

California Department of Insurance Enforcement Branch- Fraud Division



MISSION STATEMENT

The Fraud Division's mission is to protect the public and prevent economic loss through the detection, investigation, and arrest of insurance fraud offenders.

Captain Yvette Cordero
(661) 253-7400
Yvette.Cordero@insurance.ca.gov

<http://www.insurance.ca.gov/0300-fraud/0100-fraud-division-overview/>

Consumer Hotline: 1-800-927-4357 (HELP)

The Life of a Suspected Fraud Claim Referral

This session will discuss the process of a Suspected Fraud Claim Referral submitted to the California Department of Insurance Fraud Division. In addition, it will describe what employers can do to effectively report suspected fraud. Attendees can expect to learn about the investigative intricacies of a workers' compensation insurance fraud investigation. Captain Yvette Cordero will also highlight several highly publicized workers' compensation fraud investigations and subsequent prosecutions by local prosecutors. The successful prosecutions are the result of a strong collaborative effort between the Fraud Division and the California District Attorney Offices.

STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
Dave Jones, Insurance Commissioner

FRAUD DIVISION
Vacant
Deputy Commissioner
Enforcement Branch

9342 Tech Center Drive, Suite 100, Sacramento, CA 95826
Phone: (916) 854-5760 and Fax: (916) 255-3202
E-Mail: Fraud@insurance.ca.gov
Web address: www.insurance.ca.gov
HOTLINE: 800-927-4357

Martin Gonzalez
Division Chief, Fraud Division

Shawn Ferris, Bureau Chief
Urban Auto & Auto Programs

Lauren Pedroza, Bureau Chief
Workers' Compensation & Healthcare Programs

REGIONAL OFFICES AND ASSIGNED COUNTIES

Southern Los Angeles County

David Goldberg
Captain
5999 E. Slauson Avenue
City of Commerce, CA 90040
Phone: (323) 278-5000
Fax: (323) 838-0028

Southern Los Angeles County

Fresno

Eric Charlick
Captain
1780 E. Bullard, Suite 101
Fresno, CA 93710
Phone: (559) 440-5900
Fax: (559) 440-5543

Fresno, Inyo, Kern, Kings, Madera,
Mariposa, Merced, San Luis Obispo and
Tulare Counties

Benicia

Vacant
Captain
1100 Rose Drive, Suite 100
Benicia, CA 94510
Phone: (707) 751-2000
Fax: (707) 747-8233

Alameda, Contra Costa, Del Norte,
Humboldt, Lake, Marin, Mendocino,
Napa, San Francisco, Solano and
Sonoma Counties

Orange

Victoria Martinez
Captain
333 South Anita Drive, Suite 450
Orange, CA 92868
Phone: (714) 712-7600
Fax: (714) 456-1838

Orange County

Inland Empire

Joe Chavez
Captain
9674 Archibald Ave, Suite 100
Rancho Cucamonga, CA 91730
Phone: (909) 919-2200
Fax: (909) 980-2196

Riverside and San Bernardino Counties

San Diego

Shawn Conner
Captain
10021 Willow Creek Rd., Suite 100
San Diego, CA 92131
Phone: (858) 693-7100
Fax: (858) 635-3760

Imperial and San Diego Counties

Silicon Valley

Kathleen Harris
Captain
18425 Technology Drive
Morgan Hill, CA 95037
Phone: (408) 201-8800
Fax: (408) 779-7299

Monterey, San Benito, San Mateo,
Santa Clara and Santa Cruz Counties

Sacramento

Kathleen Rooney
Captain
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Sacramento, CA 95826
Phone: (916) 854-5700
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Alpine, Amador, Butte, Calaveras,
Colusa, El Dorado, Glenn, Lassen,
Modoc, Mono, Nevada, Placer, Plumas,
Sacramento, San Joaquin, Shasta,
Sierra, Siskiyou, Stanislaus, Sutter,
Tehama, Trinity, Tuolumne, Yolo and
Yuba Counties

Valencia

Yvette Cordero
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Northern Los Angeles, Santa
Barbara and Ventura Counties

Headquarters

9342 Tech Center Dr., Suite 100
Sacramento, CA 95826
Phone: (916) 854-5760
Fax: (916) 255-3202

**Suspected Fraudulent Claim (SFC)
Referral Form (FD-1)**

CDI USE ONLY

Parties to the Loss/Injury

Case #: _____ County Code: _____ SFC #: _____
 AUTOMOBILE WORKERS' COMPENSATION SPECIAL OPS
 URBAN AUTO FRAUD PROGRAM OTHER HEALTHCARE

Claim #: _____ Policy #: _____ Date of Loss/Injury: ____ / ____ / ____

SECTION VI. INSURED/EMPLOYER INFORMATION (Party A)

PARTY A. INSURED EMPLOYER (CHECK ONE/If Workers' Compensation, must show employer here.)
 Name: _____ Phone #: _____ () _____
Last Name First Name MI
 Address: _____ City: _____ State: _____ Zip: _____
 DOB/Age: _____ SSN: _____ Tax ID #: _____
 DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
 DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: Yes No

SECTION VII. OTHER PARTIES TO THE LOSS/INJURY (Additional Parties)

PARTY B. (Enter party code in box)
 Name: _____ Phone #: _____ () _____
Last Name First Name MI
 Address: _____ City: _____ State: _____ Zip: _____
 DOB/Age: _____ SSN: _____ Tax ID #: _____
 DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
 DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: Yes No

PARTY C. (Enter party code in box)
 Name: _____ Phone #: _____ () _____
Last Name First Name MI
 Address: _____ City: _____ State: _____ Zip: _____
 DOB/Age: _____ SSN: _____ Tax ID #: _____
 DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
 DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: Yes No

PARTY D. (Enter party code in box)
 Name: _____ Phone #: _____ () _____
Last Name First Name MI
 Address: _____ City: _____ State: _____ Zip: _____
 DOB/Age: _____ SSN: _____ Tax ID #: _____
 DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
 DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: Yes No

PARTY E. (Enter party code in box)
 Name: _____ Phone #: _____ () _____
Last Name First Name MI
 Address: _____ City: _____ State: _____ Zip: _____
 DOB/Age: _____ SSN: _____ Tax ID #: _____
 DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
 DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: Yes No

**Suspected Fraudulent Claim (SFC)
Referral Form (FD-1)**

CDI USE ONLY

Parties to the Loss/Injury (continued)

Case #: _____ County Code: _____ SFC #: _____
 AUTOMOBILE WORKERS' COMPENSATION SPECIAL OPS
 URBAN AUTO FRAUD PROGRAM OTHER HEALTHCARE

Claim #: _____ Policy #: _____ Date of Loss/Injury: ____ / ____ / ____

SECTION VII. OTHER PARTIES TO THE LOSS/INJURY (Additional Parties)

PARTY . (Enter party code in box)

Name: _____ Phone #: _____
Last Name First Name MI

Address: _____ City: _____ State: _____ Zip: _____

DOB/Age: _____ SSN: _____ Tax ID #: _____

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: Yes No

PARTY . (Enter party code in box)

Name: _____ Phone #: _____
Last Name First Name MI

Address: _____ City: _____ State: _____ Zip: _____

DOB/Age: _____ SSN: _____ Tax ID #: _____

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: Yes No

PARTY . (Enter party code in box)

Name: _____ Phone #: _____
Last Name First Name MI

Address: _____ City: _____ State: _____ Zip: _____

DOB/Age: _____ SSN: _____ Tax ID #: _____

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: Yes No

PARTY . (Enter party code in box)

Name: _____ Phone #: _____
Last Name First Name MI

Address: _____ City: _____ State: _____ Zip: _____

DOB/Age: _____ SSN: _____ Tax ID #: _____

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: Yes No

PARTY . (Enter party code in box)

Name: _____ Phone #: _____
Last Name First Name MI

Address: _____ City: _____ State: _____ Zip: _____

DOB/Age: _____ SSN: _____ Tax ID #: _____

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: Yes No

If you need to report more parties to the loss, please complete and attach additional copies of this page as needed.

Reporting

Suspected Fraudulent
Insurance Claims

**California Department of Insurance
Fraud Division**



- **Requirements**
- **Instructions**

January 2008

**California Department of Insurance
ENFORCEMENT BRANCH
FRAUD DIVISION**

9342 Tech Center Drive, Suite 100
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FAX (916) 255-3202

REGIONAL OFFICES

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1100 Rose Drive, Suite 100
Benicia, CA 94510
(707) 751-2000

Fresno

1780 E. Bullard, Suite 101
Fresno, CA 93710
(559) 440-5900

Inland Empire

9674 Archibald Avenue, Suite 100
Rancho Cucamonga, CA 91730
(909) 919-2200

Orange

333 S. Anita Drive, Suite 450
Orange, CA 92868
(714) 712-7600

Sacramento

9342 Tech Center Drive, Suite 500
Sacramento, CA 95826
(916) 854-5700

San Diego

10021 Willow Creek Rd., Suite 100
San Diego, CA 92131
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Silicon Valley

18425 Technology Drive
Morgan Hill, CA 95037
(408) 201-8800

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County**

5999 E. Slauson Avenue
City of Commerce, CA 90040
(323) 278-5000

Valencia

27200 Tourney Road, Suite 375
Valencia, CA 91355
(661) 253-7400

Mission

The mission of the Fraud Division of the California Department of Insurance is to protect the public and prevent economic loss through the detection, investigation, and arrest of insurance fraud offenders.

Every person who reports suspected fraudulent insurance claims to the Fraud Division furthers this mission.



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Reporting Requirements

Who Must Report	Anyone may report suspected fraudulent insurance claims and premium fraud to the California Department of Insurance (CDI) Fraud Division. All licensed insurers doing business in California and all self-insured employers (for Workers' Compensation cases only) that suspect fraudulent claim activity must report it. A self-insured's third-party administrator (TPA) or other contractor shall submit FD-1 referral forms on the self-insured's behalf. Refer to Appendix A. (see page 13) for detailed requirements and authority cites.
What Fraud Must Be Reported	Any suspected fraudulent insurance claim activity victimizing or involving any California insured, insurer, employee and permissibly self-insured shall be reported, regardless of the location where the fraud was allegedly committed.
What Information Is Required	The Form FD-1 Suspected Fraudulent Claim (SFC) Referral Form (see pages 6-8 for a sample completed form) requests information about the loss/injury, alleged victim, suspicious fraudulent activity, and names and identifying information of the parties involved. In addition, reporting parties who have made investigative efforts are encouraged to attach additional documentation to the referral.
When Must a Report Be Made	<p>Workers' Compensation - 60 days after insurer knows or reasonably believes a fraudulent act was committed (CIC 1877.3 (b)(1) and 1877.3 (d)). Furnished to CDI and District Attorney.</p> <p>All others – 60 days after insurer determines claim appears fraudulent (1872.4 (a)). Furnished to CDI.</p> <p><u>If you have documented results of an investigation that confirm your suspicions of fraud, please immediately contact your Fraud Division Regional Office</u> in person or by phone to discuss it (see the inside cover and the following page for contact and address information).</p>
Immunity from Civil Liability	The California Insurance Code (CIC) contains provisions affording limited immunity from civil liability for insurers and their authorized agents who provide information to the CDI Fraud Division. These provisions do vary. Please reference the language to the applicable provision (CIC Sections §1872.5, 1873.2, 1877.5, 1874.4, 1875.4, 1875.18 and 1876.4).
Where to Obtain Additional FD-1 Forms	You may reproduce the 4-page Form FD-1 (see Appendix D., page 19, for a camera-ready version). For additional copies of this booklet, call (916) 854-5760 or write to the address below. The Form FD-1 may also be accessed on the Departments web site, www.insurance.ca.gov .
Where to Submit Completed Referral Forms	<p>Completed Form FD-1s should be mailed to the following address:</p> <p style="text-align: center;">CDI Fraud Division Intake Unit 9342 Tech Center Drive, Suite 100 Sacramento CA 95826</p>

<p>How CDI Uses This Information</p>	<p>FD-1 referrals submitted by insurers, law enforcement agencies, the public and others provide the foundation for the CDI Fraud Division’s anti-fraud program. <u>The value of accurate, timely and complete referrals cannot be overstated.</u> Unreported incidents and incomplete and/or inaccurate information on FD-1s impedes CDI’s ability to gather and report intelligence information; match parties to previous fraudulent activity; and effectively evaluate whether to further investigate the circumstances.</p> <p>On receipt, the Centralized Intake Unit immediately reviews referrals for accuracy and completeness. Within 12 business days, data from incoming FD-1s are entered into the Fraud Division’s Insurance Fraud Information System (IFIS) and the referrals are directed to the appropriate CDI Fraud Division regional office. Investigative staff conduct preliminary intelligence gathering, evaluate the FD-1 information, make a decision about whether to initiate a formal investigation, and notify the reporting party about the action CDI will take.</p>																				
<p>Getting Help</p>	<p>If you have questions about reporting requirements or need help completing an FD-1 referral form, please contact the CDI Fraud Division regional office which serves your county.</p> <table border="1" data-bbox="410 787 1401 1606"> <thead> <tr> <th data-bbox="410 787 917 829">If your California county is</th> <th data-bbox="925 787 1401 829">Your Regional Office is</th> </tr> </thead> <tbody> <tr> <td data-bbox="410 840 917 976">Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Lassen, Modoc, Mono, Nevada, Placer, Plumas, Sacramento, San Joaquin, Shasta, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo, Yuba</td> <td data-bbox="925 840 1401 976">Sacramento (916) 854-5700</td> </tr> <tr> <td data-bbox="410 1008 917 1071">Alameda, Contra Costa, Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, San Francisco, Solano, Sonoma</td> <td data-bbox="925 1008 1401 1071">Benicia (707) 751-2000</td> </tr> <tr> <td data-bbox="410 1134 917 1186">Monterey, San Benito, San Mateo, Santa Clara, Santa Cruz</td> <td data-bbox="925 1134 1401 1186">Silicon Valley (408) 201-8800</td> </tr> <tr> <td data-bbox="410 1207 917 1270">Fresno, Inyo, Kern, Kings, Madera, Mariposa, Merced, San Luis Obispo, Tulare</td> <td data-bbox="925 1207 1401 1270">Fresno (559) 440-5900</td> </tr> <tr> <td data-bbox="410 1302 917 1365">Southern Los Angeles and the City of Los Angeles Metropolitan Area</td> <td data-bbox="925 1302 1401 1365">Southern Los Angeles County (323) 278-5000</td> </tr> <tr> <td data-bbox="410 1375 917 1438">Northern Los Angeles including the San Fernando Valley, Santa Barbara, Ventura</td> <td data-bbox="925 1375 1401 1438">Valencia (661) 253-7400</td> </tr> <tr> <td data-bbox="410 1449 917 1491">Orange</td> <td data-bbox="925 1449 1401 1491">Orange (714) 712-7600</td> </tr> <tr> <td data-bbox="410 1501 917 1543">Riverside, San Bernardino</td> <td data-bbox="925 1501 1401 1543">Inland Empire (909) 919-2200</td> </tr> <tr> <td data-bbox="410 1554 917 1596">Imperial, San Diego</td> <td data-bbox="925 1554 1401 1596">San Diego (858) 693-7100</td> </tr> </tbody> </table>	If your California county is	Your Regional Office is	Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Lassen, Modoc, Mono, Nevada, Placer, Plumas, Sacramento, San Joaquin, Shasta, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo, Yuba	Sacramento (916) 854-5700	Alameda, Contra Costa, Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, San Francisco, Solano, Sonoma	Benicia (707) 751-2000	Monterey, San Benito, San Mateo, Santa Clara, Santa Cruz	Silicon Valley (408) 201-8800	Fresno, Inyo, Kern, Kings, Madera, Mariposa, Merced, San Luis Obispo, Tulare	Fresno (559) 440-5900	Southern Los Angeles and the City of Los Angeles Metropolitan Area	Southern Los Angeles County (323) 278-5000	Northern Los Angeles including the San Fernando Valley, Santa Barbara, Ventura	Valencia (661) 253-7400	Orange	Orange (714) 712-7600	Riverside, San Bernardino	Inland Empire (909) 919-2200	Imperial, San Diego	San Diego (858) 693-7100
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Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Lassen, Modoc, Mono, Nevada, Placer, Plumas, Sacramento, San Joaquin, Shasta, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo, Yuba	Sacramento (916) 854-5700																				
Alameda, Contra Costa, Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, San Francisco, Solano, Sonoma	Benicia (707) 751-2000																				
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Orange	Orange (714) 712-7600																				
Riverside, San Bernardino	Inland Empire (909) 919-2200																				
Imperial, San Diego	San Diego (858) 693-7100																				
	<p>If you are calling from another state or country and are unsure which Regional Office to contact, please call our Fraud Division headquarters in Sacramento at (916) 854-5760.</p>																				

Sample of Completed Form FD-1 (Page 1)

California Department of Insurance

Fraud Division

**Suspected Fraudulent Claim (SFC)
Referral Form (FD-1)**

CDI USE ONLY

Case #: _____ County Code: _____ SFC #: _____
 AUTOMOBILE WORKERS' COMPENSATION SPECIAL OPS
 URBAN AUTO FRAUD PROGRAM OTHER HEALTHCARE

REPORTING REQUIREMENTS: Please print legibly or type. California Insurance Code (CIC) § 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 § 1877.5 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**.

