Illinois Department of Financial and Professional Regulation
Division of Insurance
Workers' Compensation Fraud Unit

2008 Annual Report to the Workers' Compensation Advisory Board

Rod R. Blagojevich, Governor

Dean Martinez, Secretary
Michael T. McRaith, Director of Insurance

Illinois Department of Financial and Professional Regulation

Division of Insurance

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Secretary

MICHAEL T. McRAITH
Director
Division of Insurance

July 22, 2008

Dennis Ruth
Chairman
Illinois Workers' Compensation Commission
100 W. Randolph St., Suite 8-200
Chicago, IL 60601

Dear Chairman Ruth:

On behalf of the Division of Insurance and pursuant to Section 25.5(h) of the Workers' Compensation Act, I hereby submit the Workers' Compensation Fraud Unit's 2008 Annual Report to the Workers' Compensation Advisory Board.

Respectfully Submitted,

Illinois Division of Insurance

Michael T. McRaith
Director

I. Introduction

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

Today, almost every working resident of Illinois must be covered by workers' compensation insurance. State law requires employers to pay for workers' compensation benefits through insurance policies or self-insurance. Employers and employees benefit from the State's mandatory no-fault system: employers avoid costly litigation and employees receive fair compensation for work-related injuries.

Illinois enjoys a favorable business environment in part due to the continued availability of cost-effective insurance to guard against employment-related injuries. The Illinois market is highly competitive – in 2007, more company groups wrote direct workers' compensation premium in Illinois than in any other state.[1] This competition

[1] A.M. Best, Workers' Compensation Top Writers by State (2007 Direct Written Premium), 2008.

helped Illinois reduce its inflation-adjusted advisory rate for workers' compensation insurance by 33% from 1990 to 2008.[2]

In 2005, Governor Blagojevich's administration led a group of business, labor, and government leaders seeking to further reduce costs by addressing the problem of fraud and non-compliance in the Illinois workers' compensation system. Later that year, on July 20, 2005, Governor Blagojevich signed into law HB 2137 (Public Act 94-0277), which amended the Illinois Workers' Compensation Act. This historic legislation established in Illinois, for the first time, a statute devoted specifically to criminalizing and authorizing investigation of workers' compensation insurance fraud.

II. General Summary of Reform

Public Act 94-0277, later codified as Section 25.5 of the Workers' Compensation Act ("Act"), introduced two major anti-fraud reforms. First, the Act calls for the Illinois Department of Financial and Professional Regulation, Division of Insurance ("Division"), to create an investigative unit, hereafter referred to as the Workers' Compensation Fraud Unit ("WCFU"), to examine reports of workers' compensation fraud and insurance non-compliance. Section 25.5(c) provides that it "shall be the duty of the [WCFU] to determine the identity of insurance carriers, employers, employees, or other persons or entities who have violated the fraud and insurance non-compliance provisions."

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[2] The reduction in the advisory rate was calculated using advisory rates filed annually by the National Council on Compensation Insurance ("NCCI"), a rating organization authorized to file rates on behalf of companies pursuant to Section 459 of the Insurance Code (215 ILCS 5/459). Pursuant to state law, every insurance company offering workers' compensation insurance in Illinois must file rates with the Division (215 ILCS 5/457 and 50 Ill. Admin. Code 2902). Most companies satisfy this requirement by adopting the annual rate filed with the Division by NCCI.

The Act's fraud and insurance non-compliance provisions – provisions which define the WCFU's investigative mission – constitute the second major anti-fraud reform. Prior to the passage of P.A. 94-0277, the Workers' Compensation Act did not specifically define as unlawful the fraudulent receipt, denial, or application for workers' compensation benefits. The Act now outlaws eight specific fraudulent acts, namely:

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 statements with regard to entitlement to workers' compensation benefits with the intent to prevent an 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 define the nature and scope of WCFU investigations.

WCFU responsibilities under the Act involve investigation and referral for prosecution. Violations must be reported to the Attorney General or to the appropriate county State's Attorney for prosecution. Penalties vary based upon the offense. For example, persons who make a false report of fraud are guilty of a Class A misdemeanor while those who violate any of the Act's fraud provisions are guilty of a Class 4 felony and must pay restitution in addition to any fine.

III. Creating and Overseeing the WCFU

Section 25.5(c) of the Illinois Workers' Compensation Act charged the Division with responsibility for establishing the WCFU. The Division established the WCFU in 2006 and now oversees and guides its operations.

A. Best Practices

As a result of a nationwide survey of best practices and careful Illinois-specific planning, clear and efficient systems govern WCFU operations from the report of fraud to closure or referral for prosecution.

1. Reports

The WCFU reporting system solicits, records, and tracks reports of insurance fraud. Complainants are required by statute to identify themselves and can report fraud by regular mail, electronic mail, or by calling the Unit's toll-free telephone number (1-877-923-8468). After receiving a report, a WCFU investigator contacts the complainant and, if necessary, requests additional information. The investigator may refer the complainant to the Division of Insurance website, which prominently displays detailed information about the complaint process, including the minimum information necessary

to initiate an investigation. (See http://www.idfpr.com/DOI/General/WorkCompFraudCheckList.asp).

2. Investigations

An investigation begins after the WCFU receives all necessary information. The Supervisor first reviews the report of alleged workers' compensation fraud. If the report is frivolous or unsubstantiated, the investigation ceases and the report is closed. If the Supervisor finds evidence sufficient to justify further inquiry, the report information is entered into a central computer database and a case number and investigator are assigned.

