The Making of a Claimant Fraud Criminal Referral

History of NV Office of the Attorney General Fraud Unit

Red flags of Claimant Fraud

Types of Claimant Fraud investigated & prosecuted

Employer/Insurer responsibilities

Prosecuting office’s responsibilities and requirements

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The views and opinions expressed in the written materials and in any of the presentations at this conference are those of the presenter and do not necessarily reflect the official policy or position of the Department of Business and Industry, Division of Industrial Relations. The Division does not warranty the materials' completeness or accuracy.

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- Retired Assistant Director, Clark County District Attorney's Office
- Retired Chief of Staff, Nevada Office of the Attorney General
  - Former Chief of Investigations
  - 17 years law enforcement officer
- MA & BA Criminal Justice - UNLV
- Current CFO, CEO, **BOM** – Capricorn Consulting LV, LLC !!!

History of WCFU

- Created in 1993
- “Ex-line”
- 4 Prosecutors
- 13 Investigators
- Las Vegas, Reno, Carson
- Early year referrals:
  - Provider – very few referrals
  - Employer – mostly misrepresentation and under-reporting
  - Claimant – bulk of referrals (SIIS), until 1999

Claimant Referrals

Working while collecting

Misrepresentation

“Ex-line” – Everything under the sun

Red Flags

Employment Change:	A reported accident occurs just before or after a strike, job determination, layoff, end of a big project, or at the conclusion of seasonal work.
No Witnesses:	No one sees the accident, and the employee's own description does not logically support the cause of injury.
Suspicious Claims History:	A record of numerous, suspicious or litigated claims.
Treatment is Refused:	The claimant refuses diagnostic procedures to confirm an injury.
Late Reporting:	The employee delays reporting the claim.
History of Changes:	The claimant has a history of frequently changing physicians, changing addresses and numerous past employment changes. Beware of an alleged disabled claimant who is hard to get ahold of at home.
Group Claims:	Watch for use of the same doctor and lawyer by several claimants.

Employer/Insurer’s responsibilities - I

- Desk manuals?
- Is training consistent for all those within the same job classification?
- If changes are made to practices, policies and procedures, how do staff receive notices of those changes?
- Do all cases follow a consistent track?
- What percentage of your cases are appealed?

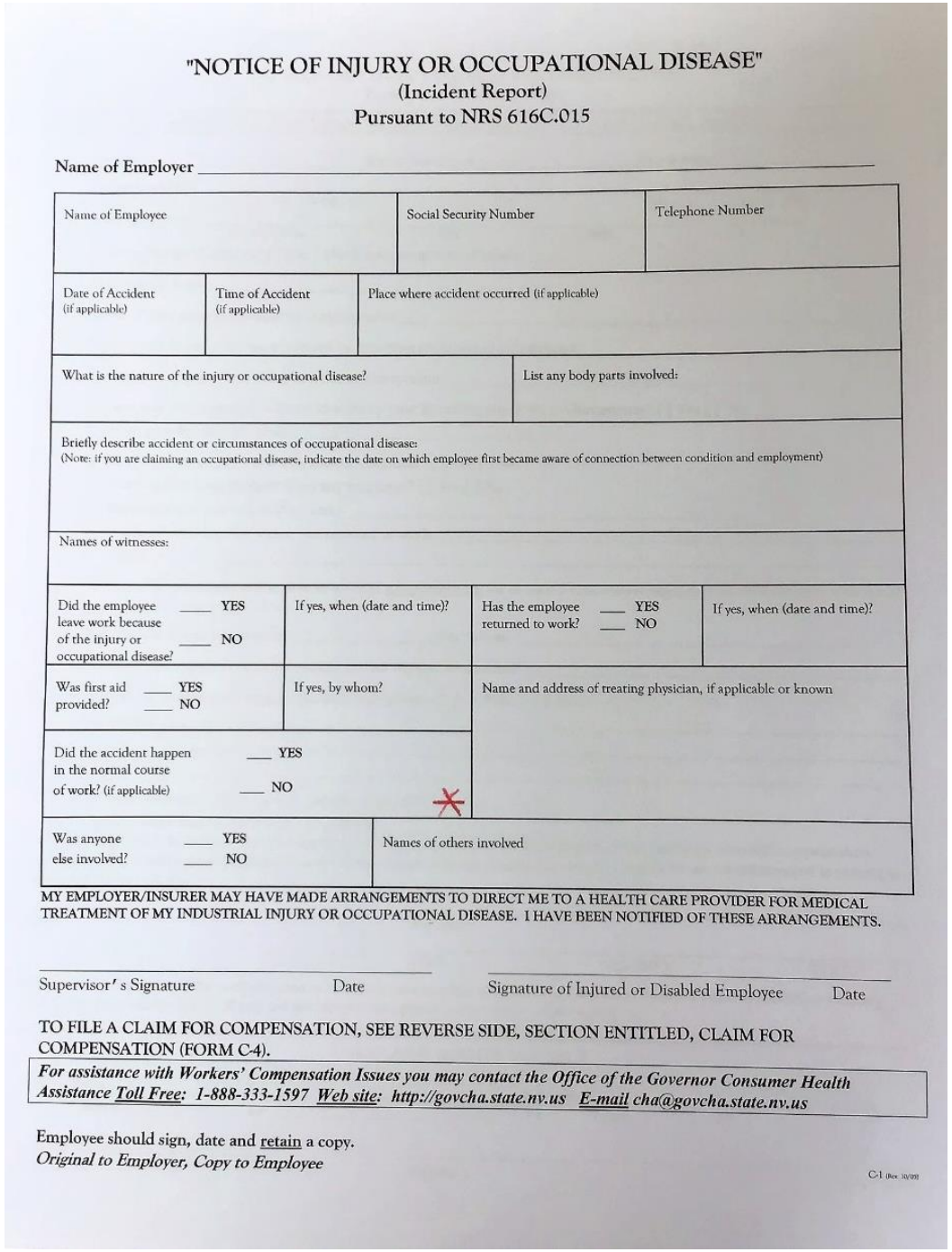
Employer/Insurer’s responsibilities - II

