Illinois Department of Insurance
Workers' Compensation Fraud Unit

2017 ANNUAL REPORT

Bruce Rauner, Governor

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I. Introduction

In 1911, Illinois became one of the first states in the nation to pass comprehensive workers' compensation laws. While state law has changed over the years, the basic principle guiding workers' compensation remains the same: employees and employers deserve a reliable and affordable system of insurance which protects employers, injured workers, and their families from financial catastrophe.

Today, state law requires almost every working resident of Illinois to be covered by workers' compensation insurance. Employers provide workers' compensation benefits either by purchasing insurance policies or by paying for the benefits themselves (known as self-insurance). Employers and employees benefit from the state's mandatory system, which allows employers to avoid costly litigation and provide employees protection and compensation for work-related injuries.

The business environment in Illinois could benefit significantly from greater fraud protection because a decrease in fraudulent claims would lead to more cost-effective insurance and, therefore, a more efficient market. The Illinois market is highly competitive, with 328 different companies competing to write direct workers' compensation premiums in 2016.

II. 2005 Reforms

In 2005, representatives from the business sector, labor, and government leaders united to address the problems of fraud and non-compliance in the Illinois workers' compensation system. Later that year, the General Assembly passed House Bill 2137, which would become Public Act 94-277. This legislation established in Illinois, for the first time, a statute devoted specifically to criminalizing and combating workers' compensation fraud.

Public Act 94-277, later codified as Section 25.5 of the Illinois Workers' Compensation Act (Act) (820 ILCS 305/25.5), introduced two anti-fraud reforms. First, the Act required the Illinois Department of Insurance (Department) to create an investigative unit, hereafter referred to as the Workers' Compensation Fraud Unit (WCFU).[1] The WCFU is charged with examining allegations of workers' compensation fraud and insurance non-compliance.[2] Section 25.5(c) of the Act specifically provides that it "shall be the duty of the [WCFU] to determine the identity of insurance carriers, employers, employees, or other persons or entities that have violated the fraud and insurance non-compliance provisions of this Section." 820 ILCS 305/25.5(c).

The Act's fraud and insurance non-compliance provisions constitute the second major anti-fraud reform. Prior to the passage of Public Act 94-277, fraudulent receipt, denial, or application for workers' compensation benefits were not specifically defined as unlawful by the Act. The 2005 reforms established eight specific fraudulent acts:

1. Intentionally presenting or causing to be presented any false or fraudulent claim for the payment of any workers' compensation benefit;
2. Intentionally making or causing to be made any false or fraudulent material statement or material representation for the purpose of obtaining or denying any workers' compensation benefit;
3. Intentionally making or causing to be made any false or fraudulent statement with regard to entitlement to workers' compensation benefits with the intent to prevent an

[1] Section 25.5 states that the "Division of Insurance of the Department of Financial and Professional Regulation" shall establish the WCFU. Pursuant to Executive Order 4 (2009) and a statute passed by the General Assembly, the Division of Insurance was re-established as the Department of Insurance effective June 1, 2009. Section 25.5 was amended to reflect this change in 2011.

[2] In addition to the WCFU, the Illinois Workers' Compensation Commission (IWCC), which is separate and apart from the Department, also employs a number investigators charged with investigating insurance non-compliance pursuant to Section 4 of the Act, which requires employers to provide workers' compensation benefits to employees.

injured worker from making a legitimate claim for workers' compensation benefits;

4. Intentionally preparing or providing an invalid, false, or counterfeit certificate of insurance as proof of workers' compensation insurance;
5. Intentionally making or causing to be made any false or fraudulent material statement or material representation for the purpose of obtaining workers' compensation insurance at less than the proper rate for that insurance;
6. Intentionally making or causing to be made any false or fraudulent material statement or material representation on an initial or renewal self-insurance application or accompanying financial statement for the purpose of obtaining self-insurance status or reducing the amount of security that may be required to be furnished;
7. Intentionally making or causing to be made any false or fraudulent material statement to the WCFU in the course of an investigation of fraud or insurance non-compliance; and
8. Intentionally assisting, abetting, soliciting, or conspiring with any person, company, or other entity to commit any of the acts listed above.

These eight prohibitions defined the nature and scope of WCFU investigations from 2005 to 2011.

III. 2011 Reforms

In 2011, the General Assembly passed House Bill 1698, which would become Public Act 97-18. The 2011 amendments to Section 25.5 of the Act provided the WCFU with additional tools to combat workers' compensation fraud. The first change enacted was the addition of a ninth prohibition. This provision makes it illegal to "intentionally present a bill or statement for the payment for medical services that were not provided." 820 ILCS 305/25.5(a)(9).

