IDENTIFYING THE MEDICAL AND LEGAL PERSPECTIVES OF BODILY INJURY FRAUD

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I. INTRODUCTION.

When we talk about insurance fraud, even those who are knowledgeable within the industry generally first think of first-party property insurance claims. The traditional investigation of insurance fraud has centered upon claims under homeowners and business polices for such actions as arson and staged thefts. Although these issues remain huge problems for the insurance industry, and for consumers who ultimately pay higher premiums, perhaps the largest area of insurance fraud still remains in the area of first and third party bodily injury fraud claims. To say our industry has been lax and "behind the curve" in identifying and properly investigating these types of claims would be an understatement.

Key statistics involving insurance fraud include the shocking estimate as much as Twenty Billion Dollars is lost per year due to insurance fraud and as many as thirty-one percent of all personal injury claims submitted involve some aspect of insurance fraud. [1]What is even more staggering is the best estimates within our profession show these numbers have not decreased at all in the past four years, and in fact are steadily increasing and have increased even more dramatically in the past several years with the economic downturn.

1 Source Insurance Research Council

To think bodily injury fraud is not occurring in your company or practice is foolishness. To understand fully the scope of the problem, and using a conservative estimate of one-third of all personal injury claims involving some aspect of fraud, consider the number of bodily injury claims you are currently involved in, or the amount of indemnity dollars paid out in the past year, for bodily injury claims and take one-third of that number. The results may shock you.

Unlike first party property claims, bodily injury fraud is generally not pre-planned or thought-out in advance. In an arson fire one of things we look for is whether the person pre-planned the event and took steps prior to the claim showing an intent to commit insurance fraud. Bodily injury fraud generally is much different in that normally a legitimate accident or occurrence under the policy does arise and the fraud arises from what originally was a legitimate claim. Although it does sometimes occur, very few people are actually involved in rings orchestrating staged accidents so most of the bodily injury fraud claims actually begin as legitimate accidents and then the fraud occurs afterward in claiming injuries which were never present or inflating injuries for purposes of monetary gain.

II. YOU CANNOT IDENTIFY THE FRAUDULENT CLAIM IF YOU DO NOT KNOW WHAT YOU ARE LOOKING FOR.

Let me ask you a question at the start: *"What policy and procedure do you have in place to identify from the onset whether a bodily injury claim involves fraud?"* My strong suspicion is your answer is nothing. By that I am not implying you or your company do not have an interest in identifying fraudulent claims, but instead you are doing nothing pro-actively to determine whether fraud is occurring. At best you are probably instead reacting when some evidence comes to the surface indicating a potentially fraudulent claim exists. This is the mind set we must correct.

If we are not implementing programs and plans to identify potential bodily injury fraud claims then it is literally like looking for a needle in a haystack because we have no idea what it actually is we are searching for and because of that are simply groping around hoping something will fall into our grasp.

The traditional "fraud indicators" of means, motive and opportunity also will really get you nowhere in investigating bodily injury fraud. We are dealing here with a whole different environment which requires entirely different skills and investigative techniques to locate and determine where bodily fraud may be occurring.

The indicators you are looking for in bodily injury fraud are vastly different. Although some similarities exist, especially financial motive, what you are really attempting to find out is whether or not legitimate injuries were sustained in the accident and whether or not reasonable and necessary treatment has been rendered for those injuries. Investigation of these claims is also more difficult since especially where third parties are involved you do not have the right to invoke provisions such as the duty to cooperate, the duty to produce records and the requirement to submit to examinations under oath which can occur in first party claims. An allegedly injured third-party plaintiff actually owes no duty to cooperate with your company in the investigation of the accident or their claim in any respect until such time as suit is filed and the rules of discovery of the court take over.

Oftentimes as well the best way to identify whether bodily fraud is occurring is not only by looking at the claim in front of you, but analyzing whether similar patterns and practices are emerging concerning bodily injury claims involving the same attorneys and/or medical providers. Such patterns and practices can be one of the best ways to determine whether bodily injury insurance fraud is present. Unlike arson and theft claims which generally do not involve

organized rings of activity, there is a vast network operating across the United States today of attorneys and medical providers engaging in questionable, if not actually fraudulent, advancement of bodily injury insurance claims.

