

WorkCover SA

Claims Operational Guidelines

Chapter 15: Fraud

January 2013

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Chapter 15: Fraud

Fraud

Like all other similar schemes, WorkCover is exposed to exploitation by those in the community who undertake fraudulent activities. In respect of fraudulent activity, WorkCover:

- targets potential threat and risk areas to determine exposure and to review procedures to ensure that proper controls are in place and working effectively - this may involve the use of information held by the claims agent and WorkCover
- tests the validity of claims
- determines if there are patterns emerging that require specific investigation
- rigorously pursues those instances when there are grounds to suspect that fraudulent activity is occurring or has occurred
- publishes details of prosecutions where appropriate - this will make the community aware of WorkCover's attitude towards fraud and the consequences of fraudulent activity.

These measures combine to form a preventative approach to fraud ie, an approach which actively aims to minimise the opportunities and to discourage persons from committing fraud.

Definition of fraud

Fraud means activities undertaken by a person or persons to deceive, avoid liabilities, or obtain benefits or other entitlements for which there is no legitimate justification.

The definition used by WorkCover describes fraud as 'obtaining by deception or dishonest means money or any other benefit'.

It must be remembered that in the legislative context fraud is a criminal offence and the onus of proof lies with WorkCover to prove any allegation beyond reasonable doubt.

Worker fraud

WorkCover believes worker fraud falls into two categories:

- The first category is where the worker does not have a compensable injury or has an injury that does not fall within the ambit of the Act ie, it did not arise out of or in the course of employment. For example, the worker sustained no injury but feigns the symptoms to seek compensation or, alternatively, received an injury during a football match and then claims it occurred at work. In this circumstance there is a clear intent by the person to obtain a benefit to which they are not entitled. This type of fraud, if proven, invalidates the whole claim.
- The second category is referred to as 'situation fraud'. This type of fraud occurs when the worker has a compensable injury but at some time during the management of their claim, they obtain benefits to which they are not entitled, by misleading. This can occur by misleading the case manager in regard to their entitlement for such benefits. For example, the worker may return to employment while claiming full

compensation or may claim for home help when they are capable of doing it themselves. While there is still intent by the injured worker to deceive, this fraud does not invalidate the whole claim.

Examples of worker fraud offences under the Act are:

- claiming for an injury that does not exist
- claiming for an injury that is not related to employment or did not occur out of or in the course of employment
- claiming weekly payments while earning income from other employment and failing to advise their claims manager
- falsely altering medical certificates to obtain compensation or greater benefit
- providing false information in relation to a claim for compensation
- substantial activity contradicting medical certificates/reports (exaggeration of an injury or incapacity).

Employer fraud

Employer fraud may fall under the following descriptions:

- Understating remuneration including 'cash-in-hand' payments
- Employer continues to claim income maintenance reimbursement after injured worker returns to work
- An employer claiming income maintenance reimbursement having paid the worker a lesser amount
- Employer coerces worker to make false or misleading statements

Provider fraud

Provider fraud may fall under the following descriptions:

- Misuse of provider number
- Misuse of item number
- Aiding and abetting
- Collusion
- Charging for services that have not been rendered

Other

General witnesses to workers compensation matters can also commit offences by providing false or misleading information during investigations.

Investigation Unit

The role of WorkCover's Investigation Unit is to manage the identification, prevention, investigation and subsequent prosecution of any fraudulent activity.

All cases of suspected fraud must be referred to WorkCover's Investigation Unit who will make an assessment and commence an investigation if appropriate.

The Investigation Unit is responsible for the management of investigations of suspected dishonesty and non-compliance and any other matters considered necessary by the manager, Investigations.

The activities of the Investigation Unit will, in the majority of cases, have minimal impact on the day to day conduct of claims by the agent.

