CALIFORNIA WORKERS’ COMPENSATION SIU INVESTIGATOR REFERENCE MANUAL

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B.A., University of California, Davis, 2003

PROJECT

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF SCIENCE

in

CRIMINAL JUSTICE

at

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

FALL
2009
CALIFORNIA WORKERS’ COMPENSATION SIU INVESTIGATOR REFERENCE MANUAL

A Project

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Division of Criminal Justice
Abstract

of

CALIFORNIA WORKERS’ COMPENSATION SIU INVESTIGATOR REFERENCE MANUAL

by

Christine Diana Wilson

The purpose behind the creation of the California Workers’ Compensation Investigator Reference Manual is to compile important laws, regulations, websites and training information into one central place for the investigator. This type of a reference manual will be a tremendous asset to a new investigator and will provide reference information that could assist with their investigation. The manual aims to increase their effectiveness in the role by allowing them to consider different investigative avenues that they might not have known about otherwise.

_________________________, Committee Chair
Sue C. Escobar, J.D., Ph.D.

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TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>1</td>
</tr>
<tr>
<td>Purpose and Need for Manual</td>
<td>3</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>3</td>
</tr>
<tr>
<td>2. LITERATURE REVIEW</td>
<td>5</td>
</tr>
<tr>
<td>Background of Insurance Fraud</td>
<td>5</td>
</tr>
<tr>
<td>Types of Insurance Fraud: Opportunistic and Planned</td>
<td>7</td>
</tr>
<tr>
<td>Deterrents to Insurance Fraud</td>
<td>11</td>
</tr>
<tr>
<td>Deterrents to Insurance Fraud in California</td>
<td>12</td>
</tr>
<tr>
<td>Public Perception about Insurance Fraud</td>
<td>15</td>
</tr>
<tr>
<td>Relevant Laws</td>
<td>19</td>
</tr>
<tr>
<td>Theoretical Framework</td>
<td>21</td>
</tr>
<tr>
<td>3. PROJECT PROCESS</td>
<td>29</td>
</tr>
<tr>
<td>4. CONCLUSION</td>
<td>33</td>
</tr>
<tr>
<td>Limitations of the Project</td>
<td>33</td>
</tr>
<tr>
<td>Implications</td>
<td>34</td>
</tr>
<tr>
<td>Appendix. California Workers’ Compensation SIU Investigator Manual</td>
<td>35</td>
</tr>
<tr>
<td>References</td>
<td>73</td>
</tr>
</tbody>
</table>
Chapter 1

INTRODUCTION

Statement of the Problem

For a new employee entering a company, a clear understanding of the employer’s expectations is critical to their success in the role. In some cases, an employee can have a clear understanding of the employer’s expectations but due to their newness in the role, he or she may not have the knowledge base to effectively assess situations that come their way in the course of their work day. Such is the case for many new investigators entering into the world of insurance investigations in the private sector.

Workers’ Compensation insurance investigators in California work in what is known as a Special Investigation Unit (SIU). Investigators in the SIU are tasked with reviewing cases of suspected fraud to determine the facts and uncover the truth. It is not the job of the SIU investigator to get people arrested. That is a job best left to law enforcement. The SIU investigator is tasked with using his or her expertise to determine what is occurring (based on the facts) and then being able to recognize whether or not it is something that should be referred to law enforcement for further handling. For some new investigators, recognizing whether or not it is something that should be referred to law enforcement can be challenging.
Many SIU investigators can spend their careers only knowing how to identify the four elements of fraud: materiality, intent, lie and knowledge. These same investigators also know section 1871.4 of the Insurance Code by heart:

1871.4. (a) It is unlawful to do any of the following:
(1) Make or cause to be made a knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying any compensation, as defined in Section 3207 of the Labor Code.

If what they are looking at cannot be applied to 1871.4, the investigator might not think that they have a case worth pursuing. While knowing the elements of fraud and Insurance Code 1871.4 are extremely important for a SIU investigator, these are not the only tools the investigator should have in his or her tool kit. There are a tremendous amount of laws, codes, sections and other information that can assist the investigator in their fight against insurance fraud. The problem is that there is no “one stop shop” to find all of this information. It is left to the investigator to learn this information on their own and it could take years for some investigators to stumble across a different way to approach an investigation. For this reason, there is a definite need for a creation of a reference manual that covers a variety of areas that a new investigator might not be familiar with upon entry to the SIU. The reference manual would include information about the various laws investigators should be aware of, information about training and information about what the state of
California expects of them in their role. This would enable the investigator to do their jobs as effectively and efficiently as possible.

**Purpose and Need for the Manual**

The purpose behind the creation of the California Workers’ Compensation Investigator Reference Manual is to compile important laws, statutes, codes and other information into one central place for the investigator. This type of a reference manual will be a tremendous asset to a new investigator as they will easily be able to flip through the pages and reference information that could assist them with their investigation. The manual aims to increase their effectiveness in the role by allowing them to consider different investigative avenues that they might not have known about otherwise. The manual will also assist the investigator in the area of efficiency. With the availability of the reference manual, the investigator will be able to quickly look through the manual and compare and contrast the case they are reviewing with the information available.

**Definition of Terms**

Insurance Fraud: When a material misrepresentation is made, whether written or oral, during the course of an insurance claim that causes benefits to be bestowed that would not otherwise be owed (California Insurance Code).

Moral Hazard: When an insured behaves a certain way because they feel that by doing so they will receive monetary gain (Ruser, 1998).
Path-Goal Theory: A leader (manager) provides a path to their employees that will allow them to achieve their organizational goals (Robbins & Judge, 2007).

Special Investigation Unit: Unit that investigates suspected fraud for insurance companies (State of California SIU Regulations, 2005).
Chapter 2
LITERATURE REVIEW

Background of Insurance Fraud

To understand why a reference manual is needed for an insurance investigator, the reader must have an understanding of what constitutes insurance fraud and the mindset of those who choose to commit insurance fraud. Simply stated, insurance fraud takes place when a party to an insurance claim knowingly lies about something that matters to the claim in order to obtain a benefit that they would not otherwise be entitled to receive (Derrig, 2002). The key word to focus on is “knowingly.” In order for a successful insurance fraud prosecution to take place, it must be proven that the claimant intended to deceive the insurance carrier. It is the burden of the insurance carrier to prove that the claimant knew that intentionally deceiving the insurance carrier is a crime and also that the claimant understands their responsibilities as a party to the claim. The carrier must show that the claimant knowingly misrepresented themselves for the purpose of obtaining benefits they would not otherwise receive had they been truthful (Derrig & Zicko, 2002).

Studies have investigated whether or not insurance claims create a “moral hazard” for claimants due to the benefits that can be recovered after sustaining a loss (Campolieti & Hyatt, 2006; Ruser, 1998). “Collectively, the impact of insurance on
injury outcomes is termed moral hazard” (Ruser, 1998). A moral hazard with respect to insurance claims takes place when an insured perceives that they have something to gain from behaving in a way that will cause the insurance company to incur a loss (Ruser, 1998). Both planned and opportunistic types of insurance fraud can be viewed as examples of moral hazards to claimants. Claims fraud constitutes a moral hazard because the claimant has incentive to commit the fraudulent act because of anticipated financial gain. In the absence of the moral hazard there would be no reason for the claimant to commit insurance fraud because they would not stand to gain any benefit through deception.

Along with the concept of the moral hazard comes the “Monday effect.” The Monday effect is a well-known occurrence in the insurance claims industry. It takes place when a claimant comes in on a Monday morning after having the weekend off and reports a work related injury (Campolieti & Hyatt, 2006). These claims are usually not witnessed and are alleged to have taken place as soon as the claimant arrived at the insured work location. Studies about “Monday morning” injuries reported by claimants have attempted to discover the reasons for the Monday effect. Questions have been raised as to whether lack of private healthcare would encourage an employee to report a non-work related injury to his employer on a Monday because the employee could have his injury covered through workers’ compensation (Card & McCall, 1996). Since the threat of sanctions for committing insurance fraud
is so low, reporting a “Monday morning” injury might seem reasonable and harmless to an otherwise honest individual (Tennyson, 1997).

**Types of Insurance Fraud: Opportunistic and Planned**

There are two different types of insurance fraud perpetrated by a claimant: opportunistic and planned. Examining the differences between these two fraud types is important to understanding public attitudes about insurance fraud and why people might choose to commit insurance fraud. Opportunistic and planned types of insurance fraud are specifically caused by the claimant (Tennyson, 2002). While there are a number of different ways that insurance fraud can take place, in order to understand public attitudes about the seriousness of insurance fraud, their opinions on “claimant fraud” need to be examined because that is the type of insurance fraud that they would be most likely to come into contact with through their dealings with insurance. Opportunistic fraud takes place when the claimant exaggerates some part of a claim for an actual loss that the claimant sustained (Tennyson, 2002). A research study about public acceptance of insurance fraud has shown that some consumers feel that it is acceptable to pad a legitimate insurance claim to make up for a deductible or premium paid to the carrier (O’Rourke, 2003).

