LAUGHLIN FALBO LEVY & MORESI LLP

THE WORKERS' COMPENSATION NEWSLETTER

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255 California Street, Suite 700
San Francisco, CA 94111
Tel: (415) 781-6676
Fax: (415) 781-6823

1 Capital Mall, Suite 400
Sacramento, CA 95814
Tel: (916) 441-6045
Fax: (916) 441-7067

250 Hemsted Drive, Suite 310
Redding, CA 96002
Tel: (530) 222-0268
Fax: (530) 222-5705

200 S. Los Robles, Suite 500
Pasadena, CA 91101-2431
Tel: (626) 568-9700
Fax: (626) 568-3905

555 12th Street, Suite 1900
Oakland, CA 94607
Tel: (510) 628-0496
Fax: (510) 628-0499

1900 S. State College Blvd., Suite 505
Anaheim, CA 92806
Tel: (714) 385-9400
Fax: (714) 385-9055

1520 The Alameda, Suite 200
San Jose, CA 95126
Tel: (408) 286-8801
Fax: (408) 286-1935

600 B Street, Suite 2300
San Diego, CA 92101
Tel: (619) 233-9898
Fax: (619) 233-6862

575 E. Locust Street, Suite 311
Fresno, CA 93720
Tel: (559) 431-4900
Fax: (559) 431-4046

625 East Carnegie Drive, Suite 120
San Bernardino, CA 92408
Tel: (909) 890-2265
Fax: (909) 890-2377

2901 28th Street, Suite 200
Santa Monica, CA 90405
Tel: (310) 392-8101
Fax: (310) 392-8057

IN THIS ISSUE...

STOP THE ABUSE: A PRIMER ON WORKERS' COMPENSATION FRAUD

By Devon Craft, San Jose

It is no secret that workers' compensation fraud is rampant in California. It is estimated that fraud costs carriers in California $1 billion to $3 billion per year. This unfortunate burden on the system can have a widespread effect on those legitimately working within the workers' compensation system, including carriers and employers, as well as on actual injured workers whom the system is designed to benefit.

It should be noted that fraud in workers' compensation is not only committed by supposedly injured workers, but also by employers, insurance carriers, and medical providers. In this article we will discuss what acts of fraud are committed by all parties involved in workers' compensation cases, and how an employer and/or carrier can take steps to mitigate the effects of fraud on their claims.

Defining Fraud

In order to identify fraud, it helps to know the legal elements to proving a fraud case in court. As you will see, a simple lie may not be enough to bring charges against a claimant.

Insurance Code Section 1871.4, part of The Insurance Frauds Prevention Act, provides the details for what acts constitute workers' compensation fraud. These acts include:

1. Knowingly making or causing to be made false or fraudulent material statements or representation for the purpose of obtaining or denying workers' compensation benefits;
2. Knowingly presenting or causing to be presented a 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 workers' compensation benefits;
3. Knowingly assist, abet, conspire with, or solicit a person to commit workers' compensation fraud;
4. Knowingly making or causing to be made a false or fraudulent statement in regard to an entitlement to benefits with the intent to discourage an injured worker from claiming benefits or pursing a claim.

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PROVING FRAUD WITH TIME AND STRATEGY

A Case Study

By Vicki Lindquist, Oakland

What follows is a short story of an actual fraud case handled by our Firm. It began as a normal injury claim, but soon turned into questions and responses that simply did not add up. The observant claims professional became suspicious and referred the case to Vicki Lindquist in our Oakland office for legal defense handling of the workers' compensation claim. Working together, the attorney and claims professional brought the case to a satisfactory close with a fraud conviction and restitution.

The Beginning

A Maintenance Mechanic of a large multi-national employer sustained an industrial back injury that initially resulted in very little time off. However, after an unsuccessful return to full duty, the injured worker eventually underwent back surgery. Shortly after surgery, and while allegedly still temporarily totally disabled, the claims professional noticed a very brief mention in one of the medical reports about how the injured worker purchased a gas station. Apparently, the physician did not give it much thought, and did not question it. Instead, he simply continued certifying the worker for temporary disability benefits (TTD) and more medical treatment.

