Reducing Insurance Fraud – The Indicators Can Help Point You in the Right Direction

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The Coalition Against Insurance Fraud estimates at least $80 billion in fraudulent claims are made annually in the United States. According to the National Insurance Crime Bureau, estimates by the insurance industry indicate that 10 percent or more of property-casualty claims may be fraudulent. This results in higher insurance rates, increased taxes and inflated prices for consumer goods.

So, what can you do?

Understanding what fraud is, conducting a thorough investigation at the onset of a claim, and identifying and reporting indicators of possible fraudulent activity in claims are essential in the fight against insurance fraud.

Fraud can be defined as a false statement of a material matter, willfully made with intent to deceive. For criminal cases in Florida, each of these elements must be proven beyond a reasonable doubt. The threshold that applies to civil cases in Florida is preponderance of evidence. It's critical to recognize that the false statement (misrepresentation) *must* be material to the claim.

Just because a claimant makes a false statement or misrepresents something in the course of the claim does not mean he or she is guilty of insurance fraud. The false statement or misrepresentation must be material to that claim, e.g., a claimant injures his low back and denies ever having previous low-back injuries, when he has had three in the past few years.

Conducting a thorough investigation at the onset of a claim is a very important part of identifying suspected fraud. The claimant's description of the accident and/or accident report form provides an account of what happened in his or her own words. Obtaining witnesses accounts or statements while the event is still fresh in their minds can provide an accurate description of what occurred.

Any video documentation such as police dashboard cameras or similar footage should be preserved. Photographs of the accident scene, claimant and the alleged injuries can document what occurred and might be useful later for an accident reconstruction. Known pre-existing injuries or conditions should be documented.

Thorough and effective hiring practices, including background checks, and knowing the work status of the claimant may help thwart fraudulent activity relative to workers' compensation claims.

Being able to identify indicators of potential fraudulent activity in claims and reporting them to the claims adjuster or the Special Investigation Unit (SIU) is one of the most important steps you can take.

Some common indicators of possible fraudulent activity in workers' compensation claims include:

- Monday morning or Friday afternoon unwitnessed accidents.
- The claimant was recently hired.

- The accident occurred prior to layoff or termination.
- The claimant is disgruntled or soon to retire.
- There is a conflict in accident description between the employer's report, claimant's statement and initial medical evaluation.
- There is difficulty reaching the claimant at home during normal daytime hours when the claimant is on a no work or light duty status.
- Medical provider work status forms appear altered.
- The claimant is active on social media.
- The claimant has known pre-existing injuries or conditions related to the injured body part(s).
- The claimant has immediate attorney representation.

Some common indicators of possible fraudulent activity in liability claims include:

- The claimant has immediate attorney representation.
- The claimant is unusually familiar with insurance terms and procedures, medical and/or vehicle repair terminology.
- The claimant is pushing for a quick settlement.
- The claimant's documented injuries appear exaggerated or grossly out of proportion to a minor accident.
- The claimant is active on social media.
- There are varying accounts of the accident description between the claimant and witnesses.

The presence of one or more of these indicators is not evidence of a fraudulent claim or proof that insurance fraud has been committed. Rather, the presence of indicators suggests the claim warrants further investigation by the adjuster and/or the SIU.

When a claim is referred to the SIU for suspected fraud, a thorough investigation is conducted. This includes an in-depth background check of the claimant and a complete review of the claim file. If evidence supports suspected fraud, a referral is made to the Florida Department of Financial Services, Division of Investigative and Forensic Services (DIFS). The DIFS conducts an independent review or investigation and refers likely prosecutable case to the local state attorney's office.

Simultaneously, remedies may be undertaken in the civil court (Office of the Judges of Compensation Claims – workers' compensation claims) for litigated claims involving suspected fraudulent activity.

Claimants charged with insurance fraud can face criminal conviction and restitution; termination of claim or benefits; reduced or mitigated settlement amounts; modified physician's medical orders (workers' compensation); and modified judge's orders (workers' compensation).

For cases it has recently referred to the DIFS, the League's SIU has seen a trend in claimants providing false testimony or misrepresentations regarding prior medical conditions, physical problems, injuries and treatment to the same body part(s) that they are claiming were injured as a result of their accident. The false statements or misrepresentations usually occur in recorded statements, depositions or to medical providers.

However, insurance fraud comes in many shapes and forms. The League's SIU has also referred cases to DIFS involving video documentation (surveillance) that is contrary to medical documentation or testimony; false submission of mileage statements, attendant care forms and employee earnings reports (workers' compensation); and altered medical provider work status forms (workers' compensation).

Employers, co-workers and taxpayers must pay the price for this very costly white-collar crime. Hopefully, these tips will help your city reduce its exposure to fraudulent insurance claims.

The Special Investigation Unit (SIU) was created by the Florida League of Cities to investigate suspected fraudulent claims against members of the Florida Municipal Insurance Trust. The SIU, housed in the Legal Department in Tallahassee office, is staffed by a manager, investigator analysts and an assistant. Collectively, the SIU team has approximately 40 years of investigative experience. Since its inception in 1999, the SIU's efforts have resulted in more than $7.3 million in estimated cost savings, approximately $2.1 million in court-ordered restitution and approximately $243 thousand in restitution collected.

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