SECTION I. REPORTING PARTY INFORMATION CODE

FRAUD TYPE CODE: 140 REPORTING PARTY CODE: 04 CHECK ONE: NEW REFERRAL AMENDED REFERRAL
 REPORTING PARTY: Rest Assured Services 11122
Company Name California Company (CA) # Self Insured (TFA#)
 ADDRESS: 123 Assured Street, Suite 100 CITY: AnyCity STATE: CA ZIP: 11111
 E-MAIL ADDRESS (IF APPLICABLE): _____

SECTION II. LOSS/INJURY INFORMATION

ALLEGED VICTIM: C&W Trucking Company 5-2222-13-000
Company Name California Company (CA) # Self Insured (TFA#)
 ADDRESS: 456 Safe Street, Suite 101 CITY: AnyCity STATE: CA ZIP: 22222
 CLAIM #: AB1234567 POLICY #: X9876543 DATE OF LOSS/INJURY: 10/01/99
 ADDRESS OR LOCATION WHERE LOSS/INJURY OCCURRED:
 ADDRESS: First & Main Streets CITY: Everywhere STATE: CA ZIP: 33333
 PREMIUM LOSS: _____ POTENTIAL LOSS: \$47,000.00 ACTUAL PAID TO DATE: \$8,500.00 SUSPECTED FRAUDULENT LOSS TO DATE: _____

SECTION III. SUSPECTED FRAUDULENT CLAIM ACTIVITY

SYNOPSIS: State the facts (who, what, when, where, how, why) that support your suspicion of fraudulent claim activity including any material misrepresentation(s). Provide details regarding any prior history of fraudulent insurance claim activity by any of the parties. If known, include relevant claim numbers. *Attach additional summary sheets if needed.*
 Mike and Susie Smith alleged accident at First and Main Streets in Everywhere, California on October 1, 1999. They deny involvement in previous accidents, but index links them to five others at the same intersection. Treating chiropractor, Noel Jones, is refusing to provide treatment records.
 History on index shows five other claims for other carriers and two potential aliases for suspect driver (copies attached).

You may include attachments documenting the suspected fraudulent activity. If a complete copy of the claim file has been submitted to the District Attorney's Office, please attach a complete copy to this Form FD-1. Otherwise, a complete copy of your claim file is not required.

DISASTER CLAIMS: If this suspicious activity is related to a major natural or non-natural disaster, check the box below that best describes the related event:
 EARTHQUAKE FLOOD FIRESTORM WIND OTHER NATURAL NON-NATURAL (MAN-MADE)

SECTION IV. REPORTS TO OTHER AGENCIES

OTHER LAW ENFORCEMENT AGENCY (specify name): _____
 DISTRICT ATTORNEY'S OFFICE (specify name): _____
 NICB OTHER: _____

SECTION V. CONTACT INFORMATION

CONTACT (name/title): Able Seer PHONE: (111) 222-3333
 FILE HANDLER (if different): Hal Helpful PHONE: (444) 555-6666 DATE FORM COMPLETED: _____
 COMPLETED BY (if different): _____ PHONE: () _____ 10/09/99

Sample of Completed Form FD-1 (Page 2)

California Department of Insurance

Fraud Division

Suspected Fraudulent Claim (SFC) Referral Form (FD-1)

CDI USE ONLY

Case #: County Code: SFC #:

AUTOMOBILE WORKERS' COMPENSATION SPECIAL OPS URBAN AUTO FRAUD PROGRAM OTHER HEALTHCARE

Parties to the Loss/Injury

Claim #: AB1234567 Policy #: X9876543 Date of Loss/Injury: 10/01/99

SECTION VI. INSURED/EMPLOYER INFORMATION (Party A)

PARTY A. INSURED EMPLOYER (CHECK ONE/IF Workers' Compensation, must show employer here.) Name: C & W Trucking Company Phone #: (222) 222-2222 Address: 456 Safe Street, Suite 101 City: AnyCity State: CA Zip: 22222

SECTION VII. OTHER PARTIES TO THE LOSS/INJURY (Additional Parties)

PARTY B. 30 (Enter party code in box) Name: Smith, Mike Phone #: (555) 555-5555 Address: 2000 Repeater Street City: Overland State: CA Zip: 55555

PARTY C. 32 (Enter party code in box) Name: Smith, Susie Phone #: (666) 666-6666 Address: 2000 Repeater Street City: Overland State: CA Zip: 55555

PARTY D. 06 (Enter party code in box) Name: Jonee, Noel Phone #: (777) 777-7777 Address: 15 Gangland Way City: Overland State: CA Zip: 77777

PARTY E. (Enter party code in box) Name: Phone #: () Address: City: State: Zip: DOB/Age: SSN: Tax ID #: DL #: State: License Plate #: State: VIN #: DBAs/Multiple Numbers/AKA's: Party Claiming Injury: Yes No

Sample of Completed Form FD-1 (Page 3)

California Department of Insurance

Fraud Division

Suspected Fraudulent Claim (SFC) Referral Form (FD-1)

CDI USE ONLY

Case #: County Code: SFC #:

AUTOMOBILE WORKERS' COMPENSATION SPECIAL OPS URBAN AUTO FRAUD PROGRAM OTHER HEALTHCARE

Parties to the Loss/Injury (continued)

Claim #: AB1234567 Policy #: X9876543 Date of Loss/Injury: 10/01/99

SECTION VII. OTHER PARTIES TO THE LOSS/INJURY (Additional Parties)

PARTY E. 02 (Enter party code in box)

Name: Sanford, Fred Phone #: () Address: Last Name First Name MI City State Zip DOB/Age: 6/20/66 SSN: 888-88-8888 Tax ID #: DL #: State: License Plate #: State: VIN #: DBAs/Multiple Numbers/AKA's: Party Claiming Injury: Yes No

PARTY F. 31 (Enter party code in box)

Name: Innocent, Truly Phone #: (444) 444-4444 Address: 2 Runover Lane City: Hitagin State: CA Zip: 44444 DOB/Age: February 20, 1959 SSN: 444-44-4444 Tax ID #: DL #: A4444444 State: CA License Plate #: HITME2 State: CA VIN #: DBAs/Multiple Numbers/AKA's: Party Claiming Injury: Yes No

PARTY . (Enter party code in box)

Name: Phone #: () Address: Last Name First Name MI City State Zip DOB/Age: SSN: Tax ID #: DL #: State: License Plate #: State: VIN #: DBAs/Multiple Numbers/AKA's: Party Claiming Injury: Yes No

PARTY . (Enter party code in box)

Name: Phone #: () Address: Last Name First Name MI City State Zip DOB/Age: SSN: Tax ID #: DL #: State: License Plate #: State: VIN #: DBAs/Multiple Numbers/AKA's: Party Claiming Injury: Yes No

PARTY . (Enter party code in box)

Name: Phone #: () Address: Last Name First Name MI City State Zip DOB/Age: SSN: Tax ID #: DL #: State: License Plate #: State: VIN #: DBAs/Multiple Numbers/AKA's: Party Claiming Injury: Yes No

If you need to report more parties to the loss, please complete and attach additional copies of this page as needed.

Instructions for Completing Form FD-1: Suspected Fraudulent Claim Referral

SECTION I. Reporting Party Information

Using The FD-1 Form Via Computer	This form was created in Microsoft Word 97. It is recommended that you use the “Tab” key to navigate between fields and not the “Enter” key when using the FD-1 form on your computer.
Fraud Type Code	Enter the most appropriate Suspected Fraud Type code. For a list of codes, refer to Appendix B. Code Listing (see page 14-15). If you are unsure which code to use, refer to Appendix C. Code Definitions (see pages 16–18).
Reporting Party Code	Enter the most appropriate Reporting Party code. For a list of codes, refer to Appendix B. Code Listing (see page 16-18). If you are a third-party administrator (TPA) or other contractor, select, from codes 1, 2, 3, or 4, the code that best describes the nature of the insurer for which you are working.
New Referral/ Amended Referral Check One:	Check the “New Referral” box if this is the first referral you have made for this incident of suspected fraud. Check the “Amended Referral” box if you have previously reported this incident and are adding, deleting or correcting information you previously provided.
Reporting Party	To ensure proper identification, enter the full and complete company name of the reporting carrier, self-insured, TPA, law enforcement agency, or other entity/individual making the referral. To ensure proper identification, do not use acronyms or initials unless they are part of the formal name.
California Company (CA) #	If you are an insurer authorized to transact business in California, enter your CDI-assigned California Company (CA) number.
Self-Insured #/ TPA#	If you are a Third Party Administrator (TPA), enter the TPA number assigned by the California Department of Industrial Relations. If you are self-insured, enter one of the following: self-insured number assigned by either the California Department of Industrial Relations or California Department of Motor Vehicles.
Address/City/ State/ZIP/E-mail	Enter your mailing address and e-mail address (if applicable).

SECTION II. Loss/Injury Information

Alleged Victim	Enter the full and complete company name of the insurance carrier or self-insured that you suspect is being victimized. In the case of an employer defrauding an employee (Suspected Fraud Type Code 510), enter the name of the employee whom you suspect is being victimized. To ensure proper identification, do not use acronyms or initials unless they are part of the formal name.
California Company (CA) #	If the alleged victim is an insurer licensed to transact business in California, enter the CDI-assigned California Company (CA) number.
Self-Insured #/ TPA#	If the “Alleged Victim” is self-insured, enter one of the following: self-insured number assigned by either the California Department of Industrial Relations or California Department of Motor Vehicles, or TPA number assigned by the California Department of Industrial Relations.

Claim Number	Enter the claim number issued by the insurer. For amended referrals, be sure to include the identical claim number as originally reported on the initial referral.
Policy Number	Enter the policy number issued by the insurer. For amended referrals, be sure to include the identical policy number as originally reported on the initial referral.
Premium Dollar Loss	For premium fraud cases only (Suspected Fraud Type Code 561 (Misclassification), 562 (Under-Reported Wages), or 563 (X-Mod Evasion)), enter the potential loss in total premium dollars if the fraud had gone undiscovered. Otherwise, leave blank.
Location Of Loss/ Injury	Indicate the name of the city, state and zip code where the loss or injury is alleged to have occurred. If the specific address is not known, please note such details as the intersection, mall name, or other location identifying information. NOTE: The accuracy of this information is critical, as it will determine which CDI Fraud Division regional office is assigned to handle the case.
Date of Loss/ Injury	Enter the reported date of loss or injury. If more than one date has been reported for the loss or injury, enter the earliest alleged date.
Potential Loss	Enter the potential dollar loss/exposure for this claim if the fraud had gone undiscovered.
Actual Paid to Date	Enter the total dollar amount paid on the claim as of the referral date. Include amounts you suspect to be fraudulent as well as those that may be legitimate. For premium fraud cases (Suspected Fraud Type Code 561 (Misclassification), 562 (Under-Reported Wages), or 563 (X-Mod Evasion)), leave this field blank.
Suspected Fraudulent Loss To Date	Of the amount you reported on the "Actual Paid to Date" line, enter the dollar amount you suspect to be fraudulent.

SECTION III. Suspected Fraudulent Claim Activity

Synopsis	<p>State the <u>facts</u> that support your suspicion(s) of fraudulent insurance claim or premium fraud activity. Detail the material misrepresentation(s) made by the parties. Be specific and concise. Include information addressing the basic questions: who, what, when, where, why, how much and how often. Attach additional summary sheets if needed to complete the synopsis.</p> <p>Examples:</p> <ul style="list-style-type: none"> • Suspected Fraud Type Code 140 (Auto Collision/Right-of-Way): Accident appears staged. Suspect driver and passenger deny involvement in any previous accidents, but Index links them to 5 others including an earlier incident (7/23/98) at this same location. Treating chiropractor is refusing to provide medical records. • Suspected Fraud Type Code 500 (Workers' Compensation/Claimant Fraud): Doctor reports claimant malingering. Claimant maintains he cannot walk. Sub Rosa video on day of medical appointment shows claimant faking inability to walk; on video, claimant runs and walks normally. • Suspected Fraud Type Code 561 (Workers' Compensation/Premium Fraud): Suspect misclassification of workers' hourly rates to avoid premium costs. <p><u>In all cases, provide any known details, of each party's history of involvement in fraudulent insurance claims.</u></p> <p>Examples:</p> <ul style="list-style-type: none"> • Insured has reported four other claims in last two years including: XYZ Company, Claim #122321/ABC Insurer, loss dates 7/23/98, 9/19/97 and 8/24/98. • Index shows 5 hits on similar names, three of which are for the same address as the insured (copies attached). • NICB shows several previous claims involving the suspect driver and passenger.
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Disaster-Related	Check the box if suspected fraudulent claim activity is related to a major disaster,
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Activity	i.e., a disaster that has produced a gubernatorial or presidential declaration of emergency. Indicate the type of disaster to which the activity is related: natural (earthquake, flood, firestorm, wind or other natural disaster) or non-natural (civil unrest, chemical spills, airborne contamination, etc.).
Attachments	Attach any documentation you have of investigative efforts you have completed. If you are submitting a complete copy of the claim file to the District Attorney, reciprocate by including a complete copy with this referral to CDI.

SECTION IV. Reports to Other Agencies

Other Law Enforcement Agency	Check this box if you have reported this suspected fraudulent claim to any other law enforcement agency and enter the specific name of the agency to which this suspected fraudulent claim was referred.
District Attorney's Office	Check this box if you have reported this suspected fraudulent claim to any District Attorney's Office (required for workers' compensation claims under CIC 1877.3(b)(1)), and enter the name of the county served by the District Attorney's office to which the claim was referred.
NICB	Check this box if you have reported this suspected fraudulent claim to the National Insurance Crime Bureau (NICB).
Other	Check this box if you have reported this suspected fraudulent claim to any other agency and enter the specific name of the agency to which the claim was referred.

SECTION V. Contact Information

Contact	Enter the name, title and telephone number of the person who should be contacted by a CDI investigator(s) needing additional information relative to the claim.
File Handler	If different from the contact person listed previously, enter the name and phone number of the file handler (the adjuster/claims representative assigned to the claim who can provide requested information and documentation).
Completed By	Enter the name and phone number of the person completing the Form FD-1, if different from both the contact person and file handler. Enter this information in the format of First Name, Middle Initial and Last Name.
Date Form Completed	Indicate the date form was completed.

SECTION VI. Insured/Employer Information (Party A)

Claim/Policy Number	Enter the claim and policy numbers you reported on the first page of the FD-1. If you are submitting an amended referral, these numbers should be identical to those originally reported on the initial referral.
Date of Loss/Injury	Enter the date of loss/injury you reported on page 1 of the FD-1.
Insured/Employer Check Box	<u>The employer must be listed in the Party A section for any Workers' Compensation fraudulent claim referral.</u> If you are reporting a suspicious workers' compensation claim, check the employer box. Otherwise, check whichever box is appropriate.
Name	<u>The employer must be listed in the Party A section for any Workers' Compensation fraudulent claim referral.</u> If you are reporting a suspicious workers' compensation claim, enter the name of the employer. Otherwise, enter the appropriate name.

Party Claiming Injury	Check the "yes" box if Party A is claiming to be injured or believed to have died as a result of the situation being reported. Otherwise, check the "no" box. When
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	an injury/death is being claimed, check the “yes” box regardless of whether you believe the injury/death to be real.
Additional Instructions	Include all of the requested information if you know it. When providing AKAs, include all nicknames, monikers, maiden names and other aliases. On the “DBAs/Multiple#s/AKAs” line, provide any company name(s) under which Party A is “doing business as” (DBA) as well as additional nicknames, monikers, maiden names and/or other aliases, dates of birth, social security or other numbers Party A may be using, e.g., DBA XYZ and Company; SSN 444-44-4444; DL A0123456.
SECTION VII. Other Parties to the Loss/Injury (Additional Parties) Page 2-3	
Instructions	Make a separate entry for every other party to the loss/injury. <u>Be sure to enter the appropriate Party Code in the box</u> (for a list of party codes, refer to the Appendix B. Code Listing, pages 12-13). As you did for Party A, enter all other requested information known about the party, including whether or not he/she claims to be injured. On the “DBAs/Multiple#s/AKAs” line, provide any company name(s) under which Party is “doing business as” (DBA) as well as additional nicknames, monikers, maiden names and/or aliases, dates of birth, social security or other numbers Party B may be using, e.g., DBA XYZ and Company; SSN 444-44-4444; DL A0123456.
Claim/Policy Number	Enter the claim and policy numbers you reported on the first page of the FD-1. If you are submitting an amended referral, these numbers should be identical to those originally reported on the initial referral.
Date of Loss/Injury	Enter the date of loss/injury you reported on page 1 of the FD-1.
Page 3 Parties to the Loss Continued	You may copy this page as needed to report additional parties to the loss/injury.

