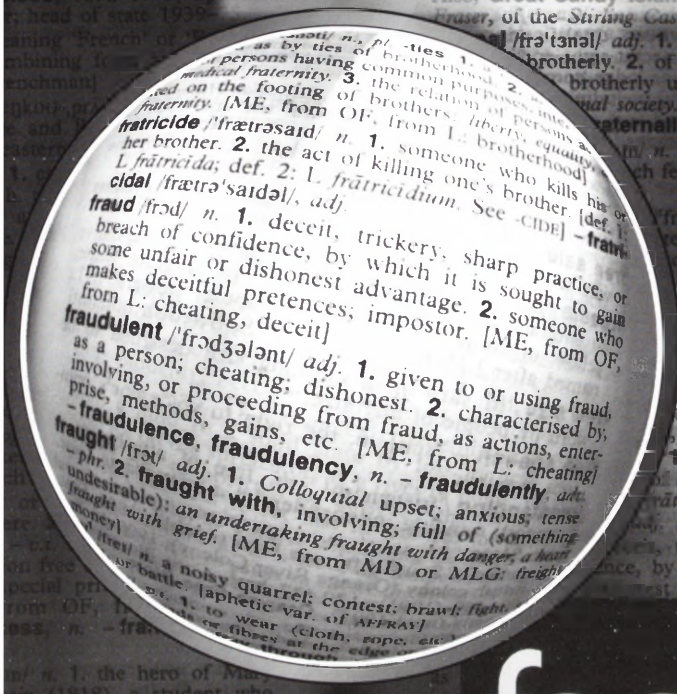
Workers compensation fraud: fact or *fiction*?



BY SIMON GARNETT, DANDENONG

There is a general perception that claimant fraud in the Australian Workers Compensation systems is rife and is a major cost which is ultimately borne by employers and the community in general.

Simon Garnett is a Partner at Ryan Carlisle Thomas, PO Box 913 Dandenong Vic 3175, **PHONE** (03) 9238 7878 **fax** (03) 9238 7825 **EMAIL** sgarnett@rct-law.com.au

Generally allegations of fraud against workers can be categorised as follows:

- claiming for an injury that does not exist
- claiming for an injury which has not arisen out of or in the course of employment
- claiming weekly payments whilst receiving other undeclared earnings
- altering medical certificates to obtain compensation or an increased benefit
- providing false information in relation to a claim for compensation
- substantial activity which contradicts medical certificates/reports

The perception of the "compo bludger" and "compo cheat" is reinforced by statements made by various groups as to the nature and extent of fraud in the system:[1]

"The insurance industry in general has rules of thumb as to the amount of fraud that occurs," says Comcare Australia's action CEO, Robert Knapp. "But it is the iceberg problem. You just do not know how much is above the surface. Any measurement is more in terms of what we catch with the difficulty being how much gets away."

The various compensation authorities and employer/insurance groups regularly publicise the issue of claimant fraud. The "Australian Safety News" published by The National Safety Council of Australia conducted a fraud survey in 1998 with employers.

The Cooney Report into the Victorian Workers Compensation System (1983-1984) received submissions of interested parties and it was the employer groups who were most trenchant in criticising the honesty and integrity of some involved in the making and prosecuting of injured workers' claims for compensation.

The Metal Trades Industry Association of Australia, in a submission to the Inquiry wrote:

> "There is...the sort of feeling at large in our industry, the system is there to be ripped off...That seems to be what our members perceive the system provides."

Mr Ken Crompton, who spoke to the Committee of Inquiry on behalf of the Victorian Chamber of Manufacturers said:

> "I was trying to make the point that there is an impression given to us from enough complaints around that a lot of claims are not genuine. There are no figures or evidence to prove it. If that feeling is about, what is the cause of it?"[2]

Most compensation systems in Australia now have an established fraud detection unit and all (except New South Wales) have specific legislative provisions relating to fraud:

One would assume from the statements above that claimant fraud is rife. What are the facts?

The facts

Inquiry Findings:

Despite the claims expressed by the insurance industry, employer groups and Workers Compensation authorities that there are widespread rorts and fraud by claimants, the 16 official inquiries into the various workers compensation schemes in Australia in the last 15 years have found no cogent evidence to support claims of widespread fraud, malingering and malpractice.