Public Act 97-18 also reformed the sentencing provisions in the Act. Previously, those

convicted of workers' compensation fraud were guilty of a Class 4 felony and required to pay appropriate restitution. The amended sentencing provisions now base the punishment for a violation of the Act's fraud provisions on the value of the property the person convicted of fraud obtained or attempted to obtain. The new sentencing scheme, codified at 25.5(b) of the Act, is as follows:

1. A violation in which the value of the property obtained or attempted to be obtained is $300 or less is a Class A misdemeanor;
2. A violation in which the value of the property obtained or attempted to be obtained is more than $300 but not more than $10,000 is a Class 3 felony;
3. A violation in which the value of the property obtained or attempted to be obtained is more than $10,000 but not more than $100,000 is a Class 2 felony;
4. A violation in which the value of the property obtained or attempted to be obtained is more than $100,000 is a Class 1 felony.

These changes to the sentencing scheme have led to greater interest from prosecutors.

Unfortunately, the changes to the sentencing scheme have also had a number of unintended consequences. As the new sentencing scheme is based upon the monetary value of the fraud committed, an issue exists for a number of violations where a value cannot be quantified. While the new sentencing guidelines work well for cases involving false claims and benefits received by workers' compensation claimants through false statements or fraudulent means, the guidelines pose problems for a number of other violations.

Thirdly, the recent reforms have given the WCFU broader powers of subpoena. While the WCFU utilized the subpoena power granted to the Director of the Department from its inception, the statute now clearly states that the WCFU has "the general power of subpoena of the Department

of Insurance, including the authority to issue a subpoena to a medical provider, pursuant to section 8-802 of the Code of Civil Procedure." 820 ILCS 305/25.5(c). Section 8-802 of the Code of Civil Procedure, which defines the physician-patient privilege in Illinois, states that "no physician or surgeon shall be permitted to disclose any information he or she may have acquired in attending any patient in a professional character, necessary to enable him or her professionally to serve the patient, except . . . [upon] the issuance of a subpoena pursuant to Section 25.5 of the Workers' Compensation Act."[3] 735 ILCS 5/8-802. This makes it clear that medical providers not only have to provide the medical records but may speak to investigators about what would otherwise be privileged.

Additionally, Public Act 97-18 removed the notice requirement from Section 25.5(e) of the Act. Prior to the 2011 amendments, the WCFU was required to contact the target of a potential investigation immediately upon receipt of a complaint, notifying them of the investigation, the nature of the reported conduct, and the name and address of the complainant. This requirement hindered the WCFU greatly in that it made attempts to conduct surveillance futile, as the target was aware of the investigation. The notice requirement also discouraged complainants from coming forward, as they would have their identity and address given to the target of the investigation. Without this requirement, the WCFU can be much more effective as well as more inviting to potential complainants.

The time limit for the WCFU to conduct a fraud investigation was removed from Section 25.5(e) of the Act. Previously, the WCFU had to complete its investigation within one hundred twenty (120) days of the time a complaint was received. Given the resources available, this limitation often proved to be impossible to comply with as the time limit started to run before the

[3] The language in Section 8-802 of the Code of Civil Procedure concerning subpoenas pursuant to Section 25.5 of the Illinois Workers' Compensation Act was added by PA 97-18.

case was even assigned to an investigator, and subpoena compliance took up the majority of the one hundred twenty (120) days. However, with that requirement removed, the WCFU can collect all of the relevant records, complete thorough investigations, and make better referrals to prosecutors, resulting in more convictions.

Finally, the 2011 amendments require that the WCFU to procure and implement a system utilizing advanced analytics inclusive of predictive modeling, data mining, social network analysis, and scoring algorithms for the detection and prevention of fraud, waste, and abuse by January 1, 2012.

The Department and the WCFU did issue a Request for Information (RFI) regarding this system in March of 2012 in the hopes of receiving information regarding how to draft a Request for Proposal (RFP) to obtain such a system. The Department received a number of responses. To date, no system has been procured. It has become increasingly clear that the Department does not possess the type of data necessary to fuel such an advanced analytics system. Neither the WCFU nor any other division of the Department collects the type of claims and medical data necessary to do effective data mining or predictive modeling. In early 2015, this determination was confirmed by representatives from two large workers' compensation carriers who are at the forefront of using advanced analytics to combat fraud. Both companies, independent of one another, indicated that the information available to the Department is insufficient for purposes of predictive modeling. Additionally, no funding has ever been provided for this mandate.

