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Dear Insurer:

The California Department of Insurance, Enforcement Branch and the Workers' Compensation Fraud Advisory Committee is pleased to offer insurers and employers the six modules of the ***Workers' Compensation Insurance Special Investigations Unit Guidelines and Protocols***. Many hours of voluntary efforts by members of the insurance industry, prosecutors, and Fraud Division personnel developed this training and educational document to assist you in combating workers' compensation insurance fraud.

The manual is intended to provide general guidelines for employees assigned with anti-fraud responsibility. It is not intended to change any current reporting requirements. Use of the material is strictly voluntary. The California Department of Insurance offers these *Guidelines and Protocols* as an educational and training tool.

**Legal Disclaimer:** A documented referral is never required. Failure to submit a documented referral is never the basis upon which the Department declines to pursue an investigation pursuant to the California Insurance Code. Documented referrals are voluntary and merely increase and improve the factual basis upon which determinations to pursue legal actions based on referrals are made. Notably, these decisions are made on a case-by-case basis. Persons submitting referrals should anticipate requests for additional information and such requests may differ amongst the 58 independent District Attorney offices' within the State of California.

To request a DVD or copy of this manual, please contact:

California Department of Insurance
Enforcement Branch, Fraud Division
Attention: Intake Unit
9342 Tech Center Drive, Suite 100
Sacramento, CA 95826

We can only make a difference in the fight against workers' compensation insurance fraud by working together. We hope that you find this training manual beneficial to your anti-fraud program.

Sincerely,

Rick Plein
Deputy Commissioner
Enforcement Branch

**CALIFORNIA DEPARTMENT OF INSURANCE**
**Enforcement Branch**
**Fraud Division**

# *WORKERS' COMPENSATION INSURANCE*

# *SPECIAL INVESTIGATIVE UNIT*

# *GUIDELINES & PROTOCOLS*

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# *DEDICATION*

This manual is dedicated to the voluntary efforts of subcommittee members of the Workers' Compensation Fraud Advisory Committee representing the insurance industry, prosecutors, and staff from the California Department of Insurance.

Subcommittee Members:

- Sam King, Subcommittee Chair
- Tony Bartolotto
- Tim Cloney
- Mickaela Erath
- Pat Farrell
- Ed Feldman
- Donna Gallagher
- George Griffith
- Kristie Hutchinson
- Wendy McBride
- Harry Ysselstein

The *WORKERS' COMPENSATION INSURANCE SPECIAL INVESTIGATIVE UNIT GUIDELINES & PROTOCOLS* manual may be obtained by contacting:

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**CALIFORNIA DEPARTMENT OF INSURANCE**
**Enforcement Branch**
**Fraud Division**

# *FOREWORD*

The *WORKERS' COMPENSATION INSURANCE SPECIAL INVESTIGATIVE UNIT GUIDELINES & PROTOCOLS* manual is intended to provide general guidelines for employees assigned with anti-fraud responsibility. It is not intended to change any current reporting requirements. Use of the material is strictly voluntary. The California Department of Insurance (CDI) offers this informational product as an educational and training tool.

Many volunteers from the insurance industry, prosecutors, and CDI Fraud Division personnel have participated in organizing and writing the modules to assist you in combating workers' compensation fraud. The voluntary time and effort spent will assist you in saving California consumers untold costs in rising premiums.

The six modules of the manual describe step-by-step how to distinguish fraud from abuse, identify statutes that prohibit fraud, and statutes that cover both claims and premium-related fraud. There are several examples of *red flags* that indicate fraud *may* be present and expanded text gives the *four elements* of fraud that *mus*t be present to establish a case of fraud. All companies hire outside investigators at one time or another; each company has its own policy of when a *suspected* fraud case requires the use of an outside investigator. Therefore, a module has been included on the role and responsibilities as well as qualifications and experience required of outside investigators. Extensive legal references are used with many examples such as understanding that *an articulable suspicion* of illegal activity must be required before a surveillance investigation can be authorized: *(*See: *California Civil Code Section 1708.8(f))*. The module entitled, "The Deposition", describes how to prepare for and conduct a successful deposition. There is a list of the State of California mandates requiring reporting *suspicion* of fraud as well as an example of what a typical claimant and premium workers' compensation documented case referral should include.

And the *WORKERS' COMPENSATION INSURANCE SPECIAL INVESTIGATIVE UNIT GUIDELINES & PROTOCOLS* was completed in 2002 and updated in March 2011. These Guidelines may be obtained by contacting the California Department of Insurance at the address shown on the previous page.

Thanks to all of the volunteers and staff who have willingly dedicated many hours of writing, editing, and assisting in making this manual a reality. Our special thanks to all contributors!

Rick Plein
Deputy Commissioner
Enforcement Branch

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# Identifying the Elements of Fraud

**Summary**

This section explains how to identify fraud in the workers' compensation system, including how to separate potential fraudulent claims from those that abuse the system. Additionally, the specific elements of fraud that must be present to develop a prosecutable case are explained in this module.

**How are Suspicious Claims Handled?**

When a claim is referred to the Special Investigative Unit (SIU), someone has already spotted one or several "red flags" that indicate fraud may have been committed. However, the presence of one or more red flags does not confirm fraud; the red flags are only leads to be further investigated.

The role of the SIU Investigator is to conduct further research into these suspicious claims, and if found to be potentially fraudulent, the facts and misrepresentations are documented. Then the facts supporting a suspicion or allegation of fraud can be referred to the proper authorities.

**How is an Investigation Started?**

For every claim brought to the attention of the SIU, each investigator has to answer two main questions:

(1) Is this a situation of potential fraud or a case of abuse? What is fraud? What is abuse? Both forms of conduct are wrong. But what is the difference between them? Since the term "abuse" is very broad, it is sometimes easy to confuse with fraud. The definitions of both terms are listed below with examples.

(2) If this claim is potentially fraudulent, can it be proven? To prove fraud, four elements of fraud have to be established. The four elements are listed below with examples

**Definition: Abuse**

Abuse is any practice that uses the workers' compensation system in a way that is contrary to either the intended purpose of the system or law. Abuse includes some behavior that is criminal and some that is not. Criminal abuse is called fraud.

**Definition: Fraud**

In elementary terms, fraud occurs when someone knowingly lies to obtain some benefit or advantage to which they are not otherwise entitled, or to deny some benefit that is due and to which someone is entitled, or to obtain a workers' compensation insurance policy at less than the proper rate, cost, or premium.

**How Is Fraud Different From Abuse?**

To separate fraud from abuse, it is necessary to find a specific, provable lie. An outright lie, a misrepresentation, or behavior that implies a lie, must be found for a claim to be considered potentially fraudulent.

**Examples of Abuse**

Any of the typical abuses listed below could involve fraud if they are accompanied by a provable misrepresentation. Without a misrepresentation or a strong pattern of behavior that can establish intent to defraud, only a simple abuse may exist.

Typical abuses of the system include:

(1) Magnification of complaints or disability that falls short of an outright lie.
(2) Overutilization of benefits and services.
(3) An employer failing to advise its insurance carrier that additional classifications have been added to the business for coverage purposes.
(4) Filing a claim that may not be compensable.
(5) Violating the rules of the workers' compensation system.
(6) Making a mistake on an estimate of future payroll.

The examples listed above may be wrong and constitute abuse but this behavior may not rise to the level of criminal fraud. It can be dealt with in other ways: thorough claims handling, underwriting, or the Workers' Compensation Appeals Board (WCAB). Also, evaluating whether or not a workers' compensation claim is compensable is not the test to determine whether the claim is fraudulent. The specific elements of fraud must be present.

**Question: Is it Fraud or Abuse?**

Question: If a doctor performs a medical-legal evaluation and submits a report along with a $4,000 bill, would the bill be considered fraud or abuse?

Answer: If all that was submitted was a $4,000 bill, with no lies to support it, this would not be fraud, just an outrageous (abusive) bill. But, if the doctor justifies the $4,000 bill by stating those 15 hours were spent with the patient, when this is not true, that would be fraud.

Question: When employees return to work after recovering from a job-related injury, can they continue to receive temporary disability payments? Would receiving benefits constitute abuse or fraud?

Answer: Depending on the circumstances, employment while receiving temporary disability payments might be permissible, might be abuse or might be fraud. See below for an exploration of this topic.

**What are the Elements of Fraud?**

To build a case for fraud, the four elements of fraud have to be established. The first element of fraud, the lie, separates fraud from abuse. The other factors regarding the lie must also be provable in order to build a substantiated case.

The four elements of fraud are:

(1) There is always a false representation—the lie.
(2) The lie must be knowingly made.
(3) The lie must be made for the intent of obtaining a benefit that is not due, denying a benefit that is due or obtaining insurance at less than the proper rate, premium, or cost.

(4) The lie must be material. In other words, the lie must make a difference. Ask the question, "If the truth had been told, would anything have been done differently?"

**Where is the Lie?**

Finding a lie is the first step in a workers' compensation fraud investigation. The lie must be a specific misrepresentation, not just an omission. (Note: Exception to this area is discussed under California Penal Code Section 550(b) (3) and explained on page 13 in this document). It may be written or oral. It may also be "assertive behavior," such as a patient limping at the doctor's office but never limping at any other time. Before making an assumption of misrepresentation, ask the following questions:

(1) Was the misrepresentation actually a lie when it was stated or submitted?
(2) Is the statement ambiguous?
(3) Could there be two meanings or a reasonable explanation for the misrepresentation?

**Was the Lie Knowingly Made?**

An inadvertent or unintentional misstatement is not fraud. The suspect must have known the statement was a lie when it was told. To prove the suspect knew the truth when the lie was told can sometimes be difficult. Oftentimes, what the suspect knew is obvious. Sometimes the proof of knowledge must be inferred from circumstantial evidence.

