal prosecution is still extremely small. The risk/reward ratio is still very attractive in insurance fraud – small risk with high reward. There is great potential in shifting the investment balance from heavily weighted identification of already committed crime – the "pay and chase" model – to more investment in detecting attempted fraud and defeating it.
6. Today's fraud control systems mirror the production environment. Generally, our fraud fighting programs examine claims or transactions one at a time so we address only the least sophisticated fraud schemes.

Given all this, Professor Sparrow identifies two fatal flaws in fraud fighting efforts:

- Because fraud control is dynamic and continuously evolving, a static set of "filters" has only short-term value.
- Sophisticated fraudsters study unsophisticated fraud control programs and

(Continued on page 5)

(Continued from page 4)

easily design schemes to avoid detection.

The result of these flaws is that today's fraud programs detect primarily the casual, careless, and opportunistic scheme – the seasoned, sophisticated fraud perpetrator is generally successful.

Professor Sparrow points out that there are other factors impeding our success in defeating fraud:

1. Insurers are socially acceptable fraud targets.
2. Fraud is not "self-revealing." Claimants rarely see the bills and accompanying details of treatment, which are sent directly from the provider to the insurance carrier. Moreover, explanation of benefit material is cryptic, rarely reviewed, and easily misunderstood, if even seen by the claimant.
3. There exists great consumer respect of and confidence in the health care and the legal professions. The public trusts providers. Fraud discovery is a direct attack on the integrity of professions and their ability or inclination to police themselves.
4. The public can be deceived and confused. Outright criminal fraud can be overshadowed and shielded by indignant rebuttals to challenges to "professional judgement" and "medical necessity" by insurance clerks.
5. Unnecessary treatment, unnecessary testing and other abuses relating to the question of medical necessity also confuse the issues.

Point one of Professor Sparrow's factors which impede fraud fighting is not a simple issue to deal with and will require a concerted effort by the insurance industry to change the public's perception.

Point two would be easy to deal with by a simple administrative change of payment procedure. Claimants could be required to authorise the payment of a service provision before the accounts are remitted to their employer/insurer. In this way the claimant is fully aware of the cost of their treatment.

Doctors, care providers and insurers aid and abet fraud

Point three of Professor Sparrow's fraud fighting impeding factors alludes to one of the more costly types of fraud in NSW. As noted earlier, precious few prosecutions for obtaining a benefit by deception have been successful, however the legislative wherewithal already exists to deal with this type of fraud most effectively. The strategy will need to be embraced by doctors, employers, rehabilitation providers, insurers and the regulator.

During the 2001 Parliamentary session, new provisions dealing with fraud on the workers compensation scheme were introduced. Section 235C of the Workplace Injury Management and Workers Compensation Act 1998 states that a person must not make a statement knowing that it is false or misleading

(Continued on page 6)

NOTES

❶ Copies of the WorkCover Medical Certificate and Assistance Notes can be downloaded from WorkCover's web site www.workcover.nsw.gov.au/medical/mc-home.asp

(Continued from page 5)

in a material particular in a claim made by the person, or in a medical certificate or other document that relates to a claim, or when furnishing information to any person concerning a claim or likely claim (whether the information is furnished by the person who makes or is entitled to make the claim or not). Penalties for breaches are significant and include fines of up to $55,000, two years in gaol or both.

In essence the provisions of s.235C put medical practitioners on notice that their medical opinions must be properly considered and that there is no room for lazy, incompetent or greedy behaviour on their part. It also puts rehabilitation providers, employers and insurance companies on notice that they must be more vigilant in the way that they accept medical and other information as the basis for making payments on claims.

S.235C should outlaw the very common practice by doctors of certifying injured workers as totally incapacitated when they are plainly able to do some duties, albeit on a restricted basis. If a patient is able to drive to a doctor's surgery, sit in the waiting room for an hour, walk into the doctor's room, it is highly unlikely that they are totally incapacitated. In fact, most observers would say that total incapacity for work means that the person is incapable of any kind of duty and needs to be confined to bed or hospitalised.