Despite the fact that the system has yet to be procured and implemented as required by statute, the WCFU has several recommendations regarding opportunities for additional fraud prevention and detection of fraud, waste, and abuse, including a number of recommendations first made in the 2013, 2014, 2015, and 2016 Annual Reports.

First, the WCFU recommends that the General Assembly repeal Section 25.5(e-5) of the Act for the reasons stated above. The Department believes the state would be better served by expanding the WCFU by hiring additional investigators to investigate actual or suspected fraud.

Second, the WCFU again recommends that injured employees be required to submit a form to the IWCC on a monthly basis, similar to the North Carolina Industrial Commission's Form 90,[4] regarding any employment or earnings during that time period.

The WCFU continues to recommend that the General Assembly consider additional amendments to Section 25.5 of the Workers' Compensation Act that would amend the language of Section 25.5(a)(5) to remove any ambiguity as to whether cases involving the underreporting of payroll may be charged under this section by replacing the word *rate* with *amount* and add language to the sentencing provisions of Section 25.5(b) to account for violations of the Act that do not have associated dollar amounts.

The WCFU continues to suggest that Sections 25.5(a) and (b), which define the offense of and penalties for Workers' Compensation Fraud, be re-codified within Article 17 of the Illinois Criminal Code, which includes crimes of deception and fraud, including the offense of Insurance Fraud.

IV. WCFU Operations

Section 25.5(c) of the Act charged the Department with establishing the WCFU. The Department established the WCFU in 2006 and now oversees its operations, investigations, personnel, and progress.

A. Complaints

The WCFU tracks reports of workers' compensation fraud. Complainants are required by

[4] Attached as Exhibit A.

statute to identify themselves and can report fraud by regular mail, electronic mail, or by calling a toll-free telephone number (1-877-WCF-UNIT or 1-877-923-8648). After receiving a report, the WCFU supervisor reviews each complaint to determine whether the complaint alleges a violation of the Act's fraud provisions that warrants investigation. In conducting this review, the supervisor assigns a case number to each complaint and enters it into the WCFU's case management system. If necessary, the supervisor contacts the complainant or requests additional information in order to complete the review process. If the report is frivolous, legally insufficient, or unsubstantiated, the investigation ceases and the report is closed. If the supervisor finds evidence sufficient to justify further inquiry the case is assigned for investigation.

B. Investigations

The primary responsibility of the WCFU is to conduct investigations and refer worthy cases for prosecution. To fulfill this task, WCFU investigators spend countless hours each year conducting field investigations, reviewing surveillance footage, issuing numerous subpoenas, and reviewing insurance, payroll, medical, and other records. An investigation begins after the WCFU supervisor assigns it to an investigator.

During 2016, the number of active WCFU investigators varied between two and five throughout the course of the year. During the past year, the WCFU completed the process of hiring additional investigators to bring the unit to its maximum complement of five investigators. This increase in staff, has allowed for more investigations to be assigned and completed, and will lessen the impact the departure of a single investigator has on the unit.

While structurally similar, each investigation differs based upon a host of factors, including the nature and quality of the initial complaint. Most investigations involve: (1) review of documentary and physical evidence; (2) detailed background checks of persons related to the case

(*e.g.*, investigative targets and witnesses); and (3) interviews of persons related to the case (*e.g.*, complainants, witnesses, insurance company personnel, medical treatment providers, and the investigative target).

C. Referrals for Prosecution

At the conclusion of each investigation, a review of the sufficiency of evidence is conducted. If the inquiry does not produce evidence deemed sufficient to convict an individual or entity of workers' compensation fraud, the case is dismissed. Investigations that produce sufficient evidence to convict are referred to the Attorney General's office or the State's Attorney of the county where the offense occurred. The power to decide whether to file criminal charges rests solely with the prosecutor who receives the WCFU referral.

The WCFU is building working relationships with relevant prosecuting authorities. Since its creation, the WCFU has referred cases to and worked with State's Attorneys representing forty-one (41) counties: Bureau, Cass, Champaign, Christian, Cook, DeKalb, DeWitt, DuPage, Edgar, Ford, Franklin, Gallatin, Jackson, Jasper, Jefferson, Kane, Kankakee, Knox, Lake, Livingston, Macon, Macoupin, Massac, McHenry, McLean, Morgan, Madison, Ogle, Peoria, Perry, Saline, Sangamon, Shelby, St. Clair, Tazewell, Union, Vermilion, White, Will, Williamson, and Winnebago.