Suspicions Arise

The claims professional, however, realized the significance of the gas station purchase. If the worker was TTD, how does the gas station fit in? Does he co-own it? Does he just own it on paper but otherwise have nothing to do with it? Or is he actually involved in the day-to-day activities of running the station? Why did he purchase the station now? How did he purchase it? What involvement does the worker have with the station?

With such questions and suspicions in mind, the claims professional referred the workers' compensation case to our office. The plan of action was to conduct the usual discovery activity but to also be on the look out for anything else that doesn't quite fit in a normal run-of-the-mill injury claim. The intention ultimately was to uncover suspected fraud if indeed there was fraud.

Action

The injured workers' deposition was set and taken. During the course of extensive questioning, the injured worker finally admitted that he had indeed purchased a gas station, but that his wife ran it. He testified that he had little to no involvement. According to him, he rarely ever went to the gas station. He did not work there. It was his wife or employees that did all the work. At that point, that small bit of testimony was all we needed to really get started. We already knew his wife worked full-time elsewhere. We also knew that the couple had a child still in school. The likelihood of his wife running the gas station business while working full-time elsewhere was simply implausible.

Meanwhile, the injured worker continued treating. A new treating physician maintained the usual pain management treatment modalities, temporary disability certifications, and recommended psychotherapy and a functional restoration program. The physician continued to report that the worker was unable to work due to significant physical limitations caused by pain.

The treating psychotherapist continuously reported the injured worker's complaints of cognitive difficulties and severe depression with a loss of social functioning all due to his chronic pain resulting from the industrial injury. The worker continued receiving TTD.

We knew where the applicant cashed his TD checks, and, thanks to the deposition, we now knew the name of the gas station business. Our next avenue of discovery was to subpoena the bank records for the gas station and conduct surveillance.

The subpoena turned up lots of relevant bank records, over 1,000 pages. Those records revealed that with the exception of a single check, every check written and every cash deposit made in person (almost daily) were all done by the injured worker. This was an initial con-

FRAUD CASE STUDY CONT.

firmation of what we strongly suspected – that the injured worker, not his wife, was operating the gas station business.

The ability to run a business like the gas station is entirely inconsistent with the reports by the worker about his psychiatric and cognitive complaints: that he was too depressed to get out of bed, was having difficulty interacting with others due to pain, and was otherwise experiencing cognitive problems as a result of his chronic pain.

By the way, there was not one mention in the psychotherapy reports about the fact that he was operating his own business, or that the business even existed. But the reports were full of his concerns and fears over the uncertainty of his future, his disability and his persistent pain that was **affecting every aspect of his life**. Little did he know how his own fraudulent actions would soon cause his own fears to become reality.

Time for Video Surveillance

After a sufficient amount of recovery time passed after his back surgery, we deemed it the right time to undertake surveillance. The first few days of surveillance were fruitful. He was filmed at a large warehouse store buying supplies which included a rather large box. Despite the supposed pain, he was able to shop, load his items including the large box onto a large cart, and then transfer the items from the cart into the back of his vehicle after leaving the store. For someone having difficulty interacting with others due to pain and cognitive problems, this activity is extraordinary. At the very least, it is inconsistent with the workers' reported pain complaints.

But a day or two of surveillance alone is not sufficient to prove fraud. We recommended that our client conduct additional surveillance. We then scheduled a QME evaluation to assess his MMI status and orthopedic disability.

Gotcha!

The additional surveillance was gold! This time we had him **physically working at the gas station** both in the storefront and outside, bending and stooping to **hammer signs into the ground** around the gas station property.

Meanwhile, the QME found him at MMI, but provided a generous impairment rating, **including an add-on for pain**. The physical limitations the worker reported to the QME were obviously inconsistent with what the surveillance showed. It was time to refer this matter to the District Attorney for consideration.

Investigation by the District Attorney's Office

The District Attorney's office conducted their own investigation. Part of their investigation was to interview the gas station employees. They confirmed that the injured workers' wife was never involved in the gas station except on the rare occasion when the injured worker was out of town. With the evidence we obtained through discovery on the workers' compensation case in conjunction with the results of the District Attorney's separate investigation, there was sufficient grounds to charge the injured worker with two felony counts pursuant to Penal Code Section 550(b)(3) and Insurance Code Section 1871.4(a).