Example: An injured worker cashes a settlement check from another insurance company. The next day, in a deposition, denies ever having had any other insurance claims. In the example, it is clear the suspect knew the truth when the lie was told.

Example: For a year, an employer submits payroll reports with wages properly segregated between class codes. Suddenly, the employer starts putting all the wages in the lowest-rated (least expensive) class. In the example, it can be inferred that the employer knew how to classify the payroll properly because it had been done correctly in the past.

**Was the Lie Made to Obtain or Deny Benefits? - Or to Obtain Insurance for Less?**

Like knowledge, these questions can be a difficult element to prove. Because it is not possible to get into people's minds to see what they are thinking, their behavior must be analyzed. The following are some ways to show that the actions of the suspect were not an accident or an innocent mistake:

(1) Alteration of documents or other evidence
(2) Concealment or attempted concealment of evidence
(3) Destruction or attempted destruction of evidence
(4) Attempts to recruit false witness(es)
(5) False exculpatory (the suspect tells a lie in an attempt to prove innocence of the suspected fraud)
(6) There is no other reasonable explanation for the lie except personal gain
(7) Pattern of conduct, repetition of conduct
(8) Entering into a conspiracy
(9) Confession and/or admission

**Was the Lie Material?**

To determine if a lie is material, two questions have to be asked. If either question is answered with a yes, then the lie is material.

(1) Is the lie important enough to affect the benefits being provided or not provided (claims fraud), or the amount of premium due (premium fraud)?
(2) If the truth were known, would the payment of benefits or the amount of premium have been altered?

Examples: Would temporary disability benefits or any benefits were paid? Would a Qualified Medical Examiner or an Agreed Medical Examiner or an interpreter been paid for any service? Would the case have settled instead of going to trial? Would prior injuries or accidents been investigated? Would the account have been surcharged or would higher-rated classifications have been added to the policy?

**Applying the Four Elements**

The four elements are applied below using an example from a typical case of applicant fraud.

**The False Representation:** When an employee knowingly lies about a material fact to obtain workers' compensation benefits to which he or she is not entitled. The lie can be either verbal or written; however, to establish fraud, a specific lie must be identified and proven.

**Knowingly Made:** The lie must be knowingly made. An inadvertent or unintentional misstatement is not fraud. The circumstances will generally demonstrate the knowledge of the claimant. Someone who states they have not been out of bed for three months but was taped on the ski slopes three days earlier obviously intends to lie.

**Intent to Obtain or Deny Benefits:** The lie must be made for the purpose of obtaining or denying benefits. Intentional lies about weight, height, or even age, may not qualify if they do not affect benefits.

**Materiality:** The lie must be important enough to affect the benefits. People lie about all types of things, such as their age, weight, and height. The test to apply to the lie is if the truth were known, would the payment or amount of benefits have been altered.

**Look at the Big Picture**

Finally, when all the elements have been identified—the lie, knowledge, intent, and materiality—examine them in the context in which they were given. Do not just look at isolated facts and assume they add up to fraud; look at the whole picture. Ask the following questions: Did the suspect know the truth when the misstatement was made? Did the suspect intend to defraud the workers' compensation system, or have a different purpose for the lie? Or was the suspect ignorant of the proper procedures? What objective indicators and facts exist to support the suspicion of fraud?

**In Conclusion**

The information, provided in this module, gives the investigator a basic way to approach all cases. The basic questions are:

(1) Is it fraud or abuse?

(2) If fraud, can it be proven?

Getting an answer to these two questions is the fundamental mission of the SIU investigator. Once put into practice, this approach will increase the chances of an investigator preparing a prosecutable case and reducing the occurrence of fraud.

# Some "Red Flags" of Potential Fraud

**"Red Flags": Applicant Fraud**

(1) Employment Background: When an injured worker reports an alleged injury immediately following disciplinary action or notice of probation, demotion, or being passed over for promotion;
(2) Personal Background: The injured worker recently purchased private disability policies;
(3) Facts Relating to the Accident: The accident allegedly occurs early on a Monday morning or was unreported the previous Friday;
(4) Interactions with the Claimant: When speaking with the claimant by phone, the background noises are inconsistent with a residence, or the phone is answered by a business. An answering machine is used to screen all calls. Claimant uses a post office box as a residential address.

**"Red Flags": Provider Fraud**

(1) Medical treatment that is inconsistent with the injuries originally alleged by the employee:
(2) Employee reports that nonmedical personnel took medical history or rendered medical treatment;
(3) Diagnostic testing performed by a mobile diagnostic service;
(4) Various reports by a doctor on different employee cases read either identically or similarly;
(5) Medical bills that appear to be second- or third-generation photocopies.

**"Red Flags": Attorney Fraud**

(1) The majority of claims in which a law firm is involved are of a highly questionable nature;
(2) A letter of representation is received, but the applicant denies representation or meeting with the attorney;
(3) In what is referred to as solicitation fraud, several employees from the same employer have reported similar injuries and are represented by the same law firm.

**"Red Flags": Adjuster Fraud**

(1) Inconsistent application of cost-containment measures or agreement to pay above the fee schedule;
(2) Sloppy observance of procedure for referrals to outside vendors, or increase in the use of a particular vendor, to the exclusion of others;
(3) User of vendors outside the preapproved vendor panel;
(4) Assignments made to vendors where the need for the assignment is questionable;
(5) Adjuster has social relationship with the applicant's attorney or doctor;
(6) Adjuster is overheard soliciting, or is observed receiving, tickets or other gifts from vendors;
(7) Adjuster's lifestyle grossly exceeds apparent income.

**"Red Flags": Employer Fraud**

(1) Occupations in claims file don't match the type of business being insured;
(2) Addition of many DBAs (doing business as) on a small policy;

(3) Policyholder claiming "independent contractor" status of employees;
(4) Employees reporting wages paid in cash or by personal check;
(5) Policyholder appears to be "hiding" injuries: Paying medical bills or not reporting the claim;
(6) Employee has difficulty getting claim form from employer;
(7) Employer denies all claims.

**The Most Common Workers' Compensation "Red Flags"**

(1) The injured worker is a new hire.
(2) The applicant took unexplained or excessive time off prior to claimed injury.
(3) The alleged injury occurs prior to or just after a strike, layoff, plant closure, job termination, completion of seasonal or temporary work, or notice of employer relocation, and so on.
(4) Applicant reports an alleged injury immediately following disciplinary action, notice of probation, demotion, or being passed over for promotion.
(5) Applicant has a history of personal injury, workers' compensation claims, and/or of reporting "subjective" injuries.
(6) Applicant's job history shows many jobs held for fairly short periods of time.
(7) The alleged injury relates to a preexisting injury or health problem.
(8) Applicant uses addresses of friends, family, or post office boxes; has no known permanent address, and frequently moves.
(9) Applicant's family members know nothing about the claim.
(10) Applicant was experiencing financial difficulties and/or domestic problems prior to submission of claim.
(11) Applicant has a high-risk activity, such as skydiving, as a hobby.
(12) The applicant's version of the accident has inconsistencies; is not credible.
(13) There are no witnesses to the accident or witnesses to the accident conflict with the applicant's version or with one another.
(14) Applicant fails to report the injury in a timely manner.
(15) Accident or type of injury is unusual for the applicant's line of work.
(16) Facts regarding accident are related differently in various medical reports, statements, and employer's first report of injury.
(17) The Social Security number provided does not belong to the applicant.
(18) Applicant refuses to or cannot produce solid or correct identification.
(19) Applicant avoids use of U. S. mail; hand-delivers documents.
(20) Applicant cannot be reached at home during working hours although he claims to be disabled from working; or the message taker is vague and noncommittal. Applicant is otherwise unavailable and elusive.
(21) Applicant's lifestyle does not coincide with reported/known income.
(22) Several of applicant's family members are receiving workers' compensation, unemployment, Social Security, welfare, etc.
(23) Income from workers' compensation and collateral sources (unemployment, Social Security, long-term disability, etc.) meet or exceed wages after taxes.
(24) Applicant refuses diagnostic procedures to confirm injury, or refuses to attend a scheduled defense medical exam.
(25) Applicant's co-workers express opinion that injury is not legitimate.
(26) Alleged injuries are all subjective; i.e., soft tissue, pain, and emotional issues.
(27) Applicant changes version of accident after learning of inconsistencies; misrepresentation or fabrication by any party.