The Rowe Parliamentary Committee Report into the Victorian Workers Compensation System in August, 1988 recommended that quantified results of fraud detection should take due account of only reasonably calculated savings. Without such calculation safeguards, inflated monetary savings can be used to justify large and unnecessary increases in fraud investigation staff.[3]

On 21st April, 1994 the Commonwealth Industry Commission Report into Workers Compensation in Australia was released and simply stated:

"Clear cases of fraud should be subject to criminal prosecution."

The Commonwealth response was:

> "The Commonwealth supports the view that all compensation schemes should maintain and implement balanced fraud control strategies involving prevention, education and detection and prosecution of fraud in order to promote appropriate behaviour in the use of the schemes. Such strategies must ensure that prompt action is taken when fraud is detected, both to stop the fraud and to discourage others who may be inclined to commit similar conduct. The Commonwealth considers that all jurisdictions should maintain or implement, as appropriate, a separate legislative framework for the pursuit, by their compensation authorities, of claimed, employer and service provider fraud and over-servicing."

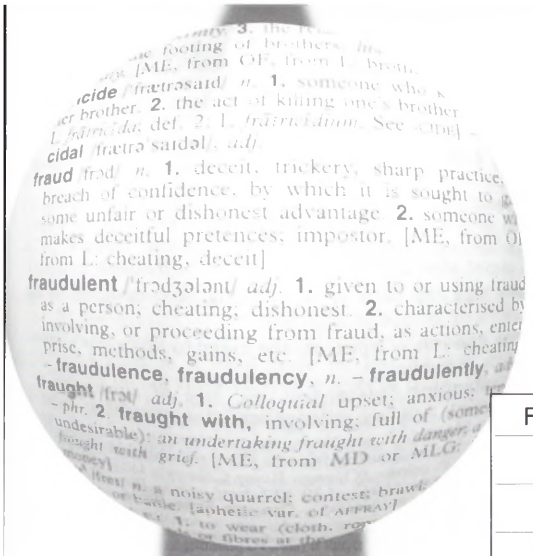
The 1996 Interim Report to the Labour Minister's Council by the Heads of Workers Compensation Authorities believed that there was a strong need for schemes to be able to share information for more operational purposes, particularly those related to fraud control.

> "This involves the exchange of information both between the various workers compensation schemes and between workers compensation schemes and a range of Federal agencies. The inter-jurisdictional exchange would primarily be to ensure that a claimant is not improperly attempting to access benefits from more than one system."[4]

The final recommendation was that State, Territory and Federal Workers Compensation legislation should be amended to allow the exchange of information between jurisdictions relevant to fraud control.[5]

It is interesting to note that the HWCA Report primarily was concerned with abuse by workers and no mention was made about employer or insurance company practices. The Kennedy Commission of Inquiry Report into the Queensland Compensation system also stated that it was not possible to calculate the extent of evasion[6] but it failed to investigate the nature and extent of rorting by employers.

All enquiries into the various compensation schemes have addressed the issue of fraud but have found that it is a negligible component of workers compensation. Not one Inquiry has found evidence of significant claimant fraud nor have any of the employer, insurer or workers compensation authorities been able to produce evidence to any inquiry that there is significant claimant fraud.