- Is there a common theme of the cases that are appealed?
- Is there a common examiner/adjuster/team whose cases are appealed?
- What percentage of your appeals do you lose administratively?
- How does your staff interview injured workers?
- Are all interviews recorded?

Employer/Insurer's responsibilities - III

- If an injured employee does not speak English, what are their options?
- Are your interpreters certified? If so, how often?
- Is there a consistency with which forms are reviewed by staff?
- Is there a department reliance upon the standard documents that exist within a typical claim file?

C-1 Notice of Injury



"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"
(Incident Report)
Pursuant to NRS 616C.015

Name of Employer _____

Name of Employee	Social Security Number	Telephone Number

Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)

What is the nature of the injury or occupational disease?	List any body parts involved:

Briefly describe accident or circumstances of occupational disease:
(Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)

Names of witnesses:

Did the employee leave work because of the injury or occupational disease? ___ YES ___ NO	If yes, when (date and time)?	Has the employee returned to work? ___ YES ___ NO	If yes, when (date and time)?

Was first aid provided? ___ YES ___ NO	If yes, by whom?	Name and address of treating physician, if applicable or known

Did the accident happen in the normal course of work? (if applicable) ___ YES ___ NO	

Was anyone else involved? ___ YES ___ NO	Names of others involved

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

Supervisor's Signature Date Signature of Injured or Disabled Employee Date

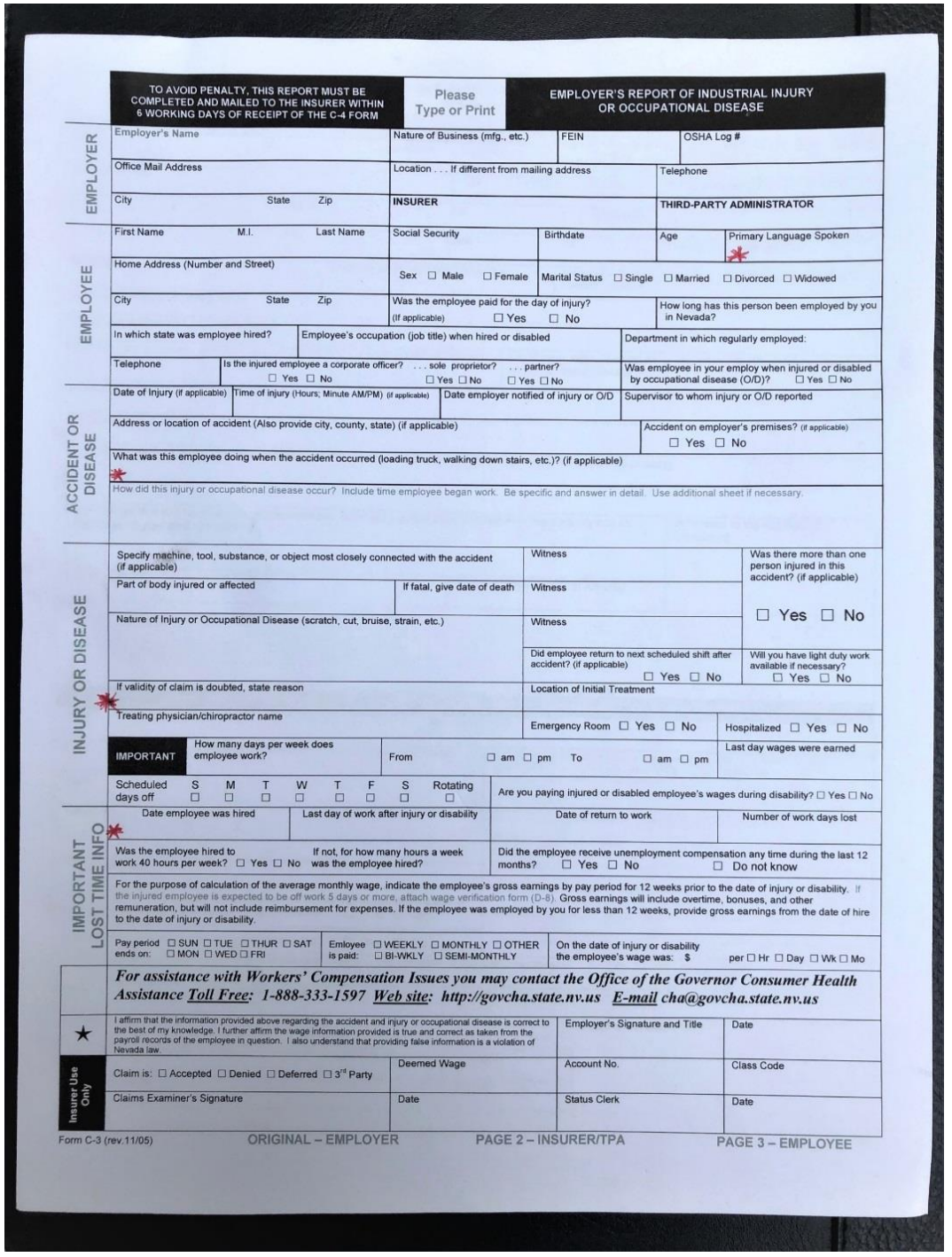
TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us

Employee should sign, date and retain a copy.
Original to Employer, Copy to Employee

C-1 (Rev. 10/09)

C-3 Employer's Report of Injury



TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF RECEIPT OF THE C-4 FORM

Please Type or Print

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name | Nature of Business (mfg., etc.) | FEIN | OSHA Log #

Office Mail Address | Location . . . If different from mailing address | Telephone

City | State | Zip | INSURER | THIRD-PARTY ADMINISTRATOR

EMPLOYEE

First Name | M.I. | Last Name | Social Security | Birthdate | Age | Primary Language Spoken

Home Address (Number and Street) | Sex ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

City | State | Zip | Was the employee paid for the day of injury? (If applicable) ☐ Yes ☐ No | How long has this person been employed by you in Nevada?

In which state was employee hired? | Employee's occupation (job title) when hired or disabled | Department in which regularly employed:

Telephone | Is the injured employee a corporate officer? . . . sole proprietor? . . . partner? ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No | Was employee in your employ when injured or disabled by occupational disease (O/D)? ☐ Yes ☐ No

ACCIDENT OR DISEASE

Date of Injury (If applicable) | Time of injury (Hours; Minute AM/PM) (If applicable) | Date employer notified of injury or O/D | Supervisor to whom injury or O/D reported

Address or location of accident (Also provide city, county, state) (if applicable) | Accident on employer's premises? (If applicable) ☐ Yes ☐ No

What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)

How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable) | Witness | Was there more than one person injured in this accident? (if applicable) ☐ Yes ☐ No

Part of body injured or affected | If fatal, give date of death | Witness

Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.) | Witness

Did employee return to next scheduled shift after accident? (if applicable) ☐ Yes ☐ No | Will you have light duty work available if necessary? ☐ Yes ☐ No