While structurally similar, each investigation differs based upon a host of factors, including the nature and quality of the initial report. Most investigations involve: 1) review of documentary and physical evidence; 2) interview of persons related to the case (*e.g.*, complainants, witnesses, insurance company personnel, and physicians); 3) analysis of physical and geographic circumstances; and 4) detailed background checks of persons related to the case (*e.g.*, investigative targets and witnesses). The WCFU also issues subpoenas and engages in undercover surveillance to ensure complete and meaningful investigations.

3. Referrals for Prosecution

At the conclusion of each investigation, the WCFU either closes the case or refers it for prosecution. If the inquiry does not produce evidence sufficient to find probable cause to believe an individual or entity committed a Class 4 felony under the Act, the case is closed.[3] Investigations that produce evidence sufficient to meet the probable

[3] Some of the closed cases involve employees who have been falsely accused of committing workers' compensation fraud by an insurance company or employer.

cause standard are referred to the Attorney General or the State's Attorney of the county in which the offense allegedly occurred.

The WCFU has built strong working relationships with relevant prosecuting authorities. Investigators regularly work with and refer cases to the Attorney General. In 2007, the WCFU referred cases to and worked with State's Attorneys representing 25 counties: Cass, Champaign, Cook, DeKalb, DuPage, Edgar, Franklin, Gallatin, Jasper, Jefferson, Kane, Kankakee, Lake, Macoupin, Madison, McHenry, Morgan, Ogle, Peoria, Perry, Sangamon, Santa Fe, Vermillion, Will, and Winnebago.

4. Confidentiality

The confidentiality of all fraud reports and associated medical records is strictly maintained. The Act makes two exceptions to this general rule. First, WCFU referrals to prosecuting authorities include case-related confidential information. Second, in limited circumstances, the Act requires disclosure of limited information about the report. For example, upon initiation of an investigation, the Unit must immediately notify the respondent of the reported conduct, including the verified name and address of the complainant if the complainant is connected to the case.

5. State Agency Coordination

To promote efficient administration of state government, the WCFU takes reports from and shares expertise with existing state agencies, including the Illinois' Workers' Compensation Commission and the Department of Employment Security. The Unit also benefits from expertise provided by the Attorney General and various county State's Attorneys.

B. Outreach

To promote awareness of the WCFU, Director McRaith and WCFU members reach out to individuals and entities most likely to be affected by workers' compensation fraud. The primary targets of the outreach include elected officials and their constituents, local chambers of commerce, insurance companies, and insurance-related associations. WCFU investigators are also in regular contact with appropriate law enforcement and prosecutorial authorities.

In 2006 and 2007, the WCFU initiated 140 case investigations. These investigations bring the WCFU into direct contact with thousands of employers, witnesses, local and state police officers, federal agents, prosecutors, and insurance company employees. This on-the-ground reputation is critical to the future success of the WCFU.

IV. Lessons Learned

WCFU investigators report learning valuable lessons during the Unit's first two years of operation, including the importance of building working relationships with prosecutorial authorities. Hard-working state and county prosecutors possess broad discretion but limited resources. WCFU investigators, therefore, work to aid prosecutors in the exercise of their discretion. For example, cases referred for prosecution are presented clearly and succinctly and investigators assist the Attorney General or State's Attorney throughout any criminal case. This communication and assistance builds understanding and trust, which improves future referrals and prosecutions.

Clear communication of the WCFU's investigative authority has also improved results. Some complainants (*e.g.*, employers, insurers, employees) were, at first, confused about what kind of evidence the WCFU needed to successfully investigate an allegation of fraud. For example, insurance company special investigation units were copying and sending entire employee personnel files rather than just those parts relevant to the alleged fraud. WCFU investigators contacted the companies and detailed the evidence needed to prove workers' compensation fraud.

As the size and complexity of WCFU cases has grown, so too has the WCFU's cooperation and coordination with other investigative and law enforcement agencies. WCFU investigators work with the Federal Bureau of Investigation, the Postal Inspector's Office, the Internal Revenue Service, state medical investigators, local police departments, Illinois state police, and county 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 and the Health Care Fraud Working Group assembled by the U.S. Department of Justice.

The WCFU has increased the number of investigations referred for prosecution. Compared to 2006, the number of investigations initiated by the WCFU increased 168%, while referrals for prosecution increased 346%. (Exhibits A-C). Total fraud dollar amounts increased 949%: referred cases from 2006 involved an approximate total fraud amount of $618,391; in 2007, referred cases involved an approximate total fraud amount of $6,486,771. (Exhibit D). Progress was made from 2006 to 2007 with respect to employer-based fraud referrals, with referrals increasing from 1 to 7 and with total fraud amounts increasing from $24,000 to $4,333,405. (Exhibits B, E).

V. Investigations and Referrals – 2007

The WCFU received reports of workers' compensation fraud in 2007 that did not warrant further investigation because of insufficient evidence or because the statute of limitations expired. Sufficient evidence did exist, however, to initiate 102 investigations. To complete open investigations, the WCFU: 1) spent over 2,000 hours conducting field investigations; 2) reviewed approximately 293 hours of surveillance footage; 3) issued 272 subpoenas seeking insurance, payroll, medical, and other records; and 4) reviewed approximately 406,000 emails and hard-copy documents.