(28) Applicant frequently changes physicians, or does so after being released to return to work.
(29) Physical description of applicant indicates muscular, well-tanned individual, with callused hands, grease under fingernails, or other signs of active work.
(30) Medical treatment is inconsistent with injuries originally alleged by employee.
(31) Applicant undergoes excessive treatment for soft tissue injuries.
(32) Treatment as reported by applicant is different from doctor's statements in medical report.
(33) Applicant is examined by several doctors when one doctor could have taken all the information and reached a diagnosis.
(34) Applicant reports seeing a doctor for a very brief period of time; however, reports and billing indicate a lengthy visit.
(35) Applicant's description of treatment indicates nonmedical personnel rendering medical treatment.
(36) Applicant sends in medical reports that appear to be altered.
(37) Applicant lives far from medical facility, yet receives frequent treatment.
(38) Surveillance shows applicant's activities are inconsistent with physical limitations related in medical reports and disposition.
(39) Surveillance or "tip" reveals totally disabled worker is employed elsewhere (especially suspicious if employment conflicts with work restrictions given by treating doctor).
(40) Applicant cannot describe either diagnostic tests or treatment for which employer was billed.
(41) The doctor ordered diagnostic testing that is not necessary to determine extent of applicant's injury; or, diagnostic testing is performed, yet there is no request by doctor in medical files.
(42) Diagnostic tests are performed by a vendor not in close proximity to doctor's office or applicant's home, vendor uses post office boxes on all documents, or cannot supply diagnostic records.
(43) Doctor or medical clinic has ownership share in diagnostic group.
(44) Various reports by a doctor on different applicants' cases read identically or similarly.
(45) Post office box used for a clinic/doctor address instead of a street address.
(46) Medical reports appear to be second- or third-generation photocopies.
(47) Physician cannot be located at address shown on documentation.
(48) Doctor's report never identifies claimant by gender or gets gender wrong.
(49) New or additional medical problems are alleged and attributed to the original injury.
(50) Specific "soft tissue" injury develops psychiatric overtones.
(51) Medical reports contain inaccurate terminology, spelling errors, variations in physician's signature or are rubber-stamped with the doctor's name.
(52) Medical facility uses multiple names or changes name often.
(53) RVS/CPT (Relative Value Scale/Current Procedural Terminology) codes show evidence of upgrading level of services.
(54) Billings are received for unnecessary or not rendered services.
(55) Medical facility has consistently billed the workers' compensation, auto, health, and other insurance carriers and has received payments from more than one.
(56) Applicant is unable to define medical ailments as listed on claim form.
(57) Lawyer's letter of representation or letter from medical clinic is first notice of claim.
(58) Lawyer's letter is dated the same day as the reported incident or shortly thereafter.
(59) There is a repeated pattern of doctor/attorney referrals; the same doctor and attorney work together on a large volume of claims.

(60) Applicant states that a "friend," whose name is no longer remembered, provided referral to attorney/clinic.
(61) Applicant filed for unemployment or disability benefits before visiting attorney or clinic.
(62) Applicant alleges doctor or clinic was found through a "hot line."
(63) Applicant is overly pushy, demanding a quick settlement, commitment, or decision.
(64) Applicant is unusually familiar with claims-handling procedures, workers' compensation rules, laws, and proceedings.

# Fraud and the Law

**Summary**

This section identifies statutes that prohibit workers' compensation fraud. The statutes cover both claims and premium-related fraud. This module will examine the principle laws and review some court cases as they relate to the elements of fraud.

**Criminal Statutes Regarding Fraud**

There are four major statutes for workers' compensation insurance fraud. The statutes covering claims-related fraud to be discussed in this chapter are:

- California Insurance Code Section 1871.4
- California Penal Code Section 550

The statutes covering premium-related fraud to be discussed in this chapter are:

- California Insurance Code Section 11760
- California Insurance Code Section 11880

**California Insurance Code Section 1871.4**

It is unlawful to do any of the following:

(1) Make or cause to be made a knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying any compensation, as defined in Section 3207 of the Labor Code**.**

(2) Present or cause to be presented a knowingly false or fraudulent written or oral material statement in support of, or in opposition to, a claim for compensation for the purpose of obtaining or denying any compensation, as defined in Section 3207 of the Labor Code**.**

(3) Knowingly assist, abet, conspire with, or solicit a person in an unlawful act under this section.

(4) Make or cause to be made a knowingly false or fraudulent statement with regard to entitlement to benefits with the intent to discourage an injured worker from claiming benefits or pursuing a claim.

For the purposes of this subdivision, "statement" includes, but Is not limited to, a notice, proof of injury, bill for services, payment for services, hospital or doctor records, X-ray, test results, medical-legal expense as defined in Section 4620 of the Labor Code, other evidence of loss, injury, or expense, or payment.

(5) Make or cause to be made a knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying any of the benefits or reimbursement provided in the Return-to-Work Program established under Section 139.48 of the Labor Code.

(6) Make or cause to be made a knowingly false or fraudulent material statement or material representation for the purpose of discouraging an employer from claiming any of the

benefits or reimbursement provided in the Return-to-Work Program established under Section 139.48 of the Labor Code.

(b) Every person who violates subdivision (a) shall be punished by imprisonment in the county jail for one year, or in the state prison, for two, three, or five years, or by a fine not exceeding one hundred fifty thousand dollars ($150,000) or double the value of the fraud, whichever is greater, or by both that 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. A person convicted under this section may be charged the costs of investigation at the discretion of the court.

(c) A person who violates subdivision (a) and who has a prior felony conviction of that subdivision, of former Section 556, of former Section 1871.1, or of Section 548 or 550 of the Penal Code, shall receive a two-year enhancement for each prior conviction in addition to the sentence provided in subdivision (b).

The existence of any fact that would subject a person to a penalty enhancement shall be alleged in the information or indictment and either admitted by the defendant in open court, or found to be true by the jury trying the issue of guilt or by the court where guilt is established by plea of guilty or nolo contendere or by trial by the court sitting without a jury.

(d) This section may not be construed to preclude the applicability of any other provision of criminal law that applies or may apply to a transaction.

**California Penal Code Section 550(a)**

Much of the language of California Penal Code Section 550 is similar to the language of Section 1871.4. However, Section 550 is more specific to criminal behavior and may better fit specific case fact.

California Penal Code Section 550 covers making false or fraudulent claims. It reads in part as follows:

a. It is unlawful to:
   (1) 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.
   (2) 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. Knowingly present multiple claims for the same loss or injury, including presentation of multiple claims to more than one insurer with an intent to defraud.
   (3) Knowingly cause or participate in a vehicular collision, or any other vehicular accident, for the purpose of presenting any false or fraudulent claim.
   (4) Knowingly present a false or fraudulent claim for the payments of a loss for theft, destruction, damage, or conversion of motor vehicle, a motor vehicle part, or contents of a motor vehicle.

(5) Knowingly prepare, make, or subscribe any writing, with the intent to present or use, or to allow it to be presented in support of any false or fraudulent claim.
(6) Knowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit.
(7) Knowingly submit a claim for a health care benefit that was not used by, or on behalf of, the claimant.
(8) Knowingly present multiple claims for payment of the same health care benefit with intent to defraud.
(9) Knowingly present for payment any undercharges for health care benefits on behalf of a specific claimant unless any known overcharges for health care benefits for that claimant are presented for reconciliation at that same time.

Under Section 550(a)(10), the provisions in paragraphs (6) through (9) are specifically made applicable to claims for health care benefits under the workers' compensation system.

**California Penal Code Section 550(b)**

b. It is unlawful to:
(1) 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.
(2) 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. Knowingly present multiple claims for the same loss or injury, including presentation of multiple claims to more than one insurer with an intent to defraud.
(3) Knowingly cause or participate in a vehicular collision, or any other vehicular accident, for the purpose of presenting any false or fraudulent claim.

**California Penal Code Section 550(c)**

(1) Every person who violates paragraph (1), (2), (3), (4), or (5) of subdivision (a) is guilty of a felony punishable by imprisonment in the state prison for two, three, or five years, and by a fine not exceeding fifty thousand dollars ($50,000), or double the amount of the fraud, whichever is greater.
(2) Every person who violates paragraph (6), (7), (8), or (9) of subdivision (a) is guilty of a public offense.

(A) When the claim or amount at issue exceeds nine hundred fifty dollars ($950), the offense is punishable by imprisonment in the state prison for two, three, or five years, or by a fine not exceeding fifty thousand dollars ($50,000) or double the amount of the fraud, whichever is greater, or by both that imprisonment and fine, or by imprisonment in a county jail not to exceed one year, by a fine of not more than ten thousand dollars ($10,000), or by both that imprisonment and fine.

(B) When the claim or amount at issue is nine hundred fifty dollars ($950) or less, the offense is punishable by imprisonment in a county jail not to exceed six months, or by a fine of not more than one thousand dollars ($1,000), or by both that imprisonment and fine, unless the aggregate amount of the claims or amount at

issue exceeds nine hundred fifty dollars ($950) in any 12-consecutive-month period, in which case the claims or amounts may be charged as in subparagraph (A).

(3) Every person who violates paragraph (1), (2), (3), or (4) of subdivision (b) shall be punished by imprisonment in the state prison for two, three, or five years, or by a fine not exceeding fifty thousand dollars ($50,000) or double the amount of the fraud, whichever is greater, or by both that imprisonment and fine, or by imprisonment in a county jail not to exceed one year, or by a fine of not more than ten thousand dollars ($10,000), or by both that imprisonment and fine.

(4) Restitution shall be ordered for a person convicted of violating this section, 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.

d. Notwithstanding any other provision of law, probation shall not be granted to, nor shall the execution or imposition of a sentence be suspended for, any adult person convicted of felony violations of this section who previously has been convicted of felony violations of this section or Section 548, or of Section 1871.4 of the Insurance Code, or former Section 556 of the Insurance Code, or former Section 1871.1 of the Insurance Code as an adult under charges separately brought and tried two or more times. The existence of any fact that would make a person ineligible for probation under this subdivision shall be alleged in the information or indictment, and either admitted by the defendant in an open court, or found to be true by the jury trying the issue of guilt or by the court where guilt is established by plea of guilty or nolo contendere or by trial by the court sitting without a jury.

Except when the existence of the fact was not admitted or found to be true or the court finds that a prior felony conviction was invalid, the court shall not strike or dismiss any prior felony convictions alleged in the information or indictment.