APPENDIX A. Reporting Requirements & Authorities

If your agency is:	You are required to submit:	Within the following time frame	Authority
<ul style="list-style-type: none"> A company licensed to write insurance in California 	A separate FD-1 Referral Form for every suspected fraudulent claim	<ul style="list-style-type: none"> For workers' compensation claims, within 60 days of knowing or reasonably believing a claim to be fraudulent For any other type of suspected fraudulent claim, within 60 days of determining that a claim appears to be fraudulent 	CIC §1872.4(a) CIC §1877.3(d) CIC §1872.85
<ul style="list-style-type: none"> An insurer admitted to transact workers' compensation insurance in California The State Compensation Insurance Fund An employer that has secured a certificate of consent to self-insure pursuant to Section 3700 (b) or (c) of the Labor Code A third-party administrator that has secured a certificate pursuant to Section 3702.1 of the Labor Code 	A separate FD-1 Referral Form for each suspected fraudulent Workers' Compensation claim	Within 60 days of knowing or reasonably believing a person or entity has committed a fraudulent act relating to a workers' compensation claim	CIC §1877.1(c) CIC §1877.3(b) CIC §1877.3(c) CIC §1877.3(d) CIC §1872.85
<ul style="list-style-type: none"> Any California police, sheriff, disciplinary body governed by the provisions of the Business and Professions Code, or any California law enforcement agency 	All papers, documents, reports, complaints, or other facts or evidence CDI requests.	None specified in law	CIC §1872.4(d) CIC §1872.85
<ul style="list-style-type: none"> California Departments of Highway Patrol, Motor Vehicles, and Justice Any California city or county law enforcement agency Any California city or county agency employing peace officers as designated in Penal Code Sections 830.1 (a) and (b); 830.2 (a); and 830.3 (b), (d), (k) Any other California law enforcement agency Any licensing agency governed by the Business and Professions Code 	Any or all information released to or received from an insurer or authorized agent of an insurer relating to any specific insurance fraud, except for motor vehicle fraud and workers' compensation fraud must also be submitted to CDI	Within 10 days of receipt of the information from the insurer or agent	CIC §1873.4 CIC §1872.85

APPENDIX B. Code Listing

- This listing contains codes for the three fields on the Form FD-1 that require them: Suspected Fraud Type, Reporting Party, and Party to the Loss.
- Detailed definitions for Suspected Fraud Type is included in Appendix C. (refer to pages 14-16). Code names assigned to the other two fields are self-explanatory.
- Establishing new codes for this revision of the Form FD-1, while maintaining the historical integrity of CDI's database, required leaving the majority of the original codes and their meanings intact. You will also notice that "other" codes, which are found at the end of a list, are numerically out of sequence. We apologize for any inconvenience this may cause.

APPENDIX B. Code Listing

Suspected Fraud Type Code		Miscellaneous		General (Cont'd)	
Auto Collision		Casualty	600	Employer	15
Swoop & Squat	100	Agricultural / Livestock	610	Claims Adjuster	16
Sudden Stop	110	Fire		Agent / Broker	20
Backing	120	Commercial Fire	700	Other	09
Pedestrian vs. Auto	130	Arson for Hire	710	Medical/Healthcare	
Right of Way	140	Residential Fire	720	Medical Clinic	03
Phantom Vehicle	150	Inflated Fire Loss	730	Medical Doctor	05
Hit & Run	160	Property		Chiropractor	06
Paper Collision	170	Theft – Residential	800	Psychologist	11
Organized Ring	180	Theft – Commercial	810	Physical Therapist	12
Medical Provider	190	Theft – Commercial Carrier	820	Osteopath	17
Auto Property		Watercraft / Aircraft Theft	830	Physician's Assistant	18
Faked Damages	200	Watercraft / Aircraft Arson	840	Nurse Practitioner	19
Inflated Damages	210	Vandalism	860	Clinic Administrator	22
Vehicle Theft	220	Property Theft From Vehicle	870	Dentist	23
Vehicle Arson	230	Agent / Broker	880	Medical Management	24
Auto Property / Vandalism	240	Other Property Damage	850	Company	
Agent / Broker	250	Mold Related	890	Vocational Rehab Counselor	25
Embezzlement	260	Healthcare		Pharmacy / Pharmacist	26
Trailered Watercraft / Theft	270	Embezzlement	001	Laboratory	27
Damage		Identify Theft	002	Other Medical	28
Trailered Watercraft Arson	280	Unlawful Solicitation/Referral	003	Surgery Centers	35
Other Auto Property	290	Billing Fraud	004	Diagnostic / Imaging Centers	36
Medical		Immunization Fraud	005	Pain Management Clinics	37
Slip & Fall	300	Other Healthcare	006	Cosmetic Surgery Centers	38
Inflated Billing	320	Pharmacy	007	Legal	
Disability	330	Surgery Center Fraud	008	Attorney	07
Food Contamination	340	Disability	009	Law Firm	10
Pharmacy	350	Reporting Party Code		Legal Administrator	14
Dental	360	Carrier / Licensed Insurer	01	Paralegal	26
Embezzlement	370	Private Sector Self-Insured	02	Auto	
Other Medical	310	Public Sector Self-Insured	03	Suspect Driver	30
Life		Third Party Administrator	04	Victim Driver	31
Questionable Death	400	State Fund (SCIF)	05	Suspect Passenger	32
Suspicious/False Policy	420	District Attorney's Office	06	Suspect Pedestrian	33
Application		Law Enforcement Agency	07	Body Shop	08
Other Life	410	Incoming CDI Hotline Call	08	Repair Shop / Mechanic	34
Workers' Compensation		(CDI Use Only)		Capper	21
Claimant Fraud	500	Other CDI Information Source	09	Workers' Compensation	
Employer Defrauding Employee	510	(CDI Use Only)		Autobody-Premium Fraud	40
Legal Provider	520	Other Reporting Party	10	Contractor	41
Medical Provider	530	Party To The Loss/Injury Code		Employee Leasing	42
Pharmacy	540	General		Janitorial	43
Misclassification	561	Insured	00	Manufacturing	44
Under-Reported Wages	562	Claimant	01	Other Services	45
X-Mod Evasion	563	Witness	02	Professional Employment	46
Embezzlement	570	Alias/Also Known As (AKA)	04	Agency	
Uninsured Employer	580	Interpreter	13	Professionals	47
Other Workers' Compensation	550			Restaurant/Bar	48
				Retail	49
				Temp. Agency	51
				Transportation	54

Continued in next column

APPENDIX C. Suspected Fraud Type Code Definitions**Auto Collision**

A staged auto collision is defined as a planned incident designed to fraudulently obtain monies from an insurance entity. A planned incident may take on various forms:

- 100 “Swoop” vehicle swerves in front of “squat” vehicle causing “squat” vehicle to slam on its brakes, which causes a rear-end collision with the victims vehicle.
- 110 “Squat” vehicle slows down to close gap between his vehicle and victim’s vehicle, then brakes suddenly causing a rear-end collision with victim.
- 120 Victim’s vehicle collides with suspect’s vehicle while backing out of a driveway or while backing out of a parking space in a parking lot.
- 130 Pedestrian versus auto.
- 140 Suspect driver appears to give right-of-way to victim driver, usually in an intersection, causing vehicles to collide; suspect later claims no right-of-way was offered.
- 150 Solo vehicle crashes due to vehicle of unknown origin/description.
- 160 “Hit and run” vehicle strikes victim’s car and leaves scene of the accident.
- 170 Parties conspire to create illusion of legitimate accident, using either pre-damaged vehicles or by intentionally and covertly inflicting damage on the suspect’s vehicle(s). Generally, law enforcement is not called to the scene of the accident.
- 180 Collision orchestrated by organized criminal activity involving attorneys, doctors, other medical professionals, office administrators and/or cappers.
- 190 Medical provider inflates billing, knowingly submits bills with improper medical codes, and misrepresents facts.

Auto Property

- 200 Damages to vehicle exaggerated, non-existent, pre-existing, or vehicle damaged at a later point in time.
- 210 Damages inflated or exaggerated, non-existent or pre-existing; excessive billing of vehicle body parts or repair work.
- 220 Vehicle or motor home theft.
- 230 Vehicle or motor home arson.
- 240 Vehicle or motor home vandalism including such items as car rims, stereo equipment, and engine parts.
- 250 Policy backdated prior to loss date and/or theft of premium dollars intended for payment of coverage.
- 260 Embezzlement of funds.
- 270 Watercraft stolen or damaged while being transported on trailer.
- 280 Arson of a watercraft while transported on trailer.
- 290 Any other auto-related circumstance not listed above involving the presentation of false documents as proof of insurance.

Medical

- 300 Suspicious slip/fall claim.
- 310 Non-auto injury reported by insured and/or claimant; medical assistance was reported.
- 320 Inflated billing by any medical facility, doctor, chiropractor, laboratory, etc.
- 330 Disability claim submitted against disability insurance policy while claimant on permanent or temporary disability and receiving continual benefits and/or vocational benefits and/or claimant reported working or performing activities exceeding alleged physical limitations.
- 340 Foreign object found within food/drink products.
- 350 Pharmacist or pharmacy inflates bills or falsifies billing; person illegally obtains medical prescriptions and submits prescriptions for habitual need.
- 360 Dentist or dental office inflates bills or falsifies billing codes.
- 370 Embezzlement of funds.

Life

- 400 Questionable circumstances surrounding reported death; staged death/false identity.
- 410 Other life insurance claim-related fraud not described by other Life category code.
- 420 Suspicious or questionable actions by applicant or policyholder (insured's health misrepresented on application; suspicious timing of application in relation to insured's death); potential for monetary gain from life insurance policy. Include suspicious claims involving murder for profit and claims pertaining to viatical settlements.

Workers' Compensation

- 500 Suspicious employee applicant claim.
- 510 Employer committing illegal act against employee(s).
- 520 Legal provider inflates billing or materially misrepresents the facts.
- 530 Medical provider inflates billing, knowingly submits bills with improper medical codes, and misrepresents facts.
- 540 Pharmacy inflates bills or falsifies codes.
- 550 Any situation dealing with a Workers' Compensation claim that is not described by any other Workers' Compensation category code.
- 561 Misclassifying the type of workers to obtain workers' compensation coverage at a lower premium. (Example: classifying roofers as clerical, etc.)
- 562 Misrepresenting payroll to obtain workers' compensation coverage at a lower premium. (Example: Over-reporting wages as if employees are experienced journeyman with less likelihood of injury and thus allowing for lower premiums or under-reporting payroll to keep premiums lower.)
- 563 Misrepresenting claims history by not reporting reportable injuries or by creating shell companies to give the impression of a non or low claims history to obtain workers' compensation coverage at a lower premium.
- 570 Embezzlement of funds.
- 580 Uninsured Employers.

Other

- 600 Casualty, injury or theft that does not pertain to other fraud code definitions.
- 610 Suspicious loss or damage incurred to agricultural products and/or livestock not caused by acts of nature.

Fire

- 700 Suspicious commercial/business fire damage.
- 710 Suspected arson for hire.
- 720 Suspicious residential fire damage.
- 730 Inflated claims from fire loss.

Property

- 800 Suspicious residential theft.
- 810 Suspicious commercial business theft.
- 820 Insured reports baggage/cargo lost by commercial carrier (airline, bus, train, vessel).
- 830 Theft or damage to watercraft/aircraft while not on a trailer.
- 840 Arson of watercraft/aircraft while not on a trailer.
- 850 Property damage not included in other definitions.
- 860 Vandalism or malicious mischief to the interior or exterior of business or residence.
- 870 Suspicious theft of personal property while stored in a vehicle or motor home (commonly claimed under a homeowner's insurance policy).
- 880 Policy backdated prior to loss date and/or theft of premium dollars intended for payment of coverage.
- 890 Mold related.

Healthcare

- 001 Embezzlement of funds.
- 002 Using another's identity to secure health care benefits.
- 003 Medical provider knowingly submits false medical bills by billing for services not rendered, billing for wrong procedure codes, or billing for procedures of a medical necessity when procedures may have been elective or cosmetic in nature and not covered by health insurance.
- 004 Denotes cases where patients are recruited and given incentives to undergo medical procedures, whether those procedures were actually performed or not.
- 005 False billings by medical providers for immunizations that were not given.
- 006 Any other health care related circumstances not listed above or covered by another category code.
- 007 Pharmacy.
- 008 Surgery Center Fraud
- 009 Disability

APPENDIX D. Form FD-1 Suspected Fraudulent Claim Referral

- The next page is reference information only. Do not include with submitted referral. Use it to assist in correctly coding Pages 19-21, but **do not include page 18** when reporting to CDI.
- The final three pages contain a camera-ready version of the Form FD-1 suitable for offset printing or photocopying. This is used to report suspected fraudulent claims. **Please submit single sided copies only.**



California Department
of Insurance Fraud Division



Suspected Fraudulent Claims (FD-1's):

The Life of a Fraud Referral

22nd Annual DIR Educational Conference

Yvette Cordero, Captain
27200 Tourney Road #375
Valencia, CA 91355
(661) 253-7400

The Fraud Division

To achieve this mission, the Fraud Division is staffed by over 275 dedicated staff, of which 221 are sworn peace officers pursuant to Section 830.3(i) of the California Penal Code. Fraud Division peace officers are known as Detectives. Detectives conduct a variety of specialized criminal investigations that pertain to insurance fraud within four primary programs:

- * Workers' Compensation Fraud
- * Automobile Insurance Fraud
- * Property, Life and Casualty Fraud
- * Disability and Healthcare Fraud

Crimes investigated under these programs are under Section 550 of the Penal Code, the California Insurance Code, and other related crimes such as conspiracy, theft, and automobile theft statutes.

Suspected Fraud Referral Requirement - 1877.3 CIC

- Electronic
- Documented Referral
- Located on website: <http://www.insurance.ca.gov/0300-fraud/0100-fraud-division-overview/0300-fraud-claims-and-forms/>
- 1-800-927-HELP [4357]

Reporting Fraud

- Referral's Come From:
 - Insurance Companies
 - Special Investigation Units
 - Third Party Administrators
 - WCAB
 - Medical Board
 - Contractor's State Licensing Board
 - Citizens

Workers' Compensation Reporting

- CIC 1877.3 (b)(1) & (d)
When an insurer knows or reasonably believes it knows the identity of a person who has committed fraud they must report it to CDI & DA within a reasonable time not to exceed 60 days...

Statewide Suspected Fraud Referral Count

	FY 2013-2014	FY 2012-2013
Auto	19,248	17,558
Property Casualty	5,083	6,346
Healthcare	503	646
Workers' Compensation	5,703	5,084
Urban Grant	321	409
Total	30,858	30,043

FD-1 Referrals !!

- * Be detailed in the narrative section.
- * Why is this claim fraudulent.
- * What are the misrepresentations and are they material.
- * Note any corroborative evidence such as videos, recordings, depositions, witness statements, and medical reports.

8

California Department of Insurance **Fraud Division**

Suspected Fraudulent Claim (SFC) Referral Form (FD-1)

CASE # _____ COUNTY CODE _____ SFC # _____

AUTOMOBILE WORKERS' COMPENSATION SPECIAL OPS
 URBAN AUTO RECALL PROGRAM OTHER HEALTHCARE

REPORTING REQUIREMENTS: Please refer to the California Insurance Code (CIC) § 1871.2 regarding companies licensed in this insurance to California to submit this form. ALLIED or CLAIM only. Department has a claim against to be resolved. CIC § 1871.2 applies to claims reporting of completed Workers' Compensation claims. THIS FORM IS NOT TO BE USED FOR REPORTING CLAIMS WITHIN THE STATE OF CALIFORNIA.