Many WCFU investigations produced evidence sufficient to meet the probable cause standard required for referral to prosecuting authorities. The following are referral results for 2007, which include referrals resulting from investigations begun in 2006:

- 58 cases were referred for prosecution, with an approximate total fraud amount of $6,486,771. (Exhibits B, F-G)
  - 47 referrals involved allegations of workers' compensation fraud committed by an employee, with an approximate total fraud amount of $2,001,746.
  - 7 referrals involved employer-based workers' compensation fraud, with an approximate total fraud amount of $4,333,405.
  - 3 referrals involved healthcare provider fraud, with an approximate total fraud amount of $151,620.
  - 1 referral involved insurance producer fraud. No dollar value was associated with the producer's preparation of a fraudulent certificate of insurance.
- 36 cases were investigated and closed without referral for prosecution due to insufficient evidence or lack of probable cause.
- 29 cases remained active at the close of calendar year 2007.

The investigated cases involve a variety of fraudulent actors (*e.g.*, employees, employers, insurers, insurance producers, medical providers) and a range of ill-gotten gains. In some cases the fraud did not involve paid benefits (*e.g.*, one employer submitted a fraudulent certificate of insurance as part of a bid for a municipal construction contract) or was detected before the payment of benefits; other cases involved total payments ranging from $2,425 to $2,895,082. Examples of cases referred for prosecution include:

- Employee or Claimant Fraud (Exhibit H)
  - An employee claimed he suffered a work-related back injury and collected a total of $288,952 in payments. Evidence uncovered by the WCFU indicates he sustained the injury riding his lawn mower at home. The employee told his wife and house guests that he planned to fabricate a work-related injury in order to file a workers' compensation claim.
  - An employee fractured his foot in a work-related injury and subsequently collected more than $40,000 in temporary total disability payments and medical benefits. Based on the employee's reports of continued foot pain without improvement, doctors even considered a below-the-knee amputation. WCFU investigators concluded the employee greatly exaggerated the extent and duration of his injury. While collecting benefits and reporting unimproved foot pain, the employee participated in five different bowling leagues, bowling three nights per week and setting several league records. He was also observed playing softball without any difficulties.

- Employer Fraud (Exhibit H)
  - An employee suffered a severe injury after his hand was grabbed by a mechanical cheese shredder, requiring extensive reconstructive surgery and months of physical therapy. The employer denied the claimant ever worked for him. The employer eventually admitted to WCFU investigators that the claimant was, in fact, working as an employee at the time of injury. As a result of the investigation, the employee was able to collect over $50,000 in workers' compensation claims.
  - A businessman seeking a contract with a municipality forged the required certificate of workers' compensation insurance. The municipality discovered the fraudulent certificate and entered into a contract with another bidder, but only after incurring over $5,000 in expenses as a result of the fraud.
- Healthcare Provider Fraud (Exhibit H)
  - A doctor was reported to the WCFU for improper billing. The doctor would perform a procedure known as "Manipulation under Anesthesia" in order to treat an injured body part, and then bill the insurance company for performing the same procedure to 12-13 other body parts without connection to the actual injury. Evidence indicates the billing fraud totaled over $250,000. The WCFU referred this case to law enforcement authorities, who continue to investigate.

- Insurance Producer Fraud (Exhibit H)
    - An insurance producer admitted to providing a fraudulent certificate of workers' compensation insurance to the owners of a towing company. The company was required to produce evidence of coverage in order to maintain its state transportation license.

VI. Prosecutions

The WCFU investigates workers' compensation fraud but does not prosecute. The power to decide whether to press criminal charges rests solely with the prosecutor who receives the WCFU referral – the Attorney General or relevant county State's Attorney.

The number of WCFU referrals resulting in felony indictments and convictions continues to increase.

- In 2007, as a result of WCFU referrals, county State's Attorneys from Cook, DeKalb, DuPage, Lake and Peoria Counties secured felony indictments against a total of 7 individuals.
    - Two 2007 Cook County felony indictments resulted in 2008 convictions – one defendant was convicted of Class 4 Felony Forgery and sentenced to 2 years in state prison, and another defendant was convicted of a misdemeanor.
- In the first five months of 2008, as a result of WCFU referrals, the Attorney General and county State's Attorneys from DeKalb, Lake, and Kankakee Counties secured felony indictments against a total of 4 individuals.

Additional indictments and convictions are expected during the summer of 2008.