This subdivision does not prohibit the adjournment of criminal proceedings pursuant to Division 3 (commencing with Section 3000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code**.**

e Except as otherwise provided in subdivision (f), any person who violates subdivision (a) or (b) and who has a prior felony conviction of an offense set forth in either subdivision (a) or (b), in Section 548, in Section 1871.4 of the Insurance Code, in former Section 556 of the Insurance Code, or in former Section 1871.1 of the Insurance Code shall receive a two-year enhancement for each prior felony conviction in addition to the sentence provided in subdivision (c). The existence of any fact that would subject a person to a penalty enhancement shall be alleged in the information or indictment and either admitted by the defendant in open court, or found to be true by the jury trying the issue of guilt or by the court where guilt is established by plea of guilty or nolo contendere or by trial by the court sitting without a jury. Any person who violates this section shall be subject to appropriate orders of restitution pursuant to Section 13967 of the Government Code.

f Any person who violates paragraph (3) of subdivision (a) and who has two prior felony convictions for a violation of paragraph (3) of subdivision (a) shall receive a five-year enhancement in addition to the sentence provided in subdivision (c). The existence of any fact that would subject a person to a penalty enhancement shall be alleged in the information or indictment and either admitted by the defendant in open court, or found to be true by the jury trying the issue of guilt or by the court where guilt is established by plea of guilty or nolo contendere or by trial by the court sitting without a jury.

g Except as otherwise provided in Section 12022.7, any person who violates paragraph (3) of subdivision (a) shall receive a two-year enhancement for each person other than an accomplice who suffers serious bodily injury resulting from the vehicular collision or accident in a violation of paragraph (3) of subdivision (a).

h This section shall not be construed to preclude the applicability of any other provision of criminal law or equitable remedy that applies or may apply to any act committed or alleged to have been committed by a person.

i Any fine imposed pursuant to this section shall be doubled if the offense was committed in connection with any claim pursuant to any automobile insurance policy in an auto insurance fraud crisis area designated by the Insurance Commissioner pursuant to Article 4.6 (commencing with Section 1874.90) of Chapter 12 of Part 2 of Division 1 of the Insurance Code**.**

**California Penal Code Section 550(b)(3) Explained**

This law made an omission of information the functional equivalent of an affirmative misrepresentation. In other words, it made an omission equal to a lie under certain circumstances.

This law means that a person who is either receiving insurance benefits or assisting or conspiring with a person receiving insurance benefits may be guilty of a felony where both of the following elements are present:

- The person conceals or fails to disclose the occurrence of an event that affects his initial or continued right or entitlement to an insurance benefit or payment, or the amount thereof, and

- The person has knowledge that the event occurred, and that the occurrence of the event affects the initial or continued right or entitlement to or the amount of any insurance benefit or payment.

For this law to apply, the following must be true:

- The event must be material. It must affect the person's entitlement to benefits, payment, or the amount thereof.
- The person must know the event occurred and that the event is material.
- The person must conceal or fail to disclose the event.

**California Insurance Code Sections 11760 and 11880**

California Insurance Code Sections 11760 and 11880 apply to premium fraud. The difference between the two sections is whether the victim of the fraud is a private carrier or the State Compensation Insurance Fund (SCIF).

Code Section 11760 states, "It is unlawful to make or cause to be made any knowingly false or fraudulent statement, whether made orally or in writing, of any fact material to the determination of the premium, rate, or cost of any policy of workers' compensation insurance, for the purpose of reducing the premium, rate, or cost of the insurance."

**California Insurance Code Section 1871.8**

An insurer or self-insured employer shall provide the following notice, in both English and Spanish, to an injured worker on or with a check for temporary disability benefits:

> WARNING: You are required to report to your employer or the insurance company any money that you earned for work during the time covered by this check, and before cashing this check. If you do not follow these rules, you may be in violation of the law and the penalty may be jail or prison, a fine, and loss of benefits.

The law allows for an optional warning to injured workers who receive temporary total disability.

The warning is only one tool that can assist in establishing the injured worker's knowledge of the wrongfulness of working while collecting benefits. In these types of situations, additional investigation will be necessary.

**Applying the Law: Intent and Materiality**

Several court rulings have discussed the related issues of intent and materiality. One is the United States Supreme Court case of *Claflin v. Commonwealth Insurance Company* (1884, 110 US 81, 3 S.Ct. 507, 28 L.Ed. 76), and *Cummings v. Farmers Insurance Exchange* (1988, 202 Cal.App. 3d 1407). In both cases, the following was stated with regard to intent and materiality:

> "The Supreme Court affirmed the judgment, saying, The object of the provisions in the policies of insurance, requiring the assured to submit [202 Cal.App.3d 1416] himself to an examination…was to enable the company to possess itself of all knowledge, and all information as to other sources and means of knowledge, in regard to the facts, material to their rights, to enable them to decide upon their obligations, and to protect them against false claims. And every interrogatory that was relevant and pertinent in such an examination was material, in the sense that a true answer to it was of the substance of the obligation of the assured. **A false answer as to any matter of fact material to the inquiry, knowingly and willfully made, with intent to deceive the insurer, would be fraudulent. . . . And if the matter were material and the statement false, to the knowledge of the party making it, and willfully made, the intention to deceive the insurer would be necessarily implied, for the law presumes every man to intend the natural consequences of his acts…By the terms of the contract he was bound to answer truly every question put to him that was relevant to that inquiry. His**

> **answer to every question pertinent to that point was material, . . . so that every false statement on that subject, knowingly made, was intended to deceive and was fraudulent.**' (Emphasis added)."

In these two cases, the courts stressed that materiality is not determined by the end result alone. The following is the explanation provided: "…The materiality of a statement is not defined and determined by the [sic] affect it has on the outcome of the investigation. Rather, a question and answer are material when they relate to the insured's duty to give to the insurer all the information he has as well as other sources of information so that the insurer can make a determination of its obligations [202 Cal.App.3d 1417]. Thus, materiality is determined by its prospective reasonable relevance to the insurer's inquiry. In *Fine v. Bellefonte Underwriters Insurance Company*, (2d Cir. 1984, 725 F.2d 179, 182-184), citing Claflin, the court held that a statement is not material only if it relates to a matter that ultimately proves to be significant in the ultimate disposition of the claim. Rather, if the misrepresentation concerns a subject reasonably relevant to the insured's investigation, and if a reasonable insurer would attach importance to the fact misrepresented, then it is material."

Most recently, the case decision in *People v. Gillard*, 1997) [57 Cal.App.4$^{th}$ 136; 66 Cal.Rptr.2d 790], the California Appellate Court ruled on a materiality issue involving a claimant convicted of workers' compensation fraud as a third strike. Gillard had applied for workers' compensation benefits by claiming that his knee and back were injured when a security guard backed a cart into him. During three follow-up treatments and evaluations, Gillard said he had not suffered any previous injury to that knee. Gillard's true medical history, however, included three prior workers' compensation claims, one for his knee and two for his back. The court ruling on his criminal sentencing concluded, in short, that a misrepresentation is material if it can influence a determination, even if it does not. Although the decision in Gillard seems to broaden the definition of materiality, it is important to note that the circumstances of Gillard were especially egregious and this broad view of materiality may not match the facts of every case.

**Is All Fraud Prosecutable?**

Suspicious claims may be criminal and reportable, but may not be prosecutable. In order for a criminal case to be filed, the prosecutor must believe there is sufficient admissible evidence to convince twelve jurors beyond a reasonable doubt.

The special unit investigator must recognize the following: An insurer may ask a question to which a lie is given in answer; this is material for reporting a suspected fraud. However, where the misrepresentation did not affect benefits, only the ability to investigate and evaluate a claim, the offense may not be viewed by the courts or the district attorneys as being sufficiently culpable to support a felony prosecution. Prosecutors also observe that juries are less inclined to convict where the level of culpability is relatively low.

**More Information**

Crimes are divided into two major categories: misdemeanors and felonies. They are defined in California Penal Code Section 17 according to their exposure of punishment. Felonies are defined as those punishable by death or imprisonment in state prison. A misdemeanor is punishable by a fine and up to one year in the county jail.

Many of the code sections used in workers' compensation fraud, however, are referred to as "wobblers," which are a hybrid variety of felonies. A "wobbler" can be filed or charged as either a misdemeanor or a felony based on a variety of case specific factors. A "wobbler" crime filed as a felony can be reduced as a misdemeanor at any time from charging to the end of the probationary period.

Some examples of "wobblers" are California Insurance Section 1871.4 and California Penal Code Section 550 (b)(1) through (4). Felonies that can not be reduced are commonly referred to as "straight felonies." Examples of "straight felonies" are California Penal Code Section 118 perjury and California Penal Code Section 550 (a)(1) through (5).

Knowledge of the law is fundamental to the work of an SIU investigator. This module however, has only covered the basic laws regarding insurance fraud. Experienced investigators need to be familiar with more laws than have been discussed. Below is a partial list of additional laws that can be referenced as necessary.

**18 United States Code**

Section 1341 - Mail Fraud
Section 1343 - Wire Fraud
Section 1956 - Money Laundering
Section 1957 - Money Laundering

**26 United States Code**

Section 7201 - Tax Evasion
Section 7206 - Tax Evasion

**Business & Professions Code**

Section 650 - Referral of patients
Section 810 - Health Care Insurance Fraud
Section 2273 - Employing cappers
Section 6152 - Prohibits solicitation, capping

**California Insurance Code**

Section 750 - Unlawful referrals
Section 756 - Misrepresentation of payroll
Section 757 - Insurer's acceptance of false payroll information
Section 1871.8 - Receiving temporary disability payments while working
Section 11760 - Premium Fraud
Section 11880 - Premium Fraud

**California Penal Code**

Section 17 - Defining felonies and misdemeanors
Section 118 - Perjury
Section 186.10 - Money laundering
Section 487 - Grand theft
Section 532 - Grand theft by false pretense
Section 549 - Exploiting fraudulent claims

**Labor Code**

Section 3215 - Referral of clients or patients for compensation
Section 3207 -
Section 4620 -
Section 3700.5 – Uninsured

**Revenue &Taxation Code**

Section 19705 - Tax Evasion
Section 19706 - Tax Evasion

# Hiring Outside Investigators

## Summary

This module covers the evaluation and hiring of outside investigators. Outside investigators may be used to supplement the work of an insurer's staff investigator or retained to perform the entire investigation. This module provides guidelines to follow when assessing the experience of an outside investigator and provides standards for the investigator to follow while working on behalf of the insurer.