If validity of claim is doubted, state reason | Location of Initial Treatment

Treating physician/chiropractor name | Emergency Room ☐ Yes ☐ No | Hospitalized ☐ Yes ☐ No

IMPORTANT | How many days per week does employee work? | From ☐ am ☐ pm To ☐ am ☐ pm | Last day wages were earned

Scheduled days off: S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ Rotating ☐ | Are you paying injured or disabled employee's wages during disability? ☐ Yes ☐ No

IMPORTANT LOST TIME INFO

Date employee was hired | Last day of work after injury or disability | Date of return to work | Number of work days lost

Was the employee hired to work 40 hours per week? ☐ Yes ☐ No | If not, for how many hours a week was the employee hired? | Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☐ No ☐ Do not know

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on: ☐ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI | Emloyee is paid: ☐ WEEKLY ☐ MONTHLY ☐ OTHER ☐ BI-WKLY ☐ SEMI-MONTHLY | On the date of injury or disability the employee's wage was: $ per ☐ Hr ☐ Day ☐ Wk ☐ Mo

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law. | Employer's Signature and Title | Date

Insurer Use Only

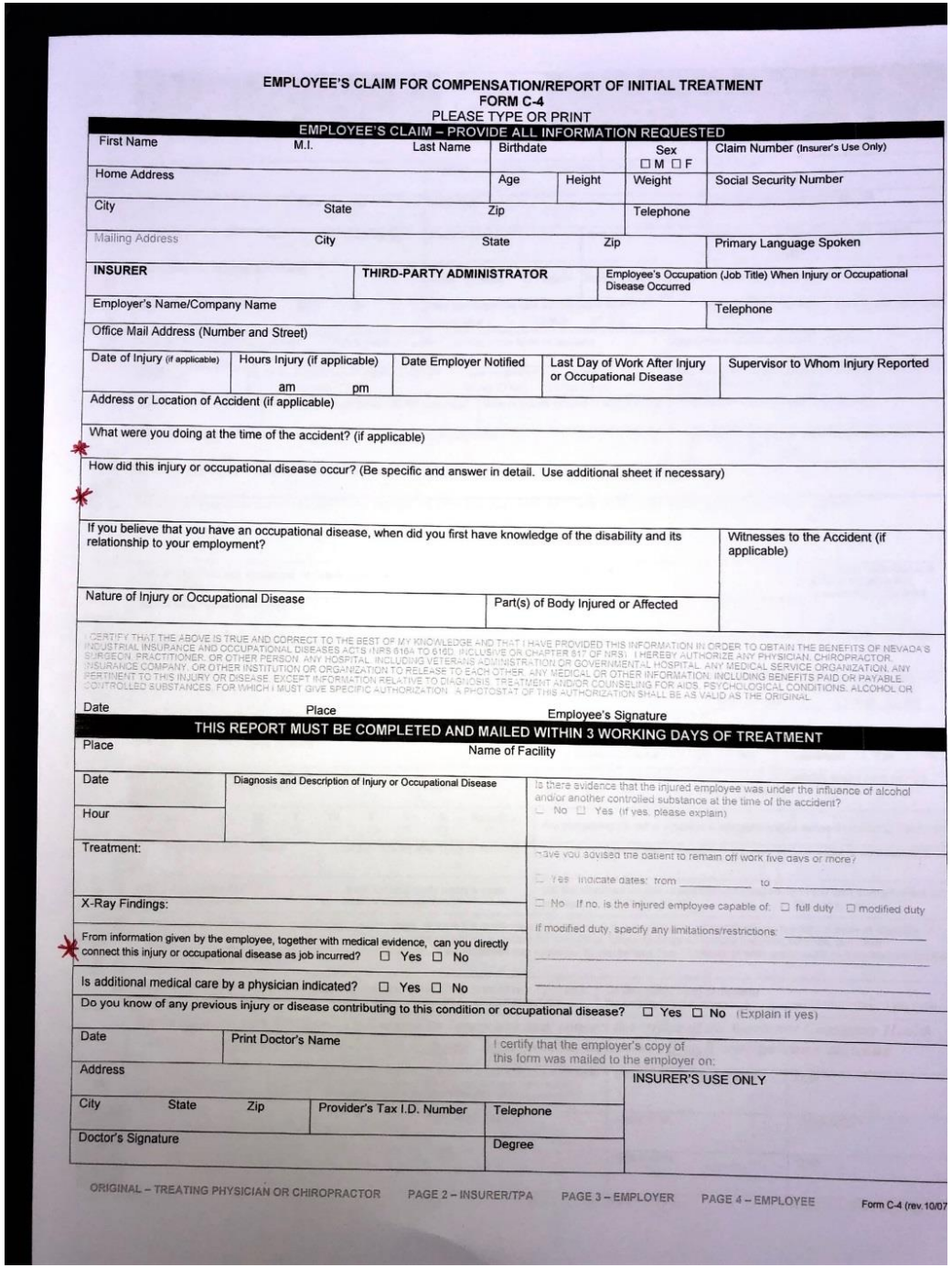
Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party | Deemed Wage | Account No. | Class Code