NUMBER OF INVESTIGATIONS
<u>2006 v. 2007</u>

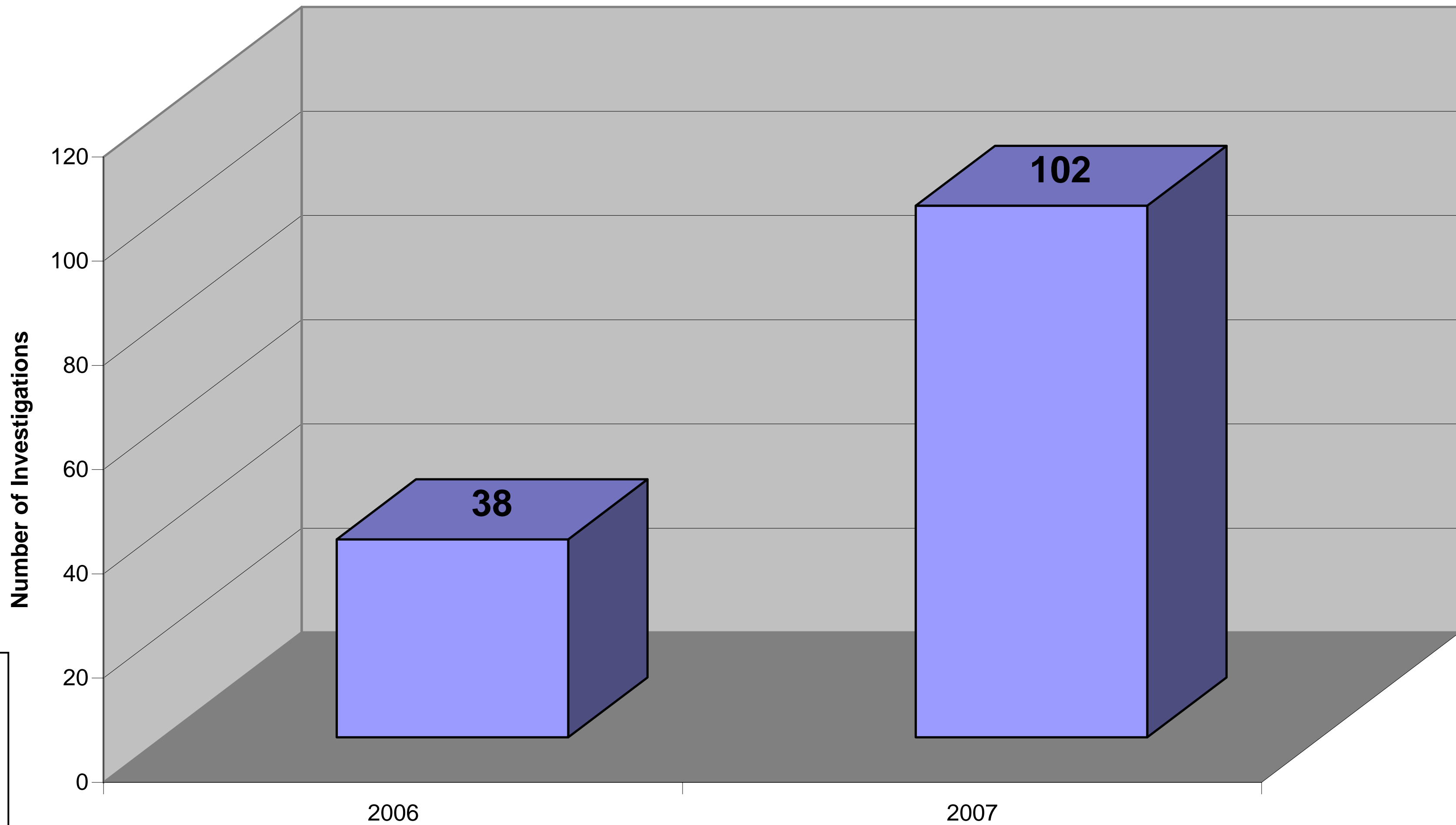


Exhibit A

REFERRED CASE COMPARISON
2006 v. 2007

	2006		2007	
	Referred Cases	**Fraud Amount**	**Referred Cases**	**Fraud Amount**
Employee / Claimant	12	$594,391	47	$2,001,746
Employer	1	$24,000	7	$4,333,405
Healthcare Provider	0	$0	3	$151,620
Insurance Producer	0	$0	1	$0
TOTAL	**13**	**$618,391**	**58**	**$6,486,771**

Exhibit B

CASES REFERRED FOR PROSECUTION

(BY CATEGORY)