D. Confidentiality

The confidentiality of all fraud reports and associated medical records is strictly maintained in accordance with the relevant statutes, and is only shared in the course of referring a case for prosecution or in complying with other lawful requests.

V. Building Relationships

WCFU investigators have learned many valuable lessons since the unit was established in

2006. Primary among them is the importance of building working relationships with various law enforcement authorities. WCFU investigators work to aid prosecutors in the exercise of their discretion. Cases referred for prosecution are presented clearly and succinctly. WCFU investigators are committed to their investigations, and for this reason assist the Illinois Attorney General or respective State's Attorney throughout any criminal case. This level of communication and continued assistance establishes trust, which improves future referrals and prosecutions.

As the WCFU has grown in experience over the years, the WCFU's cooperation and coordination with other investigative and law enforcement agencies has also grown. WCFU investigators have worked with the Federal Bureau of Investigation, the Postal Inspector's Office, the Drug Enforcement Administration, the Internal Revenue Service, U.S. Department of Labor, state medical investigators, local police departments, the Illinois State Police, and numerous State's Attorney investigators. Investigators also share non-confidential information with organizations dedicated to identifying and stopping fraud conspiracies, including the National Insurance Crime Bureau.

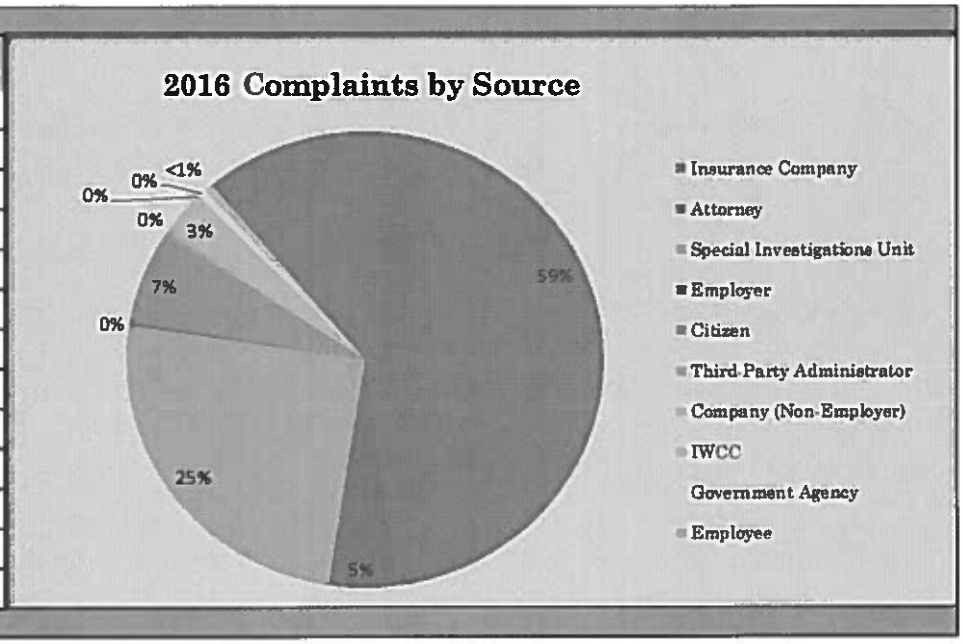
The progress of WCFU investigations over the years has improved the general public's understanding of workers' compensation fraud investigations. In the past, some complainants (*e.g.*, employers, insurers, employees) were confused about the kind of evidence the WCFU needed to successfully investigate an allegation of fraud. Establishing working relationships with workers' compensation stakeholders has helped to clarify the type of information that is required to prove workers' compensation fraud. To advance those efforts, the WCFU conducts a variety of educational presentations to public prosecutors and private law firms, as well as the insurance industry, self-insureds, other state agencies, and third party administrators, in an effort to assist them in better understanding the Illinois Workers' Compensation Act and the responsibilities of

the WCFU.