Planned fraud is when a claimant files a claim that is completely false for the purpose of obtaining insurance benefits. Much of the claimant fraud committed involves a person who has legitimately sustained a loss or has been injured
(Tennyson, 2002). In the case of automobile fraud, a claimant might say that an area of their vehicle was damaged during a legitimate car crash when it was really damaged 6 months earlier during a lapse in insurance coverage. In the case of workers’ compensation fraud, an injured worker might claim to their adjuster that they drive 120 miles roundtrip from their home to their physical therapist’s office when they are really only driving 20 miles roundtrip (Dean, 2004). These scenarios are meant to give an example of the types of things that are considered to be insurance fraud but are often committed by claimants who do not feel that the seemingly minor exaggeration is a criminal act.

A sense of entitlement is another area to examine when it comes to why a person might choose to commit insurance fraud. There are some claimants who feel that because they pay their premiums and deductibles, inflating their claim to recoup a loss is completely justifiable (Dean, 2004). The people who fall into the “sense of entitlement” category may be unaware that there are deterrents in place to try and fight insurance fraud. The prosecution rates of insurance fraud cases are extremely low. “Insurance companies seem to pay many claims that they suspect of being fraudulent or exaggerated” (Tennyson, 1997, p. 248). It is for this reason that many insurance fraud perpetrators believe that it is not a serious crime. How serious can a crime be if prosecution rates are low and insurance companies actually pay on claims that they suspect to be fraudulent? The payment of suspected fraudulent claims and
lack of prosecutions does not help convey the message that insurance fraud is a serious crime. Instead, it makes insurance fraud seem like an acceptable crime that is not easily detected by the carrier.

Most of the literature written on the topic of insurance fraud can be categorized into two general areas with slight variations on themes depending on the type of insurance being discussed. The first area includes discussions about the insurance fraud problem. The second area relates to how to detect, deter and prosecute insurance fraud (Derrig & Zicko, 2002). This literature is helpful when it comes to analyzing the scope of the insurance fraud problem and how to fight insurance fraud. While there is an abundance of literature about the insurance fraud epidemic there fails to be much written on the subject of public attitudes about the crime. Understanding public attitudes about insurance fraud is important for an insurance investigator as it provides insight into the motivation behind those that choose to commit fraud.

There are two known studies that examine public attitudes about insurance fraud and both were conducted by the same individual. Tennyson (1997) conducted a study regarding public attitudes towards automobile fraud and, “formulates and tests hypotheses on consumers’ approval or disapproval of claims exaggeration” (p. 247). Tennyson (1997) sought to uncover whether or not an individual’s experience (positive or negative) with an insurance company would correlate to whether or not
they felt that insurance fraud was acceptable. The study found that there was a
correlation between individual experience with insurance and acceptance of
insurance fraud. Tennyson’s study expanded on a 1991 general survey conducted
by the Insurance Research Council about public attitudes about various areas of
insurance. There were 1,987 respondents to the 1991 survey. The survey revealed
that over 20 percent of the respondents felt that claims padding/exaggeration is
“probably” acceptable if the claimant was trying to make up for a deductible or past
premium (Tennyson, 1997). The problem with this type of reasoning is that padding
or exaggerating a claim to make up for a prior premium or deductible is considered
to be insurance fraud. It would be interesting to know what knowledge level these
survey respondents had about the deterrents to insurance fraud. If they had more
knowledge about what is considered to be fraudulent claim and the penalties for the
crime, they may not feel that padding/exaggerating a claim is acceptable. On the
other hand, if they did know that padding/exaggerating a claim to recover premiums
or deductibles is considered to be a fraudulent, it would suggest that there the public
has no fear of criminal sanctions for insurance fraud.

A subsequent study by Tennyson (2002) “examines whether consumers’ level
of experience with insurance is related to their attitudes towards insurance fraud” (p. 35). The 2002 study picked up on the same concepts as the 1997 study but focused
on all types of insurance claims, not just automobile. These studies did not examine
the public’s understanding of the criminal penalties associated with the crime, only their views on whether or not it was acceptable. What is interesting to take away from the 2002 study is that it found that individuals are more accepting of insurance fraud if it is framed in a way that has the claimant trying to recoup deductibles or premiums rather than submitting false receipts or an act that comes across as blatantly fraudulent behavior. Even though both of these actions are considered to be insurance fraud, public opinion seems to accept fraudulent behavior that can be justified.

**Deterrents to Insurance Fraud**

There are many studies that support the fact that insurance fraud is a serious economic crime and much of the literature written about insurance fraud explores the financial costs passed onto the public from fraudulent claims (Derrig & Zicko, 2002; O’Rourke, 2003; Pathria, 1999; Tennyson 1997; Tennyson, 2002). Authors point out the staggering costs associated with insurance fraud and will suggest that if the public becomes aware of these costs they will become less tolerant of the crime (O’Rourke, 2003, p. 9). This is not necessarily the case. From the results of Tennyson’s surveys, it can be argued that most people do not consider claim padding/exaggeration to be insurance fraud. It seems more likely that if the public had more knowledge about what constitutes insurance fraud, they would become less tolerant of the crime. It would difficult for the public to understand the depth of the
problem unless a clear understanding of what is considered insurance fraud is known. Throwing out the enormous 80 billion dollar figure generated by the Coalition Against Insurance Fraud that estimates the cost of insurance fraud to the public does not mean much to the public if their mindset it that insurance fraud is only committed by hardened criminals rather than people in their own communities (http://www.insurancefraud.org).

**Deterrents to Insurance Fraud in California**

California is a progressive state with its anti-fraud legislation. “Workers’ compensation abuse costs are estimated to total about $6 billion a year. And while only 10 percent of all workers’ comp claims are fraudulent, most of this abuse goes undetected” (Pathria, 1999, p. 23). It is for this reason that California Insurance Code has implemented three major deterrents in an attempt to fight the crime. The first deterrent is that in California, all types of insurance fraud are considered to be a felony offense. Section 1871.4 of California Insurance Code states that “it is unlawful to make false or fraudulent material statements or representations for the purpose of obtaining or denying compensation.” The language from Section 1871.4 is written at the top of the initial claim form that an injured worker must complete and sign when reporting an injury. Claims adjusters also commonly read this language to claimants when obtaining their statements about how their work related injury took place. The reason this “fraud language” is brought to the attention of the
The claimant is to put them on notice in the early stages of their claim that insurance fraud is a felony offense.

The second deterrent is outlined in California Code of Regulations, Special Investigation Unit Regulations. Section 2698.32 requires that insurance carriers conducting business in the state must staff a Special Investigation Unit (SIU) whose primary purpose is to detect and investigate suspected fraudulent claims. In addition to detecting and investigating suspected fraudulent claims, SIU investigators are required by the state to provide ongoing anti-fraud training to the claims staff so that they are aware of what types of “red flags” to look for when handling the claim. The SIU is the liaison between the claims department and the law enforcement agencies that investigate and prosecute insurance fraud. As stated earlier, much of the workers’ compensation “abuse” goes undetected (Pathria, 1999). The SIU is charged with reviewing claims that are referred from the claims department for suspected fraud. If fraud is suspected, the SIU will conduct an in depth investigation into the claim to determine if there is reasonable suspicion of suspected fraud. If the SIU is able to present a case of reasonable suspicion, the claim is referred to the Department of Insurance – Fraud Division.

The Fraud Division in conjunction with grant funded District Attorney’s offices throughout the state are the third deterrent. These agencies are the dedicated law enforcement agencies that specifically investigate and prosecute suspected
fraudulent claims referred to them from insurance carriers (http://www.insurance.ca.gov/0300-fraud/). Section 1871.4 of the California Insurance Code, carrier SIU departments and the law enforcement agencies in place to fight insurance fraud not only seek to uncover and punish those who defraud an insurance carrier, but are in place to let the public know that insurance fraud is a serious crime and show that it will not be tolerated in California.

With all of these deterrent factors in place, it would seem that workers’ compensation fraud would not be such a widespread issue (Derrig & Zicko, 2002). It is hard to imagine how much more severe the cost of insurance fraud would be without these deterrents in place; however, even with these deterrents in place fraud still runs rampant throughout the state. One reason that insurance fraud may be so rampant is because the deterrents in place to fight fraud are largely “reactive” to the crime. Each deterrent comes into play only after a claim has been filed.

It is difficult to gauge what the public actually knows about insurance fraud. Since there is little to no coverage of insurance fraud cases through the media, it is unknown how the public learns about what actions constitute insurance fraud. Ball (1955) points out that the “deterrent effect of a law obviously depends upon the individual’s knowledge of the law and the punishment prescribed” (Ball, 1955, p. 351). Unless we can definitively show that public is aware of the deterrents to insurance fraud, it is difficult to know whether or not the deterrents in place to fight
the crime are actually serving their intended purpose. It has been suggested by Tennyson (2002) that “better fraud detection and stricter penalties for fraud may reduce the prevalence” of opportunistic and planned insurance fraud (p. 36). The trouble with this line of thinking is that fraud detection only captures suspected fraud after the crime is in motion. Stricter penalties would send a stronger message, but only if the public actually heard about people getting convicted for committing the crime.

**Public Perception about Insurance Fraud**

There have been very few research studies that delve into the question of what the public knows about the deterrents to insurance fraud. As discussed earlier, there are major deterrents that were put into place by the California legislature, but due to the lack of insurance fraud prosecutions or publication through the media, the public is left uninformed about the serious consequences for committing insurance fraud. Public perception about street crime is that it is serious and should have serious consequences (Stylianou, 2004). Public perception research about insurance fraud has found that it is acceptable in certain circumstances (Tennyson 1997; Tennyson, 2002). As a general rule, people do not think that it is acceptable to steal from another person. For some reason the lines seem to become blurred when it comes to “stealing” from an insurance company after you have paid them for insurance coverage (O’Rourke, 2003). What those who commit insurance fraud fail
to see is that their actions end up costing their peers. The insurance company passes down the losses they take from fraudulent claims down to their policyholders. Fraudulent claims add around $300 extra in premiums per year for each American household (Dean, 2004).