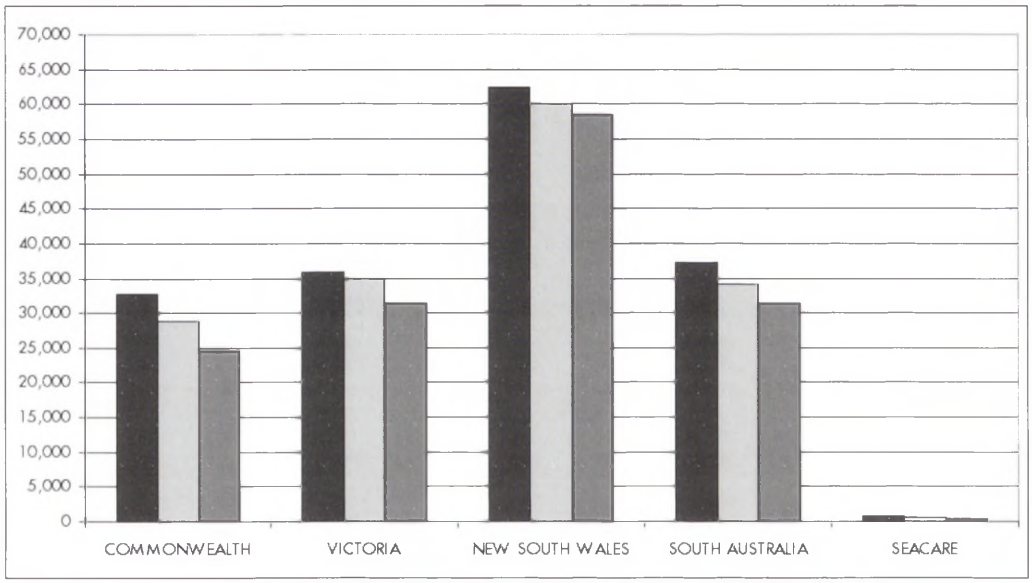
"(Employee) Fraud is a negligible component of workers compensation."

"There is undeniable evidence to suggest that employer fraud is a greater cost to the system"

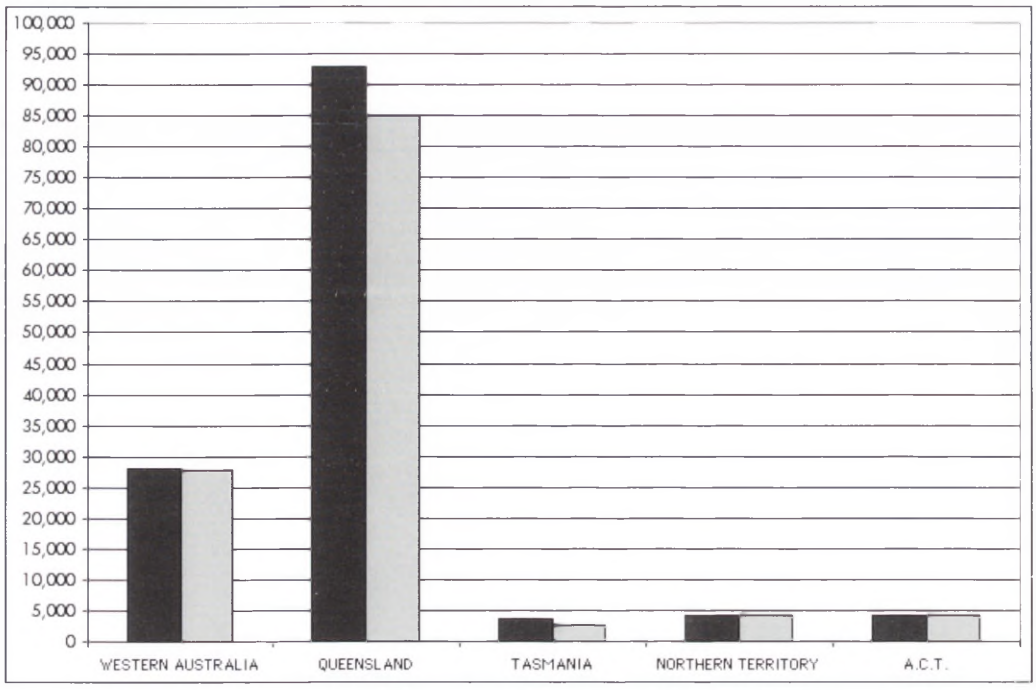
Statistics:

There are ten different Workers Compensation schemes which operate throughout Australia and which cover approximately 7 million workers. The number of reported claims in the financial years 1995/6 to 1997/8 were:[7]

Financial year	Cth	Vic	NSW	SA	Seacare
1995-96	32,796	35,827	62,469	37,167	702
1996-97	28,807	34,919	60,109	34,046	521
1997-98	24,532	31,369	58,604	31,317	365