## Why Hire An Outside Investigator?

When there is a suspicion of fraud, but not enough information to confirm or disprove, an investigation is launched by the Special Investigative Unit. Some insurers hire an investigator for specialized work that the internal staff does not have the time or experience to handle. Other companies *only* use outside investigators where the investigator is acting as the insurer's Special Investigation Unit. *All* companies hire outside investigators at one time or another. Each company has its own policy of when a suspected fraud case requires the use of an outside investigator. Regardless of who does the investigative work, the carrier is still responsible for ensuring that the appropriate facts are identified and documented in the claim file and the Suspected Fraudulent Claim (SFC) referral form is completed.

## What Does the Outside Investigator Do?

The retention of an outside investigator can range from a single task assignment to authority and responsibility of managing an entire Special Investigative Unit (SIU) for the insurer. Outside investigators are hired to handle investigations of any complexity. The investigation undertaken can be in the form of a telephone investigation, an on-site investigation, or a sub rosa (surveillance) investigation. The investigator can be assigned a variety of tasks such as interviews, status checks, photographs, collection of evidence, and clinic inspections.

## Before the Investigation Begins

It is important to remember that before a surveillance investigation is authorized, the assignment must be supported by "an articulable suspicion" of suspected illegal activity. This applies to both an inside investigation and contract outside investigation. See California Civil Code Section 1708.8(f). Become familiar with this code section and its protection of privacy implications.

## Roles and Responsibilities

A private investigator or firm may be retained by an insurer and authorized to act on behalf of the insurer as its designated Special Investigative Unit. The insurer is ultimately responsible for the purpose, objective, function and activity of the designated SIU. See California Code of Regulations, (CCR) Title 10, Chapter 5, Sub-chapter 9, Article 2, sections 2698.40 through 2698.45.

If the role of the outside investigator is that of SIU representative, the investigator must be thoroughly trained and knowledgeable of the requirements outlined in the above mentioned CCR.

Additionally, the investigator should be familiar with the educational material produced by the Department of Insurance, Fraud Division and its Advisory Training Sub-Committee.

**Qualifications and Experience**

The assessment of the outside investigator's qualifications should be based on the specific assignment at hand. It should be confirmed that the outside investigator's background includes specialized training in the area of workers' compensation. This may include the use of specialized equipment, experience with law enforcement/prosecutorial staff, and AOE/COE (Arising Out of Employment/In the Course Of Employment).

Review the following items with the prospective outside investigator:

(1) Does the State of California Department of Consumer Affairs Licensing Bureau license them? The State of California requires that anyone conducting business as a Private Investigator shall be licensed according to the Business and Professions Code. See B&P Code Sections 7512 et seq.; more commonly known as the Private Investigator's Act.

(2) Are they insured? Verify the investigator carries both Workers' Compensation and Errors and Omissions coverage due to possible liability issues that may arise during the course of an outside investigation. Determine if the investigator has other active insurance policies, specifically indemnification. The company should be named as an additional named insured on the outside investigator's E&O (Errors and Omission) coverage. Refer to the company policy regarding naming an additional insured.

(3) Who is the Qualified Manager? Owner? It is important that these individuals be identified. The Private Investigator's Act requires the qualified manager be responsible for all quality assurance issues and spends a certain amount of time at the firm's location. See B&P Code §7536. Oftentimes, the qualified manager and the owner are two different individuals.

(4) What geographical areas can they cover? This question is based on the geographical area in which investigative work may need to be conducted. Find out what areas their investigators are close to, especially when the issues of payment for mileage and travel time arise.

(5) How many investigators are on staff and what is their experience level? Determine who will be doing the investigative work; if they have ever conducted such investigations before, as well as how long they have been in the investigative industry; and other related experience. It is important to gather a solid profile of the investigators that will be working on the assignment, as they are serving as the insurer's representative in the field.

(6) Does the outside investigator use contract investigators? Any contract investigator will also be expected to follow the specific guidelines set forth prior to hiring any firm.

(7) How long have the investigators been in business? This question helps to verify experience levels of key individuals within the firm, as well as the ability of the firm to be flexible to the needs of the investigation.

(8) What type of equipment is used, e.g., cameras, recorders, vehicles, etc.? What procedures do they have in place to store and maintain the original video evidence? There is always the potential for any information obtained during an investigation from an outside investigator to be used in a court of law. Therefore, it is important to determine whether the firm hired has quality equipment that will provide a quality investigative product. Quality usually parallels credibility.

## Report Writing Standards

Depending on the specific needs, consider standard report writing formats. Data entry capabilities may dictate how an outside investigator's report should read. Establish the report format, itemizing what is wanted and not wanted in an outside investigator's report, e.g., opinions, recommendations. Also, establish the turn-around time based on the needs of the SIU.

When considering report writing formats, content, and processing, consider the following:

(1) Cover sheet
(2) Field Investigative Reports, including surveillance
(3) Video Recorded Evidence (VRE)
(4) Quality assurance measures (Who signs reports?)

## General Investigative Guidelines

The outside investigator's work has a direct reflection on the SIU and the insurer's ability to provide objective investigations concerning suspicious claims activity.

(1) Staff the case assignment with the claims handler/SIU representative so the assignment needs and goals are clear to all involved.
(2) Information reported should be detailed, verifiable, timely.
(3) Outside investigators should avoid actions beyond the scope of why they were hired.
(4) Outside investigators and their employees, representatives, agents, etc., shall adhere to all laws and regulations, and should in no way adversely effect either the insured or insurer with their independent actions, thoughts, opinions, or recommendations.
(5) Every effort should be made to ensure the accuracy of the information before submitting the investigative report.
(6) In cases where an attorney represents the claimant, outside investigators should avoid contact with the claimant by telephone or in person unless authorized.

## In Conclusion

The issues associated with the hiring of an outside investigator can have serious impact on the Special Investigative Unit; therefore, it is vital that the insurer and the investigator understand the topics covered above.

# The Deposition

**Summary**

This chapter covers how to prepare for and conduct a deposition. The process of scheduling, preparing, and asking questions is discussed in this section.

**What is a Deposition?**

A deposition is a method of discovery where information is obtained through a question and answer session, with lawyers and a court reporter present. All information in the deposition is given under oath and transcribed into a permanent record by a court reporter.

The purpose of a deposition is to obtain the truth. When a workers' compensation claim involves suspected fraud, the deposition may be the single most important tool in discovering discrepancies, inconsistencies and outright false statements about the compensation claim.

**When is a Deposition Necessary?**

The fraud deposition is an important tool on the right case. Multiple red flags should be present before investing the time, preparation and expense of a fraud deposition. Examples are provided below for common types of fraud:

Claimant fraud:

(1) The claimant's apparent physical ability exceeds what the treating or evaluating doctors portray as the physical restrictions.
(2) The claimant is never available for medical or vocational rehabilitation appointments.
(3) Some evidence exists that the claimant is working while collecting Total Temporary Disability (TTD) or Vocational Rehabilitation Maintenance Allowance (VRMA).

Provider fraud:

(1) The provider refuses to supply the necessary follow-up reports.
(2) The provider does not identify the actual provider of services.
(3) Some evidence exists that the billed services were not actually incurred or actual services were over billed.

Employer fraud:

(1) The employer's story of injury or accident events differs greatly from the claimant's or eyewitness accounts.
(2) The employer's records do not comport with the actual premium paid or type of injuries incurred.

**How do Fraud Depositions Differ?**

The fraud deposition differs from a regular workers' compensation deposition in the following ways:

(1) The intent of the fraud deposition extends beyond the injury, complaints, and employment in question in the current case.

(2) The suspected fraud deposition must explore the deponent's past and present in such detail that every opportunity is provided the deponent to tell the entire truth and remove all suspicion about the claim.
(3) Vague, ambiguous, and nonspecific answers to questions cannot be allowed in the suspected fraud deposition. Likewise, the questions must be specific yet all-inclusive to produce the true reflections and knowledge of the deponent.
(4) In addition to the above, the suspected fraud deposition, if handled properly, will not only determine the claim parameters, the applicant's and/or lien claimant's demands but will also obtain evidence for possible criminal prosecution. If the truth is not told, the suspected fraud deposition will uncover the necessary information needed for criminal prosecution and/or case dismissal.

**Who Conducts the Deposition?**

It is highly recommended that the person selected to take the deposition be trained in workers' compensation fraud and criminal law, whether or not they are an attorney or a hearing representative. The deposition of a party to a suspected fraudulent claim is different from the usual workers' compensation deposition. Beyond the difference in focus, a fraud deposition will take more time and need special expertise. Too often, an attorney who has a great reputation for handling regular workers' compensation cases will be assigned a fraud deposition, and too frequently, the information needed is not obtained to turn suspicion into a criminal fraud filing.

**Scheduling the Deposition**

Follow these guidelines when scheduling a deposition.

(1) Notify the deponent, the opposing counsel and court reporter that an extended amount of time will be needed to cover the required material.
(2) Schedule morning depositions; they are more likely to be completed that day.
(3) Provide ten days notice and stick to the schedule. The SIU investigator is not required to make the deposition convenient for the other parties. If the other side fails to appear, immediately petition the Workers' Compensation Appeals Board (WCAB) for an Order to Compel.

**Using an Interpreter**

If in doubt whether or not the deponent will need an interpreter, schedule one. For a suspected fraud deposition, do not settle for less than a court certified interpreter; be sure to check their accreditation. Also, keep the interpreter's name and address in the file in case it becomes necessary to confirm accurate interpretations. If there is a dispute in the interpretation, the interpreter may need to be called as a witness.