A 2007 study by Schoepfer, Carmichael and Piquero investigated public perception of punishment between white-collar crime and street crime. The specific areas of the study that were particularly interesting were the punishment “certainty” and “severity” findings with respect to the two forms of crime. The study used robbery as the street crime and fraud as the white-collar crime. These two examples of crime are essentially one and the same at the core; they involve stealing from another party. Robbery, the street crime, involves using force to steal whereas fraud, the white-collar crime, is monetary theft committed by a lone actor in a non-violent way. The survey results showed that with regard to certainty of punishment for the two crimes, the public felt robbery was much more likely to be punished than fraud. When it came to severity of punishment, the public felt that robbery, overwhelmingly, would receive a more severe punishment than fraud (Schoepfer et al., 2007). The survey went further and asked which punishment the respondent felt should receive a more severe punishment. The results were in favor of both crimes receiving equally severe punishments. The study raised the point that this “suggested that respondent’s perceptions of what the crime severity should be was not in line
with their perceptions of the criminal justice system’s actual treatment of the two crime types” (Schoepfer et al., 2007, p. 157). This can be applied to what the public knows about the deterrents to insurance fraud. A person might know that it is wrong to commit fraud, but when the perceived risk of getting caught and punished for the crime is low, there is little stopping a would-be offender from committing the crime. It does not take much to commit insurance fraud. The claimant just has to embellish the truth to a person bestowing benefits during the claims process. Nobody will be physically accosted like in a robbery and the victim whose money is being taken is a faceless insurance company (Dean, 2004).

The deterrence doctrine has its roots in hedonism. People seek pleasure and avoid pain. The average person does not want to go to prison and will therefore refrain from engaging in criminal activity (Kleck, Sever, Li & Gertz, 2005). They will especially try to avoid behavior that is likely to be “detected and punished” (Miller & Anderson, 1986). The deterrence doctrine assumes that the offender has knowledge about the penalties for their crimes before they commit the crime. In order for the offender to be able to weigh the costs of committing the crime, those who create the laws must make sure that they are “communicated” through the media to the public and also that the laws “are imposed by the courts” (Miller & Anderson, 1986). If these two things do not occur, the public will have no knowledge about the
penalties for different types of crimes. They will not be able to properly evaluate the seriousness of a crime.

The “punishment perception” study conducted by Schoeper et al. (2007) pointed out, “at its core, the deterrence doctrine hypothesizes that the perceived threat of swift, certain and severe sanctions will inhibit criminal activity” (p. 151). Application of this doctrine to public knowledge about the deterrents to insurance fraud will give an understanding of whether or not the public feels that insurance fraud is a serious crime. Those who are unaware of the deterrents will be more likely to find insurance fraud acceptable in some circumstances. Unless the public knows what is considered to be insurance fraud, their attitudes will remain accepting of seemingly harmless claims embellishment behavior that if detected could lead to criminal prosecution. It would seem that if the public were aware of the deterrents to insurance fraud, those who engage in the opportunistic fraud would think twice before continuing to pursue a fraudulent claim. In order for the deterrents to work, the public has to know that they exist. Due to the lack of media coverage about insurance crimes it would be unlikely that the average citizen would become aware of the deterrents to insurance fraud outside of being involved in a claim or knowing somebody that had been convicted of insurance fraud (Evans, Cullen & Dubeck, 1993).
Relevant Laws

Codes are a grouping of laws about the same subject. They are laws that are passed by the state legislature. The following Codes represent the foundation of what an insurance investigator needs to know in order to better evaluate his or her cases.

The California Labor Code is an important framework within which Workers’ Compensation laws operate. A California Court website defines the Labor Code as “A collection of laws regarding the broad spectrum of activities concerning the relationship between employers and employees” (Judicial Council of California, 2009). Under the Labor Code Section 3820, the following is stated:

3820. (a) In enacting this section, the Legislature declares that there exists a compelling interest in eliminating fraud in the workers' compensation system. The Legislature recognizes that the conduct prohibited by this section is, for the most part, already subject to criminal penalties pursuant to other provisions of law. However, the Legislature finds and declares that the addition of civil money penalties will provide necessary enforcement flexibility. The Legislature, in exercising its plenary authority related to workers' compensation, declares that these sections are both necessary and carefully tailored to combat the fraud and abuse that is rampant in the workers' compensation system.

The Labor Code contains a tremendous amount of information that the SIU Investigator must understand in order to fully grasp what is taking place in the cases that he or she analyzes.
Like the Labor Code, The Insurance Code is a grouping of laws that pertain to all aspects of insurance. The Insurance Code has sections that specifically cover insurance fraud issues and are especially relevant to the SIU investigator. It is important that the SIU investigator review these sections so that they are well versed in areas that affect their job.

The California Penal Code Section 548 – 551 outline unlawful insurance related activity. Portions of Penal Code 550 are of tremendous use to a workers’ compensation insurance investigator. Specifically:

550  (a) It is unlawful to do any of the following, or to aid, abet, solicit, or conspire with any person to do any of the following:
(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss or injury, including payment of a loss or injury under a contract of insurance.

(b) It is unlawful to do, or to knowingly assist or conspire with any person to do, any of the following:
(1) Present or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.
(2) Prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.
(3) Conceal, or knowingly fail to disclose the occurrence of, an event that affects any person's initial or continued right or entitlement to any insurance benefit or payment, or the amount of any benefit or payment to which the person is entitled.
This section of the Penal Code is more generic than the Insurance Code when it comes to their application. Sometimes, law enforcement might be able to charge a case with these sections when Insurance Code 1871.4 does not apply.

**Theoretical Framework**

In terms of theory, the manual will be created with the path-goal theory as a framework. The manual will essentially be the “path” provided by management that the investigator can use realize their “goal” of successfully investigating cases; thus being effective and efficient in their role. The path-goal theory emerges out of organizational literature.

The path-goal theory states that:

> It is the leader’s job to assist followers in attaining their goals and to provide the necessary direction and/or support to ensure that their goals are compatible with the overall objectives of the group or organization (Robbins & Judge, 2008, p. 419).

This theory provides an excellent framework for why the creation of a reference manual is needed for workers’ compensation insurance investigators. The goal of the investigator is to analyze a set of facts and decide whether or not the case is something that should be referred over to law enforcement. Being able to provide a new investigator with a reference manual will assist the investigator with attaining his or her goals and provide them with necessary direction.

Since most investigators work remotely, it is not as though they are in a situation where they are working one on one with their manager and peers and can
ask questions and brainstorm as issues arise. Without a reference manual, a new investigator is left to problem solve for extremely complex situations on their own. They are not able to be as effective as they could be because most of their time is going to be spent searching around for information or simply not knowing that there are other investigative avenues that they could pursue. The reference manual will solve this problem and make the investigator more efficient and effective in their role.

An article by Erwin Rausch (2009) discusses “common sense” in the workplace and ways that it can be enhanced. The article goes into detail about how “greater skill in decision making leads to “better” common sense” (Rausch, 2009, p. 413). Providing employees with a reference manual is something that will definitely assist with giving them the tools to enhance their decision making skills.

There are six guidelines that Rausch discusses that can enhance the “common sense” of the participant. A few of them especially held true when thinking about their application to a SIU investigator. The first is that the person needs to have the ability to make the decision but also that being able to bounce ideas off of somebody enhances decision making (Rausch, 2009, p. 418). This would hold true with the SIU investigator because they are the person tasked with deciding which direction they should take their investigation based on the facts and their application to available laws. The reference manual will enable the investigator to “bounce” their thoughts
on a particular case off of the material in the manual to give them alternative avenues to consider in their decision making process.

The second guideline is competence (Rausch, 2009). Clearly, there must be a baseline level of competence in the subject matter for the person to be able to make a sound decision. Before using the reference manual, the SIU investigator should already have a baseline understanding of how to investigate a suspicious claim. Without competence in the area of insurance investigations, the person using the manual would not really understand how the material they are reviewing may or may not apply to their case.

The third guideline outlined by Rausch (2009) speaks to consideration of the “satisfaction of those involved or affected by the decision” (p. 418). Rausch (2009) feels that this must be considered or the decision maker is not using common sense. This guideline can also be viewed as important because the SIU investigator is completing investigations on claims that are managed by case managers in the claims department. If the SIU investigator does not consider every possible angle, they are could leave the claims department dissatisfied with their investigative efforts.

The fourth guideline outlined by Rausch (2009) states that, individuals who violate widely accepted norms, especially those that pertain to fairness and consistency, or reasonable ethical standards, are not considered to use good common sense (p. 419).
This guideline can be applied to why they reference manual is important to the SIU investigator. It will allow them to ensure they are applying all of their cases to the same laws and standards.

Guideline 5 discusses goals and planning. Rausch discusses how planning is important when it comes to decision making (Rausch, 2009). The SIU investigator definitely needs to plan their investigative steps with the goal of uncovering the truth and completing their investigation. The manual will assist with this goal by allowing the SIU investigator to thoroughly assess what options are available and efficiently work through their analysis of the case.