2006 v. 2007

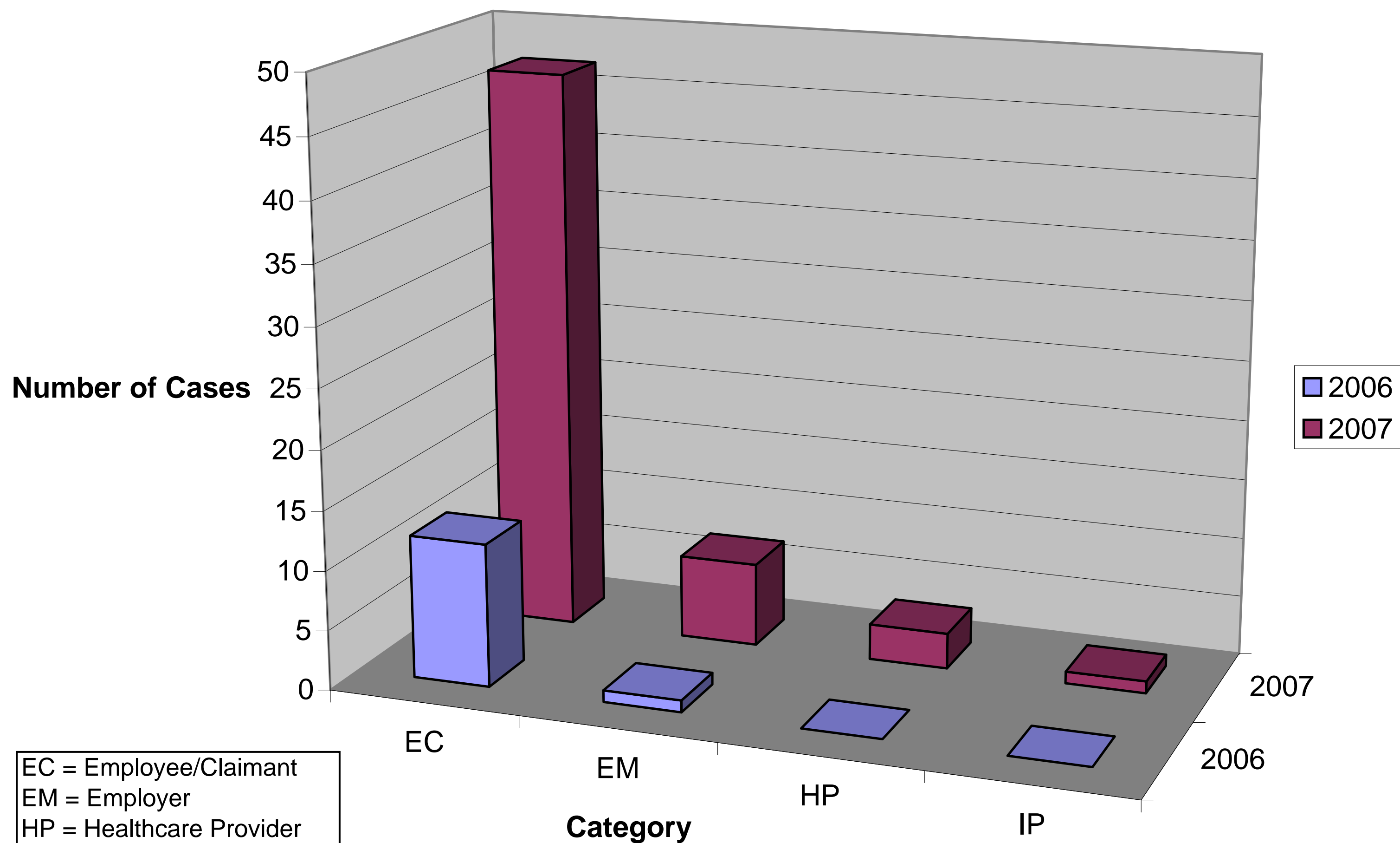
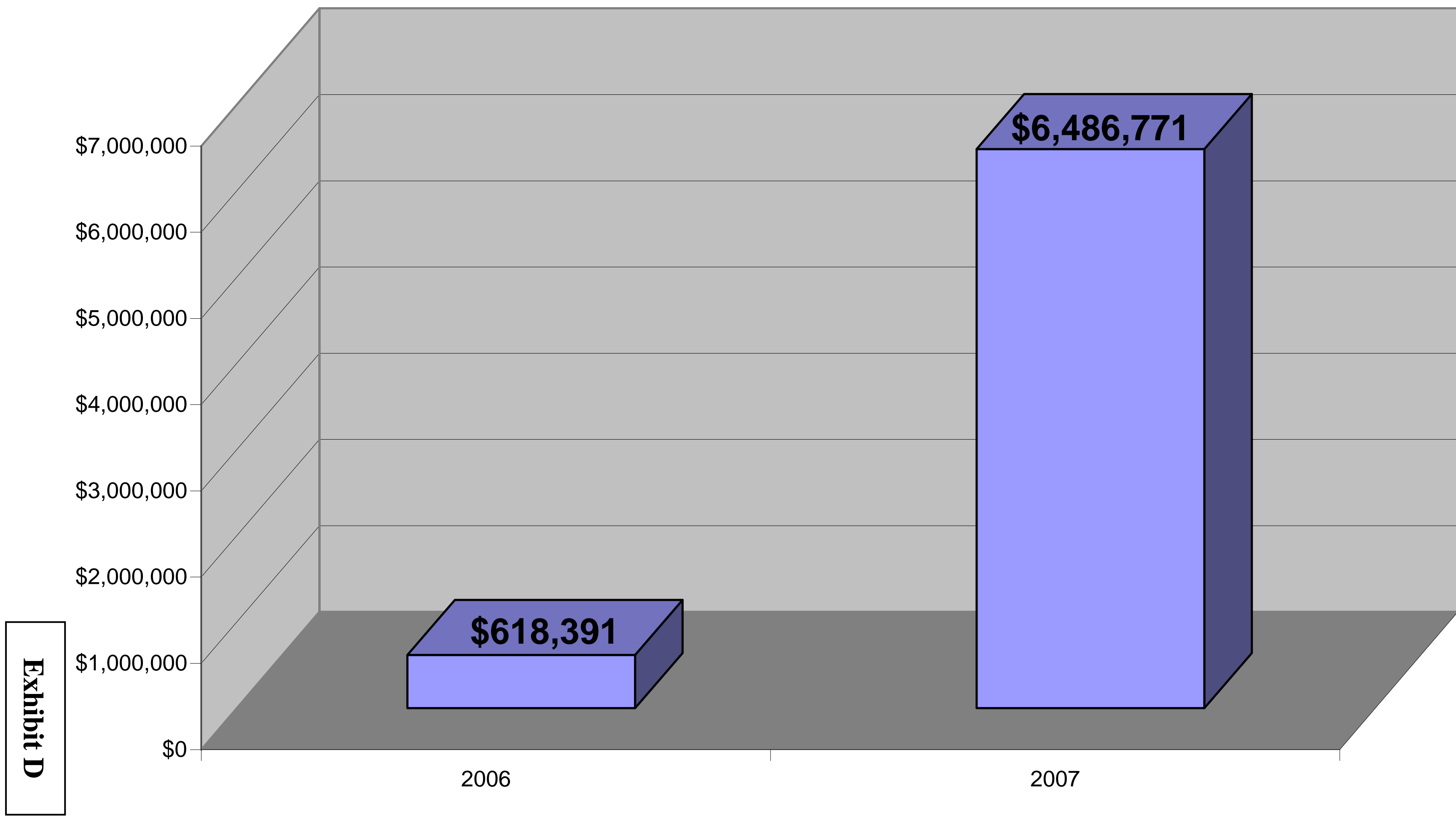