Before entering the deposition, allow the interpreter and court reporter to chat with the deponent. This will be important because once the deposition begins the examiner will want to question the deponent to confirm, on the record, that the deponent can understand the interpreter.

**Preparing for the Deposition: Strategy**

The SIU representative, the claims handler and the person assigned to take the deposition (possibly an attorney) must communicate and map out a strategy before the deposition. The success of the deposition depends on how well the investigator prepares. Review the following guidelines to prepare for the deposition.

(1) Identify the suspicions surrounding the claim and know their effects as it relates to the criminal elements of workers' compensation fraud before beginning the deposition.
(2) The person who will take the deposition should review all the workers' compensation claim file documents and be very familiar with the various witnesses, doctors, and known facts.
(3) Key documents should be identified and copies retained separately so that the deponent can verify certain data.
(4) A timeline should be developed from the file documentation. This timeline then can be used during the deposition to fill in missing information or to verify information given in the past.
(5) It is an individual choice, and not a requirement, that the investigator write down the questions to ask the deponent. Doing this ahead of time may make it easier to focus on the deponent's responses. Sometimes the damaging evidence comes from something not said rather than what is said.

**Preparing for the Deposition: Reviewing Documentation**

Consideration should be given to reviewing the following documents in preparation for the deposition. Any inconsistencies found in the applicant's personnel documents, medical bills or reports should be flagged so they can be explored during the deposition.

(1) Claim file
(2) Employer records
(3) Personnel file
(4) Investigation
(5) DWC – 1
(6) Index checks
(7) Medical bills and reports
(8) Statements of employer, coworkers, witnesses
(9) Photo or video of work/accident site
(10) Sub rosa film
(11) Job description
(12) Wage Statement

**Registering Emotions in a Deposition**

The transcribed record will not register emotion. The person asking the questions must be aware of how the deponent is reacting and ask questions that reflect the mood change or emotion.

For example, if a previous mention of Dr. "X" caused the deponent to look uncomfortable, consider asking:

(1) Does it make you feel uncomfortable to talk about Dr. "X"? Why is that?

(2) Did you think of something that you want to tell me?
(3) Was there something funny about that incident?

**Beginning the Deposition: Admonitions**

To preserve the admissibility of the deposition, the following questions and admonitions, at the minimum, should be put to the applicant at the very beginning of the proceeding.

(1) In your own words, please explain why you are being deposed today.
(2) Have you ever given any prior depositions in this case or in any other case?
(3) Are you aware that the deposition you are about to give is the same as court testimony?
(4) Do you understand that you have been sworn under oath by a court reporter, a notary public?
(5) While an informal proceeding, these are solemn proceedings: you should be aware that the penalty of perjury applies to your testimony here today. Do you understand that?

**Admonitions Regarding Perjury**

The suspected fraud deposition must contain a clear and understandable admonition/explanation, directed to the deponent, concerning the meaning of a statement under oath. Specifically, the deponent should understand the ramifications of perjury, should the deponent elect not to testify truthfully.

**California Penal Code Section 118(a): Perjury**

"Every person who, having taken an oath that he or she will testify, declare, depose, or certify truly before any competent tribunal, officer, or person, in any of the cases in which the oath may be law of the State of California be administered, willfully and contrary to the oath, states as true and material matter which he or she knows to be false, and every person who testifies, declares, deposes, or certifies under penalty of perjury in any of the cases in which testimony, declarations, depositions, or certification is permitted by law of the State of California also under penalty of perjury and willfully states as true any material matter which he or she knows to be false is guilty of perjury."

In addition to the standard information given to the deponent about perjury, the deponent should also be asked if they understand the consequences of committing perjury.

"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."

**More Admonitions**

Explain to the deponent the conditions under which the deposition will be held.

(1) My questions and your answers will be typed into a booklet by the court reporter.
(2) You will be given an opportunity to read, correct, and sign the transcript. You will be asked to stipulate (agree), at the end of the deposition, that you exercise that privilege within a set time limit or waive the signing. Should you waive the signing, you will be agreeing that what you said today was the truth and will not require any changes. Do you understand?

(3) If during the reading process you make any changes of a substantive nature, those changes can be commented upon at the time of trial; it is, therefore, important that you give careful and thoughtful consideration to your answers.
(4) If you do not understand one of my questions, please do not answer it. Ask me for clarification, and I will rephrase the question. In particular, please do not guess or speculate.
(5) To create an understandable transcript, you need to give audible answers; please do not nod your head. Always respond verbally so that your meaning will not confuse the transcriber and the attorneys.
(6) To provide an accurate transcript, it is necessary that only one person speak at a time. If you will wait until I have completed my questions before answering, I will try to do likewise.
(7) If during the course of this deposition opposing counsel makes an objection, please wait until counsel have sorted out the objection before you respond to the question. Many of these objections are for purposes of preserving the record: after they have been made, you will be permitted to answer the question.
(8) A deposition is not an endurance contest: if at any time you wish to go off the record, step down the hall, or confer with your counsel, please tell me and I will break the deposition as soon as possible.
(9) Most people do not have perfect recollection; however, in this proceeding I am entitled to have you state your best recollection of the events that I will be questioning.
(10) Also, if you recall only part of the transaction, conversation, or the like, I am entitled to your best recollection of that which you do recall.
(11) Are you currently taking any medication? If yes, what kind and for what reason? Did you take it before coming here today? If yes, when and how much?
(12) Do you take drugs? If yes, did you take any today?
(13) Are you currently under the influence of any drugs?
(14) Do you drink alcohol?
(15) Are you currently under the influence of alcohol?

**Beginning the Factual Questions**

After the admonitions are completed, the specific factual questioning begins. Some examples of question categories follow. Do not assume that your inquiries should be limited in any fashion.

Each general area of questioning should be concluded by reviewing the information given . . . "Is this all the information you have—all the employment, income, doctors, etc.?"

**Identification and Background Information**

Gather all pertinent identification and background information on the deponent. This includes obtaining the following:

(1) Verify date of birth
(2) Copies of the driver's license, Social Security card, and union membership card
(3) Photograph of deponent
(4) All names used
(5) Prior residences and occupants
(6) Family, educational, military and legal history

(7) Full employment history, name of immediate supervisor, job duties, reasons for leaving, previous injuries
(8) Three closest friends at current employment name and job title
(9) Determine if the deponent knows the defense witnesses

**Facts About the Occurrence**

Ask questions regarding how the injury happened.

(1) Set the scene, date, time, and location.
(2) Step-by-step, trace the events of the day and incident.
(3) Ask about the biodynamic or mechanics of injury.
(4) Ask about any witnesses.

**Facts About the Injury**

Ask specific questions regarding the injury(ies).

(1) Specific injuries
(2) Onset of each symptom
(3) Referral to attorney, doctors, etc.
(4) History and symptoms applicant disclosed to physician in reports
(5) Description of treatment received – felt like, therapy equipment looked like
(6) Psyche injury – "What are the ten most stressful events in your life?"
(7) Full medical history
(8) Condition before injury

**Facts About the Disability**

Ask questions regarding the deponent's state of disability.

(1) Ask the deponent to describe in detail his physical restrictions. Have him explain how the injuries impair job performance or the performance of everyday activities.
(2) Ask the deponent to describe the activities of a typical day and night. How do they currently differ from the activities before the injury?
(3) What are the expected restrictions once the deponent returns to work, if ever?
(4) Has the deponent looked for work or received any form of payment for any type of work since the industrial injury.
(5) If the deponent will not be able to perform his former job duties, what other kind of work is of interest?
(6) Did the deponent file the claim in order to obtain compensation for this disability? What is considered compensation?

**Facts About Claims History**

Ask questions regarding prior and subsequent claims history.

(1) Details of all injuries – home, work related, auto, general liability
(2) Identity of attorney, doctors, and witnesses

(3) Settlement amounts

**Facts About Documents**

Gather facts to show a document's reliability and importance, or facts which "set the stage" for a conversation or event.

(1) Do you recognize this document?
(2) What is it?
(3) Is that your signature?
(4) Where was the form prepared?
(5) Who filled out this portion of the claim form? Did someone help you prepare this? Who? Was an interpreter used? If so, who? Did you watch them fill it out?
(6) Can you read what it says? Is everything on the form true and correct?
(7) Is this the address of the clinic where you received treatment?

**Difficult Deponent Situations**

There are some situations that come up during a deposition that, if not handled well, can undermine the proceeding. Follow the guidelines below when confronted with a difficult deponent situation.

(1) Witness supposedly does not understand simple questions. Determine whether the witness understands the key words or terms of the question.
(2) Witness refuses to answer. Why do you refuse to answer the question? Is that the only reason why you refuse to answer? Did anyone advise you to not answer that type of question? Who? Did Mr. "Y" advise you not to answer questions regarding other subjects? What subjects?
(3) Non-responsive or vague/ambiguous answer. Repeat the question. Point out to the witness the difference between what was asked and the supplied answer. Point out how the answer is not clear. If it appears the witness does not understand the question, ask what he does not understand. Consider re-wording the question.
(4) Attorney objects: The attorney may object to some of the questions, but the deponent is required to answer unless he gets a protective order from the judge. This is not trial testimony, it is deposition testimony, and all questions are fair and must be answered. The attorney can say, "I object to", but the client must answer. Do not argue. Let the objection be stated; then turn to the deponent and say, "You may answer." If the attorney then instructs the client not to answer, ask that the objection be stated on the record along with the basis for the objection. You can then state for the record your opinion of the basis for the objection. Do not hesitate to go out in the hall and call the judge to get a ruling over the telephone.