Guideline 6 discusses “cooperation” and conflict resolution as well as evaluation of employee performance (Rausch, 2009). Rausch does not go into detail about guideline 6 because he states it is “too extensive to cover in such a brief article” (Rausch, 2009, p. 419).

Rausch raises some good points about decision making in the workplace. Without knowledge and the ability to make decisions, an employee can be left feeling dissatisfied with their role and head down a path to low productivity. Increasing their knowledge level with a reference manual is a way to ensure the employee has the right tools available to make decisions.

Hall & Hursch (1982) conducted a study concerning employees at West Virginia University and the difficulty that they were having with completing “high-
priority” tasks. The authors point out that the reasons these employees were having trouble completing their job duties was because of “procrastination, interruptions or poor planning” (p. 1). One specific component of their study was to see if the use of a time management training manual could assist with completion of high priority tasks. The article points out that “poor time management” can be the catalyst for the deterioration of an employee on a myriad of different levels (Hall & Hursch, 1982). On the one hand, the employee’s work performance will suffer because they will get behind on their day-to-day job tasks. The second an employee starts getting behind with their work it becomes increasingly more difficult to catch up due to continued incoming assignments. In addition to work performance suffering, the employee will suffer psychologically (Hall & Hursch, 1982). The psychological component comes into play because the employee will invariably begin to feel bad about themselves since their work performance is in decline. When an employee’s work performance suffers, it is not just the employee who suffers the company will suffer as well (Hall & Hursch, 1982). It is easy to see how poor work performance on the part of the employee can leave them feeling disconnected from the organization. It is in the best interest of both the employee and the employer to have a manual in place so that there is no ambiguity about what is expected by the employer and what is needed for the employee to efficiently do their job.
An interesting point that was uncovered in Hall and Hursch’s (1982) study was that professionals in a field who are extremely knowledgeable may struggle in areas of time management. The reason for this was because even though they were skilled in their field, they did not have a good grasp of organizational procedures (Hall & Hursch, 1982, p. 22). It is easy to see how a person who is very knowledgeable in a field may not necessarily be the most efficient employee if they do not have a solid understanding of organizational procedures. They may be focusing their energies in areas that they think are important but be neglecting tasks that need to be completed and are important to the productivity of the company.

Desmond (2009) writes about how innovation can improve an organization by “liberating staff” (p. 321). Development of a reference manual that houses useful information for working through investigative assignments is an innovative way to get an employee to think outside of the box. Desmond (2009) points out that an employee cannot just be told to be innovative. According to Desmond, innovation needs to be “planned, encouraged and managed” (Desmond, 2009, p. 321). The reference manual is something that will be provided from management to employees; however, it is something that can and should be updated as new laws or techniques are learned. Not only will employee contributions to the manual be valuable in terms of the breadth of knowledge it will encompass, but employee contribution to the manual will hopefully encourage continued use of the manual by employees.
Sarin and O’Conner (2009) used path-goal theory as they examined the role of the “team leader” on “New Product Development” teams (Sarin & O’Conner, 2009, p. 188). They discuss how the team leader plays a critical role with the staff that they manage. The authors emphasize that path-goal theory plays a pivotal role in shaping team interactions and the overall success of a project (Sarin & O’Conner, 2009 p. 189). By providing a team with expectations and direction, they will be better able to work towards achieving their goals (Sarin & O’Conner, 2009, p. 193).

Sarin and O’Conner (2009) also discuss that while providing structure will ensure that tasks are being completed the way that the leader wants them to be completed, it can also have a downside. That downside is that the ability of the individual to think outside of the box might be stifled (Sarin & O’Conner, 2009, p. 193). It is for this reason that the “reference manual” style would be a good fit for an investigator. One thing that the investigator should not do is work each investigation the same way. There is no “cookie cutter” approach to follow as each investigation is different and will need to be worked on a case by case basis. Providing the investigator with reference material to ponder in their decision making process will provide them with avenues to consider without forcing them to work their case in a particular way.

Danby (2009) points out that,
An effective delegation process can help a leader move an individual or team from dependence requiring close supervision to a state of empowerment (p. 59).

This concept is especially important to consider when it comes to support of the creation of a reference manual for employees. Danby (2009) discusses how in a nutshell it is the job of management to “get work done through others” (p. 59). An employee may be delegated an assignment to complete but without proper direction or interaction by the manager, the employee may not fully grasp what needs to be done on that particular project (Danby, 2009, p. 61). By providing an employee with a reference manual, they will be better able to evaluate the tasks that they are presented with and produce a better product. Danby really stresses that expectations by the manager need to be clear (Danby, 2009, p. 62). Without clarity, an employee will be unsure of the expectations of management and will continue to complete tasks the best way that they think they should be completed which could conflict with the way that management thinks they should be completed. If there were other ways to complete the task that might have yielded a better outcome, they should have been made available to the employee ahead of time.
Chapter 3
PROJECT PROCESS

The intent of this project was to prepare a reference manual for workers’ compensation insurance fraud investigators. The reason that this reference manual is being created is because at this time no such manual exists. The idea for a reference manual came to be after I started working in a management position. Upon hiring a new investigator, I found that I had to pull information from several different areas rather than having everything in one place. Another reason why I felt that this manual would be relevant is because oftentimes in positions as an investigator we are told “how” to complete a task but do not have a full understanding of why we do it that particular way. This manual would help to eliminate the question of “why” and provide the investigator with the source behind what they are using in their investigations.

This reference manual will contain a variety of information sources that will help the SIU investigator when he/she is tasked with reviewing a suspicious workers’ compensation claim. The manual will contain information from California Labor Code, Insurance Code, and Penal Code and the SIU regulations. There will be information about the elements of fraud, various websites for use during the investigative process and information on what to include in a case package. This will
not be a “how to” manual but instead, a compilation of information that the SIU investigator can use to better analyze the cases that they review.

As stated earlier, the reference manual is comprised of several different types of information sources that will be important to a new investigator. The information contained in the manual will appear under the following headings:

- Relevant Codes/Laws
- Websites
- Training ideas
- California SIU Regulations
- California SIU Annual Report
- Personal Development Opportunities

Understanding how these areas affect their job is critical to the success of a SIU investigator.

The Codes and Laws are all pulled from http://www.leginfo.ca.gov/l. This is a website that is located on the State of California government website. The website will take the user to any section of a California code/law based on the search criteria entered. This website is extremely helpful as it saves the investigator from having to purchase hard copies of the Code books and ensure that they have the latest edition.

The websites included in the reference manual are a compilation of some public search websites that may be useful to an investigator. The reason that they are
included is because they can assist an investigator with knowing what free, public search tools are available to them on the internet. Becoming familiar with these websites will get the investigator in the mindset of utilizing the internet during the investigative process. The internet is a powerful tool and these websites are only a partial list of what the investigator will develop over time.

The training ideas provided are generic training ideas that a SIU investigator is required to train integral anti-fraud staff about at least once annually per the California SIU regulations. It will be left to the investigator to decide how they want to handle presenting the information. The training ideas are just to give the investigator a starting point to develop meaningful training and ensure that they are in compliance with the requirements set forth in the California SIU regulations.

The California SIU regulations are included so that the SIU investigator has a better idea about what the Department of Insurance expects from a SIU. The SIU regulations are extremely helpful for a new investigator in defining their role and what is expected from them on a macro level. While insurance companies have their own unique guidelines for what is expected from their SIU investigators, a new SIU investigator will benefit from being able to compare how their company operates with the California mandated regulations.

The form that is used for the California SIU Annual Compliance Report is included in the reference manual so that an investigator can see what statistics the
Department of Insurance is interested in obtaining from insurance companies. This will give the SIU investigator a better understanding of how what they do affects the compliance of the organization. As with the California SIU regulations, being able to review the Compliance Report will allow the investigator to compare how their company operates with California mandated regulations.

The Personal Development Opportunities section of the reference manual is in place to provide the investigator with a list of some of the industry recognized insurance designations that are available. As a new investigator, these development opportunities are a great place to seek knowledge and gain a better understanding for what the standards are across the industry. This section will give an overview of each designation and a website where more information about the designation can be obtained.
Chapter 4

CONCLUSION

At this time, I feel that the project was successful in meeting its objectives. The objective of the project was to create a reference manual that included important and relevant information for a new investigator. When starting a new job, it is important that the new employee feel comfortable in their role. The reference manual is a tool that management can provide to a new employee that gives direction and helps them understand what is expected of them as a SIU investigator.

Limitations of the Project

 Obviously, there is no way to compile every last piece of information that an investigator might need or would find useful. This project will contain mostly high level industry recognized information that will serve as a solid foundation for the investigator. Another limitation of the project is that the investigative tools found in the manual will change and eventually, the manual will need to be updated to ensure that it is current for the investigator.

A way to enhance this project in the future would be to interview a sample of California insurance investigators. The purpose of the interview would be to ask questions about what they feel might be relevant in a reference manual for a new investigator. By interviewing a number of different investigators, the strength of the manual would be enhanced. The reason for this is that a variety of different
perspectives about important material for the reference manual would be obtained.

As it stands, this manual only contains information that I feel is relevant for a new investigator.