Claims Examiner's Signature | Date | Status Clerk | Date

Form C-3 (rev.11/05) ORIGINAL – EMPLOYER PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYEE

C-4 Employee's Claim for Compensation –

Report of Initial Treatment



EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM – PROVIDE ALL INFORMATION REQUESTED

First Name | M.I. | Last Name | Birthdate | Sex ☐ M ☐ F | Claim Number (Insurer's Use Only)

Home Address | Age | Height | Weight | Social Security Number

City | State | Zip | Telephone

Mailing Address | City | State | Zip | Primary Language Spoken

INSURER | THIRD-PARTY ADMINISTRATOR | Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred

Employer's Name/Company Name | Telephone

Office Mail Address (Number and Street)

Date of Injury (if applicable) | Hours Injury (if applicable) am pm | Date Employer Notified | Last Day of Work After Injury or Occupational Disease | Supervisor to Whom Injury Reported

Address or Location of Accident (if applicable)

What were you doing at the time of the accident? (if applicable)

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)

If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?

Witnesses to the Accident (if applicable)

Nature of Injury or Occupational Disease | Part(s) of Body Injured or Affected

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER, OR OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Date | Place | Employee's Signature

THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT

Place | Name of Facility

Date / Hour | Diagnosis and Description of Injury or Occupational Disease | Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? ☐ No ☐ Yes (if yes, please explain)

Treatment: | Have you advised the patient to remain off work five days or more? ☐ Yes Indicate dates: from _____ to _____ ☐ No If no, is the injured employee capable of: ☐ full duty ☐ modified duty

X-Ray Findings: | If modified duty, specify any limitations/restrictions: _____

From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? ☐ Yes ☐ No

Is additional medical care by a physician indicated? ☐ Yes ☐ No

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ No (Explain if yes)

Date | Print Doctor's Name | I certify that the employer's copy of this form was mailed to the employer on:

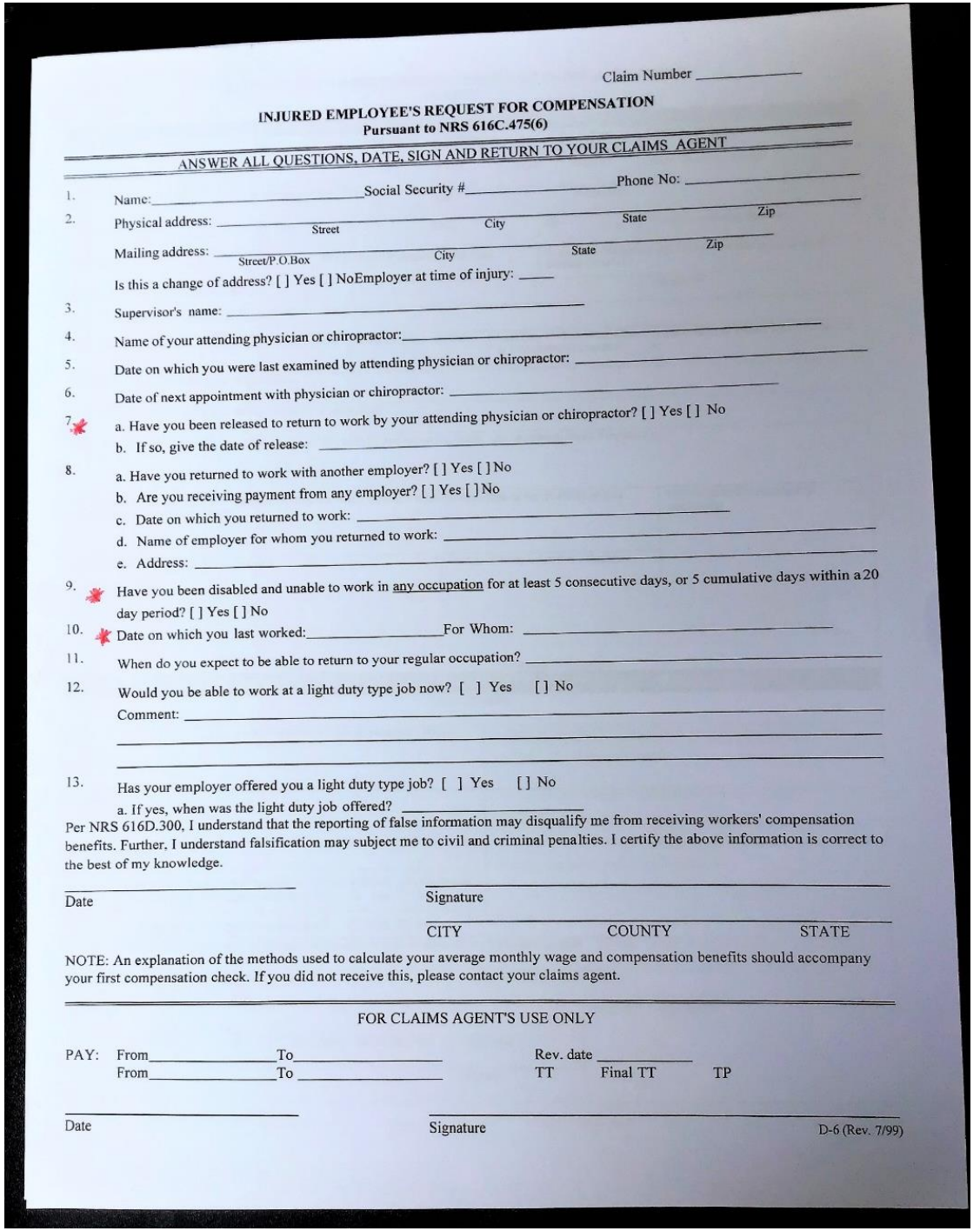
Address | INSURER'S USE ONLY

City | State | Zip | Provider's Tax I.D. Number | Telephone

Doctor's Signature | Degree

ORIGINAL – TREATING PHYSICIAN OR CHIROPRACTOR PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE Form C-4 (rev. 10/07

D-6 Injured Employee's Request For Compensation



Claim Number _____

INJURED EMPLOYEE'S REQUEST FOR COMPENSATION
Pursuant to NRS 616C.475(6)

ANSWER ALL QUESTIONS, DATE, SIGN AND RETURN TO YOUR CLAIMS AGENT

1. Name:_____ Social Security #_____ Phone No: _____
2. Physical address: _____ (Street / City / State / Zip)
   Mailing address: _____ (Street/P.O.Box / City / State / Zip)
   Is this a change of address? [ ] Yes [ ] No Employer at time of injury: ____
3. Supervisor's name: _____
4. Name of your attending physician or chiropractor:_____
5. Date on which you were last examined by attending physician or chiropractor: _____
6. Date of next appointment with physician or chiropractor: _____
7. a. Have you been released to return to work by your attending physician or chiropractor? [ ] Yes [ ] No
   b. If so, give the date of release: _____
8. a. Have you returned to work with another employer? [ ] Yes [ ] No
   b. Are you receiving payment from any employer? [ ] Yes [ ] No
   c. Date on which you returned to work: _____
   d. Name of employer for whom you returned to work: _____
   e. Address: _____
9. Have you been disabled and unable to work in <u>any occupation</u> for at least 5 consecutive days, or 5 cumulative days within a 20 day period? [ ] Yes [ ] No
10. Date on which you last worked:_____ For Whom: _____
11. When do you expect to be able to return to your regular occupation? _____
12. Would you be able to work at a light duty type job now? [ ] Yes [ ] No
    Comment: _____
13. Has your employer offered you a light duty type job? [ ] Yes [ ] No
    a. If yes, when was the light duty job offered? _____

Per NRS 616D.300, I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits. Further, I understand falsification may subject me to civil and criminal penalties. I certify the above information is correct to the best of my knowledge.