VI. Statistics

From 2010 to 2016, the WCFU received an average of 200 complaints of fraud per year. In 2016, the WCFU received 349 complaints.[5] The complaints received in 2016 were submitted by a variety of sources. The table and graph below shows the origin of the 2016 complaints:

Source	Complaints
Insurance Company	206
Attorney	16
Special Investigations Unit	87
Employer	1
Citizen	23
Third-Party Administrator	1
Company (Non-Employer)	10
IWCC	1
Government Agency	2
Employee	2
Total	349



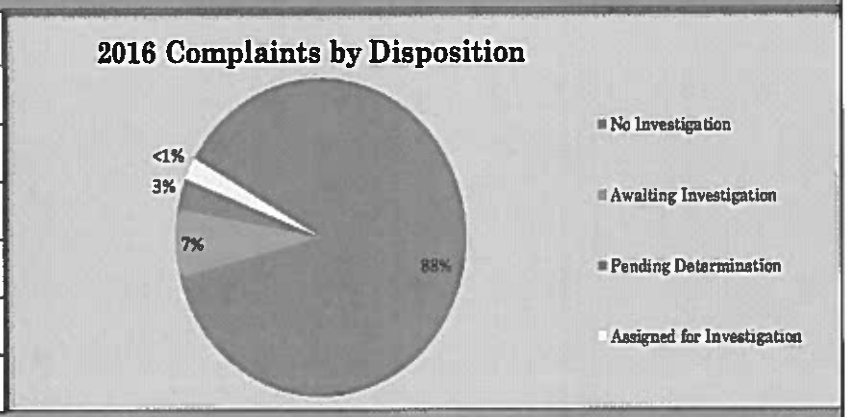
Of the 87 complaints submitted by Special Investigation Units (commonly referred to as SIUs), 76 were referred on behalf of insurance companies, seven were private SIUs, and two each were referred on behalf of employers and third-party administrators (TPAs). Additionally, the Illinois Attorney General's Office, who defends workers' compensation cases involving state employees, accounted for two referrals (these are included within the 16 complaints submitted by

[5] In June 2015, the WCFU worked with the National Association of Insurance Commissioners (NAIC) to establish a mechanism to receive daily reports of workers' compensation insurance fraud complaints derived from NAIC's Online Fraud Reporting System (OFRS), an online portal consumers and companies may use to directly contact the appropriate state insurance department to report suspected fraud. While the OFRS reports on fraud complaints from all lines of insurance, those complaints involving allegations of workers' compensation fraud are now being reviewed by the WCFU.

attorneys). Notably, the WCFU has again not received any complaints from TriStar, the TPA contracted to handle claims involving state employees.

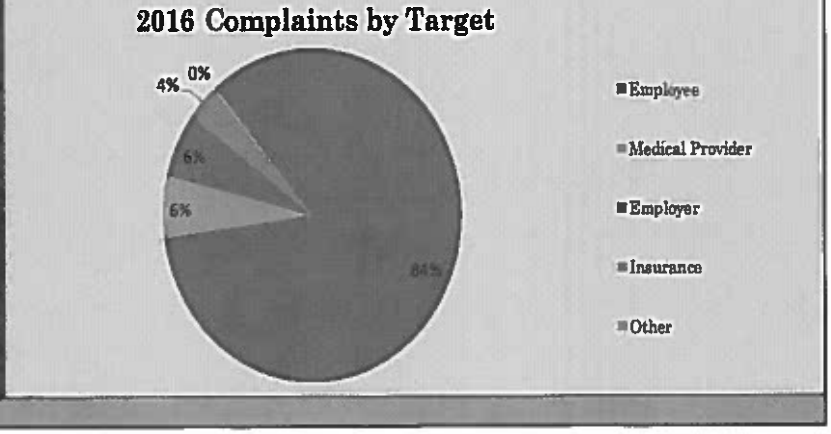
The majority (306) of the 349 complaints received in 2016 did not warrant further investigation because of insufficient evidence, lack of jurisdiction, or because the statute of limitations expired. A table and graph showing the disposition of these complaints is below:

Disposition	Complaints
No Investigation	306
Awaiting Investigation	24
Pending Determination	11
Assigned for Investigation	8
Total	349



As detailed earlier in this report, workers' compensation fraud occurs in many forms. The complaints received in 2016 alleged fraud on the part of various workers' compensation stakeholders. A table and graph showing the targets of these complaints is below:

Target	Complaints
Employee	293
Medical Provider	21
Employer	22
Insurance	12
Other	1
Total	349



The WCFU investigated 49 allegations of insurance fraud in 2016. Of these investigations,

16 investigations remained open from 2015, one remained open from 2014, and two remained open from 2013, while an additional 30 cases were opened in 2016. Of the 30 cases opened in 2016, eight were reported in 2016, 12 were reported in 2015, and ten were reported in 2014. Twenty-four of the investigations initiated in 2016 remained open at the beginning of 2017.