Financial year	WA	Qld	Tas	NT	ACT
1995-96	28,115	93,008	3,638	4,070	4,317
1996-97	27,939	85,110	2,675	4,272	4,193
1997-98	27,470	79,686	2,553	4,334	4,297



There are approximately 275,000 reported Workers Compensation claims per year across Australia. Despite what the insurance industry, employer groups and compensation authorities may allege, the number of fraud prosecutions against claimants are small:

Victoria:[8]

Year	Number of Prosecutions
1996/7	11
1997/8	11
1998/9	12

Queensland:[9]

Year	Number of Prosecutions
1996/7	91
1997/8	92
1998/9	94

South Australia:[10]

Year	Number of Prosecutions
1996/7	21
1997/8	24
1998/9	17

New South Wales:[11]

Year	Number of Prosecutions
1996/7	3
1997/8	5
1998/9	5

ACT WorkCover, NT Work Health and the Western Australian Workers Compensation and Rehabilitation Commission were unable to provide any statistical information as their schemes are privately underwritten.

A more significant problem and the area where more resources should be directed is in the area of:

Employer fraud:

There is undeniable evidence to suggest that employer fraud is a greater cost to the system. Employer fraud can consist of:

- Incorrectly informing employees that they are not covered under the Act.
- Failing to declare remuneration/ wages for the purposes of evading or minimising an insurance premium.
- Failing to have workers compensation insurance.
- Failing to pass on a full benefit to a claimant.
- Deducting money from employees' wages for the purposes of contributing to their levy.
- Demanding an employee take sick leave or other leave entitlements for a work injury.
- Failing to submit a claim to the insurer.
- Requesting an employee to enter into a work agreement which does not reflect the true nature of the working relationship.

In 1996 the NSW Government conducted an amnesty on underpayment which produced a $15m improvement in compliance. The CFMEU (New South Wales branch) has recommended a stricter policing of employer premium compliance on building sites. Their investigations discovered many companies do not have workers compensation insurance and many others falsely declare wage levels or provide misleading information regarding industry classification to minimise premiums. According to Andrew Ferguson of the CFMEU non-compliance is between 30% and 60%.[12]

The Victorian WorkCover Authority has conducted audits of the remuneration declarations and WorkCover Industry Classifications of Victorian employers since 1995. In that time, the total number of audits conducted was approximately 21,000 of which 9821 employers complied, 4225 over-declared and 6860 employers under-declared, resulting in an underpayment of premium to the amount of *$41 million*.[13]

In the 1995/6 financial year in Victoria 11 employers were prosecuted for premium/levy offences.[14] Most of these cases involved the failure to obtain a workers compensation policy and pay the premium as well as a failure to pay a levy.

One employer was convicted not only of these offences but also of a failure to forward a workers claim to the insurer and providing false information.

In the 1996/7 financial year 6 employers were prosecuted, 4 of whom had no workers compensation insurance policy and in 1997/8, 4 were prosecuted for failing to register a business.[15]

In 1995/6 WorkCover Queensland identified a total of $1.87m in additional premium income from uninsured and underinsured employers and the Board obtained judgements against 320 employers.[16]

In the 1996/7 financial year WorkCover Queensland identified $2.65m in premiums owed by employers who had either under-declared their payroll for the purposes of being charged a lower premium or who were completely uninsured. This increased to $5m in the 1997/8 financial year and to $6.1m in the 1998/9 financial year.[17]

In the 1995/6 financial year WorkCover Western Australia contacted 23,500 businesses, 18% of which did not have a workers compensation insurance policy.

In 1996/7 16% of 18,000 contacted did not have a workers compensation insurance policy, which resulted in additional premium of over $500,000. The Compliance Section recorded an average 100 uninsured employers per month.

The report noted:

> "Anecdotal evidence from insurers and employers suggest concern over the possibility some employers may under declare the amount of wages paid in order to reduce their premium. Further investigation of this trend is under way. Trends over the last ten years suggest small businesses who engage part time, casual and contract workers have a greater tendency to be uninsured for workers compensation."