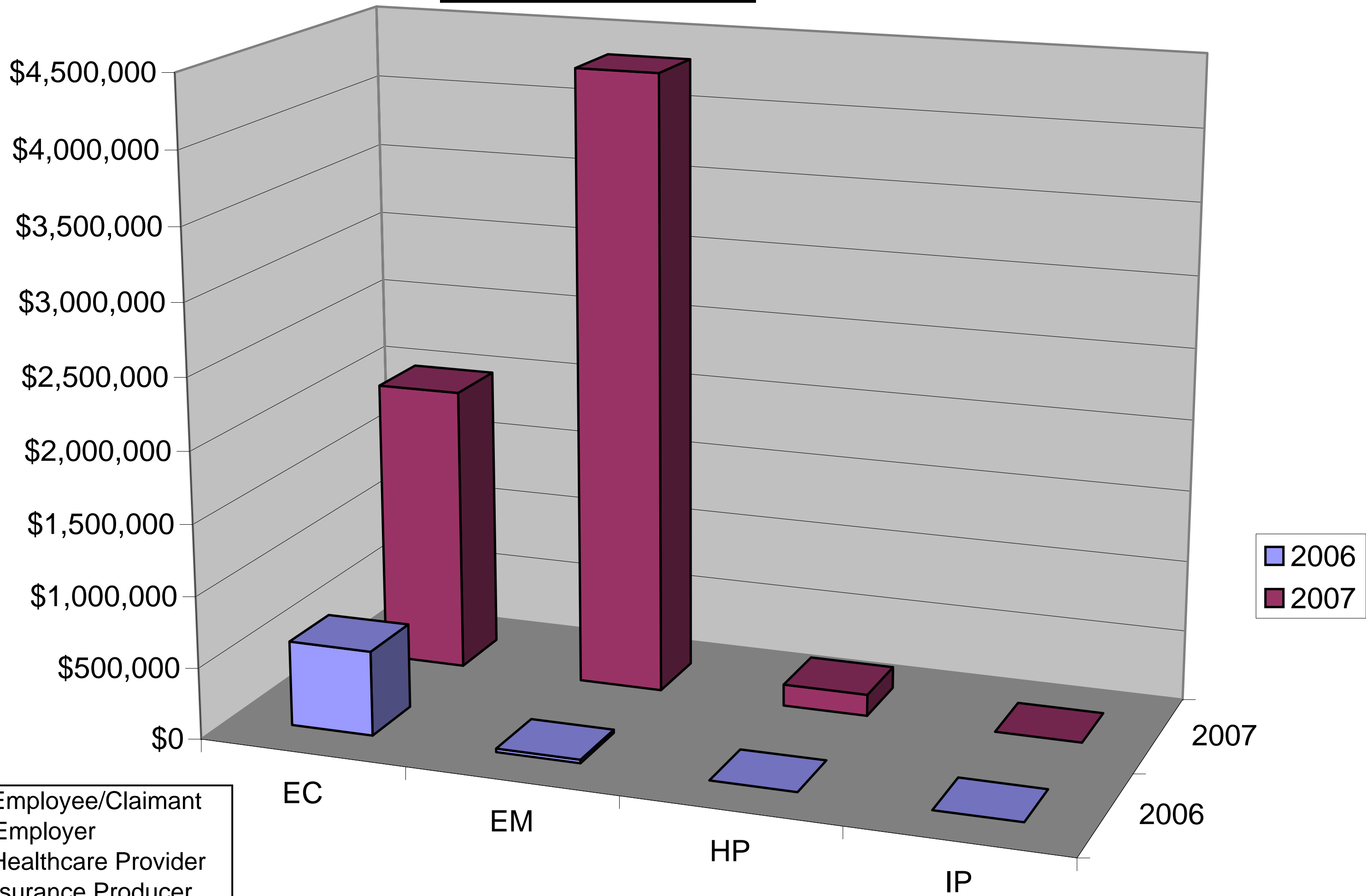
Exhibit C

EC = Employee/Claimant
EM = Employer
HP = Healthcare Provider
IP = Insurance Producer

TOTAL REFERRED CASE FRAUD AMOUNTS
2006 v. 2007



REFERRED CASE FRAUD AMOUNTS
(BY CATEGORY)
2006 v. 2007



EC = Employee/Claimant
EM = Employer
HP = Healthcare Provider
IP = Insurance Producer