REPORTING PARTY: _____ REPORTING PARTY TYPE: _____ CLAIM TYPE: NEW REFERRAL ADDED RECAL

ADDRESS: _____ CITY: _____ COUNTY: _____ ZIP: _____

E-MAIL ADDRESS (IF APPLICABLE): _____

ALLEGED VICTIM: _____ CLAIM TYPE: _____

ADDRESS: _____ CITY: _____ COUNTY: _____ ZIP: _____

CLASS # _____ POLICY # _____

ADDRESS OR LOCATION WHERE LOSS ENEMY OCCURRED: _____ CITY: _____ STATE: _____ ZIP: _____

REPORTING PARTY: _____ ACTUAL LOSS DATE: _____ LOSS TO DATE: _____

SYNOPSIS: _____

The FD-1

You may include original documents for support. If a complete copy of the claim has been submitted to the District Attorney's Office, please attach a copy of this Form FD-1. However, a complete copy of your claim file is not required.

OTHER LAW ENFORCEMENT AGENCY (Specify name): _____

DISTRICT ATTORNEY'S OFFICE (Specify name): _____

OTHER _____

CONTACT (Name and phone): _____ PHONE: () _____

FILE HANDLER (Name and phone): _____ PHONE: () _____

COMPLETED BY (Name and phone): _____ PHONE: () _____

DATE FILED _____

Completed Form No. CDFI Fraud Division Service Unit, P.O. Box 37720, Sacramento, CA 95877-0200

Examples

- Joe Plumber sustained a burn injury on 5/11/2000. Applicant untwisted a cap off a pipe and hot steam went onto his left leg and parts of groin area. Applicant told doctor and employer that he was unable to work due to injury. On 5/26/06, Joe's manager was informed by co-worker, John Witness that Joe Plumber was seen at a local Plumbing Supply store buying supplies and that Joe Plumber offered John Witness a job making extra money on the side. On 6/22/06 and 6/23/06 Carrier obtained video of applicant working. On 7/1/06 applicant went to the doctor and stated he still is unable to work and has not done anything since he has been injured other than sit on the couch resting.
- Jack Spratt was working on 8/22/05 when he twisted his back. He reported an injury to his supervisor and was sent for medical attention. Spratt was placed on TTD six months. During this time, Spratt was seen by three medical doctors. When asked if he ever injured his back prior to 8/22/05, Spratt told the doctors he did not. Spratt was deposed on 1/15/06 and was asked if he ever injured his back prior to 8/22/05 either at work or other type of accident and Spratt said no. Records obtained from another insurance carrier indicates Spratt hurt his back in 2003 when he was involved in a car accident.

Examples

- Mary Goose injured her wrist when a file cabinet closed on her hand. Mary was sent to the doctor for treatment over a six month period and was out of work for a majority of this time. Mary's attorney sent her to see Doctor Fraud for treatment and evaluation. After receiving bills for treatment from Doctor Fraud, the insurance company sent them to Mary Goose for review. Mary Goose reported that she did not receive many of the treatments indicated on the bills and she kept detailed notes of the treatments she did receive. We contacted another patient of Doctor Fraud, who after reviewing the bills, made the same claim as Mary, he did not receive all the treatments indicated on the bill.

Poor Referral Examples

- Doctor is known to handle suspicious claims
- Injury did not occur the way it was reported
- We feel the doctor is treating excessively
- Applicant may be working while collecting TTD
- Attorney not cooperating

Questions Regarding This Process (Referral Rejection – Now What)

- Contact:
 - Local District Attorney or
 - Any Fraud Division Regional Office Captain

Types of Workers' Compensation Fraud

- Workers' Compensation Fraud
 - Claimant Fraud
 - Attorneys/Medical Providers
 - Use of Cappers
 - Provider Fraud
 - Medical Mills
 - Interpreters
 - Vocation Rehabilitation
 - Employer Fraud
 - Premium Fraud
 - Uninsured Employer
 - Insider Fraud/Insurance Company Fraud
 - Embezzlement of Claim File
 - Agent/Broker Fraud
 - Claim handling Fraud

Insurance Fraud

FRAUD: Fraud occurs when someone knowingly lies to obtain/deny compensation.

MILK:

- M** = Material
- I** = Intent
- L** = Lie
- K** = Knowledge

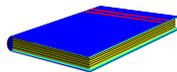


The Criminal Investigation



Documents Important to an Investigation

- The **entire** claim file
- Depositions (Signed if possible)
- Claim Examiners notes
- All DWC-1's
- All medical reports
- Payment History



Investigative Tasks

- * Review FD-1
- * Demand letter
- * Discussion with referring party
- * Pre-investigative meeting with district attorney
- * Investigative plan
- * Review all contents of claim file: Adjuster notes, medical reports, TTD payment checks, billing invoices, depositions, videos, correspondences
- * Create time line
- * Search databases
- * Conduct surveillance
- * Trash pick-ups
- * Conduct interviews
- * Prepare and serve a search warrant
- * Review evidence
- * Prepare report of investigation
- * Pre-filing meeting with district attorney
- * Serve arrest warrant

Insurance Fraud Elements



- 550(a) P.C.
- It is unlawful to:
- Knowingly present, or cause to be presented any false or fraudulent claim for the payment of a loss.*
- *This differs from abuse which is the practice of using a system in a way that is contrary to either the intended purpose of the system or the law.

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Statute of Limitations

- Four years from the date of offense, unless the crime was not discoverable by reasonable means and then it is four years from the date of discovery
- Overt acts can continue a statute
- Claims notes can establish when the statute begins



Immunity for Insurer and Governmental Agency

CIC Section 1873.2 In the absence of fraud or malice, no insurer or no governmental agency representatives 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 1873 or 1873.1.

Immunity for Insurer and Governmental Agency – Workers Compensation

CIC Section 1877.5 No insurer who furnishes information and no governmental agency who furnishes or receives information shall be subject to any civil liability in a cause or action of any kind where the insurer or agency acted in good faith, without malice and reasonably believes that the action taken was warranted by the then known facts obtained by reasonable effort.

Insurance Fraud

Insurance Fraud Suspects Are Often Involved in Other Illegal Activities

* - Weapons - Money Laundering - Drugs



Insurance Fraud – Getting the Word Out

- Social Media
- E-Blasts
- Press Conferences
- Press Releases



Underground Economy



FOR IMMEDIATE RELEASE: August 28, 2014
MEDIA INQUIRIES ONLY: Media Relations: 916-492-3566 / After Hours: 916-599-1320
(#081)

NEWS RELEASE

Multiple state agencies combine efforts to conduct statewide underground economy sweep - many violations found

SACRAMENTO, Calif. – The California Department of Insurance yesterday led a statewide multi-agency outreach effort, visiting more than 50 businesses to educate business owners about their obligations to comply with insurance, licensing, workplace safety and labor laws, tax codes, and regulations. Enforcement teams from five state agencies and several county district attorneys, including the Department of Industrial Relations, Contractors State License Board, Department of Insurance, Franchise Tax Board, Employment Development Department and the Board of Equalization swept across the state to visit a wide variety of businesses, such as construction, hotels, restaurants, car washes and auto repair.

Recent Workers' Compensation Investigations

Bomb-strapped bank robbery co-conspirator charged with workers' comp fraud

News: 2014 Press Release
For Release: August 11, 2014
Media Calls Only: 916-492-3566

Bomb-strapped bank robbery co-conspirator charged with workers' comp fraud

DOWNEY, Calif. - Aurora Barrera, 33, of Downey was arrested on charges related to her allegedly submitting a fraudulent workers' compensation claim for treatment of post-traumatic stress disorder associated with a robbery, that she actually assisted in staging, at a bank where she worked as an assistant bank manager.

"This conspiracy led to a major law enforcement response, including the bomb squad," said Insurance Commissioner Dave Jones. "It's shocking to think that, Barrera, a trusted financial institution manager would be a co-conspirator in a bank robbery and staged kidnapping, and then have the audacity to file a bogus workers' comp claim for traumatic stress and believe she could get away with it."

Recent Workers' Compensation Investigations

Mother and son conspire to commit fraud forging dead woman's signature to collect more than \$165,000 in benefits

News: 2014 Press Release
For Release: September 2, 2014
Media Calls Only: 916-492-3566

Mother and son conspire to commit fraud forging dead woman's signature to collect more than \$165,000 in benefits

Co-conspirator worked as background singer for pop sensation Justin Bieber
LOS ANGELES, Calif. - Vernon Burris, 30, pleaded guilty to fraud and forgery in a scheme to collect more than \$165,000 in workers' compensation checks sent to his deceased aunt and deposit them into his mother's bank account. Burris' mother, Dolly Burris Bennett, 61, was arrested at his sentencing and charged with 20 counts of forgery and one count of grand theft. Burris Bennett was booked into Century Regional Detention Facility in Lynwood with bail set at \$465,000.

"The theft of benefit checks and forgery is another way the workers' compensation system is attacked and is a huge problem that affects all Californians by increasing insurance premiums for businesses and ultimately prices consumers

Recent Workers' Compensation Investigations

Parks and recreation worker exploits Lyme disease diagnosis for \$364,000 through a fraudulent workers' compensation claim

News: 2014 Press Release

For Release: May 7, 2014

Media Calls Only: 916-492-3566

Parks and recreation worker exploits Lyme disease diagnosis for \$364,000 through a fraudulent workers' compensation claim

LOS ANGELES, Calif. – Susette Boggs, 52 of Palmdale, was arrested last month for alleged workers' compensation fraud. Boggs worked for the Los Angeles County Department of Parks and Recreation for over 10 years at the Placenta Canyon Nature Center in Newhall handling variety of animals, including owls, skunks, reptiles and opossums. Boggs reported that she had been bitten by a tick, contracted Lyme disease and as a result filed a workers' compensation claim with a date of injury of April 19, 2007.

"Exaggerating symptoms and deceiving physicians in hopes of a monetary workers' compensation windfall is not a smart retirement plan," said Commissioner Jones. "The detectives in my department are diligent in their investigations to

Recent Workers' Compensation Investigations

CDI Case Number: 12JW000682

County: Los Angeles

Defendant: Carlos Louis Rivas

City/County of Residence: Palmdale/Los Angeles

Conviction Date: 02/26/14

Offense: 1 Count of IC 11880(a) (Premium Fraud); 2 Counts of PC 550(a)(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)

Amount Allegedly Defrauded: \$156,878.71

Sentence: 3 Years State Prison (Suspended), 600 Hours Community Service, 5 Years Formal Probation, \$156,878.71 Restitution to State Compensation Insurance Fund, \$280 Civil Fine

Goal

- The CDI, Fraud Division will review all SFCs received, and together with local District Attorneys, insurers and employers, attempt to identify current patterns and trends of insurance fraud. Utilizing that information and all available manpower, our goal is to investigate and prosecute persons suspected of insurance fraud crimes.
- Report it!

* <http://www.insurance.ca.gov/>

YOU the consumer

- Each of us is a victim because widespread insurance fraud ultimately translates into higher premiums for each of us and results in elevated costs of goods and services.

**California Department
of Insurance Fraud Division**

Yvette Cordero, Captain
27200 Tourney Road #375
Valencia, CA 91355
(661) 253-7400
corderoy@insurance.ca.gov

Medical Fraud

Medical-Legal Evaluations and the Insurance Industry; an Investigator's Perspective



KEVIN MCINERNEY
FRESNO COUNTY DISTRICT ATTORNEY'S OFFICE
BUREAU OF INVESTIGATIONS

HOW I SEE IT...

THE GOOD

- Qualified Medical Evaluators (QMEs) and Agreed Medical Evaluators (AMEs) provide unbiased evaluations of claimants when there is a dispute regarding a claim;
- The panel QME process is well regulated;
- Billing for medical-legal reports is regulated by the California Code of Regulations;
- Most medical providers certified by the Department of Industrial Relations Division of Workers' Compensation are fair, unbiased medical professionals who do not commit fraud;
- Most insurance providers are willing to provide assistance to law enforcement;
- Investigation and prosecution of billing fraud generally relies on objective provable facts;

HOW I SEE IT...

THE BAD

- Our industry is focused on premium fraud and claimant fraud, less so on medical provider fraud;
- Medical provider billing fraud is often complex:
 - Less likely to be recognized by claims adjusters, SIU investigators, or law enforcement investigators.
 - Once recognized and reported, medical provider fraud often takes months, if not years, to investigate and prosecute.
- Insurance providers often fail to recognize fraudulent billing;
- Insurance providers sometimes pay bills they suspect are fraudulent;
- There seems to be very little communication between claims adjusters, SIU investigators, and the law enforcement agencies responsible for investigating fraud.

The FRAUD!

Easily recognizable medical-legal billing fraud:

1. Inflation of the complexity of the report:
 - a. Addressing apportionment when the patient is not PNS;
 - b. Addressing causation when the cause of the injury is not in question;
2. Billing for a large, unreasonable number of hours related to:
 - a. Record review (i.e. 10 hours billed for 100 pages of records reviewed);
 - b. Medical Research (i.e. a Diplomate of the American Board of Orthopedic Surgery doing 22 hours of medical research for a simple shoulder injury);
3. There is no dispute, but you receive a medical-legal report purported to be from a QME. The report likely doesn't reference the referring provider or the nature of the pseudo-dispute. A CMS 1500 is attached and requests payment be sent to a P.O. Box in southern California.

EXAMPLES OF MED-LEGAL FRAUD

Third Party Medical Management Company

- Management company provides facilities, patients, scheduling, transcription services, and billing
- Physician sees patients and dictates reports
- CMS 1500 instructs insurance providers to send all payments to the same address
- Management company is not referenced in any of the documents sent to the insurance providers
- Many of the medical-legal reports are overbilled

Primary Treating Physician/ Pseudo QME

- Insurance provider receives medical-legal reports that appear to be legitimate; prepared by a QME
- The fee disclosure and accompanying CMS 1500 may or may not be billed correctly
- Review of the report revealed that it failed to reference who requested the evaluation and why it was requested
- Comparison of the report in question to other reports authored by the same medical provider revealed they were nearly identical

WHAT WE CAN DO ABOUT IT.

Steps we can take to prevent and dissuade medical providers from committing billing fraud, increase successful investigation and prosecution of medical providers who commit fraud, and decrease fraud related loss to the industry:

- Patterns of overbilling and fraudulent billing are the key – claims adjusters are often in the best position to recognize the patterns. Insurance providers should teach their adjusters to recognize fraudulent billing;
 - Med-legal reports require thorough review before payment; the fee disclosure should be compared to the content of the report to confirm consistency;
 - Communication and information sharing between claims adjusters, SIU Investigators, law enforcement investigators, prosecutors, and the Department of Industrial Relations Division of Workers' Compensation needs improvement;
 - Work with your legal counsel and management to develop a plan for dealing with fraudulent bills (i.e. a form letter advising the medical provider that you suspect fraud, the bill will not be paid, and law enforcement has been notified). Notify the Department of Insurance and your local District Attorney's Office.
- **Don't pay fraudulent bills!** If you have questions you can always contact me.

THANK YOU!

Kevin McInerney

Senior Investigator

Fresno County District Attorney's Office

kmcinerney@co.fresno.ca.us

(559) 600-7011

LABOR CODE SECTION 139.3 – 139.32

139.3. (a) Notwithstanding any other law, to the extent those services are paid pursuant to Division 4 (commencing with Section 3200), it is unlawful for a physician to refer a person for clinical laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, outpatient surgery, diagnostic imaging goods or services, or pharmacy goods, whether for treatment or medical-legal purposes, if the physician or his or her immediate family has a financial interest with the person or in the entity that receives the referral.

(b) For purposes of this section and Section 139.31, the following shall apply:

(1) "Diagnostic imaging" includes, but is not limited to, all X-ray, computed axial tomography magnetic resonance imaging, nuclear medicine, positron emission tomography, mammography, and ultrasound goods and services.

(2) "Immediate family" includes the spouse and children of the physician, the parents of the physician, and the spouses of the children of the physician.

(3) "Physician" means a physician as defined in Section 3209.3.

(4) A "financial interest" includes, but is not limited to, any type of ownership, interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between a licensee and a person or entity to whom the physician refers a person for a good or service specified in subdivision (a). A financial interest also exists if there is an indirect relationship between a physician and the referral recipient, including, but not limited to, an arrangement whereby a physician has an ownership interest in any entity that leases property to the referral recipient. Any financial interest transferred by a physician to, or otherwise established in, any person or entity for the purpose of avoiding the prohibition of this section shall be deemed a financial interest of the physician.

(5) A "physician's office" is either of the following:

(A) An office of a physician in solo practice.

(B) An office in which the services or goods are personally provided by the physician or by employees in that office, or personally by independent contractors in that office, in accordance with other provisions of law. Employees and independent contractors shall be licensed or certified when that licensure or certification is required by law.

(6) The "office of a group practice" is an office or offices in which two or more physicians are legally organized as a partnership, professional corporation, or not-for-profit corporation licensed according to subdivision (a) of Section 1204 of the Health and Safety Code for which all of the following are applicable:

(A) Each physician who is a member of the group provides substantially the full range of services that the physician routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel.