Section 3 of the WorkCover Medical Certificate❶ deals with fitness for work. It makes specific reference to a range of capabilities, one of which is walking and requires that the doctor assesses a worker's capabilities. Section 3 recognises that the worker may not be fit for pre injury work but requires an assessment of suitable duty capability by the doctor. In the Notes to Assist in Completing the Medical Certificate it is clearly stated that:

Suitable duties are duties that are different from the worker's usual pre-injury duties and/or hours of work. If a worker is unable to return to the pre-injury job but is capable of doing some work tasks, you (the doctor) *should certify the worker as fit for suitable duties for a specified period. Your* (the doctor's) *certification enables the employer to make an offer of suitable employment. The availability of such employment does not affect your certification. It is the responsibility of the employer to try to identify duties in accordance with the medical certificate. You are encouraged to contact the employer to discuss the availability of suitable duties. Alternatively, you may refer the worker to an accredited rehabilitation provider, who can conduct a workplace assessment to determine whether or not suitable duties can be identified. The worker's fitness for work must be regularly reviewed, to ensure that work duties continue to match the level of fitness.*

When an injured worker obtains a medical certificate which states that they

(Continued on page 7)

Doctors, Care Providers and Insurers aid and abet fraud

(Continued from page 6)

are unfit for work and yet they are able to do some work they are more than likely to be committing a fraud on the workers compensation system if they knowingly rely on that certificate to obtain total incapacity benefits.

Any employer which accepts the certificate as evidence of unfitness for any work, knowing that the worker is, for example able to walk, is probably aiding and abetting a fraud.

Any insurer which fails to establish the true extent of the worker's fitness either during the provisional liability process or injury management contacts and accepts a certificate or statement from a doctor that the worker is totally incapacitated when they are, for example, able to walk is most likely to be aiding and abetting a fraud on the scheme if they then make or authorise total incapacity payments.

A rehabilitation provider which accepts a medical certificate or medical report which indicates total incapacity for work knowing that this may not be the case and because of this, delays implementation of a rehabilitation plan may not be guilty of aiding and abetting a fraud but is certainly jeopardising the return to work process.

The WorkCover Authority needs to enforce the provisions of s.235C and prosecute doctors who, because of claimed ignorance, laziness, incompetence or greed refuse to comply with their obligations under the workers compensation system. Enforcement is used as a deterrent for employer and worker fraud, doctors should be treated no differently.

Education of the medical profession has shown not to work, a hefty fine or a stint behind bars might be just the ticket to change their behaviour.

Employers, insurers and rehabilitation providers can provide ample evidence of the practice of issuing total unfitness for work certificates when the worker is plainly able to do some form of work, even if this is on a very restricted basis. Doctors who do issue such certificates should be given the opportunity to put their errors right, if they refuse or fail to do so the circumstances must be reported to WorkCover.

To report a suspicious claim, or potentially fraudulent activities by a medical services provider contact WorkCover on:

Telephone: (02)4321 5409

Facsimile: (02)9287 5409

E-mail: ken.shearing@workcover.nsw.gov.au

Fraud Measurement

One of the major impediments to managing workers compensation claims fraud is the lack of any detailed data; you can't manage what you don't measure. There is no National or State data base specific to workers compensation fraud.

Given the widespread belief that the phenomenon is significant, it is incumbent on scheme regulators to collect reliable fraud information.

NSW WorkCover needs to establish a fraud database containing all reports of claims which exhibit fraud predictors. WorkCover's own web site contains a list of fraud indicators which could be the basis for any suspected fraudulent claims. The same web site exhorts employers to use the indicators as triggers for fraud reporting. These are the indicators:

- *Alleged injuries that occur a day or two before or after a holiday.*
- *Alleged injuries that occur first thing on Monday morning, or late Friday afternoon, but not reported until Monday. These could be sporting injuries.*
- *An accident is reported after job termination, layoff, an industrial dispute, end of a project or contract, or at the end of seasonal work.*
- *The injured worker is about to be retrenched, passed over for a promotion or demoted.*
- *There are no witnesses or the witness is of questionable character, or the worker's description of the accident does not support the cause of the injury.*
- *The injured worker has a history of suspicious claims.*
- *Late reporting of a claim without a reasonable explanation.*
- *Conflicting descriptions of the accident with injury or location, and inconsistencies with the medical record and the initial report .*
- *If you have difficulty contacting a claimant at home when they are allegedly disabled. They may use an answering machine, their partner or another family member as a contact person to cover for the fact that the claimant is absent.*
- *The injured worker refuses to take medical tests to confirm the nature and extent of an injury, or has no ongoing treatment for the injury.*

Reports based on the presence of a number or combination of these indicators could form the basis for a comprehensive fraud data base. Regular, transparent, analysis of data so obtained should then be used to construct fraud deterrence and detection programmes and would be used to measure the success of any such programmes.

COMPAS is published by The RiskNet Group. Managing Editor: Richard Gilley.
Email: consultant@risknet.com.au
For more information about workers compensation or the range of OH&S services provided by The RiskNet Group, visit our web site at: www.risknet.com.au