Exhibit E

2007 REFERRED CASE FRAUD AMOUNTS BY CATEGORY

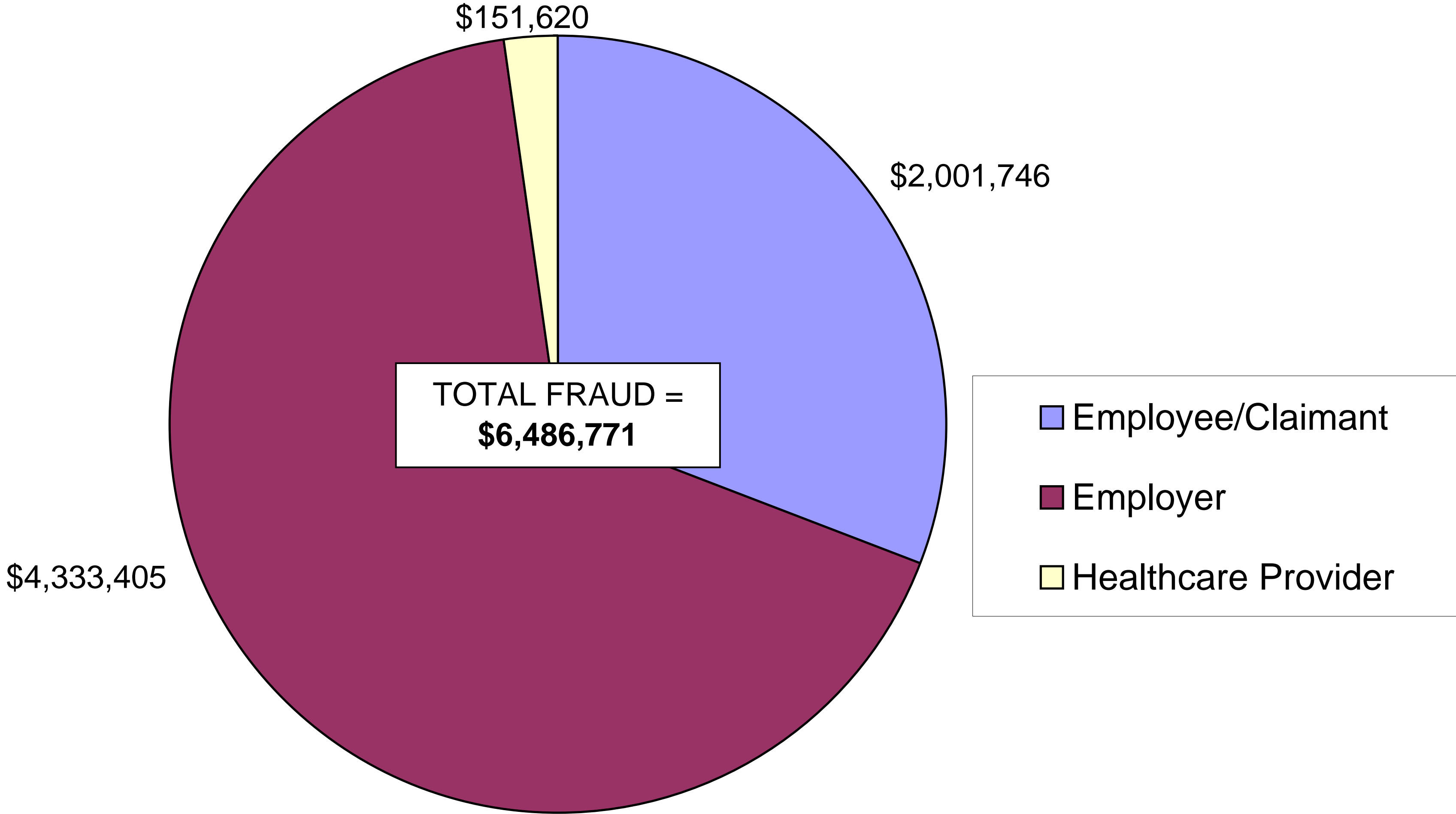


Exhibit F

2007 REFERRED CASES BY FRAUD AMOUNT
(Employee/Claimant Cases Only)

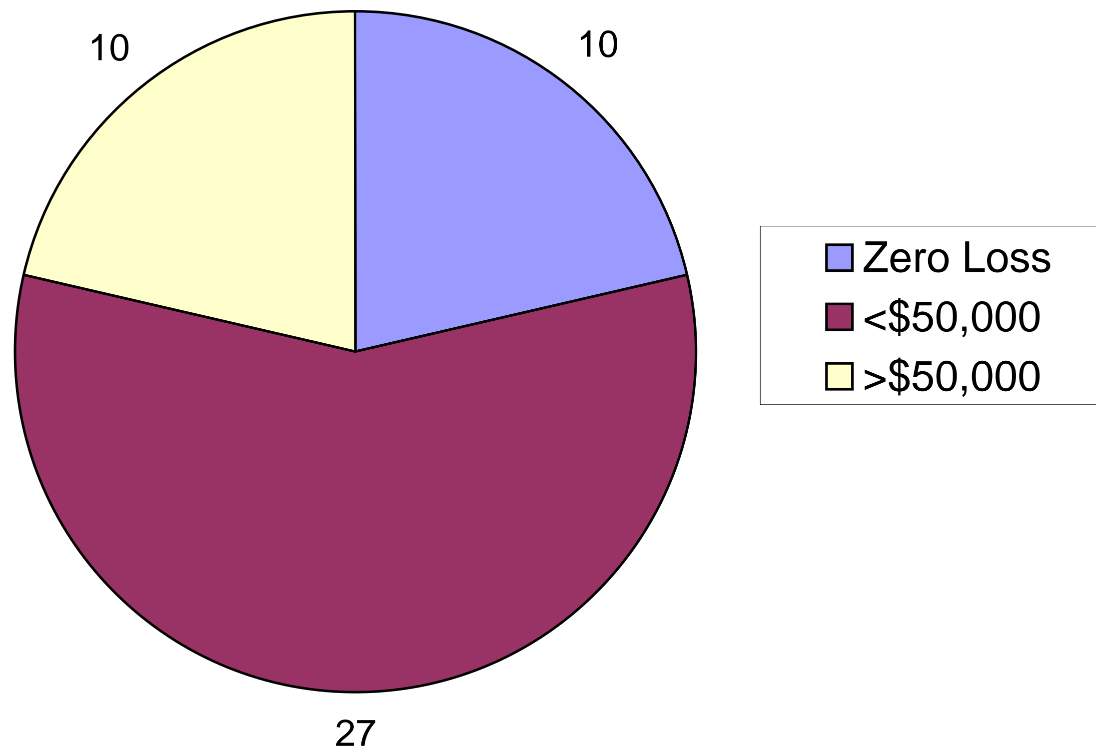


Exhibit G

2007 WCFU Referrals for Prosecution

Employee/Claimant Fraud

FRAUD AMOUNT	CASE DESCRIPTION
$285,952	Eyewitness accounts indicate injury occurred while riding lawn mower at home
$228,222	Claimant owns and operates a bar that requires work in conflict with medical restrictions
$193,576	Claimant exaggerates extent of injuries to increase benefits
$145,511	Injury from playing basketball, not work
$137,638	Self-employed claimant works construction while collecting TTD
$133,709	Medical records show wrist was broken while roller skating, 2 days after alleged workplace injury
$114,000	Gives conflicting accounts of workplace injury; uses fraudulent Social Security number
$95,413	Witnesses dispute claimant's account of work-related back injury
$63,412	Witnesses indicate claimant was injured playing softball
$54,139	In conflict with medical restrictions, works for airline unloading bags while collecting TTD
$47,393	Diagnosed with herniated disc 7 months prior to alleged workplace injury
$46,098	Performs heavy lifting despite medical restrictions while collecting TTD
$42,530	Work as a security guard directly conflicts with sitting and standing restrictions
$36,089	Fails to report TTD benefits to new employer; new work conflicts with medical restrictions
$34,709	Completes roofing and other home projects despite shoulder injury
$33,002	Videotape shows claimant performing activities outside medical restrictions
$28,063	Multiple witnesses dispute account of work-related neck injury
$27,519	Friend reveals back injury was fabricated
$27,113	Sells and repairs RVs despite injuries to back and leg
$25,602	Works as contractor while collecting TTD for a back injury
$25,503	Performs work in conflict with medical restrictions; receives unnecessary medical treatment
$22,800	Work and personal activity are inconsistent with hand injury
$21,898	Witness verifies injury occurred during fall down stairs at home, not work
$16,000	Exaggerates extent of injury to collect benefits
$15,061	Claimant dies in 2001 but checks are cashed until 2006
$14,292	Works construction job despite injury to right shoulder
$13,746	Installs auto glass while collecting TTD
$11,354	Video shows claimant walking without impairment despite severe ankle injury
$10,308	Works for construction company while collecting TTD
$9,315	Pushes watercraft and carries boat motor despite back injury