The injured worker was arrested days later. Upon arrest, and after learning of the evidence, he did not contest the charges.

The Payoff

Our next task was to determine the cost of the temporary disability benefits and medical treatment that arose as a result of the injured worker's fraud. That formed the basis of our demand for restitution. Ultimately, we obtained restitution for our client in the amount of $50,000, very close to our demand. The applicant pled guilty to a felony, and was sentenced to jail time and probation.

This true story is a perfect example of what can be accomplished when an observant claims professional and savvy defense attorney work together to ferret out fraud. It takes time and strategic planning but in the end, it pays off. ◆

AVOIDING PENALTIES:
Payment Deadlines for Findings & Awards Under the *Leinon* Case

By Jason Sanders, Santa Monica

For many adjusters and attorneys, issuing payment of accrued or ongoing TD or PD benefits after a Findings and Award (F&A) may not seem controversial. However, case law suggests that the issue may not be as clear as we think. There may be consequences for not identifying the appropriate payment deadline.

When is a Findings and Award Payable?

The potential for selecting the wrong payment deadline may come from the fact that the Labor Code and California Code of Regulations do not expressly state the time frames for paying an Order Approving Compromise and Release ("OACR"), Stipulated Award or F&A. Labor Code Section 5800 states that "all awards shall carry interest on all due and unpaid amounts from the date of the making and filing of said award". This implies that due and unpaid amounts are payable immediately upon the issuance of the OACR, Stipulated Award or F&A, along with post-award interest.

So why do we not see more penalty petitions being filed the day after an OACR, Award or F&A issues? There are two primary reasons. The first reason is that, in the context of an OACR or Stipulated Award, the parties may agree to certain contract terms. The second reason is that parties are granted time to file for reconsideration of awards/orders.

Contractual Deadline

The most common deadline for payment on an OACR or Stipulated Award is 30 days because defendants insist on adding language that any interest (due under Section 5800) and penalties for failure to pay the OACR or Stipulated Award immediately, are waived if paid within 30 days. However, the parties do not have the ability to mutually agree to a 30-day deadline in the context of an F&A. The judge is solely responsible for drafting the F&A.

Nevertheless, some may still think the 30-day deadline applies to an F&A. This confuses the agreed-upon contractual 30-day deadline in an OACR or Stipulated Award with the statutory deadline for F&As. The 30-day contractual deadline does not apply to F&As. If payment is issued on the 30th day, it will be late. Note that the new C&R forms have the 30 day provision already included in the document. This provision is not included in the Stipulated Award form and will still have to be written in by defense counsel.

Deadline Based on Reconsideration

Others will say the appropriate payment deadline for an F&A is 20 days, plus an additional 5 days for mailing. The 25-day deadline is inferred from Labor Code Section 5903, which gives a party the ability to challenge the award within 20 days after the service of any final order, decision, or award. The rules for service would extend this to 25 days if the award is served by mail.[1] The inference is that since the party has 25 days to file a petition for reconsideration, they should also have the same time frame to pay the award, because the award is not final until after the reconsideration period expires. Initially, this may seem like the correct deadline.

14-Day Deadline

However, Section 5903 may be trumped by Labor Code Section 4650. There is an issue as to whether a 14-day deadline would apply to F&As based on Section 4650. Section 4650 controls the time frame for making the first periodic payment of TD or PD. According to subsections (a) and (b), that time frame is 14 days after knowledge of the injury and disability, unless liability for the injury is earlier denied. How can a section controlling periodic payments of TD or PD apply to an F&A, where lump sums of retroactive TD or PD are often being awarded?

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1 Subsequent references to the 25-day deadline will assume the additional 5 days apply due to service by mail.

AVOIDING PENALTIES CONT.