Even what may appear on the surface to be the most clear cut liability and injury claim may still contain vast elements of insurance fraud. Several years ago I had breakfast with an acquaintance of mine who was involved in an automobile accident. He and his daughter were en route to a school event when their car was stuck by a vehicle going left of center. On the evening of the accident this gentleman actually called me to advise me he had been in an accident, but he and his daughter were entirely fine. I was surprised several days later when he contacted me asking whether I would represent him or refer him to another attorney. I knew at the time this individual was experiencing financial difficulties and although I gave him the name of an attorney, I also inquired of him about his statement he and his daughter were not injured. He confirmed to me he was not injured, but was concerned his daughter might have some unknown injuries and just wanted to be "safe." Approximately two weeks later he advised me he was now in medical treatment after talking to the attorney and his daughter may have more serious injuries than he thought. At our breakfast I learned this gentleman was also on the verge of filing bankruptcy and he told me he hoped to turn around his financial condition when he received the anticipated insurance settlement. I am certain all of this is unbeknownst to this particular insurance company as they are simply looking at this as a clear liability case on the part of their insured and trying to reach an amicable settlement. I am equally certain the carrier has done no investigation to determine the financial condition of this family or even made any attempt to learn the allegedly injured daughter was back playing competitive sports in a very short period of time.

Although I realize fully every claim cannot be investigated through every possible lead, in this presentation we will attempt to discuss the type of procedures to have in place to hopefully identify and follow through on bodily injury fraud investigations.

III. IDENTIFYING FRAUD BEFORE IT EVEN OCCURS.

One of the strongest ways you can identify insurance fraud is by analyzing the claims your company or firm have handled historically to identify which attorneys and medical providers may be involved in fraudulent practices so you have identified those files before the next suspicious or fraudulent claim ever even occurs. This requires a commitment to "data mining" to determine, based upon prior claim history, whether reasonable justification exists to warrant investigation of future claims.

Most people in this audience should be acquainted with the extensive investigation which has been done of a chain of chiropractic clinics operating in approximately thirteen states and involving severe questions regarding potential insurance fraud. These clinics literally take in millions of dollars a year for chiropractic treatment and in each state have a network of attorneys who are settling millions of dollars of claims. The general manner in which these clinics and law firms operate is to review police reports to identify clear liability cases, solicit those not at fault parties by telemarketing and then provide a limited amount of chiropractic treatment lasting six to seven weeks and generating medical expenses between $2,500.00 and $3,500.00 per file.

These are exactly they type of claims which insurance companies pay on a routine basis to simply close the file. There is no evidence of excessive or extended chiropractic treatment and generally the charges are in keeping with the recommended fees for services. In short, there are no "red flags" created relative to the amount charged or the duration of the treatment. Nevertheless, what is occurring behind the scenes appears to be a very well orchestrated network

using telemarketing, the purchasing of police reports and conveniently having lawyers from the law firms present at the clinic at the time of the first visit to sign-up clients. In short, what have may have been a no injury claim or simply a very minor claim now becomes a file involving attorney representation and several thousand dollars of chiropractic treatment. If your company, however, is not tracking the number of claims involving these clinics and attorneys, it would be very easy for these files to simply "fly below the radar screen" and be paid on a routine basis with no questions asked.

This is where the insurance industry needs to become more pro-active. What our industry has failed to do in the past is analyze claims which are being paid to determine whether any suspicious patterns and practices are emerging which warrant further investigation. One of the strongest things I urge our law firm clients to consider is to keep a matrix of claims involving major law firms and medical providers. This information can now be kept electronically and can track information such as the attorney, the medical provider, the amount of medical expenses, and the duration of treatment. The matrix can be expanded to include information such as how soon after the accident date legal representation is noted on the file and whether or not suit is actually filed or the claim is routinely settled. A copy of a format for conducting such a matrix (which can be done either in handwritten form or on a computer) is attached to this paper.