In 1997/8 financial year 16.9% of the 19,432 businesses contacted failed to have a workers compensation insurance policy, which resulted in additional premiums of $450,000.[18]

The Kennedy Report in Queensland mentioned that:

> "Some employers are rorting the system but that it was not possible to calculate the extent of the evasion."[19]

"Unofficial estimates of premiums evaded by employers is as high as $50m per annum. "[20]

A Performance Audit Report by Des Knight estimates that the value of outstanding premiums is $28.8m and $3m is lost each year in bad debts from employers.[21]

In June, 1999 Queensland ▶

WorkCover Chief Executive Tony Hawkins confirmed that:

"Some employers under-declare to save or defer on their insurance premiums" [22]

The Tasmanian Workplace Standards Authority Annual Report in 1997/8 noted an "extremely high level of compliance".[23]

WorkCover NSW reported that for the 30th June, 1997 to 30th June, 1998 policy year, licensed insurers completed 4,184 audits and recovered $4.9m in additional premium and WorkCover conducted 499 wage audits and recovered $741,482 for the same period.[24]

Recently the ACT Legislative Assembly convened the first Parliamentary Inquiry into employer fraud and premium evasion. In view of the loss of premium revenue to most schemes, all governments should consider similar inquiries!

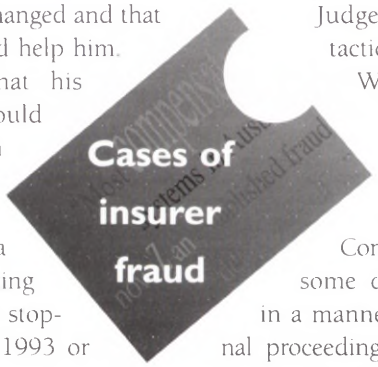
Insurer fraud

A significant amount of the costs involved in operating workers compensation schemes can be attributed to the conduct of insurance companies defending claims. Consider the following examples of questionable insurance conduct:

(a) In the Victorian County Court matter of *David McCubbin v MMI* (7-11-97) the worker was a shearer from the age of 18 until he ceased work at the age of 51 in 1990. On 3rd July, 1990 while shearing a very large ram, its horns locked around his legs causing him to fall sustaining an injury to his neck, back and left and right arms. His claim was accepted and he began to receive weekly payments until 27th September, 1993. On that date at the invitation of the insurer he attended a motel in Stawell and signed a document purporting to be a final settlement of his compensation entitlements for the sum of $8,000 pursuant to section 115 of the *Accident Compensation Act* 1985. The Court accepted the worker's evidence that prior to arriving at the motel he had no inkling as to the real purpose of the meeting or that settlement of his claim would be discussed. The two senior claims officers who attended the meeting gave evidence that they had previously attended a meeting with the Victorian WorkCover Authority concerning settlement of these claims and were directed to follow the Victorian WorkCover Authority Guidelines which state that:

"The settlement must be cost effective and ... Insurers must also ensure that each worker fully understands the terms of offer and a settlement including the non entitlement to future compensation and common law damages and appropriate verbal and written advice is given".

The worker gave evidence that he was told the law had changed and that they were to advise and help him. He was informed that his weekly payments would stop on 30th November, 1993 and that he had a chance of signing a piece of paper and getting $8,000 with payments stopping on 5th October, 1993 or he would get nothing.



He gave evidence that he was told that he was not entitled to legal advice and if he did go to Court he would have a "snowflake's chance in hell" of winning. The worker said he felt depressed and pressured and if he did not sign it there and then he would get nothing. The Court found the Insurer's conduct to be unconscionable and set aside the agreement.

(b) In the Victorian County Court matter of *Hill v FAI* (4 December 1997) the Plaintiff was assaulted by two men on 6th September, 1991 and sustained head injuries and consequential anxiety and depression. His claim was accepted and he received weekly payments. In January, 1993 as a result of negotiations with FAI he settled his claim pursuant to Section 115 for $6,000. The Court found that when the worker attended FAI's offices and signed the document he genuinely believed he was only settling his claim for weekly payments and not any lump sum entitlement. The Court found that the Claims Officer knew the Plaintiff was only concerned about weekly payments and made no attempt to disabuse the Plaintiff of his mistaken belief or to inform him of other possible entitlements. The agreement was set aside.