To investigate suspected fraudulent activities, WorkCover's Investigation Unit:

- has unrestricted access to information held by the agent (information should only be released to WorkCover's Investigation staff or approved service provider)
- has direct access to agency staff at all levels
- has authority to conduct such lawful investigations as are necessary to prevent and detect fraud and to institute legal proceedings
- during a fraud investigation or prosecution, through consultation with the agent, may recommend that a particular course of action be taken.

The Investigation Unit contracts investigations to approved service providers. The approved service provider will be authorised to make enquiries and obtain information on behalf of WorkCover.

The Investigation Unit will recommend amendments to forms, work systems, legislation and training that will help to minimise the incidence and effect of fraudulent activity.

Any dispute regarding the powers of the Investigation Unit will ultimately be referred to the Chief Executive Officer of WorkCover for arbitration.

Detecting and reporting suspected fraud

Potential offences are identified by three main sources:

1. the claims agent during the management of a claim
2. referrals and allegations made by other sources, including employers, workmates, family, neighbours and the public in general
3. WorkCover's Compliance unit through analysis of data and trends.

The vigilance of all claims staff is vital to help prevent, detect and control fraud. Any behaviour that is unusual or suspicious should be referred to the Investigation Unit in line with the agent's reporting procedure, and at least within five business days.

In relation to the reporting of fraud:

- all telephone calls and correspondence alleging fraud must be directed to the Investigation Unit
- any staff member suspecting fraudulent activities will ensure that the information is passed on to the Investigation Unit in accordance with Claims Management Agreement using the referral form in Curam.
- where suspicion is attached to the agent or staff member, the matter must be reported directly to the:
 - Manager, Investigation Unit, or
 - designated officer within the agency
- all information provided to the Investigation unit will be kept confidential unless its release is compelled by Commonwealth or state legislation.

Non-compliance

There are some matters that are not fraud but are referred to as compliance issues, where an individual or organisation has not strictly complied with an instruction, requirement or order but there is no intent to defraud. It is WorkCover's view that this type of activity is often characterised by the public as fraud, which it is not.

The Investigation Unit is charged with the responsibility of investigating non-compliance issues that cannot be remedied by normal business processes (eg, an employer fails to register after being requested on a number of occasions to comply).

Some examples of non-compliance breaches are:

- employer unregistered
- deducting premium from employee's wages
- employer refuses to lodge a claim or lodges a claim outside the prescribed period
- employer enters into an agreement with an employee to avoid the Act - employer informs employees they are not covered by WorkCover and suggests employees are responsible for their own cover
- a person who fails to maintain confidentiality
- a person who hinders or obstructs an authorised officer.

Indicators of possible fraud

There is no 'typical individual' who commits fraud. Employers, workers, service providers, agency and corporation staff are in a position to act alone or together in a manner designed to defraud WorkCover. However, it is important to remember that the large majority of persons dealing with the claims agent or WorkCover are honest.

The following indicators may provide a guide for detecting possible worker fraud:

Timing of report

The alleged injury occurs first thing on Monday morning, or late Friday afternoon, and is not reported until Monday without a credible explanation. Be conscious of sporting injuries.

Employment change

The reported incident occurs immediately before or after an industrial dispute, job termination, lay-off, end of a big project, at the conclusion of seasonal work or the injured worker is a short-term or contract employee and there is insufficient information to demonstrate that the injury arose from employment.

No witness or a witness of questionable character

The incident has no witnesses and the injured worker's own description does not logically support the cause of the injury; or the witness has a poor record with compensable injuries and provides a questionable version of the incident.

History of claims

The injured worker has a history of numerous suspicious claims, or the medical provider or legal consultant has a past history of handling suspect claims.

Late reporting

The worker's description of the incident conflicts with the medical history; or the employer's first report of the claim or circumstances described does not fit the injury or location, or differing descriptions of how the injury occurred are provided to different people.

Hard to contact

Case manager has difficulty contacting the worker at home when they are allegedly incapacitated. Their partner or another family member is the contact person for the injured employee. An answering machine is another way of covering the fact that a worker is continually absent from home.