At this time, the reference manual has been created, but it has not been tested. By tested, I mean that it has not been provided to new investigators for their use and review. It would be interesting to provide this manual to a sample of new investigators and then survey or interview them about how and if the manual assisted them in their new role. We know from the research that providing direction to a new employee is important, but whether or not the manual is effective in providing that direction will not be known until it has been used by a new investigator.

Implications

If the feedback received from new investigators about the reference manual is positive, there is a possibility that it could be replicated for other lines of insurance (this manual pertains to workers’ compensation only.) If it is successful with other lines of insurance the manual could be replicated in other states.
APPENDIX

California Workers’ Compensation SIU Investigator Manual
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of Department of Insurance</td>
<td>38</td>
</tr>
<tr>
<td>Relevant Laws</td>
<td>40</td>
</tr>
<tr>
<td>Websites</td>
<td>56</td>
</tr>
<tr>
<td>Training Ideas</td>
<td>60</td>
</tr>
<tr>
<td>California SIU Regulations</td>
<td>61</td>
</tr>
<tr>
<td>California SIU Annual Report</td>
<td>62</td>
</tr>
<tr>
<td>Personal Development Opportunities</td>
<td>63</td>
</tr>
<tr>
<td>Appendix A. 90-day training</td>
<td>65</td>
</tr>
<tr>
<td>Appendix B. Annual Training</td>
<td>69</td>
</tr>
</tbody>
</table>
Department of Insurance

California Department of Insurance
Workers’ Compensation Insurance Fraud Program

This information was obtained from the California Department of Insurance Website: http://www.insurance.ca.gov/0300-fraud/0100-fraud-division-overview/0500-fraud-division-programs/workers-comp-fraud/index.cfm

It gives an overview of workers’ compensation, workers’ compensation fraud, and how the Department of Insurance – Fraud Division investigates workers’ compensation fraud.

During the 1920s, most states, including California, accepted a new social insurance program known as workers' compensation. In California, workers' compensation insurance is a no-fault system. Injured employees need not prove the injury was someone else's fault in order to receive workers' compensation benefits for an on-the-job injury. The National Insurance Crime Bureau estimated in the year 2000, workers' compensation insurance fraud was the fastest-growing insurance scam in the nation, costing the industry $5 billion per year by what many people consider a victimless crime. Often white-collar criminals, including doctors and lawyers, dupe the system through fraudulent activity and insurance companies "pick up the tab," passing the cost onto policyholders, taxpayers and the general public.

The Workers' Compensation Fraud Program was established in 1991 through the passage of Senate Bill 1218 (Chapter 116). The law made workers' compensation fraud a felony, required insurers to report suspected fraud and established a mechanism for funding enforcement and prosecution activities. Senate Bill 1218 also established the Fraud Assessment Commission to determine the level of assessments to fund investigation and prosecution of workers' compensation insurance fraud. The funding comes from California employers who are legally required to be insured or self-insured. The total aggregate assessment for Fiscal Year 2007-08 is $43,887,233.

During Fiscal Year 2007-08, the Fraud Division identified and reported 4,973 SFCs, assigned 515 new cases, made 375 arrests and referred 432 submissions to prosecuting authorities. Potential Loss amounted to $292,390,871.
The investigation of Workers' Compensation Fraud very often involves difficult and lengthy investigations. These investigations have resulted in convictions and the reduction of a number of medical and/or legal workers' compensation mills. Since Fiscal Year 2003-04, the CDI has participated as a member of the "Underground Economy Strike Force," per Assembly Bill 202. The Fraud Division continues to focus its efforts in that area of the Underground Economy known as employer misrepresentation or Premium Fraud. Participation on the Strike Force helps the Fraud Division and district attorneys investigate and prosecute the premium fraud cases which most significantly impact the California economy and business climate.

Evidence suggests that the aggressive anti-fraud campaign by the Department, the district attorneys, the insurance industry and California employers continues to play a substantial role in reducing crime and helps lower workers' compensation premiums for employers statewide.

Relevant Laws

http://www.leginfo.ca.gov/calaw.html

The legal information website is a government site that contains all California Law documents online. This is a great tool for an investigator because you can enter keywords if you are unaware of what you are searching for and the site will bring up sections that include the keyword in the code that you selected.

The following pages contain excerpts from the Insurance, Penal and Labor Code that each SIU investigator should understand.
1873. (a) Upon written request to an insurer by officers designated in subdivisions (a) and (b) of Section 830.1 and subdivision (a) of Section 830.2, and subdivisions (a), (c), and (i) of Section 830.3 of the Penal Code, an insurer, or agent authorized by that insurer to act on behalf of the insurer, shall release to the requesting authorized governmental agency any or all relevant information deemed important to the authorized governmental agency that the insurer may possess relating to any specific insurance fraud. Relevant information may include, but is not limited to, all of the following:

(1) Insurance policy information relevant to the insurance fraud under investigation, including, but not limited to, any application for a policy.
(2) Policy premium payment records which are available.
(3) History of previous claims made by the insured.
(4) Information relating to the investigation of the insurance fraud, including statements of any person, proof of loss, and notice of loss.
(5) Complete copies of both sides of payment drafts.

(b) The provisions of subdivision (a) shall not operate to authorize disclosure of medical information not otherwise authorized for disclosure pursuant to law.

1873.1. Any information acquired pursuant to this article shall not be a part of any public record. Except as otherwise provided by law, any authorized governmental agency, an insurer, or an agent authorized by an insurer to act on its behalf, which receives any information furnished pursuant to this article, shall not release that information to public inspection until the time that its release is required in connection with a criminal or civil proceeding.

1873.2. In the absence of fraud or malice, no insurer, or any employee or agent authorized by an insurer to act on behalf of the
insurer, and no authorized governmental agency or its respective employees, shall be subject to any civil liability for libel, slander, or any other relevant cause of action by virtue of releasing or receiving any information pursuant to Section 1873 or 1873.1. Nothing in this article is intended to, nor does in any way or manner, abrogate or lessen the existing common law or statutory privileges and immunities of an insurer, or any employee or agent authorized by the insurer to act on behalf of the insurer, or of any authorized governmental agency or its respective employees.

1873.3. (a) For purposes of this article and Article 2 (commencing with Section 1872), "insurance fraud" does not include motor vehicle theft and motor vehicle insurance fraud reporting subject to the provisions of Article 4 (commencing with Section 1874), or workers' compensation insurance fraud reporting subject to Article 7 (commencing with Section 1877).

(b) As used in this article, "authorized governmental agency" means the Department of the California Highway Patrol, the Department of Motor Vehicles, the Department of Insurance, the Department of Justice, the police department of a city, or a city and county, the sheriff's office or department of a county, the district attorney of any county, or city and county, those agencies employing officers designated in subdivisions (a) and (b) of Section 830.1, subdivision (a) of Section 830.2, and subdivisions (b), (d), and (k) of Section 830.3 of the Penal Code, any other law enforcement agency of this state or any city or county, or city and county, and any licensing agency governed by the Business and Professions Code.

1873.4. Any or all information released or received by an authorized governmental entity pursuant to Section 1873 or 1873.1 shall be provided by that agency to the Fraud Division within 10 days of the agency's receipt of the information.

CALIFORNIA CODES
INSURANCE CODE
SECTION 1874-1874.8
1874. This article shall be known and may be cited as the Motor Vehicle Theft and Motor Vehicle Insurance Fraud Reporting Act.

1874.1. The following definitions govern the construction of this article, unless the context requires otherwise:

(a) "Authorized governmental agency" means the Department of the California Highway Patrol, the Department of Insurance, the Department of Justice, the Department of Motor Vehicles, the police department of a city, or a city and county, the sheriff's office or department of a county, a law enforcement agency of the federal government, the district attorney of any county, or city and county, and any licensing agency governed by the Business and Professions Code or the Chiropractic Initiative Act.

(b) "Relevant" means having a tendency to make the existence of any fact that is of consequence to the investigation or determination of an issue more probable or less probable than it would be without the information.

(c) Information shall be deemed important if, within the sole discretion of the authorized governmental agency, that information is requested by that authorized governmental agency.

(d) "Insurer" means the automobile assigned risk plan established pursuant to Section 11620 of the Insurance Code, as well as any insurer writing insurance for motor vehicles or otherwise liable for any loss due to motor vehicle theft or motor vehicle insurance fraud.

(e) "Motor vehicle" means motor vehicle as defined in Section 415 of the Vehicle Code.

1874.2. (a) Upon written request to an insurer by an authorized governmental agency, an insurer or agent authorized by that insurer to act on behalf of the insurer, shall release to the requesting authorized governmental agency any or all relevant information deemed important to the authorized governmental agency that the insurer may possess relating to any specific motor vehicle theft or motor vehicle insurance fraud. Relevant information may include, but is not limited to, all of the following:

1. Insurance policy information relevant to the motor vehicle theft or motor vehicle insurance fraud under investigation, including, but not limited to, any application for a policy.
(2) Policy premium payment records that are available.

(3) History of previous claims made by the insured.

(4) Information relating to the investigation of the motor vehicle theft or motor vehicle insurance fraud, including statements of any person, proof of loss, and notice of loss.