(c) In the Victorian County Court matter of *Fischer v Keys Road Clearance Centre* (11 December 1998). An injured worker who developed psychological stress from the intensity of the surveillance that the insurers, FAI, put him under prior to trial, was relentlessly called a liar and a fraud during his trial only to have the defence fail to produce any evidence to support their allegations. Judge Strong described the tactics used by the Victorian WorkCover Authority as, "amongst the most shameful things he had ever seen." The Judge also said, "Workers Compensation cases are to some degree being conducted in a manner more akin to a criminal proceeding where a person before the Court stands accused of some serious wrong doing".

(d) In the Victorian Supreme Court matter of *FAI Workers Compensation (Vic) Pty Ltd v Brewster* (15/10/1999), the worker lodged a claim for weekly payments which was rejected by the insurer on the grounds that the alleged injury did not arise out of or in the course of her employment. The insurer was required by law to set out in a notice the reasons for their decision and in doing so "incorrectly" quoted their doctor's opinion to the effect that he had said, "Your employment was not a significant contributing factor."

Counsel for the worker submitted that the notice was fraudulent...tainted by dishonesty and was false.

Counsel for the insurer submitted that it may have been "misleading" but it was not intended as deception. He ultimately conceded that the statement was grossly misleading.

The Judge at first instance reached the conclusion that the notice of rejec-

tion was, ..."a travesty, it being such a gross misrepresentation of the truth. I am not saying there is fraud...it is a big step to go that far..."

The Supreme Court on appeal agreed with the Magistrate's decision and description of what occurred as a "travesty". The Court held that the insurer acted ultra vires and therefore the insurer's decision, notice and reasons were invalid.

His Honour, Mr. Justice Smith, also went onto say that, "the Scheme imposes on the Authority or self-insurer an obligation to sit in judgment on claims made against it. It was not intended that the consideration of claims be a sham. Rather, the statutory scheme plainly depends upon a careful, reasoned and bona fide exercise of the statutory powers and duties given to and imposed upon the persons authorised to consider claims. It would make a mockery of the statutory scheme for a decision and a notice and reasons, like those in question in this case, to be accorded any validity."

Service provider fraud

This type of fraud generally occurs where a provider bills for a treatment that never occurred or over-services. The HWCA Interim Report found that the level of medical costs, as a percentage of total costs, varies between the schemes, ranging from around 13% to over 20% of workers compensation benefit expenditure. The final report recommends that only providers who meet minimum competency standards be accredited to practice in the Workers Compensation field[25] and that schemes enact legislative provisions giving power to remove the ability of a provider with aberrant performance patterns which continue after review, and following appropriate counselling, to practice within the system.[26]

The Cooney Report stated that the accusation of over-servicing is in effect an accusation of malpractice. The Committee of Inquiry did not pursue any formal investigation in this area. Dr McCubbery on behalf of the AMA submitted:

> "I believe that it is rather a scurrilous aspersion which has not been accompanied by appropriate documentation to justify it."[27]

In Victoria a medical peer review process began in 1995 which, according to the Victorian WorkCover Authority,[28] has led to a change in the servicing patterns of some providers. 17 physiotherapists, 7 chiropractors and 4 psychologists were investigated regarding the number of services per claim. In the 1996/7 financial year two providers were prosecuted, one for furnishing false information and the other for obtaining property by deception. In the 1997/8 financial year two providers were prosecuted, one for obstructing an investigation and the other for falsifying 44 invoices for treatment not provided.

Dubious activities of some providers actually resulted in legislative change in Victoria with the introduction of the Accident Compensation Act (Further Amendment) Bill in 1996. The following is an extract from the Minister's Second Reading speech: ▶

"Service provider fraud generally occurs where a provider bills for a treatment that never occurred,"

> "The activity of a number of organisations associated with the lodgement of hearing loss claims under the *Accident Compensation Act* 1985 are well known to Parliament. These companies prey on the elderly and those who have difficulty with English offering to lodge a claim for hearing loss for a fee. This Bill introduces provisions similar to those adopted by the New South Wales Parliament late last year which will provide penalties for companies and individuals who come within the definition of an agent for the purposes of the provisions and who engage in prohibited conduct as defined..."