In 2016, the WCFU referred eight investigations to the Office of the Illinois Attorney General for possible prosecution. One of the cases referred in 2016 was from an investigation begun in 2016, while six of the referred investigations were initiated in 2015, and one was initiated in 2014.

Of the investigations referred for prosecution in 2016, two were indicted by a grand jury or initiated by the filing of criminal information, two were declined, and four were still awaiting a prosecution decision. In addition to the cases referred in 2016, charging decisions were made on seven cases referred prior to 2016. Six of those cases were declined, while one resulted in an indictment.

Additionally, two cases referred for prosecution prior to 2016 were also resolved this past year. In a case referred to the Illinois Attorney General in 2015, the defendant pleaded guilty to Forgery (Class 3 felony) and was sentenced to 24 months probation. The other case was referred to the DuPage County State's Attorney in 2014. The defendant pleaded guilty to Attempt (Forgery) (Class A misdemeanor) and was sentenced to 20 days in jail (credit of 1 day-stayed until December 15, 2016), one year conditional discharge, and ordered to pay $312 in fines, fees, and costs.[6]

[6] A table containing additional information concerning the two convictions can be found at Exhibit B.

North Carolina Industrial Commission

REPORT OF EARNINGS

IC File #_____

Emp. Code #_____

Carrier Code #_____

Carrier File #_____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act Employer FEIN _____

(EMPLOYER/INSURANCE CARRIER TO COMPLETE THIS SECTION)

Employee's Name	Employer's Name ( ) Telephone Number
Address	Employer's Address City State Zip
City State Zip	Insurance Carrier
( ) ( )	
Home Telephone Work Telephone	Carrier's Address City State Zip
☐M ☐F / /	( ) ( )
Social Security Number Sex Date of Birth	Carrier's Telephone Number Fax Number

To Employees: The Employer/Insurance Carrier periodically needs to verify your continuing eligibility for workers' compensation benefits and to update their records. **You are required to complete Page 2 of this Report of Earnings and return it to the insurer or employer address provided on page 2 of this form within 15 days after receipt of this form, even if you have no earnings.**

****YOUR WORKERS' COMPENSATION BENEFITS MAY BE SUSPENDED IF YOU FAIL TO COMPLETE THIS REPORT IN A TIMELY MANNER.****

NOTICE TO EMPLOYEES RECEIVING WORKERS' COMPENSATION

When you are receiving weekly workers' compensation benefits, YOU MUST REPORT ANY EARNINGS YOU RECEIVE TO THE INSURANCE CARRIER (OR EMPLOYER IF THE EMPLOYER IS SELF-INSURED) THAT IS PAYING YOU THE BENEFITS. "Earnings" include any cash, wages or salary received from self-employment or from any employment other than the employment where you were injured. Earnings also include commissions, bonuses, and the cash value for all payments received in any form other than cash (e.g., a building custodian receiving a rent-free apartment). Commissions, bonuses, etc., earned before your disability do not constitute earnings that must be reported.

You must report any work in any business, even if the business lost money or if profits or income were reinvested or paid to others.

Your endorsement on a benefit check or deposit of the check into an account is your statement that you are entitled to receive workers' compensation benefits. Your signature on a benefit check is a further affirmation that you have made no false claims or statements or concealed any material fact regarding your right to receive workers' compensation benefits.

MAKING FALSE STATEMENTS FOR THE PURPOSE OF OBTAINING WORKERS' COMPENSATION BENEFITS MAY RESULT IN CIVIL AND CRIMINAL PENALTIES.

TIME PERIOD COVERED BY THIS REPORT: _____ **to** _____
(Employer/Insurance Carrier must complete)

FORM 90

NORTH CAROLINA INDUSTRIAL COMMISSION
4340 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4340
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

EXHIBIT A

EXHIBIT A

2016 Convictions Resulting from WCFU Referrals

County	Date	Offense	Sentence	Summary
LaSalle*	05/16/16	Forgery (Class 3 felony)	24 months probation, fines, fees, and costs waived.	The defendant created and presented false certificates of insurance in an effort to obtain work.
DuPage	09/09/16	Attempt (Forgery) (Class A Misdemeanor)	20 days in jail (credit of 1 day-stayed until 12/15/16), one year conditional discharge, $312 in fines, fees, and costs.	The defendant presented a false certificate of insurance in an effort to obtain work.

* Prosecuted by the Illinois Attorney General's office

EXHIBIT B