The key point with the matrix is to look for patterns emerging which demonstrate the need for your company to be aware of and look closer at insurance claims involving certain law firms or medical care providers. Only if you look at the prior claims history will you be able to identify at the onset new files which may come into the claims department which warrant further in depth investigation.

In like manner, you also should routinely be in touch with your state insurance department, state medical board and state chiropractic board to find out what medical

practitioners may be under investigation for potential insurance fraud. At least in my experience I have found state departments of insurance and medical/chiropractic boards are generally willing to share this information with insurance carriers through their SIU personnel. Once you are in possession of this information, your company should then be monitoring these files very closely where medical providers who are under investigation are known to be treating first or third party claimants who have submitted losses to your company.

One of the other pro-active things you can do if you are an insurance carrier claims or SIU professional is to stay in close contact with your defense counsel. In all the years I have been practicing as an insurance attorney, the vast majority of which have been specializing in insurance fraud, I have rarely, if ever, had an insurance claims professional or SIU investigator contact me and ask me to provide them with information concerning attorneys or medical providers their companies should be actively monitoring for possible insurance fraud. To me it is amazing how we all give "lip service" to wanting to fight insurance fraud, however, doing something as simple as asking your own legal counsel which attorneys or medical providers should be placed on a closer watch to detect insurance fraud never even occurs.

The reason I feel this is so important is because the vast majority of all claims are settled without suit ever being filed. Accordingly, if you are running an insurance claims office and you have not spoken to your defense counsel, how do you know whether the claims you are settling involve attorneys and medical practitioners who may be involved in fraudulent activities warranting further investigation on the files you are routinely settling and paying upon? If you do not even place the call there is no way of knowing what valuable information regarding claims you may be missing.

IV. CONDUCTING A THOROUGH INVESTIGATION ON BODILY INJURY CLAIM FILES.

A. *Identifying the claim.*

To be successful in identifying bodily injury fraud a well trained claims professional or SIU investigator needs to become involved in the claim as soon as possible. Remember if you have already been keeping a matrix to identify suspicious bodily injury claims you should have already identified certain medical providers and/or attorneys whose claims should be "red flagged" from the start and forwarded for appropriate review.

Routine file reviews, claim file audits and direct referrals from claims representatives to the SIU department are also excellent ways to identify claim files warranting further investigation. Although not exhaustive, the following is a brief listing of the type of bodily injury claims which should warrant further investigation:

1.) A low impact or mild impact collision where the injuries being claimed at the scene or, shortly thereafter, do not appear to be in keeping with the severity of the impact. Please note this could be a first or a third party type of claim.

2.) Almost immediate representation by legal counsel.

3.) Almost immediate contact from the first or third party claimant either desiring an immediate cash payment or threatening to secure medical treatment if a quick settlement is not paid.

4.) Multiple parties all claiming injuries, or who are all treating with the same medical provider(s) and represented by the same attorney or law firm. These types of cases may or may not involve members of the same family, however, if the claimants are not members of the same household an even stronger basis may exist for investigation.

Although not exhaustive this brief listing should assist you in identifying the type of claims where potential bodily injury fraud may exist.

B. Documenting the claim file.

Once you have identified a potential claim as warranting further investigation, the most important thing to do at the onset is to document the claim file as fully as possible. Documenting the claim file means identifying the type of evidence which may be perishable, and either securing that evidence or documenting the evidence through photographs, videotape, or other similar means. Examples of perishable evidence which needs to be documented as quickly as possible would include the following:

1.) *Inspection of the accident scene.* Tangible evidence at the accident scene can be lost or destroyed almost immediately. If at all possible photographic evidence of the scene should be secured including as soon as possible any visible skid marks, pavement gouges or other evidence. Our firm was recently involved in a case where an expert was retained the day of the accident and went and inspected the accident scene the very next day. This expert was adverse to our client's interest in the case and when he was cross examined he conceded even though he went to the accident scene the next day and based his opinion upon three gouge marks in the pavement, he was not able to testify the gouge marks came from the accident in question and not from another source. Although that case remains pending there is a substantial likelihood the expert's opinions will not be permitted in court as they are based upon evidence which he cannot relate to the accident scene within a reasonable degree of scientific certainty.