(B) Substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group, and except that in the case of multispecialty clinics, as defined in subdivision (1) of Section 1206 of the Health and Safety Code, physician services are billed in the name of the multispecialty clinic and amounts so received are treated as receipts of the multispecialty clinic.

(C) The overhead expenses of, and the income from, the practice are distributed in accordance with methods previously determined by members of the group.

(7) Outpatient surgery includes both of the following:

(A) Any procedure performed on an outpatient basis in the operating rooms, ambulatory surgery rooms, endoscopy units, cardiac catheterization laboratories, or other sections of a freestanding ambulatory surgery clinic, whether or not licensed under paragraph

(1) of subdivision (b) of Section 1204 of the Health and Safety Code.

(B) The ambulatory surgery itself.

(8) "Pharmacy goods" means any dangerous drug or dangerous device as defined by Section 4022 of the Business and Professions Code, any medical food as defined by Section 109971 of the Health and Safety Code, and any over-the-counter drug as classified by the federal Food and Drug Administration, except over-the-counter drugs sold at commercially reasonable rates in physical retail outlets commonly accessed by the public.

(c) (1) It is unlawful for a licensee to enter into an arrangement or scheme, such as a cross-referral arrangement, that the licensee knows, or should know, has a principal purpose of ensuring referrals by the licensee to a particular entity that, if the licensee directly made referrals to that entity, would be in violation of this section.

(2) It shall be unlawful for a physician to offer, deliver, receive, 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 a referred evaluation or consultation.

(d) No claim for payment shall be presented by an entity to any individual, third-party payor, or other entity for any goods or services furnished pursuant to a referral prohibited under this section.

(e) A physician who refers to or seeks consultation from an organization in which the physician has a financial interest shall disclose this interest to the patient or if the patient is a minor, to the patient's parents or legal guardian in writing at the time of the referral.

(f) No insurer, self-insurer, or other payor shall pay a charge or lien for any goods or services resulting from a referral in violation of this section.

(g) A violation of subdivision (a) shall be a misdemeanor. The appropriate licensing board shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. Violations of this section may also be subject to civil penalties of up to five thousand dollars (\$5,000) for each offense, which may be enforced by the Insurance Commissioner, Attorney General, or a district attorney. A violation of subdivision (c), (d), (e), or (f) is a public offense and is punishable upon conviction by a fine not exceeding fifteen thousand dollars (\$15,000) for each violation and appropriate disciplinary action, including revocation of professional licensure, by the Medical Board of California or other appropriate governmental agency.

139.31. The prohibition of Section 139.3 shall not apply to or restrict any of the following:

(a) A physician may refer a patient for a good or service otherwise prohibited by subdivision (a) of Section 139.3 if the physician's regular practice is where there is no alternative provider of the service within either 25 miles or 40 minutes traveling time, via the shortest route on a paved road. A physician who refers to, or seeks consultation from, an organization in which the

physician has a financial interest under this subdivision shall disclose this interest to the patient or the patient's parents or legal guardian in writing at the time of referral.

(b) A physician who has one or more of the following arrangements with another physician, a person, or an entity, is not prohibited from referring a patient to the physician, person, or entity because of the arrangement:

(1) A loan between a physician and the recipient of the referral, if the loan has commercially reasonable terms, bears interest at the prime rate or a higher rate that does not constitute usury, is adequately secured, and the loan terms are not affected by either party's referral of any person or the volume of services provided by either party.

(2) A lease of space or equipment between a physician and the recipient of the referral, if the lease is written, has commercially reasonable terms, has a fixed periodic rent payment, has a term of one year or more, and the lease payments are not affected by either party's referral of any person or the volume of services provided by either party.

(3) A physician's ownership of corporate investment securities, including shares, bonds, or other debt instruments that were purchased on terms that are available to the general public through a licensed securities exchange or NASDAQ, do not base profit distributions or other transfers of value on the physician's referral of persons to the corporation, do not have a separate class or accounting for any persons or for any physicians who may refer persons to the corporation, and are in a corporation that had, at the end of the corporation's most recent fiscal year, total gross assets exceeding one hundred million dollars (\$100,000,000).

(4) A personal services arrangement between a physician or an immediate family member of the physician and the recipient of the referral if the arrangement meets all of the following requirements:

(A) It is set out in writing and is signed by the parties.

(B) It specifies all of the services to be provided by the physician or an immediate family member of the physician.

(C) The aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement.

(D) A written notice disclosing the existence of the personal services arrangement and including information on where a person may go to file a complaint against the licensee or the immediate family member of the licensee, is provided to the following persons at the time any services pursuant to the arrangement are first provided:

(i) An injured worker who is referred by a licensee or an immediate family member of the licensee.

(ii) The injured worker's employer, if self-insured.

(iii) The injured worker's employer's insurer, if insured.

(iv) If the injured worker is known by the licensee or the recipient of the referral to be represented, the injured worker's attorney.

(E) The term of the arrangement is for at least one year.

(F) The compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties, except that if the services provided pursuant to the arrangement include medical services provided under Division 4, compensation paid for the services shall be subject to the official medical fee schedule promulgated pursuant to Section 5307.1 or subject to any contract authorized by Section 5307.11.

(G) The services to be performed under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

(c) (1) A physician may refer a person to a health facility as defined in Section 1250 of the Health and Safety Code, to any facility owned or leased by a health facility, or to an outpatient surgical center, if the recipient of the referral does not compensate the physician for the patient referral, and any equipment lease arrangement between the physician and the referral recipient complies with the requirements of paragraph (2) of subdivision (b).

(2) Nothing shall preclude this subdivision from applying to a physician solely because the physician has an ownership or leasehold interest in an entire health facility or an entity that owns or leases an entire health facility.

(3) A physician may refer a person to a health facility for any service classified as an emergency under subdivision (a) or (b) of Section 1317.1 of the Health and Safety Code. For nonemergency outpatient diagnostic imaging services performed with equipment for which, when new, has a commercial retail price of four hundred thousand dollars (\$400,000) or more, the referring physician shall obtain a service preauthorization from the insurer, or self-insured employer. Any oral authorization shall be memorialized in writing within five business days.

(d) A physician compensated or employed by a university may refer a person to any facility owned or operated by the university, or for a physician service, to another physician employed by the university, provided that the facility or university does not compensate the referring physician for the patient referral. For nonemergency diagnostic imaging services performed with equipment that, when new, has a commercial retail price of four hundred thousand dollars (\$400,000) or more, the referring physician shall obtain a service preauthorization from the insurer or self-insured employer. An oral authorization shall be memorialized in writing within five business days. In the case of a facility which is totally or partially owned by an entity other than the university, but which is staffed by university physicians, those physicians may not refer patients to the facility if the facility compensates the referring physician for those referrals.

(e) The prohibition of Section 139.3 shall not apply to any service for a specific patient that is performed within, or goods that are supplied by, a physician's office, or the office of a group practice. Further, the provisions of Section 139.3 shall not alter, limit, or expand a physician's ability to deliver, or to direct or supervise the delivery of, in-office goods or services according to the laws, rules, and regulations governing his or her scope of practice. With respect to diagnostic imaging services performed with equipment that, when new, had a commercial retail price of four hundred thousand dollars (\$400,000) or more, or for physical therapy services, or for psychometric testing that exceeds the routine screening battery protocols, with a time limit of two to five hours, established by the administrative director, the referring physician obtains a service preauthorization from the insurer or self-insured employer. Any oral authorization shall be memorialized in writing within five business days.

(f) The prohibition of Section 139.3 shall not apply where the physician is in a group practice as defined in Section 139.3 and refers a person for services specified in Section 139.3 to a multispecialty clinic, as defined in subdivision (l) of Section 1206 of the Health and Safety Code. For diagnostic imaging services performed with equipment that, when new, had a commercial retail price of four hundred thousand dollars (\$400,000) or more, or physical therapy services, or psychometric testing that exceeds the routine screening battery protocols, with a time limit of two to five hours, established by the administrative director, performed at the multispecialty facility, the referring physician shall obtain a service preauthorization from the insurer or self-insured employer. Any oral authorization shall be memorialized in writing within five business days.

(g) The requirement for preauthorization in Sections (c), (e), and (f) shall not apply to a patient for whom the physician or group accepts payment on a capitated risk basis.

(h) The prohibition of Section 139.3 shall not apply to any facility when used to provide health care services to an enrollee of a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(i) The prohibition of Section 139.3 shall not apply to an outpatient surgical center, as defined in paragraph (7) of subdivision (b) of Section 139.3, where the referring physician obtains a service preauthorization from the insurer or self-insured employer after disclosure of the financial relationship.

(j) The prohibition of Section 139.3 shall not apply to a physician's financial interest in a retailer of prescription drugs sold by a physical retail outlet commonly accessed by the public or a mail-order pharmacy serving a broad national or regional market, provided that the majority of the physician's practice, with regard to income, time, and number of patients, does not relate to occupational medicine and the physician receives no remuneration from the retailer of prescription drugs to market or otherwise solicit occupational injury or occupational disease patients.

139.32. (a) For the purpose of this section, the following definitions apply:

(1) "Financial interest in another entity" means, subject to subdivision (h), either of the following:

(A) Any type of ownership, interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between the interested party and the other entity to which the employee is referred for services.

(B) An agreement, debt instrument, or lease or rental agreement between the interested party and the other entity that provides compensation based upon, in whole or in part, the volume or value of the services provided as a result of referrals.

(2) "Interested party" means any of the following:

(A) An injured employee.

(B) The employer of an injured employee, and, if the employer is insured, its insurer.

(C) A claims administrator, which includes, but is not limited to, a self-administered workers' compensation insurer, a self-administered self-insured employer, a self-administered joint powers authority, a self-administered legally uninsured employer, a third-party claims administrator for an insurer, a self-insured employer, a joint powers authority, or a legally uninsured employer or a subsidiary of a claims administrator.

(D) An attorney-at-law or law firm that is representing or advising an employee regarding a claim for compensation under Division 4 (commencing with Section 3200).

(E) A representative or agent of an interested party, including either of the following:

(i) An employee of an interested party.

(ii) Any individual acting on behalf of an interested party, including the immediate family of the interested party or of an employee of the interested party. For purposes of this clause, immediate family includes spouses, children, parents, and spouses of children.

(F) A provider of any medical services or products.

(3) "Services" means, but is not limited to, any of the following:

(A) A determination regarding an employee's eligibility for compensation under Division 4 (commencing with Section 3200), that includes both of the following:

(i) A determination of a permanent disability rating under Section 4660.

(ii) An evaluation of an employee's future earnings capacity resulting from an occupational injury or illness.

(B) Services to review the itemization of medical services set forth on a medical bill submitted under Section 4603.2.

(C) Copy and document reproduction services.

(D) Interpreter services.

(E) Medical services, including the provision of any medical products such as surgical hardware or durable medical equipment.

(F) Transportation services.

(G) Services in connection with utilization review pursuant to Section 4610.

(b) All interested parties shall disclose any financial interest in any entity providing services.

(c) Except as otherwise permitted by law, it is unlawful for an interested party other than a claims administrator or a network service provider to refer a person for services provided by another entity, or to use services provided by another entity, if the other entity will be paid for those services pursuant to Division 4 (commencing with Section 3200) and the interested party has a financial interest in the other entity.

(d) (1) It is unlawful for an interested party to enter into an arrangement or scheme, such as a cross-referral arrangement, that the interested party knows, or should know, has a purpose of ensuring referrals by the interested party to a particular entity that, if the interested party directly made referrals to that other entity, would be in violation of this section.

(2) It is unlawful for an interested party to offer, deliver, receive, 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 to refer a person for services.

(e) A claim for payment shall not be presented by an entity to any interested party, individual, third-party payer, or other entity for any services furnished pursuant to a referral prohibited under this section.

(f) An insurer, self-insurer, or other payer shall not knowingly pay a charge or lien for any services resulting from a referral for services or use of services in violation of this section.

(g) (1) A violation of this section shall be misdemeanor. If an interested party is a corporation, any director or officer of the corporation who knowingly concurs in a violation of this section shall be guilty of a misdemeanor. The appropriate licensing authority for any person subject to this section shall review the facts and circumstances of any conviction pursuant to this section and take appropriate disciplinary action if the licensee has committed unprofessional conduct, provided that the appropriate licensing authority may act on its own discretion independent of the initiation or completion of a criminal prosecution. Violations of this section are also subject to civil penalties of up to fifteen thousand dollars (\$15,000) for each offense, which may be enforced by the Insurance Commissioner, Attorney General, or a district attorney.

(2) For an interested party, a practice of violating this section shall constitute a general business practice that discharges or administers compensation obligations in a dishonest manner, which shall be subject to a civil penalty under subdivision (e) of Section 129.5.

(3) For an interested party who is an attorney, a violation of subdivision (b) or (c) shall be referred to the Board of Governors of the State Bar of California, which shall review the facts

and circumstances of any violation pursuant to subdivision (b) or (c) and take appropriate disciplinary action if the licensee has committed unprofessional conduct.

(4) Any determination regarding an employee's eligibility for compensation shall be void if that service was provided in violation of this section.

(h) The following arrangements between an interested party and another entity do not constitute a "financial interest in another entity" for purposes of this section:

(1) A loan between an interested party and another entity, if the loan has commercially reasonable terms, bears interest at the prime rate or a higher rate that does not constitute usury, and is adequately secured, and the loan terms are not affected by either the interested party's referral of any employee or the volume of services provided by the entity that receives the referral.

(2) A lease of space or equipment between an interested party and another entity, if the lease is written, has commercially reasonable terms, has a fixed periodic rent payment, has a term of one year or more, and the lease payments are not affected by either the interested party's referral of any person or the volume of services provided by the entity that receives the referral.

(3) An interested party's ownership of the corporate investment securities of another entity, including shares, bonds, or other debt instruments that were purchased on terms that are available to the general public through a licensed securities exchange or NASDAQ.

(i) The prohibitions described in this section do not apply to any of the following:

(1) Services performed by, or determinations of compensation issues made by, employees of an interested party in the course of that employment.

(2) A referral for legal services if that referral is not prohibited by the Rules of Professional Conduct of the State Bar.

(3) A physician's referral that is exempted by Section 139.31 from the prohibitions prescribed by Section 139.3.

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.

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Chapter 4.5. Division of Workers' Compensation
Subchapter 1. Administrative Director--Administrative Rules
Article 5.6. Medical-Legal Expenses and Comprehensive Medical-Legal Evaluations

[New query](#)

§9795. Reasonable Level of Fees for Medical-Legal Expenses, Follow-up, Supplemental and Comprehensive Medical-Legal Evaluations and Medical-Legal Testimony.

(a) The schedule of fees set forth in this section shall be prima facie evidence of the reasonableness of fees charged for medical-legal evaluation reports, and fees for medical-legal testimony.

Reports by treating or consulting physicians, other than comprehensive, follow-up or supplemental medical-legal evaluations, regardless of whether liability for the injury has been accepted at the time the treatment was provided or the report was prepared, shall be subject to the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1 rather than to the fee schedule set forth in this section.

(b) The fee for each evaluation is calculated by multiplying the relative value by \$12.50, and adding any amount applicable because of the modifiers permitted under subdivision (d). The fee for each medical-legal evaluation procedure includes reimbursement for the history and physical examination, review of records, preparation of a medical-legal report, including typing and transcription services, and overhead expenses. The complexity of the evaluation is the dominant factor determining the appropriate level of service under this section; the times to perform procedures is expected to vary due to clinical circumstances, and is therefore not the controlling factor in determining the appropriate level of service.

(c) Medical-legal evaluation reports and medical-legal testimony shall be reimbursed as follows:

CODE B.R. PROCEDURE DESCRIPTION

ML100 *Missed Appointment for a Comprehensive or Follow-Up Medical-Legal Evaluation.* This code is designed for communication purposes only. It does not imply that compensation is necessarily owed.

CODE RV PROCEDURE DESCRIPTION

ML101 5 *Follow-up Medical-Legal Evaluation.* Limited to a follow-up medical-legal evaluation by a physician which occurs within nine months of the date on which the prior medical-legal evaluation was performed. The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities: review of records, face-to-face time with the injured worker, and

preparation of the report. Time spent shall be tabulated in increments of 15 minutes or portions thereof, rounded to the nearest quarter hour. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour.

CODE RV PROCEDURE DESCRIPTION

ML102 50 *Basic Comprehensive Medical-Legal Evaluation.* Includes all comprehensive medical-legal evaluations other than those included under ML 103 or ML 104.