(b) (1) When an insurer knows or reasonably believes it knows the identity of a person whom it has reason to believe committed a criminal or fraudulent act relating to a motor vehicle theft or motor vehicle insurance claim or has knowledge of the criminal or fraudulent act that is reasonably believed not to have been reported to an authorized governmental agency, then, for the purpose of notification and investigation, the insurer, or an agent authorized by an insurer to act on its behalf, shall notify the local police department, sheriff's office, the Department of the California Highway Patrol, or district attorney's office, and may notify any other authorized governmental agency of that knowledge or reasonable belief and provide any additional information in accordance with subdivision (a).

(2) When an insurer provides the local police department, sheriff's office, Department of the California Highway Patrol, or district attorney's office with notice pursuant to this section, it shall be deemed sufficient notice to all authorized governmental agencies for the purpose of this chapter. Nothing in this section shall relieve an insurer of its obligations under Section 1872.4.

(3) Nothing in this subdivision shall abrogate or impair the rights or powers created under subdivision (a).

(c) The authorized governmental agency provided with information pursuant to subdivision (a) or (b) may release or provide that information to any other authorized governmental agency.

(d) An authorized governmental agency shall notify the affected insurer in writing when it has reason to believe that a fraudulent act relating to a motor vehicle theft or motor vehicle insurance claim has been committed. The agency shall provide this notice within a reasonable time, not to exceed 30 days. The agency may also release more specific information pursuant to this section when it determines that an ongoing investigation would not be jeopardized. The agency may require a fee from the insurer equal to the cost of providing the notice or the information specified in this section.

(e) An insurer providing information to an authorized agency pursuant to this section shall provide the information within a
reasonable time, but not to exceed 30 days from the day on which the duty arose.

1874.3. (a) Any information acquired pursuant to this article shall not be a part of any public record. Except as otherwise provided by law, any authorized governmental agency, an insurer, or an agent authorized by an insurer to act on its behalf, which receives any information furnished pursuant to this article shall not release that information to public inspection.

(b) The evidence or information described in this section shall be privileged and shall not be subject to subpoena or subpoena duces tecum in a civil or criminal proceeding unless, after reasonable notice to any insurer, agent authorized by an insurer to act on its behalf, and an authorized governmental agency which has an interest in the information, and a hearing, the court determines that the public interest and any ongoing investigation by the authorized governmental agency, insurer, or an agent authorized by an insurer to act on its behalf will not be jeopardized by its disclosure, or by the issuance of and compliance with a subpoena or subpoena duces tecum.

1874.4. In the absence of fraud or malice, no insurer, or agent authorized by an insurer to act on behalf of the insurer, and no authorized governmental agency or its employees, shall be subject to any civil liability in a cause of action of any kind for releasing or receiving any information pursuant to Section 1874.1 or 1874.2. Nothing in this chapter is intended to, nor does in any way or manner, abrogate or lessen the existing common law or statutory privileges and immunities of an insurer, agent authorized by that insurer to act on behalf of the insurer, or of any authorized governmental agency or its employees.

1874.6. Every insurer shall report covered private passenger automobiles involved in theft and salvage total losses, including the
vehicle identification number and any other information as may be required, to the National Automobile Theft Bureau or a similar central organization engaged in automobile loss prevention approved by the commissioner, in accordance with regulations promulgated by the commissioner.

Prior to the payment of total theft losses, insurers shall comply with verification procedures in accordance with regulations adopted by the commissioner.

No insurer, the National Automobile Theft Bureau, or a similar central organization, engaged in automobile loss prevention approved by the commissioner, or their employees or agents, shall be liable for damages in a civil action when the insurer or person acts pursuant to this section in good faith, without malice, and in reasonable belief that the action taken is warranted by the known facts after a reasonable effort to obtain the facts.

As used in this section "private passenger automobile" a motor vehicle of the private passenger or station wagon type, any other four-wheel vehicle with a load capacity of 1,500 pounds or less, or a motorcycle.

1874.8. (a) Each insurer doing business in this state shall pay an annual special assessment to be determined by the commissioner, but not to exceed fifty cents ($0.50) annually for each vehicle insured under an insurance policy it issues in this state, in order to fund the Fraud Division and an Organized Automobile Fraud Activity Interdiction Program. The commissioner shall award 3 to 10 grants for a coordinated program targeted at the successful prosecution and elimination of organized automobile fraud activity. The grants may only be awarded to district attorneys.

(b) In determining whether to award a district attorney a grant, the commissioner shall consider factors indicating organized automobile fraud activity in the district attorney's county, including, but not limited to, the county's level of general criminal activity, population density, automobile insurance claims frequency, number of suspected fraudulent claims, and prior and current evidence of organized automobile fraud activity. Funding priority shall be given to those grant applications with the potential to have the greatest impact on organized automobile insurance fraud.
activity.

(c) All participants of a grant referred to in subdivision (a) shall coordinate their efforts and work in conjunction with the bureau, other participating agencies, and all interested insurers in this regard. Of the funds collected pursuant to this section, 42.5 percent shall be distributed to district attorneys, 42.5 percent shall be distributed to the Fraud Division, and 15 percent shall be distributed to the Department of the California Highway Patrol. Funds distributed pursuant to this section to the Fraud Division and to the Department of the California Highway Patrol shall be used to fund bureau and Department of the California Highway Patrol investigators who shall be assigned to work solely in conjunction with district attorneys who are awarded grants. Each grantee shall be notified by the Fraud Division of the investigators assigned to work with the grantee. Nothing shall prohibit the referral of any cases developed by the Fraud Division to any appropriate prosecutorial entity.

(d) A grant under this section shall be awarded on the basis of a single application for a period of three years and shall be subject where applicable to the requirements of subdivision (b) of Section 1872.8, except for the requirement that grants be awarded according to population. Continued funding of a grant shall be contingent upon a grantee's successful performance as determined by an annual review by the commissioner. Any redirection of grant funds under this section shall be made only for good cause. The Department of the California Highway Patrol shall submit to the commissioner, for informational purposes only, an annual report on its expenditure of funds under this section in the same format as is required of grantees under this section.

(e) There shall be no prohibition against a joint application by two or more district attorneys for a grant award under this section.

(f) The Fraud Division shall report to the Governor, the Legislature, and to the committees of the Senate and Assembly having jurisdiction over insurance on the results of the grant program established by this section, including funding distributed to the Department of the California Highway Patrol in the annual report submitted pursuant to Section 12922.

(g) For purposes of this section, "organized automobile fraud activity" means two or more persons who conspire, aid and abet, or in any other manner act together, to engage in economic automobile theft as defined in subdivision (f) of Section 1872.8, or to violate
any of the following provisions in relation to an automobile 
insurance claim:

(1) Section 650 or 6152 of the Business and Professions Code. 
(2) Section 750 of the Insurance Code. 
(3) Section 549, 550, or 551 of the Penal Code. 

(h) This section shall remain in effect only until January 1, 
2015, and as of that date is repealed, unless a later enacted 
statute, that is enacted before January 1, 2015, deletes or extends 
that date.

CALIFORNIA CODES 
PENAL CODE 
SECTION 550 

550. (a) It is unlawful to do any of the following, or to aid, 
abet, solicit, or conspire with any person to do any of the 
following: 

(1) Knowingly present or cause to be presented any false or 
fraudulent claim for the payment of a loss or injury, including 
payment of a loss or injury under a contract of insurance. 

(2) Knowingly present multiple claims for the same loss or injury, 
including presentation of multiple claims to more than one insurer, 
with an intent to defraud. 

(3) Knowingly cause or participate in a vehicular collision, or 
any other vehicular accident, for the purpose of presenting any false 
or fraudulent claim. 

(4) Knowingly present a false or fraudulent claim for the payments 
of a loss for theft, destruction, damage, or conversion of a motor 
vehicle, a motor vehicle part, or contents of a motor vehicle. 

(5) Knowingly prepare, make, or subscribe any writing, with the 
intent to present or use it, or to allow it to be presented, in 
support of any false or fraudulent claim. 

(6) Knowingly make or cause to be made any false or fraudulent 
claim for payment of a health care benefit. 

(7) Knowingly submit a claim for a health care benefit that was 
not used by, or on behalf of, the claimant.
(8) Knowingly present multiple claims for payment of the same health care benefit with an intent to defraud.

(9) Knowingly present for payment any undercharges for health care benefits on behalf of a specific claimant unless any known overcharges for health care benefits for that claimant are presented for reconciliation at that same time.

(10) For purposes of paragraphs (6) to (9), inclusive, a claim or a claim for payment of a health care benefit also means a claim or claim for payment submitted by or on the behalf of a provider of any workers' compensation health benefits under the Labor Code.

(b) It is unlawful to do, or to knowingly assist or conspire with any person to do, any of the following:

(1) Present or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(2) Prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(3) Conceal, or knowingly fail to disclose the occurrence of, an event that affects any person's initial or continued right or entitlement to any insurance benefit or payment, or the amount of any benefit or payment to which the person is entitled.

(4) Prepare or make any written or oral statement, intended to be presented to any insurer or producer for the purpose of obtaining a motor vehicle insurance policy, that the person to be the insured resides or is domiciled in this state when, in fact, that person resides or is domiciled in a state other than this state.

(c) (1) Every person who violates paragraph (1), (2), (3), (4), or (5) of subdivision (a) is guilty of a felony punishable by imprisonment in the state prison for two, three, or five years, and by a fine not exceeding fifty thousand dollars ($50,000), or double the amount of the fraud, whichever is greater.

(2) Every person who violates paragraph (6), (7), (8), or (9) of subdivision (a) is guilty of a public offense.