Date _____ Signature _____

CITY _____ COUNTY _____ STATE _____

NOTE: An explanation of the methods used to calculate your average monthly wage and compensation benefits should accompany your first compensation check. If you did not receive this, please contact your claims agent.

FOR CLAIMS AGENT'S USE ONLY

PAY: From_____ To_____ Rev. date _____
From_____ To _____ TT Final TT TP

Date _____ Signature _____

D-6 (Rev. 7/99)

Review Findings/Prosecutor Contact?

- Are cases screened prior to going to the prosecutor’s office?
- How often are cases submitted to the prosecutor’s office?
- Who on your staff can refer cases to the prosecutor’s office?
- Do you have the name of a contact in the prosecutor’s office?
- Have you tracked the positive and negative results of your referrals?

Prosecuting Office's Responsibilities

- Cursory review by supervisor of packet to ensure contact information is included
- Supervisor submits referral to admin staff for a case number and tracking
- Case is assigned to an investigator per the supervisor
- Assigned investigator reviews referral packet
- Investigator may contact employer/insurer with follow-up questions

Prosecuting Office's Responsibilities II

Physical Misrepresentation

- The investigator needs to communicate with the treating physician:
  - Has the physician reviewed his/her initial notes regarding the claimant's injuries and representations?
  - If there is video, has the physician reviewed it?
  - When was the video taken?
  - When was the last time the physician saw the claimant in relation to when he/she viewed the video?
  - Can the physician identify the claimant from the video?
  - Is the physician willing to sign and date an affidavit indicating the claimant misrepresented his/her physical condition?
  - Investigator may interview the claimant.

Prosecuting Office's Responsibilities III

Working While Collecting Referral

- Investigator's work begins:
  - Investigator may contact employer/insurer for name, location and contact information of alleged employer.
  - Investigator will need to compare employment records with the records received from the employer/insurer.
  - If dates of employment records coincide with the D-6 dates, investigator will have to decide if the alleged unreported employer should be contacted.
  - Investigator will interview the claimant.
  - Following an interview with the claimant, the investigator may contact the employer/insurer if any inconsistencies exist.
  - Investigator will submit the case to the prosecutor for review.

Prosecuting Office's Responsibilities IV

Working While Collecting Referral/Surveillance

- If no employee records exist, but an allegation is made that the claimant is working (Ex-line), surveillance will need to be done.
- Perhaps the claimant is being paid in cash, under the table.
- Surveillance should include the following:
  - several days of video
  - the claimant in action
  - identifying footage of claimant (facial shots, starting address, vehicle plate, vehicle description, etc.)
  - no commentary by the videographer

Prosecuting Office's Responsibilities V
Working While Collecting Referral/Surveillance

- If surveillance leads to a determination that the claimant is working under the table:
  - the investigator will compare the dates of the surveillance with documents from the employer/insurer
  - the investigator will interview the claimant
  - the investigator will speak with the employer/insurer if any questions exist
  - the investigator will submit the case to the prosecutor for review

Subjects of Interviews

Claimant

Case professionals

Witnesses

A goal of your interview is to encourage useful communication from the subject.

Interview

The primary objective of an interview should always be the impartial search for the truth, **NOT** a confession.

Why no prosecution?

Burdens of Proof

Criminal prosecution standards

- Beyond a reasonable doubt
- No reasonable person could reasonably doubt the defendant's guilt
- 98% sure

Civil prosecution standards:

- Preponderance of evidence beyond a reasonable doubt
- Proposition is more than likely to be true
- 51% sure
- *"it is better that ten guilty persons escape than that one innocent suffer"*
- (source: Blackstone formulation)

Additional concerns

Better case with another entity (DEA, ICE, Business License, Labor Comm.)

Too gray

- Passive income
- Owner
- Day trader
- Not exceeding limitations
- Paperwork not consistent from TPA/Employer

No jail time

Unsympathetic victim
No criminal history
Lack of jury appeal
Amount “taken”
Not the crime of the century
Jail over-crowded

Questions

Attorney General Contact Information

555 E. Washington Avenue #3900

Las Vegas, NV 89101

(702) 486-3777

www.ag.nv.gov

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Don’t Forget . . .

Please fill out the Evaluation Online: http://dir.nv.gov/WCS/Training/

- **Session 5B-The Making of a Claimant Fraud Criminal Referral**

For complimentary Wi-Fi select the Tuscany Conventions