CODE RV PROCEDURE DESCRIPTION

ML103 75 *Complex Comprehensive Medical-Legal Evaluation.* Includes evaluations which require three of the complexity factors set forth below.

In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were required for the evaluation, and the circumstances which made these complexity factors applicable to the evaluation. An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon:

- (1) Two or more hours of face-to-face time by the physician with the injured worker;
- (2) Two or more hours of record review by the physician;
- (3) Two or more hours of medical research by the physician;
- (4) Four or more hours spent on any combination of two of the complexity factors (1)-(3), which shall count as two complexity factors. Any complexity factor in (1), (2), or (3) used to make this combination shall not also be used as the third required complexity factor;
- (5) Six or more hours spent on any combination of three complexity factors (1)-(3), which shall count as three complexity factors;
- (6) Addressing the issue of medical causation, upon written request of the party or parties requesting the report, or if a bona fide issue of medical causation is discovered in the evaluation;
- (7) Addressing the issue of apportionment, when determination of this issue requires the physician to evaluate the claimant's employment by three or more employers, three or more injuries to the same body system or body region as delineated in the Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), or two or more or more injuries involving two or more body systems or body regions as delineated in that Table of Contents. The Table of Contents of *Guides to the Evaluation of Permanent Impairment* (Fifth Edition), published by the American Medical Association, 2000, is incorporated by reference.
- (8) For dates of injury before December 31, 2012 where the evaluation occurs on or before June 30, 2013, addressing the issue of medical monitoring of an employee following a toxic exposure to chemical, mineral or biologic substances;
- (9) A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation.
- (10) For dates of injury before December 31, 2012 where the evaluation that occurs on or before June 30, 2013, addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610.

CODE RV PROCEDURE DESCRIPTION

ML104 5 *Comprehensive Medical-legal Evaluation Involving Extraordinary Circumstances.* The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary hourly fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician for any of the following:

- (1) An evaluation which requires four or more of the complexity factors listed under ML 103; In a separate section at the beginning of the report, the physician shall clearly and concisely specify which four or more of the complexity factors were required for the evaluation, and the circumstances which made these complexity factors applicable to the evaluation. An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed, and excerpt or include copies of medical evidence relied upon.

(2) An evaluation involving prior multiple injuries to the same body part or parts being evaluated, and which requires three or more of the complexity factors listed under ML 103, including three or more hours of record review by the physician;

(3) A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances. When billing under this code for extraordinary circumstances, the physician shall include in his or her report (i) a clear, concise explanation of the extraordinary circumstances related to the medical condition being evaluated which justifies the use of this procedure code, and (ii) verification under penalty of perjury of the total time spent by the physician in each of these activities: reviewing the records, face-to-face time with the injured worker, preparing the report and, if applicable, any other activities.

CODE RV PROCEDURE DESCRIPTION

ML105 5 Fees for medical-legal testimony. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician. The physician shall be entitled to fees for all itemized reasonable and necessary time spent related to the testimony, including reasonable preparation and travel time. The physician shall be paid a minimum of one hour for a scheduled deposition.

CODE RV PROCEDURE DESCRIPTION

ML106 5 Fees for supplemental medical-legal evaluations. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour or portion thereof, rounded to the nearest quarter hour, spent by the physician. Fees will not be allowed under this section for supplemental reports following the physician's review of (A) information which was available in the physician's office for review or was included in the medical record provided to the physician prior to preparing the initial report or (B) the results of laboratory or diagnostic tests which were ordered by the physician as part of the initial evaluation.

(d) The services described by Procedure Codes ML101 through ML106 may be modified under the circumstances described in this subdivision. The modifying circumstances shall be identified by the addition of the appropriate modifier code, which is reported by a two-digit number placed after the usual procedure number separated by a hyphen. The modifiers available are the following:

-92 Performed by a primary treating physician. This modifier is added solely for identification purposes, and does not change the normal value of the service.

-93 Interpreter needed at time of examination, or other circumstances which impair communication between the physician and the injured worker and significantly increase the time needed to conduct the examination. Requires a description of the circumstance and the increased time required for the examination as a result. Where this modifier is applicable, the value for the procedure is modified by multiplying the normal value by 1.1. This modifier shall only be applicable to ML 102 and ML 103.

-94 Evaluation and medical-legal testimony performed by an Agreed Medical Evaluator. Where this modifier is applicable, the value of the procedure is modified by multiplying the normal value by 1.25. If modifier -93 is also applicable for an ML-102 or ML-103, then the value of the procedure is modified by multiplying the normal value by 1.35.

-95 Evaluation performed by a panel selected Qualified Medical Evaluator. This modifier is added solely for identification purposes, and does not change the normal value of any procedure.

(e) Requests for duplicate reports shall be in writing. Duplicate reports shall be separately reimbursable and shall be reimbursed in the same manner as set forth in the Official Medical Fee Schedule adopted pursuant to Labor Code Section 5307.1.

(f) This section shall apply to medical-legal evaluation reports where the examination occurs on or after the effective date of this section. The 2006 amendments to this section shall apply to: (1) medical-legal evaluation reports where the medical examination to which the report refers occurs on or after the effective date of the 2006 amendments; (2) medical-legal testimony provided on or after the effective date of the 2006 amendments; and (3) supplemental medical legal reports that are requested on or after the effective date of the 2006 amendments regardless of the date of the original examination.

Note: Authority cited: Sections 133, 4627, 5307.3 and 5307.6, Labor Code. Reference: Sections 139.2, 4061, 4061.5, 4062, 4610.5, 4620, 4621, 4622, 4625, 4626, 4628, 5307.6 and 5402, Labor Code.

HISTORY

1. Repealer and new section filed 8-3-93; operative 8-3-93. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 32).
2. Change without regulatory effect amending subsection (a) and subsection (c) medical-legal evaluation procedure code ML104 filed 8-27-93 pursuant to section 100, title 1, California Code of Regulations (Register 93, No. 35).
3. Amendment of section heading, section and Note filed 12-31-93; operative 1-1-94. Submitted to OAL for printing only pursuant to Government Code section 11351 (Register 93, No. 53).
4. Amendment filed 2-24-99; operative 4-1-99 (Register 99, No. 9).
5. Change without regulatory effect amending subsections (b) and (d) filed 6-12-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 24).
6. Amendment of section and Note filed 6-30-2006; operative 7-1-2006. Submitted to OAL for filing with the Secretary of State and printing only pursuant to Government Code section 11340.9(g) (Register 2006, No. 26).
7. Amendment of subsection (c) (medical-legal evaluation procedure code ML103) and amendment of Note filed 12-31-2012 as an emergency; operative 1-1-2013 pursuant to Government Code section 11346.1(d) (Register 2013, No. 1). A Certificate of Compliance must be transmitted to OAL by 7-1-2013 or emergency language will be repealed by operation of law on the following day.

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**FREMONT COMPENSATION INSURANCE COMPANY et al., Petitioners, v.
THE SUPERIOR COURT OF ORANGE COUNTY, Respondent; MARAPPA V.
GOPINATH et al., Real Parties in Interest.**

No. G017435.

**COURT OF APPEAL OF CALIFORNIA, FOURTH APPELLATE DISTRICT,
DIVISION THREE**

44 Cal. App. 4th 867; 52 Cal. Rptr. 2d 211; 1996 Cal. App. LEXIS 370; 61 Cal. Comp. Cas 363; 96 Cal. Daily Op. Service 2814; 96 Daily Journal DAR 4663

April 23, 1996, Decided

PRIOR HISTORY: [***1] Superior Court of Orange County, No. 734238, Robert E. Thomas, Judge.

DISPOSITION: As mentioned above, this opinion does not deal with the malicious prosecution claim. *Section 47* does not preclude malicious prosecution actions (*Kimmel v. Goland* (1990) 51 Cal. 3d 202, 209 [271 Cal. Rptr. 191, 793 P.2d 524] [litigation privilege "has been interpreted to apply to virtually all torts except malicious prosecution"]; *Silberg v. Anderson* (1990) 50 Cal. 3d 205, 216 [266 Cal. Rptr. 638, 786 P.2d 365] ["The only exception ... has been for malicious prosecution actions."]; *Mattco Forge, Inc. v. Arthur Young & Co.* (1992) 5 Cal. Cal. App. 4th 392, 406 [6 Cal. Rptr. 2d 781] ["The privilege applies only to tort causes of action, and not to the tort of malicious prosecution."]), a point conceded at oral argument by counsel for the insurers.

SUMMARY:

CALIFORNIA OFFICIAL REPORTS SUMMARY

A doctor brought an action alleging that two workers' compensation insurers acted in bad faith by reporting the doctor for overbilling. The trial court overruled the insurers' demurrer. Although *Ins. Code, § 1877.5*,

provided insurers with immunity for reporting workers' compensation insurance fraud, the trial court ruled that the immunity was qualified, inasmuch as the statute requires that the insurers act in good faith and without malice. Plaintiff's complaint, however, alleged that the insurers acted with malice. The trial court further reasoned that any immunity otherwise afforded the insurers by virtue of *Civ. Code, § 47* (absolute privilege to report crimes), was eliminated by the existence of *Ins. Code, § 1877.5*, because the specific statute controlled the general one. (Superior Court of Orange County, No. 734238, Robert E. Thomas, Judge.)

The Court of Appeal ordered that a peremptory writ issue to the trial court commanding it to sustain defendants' demurrer without leave to amend. The court held that the trial court erred in overruling the insurers' demurrer. *Ins. Code, § 1877.5*, affords an insurer a qualified immunity by exempting it from any civil liability in a cause or action of any kind where it "acts in good faith, without malice, and reasonably believes that the action taken was warranted by the then known facts." While the complaint alleged that defendants acted in bad faith, the last sentence of *Ins. Code, § 1877.5*, provides that "existing common law or statutory privileges and immunities" of insurers are not to be lessened by the statute. Moreover, *Civ. Code, § 47*, provides everybody the right to report crimes to the police, the local

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prosecutor, or the appropriate agency, even if the report is made in bad faith. The rule that the specific controls the general applies only when the specific and general provision cannot be reconciled, and *Ins. Code*, § 1877.5, is reconcilable with *Civ. Code*, § 47, even insofar as *Ins. Code*, § 1877.5, relates to insurers reporting workers' compensation insurance fraud. Under *Civ. Code*, § 47, insurers are absolutely privileged to report insurance fraud to either the local district attorney or the department of insurance. The reason for the *Civ. Code*, § 47, privilege--to facilitate the utmost freedom of communications between victims of crime and law enforcement agencies--applies all the more to insurance fraud, where the costs of the crime are indirectly borne by all consumers, employees, and businesses, than it does to more localized crimes. (Opinion by Sills, P. J., with Wallin and Sonenshine, JJ., concurring.)

HEADNOTES

CALIFORNIA OFFICIAL REPORTS HEADNOTES

Classified to California Digest of Official Reports

(1) Workers' Compensation § 119--Insurance--Fraud--Absolute Immunity of Insurers to Report Fraud. -- --In an action by a doctor alleging that two workers' compensation insurers acted in bad faith by reporting the doctor for overbilling, the trial court erred in overruling the insurers' demurrer. *Ins. Code*, § 1877.5, affords an insurer a qualified immunity by exempting it from any civil liability in a cause or action of any kind where it "acts in good faith, without malice, and reasonably believes that the action taken was warranted by the then known facts." While the complaint alleged that defendants acted in bad faith, the last sentence of *Ins. Code*, § 1877.5, provides that "existing common law or statutory privileges and immunities" of insurers are not to be lessened by the statute. Moreover, *Civ. Code*, § 47, provides everybody the right to report crimes to the police, the local prosecutor, or the appropriate agency, even if the report is made in bad faith. The rule that the specific controls the general applies only when the specific and general provision cannot be reconciled, and *Ins. Code*, § 1877.5, is reconcilable with *Civ. Code*, § 47, even insofar as *Ins. Code*, § 1877.5, relates to insurers reporting workers' compensation insurance fraud. Under *Civ. Code*, § 47, insurers are absolutely privileged to report insurance fraud to either the local district attorney or the department of insurance. The reason for the *Civ. Code*, § 47,

privilege--to facilitate the utmost freedom of communications between victims of crime and law enforcement agencies--applies all the more to insurance fraud, where the costs of the crime are indirectly borne by all consumers, employees, and businesses, than it does to more localized crimes.

[See 2 **Witkin**, Summary of Cal. Law (9th ed. 1987) Workers' Compensation, § 148D.]

COUNSEL: Knapp, Petersen & Clarke, Paul Woolls and Antoinette S. Waller for Petitioners.

Daniel E. Lungren, Attorney General, Timothy G. Laddish, Assistant Attorney General, Jacqueline A. Schauer, James M. Robbins and Jerome M. Jackson as Amici Curiae on behalf of Petitioners.

No appearance for Respondent.

Wylie A. Aitken and Annee [***2] Della Donna for Real Parties in Interest.

JUDGES: Opinion by Sills, P. J., with Wallin and Sonenshine, JJ., concurring.

OPINION BY: SILLS, P. J.

OPINION

[*869] [**212] **SILLS, P. J.**

The nub of this case is whether relatively recent legislation to deter workers' compensation fraud left insurers with *less* protection to report insurance fraud to police and prosecutors than they had before the legislation was enacted. The answer is no.

The legislation resulted in the addition of *section 1877.5* to the Insurance Code in 1991. (See Stats. 1991, ch. 116, § 19.) *Section 1877.5* affords insurers a *qualified* immunity to report workers' compensation fraud to a local prosecutor or the Department of Insurance. The qualified immunity does not extend to reports made in bad faith.

This lawsuit was filed by a doctor who alleges that two workers' compensation insurers acted in bad faith in reporting the doctor for overbilling. However, the last sentence in *Insurance Code section 1877.5* provides that "existing common law or statutory privileges and immunities" of insurers were not to be lessened by the

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statute. As we demonstrate below, another statute, *section 47 of the Civil Code*, [***3] already gives *everybody*--including insurers--the right to report crimes to the police, the local prosecutor or the appropriate regulatory agency, *even if* the report is made in bad faith. Accordingly, the insurers sued by plaintiff Marappa V. Gopinath for reporting him to the district attorney and the Department of Insurance fraud bureau for workers' compensation fraud are entitled to a writ of mandate commanding the superior court to sustain their demurrer to three of [**213] the five causes of action in Gopinath's complaint, namely those for interference with economic advantage, intentional infliction of emotional distress, and loss of consortium.

Two causes of action remain, one for malicious prosecution and the other for violation of the federal Racketeer Influenced and Corrupt Organizations [*870] Act (civil RICO). Of these two, the malicious prosecution claim is not challenged in this writ proceeding. (There is no doubt that *Civil Code section 47* does not affect malicious prosecution actions.) As to the civil RICO claim, while it might otherwise fall within the scope of *Civil Code section 47's* absolute immunity, the claim is, after all, based on a *federal* statute; and [***4] the parties have not briefed the question of how the federal RICO statute interacts with substantive state law. Since there is an obvious (but unbriefed) federal supremacy issue involved, the civil RICO claim will not be ordered dismissed in this particular writ proceeding.

BACKGROUND

As this proceeding involves a petition challenging an order overruling a demurrer, the facts, but not the conclusions, of the complaint are considered true for purposes of our review. Most of the story is told in two workers' compensation reports prepared by Dr. Gopinath and attached and incorporated into the complaint.

In 1990, a car salesman, Richard Moreno, was sent by his workers' compensation attorney to see a doctor, Marappa Gopinath, about a lower back injury sustained two years before, in 1988, when the salesman slipped and fell on a showroom floor. On the day of the examination, January 17, 1991, Dr. Gopinath wrote a workers' compensation report stating the patient's condition had deteriorated and he had become "increasingly symptomatic and painful." However, Dr. Gopinath concluded the injury was permanent and stationary and required no additional treatment.

The next day, January 18, [***5] the same car salesman saw Dr. Gopinath again, this time regarding a workers' compensation claim for a lower back injury that took place four days before--on January 14, 1991--when the salesman was lifting a desk. Dr. Gopinath wrote another workers' compensation report. That report noted the salesman had suffered a previous injury and recounted the salesman's statement that he had "continued symptoms with regards to his lumbosacral spine." The report further stated that the salesman told Dr. Gopinath "he was completely asymptomatic for at least two weeks prior to the above-stated trauma [that is, the January 14 injury]." The report concluded the salesman would need time to recover, and placed him on total temporary disability; the possibility of a disc injury could not be ruled out. The doctor also noted he was prescribing a course of physical therapy and gave the salesman prescriptions for antiinflammatory, analgesic and muscle relaxant drugs.