2.) *Inspection of the vehicles.* Especially in low impact cases inspecting and documenting the condition of the vehicles is absolutely crucial. The old saying "a picture is worth a thousand words" is certainly true in defending bodily injury fraud claims arising from low impact collisions. Photographic or videotape evidence showing the lack of damage, or minimal damage, caused by the accident is oftentimes the single most important evidence we can present to a jury.

In one case in which I was involved recently a quick thinking adjuster actually was able to contact the body shop where the plaintiff's car was repaired and on behalf of his carrier he paid for a new bumper to go onto the vehicle in exchange for taking custody of the allegedly damaged bumper. Through scientific analysis we were able to show the interior components of the bumper contained no evidence at all of any type of force sufficient to have transferred any degree of impact to the passenger compartment of the car. Although an argument may be made he over paid on the property damage claim, this piece of evidence saved the carrier

substantially on the personal injury claim.

3.) *Witness interviews and recorded statements*. We know for a fact plaintiffs attorneys and medical providers are securing accident reports and contacting the not at fault parties within twenty four hours of the occurrence of many accidents. I am always amazed when I receive file assignment two years later only to find out the plaintiff's attorney has been working the case for the past two years and from the insurance company's perspective no witnesses have been interviewed nor any recorded statements taken even of the named insured. What is equally distressing is when we then go and attempt to contact those eye-witnesses only to find they have moved out of state, are not available or now have no recollection in detail of what they observed at the time of the accident.

I cannot stress to you enough how important it is when a suspicious claim has been identified to secure statements promptly of those who were involved and from whom you can properly secure important recollections concerning the accident. Asking eye-witnesses information such as severity of impact, comments made by allegedly injured parties and actions taken by those parties at the scene can be extremely relevant. I recall a case several years ago where an independent witness testified very effectively at trial the allegedly injured plaintiff exited the vehicle after the minor impact with no difficulty whatsoever and kept bending over and looking under the car trying to find some evidence of damage. This witness was further able to testify she then specifically overheard the plaintiff make a call from her cellular phone, not to a family member, or someone to assist her home, but to her attorney wondering what she should do at the accident scene to make sure she "didn't ruin her case."

Oftentimes you never know what information a witness may have concerning their recollection of the accident unless you call and interview them as soon as possible. If it turns out the witness has information which would be an asset in defending a potential claim then make certain the statement is recorded fully and the original tape recording is retained for future evidence.

C. Securing of testimony of the injured party.

There are three ways you may be able to secure testimony of an allegedly injured party in a suspicious bodily injury claim. Depending upon the type of claim, you should avail yourself to at least one of these alternatives:

1.) *Mandatory examination under oath of the insured or claimant under the policy.* On a first party claim the insured or claimant under the policy has the duty under the contract to cooperate in your investigation and to give

sworn testimony in an examination under oath. All too often we associate the examination under oath process only with property claims. Assuming your policy contains a duty to cooperate clause and an examination under oath provision, then you have the right not only to request, but insist upon, the insured or claimant's cooperation in submitting to an examination under oath. Like a property claim these examinations under oath should be thorough and complete and should be requested as soon after the claim as possible. At the examination under oath, or in follow-up, you may also request the insured or claimant to bring with them copies of all relevant documentation concerning their claim which would obviously include any medical reports and medical bills.

2.) *Voluntary recorded statement.* Third party claims are generally more difficult to secure cooperation from the allegedly injured party for documenting of their testimony. Nevertheless, if the individual is not represented there is nothing to preclude your company requesting a voluntary recorded statement of the allegedly injured party. If the individual does give the recorded statement be certain to retain a copy of the tape as it may be crucial evidence when the case ultimately proceeds to litigation. If the allegedly injured party is represented by counsel you may not contact them directly and chances are their attorney will not permit the recorded statement to occur. As a general rule if you do take a voluntary recorded statement of the allegedly injured party and they, or their attorney, request a copy of the recorded statement, a copy should generally be provided whether or not suit has been instituted.