(A) When the claim or amount at issue exceeds four hundred
dollars ($400), the offense is punishable by imprisonment in the state prison for two, three, or five years, or by a fine not exceeding fifty thousand dollars ($50,000) or double the amount of the fraud, whichever is greater, or by both that imprisonment and fine, or by imprisonment in a county jail not to exceed one year, by a fine of not more than ten thousand dollars ($10,000), or by both that imprisonment and fine.

(B) When the claim or amount at issue is four hundred dollars ($400) or less, the offense is punishable by imprisonment in a county jail not to exceed six months, or by a fine of not more than one thousand dollars ($1,000), or by both that imprisonment and fine, unless the aggregate amount of the claims or amount at issue exceeds four hundred dollars ($400) in any 12-consecutive-month period, in which case the claims or amounts may be charged as in subparagraph (A).

(3) Every person who violates paragraph (1), (2), (3), or (4) of subdivision (b) shall be punished by imprisonment in the state prison for two, three, or five years, or by a fine not exceeding fifty thousand dollars ($50,000) or double the amount of the fraud, whichever is greater, or by both that imprisonment and fine, or by imprisonment in a county jail not to exceed one year, or by a fine of not more than ten thousand dollars ($10,000), or by both that imprisonment and fine.

(4) Restitution shall be ordered for a person convicted of violating this section, including restitution for any medical evaluation or treatment services obtained or provided. The court shall determine the amount of restitution and the person or persons to whom the restitution shall be paid.

(d) Notwithstanding any other provision of law, probation shall not be granted to, nor shall the execution or imposition of a sentence be suspended for, any adult person convicted of felony violations of this section who previously has been convicted of felony violations of this section or Section 548, or of Section 1871.4 of the Insurance Code, or former Section 556 of the Insurance Code, or former Section 1871.1 of the Insurance Code as an adult under charges separately brought and tried two or more times. The existence of any fact that would make a person ineligible for probation under this subdivision shall be alleged in the information or indictment, and either admitted by the defendant in an open court, or found to be true by the jury trying the issue of guilt or by the
court where guilt is established by plea of guilty or nolo contendere or by trial by the court sitting without a jury.

Except when the existence of the fact was not admitted or found to be true or the court finds that a prior felony conviction was invalid, the court shall not strike or dismiss any prior felony convictions alleged in the information or indictment.

This subdivision does not prohibit the adjournment of criminal proceedings pursuant to Division 3 (commencing with Section 3000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code.

(e) Except as otherwise provided in subdivision (f), any person who violates subdivision (a) or (b) and who has a prior felony conviction of an offense set forth in either subdivision (a) or (b), in Section 548, in Section 1871.4 of the Insurance Code, in former Section 556 of the Insurance Code, or in former Section 1871.1 of the Insurance Code shall receive a two-year enhancement for each prior felony conviction in addition to the sentence provided in subdivision (c). The existence of any fact that would subject a person to a penalty enhancement shall be alleged in the information or indictment and either admitted by the defendant in open court, or found to be true by the jury trying the issue of guilt or by the court where guilt is established by plea of guilty or nolo contendere or by trial by the court sitting without a jury. Any person who violates this section shall be subject to appropriate orders of restitution pursuant to Section 13967 of the Government Code.

(f) Any person who violates paragraph (3) of subdivision (a) and who has two prior felony convictions for a violation of paragraph (3) of subdivision (a) shall receive a five-year enhancement in addition to the sentence provided in subdivision (c). The existence of any fact that would subject a person to a penalty enhancement shall be alleged in the information or indictment and either admitted by the defendant in open court, or found to be true by the jury trying the issue of guilt or by the court where guilt is established by plea of guilty or nolo contendere or by trial by the court sitting without a jury.

(g) Except as otherwise provided in Section 12022.7, any person who violates paragraph (3) of subdivision (a) shall receive a two-year enhancement for each person other than an accomplice who suffers serious bodily injury resulting from the vehicular collision or accident in a violation of paragraph (3) of subdivision (a).
(h) This section shall not be construed to preclude the applicability of any other provision of criminal law or equitable remedy that applies or may apply to any act committed or alleged to have been committed by a person.

(i) Any fine imposed pursuant to this section shall be doubled if the offense was committed in connection with any claim pursuant to any automobile insurance policy in an auto insurance fraud crisis area designated by the Insurance Commissioner pursuant to Article 4.6 (commencing with Section 1874.90) of Chapter 12 of Part 2 of Division 1 of the Insurance Code.

CALIFORNIA CODES
LABOR CODE
SECTION 3820-3823

3820. (a) In enacting this section, the Legislature declares that there exists a compelling interest in eliminating fraud in the workers' compensation system. The Legislature recognizes that the conduct prohibited by this section is, for the most part, already subject to criminal penalties pursuant to other provisions of law. However, the Legislature finds and declares that the addition of civil money penalties will provide necessary enforcement flexibility.

The Legislature, in exercising its plenary authority related to workers' compensation, declares that these sections are both necessary and carefully tailored to combat the fraud and abuse that is rampant in the workers' compensation system.

(b) It is unlawful to do any of the following:

(1) Willfully misrepresent any fact in order to obtain workers' compensation insurance at less than the proper rate.

(2) Present or cause to be presented any knowingly false or fraudulent written or oral material statement in support of, or in opposition to, any claim for compensation for the purpose of obtaining or denying any compensation, as defined in Section 3207.

(3) Knowingly solicit, receive, offer, pay, or accept any rebate, refund, commission, preference, patronage, dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for soliciting or referring clients or patients to obtain services or benefits pursuant to Division 4 (commencing with Section 3200) unless the payment or receipt of
consideration for services other than the referral of clients or patients is lawful pursuant to Section 650 of the Business and Professions Code or expressly permitted by the Rules of Professional Conduct of the State Bar.

(4) Knowingly operate or participate in a service that, for profit, refers or recommends clients or patients to obtain medical or medical-legal services or benefits pursuant to Division 4 (commencing with Section 3200).

(5) Knowingly assist, abet, solicit, or conspire with any person who engages in an unlawful act under this section.

(c) For the purposes of this section, "statement" includes, but is not limited to, any notice, proof of injury, bill for services, payment for services, hospital or doctor records, X-ray, test results, medical-legal expenses as defined in Section 4620, or other evidence of loss, expense, or payment.

(d) Any person who violates any provision of this section shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not less than four thousand dollars ($4,000) nor more than ten thousand dollars ($10,000), plus an assessment of not more than three times the amount of the medical treatment expenses paid pursuant to Article 2 (commencing with Section 4600) and medical-legal expenses paid pursuant to Article 2.5 (commencing with Section 4620) for each claim for compensation submitted in violation of this section.

(e) Any person who violates subdivision (b) and who has a prior felony conviction of an offense set forth in Section 1871.1 or 1871.4 of the Insurance Code, or in Section 549 of the Penal Code, shall be subject, in addition to the penalties set forth in subdivision (d), to a civil penalty of four thousand dollars ($4,000) for each item or service with respect to which a violation of subdivision (b) occurred.

(f) The penalties provided for in subdivisions (d) and (e) shall be assessed and recovered in a civil action brought in the name of the people of the State of California by any district attorney.

(g) In assessing the amount of the civil penalty the court shall consider any one or more of the relevant circumstances presented by any of the parties to the case, including, but not limited to, the following: the nature and seriousness of the misconduct, the number of violations, the persistence of the misconduct, the length of time over which the misconduct occurred, the willfulness of the defendant'
s misconduct, and the defendant's assets, liabilities, and net worth.

(h) All penalties collected pursuant to this section shall be paid to the Workers' Compensation Fraud Account in the Insurance Fund pursuant to Section 1872.83 of the Insurance Code. All costs incurred by district attorneys in carrying out this article shall be funded from the Workers' Compensation Fraud Account. It is the intent of the Legislature that the program instituted by this article be supported entirely from funds produced by moneys deposited into the Workers' Compensation Fraud Account from the imposition of civil money penalties for workers' compensation fraud collected pursuant to this section. All moneys claimed by district attorneys as costs of carrying out this article shall be paid pursuant to a determination by the Fraud Assessment Commission established by Section 1872.83 of the Insurance Code and on appropriation by the Legislature.

3822. The administrative director shall, on an annual basis, provide to every employer, claims adjuster, third party administrator, physician, and attorney who participates in the workers' compensation system, a notice that warns the recipient against committing workers' compensation fraud. The notice shall specify the penalties that are applied for committing workers' compensation fraud. The Fraud Assessment Commission, established by Section 1872.83 of the Insurance Code, shall provide the administrative director with all funds necessary to carry out this section.

3823. (a) The administrative director shall, in coordination with the Bureau of Fraudulent Claims of the Department of Insurance, the Medi-Cal Fraud Task Force, and the Bureau of Medi-Cal Fraud and Elder Abuse of the Department of Justice, or their successor entities, adopt protocols, to the extent that these protocols are applicable to achieve the purpose of subdivision (b), similar to those adopted by the Department of Insurance concerning medical billing and provider fraud.

(b) Any insurer, self-insured employer, third-party administrator,
workers' compensation administrative law judge, audit unit, attorney, or other person that believes that a fraudulent claim has been made by any person or entity providing medical care, as described in Section 4600, shall report the apparent fraudulent claim in the manner prescribed by subdivision (a).