The first report went to one workers' compensation insurer, defendant Pacific Compensation Insurance company (whose parent company is [*871] Fremont Compensation Insurance Company); the second report went to another, defendant Ohio Casualty/West [***6] American Insurance Companies. The two insurers found out about them when the salesman's attorney requested consolidation of the workers' compensation cases involving the two claims. Both claims were settled within the workers' compensation system in June 1991.

In February 1992, the two insurers reported Dr. Gopinath to the Department of Insurance and the Los Angeles District Attorney's office for insurance fraud for billing both companies for a *single* incident, and changing the date on the two reports to show two different injuries. The doctor was arrested and tried for presenting multiple claims for the same injury. ¹

¹ See former *Insurance Code section 1871.1*. See now *Penal Code section 550*; see also *Insurance Code section 1871.4*.

Dr. Gopinath was acquitted. As explained in the complaint, it turned out that the first appointment had been scheduled in December 1990, before the January 14, 1991, injury, and when the salesman showed up for that appointment on January 17, he told Dr. Gopinath's receptionist [***7] of the January 14 injury. However, since Dr. Gopinath did not have authorization from the salesman's attorneys [**214] to see him about the new

injury at that time, the salesman never told the doctor or his assistant of the January 14 injury. After the examination, the receptionist contacted the salesman's workers' compensation attorney and got authorization for Dr. Gopinath to see him about that injury the next day. The receptionist never told the doctor of her conversation with the salesman.

After his acquittal, Dr. Gopinath filed a complaint against the two insurers. His arrest had obviously not been good for his practice. His complaint charged the two insurers with having instigated "an aggressive campaign" to destroy his career, beginning in June 1991, just after the workers' compensation cases were settled. In particular, the insurers were alleged to have known, in June 1991, that the salesman had sustained two separate injuries with two separate employers leading to two separate medical examinations.

The complaint listed five causes of action: interference with economic advantage, intentional infliction of emotional distress, malicious prosecution, civil RICO, and loss of consortium. [***8] The insurers filed a demurrer. The trial court overruled the demurrer, reasoning as follows: a statute enacted in 1991, *section 1877.5 of the Insurance Code*,² provides insurers with certain immunity. That is, when insurers furnish information to a local district [*872] attorney's office or the fraud claims bureau in the Department of Insurance, they are immune from "any civil liability in a cause or action of any kind"--*provided* they acted " [**215] in good faith, without malice, and reasonably believe[d] that the action taken was warranted by the then known facts, obtained by reasonable efforts."³ In short, the statute only provides a qualified immunity. The complaint, however, alleged the insurers reported the doctor with malice, and, on demurrer, a court must assume that the allegations in the complaint are true. Moreover, the trial court reasoned, any immunity *otherwise* afforded the insurers by virtue of *section 47* was eliminated by the specific existence of the Insurance Code statute, because the specific controls the general.

2 All statutory references are to the Insurance Code except for *section 47*, which is to the Civil Code, and *section 1859*, which is to the Code of Civil Procedure.

[***9]

3 Here is the full text of *section 1877.5*:

"No insurer, or agent authorized by an insurer

to act on its behalf, who furnishes information, written or oral, pursuant to this article, and no authorized governmental agency or its employees who (a) furnishes or receives information, written or oral, pursuant to this article, or (b) assists in any investigation of a suspected violation of *Section 1871.1, 1871.4, 11760, or 11880*, or of *Section 549 of the Penal Code*, or of *Section 3215 or 3219 of the Labor Code* conducted by an authorized governmental agency, shall be subject to any civil liability in a cause or action of any kind where the insurer, authorized agent, or authorized governmental agency acts in good faith, without malice, and reasonably believes that the action taken was warranted by the then known facts, obtained by reasonable efforts. 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 its behalf, or any authorized governmental agency or its employees."

[***10] We summarily denied the insurers' petition for a writ of mandate commanding the trial court to vacate its decision and sustain the demurrer as to all causes of action except the one for malicious prosecution. The insurers then sought review by the Supreme Court; that court in turn issued an order commanding us to issue an alternative writ. Having now had the opportunity to study the matter in more detail, we must conclude that the demurrer should have been sustained as to three of the four challenged causes of action--namely those for interference with economic advantage, intentional infliction of emotional distress, and loss of consortium. We leave the civil RICO claim for another day.

SECTION 1877.5 DOES NOT LESSEN THE IMMUNITY INSURERS HAD PRIOR TO ITS ENACTMENT TO REPORT INSURANCE FRAUD

(1) There is no question that *section 1877.5* limits the immunity *it* establishes to reports made without malice. The statute broadly exempts insurers from "any civil liability in a cause or action of any kind where the insurer ... acts in good faith, without malice, and reasonably believes that the action taken was warranted by the then known facts." (Cf. § 1872.5 [immunizing insurers against [***11] any "relevant tort cause of action" by virtue of making certain reports "without

malice"].)

[*873] In refusing to sustain the demurrer, the trial judge relied on the well-venerated rule of interpretation that the specific controls the general. (E.g., *Code Civ. Proc.* § 1859 ["a particular intent will control a general one that is inconsistent with it"]; *Woods v. Young* (1991) 53 Cal. 3d 315, 325 [279 Cal. Rptr. 613, 807 P.2d 455] [" 'specific provision relating to a particular subject will govern a general provision' "].) So do the Gopinaths now. The idea is that by providing for immunity when fraud reporting is done in good faith, the statute necessarily implies that reporting (as alleged here) in bad faith enjoys no immunity. (*Expressio unius* and all that.) Accordingly, even if *Civil Code section 47* did provide immunity for "bad faith" fraud reporting, it would be overridden by *Insurance Code section 1877.5*.

The rule that the specific controls the general, however, applies only when the specific and general provisions cannot be reconciled. (*People v. Wheeler* (1992) 4 Cal. 4th 284, 293 [14 Cal. Rptr. 2d 418, 841 P.2d 938] ["The principle that a specific [***12] statute prevails over a general one applies only when the two sections cannot be reconciled."]; *In re Ricardo A.* (1995) 32 Cal. Cal. App. 4th 1190, 1194-1195 [38 Cal. Rptr. 2d 586].) A close reading of *Insurance Code section 1877.5* reveals that it *is* reconcilable with *Civil Code section 47*, even insofar as *section 1877.5* relates to *insurers reporting workers' compensation insurance fraud*.

Section 1877.5 consists of two sentences; the good faith language is set forth in the first. But there is a second sentence, which was not addressed by the trial court.

"Nothing in this chapter"--which certainly includes the part about acting in good faith--is either "intended to, nor does in any way or manner, abrogate or lessen the existing common law or statutory privileges and immunities of an insurer." Plainly, *if* an insurer enjoyed a privilege to report workers' compensation insurance fraud (even in bad faith) prior to the enactment of *Insurance Code section 1877.5*, the language of the second sentence of *section 1877.5* means that the insurer still had that privilege afterwards. By providing that *section 1877.5* would not abrogate any existing statutory immunities, the statute [***13] becomes easily reconcilable with *Civil Code section 47*--assuming, of course, that *section 47* afforded such immunities in the first place.

One might wonder, of course, why the Legislature should indulge in such redundancy. Why specifically establish an immunity for good faith fraud reporting yet retain existing immunity for bad faith reporting?

The answer is found in the nature of legislative compromise. Avoiding resolution of disputed points is one of the classic means by which legislators [*874] are able to achieve agreement on legislative text. (See *California Teachers Assn. v. San Diego Community College Dist.* (1981) 28 Cal. 3d 692, 709 [170 Cal. Rptr. 817, 621 P.2d 856] (conc. opn. of Newman, J.) [legislative history may show "deliberate truncation of the purpose" or "choice of words resulted from some decision quite unrelated to the point at hand"]; *J.A. Jones Construction Co. v. Superior Court* (1994) 27 Cal. Cal. App. 4th 1568, 1577 [33 Cal. Rptr. 2d 206] ["if there is ambiguity it is because the legislature either could not agree on clearer language or because it made the deliberate choice to be ambiguous--in effect, the only 'intent' is to pass the matter [***14] on to the courts"]; Eskridge, *The New Textualism* (1990) 37 *UCLA L.Rev.* 621, 677 ["The vast majority of the Court's difficult statutory interpretation cases involve statutes whose ambiguity is either the result of deliberate legislative choice to leave conflictual decisions to agencies or the courts"].) Here, the second sentence of *section 1877.5* appears to be the product of a legislative compromise to enact a qualified reporting privilege and leave to the courts the question of what reporting immunities might already exist.

Until today, no published decision has addressed the specific question whether *section 47* provides unqualified immunity to insurers for reporting workers' compensation fraud. The interest groups and lobbyists who fought for only a qualified immunity in *section 1877.5* had no reason to concede that insurers [**216] already had more than a qualified immunity to report workers' compensation fraud. In time-honored fashion, those groups and lobbyists were prepared to leave the question of the *existing* state of the law to the courts. ⁴

⁴ Gopinath attached to his opposition to the demurrer excerpts from a legislative history which indicate that the qualified privilege set out in the first sentence of *section 1877.5* was the product of considerable attention by various interest groups. These excerpts, however, do not deal with the second sentence of the statute.

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[***15] The Gopinaths contend the second sentence in *section 1877.5* refers to something other than reporting, though they do not say what. The idea is untenable in the context of the statutory scheme considered as a whole. Reporting is one of the key features of the Insurance Frauds Prevention Act; remarkably, reporting workers' compensation fraud is *mandated* by the act whenever an insurer "knows or reasonably believes" it knows the perpetrator of insurance fraud. (§ 1877.3, *subd. (b)(1)*; cf. § 1872.4, *subd. (a)*.)⁵ Indeed, not only is reporting under such circumstances affirmatively imposed on insurers, but it must be done within 30 days after the duty to report arises. (§ 1877.3, *subd. (d)*.) The context of the qualified immunity is thus fraud [*875] reporting, and the natural inference to be derived from that context is that the "existing" language refers to whatever privileges or immunities insurers had *as regards reporting*.

5 And by law, insurers are required to maintain fraud units. *Section 1875.20* provides in its entirety: "Every insurer admitted to do business in this state shall maintain a unit or division to investigate possible fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds."

[***16] If there remains any doubt after consideration of the context, it is eliminated by the general purpose of the statute. The whole point of the act is to deter insurance fraud. It would be utterly anomalous for the Legislature to seek to curtail such fraud and, in the process, create a major disincentive that did not otherwise exist for insurers to report fraud.

UNDER SECTION 47 INSURERS ARE ABSOLUTELY PRIVILEGED TO REPORT INSURANCE FRAUD TO EITHER THE LOCAL DISTRICT ATTORNEY OR THE DEPARTMENT OF INSURANCE

As interpreted in a number of cases, *section 47* protects persons who report potential criminal activity to the police or local prosecutor from lawsuits, even if the report is made with malice. (E.g., *Cote v. Henderson* (1990) 218 Cal. App. 3d 796, 806 [267 Cal. Rptr. 274] [defendant was "absolutely privileged" to report rape to police and district attorney]; *Williams v. Taylor* (1982) 129 Cal. App. 3d 745, 753-754 [181 Cal. Rptr. 423] [owner of autoshop "absolutely privileged" to tell police department of former manager's wrongdoing].)

The privilege also extends to reports to quasi-judicial government authorities, such as administrative agencies regulating a particular [*17] business. (*Williams v. Taylor, supra*, 129 Cal. App. 3d at p. 754 [defendant autoshop owner absolutely privileged to inform Department of Employment Development of reasons for shop manager's dismissal]; *O'Shea v. General Telephone Co.* (1987) 193 Cal. App. 3d 1040, 1047-1048 [238 Cal. Rptr. 715] [telephone company privileged to tell highway patrol in course of statutorily authorized background check reason for ex-employee's termination].)

True, *Fenelon v. Superior Court* (1990) 223 Cal. App. 3d 1476 [273 Cal. Rptr. 367] states a contrary rule as to reports made "solely" to the police. There, the plaintiff alleged that the defendants induced a third party to inform "police and other nonofficial persons" that the plaintiff had solicited the murder of one of the defendants. In a published opinion denying a writ petition after the defendants' demurrer was overruled, the majority held that "where the report is made solely to the police and not in a quasi-judicial context, to be privileged the statement must be made without malice." (*Id. at p. 1483*.)

The holding in *Fenelon* does not apply to the present case because the reports here were not made "solely to [*18] the police," but rather to the local [*876] district attorney and Department of Insurance fraud bureau. The [*217] central point of the *Fenelon* majority was that reports *outside* a judicial or "quasi-judicial" context lacked "safeguards" such as notice, hearing and review. (See 223 Cal. App. 3d at p. 1483, and particularly the quotation from *Toker v. Pollak* (1978) 44 N.Y.2d 211 [N.E.2d 163, 169, 405 N.Y.S.2d 1376].) But such, or similar, safeguards certainly inhere in reports to prosecutors and the Department of Insurance Bureau of Fraudulent Claims. As to prosecutors, by definition anything they do with a report of workers' compensation fraud (beyond, of course, investigating the claim), will entail notice, hearing and review. As to the fraud bureau, a statute specifically protects the person being investigated against "unwarranted injury" by making the bureau's investigation not subject to public inspection for the period of the investigation except insofar as the police or other law enforcement agency request it. (§ 1872.3, *subds. (d) & (e)*.)

Moreover, even if *Fenelon* articulated a rule which did apply to this case, we would join *Passman v. Torkan*

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(1995) 34 [***19] Cal. Cal. App. 4th 607, 616-619 [40 Cal. Rptr. 2d 291] (letter of litigant to district attorney held absolutely privileged) and *Hunsucker v. Sunnyvale Hilton Inn* (1994) 23 Cal. Cal. App. 4th 1498, 1502-1504 [28 Cal. Rptr. 2d 722] (report to police by hotel manager concerning guest's possession of a gun held absolutely privileged) in respectfully declining to follow it. The *Fenelon* majority never grappled with the substantial California authority cited in the dissent demonstrating that the solid rule in California (at least up to the *Fenelon* decision) was that the absolute privilege "applies to statements made preliminary to or in preparation for either civil or criminal proceedings," which would include reports made solely to the police. (See *Fenelon v. Superior Court*, *supra*, 223 Cal. App. 3d at p. 1484 (dis. opn. of Benke, J.); see also *Hunsucker*, *supra*, 23 Cal. Cal. App. 4th at pp. 1502-1503 ["... the weight of authority in California, the very articulate dissent in *Fenelon* by Justice Benke, and what we believe is the better view, holds that reports made by citizens to police regarding potential criminal activity fall within the *section 47* absolute [***20] privilege."])⁶ Rather, *Fenelon* relied on out-of-state cases to depart from the rule articulated in *Williams v. Taylor*, *supra*, 129 Cal. App. 3d 745. (See *Fenelon*, *supra*, 223 Cal. App. 3d at pp. 1482 & 1482, fn. 8.)

6 As the Supreme Court observed in *Slaughter v. Friedman* (1982) 32 Cal. 3d 149, 156 [185 Cal. Rptr. 244, 649 P.2d 886], the " 'official proceeding' privilege has been interpreted broadly to protect communications to or from *governmental* officials which may precede the initiation of formal proceedings." (Original italics.)

The absolute privilege in *section 47* represents a value judgment that facilitating the "utmost freedom of communication between citizens and [*877] public authorities whose responsibility is to investigate and remedy wrongdoing" is more important than the " 'occasional harm that might befall a defamed individual.' " (See *Imig v. Ferrar* (1977) 70 Cal. App. 3d 48, 55-56 [138 Cal. Rptr. 540].) But even so, *section 47* hardly leaves the [***21] wrongly defamed individual without safeguards. The malicious prosecution remedy always remains. Indeed, Dr. Gopinath's malicious prosecution cause of action survives this writ proceeding.

If *section 47* provides immunity for false reports of

rape (*Cote*) or employee theft (*Williams*), it necessarily follows that it also provides immunity for false reports of workers' compensation overbilling. The reason for the *section 47* privilege--to facilitate the *utmost* freedom of communications between victims of crime and law enforcement agencies--applies, if anything, all the more so to insurance fraud, where the costs of the crime are indirectly borne by all consumers, employees and businesses, than it does to more localized crimes. (See § 1875.10, subd. (b) ["insurers and their policyholders ultimately pay the cost of fraudulent insurance claims"].)

DISPOSITION

As mentioned above, this opinion does not deal with the malicious prosecution claim. *Section 47* does not preclude malicious prosecution actions (*Kimmel v. Goland* (1990) 51 Cal. 3d 202, 209 [271 Cal. Rptr. 191, 793 P.2d 524] [litigation privilege "has been interpreted [**218] to apply to virtually all torts except malicious [***22] prosecution"]; *Silberg v. Anderson* (1990) 50 Cal. 3d 205, 216 [266 Cal. Rptr. 638, 786 P.2d 365] ["The only exception ... has been for malicious prosecution actions."]; *Mattco Forge, Inc. v. Arthur Young & Co.* (1992) 5 Cal. Cal. App. 4th 392, 406 [6 Cal. Rptr. 2d 781] ["The privilege applies only to tort causes of action, and not to the tort of malicious prosecution."]), a point conceded at oral argument by counsel for the insurers.