3.) *Court ordered testimony.* This is the most unusual step to take and is rarely used, but is a tool which is oftentimes overlooked. Many states do afford you the opportunity to file what is called an Action for Discovery. This is a lawsuit which may be brought either in the name of your insured or in the name of the insurance company against the allegedly injured party. The sole purpose of the suit is to take a deposition of the allegedly injured party and if so requested to secure medical records and order an independent medical examination. This is a highly unusual step in that the defense actually files suit against the anticipated plaintiff rather than vise versa. The reason to take this unusual step is those cases where it is absolutely crucial to take action and not wait until the plaintiff files suit.

In our office at any given time we may have between four and eight actions for discovery pending. These are cases where severe injuries are being alleged in questionable cases and we seek intervention of the court to secure testimony of the injured party or witnesses or for purposes of securing medical records when the injured party or their counsel refuse to sign authorizations. We have also requested court intervention when an independent medical examination is required or prudent as soon after the accident as possible. An example of this type of occurrence would be where an anticipated plaintiff is getting ready to undergo extensive surgery

> and the independent medical examination will basically be meaningless unless the IME physician has the opportunity to examine the plaintiff's medical condition and restrictions before the surgery is performed.
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> Although this is an unusual, and sometimes expensive, alternative it is at least an option of which you should be aware and may wish to make use when the right claim is presented.

V. BODILY INJURY FRAUD MAY BE DETECTED AT ANY TIME.

In this presentation I have attempted to outline for you how to identify suspicious bodily injury fraud claims as early on in the claim process as possible. Although it is always advantageous to identify suspicious claims as soon after the date of loss as possible, it is also always not realistic.

Potential bodily injury fraud may be identified at any point in the claim process from the onset of the claim all the way through litigation. Often it is not until suit is filed after the expiration of a two, three, or four year statute of limitations that sufficient evidence can even be collected to determine whether potential bodily injury fraud exists. The important thing is to look for the indicators which have been highlighted in this presentation and as soon as those "red flags" are raised conduct a thorough and proper investigation.

One of the best tools for identifying potential bodily injury fraud is the independent medical examination which in most cases will not take place until after suit has been instituted. In my years of practice I have seen far too many occasions where non-aggressive defense attorneys wait until very late in the litigation process to even request an independent medical examination. Although I realize fully the need to save cost, I would strongly discourage this practice as if you believe sufficient evidence exists to warrant possible bodily injury fraud, an independent medical examination should be performed either before suit is filed if at all possible or as soon after suit is filed as can be done.

I will not comment further on the independent medical examination process and the

ability to identify potential bodily injury fraud by the medical practitioner as that will be presented by Dr. Malcolm A. Meyn, Jr., who in my years of experience is one of the most skilled and knowledgeable independent medical examination physicians anywhere.

VI. CONCLUSION.

Do not kid yourself for a second to think bodily injury fraud is not running rampant in the claims you are handling. The simple fact is bodily injury fraud has been around ever since insurance began and will continue for many years to come. The best we can hope for as skilled practitioners is to identify those claims and conduct thorough and complete investigations leading either to denial of the claim or being able to present a successful defense at trial as to why the injuries being claimed either are fraudulent or not reasonably related to the accident and facts at issue in the case.

It is my hope you will be able to return from this program more fully equipped to identify, investigate and thoroughly defend the bodily injury fraud claim.

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BODILY INJURY CLAIM MATRIX

Claim No.	Date of Loss	Legal Rep Y/N	Attorney Name	Atty Rep Date	Medical Provider(s)	Chiropractic Y/N	Date of First Treatment	Last Visit	Duration Weeks	Number of Visits	Total Medical Expenses	Suit Filed Y/N	Amount of Settlement	Settled Y/N