U.S. experience:

Allegations made by the insurance industry, employer groups and compensation authorities against workers is not restricted to Australia. Greg Tarpinian in his article "Workers Comp Fraud: The Real Story" comments:[29]

> "Dramatic increases in workers compensation premiums throughout the late 1980's and early 1990's fuelled unsubstantiated charges that costs were high in part because workers abused the system, fraudulently collecting benefits for faked injuries or remaining on benefits far longer than their recovery required. The American Insurance Association estimated fraud losses at 10% of the cost of claims paid, or about $3b. The National Insurance Crime Bureau doubled the AIA's estimate to $6b, even though it was involved in only 99 fraud prosecutions in 1994 and 134 in 1995 nation wide. The Coalition Against Insurance Fraud adopted the AIA's estimate. One insurance company president put the cost of workers compensation fraud at $30b a year. These huge numbers grabbed the attention of the public and policy holders. The presumption in the press and the state houses was that fraud was rampant and that most workers compensation fraud was claimant fraud. Since that time more than half of the states have passed legislation on workers compensation fraud, with most of the laws directed primarily at claimants. 33 states currently have active workers compensation insurance fraud units, many of them geared to fighting claimant fraud. In every state some claimant fraud has been discovered, publicity about these cases has created a deterrent for workers who might contemplate fraudulent claims. It has also created an atmosphere that Frederick Hill, California Analyst for Fire Mark Research of New Jersey, describes as the "unwarranted and anecdotal vilification of the work force."
>
> Perhaps most importantly, the fixation on claimant fraud has distracted policy makers, enforcement agencies, and the public from growing evidence of the real problem - ***millions of dollars in employer and provider fraud.***"

Conclusion

In the last 10-15 years there has been significant legislative reform across Australia in Workers Compensation which has generally resulted in either the restriction or abolition of the entitlements of injured workers, e.g. the common law entitlement has been restricted or abolished in the Commonwealth, Victoria, South Australia, Western Australia and the Northern Territory. Journey claims have been abolished in Victoria, South Australia, Western Australia and Tasmania. Limitations have been placed on stress claims in most jurisdictions and monetary/impairment thresholds have been imposed in the Commonwealth, Victoria, New South Wales, South Australia and the Northern Territory.

The AMA Guides have been introduced in Victoria, South Australia, Queensland and the Northern Territory. Changes to the definition of injury and its contribution by employment has undergone various legislative change in most jurisdictions.

The common reason for change is to lower the escalating costs of the system which has been blamed to a large extent on claimants who rort the system. In my opinion, employer fraud is a greater cost to Workers Compensation systems in Australia and more resources and publicity should be directed to the awareness and prevention of it.

Footnotes:

1. Article by Graham Turner, "Fraud Wars: Workers Compensation Rip Offs", NSCA April 1998
2. ibid. pg. 13
3. Vol 2 pg. 480
4. pg. 128-9 Final Report
5. ibid. pg. 27 Recommendation 58
6. Vol 2 pg. 121
7. Comparison of Workers Compensation Arrangements in Australian Jurisdictions Jan 1999
8. Victorian WorkCover Authority Annual Reports
9. Workcover Queensland Annual Reports
10. SA Workcover Corporation Annual Reports
11. Letter from John Grayson, General Manager, NSW WorkCover 31st August, 1999
12. Refer Footnote 1
13. Letter from Victorian WorkCover Authority dated 18th August, 1999.
14. Annual Report 1995/6
15. Annual Reports 1996/7 and 1997/8
16. Annual Report
17. ibid.
18. ibid.
19. Vol 2 pg. 121
20. APLA Commentary Article by Graham Turner; Fraud Wars: Workers Compensation Rip Offs NSCA April 1998
21. Vol 2 pg. 142
22. Workers Compensation Report Issue 352
23. pg. 17
24. letter from John Grayson, General Manager WorkCover 31/8/1999.
25. pg. 30 Recommendation 73
26. ibid. Recommendation 74
27. Chapter 11 pg. 13
28. Annual Report 1995/6
29. ATLA Trial Journal March 1999