APPENDIX I – Types of Fraud in the Workers' Compensation System

Premium fraud:	Workers' compensation insurance premiums are calculated based on a percentage of the payroll reported for each employee. Higher risk occupations require higher percentage payments, and the employer's past experience with workers' compensation claims is also factored into the rate. Premium fraud involves the intentional misreporting of information in order to obtain lower premiums (*i.e.* be changed less) for insurance coverage. Premium fraud includes reporting lower wages than were actually paid, reporting that employees work in occupations with lower risk ratings than their actual jobs, and leaving workers off of payroll reports. It can also include misrepresenting claims histories or even reorganizing as a new company with no claims history in order to obtain lower premiums.
Misclassification:	Misclassification of workers is one way to commit premium fraud. Employers may misclassify employee occupations (*e.g.* classifying roofers as clerical workers) in order to obtain lower premiums, or they may misclassify employees as independent contractors in order to avoid providing any workers' compensation coverage (or other mandated job protections) for those workers.
Uninsured Employers:	Some employers avoid their legal obligation to provide workers' compensation coverage either by misclassifying employees as independent contractors (*see* "misclassification" above) or just deciding not to obtain coverage and hoping not to get caught. Employers may also misrepresent facts to avoid liability for individual claims.
Applicant (Injured Worker) Fraud:	Injured workers are commonly referred to as "applicants" in California's workers' compensation system, and may bring fraudulent claims for nonexistent illnesses or injuries or by misrepresenting facts in order to increase compensation or obtain benefits and treatment for illnesses or injuries that were not work-related. Applicant fraud can be abetted by attorneys and medical providers who refer workers for tests and treatment for nonexistent or noncompensable illnesses and injuries and provide documentation to support fraudulent claims.

Billing fraud:	Billing fraud occurs when a service provider intentionally overcharges for services provided, including by using improper billing codes or overstating the extent of service provided, or charges for services that were not provided or are not compensable through the workers' compensation system. Billing fraud can be committed by medical service providers, pharmacies, and ancillary service providers such as interpreters and copy services. Billing fraud may include the use of billing services or shell companies to conceal the identity of the actual provider or billing source.
Treatment abuse:	Treatment abuse occurs when workers are given tests and treatments that are not needed to cure or relieve a work injury or illness or that may be unrelated to any reported signs or symptoms or diagnosed illness or injury. The primary purpose of these tests and treatments may be to generate billings to insurers.
Capping and treating:	Capping and treating schemes involve a "capper" who solicits workers to make workers' compensation claims through a clinic or advocacy group which in turn refers workers for unnecessary tests or treatment (*see* "treatment abuse" above) in order to substantiate the claims and bill insurers for the tests and treatment.
Kickback schemes:	Kickback schemes involve an obligation or agreement to share or "kick back" some part of the compensation due to the person who provides goods or services (or who bills for goods or services not provided). It includes agreements to pay referral fees prohibited by Labor Code §§ 139.3 and 4906 (g). A capping and treating scheme (*see* "capping and treating" above) may include an agreement to share in any payments obtained for claims, tests, or treatment.