The Appeals Board answered this question in *James L. Leinon v. Fishermen's Grotto; Mid-Century Insurance Company* (2004) 69 CCC 995 (*en banc*). In *Leinon,* the judge issued an F&A awarding applicant retroactive TD. Defendant filed for reconsideration, and then for writ of review. Defendant lost both petitions, and applicant then claimed that the payment under the award was not paid within 14 days under Section 4650. Ultimately, the Appeals Board found that defendant timely paid the F&A under Section 4650, so no penalty was applicable. But it's the Board's use of Section 4650 and the 14-day time period that should have attorneys and adjusters concerned about its application in other cases. The Board in *Leinon* stated that:

> Labor Code §4650 applies only to periodic payments, including accrued periodic payments, where liability is accepted or whether liability is ultimately imposed and the determination becomes final. An award becomes final for purposes of Labor Code §4650(d) when a defendant has exhausted all of its appellate rights or has not pursed them. However, there is no grace period for delay in payment provided by the statutory right to reconsideration or appellate review. Thus, if a defendant does not file a petition for reconsideration from an award of disputed benefits, but does not pay within 14 days of the award, it must pay a Labor Code §4650(d) penalty. (*Id.* at p. 999-1000).

Penalty for failing to pay F&A timely under Labor Code Section 4650

If a defendant fails to pay the F&A within 14 days[2] and no reconsideration petition is filed, the defendant would be liable for a penalty under Section 4650(d), at least according to *Leinon*. Pursuant to the language under subsection (d) the penalty is an uncapped 10% penalty **of the entire late payment**. In cases where large sums of retroactive TD or PD may be at issue, this 10% penalty may be substantial. It is important to note that there is no language regarding reasonableness in subsection (d), meaning that the penalty is imposed as a matter of strict liability. There are two exceptions that prevent a penalty from attaching. First, no penalty shall apply to payment due prior to or within 14 days of employer's receipt of claim form or when the employer advised the applicant of inability to determine whether TD is owed within 14 days. (Section 4650(d)). Second, no penalty shall apply if the injury or indemnity is denied or disputed. (Section 4650(a); see also, *Leinon, supra,* 69 CCC 995 at 999). The first exception is not applicable in the context of a F&A and the second is most likely covered by the ability to file reconsideration.

Conclusions

The unpublished 2006 decision *Zimarik v. WCAB*, 71 CCC 111 stated that the Appeals Board should reconsider *Leinon*. But *Leinon* is still a binding *en banc* decision, even though, according to *Zimarik*, it may have misapplied Section 4650.

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The Workers' Compensation Newsletter is published by Laughlin, Falbo, Levy & Moresi LLP. Contributors to this issue include Devon Craft (San Jose), Vicki Lindquist (Oakland) and Jason Sanders (Santa Monica).

Should you have any questions or comments regarding the Laughlin, Falbo, Levy & Moresi newsletter, or would like to suggest a topic or recent case you think would be of interest, please contact:

Janet Zamecki (LFLM Oakland)
E: jzamecki@lflm.com
T: (510) 628-0496

Lois Owensby (LFLM Pasadena)
E: lowensby@lflm.com
T: (626) 568-9700

[2] Labor Code Section 4650 seems to start the clock on the date of receipt (knowledge) of a medical report finding disability. It is unclear when the clock would start in the context of a F&A. It could be when the F&A is served or when it is received. *Leinon* is vague on this point, but most language in the opinion appears to address the date of the award and its issuance. So the date of service will most likely control in context of F&As.

FRAUD

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Not only must there be knowledge that the statement or representation being made is false, but the representation must be "material" to the claim for workers' compensation benefits. In *People v. Gillard* (1997), 57 Cal.App.4th 136, the Court defined "material" as it applied to Section 1871.4, finding that a representation was material if it conveyed information on subjects that are germane or reasonably relevant to the insurer's investigation of the claim, and could bear directly and importantly on the investigation and evaluation of the claim. A material misrepresentation can also include concealing facts that would fit the definition of material.

As such, not any small lie will rise to the level of fraud, rather the misrepresentation must concern a fact that is central to the granting of benefits. A claimant stating that at the time of the injury he was not wearing a baseball cap which would violate company policy when there is evidence to the contrary might be deceitful but would likely not be workers' compensation fraud. However, representations that would be material include: not disclosing a pre-existing injury to the same body part, exaggerating or fabricating the extent of the injury, claiming the injury occurred at work when it did not, working while receiving temporary disability benefits, and staging an accident or faking an injury. For the employer, this could include: misrepresenting the number of employees, misrepresenting an employee's job duties, and lying to an employee to encourage them to not file a workers' compensation claim.