$8,571	Claimant exaggerates his work-related back injury to receive benefits
$7,747	Works in landscaping despite repetitive motion injury
$7,578	Operates auction business despite standing and walking restrictions
$4,711	Reports inability to work due to PTSD suffered during bank heist, but is found working another job
$4,277	Medical records show claimant experienced pain for 2 months prior to alleged workplace injury
$3,306	Alters medical records to increase claim benefits
$2,588	Works for another employer while collecting TTD, despite claiming intractable back pain
$0*	Claims old rotator-cuff injury occurred while lifting boxes at work
$0	Video shows claimant already injured before alleged incident
$0	Fired employee reports injury date of 2 days after termination
$0	Medical records indicate back injury occurred while moving furniture at home
$0	Medical records indicate back injury could not have occurred at work
$0	Witnesses and co-workers refute claimant's account of neck and shoulder injury
$0	Back injury from slipping occurred not at work, but while fishing
$0	Uses fraudulent Social Security number in attempt to obtain benefits
$0	Claims benefits for injury sustained at previous job
$0	Witnesses dispute account of workplace injury
$2,001,746	***TOTAL CASES = 47***

(* Generally, loss amounts of $0 indicate cases where fraud was discovered prior to payment of benefits)

Exhibit H

2007 WCFU Referrals for Prosecution

Employer Fraud

FRAUD AMOUNT	CASE DESCRIPTION
$2,927,008	Owner of an employee leasing company provides fraudulent certificates of WC insurance
$1,167,609	Deliberately misclassifies employees in order to lower premiums
$220,000	Deliberately misclassifies employees in order to lower premiums
$15,000	Provides fraudulent certificate of WC insurance to general contractor
$3,788	Provides fraudulent certificate of WC insurance to secure a contract with a municipality
$0	Sends fraudulent certificate of WC insurance to prospective client
$0	Fails to report income for several employees; fabricates information regarding WC claim
$4,333,405	***TOTAL CASES = 7***

Healthcare Provider Fraud

FRAUD AMOUNT	CASE DESCRIPTION
$150,000	Physician receives payment for services unrelated to work injury; submits conflicting versions of medical report
$47,393	Physician fraudulently alters medical records to increase patient's WC benefits
$0	Physician bills for services not rendered
$151,620	***TOTAL CASES = 3***

Insurance Producer Fraud

FRAUD AMOUNT	CASE DESCRIPTION
$0	Insurance producer provides fraudulent certificate of WC insurance to towing company seeking to keep its transportation license
$0	***TOTAL CASES = 1***