Treatment

The injured worker refuses a diagnostic procedure to confirm the nature or extent of the injury, or travels to seek medical treatment in another area from his/her home or workplace without a credible reason. Be conscious of the injured worker who has no ongoing treatment.

Disgruntled employee

The injured worker is about to be or has been retrenched, demoted or passed over for promotion.

Referral or tip off

Information is received from a co-worker, spouse, domestic partner, friend or any other source.

Work history

The injured worker has a history of unstable employment or drug and alcohol abuse, or has a poor attendance or sick leave record and there is insufficient information to demonstrate that the injury arose from employment.

Claim investigation authorities

The claims agent has the delegated authority to investigate claims within its control excluding suspected fraud. WorkCover, however, issues section 110 authorities.

The claims agent may request a section 110 authority by forwarding a completed application form to the Investigation Unit.

Before applying for the issue of a section 110, consider the following:

- Is the information really necessary and is it likely to make a difference?
- Is the information requested already contained in the claims file?
- Is it necessary to engage the services and incur the cost of an investigator to obtain the information?
- Have other methods of obtaining the information been exhausted?

Investigations that require a section 110 authority can only be conducted by approved service providers.

Further information needed

In most cases when a claim is received, the agent will have sufficient information on which to determine the claim. Sometimes, however, further information will be required. Medical reports or information relative to a worker's entitlement under the Act may be sought in order to accept or reject the claim.

Section 53(1) and (2) authorise the agent to make investigations and request medical examinations.

Claims that should be investigated

There are types of claims that present difficulties in many instances in establishing eligibility for compensation pursuant to section 30 of the Act. The cost potential of these claims may also be considerable; therefore, verification of the circumstances surrounding the claim is highly desirable.

Generally the following types of claims should be referred for investigation if the case manager believes current information needs to be verified, or further information is necessary to assist in the determination or management of the claim:

- death of the worker
- stress and anxiety
- working director
- heart attack, stress and cerebral haemorrhage
- disease claims (including those referred to in the Second Schedule)
- hearing loss claims
- journey claims where there is possible substantial deviation or interruption, or where the deviation or interruption materially increased the risk of injury to the worker
- where doubt exists about whether the worker is a 'worker' under the Act
- transitional injury claims (refer First Schedule)

- situations described in section 30 (3) and (4)
- where the agent is notified by the employer that the employer is disputing the claim
- conflicting details provided by the employer and worker (only where the agent has already tried unsuccessfully to resolve the inconsistencies)
- allegations against the worker of serious and wilful misconduct
- where recovery potential from third parties is identified
- claims lodged outside the prescribed period ie, six months (it should be noted that in these situations a claim will not be invalid if the failure to make a claim resulted from ignorance, mistake or absence from the state of the worker - reasonable enquiries should be made prior to referring the matter for investigation)
- domestic workers
- territorial issues under section 6 of the Act

Fraud or suspected fraud should be immediately referred to the WorkCover Investigation Unit.

Factual investigations

The agent has the delegated authority to investigate claims within its control excluding suspected fraud and it must select an approved service provider to carry out this function.

To assist the agent, a system generated standard referral/instruction letter is provided. The following guidelines should be considered when allocating a factual investigation:

Investigation objectives

Outline what you want the investigation to achieve (eg, take photographs of the accident scene, obtain statements from nominated persons, obtain sufficient information to determine if the worker is a worker under the Act).

Points of interest

Critical information that the investigator should know to allow them to provide the best outcome for the investigation, eg, background to the investigation, previous injuries/employment, legal representation or any other details that may impact the enquiry.

Referral to WorkCover Investigation Unit

In the event that potential fraudulent activity is identified by the claims agent or investigation company, the matter must be referred to the Investigation Unit within five working days of becoming aware of the potential fraud.

The claims agent should be aware that if the investigation requires a section 110 authority.