**When is the Deposition Complete?**

The deposition can be concluded when there is a record of sufficient data to either eliminate the workers' compensation case or satisfy the intent and materiality requirement of a criminal case filing for fraud.

(1) Is the timeline complete? Do you understand the deponent's testimony and recollection of all events?
(2) Review the perjury and fraud provisions one last time for the deponent and ask if he understands their meanings. With this in mind, give the deponent an opportunity to change anything in his testimony that was untruthful.
(3) Instead of ending, adjourn the deposition with the expressed condition it may be noticed for continuance if necessary and this session will be labeled Volume I. (Note: If the deposition is closed the applicant cannot be re-deposed without a court order.)

**Tips to Getting a Signed Deposition**

A signed deposition is the best evidence. An unsigned deposition can still be useful in your trial and may be used as the basis for a lie under some criminal statutes; however, an unsigned deposition may preclude other criminal filings. Follow the suggestions below to increase the chances of getting a signed deposition.

(1) Document the attempts taken to obtain a signature.
(2) Delay payment of 5710 fees until the case in chief is resolved or until ordered to do so by the workers' compensation judge. Create a proper record of your payment objections. Ask that the judge determine the fees at the time of trial on the case in chief if the deposition record reflects evidence of fraud.

**Some Deposition Do's**

(1) Be prepared and know the case– every significant event should be in the timeline.
(2) Make sure that the deponent understands the concept of perjury.
(3) Ensure that the deponent is absent the effects of alcohol and drugs.
(4) Ask clear, concise questions.
(5) Listen to the answer as well as the tone of the answer.
(6) Once a misrepresentation is made, reconfirm the misrepresentation and ask several similar questions—give the deponent every opportunity to tell the truth!
(7) Make the deponent understand his duty to review and sign the deposition in its final form.
(8) Follow-up on delivery of the final deposition transcript and record all attempts to secure the deponent's signature.
(9) Camouflage the questions so that the best evidence is not revealed.
(10) Continue asking the question until a straight answer is obtained.
(11) Show the deponent the bills from the medical providers to confirm dates and procedures.

**Some Deposition Don'ts**

(1) Do not limit your questions or focus.
(2) Don't be in a rush.
(3) Don't ignore leads into related areas.
(4) Don't ask questions in the negative.
(5) Don't forget to follow the timeline.
(6) Don't surrender control of getting the signed deposition to the applicant's attorney.
(7) Don't hire an attorney that is not familiar with workers' compensation fraud litigation.
(8) Don't help the deponent answer questions.

(9) Don't use workers' compensation slang in the deposition.
(10) Don't be afraid to ask very basic questions.
(11) Don't assume anything.

**Follow-up**

The deponent will have time to review and make any corrections to the deposition testimony. It is imperative that the SIU or the attorney taking the fraud deposition follows up with the deponent and/or the deponent's attorney to make sure the transcript is reviewed and signed. If the deponent lies in the deposition, the criminal prosecutor may file perjury against the deponent in addition to any fraud violations evidenced by the deposition testimony. However, under current state law, a perjury case will not be filed without the deposition being signed by the deponent. See *Collins v. Superior Court, (2001) 89 Cal.App.4th 1244.*

# Reporting Fraud

**Summary**

This module explains the minimum California state-mandated requirements for reporting *suspicion* of fraud. These requirements include the mandatory filing of the Suspected Fraudulent Claim (SFC) form to state and local authorities. Also covered in this section is the topic of insurer immunity for reporting fraud.

For more information about reporting *substantiated* fraud claims, please see the chapter titled "The Documented Referral."

**When Does Fraud Have to be Reported?**

When an insurer has reasonable belief that a person has committed workers' compensation insurance fraud, the insurer is mandated to report that information to the proper authorities within 60 days of discovery.

"Reasonable belief" is defined in Section 2698.30(l) of the California Code of Regulations. As defined in regulations, "reasonable belief" is a level of belief that an act of insurance fraud may have or might be occurring for which there is an objective justification based on articulable fact(s) and rational inferences there from. Be sure to check with the SIU counsel on this issue.

**Terms to Know**

**Insurer**: Any insurance company, including the State Compensation Insurance Fund, self-insured employers, and third-party administrators. See *Insurance Code Section 1877.1.*

**Suspected Fraudulent Claim (SFC)**: For this training manual, this term covers both claims-related fraud as well as policy-related fraud

**SFC/FD-1**: The form required by the California State Department of Insurance, Fraud Division, to report suspected fraud.

**What Exactly <u>Must</u> be Done?**

Insurance Code Section 1877.3 requires the following actions:

(1) Identify potential fraudulent claims.
(2) Fill out the SFC/FD-1 form.
(3) Within 60 days, send the form to both:
    i. the California Department of Insurance (CDI), Enforcement Branch, Fraud Division
    ii. the District Attorney's office with jurisdiction.
(4) Within 60 days of receiving a written query, respond to requests for information from other governmental agencies.

**Anything Else that Should be Done?**

In addition, an insurer may chose to report to additional governmental agencies authorized to receive the SFC/FD-1. To determine if an agency is authorized to receive the form, see *Insurance Code Section 1877.3.*

(1) Office of the California Attorney General
(2) Department of Industrial Relations
(3) Any licensing agency governed by the Business and Professions Code, e.g., State Bar, Medical Board, Chiropractic Board, etc.

When supplying each of the above-mentioned agencies with information, consider that each will conduct its own investigation. Make them aware of the multiple referrals by noting that information on the form itself.

**Step 1: Identifying the Fraudulent Claim**

A fraudulent claim is any claim where a reasonable person, after due diligence and investigation of any significant indicators of a fraudulent claim, i.e., red flags, believes that the possibility of fraudulent activity has occurred**.**

For a listing of red flags, see Module 1, *Identifying the Elements of Fraud*, beginning on page 1.

**Step 2: Filling Out the Form**

The SFC/FD-1 form is available at the California Department of Insurance web site, http://www.insurance.ca.gov/0300-fraud/0100-fraud-division-overview/0300-fraud-claims-and-forms/ Instructions for filling out the form are also at the same site.

The most effective forms are those that are both completely filled-out and give a detailed summary of fraudulent activity. It is imperative that the person(s) filling out the SFC/FD-1 consult the instructions and definitions that accompany the forms. The SFC/FD-1 summary of fraudulent activity is the foundation of the referral. It is the investigator's opportunity to explain the nature of the fraud so that law enforcement can properly analyze it to determine the need for further development and/or investigation. To assure completeness and thoroughness, it is recommended that an experienced member of the SIU team review the document before referral to any agency.

**Step 3: The 60-Day Time Limit**

The 60-day reporting requirement begins on "the day on which the duty arose." There are two definitions for this phrase.

(1) The duty arose to report on the date that the reporting party first had evidence to substantiate a suspected crime.
(2) The duty arose to provide requested information to an authorized governmental agency on the date that the letter was received from that agency.

For more information, see *Insurance Code Section 1877.3(d).*

**Step 3a: Notify the CDI**

Send the completed referral to the address on the form itself.

**Step 3b: Notify the District Attorney with Jurisdiction**

Each investigator needs to review the case and determine who has jurisdiction over the case. Jurisdiction is the territory in which the legal authority extends regarding the prosecution of a case. There is a district attorney for each county, and with 58 counties in California, that makes 58 prosecuting jurisdictions.

Look at the following situations and determine in which county these situations took place.

(1) Where did the fraudulent activity take place?
(2) Where were the suspected false statements made?
(3) Where was the DWC-1 filed?
(4) Where were the benefit checks issued?
(5) Where were the medical reports completed?
(6) Where was the application for insurance filed?
(7) Where were the payroll reports completed or submitted?
(8) Where were the premium checks from?

Any questions regarding the correct jurisdiction should be addressed to the local CDI Fraud Division regional office or the District Attorney in the county that may have jurisdiction. The law states that if acts or effects of a public offense occur in two or more jurisdictions, the offense can be brought before a competent court in either jurisdiction. For more information see *Penal Code Section 781.*

If an investigator cannot determine which county has jurisdiction, multiple jurisdictions may need to be notified when filing an SFC/FD-1. If this is the case, make it clear on the form that more than one county was notified. This will prevent duplication of effort by the district attorneys. Once notified, the agencies will discuss handling jurisdiction among themselves.

**Step 4: Provide Additional Information To Government Agencies**

Be prepared to provide additional information to other governmental agencies for their own investigation. Once asked in writing, the investigator has 60 days to respond to a request for information. Authorized governmental agencies should have released to them any and all information relating to specific workers' compensations insurance fraud investigations. See *Insurance Code Section 1877.3.*

**Insurer's Limited Immunity**

Each company's reporting procedure should be consistent and applied to everyone in the same manner.

The law provides an insurer with limited immunity from civil suit when referring suspected fraud to any authorized governmental agency, such as the California Department of Insurance, Enforcement Branch, Fraud Division and a district attorney's office. This limited immunity does not just cover the reporting insurance carrier or the self-insured employer or the third-party administrator. It also

covers those agents (e.g. private investigators) retained by these entities to seek out additional information and the government agencies involved in the investigation process. See *Insurance Code Section 1877.5.* and *Civil Code Section 47.*

However, as broad as it is, the immunity statute only provides protection when the fraud referral is made to an authorized governmental agency where there is a *reasonable belief* and done *without malice, in good faith, and is based on then-known facts obtained by reasonable efforts.*

An SIU investigator will be confronted with immunity provisions. Review the *Gopinath* case, [96 C.D.O.S. 2814, *Fremont Compensation Insurance Company vs. The Superior Court of Orange County.*] This is the first case heard by the judicial system that concerns the immunity provision in Civil Code Section 47.