Health care fraud is another concern, and is covered by California Penal Code Section 550. Under this code section, a health care provider can be charged with health care fraud for knowingly making a false or fraudulent claim for payment of a health care benefit covered by workers' compensation, knowingly submitting a claim for a health care benefit covered by workers' compensation insurance that was not used be the claimant, or knowingly representing multiple claims for payment of the same workers' compensation health care benefit with an intent to defraud. Thus, if a doctor submits bills to a carrier for services he did not provide the injured worker, he can be charged under California Penal Code Section 550.

Investigating Suspected Fraud

Once you suspect fraud may have occurred, the employer and/or carrier should investigate to determine what evidence exists to support the fraud allegation. Most evidence will come in the form of documents such as medical records, police reports or company reports, and in the form of witness testimony.

It is prudent for any person tasked with conducting the investigation to follow company procedures and be familiar with the basics of how to interview witnesses. They should make sure to get the full story, asking each witness who, what, where when, why, how. Further, when talking to witnesses (likely other employees) the employer should take care to not be too aggressive in

FRAUD Cont.

their questioning, as a relaxed witness will be much more forthcoming than someone who is on the defensive.

During an interview the witness's body language can say a lot about the validity of their statements. Make sure to not just listen to the result, but also watch the witness's actions and mannerisms. The interviewer must be aware of their own body language, again making sure to not be too aggressive and making certain to control their tone and make eye contact.

As part of the investigation, the injured employee should also be interviewed, possibly before interviewing other witnesses. You will likely have the opportunity to do this soon after he files his claim. However, once the injured employee hires counsel, you will not be able to question him regarding the injury. Thus, it is important to make the most of the interview as it may be the only chance to question them without legal action. They should be asked about the injury, including the alleged mechanics of how it occurred, what body parts were supposedly injured, and any background information that may shed light on any alternative causes of the injury or preexisting conditions. Asking for a time frames of events and details of any pertinent information will help solidify their story and make any subsequent changes harder for the injured employee to explain.

At the end of any interview it is wise to ask the witness if there is any information they want to share that they think is important which was not already discussed. The witnesses may have some important piece of information that the interviewer may not have thought to ask about. This is also a good way to indicate the interview is coming to a close.

As for documentation, medical reports concerning the alleged injury will be critical to determining if an injury occurred, and if so, to what extent was the employee actually injured. A Doctor's First Report of Industrial Injury or Illness should contain the employee's description of the accident. Usually this report is generated near in time to the injury, and thus, should be considered the most accurate statement made by the injured employee. This can then be compared to statements they made in interviews, in subsequent medical reports, or to coworkers.

If the injury occurred in such a way that the police were included, such as a motor-vehicle accident or an assault, the police report should be obtained. This will also include statements made by the injured employee as well as any other witnesses present.

Reporting Fraud

After identifying what fraud may have occurred and conducting a preliminary investigation the fraud can be reported to the proper authorities. Insurance Code Section 1877.3(b)(1) states that when an insurer "knows or reasonably believes it knows the identity of a person or entity who committed a fraudulent act relating to a workers' compensation insurance claim […] [they] shall notify the local district attorney's office and the Fraud Division of the Department of Insurance […]"

In regards to fraud committed by medical providers, Labor Code Section 3823 states that when there is a belief that a fraudulent claim has been made by any person or entity providing medical care they shall report the fraud as prescribed by the administrative director.

In most circumstances the employer will report the suspected fraud to the insurance carrier. The Insurance carrier will likely have a Special Investigative Unit that will report the fraud to the necessary governmental agencies.

Crime and Punishment

If an injured worker, employer, insurer, or medical provider is accused of workers' compensation fraud, they can face either a misdemeanor charge or a felony charge depending on the circumstances of the fraud and their prior record.

Violation of Insurance Code Section 1871.4 can be charged a misdemeanor or a felony based on the circumstances of the charges and the injured worker's criminal history. If charged as a misdemeanor, the injured worker, now criminal defendant, could face up to one year in jail, a fine up to $150,000 or double the

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amount of the fraud, whichever is greater, and/or restitution to any parties who were victims of the fraud. If charged as a felony, the defendant can face up to 5 years in jail, a fine up to $150,000 or double the amount of the fraud, whichever is greater, and/or restitution to any parties who were victims of the fraud.