(c) No insurer, self-insured employer, third-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person that reports any apparent fraudulent claim under this section shall be subject to any civil liability in a cause of action of any kind when the insurer, self-insured employer, third-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person acts in good faith, without malice, and reasonably believes that the action taken was warranted by the known facts, obtained by reasonable efforts. Nothing in this section is intended to, nor does in any manner, abrogate or lessen the existing common law or statutory privileges and immunities of any insurer, self-insured employer, third-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person.
WEBSITES

The following websites may be of assistance when trying to obtain public information about a claimant during the investigative process:

Social networking sites:

www.facebook.com
www.myspace.com

While there are a number of different social networking websites available, Facebook and Myspace have a large user network and are a great place to start looking for a claimant. It is important that when the investigator signs up for an account on one of these sites that they use their true identity and company e-mail address. The investigator should not create a false identity and try and pretext the claimant. The investigator should only view information that is public and should not attempt to initiate contact/develop a relationship with the claimant. If the investigator is unable to view the claimant’s page because it is set to “private” there is still valuable information that the investigator could take away from the page. If the claimant has posted a photograph, it could be of use when trying to identify the claimant for surveillance purposes. Some sites will also tell you the last time that the user logged on even if their page is set to private.

State websites:

California Business Search
http://kepler.ss.ca.gov/list.html

Medical Board
http://www.medbd.ca.gov/lookup.html - physician search
http://www2.dca.ca.gov/pls/wllpub/wllqryna$lcev2.startup?p_qte_code=FNP&p_qte_pgm_code=6301 – Fictitious Name Permit search for medical facilities

Inmate/Offender Finder:

Alameda County
http://www.acgov.org/sheriff_app/

Calaveras County

Colusa County

El Dorado County
http://www.co.el-dorado.ca.us/sheriff/jail/jail_datalist.asp?cmd=reset

Fresno County
http://www.fresnosherriff.org/InmateInfoCenter/Main.aspx

Glenn County
http://www.countyofglenn.net/govt/departments/jail/resources.aspx

Kern County
http://www.kernsheriff.com/misc/inmatesearch/Pages/default.aspx

Kings County
http://www.countyofkings.com/sheriff/jail/detentions.html

Lake County
http://lakesheriff.com/searchinmates.asp

Los Angeles County
http://app4.lasd.org/iic/ajis_search.cfm

Madera County
http://63.192.182.24/search.aspx

Marin County
http://www.co.marin.ca.us/depts/SO/bklog/XMLProj/index.asp

Napa County
http://www.co.napa.ca.us/GOV/Departments/DeptPage.asp?DID=24500&LID=1274

Nevada County
Orange County
http://www.ocsd.org/e_services/whosinjail/

Placer County
http://www.placer.ca.gov/jail/jailreports/incustody_BN.htm

Riverside County
http://inmate1.riversidesheriff.org/iis/

Sacramento County
http://www.sacsheriff.com/inmate_information/

San Bernardino County

San Diego County
http://apps.sdsheriff.net/wij/wij.aspx

San Joaquin County

Santa Clara County
http://eservices.sccgov.org/ovr/find_inmate.do

Santa Cruz County
http://sccounty01.co.santa-cruz.ca.us/SHF/InmateLocator/default.aspx

Shasta County
http://www.co.shasta.ca.us/html/In_Custody/incustody_disclaimer.aspx

Siskiyou County
http://www.co.sisqjustice.ca.us/jail/incustody_disclaimer.htm

Solano County
http://www.co.solano.ca.us/depts/sheriff/pubinfo/jail_booking_logs.asp

Stanislaus County
http://www.stanislaussheriff.com/dailybookings/index.htm
Sutter County
http://www.co.sutter.ca.us/apps/inmates/index.aspx

Tehama County
http://www.tehamaso.org/inmates/ICURRENT.HTM

Ventura County

Yuba County
http://sheriff.co.yuba.ca.us/custody/default.aspx

Yolo County
http://www.yoloshерiffs.com/bookstats.html
Training Ideas

Per the California SIU Regulations Section 2698.39, the SIU is required to administer anti-fraud training to all integral anti-fraud personnel for an insurance company within ninety days of an employee commencing employment and annually for all employees. The presentation contained in Appendix A can be used a framework for new hires, and the presentation contained in Appendix B can be used as a framework for annual training. The investigator should add additional relevant material to each presentation. The presentations are simply meant to serve as a starting point for the investigator.
California SIU Regulations

The link below will take you to the page that contains the Special Investigative Unit Regulations. These regulations have been in effect since October 7, 2005. These regulations define the Department of Insurance’s expectations of the SIU. It is a great document for a new investigator to review to understand their role and what is expected from Department of Insurance:

http://www.insurance.ca.gov/0300-fraud/upload/revised_siu_regs.pdf
California SIU Annual Report

The link below will take you to the page that contains the SIU Annual Compliance Report that each SIU must file with Department of Insurance.


As stated on the website: The SIU Annual Compliance Report describes your anti-fraud operations as mandated by California Code of Regulations (CCR), Title 10, §2698.30 - .43. These regulations require licensed California insurers to submit an annual report. Complete the downloadable report and attach all of the required information. The report must be signed by an officer of the holder of or applicant for the Insurer's California Certificate(s) of Authority.

Typically, the manager will complete this report; however, it is important for the SIU investigator to review the report to gain a greater understanding of how their referrals, reporting, training (presented and attended) impacts the overall compliance of the SIU.
Personal Development Opportunities

Per the Department of Insurance SIU regulations Section 2698.39 (3), the SIU investigator is charged with receiving continued anti-fraud training. This can be accomplished through a myriad of different ways, including: attending law enforcement seminars, investigative conferences and also through personal development. Below are three websites that contain training information for the investigator:

http://aeiclaimslaw.com/

AEI Claims Law contains several different programs that upon successful completion, lead to designations that are recognized within the insurance industry.

http://www.acfe.com/

Association of Certified Fraud Examiners contains information about the Certified Fraud Examiner designation that is widely recognized amongst those who investigate financial crimes.

http://www.nicta.org/default.html

The National Insurance Crime Training Academy contains different training modules for a variety of investigative skill levels.
APPENDICES
Slide 1:

Anti-Fraud Training

To be administered within the first 90-days of employment

Slide 2:

Today you will learn about:

- The function and purpose of the SIU
- Overview of fraud detection
- Referral of suspected insurance fraud to the SIU for investigation
- A review of DOI Fraud Division reporting requirements
- SIU organizational chart
- SIU contact telephone numbers
Slide 3:

SIU: Function and Purpose

- Investigate suspected insurance fraud
- Refer suspected fraudulent claims to State
- Train integral anti-fraud staff
- Uncover the truth

Slide 4:

Fraud Detection

- Integral anti-fraud personnel are responsible for identifying suspected insurance fraud during the handling of insurance transactions and referring it to the SIU as part of their regular duties
- Things to look for:
  - Patterns or trends of possible fraud
  - Red flags
  - Events or circumstances present on a claim
  - Behavior or history of person(s) submitting a claim or application
Slide 5:

Referral to the SIU

• (Insert company specific guidelines for how to refer to the SIU in this section)

Slide 6:

DOI Reporting Requirements

• California Insurance Code (CIC) Section 1872.4 requires companies licensed to write insurance in California to submit this form WITHIN:
  – 60 DAYS after determining that a claim appears to be fraudulent.
  – CIC Section 1877.3 further requires reporting of suspected fraudulent Workers’ Compensation claims to BOTH the CDI Fraud Division and the local District Attorney’s Office WITHIN 30 DAYS.
Slide 7:

SIU Organization Chart

• (Insert internal SIU organization chart here)

Slide 8:

SIU Contact Information

• (Insert internal contact information here)
APPENDIX B

Slide 1:

Annual Anti-Fraud Training

Slide 2:

Today we will discuss:

• Function and Purpose of the SIU
• Review written SIU procedures regarding
  • Identification,
  • Documentation; and,
  • Referral of suspected fraud to the SIU
• ID and recognition of red flags
• DOI reporting requirements
• Fraud trends
Slide 3:

SIU: Function and Purpose

• Investigate suspected insurance fraud
• Refer suspected fraudulent claims to State
• Train integral anti-fraud staff
• Uncover the truth

Slide 4:

Identification, documentation and referral of suspected fraud:

• (Please refer to internal SIU guidelines)
Slide 5:

Elements of Fraud

• Materiality
• Intent
• Lie
• Knowledge

Slide 6:

DOI reporting requirements

• California Insurance Code (CIC) Section 1872.4 requires companies licensed to write insurance in California to submit this form WITHIN:
  – 60 DAYS after determining that a claim appears to be fraudulent.
  – CIC Section 1877.3 further requires reporting of suspected fraudulent Workers’ Compensation claims to BOTH the CDI Fraud Division and the local District Attorney’s Office WITHIN 30 DAYS.
Slide 7:

Trends

• (A good place to find information on emerging trends is your local Department of Insurance or District Attorney’s insurance fraud unit)
REFERENCES


California Labor Code, Section 3820-3823.

California Insurance Code, Section 1871-1871.9.

California Penal Code, Section 548 -551.


Rausch, E. (2009). Do we know what common sense is and, can we improve it if we don't? *Management Decision*, 47(3), 413 - 426.


Tennyson, S., & Salsas-Forn, S. (2002). Claims auditing in automobile insurance: 