Likewise, the civil RICO cause of action cannot be disposed of in this writ proceeding. To state the obvious, causes of action under the Racketeer Influenced and Corrupt Organizations Act are predicated on a federal statute. (18 U.S.C. § 1961-1968.) The parties have not briefed the question of how the state law we are construing in this opinion, *section 47 of California's Civil Code*, interacts with a cause of action based on the federal RICO statute in the context of the facts alleged. Suffice to say there is at least a colorable question as to whether the use of a state statute to dismiss a cause of action based on a federal statute would contravene the *supremacy clause of the United States Constitution*. Rather than address that question [***23] now, we defer the matter to another day.

[*878] A peremptory writ shall issue to the superior court commanding it to sustain defendants' demurrer without leave to amend as to all causes of action except the ones for malicious prosecution and civil RICO.

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Wallin, J., and Sonenshine, J., concurred.



**JAMES A. KING, Cross-complainant and Appellant, v. JOSEPH K. BORGES,
Cross-defendant and Respondent**

Civ. No. 38074

Court of Appeal of California, Second Appellate District, Division Two

28 Cal. App. 3d 27; 104 Cal. Rptr. 414; 1972 Cal. App. LEXIS 732

October 5, 1972

PRIOR HISTORY: [***1] Superior Court of Los Angeles County, No. 877245, Goscoe O. Farley, Judge.

Compton, J., with Roth, P. J., and Herndon, J., concurring.)

DISPOSITION: The order appealed from is affirmed.

HEADNOTES

SUMMARY:

CALIFORNIA OFFICIAL REPORTS HEADNOTES
Classified to McKinney's Digest

A realtor brought a libel action against an attorney arising out of a letter the attorney wrote to the Division of Real Estate complaining of the acts of the realtor in claiming a deposit made by his clients, the buyers, after a sale had been cancelled. Copies of the letter were sent to other interested parties. After the jury had returned a verdict in favor of the realtor, the court granted a new trial on the ground that it had erroneously instructed the jury that the letter to the Division of Real Estate was only conditionally privileged. (Superior Court of Los Angeles County, No. 877245, Goscoe O. Farley, Judge.)

(1a) (1b) Libel and Slander § 29(3)--Privileged Communications--Absolute Privilege--Officers and Official Acts. -- --Defamatory statements contained in a letter written to the Division of Real Estate by an attorney complaining of the action of a realtor, which letter was in the nature of a request for an investigation, was absolutely privileged within the meaning of *Civ. Code*, § 47, *subd. 2*, as a communication made in an official proceeding authorized by law, even though no action or investigation was pending at the time the letter was written.

The Court of Appeal affirmed, holding that the letter in question was in the nature of a request for an investigation, and that the activities of the Division of Real Estate in investigating and disciplining licensees, such as the realtor, is an official proceeding authorized by law, and the letter was thus absolutely privileged despite the fact that no action or investigation was pending at the time the letter was written. As to the copies of the letter sent to other persons, the court held that they were not absolutely privileged but might be within the qualified privilege of *Civ. Code*, § 47, *subd. 3*. (Opinion by

(2) Libel and Slander § 29(3)--Privileged Communications--Absolute Privilege--Officers and Official Acts. -- --The phrase "in any other official proceeding authorized by law" contained in *Civ. Code*, § 47, *subd. 2*, relating to privileged defamatory statements, encompasses those proceedings which resemble judicial and legislative proceedings, such as transactions of administrative boards and quasi-judicial and quasi-legislative proceedings, and defamatory statements made in such proceedings having some relation thereto are absolutely privileged.

(3) Libel and Slander § 29--Privileged Communications--Absolute Privilege. -- --The absolute privilege afforded to defamatory statements made in legislative, judicial, or other official proceedings by *Civ. Code, § 47, subd. 2*, is not limited to the pleadings, the oral or written evidence, to publications in open court or in briefs or affidavits, but includes communications to an official administrative agency designed to prompt action by that agency, and is a part of the official proceeding under the statute.

(4) Libel and Slander § 30(2)-- Privileged Communications -- Qualified Privileged--Communications to Persons Interested. -- --The absolute privilege afforded to defamatory statements contained in a letter to the Division of Real Estate was not applicable to copies thereof sent to other interested parties, although their interests in the subject matter might bring the copies within the qualified privilege of *Civ. Code, § 47, subd. 3*.

(5) Libel and Slander § 90--Actions--New Trial. -- --The court did not abuse its discretion in ordering a new trial in an action for libel on the ground that the court erroneously instructed the jury that the letter in question was conditionally privileged, when in fact the original, although not the copies, was absolutely privileged, where it could not be determined from the single verdict what effect the erroneous instruction had on the verdict.

(6) New Trial § 253--Appeal--Determination and Disposition. -- --On appeal from an order granting a new trial, review is limited to determining whether there was any support for the trial judge's ruling, and such ruling will not be disturbed unless a manifest abuse of discretion is demonstrated.

COUNSEL: Gainsley, Winkler, Kaufman & Ward and Richard C. Dunsay for Cross-complainant and Appellant.

Joseph K. Borges, in pro. per., and Helen E. Simmons for Cross-defendant and Respondent.

JUDGES: Opinion by Compton, J., with Roth, P. J., and Herndon, J., concurring.

OPINION BY: COMPTON

OPINION

[*29] [**414] Roosevelt and Margie Green (the

Greens) sued James A. King (King) in the municipal court to recover \$ 1,000 deposited by them in escrow. King cross-complained for libel naming as defendants the Greens and Joseph K. Borges (Borges), their attorney. King prayed for \$ 25,000 general damages and \$ 25,000 punitive damages. The matter was transferred to the superior court where the libel action was tried separately.
1

1 The Greens in the other proceeding obtained judgment against King for the deposit money. That judgment is not involved in this appeal.

A jury awarded King \$ 3,500 compensatory [***2] damages and \$ 2,500 punitive damages against Borges. ² The trial judge ordered a new trial. King appeals from that order.

2 A non-suit was granted as to the Greens. No appeal has been taken from the judgment in their favor.

[**415] The Greens were in the market to buy a house. A Mrs. Taylor offered a house for sale and King was her broker. The Greens made a deposit with King of \$ 1,000 on Taylor's house. An escrow was opened but the Greens could not qualify for the requisite financing. The escrow was mutually cancelled by Taylor and the Greens.

The Greens asked for their \$ 1,000 deposit back but King laid claim to it and the escrow refused to deliver it.

[*30] The Greens consulted Borges who wrote the following letter to the State of California, Division of Real Estate, with copies distributed as indicated:

"JOSEPH K. BORGES, Attorney at Law

1318 North La Brea Avenue

Inglewood, California -- OR 8-7678

May 25, 1965

"Division of Real Estate

107 S. Broadway

Los Angeles, California

[***3] Re: Home Builders Escrow

No. 7975, Taylor to Green

"Gentlemen:

"I have the following complaint to file against James A. King, real estate broker. Mr. King sold my clients, Mr. and Mrs. Roosevelt Green, a piece of property for \$ 30,000, subject to obtaining a loan. My clients paid him \$ 1,000 as good faith deposit. These funds were placed in Home Builders Escrow Company along with escrow instructions which were signed by the buyer and seller. My clients, the buyers, did not qualify for a loan. Therefore, both the buyer and seller signed mutual cancellation instructions. The broker is demanding the \$ 1,000 from escrow, claiming it belongs to him. He refuses to sign cancellation instructions. We have notified escrow not to release the funds to him as it is our opinion that he will spend these funds and he is one not to be trusted. Mr. King has made a demand to escrow for this \$ 1,000. From a legal standpoint, his principal, Mrs. Taylor, canceled and if he has any claim at all, it will be against his client, the seller.

"On behalf of my clients, I would like to file an accusation against James A. King for wrongfully withholding funds not belonging to him. Perhaps a [***4] letter from one of your deputies inquiring as to his reasons for holding these funds would straighten the matter out. I am enclosing a letter received from the attorneys for the escrow company whereby they plan to interplead if the matter is not resolved. The Greens should not be forced to additional attorney's fees on behalf of the escrow company for filing said interpleader. I am sure you will understand my concern for my clients.

"Very truly yours,

S/Joseph K. Borges

Joseph K. Borges

"JKB/br

cc: Mr. & Mrs. Roosevelt Green

cc: Home Builders Escrow Company

cc: James A. King

cc: Barsam and LeVeque"

[*31] This letter upon which the claim of libel is

based was written without the knowledge of the Greens, hence the non-suit as to them.

During the trial the judge instructed the jury that the letter and its copies were conditionally privileged so that the pivotal issue submitted to the jury was that of malice.

In his order granting a new trial the judge set forth the grounds therefor as *Code of Civil Procedure section 657, subdivisions 1 and 7* (irregularity in the proceedings and error in law). The reason for the order was "that the letter sent to the California [***5] Divisions of Real Estate . . . was absolutely privileged under subsection 2 of *Section 47 Civil Code* as a communication preliminary to an official proceeding authorized by law." Thus the trial judge concluded that he had erred [**416] in instructing the jury that the letter was only conditionally privileged.

This holding refers to the original letter, the court ruling that the carbon copies sent to other persons were only conditionally privileged.

Civil Code section 47 provides in pertinent part: "A privileged publication or broadcast is one made . . . 2. In any (1) legislative or (2) judicial proceeding, or (3) in any other official proceeding authorized by law; . . . 3. In a communication, without malice, to a person interested therein, (1) by one who is also interested, . . ."

King contends that the trial judge erred first in holding that the letter was absolutely privileged and secondly in granting the new trial in any event because there was sufficient evidence to sustain the verdict on the basis of the distribution of the copies.

(1a) The original letter to the division of real estate was absolutely privileged.

Business and Professions Code, division IV, section 10004 et [***6] seq., contain a licensing and regulatory scheme which governs, among other things, the conduct of the real estate brokers in this state.

Business and Professions Code section 10176 empowers the Real Estate Commissioner, either on his own motion or upon a written verified complaint of any person, to investigate the actions of any person licensed under division IV. The commissioner is authorized to suspend or revoke a license for various types of specific misconduct, as well as "Any other conduct, whether of

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the same or a different character than specified in this section, which constitutes fraud or dishonest dealing." (*Bus. & Prof. Code, § 10176, subd. (i).*)

[*32] By force of *Business and Professions Code section 10100*, the Real Estate Commissioner, in proceeding to suspend or revoke a license, is required to proceed under *section 11500 et seq. of the Government Code*, which sections in turn control administrative adjudications. *Government Code section 11501* specifically names the Real Estate Commissioner as an agency empowered to conduct administrative hearings.

Government Code section 11503 through 11510 provides for the procedure for an administrative hearing and gives [***7] the commissioner power of subpoena.

(2) "The phrase 'in any other official proceeding authorized by law' [contained] in *section 47, subdivision 2*, has been interpreted to encompass those proceedings which resemble judicial and legislative proceedings, such as transactions of administrative boards and quasi-judicial and quasi-legislative proceedings. [Citations.] In accord with the California cases, the general rule is now well established that *the absolute privilege is applicable not only to judicial but also to quasi-judicial proceedings* and defamatory statements made in both judicial and quasi-judicial proceedings having some relation thereto are absolutely privileged [citations]." (*Ascherman v. Natanson*, 23 Cal.App.3d 861, 865 [100 Cal.Rptr. 656], petition denied April 26, 1972.)

It must be conceded that the activities of the commissioner in investigating and disciplining licensees is an "official proceeding authorized by law" and thus within the ambit of *Civil Code section 47, subdivision 2* so that any matter communicated to the commissioner having some relation to such proceeding would be absolutely privileged.

(1b) King argues that no action or investigation was [***8] pending at the time Borges wrote the letter and thus under the circumstances the privilege did not attach. We disagree.

Civil Code section 47, subdivision 2 specifically exempts from the privilege statements contained in pleadings in actions for dissolution of marriage when the statements concern persons against whom no relief is [**417] sought. By implication then all other pleadings including the initial complaint are part of the judicial

proceedings.

The letter in the case at bar does not technically qualify as a formal complaint or accusation which itself would precipitate an administrative adjudication. It is in the nature of a request for investigation. As to the latter type of communication, an absolute privilege is not uniformly available in all jurisdictions.

[*33] "Some authorities have also extended the rule of absolute privilege so as to protect complaints made, or information given, to a proper officer with regard to crime which is within his authority to investigate or prosecute." (53 C.J.S., Libel & Slander, § 104.)

The Restatement of Torts, volume 3, section 587 provides as follows: "A party to a private litigation or a private prosecutor or defendant [***9] in a criminal prosecution is absolutely privileged to publish false and defamatory matter of another in communications preliminary to a proposed judicial proceedings or in the institution of or during the course and as a part of a judicial proceeding in which he participates, if the matter has some relation thereto." (Also see *Washer v. Bank of America*, 21 Cal.2d 822 and cases cited therein at p. 832 [136 P.2d 297, 155 A.L.R. 1338].)

(3) The absolute privilege in California is "not limited to the pleadings, the oral or written evidence, to publications in open court or in briefs or affidavits." (*Albertson v. Raboff*, 46 Cal.2d 375, at p. 381 [295 P.2d 405]; also see *Whelan v. Wolford*, 164 Cal.App.2d 689 [331 P.2d 86].)

In *Layne v. Kirby*, 208 Cal. 694, 697 [284 P. 441], an action for libel was premised on a letter written to the Secretary of War. On appeal from the sustaining of a demurrer, defendant claimed an absolute privilege under *Civil Code section 47, subdivision 2*. In reversing the order sustaining the demurrer, the court recognized the possibility that if the communication addressed by the defendant to the Secretary of War "was intended [***10] to, or did in fact, initiate an authorized proceeding for any purpose" the communication would be absolutely privileged by virtue of the provisions of subdivision 2 of *section 47 of the Civil Code*.

It can be argued that application of an unqualified privilege to the type of communication here involved will unduly occupy the commissioner in tracking down spurious allegations and will provide no protection to

those persons wrongfully accused.

However, the commissioner presumably has adequate expertise to sift the "wheat from the chaff." Furthermore, if the commissioner suspects that a complaint is false or improperly motivated he has the power to require a verified statement with its accompanying sanction for perjury before taking any action.

Essentially the question is one of legislative intent. The Legislature has available to it methods for preventing or minimizing false complaints. (See for example *Pen. Code*, § 148.5 making it a misdemeanor to falsely report crime to a police officer.)

[*34] However, in enacting *Civil Code section 47, subdivision 2*, the Legislature used language adequately broad in scope to cover the type of letter at hand.

We conclude that a communication [***11] to an official administrative agency, which communication is designed to prompt action by that agency, is as much a part of the "official proceeding" as a communication made after the proceedings have commenced.

It seems obvious that in order for the commissioner to be effective there must be an open channel of communication by which citizens can call his attention to suspected wrongdoing. That channel would quickly close if its use subjected the user [**418] to a risk of liability for libel. A qualified privilege is inadequate protection under the circumstances.

Malice at best is a difficult concept to articulate. Our legal system of fact finding, good as it is, does not guarantee complete accuracy in every case. Even in the case of an actor with the purest of motives, there is

always a possibility that the trier of fact on conflicting evidence might find he acted with malice sufficient to defeat a qualified privilege.

The importance of providing to citizens free and open access to governmental agencies for the reporting of suspected illegal activity outweighs the occasional harm that might befall a defamed individual. Thus the absolute privilege is essential.

(4) No such [***12] considerations apply to the copies which Borges distributed to persons other than the state agency. The interests of the recipients may be such as to bring the copies within the qualified privilege of *Civil Code section 47, subdivision 3*. While this interest might include the knowledge of the fact that a complaint had been made to the commissioner, protection of the efficacy of quasi-judicial proceedings does not require that these persons be advised of the details of the allegation.

(5) As to King's second claim of error, no abuse of the trial court's discretion has been demonstrated. The jury returned a single general verdict and it cannot be determined what effect the erroneous instruction had on the verdict.

(6) On an appeal from an order granting a new trial, review is limited to determining whether there was any support for the trial judge's ruling. Such ruling will not be disturbed unless a manifest abuse of discretion is [*35] demonstrated. (*Mehling v. Schield*, 253 Cal.App.2d 55 [61 Cal.Rptr. 159]; *Christian v. Bolls*, 7 Cal.App.3d 408 [86 Cal.Rptr. 545].)

[***13] The order appealed from is affirmed.