In an effort to fight fraud, California passed Senate Bill 863 in 2013, which required the posting to the Department of Insurance's public website the identity of defendants convicted of workers' compensation fraud. Thus, the names of defendants, their charges, and sentences are readily available online. While this information was already available via a background check, having this information readily available to the public will hopefully further dissuade any would-be fraudster.

Fighting fraud committed by healthcare providers can be just as important as fighting committed by claimants. According to the California Department of industrial Relations, $600 million in liens were filed from 2011 through 2015 by convicted or criminally indicted parties.

If a healthcare provider violated California Penal Code Section 550, they can also be charged with either a misdemeanor or a felony. If charged with a misdemeanor, the provider could face up to one year in jail and/or up to a $10,000 fine. If charged with a felony, the provider could face up to 5 years in jail and/or up to a $50,000 fine or double the amount of the fraud.

Healthcare providers can also be charged for fraud for being involved in a scheme of commercial bribery and/or kickbacks that take advantage of the workers' compensation system. This activity would fall under California Labor Code Section 549, which makes illegal the act of soliciting, accepting or referring any business to or from any person or entity, with the knowledge that that person or entity intends to commit workers' compensation fraud. A violation of Penal Code Section 549 can be charged as misdemeanor or a felony for the first offence, and as a felony for any subsequent offenses. Many of the same acts of fraud noted above can also subject to the perpetrator to civil penalties under Labor Code Section 3820, which include a penalty of at least $4,000 and up to $10,000 for each illegal claim for compensation and an assessment of up to 3 times the amount of the medical treatment or med-legal expenses paid by a workers' compensation insurer.

Conclusion

Armed with the legal framework of a fraud case, from the legal elements to the procedure and penalties, as well as tips on how to conduct your own investigation, we hope we can all work together to diminish this scourge on the workers' compensation system in California. ◆

LFLM *Holiday Parties*

Save The Date

Bay Area - Tarantino's (Fisherman's Wharf, San Francisco)	Thursday, December 1, 2016
Sacramento - California State Railroad Museum (Old Sac)	Friday, December 2, 2016
Southern California - Catal (Downtown Disney)	Thursday, December 8, 2016

AVOIDING PENALTIES

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According to *Leinon*, an F&A that includes periodic payments or accrued periodic payments of TD or PD is payable within 14 days of its issuance if the defendant does not file for reconsideration or writ of review.[3] Moreover, even if the defendant does, the F&A will still be payable within 14 days of an adverse decision on those petitions.

The 14-day deadline under Section 4650 is not favorable to defendants because under Section 5903, parties have 25 days to file for reconsideration. However, if defendants decide not to file for reconsideration on day 21, and if the F&A includes periodic payments, they are still late under Section 4650 because defendant did not make payment by day 14.

Upon receipt of the F&A, it is imperative to identify payment and filing deadlines pursuant to Section 4650 and Section 5903 respectively, and to consider the amount of potential penalties and interest, particularly when retroactive benefits have been awarded. This, combined with timely contemplation of whether to file a petition for reconsideration, will enable defendants to fully assess their exposure and make well-informed decisions regarding litigation strategy. ◆

3 While not expressly stated in the opinion, the service rules may extend this to 19 days if served by mail.

UPCOMING CONFERENCES

2016 CWCDAA Winter Conference
California Workers' Compensation Defense Attorney's Association
November 17-20, 2016
The Island Hotel, Newport Beach

2017 PARMA Annual Conference
Public Agency Risk Managers Association
February 12-15, 2017
Disneyland Hotel, Anaheim

2017 RIMS Annual Conference
Risk Management Society
April 23-26, 2017
Pennsylvania Convention Center

2017 CAJPA Annual Fall Conference
California Association of Joint Powers Authorities
September 12-15, 2017

LAUGHLIN
FALBO
LEVY &
MORESI LLP

555 12th Street, Suite 1900
Oakland, CA 94607
Tel: (510) 628-0496
Fax: (510) 628-0499

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