**What Happens to the Form After Submission?**

The California Department of Insurance, Enforcement Branch, Fraud Division headquarters in Sacramento routes the SFC/FD-1 form to its appropriate regional office for review and disposition. A Supervising Fraud Investigator will notify the SIU of the status of the SFC/FD-1. If the case is assigned to a CDI Fraud Investigator, that investigator will contact the referring SIU investigator.

The processing of the SFC/FD-1 submitted to a district attorney's office will vary from county to county. It will be necessary to contact the district attorney's office in each area for a description of their process and the status of each submitted referral.

**What if More Information is Found?**

If additional information is discovered after notifying the agencies, send that information to the law enforcement investigator assigned to the case. It is important to include the case file number assigned by the CDI Fraud Division or the district attorney's office to ensure that the information is added to the correct case.

# The Documented Referral

## Legal Disclaimer

A documented referral is never required. Failure to submit a documented referral is never the basis upon which the Department declines to pursue an investigation pursuant to the California Insurance Code. Documented referrals are voluntary and merely increase and improve the factual basis upon which determinations to pursue legal actions based on referrals are made. Notably, these decisions are made on a case-by-case basis. Persons submitting referrals should anticipate requests for additional information and such requests may differ amongst the 58 independent District Attorney offices' within the State of California.

## Summary

This chapter covers the reporting of *substantiated* fraud cases. Once all four elements of fraud are identified, a documented referral is warranted. The entire documented referral protocol is included below.

## When is a Documented Referral Necessary?

As covered in the previous chapter, any time there is suspected fraud within the workers' compensation insurance arena, it is required by law that a Suspected Fraudulent Claims report (SFC/FD-1) be submitted to the authorities.

After further investigation, more evidence to substantiate the suspicion may be found. In those cases, consider submitting a "documented referral" to law enforcement. A documented referral assists law enforcement and increases the chances of prosecution.

## What is a Documented Referral?

A documented fraud referral entails much more information than allowed for on the SFC/FD-1. While each case of suspected fraud is unique, most experts in law enforcement have agreed that the items of information discussed below in the documented referral protocol cover the necessary items. However, be aware that individual district attorney offices may have other items that they will request based on the facts of the case.

## Documented Referral Outline

Below is a suggested outline of the items and information that comprise a documented referral. Note that all the items may not be applicable to each claim. However, the more developed the case, the greater the possibility that there will be enough information for law enforcement to open a criminal investigation.

The California District Attorneys Association and the California Department of Insurance have approved the following protocol.

**Section I: General Identification Information**

Include the following general items in the report:

(1) **Case Synopsis:** A short, one-paragraph summary of the case. Include general identification information including all information available on the suspect and a short summary of the case.
(2) **Suspect's Information:** Suspect's name, alias, address, telephone number, employer, employer's address, employer telephone number, suspect's employment position, DOB, POB, sex, race, height, weight, hair color, eye color, social security number, DMV number and prior claim history.
(3) **Insurance Information**: Insurance company name, address, adjuster's name and telephone number, SIU investigator's name and telephone number, insurance company file number.
(4) If reporting a policy or premium fraud case, you may want to provide the name of the auditor, underwriter, etc., in lieu of, or addition to, the adjuster name/address/phone number.
(5) **Other Agencies**: Any other agencies working on the case, along with the contact name and telephone number.
(6) **Referral Form**: Include a copy of the previously submitted Suspected Fraudulent Claim (SFC/FD-1) form.

**Section II: Narrative Statement**

After the general identification section, complete a narrative statement of the facts of the case. Here are some tips for writing a complete narrative statement.

(1) The statement should be written in chronological order. Start with the beginning of the case, include the investigation conducted, and conclude with the current status of the fraudulent claim.
(2) When necessary, each statement should reference exhibits that support the statement.
(3) Make specific reference to relevant documents in the insurance company or claims files, reports or interview or witnesses, medical files, depositions, videotapes, etc. For every document described in the narrative statement there should be an explanation of the document's origin, i.e., where it came from, where it was found. Specify which witnesses can testify to its authenticity.
(4) The narrative should include all the facts, both good and bad.
(5) If aware of any potential defenses the suspect might assert, those should be included in your narrative.
(6) Omit opinions; use only facts.
(7) If a timeline would be helpful to explain the chronological order of events, it should be included in the exhibit section and referenced in the narrative statement.

For every misrepresentation alleged, the following information should be provided:

(1) The exact statement (misrepresentation) made
(2) The date the misrepresentation was made
(3) Where it was made and to whom

(4) Identification of the exhibit where the misrepresentation is contained (i.e., WC claim, letter from Dr. "A", report of interview of "B", computer printout, application for insurance, etc.)
(5) Evidence which proves the representation is untrue (e.g., deposition pg. 1, line 15; sub rosa videotape at 2349-3542; Dr. "C" letter dated 4/3/92; report of interview with "D")
(6) An explanation of why the misrepresentation is important to the case
(7) Identification of witnesses who will testify to this conclusion

**Section III. Date of Discovery of Suspected Fraud**

In the documented referral, it is imperative that the earliest date the possible criminal activity was discovered is provided. Include specific statements about when and how the fraud was discovered, who discovered it, and why it was not discovered earlier.

**Section IV. Exhibit List**

Every exhibit referenced in the narrative statement should have a number and be listed in the order the exhibits are referenced in the narrative statement. This list should be placed just following the narrative statement of the case. Audiotapes, videotapes, transcripts and any available photographs of the suspect should be included. If a statement is attributed to a witness in the narrative statement, there should be a report of interview for that witness in the exhibits. The report of interview should state who is being interviewed, the date, time and location of the interview. All persons present during the interview should be noted. If it is taped, this should be noted in the report or interview. For documents listed in the Exhibit List, there should be an indication of where each document came from.

**Example:** Exhibit 1- Application for insurance policy on 1994 Toyota Tercel, contained in underwriting file for "X" Insurance Company for policy number 123456; Exhibit 2- Fax letter sent by Joe Suspect to "X" Insurance Company on March 5, 1993 and place in "X" Insurance Company's claim file No. 654321 by adjuster Mary Jones.

**Section V. Crimes Requested to be Charged**

For each crime sought to be charged there should be a short statement explaining the basis for this request.

**Example:** Insurance Code 1871.4(a)(1)– Claimant stated there was no prior injuries to his back during an appointment with Dr. Jones. (See Exhibit 8 - Dr. Jones' report dated January 15, 1996). In fact, claimant had seen Dr. Smith previously and told him that he had injured his back in an auto collision (See Exhibit 11 - Dr. Smith intake report dated March 20, 1995).

**Section VI. Loss and Restitution**

There should be a summary of the monetary loss to all victims (insurance company, employer, etc.) and the basis for the computation of the loss. The total loss should also be contained in the narrative, but the computation should appear in more detail in this section. In addition to the total losses, also include the costs incurred by your company to investigate the claim.

If you have information regarding assets of the suspect, place that information here. This is particularly important if the loss exceeds $100,000.00.

## Section VII. Witness List

There should be a section that lists the names of all witnesses, their addresses, phone numbers, and any identification information available to the investigator (i.e. date of birth, Social Security number, driver's license information) in case the witness moves. This section should also reveal the importance of the witness by explaining, in one or two sentences, what he/she will be able to testify to.

### Example: Claimant Fraud

An example of a typical claimant workers' compensation documented case referral should include, but is not limited to, the following information.

(1) Suspected Fraudulent Claim Report (SFC/FD-1)
(2) Employee Claim Form (DWC-1)
(3) Employers First Report of Injury (DSLR5020)
(4) Doctors First Report of Injury (DSLR 5021)
(5) Medical reports that focus on the claimant's current disabling condition and or past medical history
(6) Documentation in support of the claim, submitted by the claimant (letter, affidavits, medical bills, etc.)
(7) Copies of deposition transcription
(8) Copies of reports of interviews and or recorded statements
(9) Photographs and/or videotapes along with investigative reports
(10) All claims database information
(11) Substantiation of employment while disabled
(12) Substantiation of prior claims from other insurers
*(13)* DO NOT send attorney-client privileged communications.

### Example: Premium Fraud

An example of a typical premium fraud documented referral should include, but is not limited to, the following information:

(1) Suspected Fraudulent claim Report (SFC/FD-1)
(2) Application
(3) Payroll Reports
(4) Audits
(5) Certificate of Insurance
(6) Claims Information
(7) Secretary of State Information
(8) Department of Corporations
(9) Contractors State License Boards
(10) Quarterly Employee Tax Statements
(11) Employee Wage Reports
(12) Prevailing Wage Statements
(13) Policy Information
(14) DO NOT send attorney-client privileged communications.

**Other Types of Suspected Fraud**

For other types of suspected fraud (e.g. medical, legal, pharmacy, employer, agent/broker, embezzlement) use the guidelines contained in this protocol.

**Sending the Documented Referral**

These documented referrals should be simultaneously submitted to California Department of Insurance, Enforcement Branch, Fraud Division and the local district attorney's office.

Include complete addresses of all agencies/entities referral information is sent to.

Do not send original documents or a copy of the entire investigative file until requested to do so

**Legal Disclaimer**

A documented referral is never required. Failure to submit a documented referral is never the basis upon which the Department declines to pursue an investigation pursuant to the California Insurance Code. Documented referrals are voluntary and merely increase and improve the factual basis upon which determinations to pursue legal actions based on referrals are made. Notably, these decisions are made on a case-by-case basis. Persons submitting referrals should anticipate requests for additional information and such requests may differ amongst the 58 independent District Attorney offices' within the State of California.

**Questions?**

For questions regarding this process, please contact the local California Department of Insurance, Fraud Division Regional Office or the local district attorney.