

Fraud worries insurance companies but should concern physicians too, industry says

Nicole Baer

In brief

THE AMOUNT OF INSURANCE FRAUD IS INCREASING in Canada. This should worry physicians, because all personal-injury claims must be substantiated by a medical certificate. The vast majority of physicians are honest and ethical, fraud investigators say, but some are being duped as patients scheme to cheat the insurance industry. In one sensational auto-insurance-fraud case, some Ontario physicians are being investigated about possible involvement in a self-referral scheme. Nicole Baer looks at insurance fraud and the challenges it poses for doctors.

En bref

LE VOLUME DES FRAUDES CONTRE L'ASSURANCE EST À LA HAUSSE au Canada. Cela devrait inquiéter les médecins parce que toutes les réclamations pour blessures corporelles doivent être appuyées par un certificat médical. La plupart des médecins sont honnêtes et éthiques, affirment les enquêteurs, mais certains sont dupés par des patients qui veulent frauder l'industrie de l'assurance. Dans le cadre d'une affaire sensationnelle de fraude d'assurance automobile, certains médecins de l'Ontario font l'objet d'une enquête qui porte sur leur rôle possible dans une organisation d'auto-référence. Nicole Baer examine les fraudes contre l'assurance et les défis qu'elles posent aux médecins.

In the spring of 1994, the car carrying Amal Sayah and her teenage son, Ronaldo, was broadsided on an Ottawa street. Ronaldo received back and jaw injuries that still ail him; Sayah suffered a fractured pelvis, 16 broken ribs and a punctured lung. Today she worries that she will "have to live with the pain for the rest of my life."

Meanwhile, the man driving the other car, who was from Toronto, has been charged with two counts of criminal negligence causing bodily harm; investigators allege the accident was staged for insurance reasons, and Sayah and her son were its innocent victims.

Jim Adams, a former police detective who manages special investigations with the Progressive Casualty Insurance Company of Canada, says that up to \$60 000 may have been collected fraudulently because of the single crash; he says the driver now faces up to 10 years in jail because of the criminal-negligence charges.

Adams thinks the crash involving Sayah marks a turning point because an innocent third party was hurt — most of the cases alleged to be fraudulent involve make-believe injuries. It is also part of Canada's biggest-ever automobile insurance fraud investigation, which involves 257 suspicious claims worth \$10 million and more than 60 allegedly "staged" accidents. Fifty-four people have been charged, and some cases involving physicians have been turned over to the College of Physicians and Surgeons of Ontario for further investigation. The chiropractic college is also investigating some cases. [Last June, *CMAJ*] reported that the College of Physicians and Surgeons of Ontario is investigating allegations of fraud and conflict of interest against 100 physicians, and has pushed the fraud issue to the top of its agenda. — Ed.]

No one knows how big a problem auto-insurance fraud is, but the industry in-



Features

Chroniques

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sists it is huge and affects the entire country. An industry-sponsored national task force estimated in 1994 that 10%–15% of claims paid out by the casualty- and property-insurance industry are fraudulent and cost about \$1.3 billion a year. The task force described a spectrum of fraudulent activities that ranged from the “opportunistic” padding of legitimate claims to involvement by organized-crime rings.

Among automobile casualty cases, the task force concluded that 10% of claims could be classed as “suspicious,” although it is not clear how many are proved fraudulent after further investigation. Moreover, the suspicion frequently centres on inflated claims for collision damage rather than phoney or exaggerated injuries to the vehicle’s human occupants.

Whatever the financial cost to the industry, fraudulent bodily-injury cases carry enormous societal costs in terms of emergency, health and social services, but little is done to detect them. In most provinces policing resources are so strapped and penalties so lax that only major crime rings attract police attention.

Adams says the courts seldom consider fraud a serious crime “because it is not a crime against a person.”

The situation is particularly grim in Ontario because of its unique combination of no-fault accident insurance, generous payouts and the failure of private insurers, until recently, to mount a common front against fraud. Moreover, insurers are obliged to pay out benefits within 14 days, leaving little time to scrutinize questionable claims.

Fraud and the physician

Every personal-injury claim must be substantiated by a medical certificate, and continued contact with a physician is required to validate insurance payouts for rehabilitation therapies and compensation for lost wages. As Adams puts it, “without a doc, this system cannot work. You’ve got no claim.”

Because of physicians’ pivotal role, fraud investigators look for 1 of 2 scenarios: doctors either become innocent dupes of the fraud artist, or actively collude with the swindler for personal gain.

By all accounts the latter scenario is extremely rare, but it happens. In a February 1996 report, Jim Maclean, director of communications at the Ontario college, noted that evidence suggested some physicians were making fraudulent referrals to clinics in which they owned an in-

terest. These “self-referrals” were being made “outside the bounds of medical necessity.” His report also alleged that some physicians, who refer patients to particular clinics, “are receiving excessive fees for providing patient information.”

In a typical case, a physician would attest that an “accident victim” has certain extensive, if hard-to-prove, injuries. The reward comes once the claim is accepted by the insurance company and the person begins to collect on the benefits. Typically, the physician then refers the patient for a prolonged course of treatment, invariably at a clinic in which the doctor has a financial interest.

Dr. Murray Waldman of Toronto says there is much money to be made. Writing in *CMAJ* last year, he noted that the average cost per claim for accident-related rehabilitation has risen from \$2108 in 1989 to \$25 305 in 1994 (154:1737-9).

Even though hospital stays for many types of treatment are being reduced, “the exact opposite is true in the treatment of patients who have suffered relatively minor injuries in automobile accidents.”

The self-referral practice that the Ontario college is investigating is confounding and controversial. On the one hand there is a widespread perception that it puts the doctor in a conflict-of-interest position that could result in a lack of objectivity in medical decision-making. On the other hand proponents, especially in the United States, say that by investing in more health care facilities doctors are contributing to economies of scale, providing competition and improving services in underserved areas.

However, several American studies have linked self-referral to a variety of negative consequences. Patients tend to be subjected to too many treatments, many of them inappropriate and excessively costly. Self-referring doctors also spend less time with patients.

In 1992, in response to this research, the American Medical Association developed a policy banning self-referral except in cases where a health-care facility is uniquely essential to the well-being of a community but could not exist without the referring physician’s financial involvement. At about the same time, Congress passed legislation prohibiting referral of Medicare and Medicaid patients for any of 11 designated health services — from clinical lab services to prosthetics suppliers — with which the referring physician or an immediate family member has a financial relationship. Violation of the law carries



Amal Sayah: living with pain



hefty fines and exclusion from the Medicare and Medicaid programs.

In Canada, no jurisdiction has gone that far. Extensive soul-searching by the Ontario college resulted in a policy that allows doctors to engage in self-referral if they disclose their financial interest to the patient and college. There is no legislative prohibition against the practice.

But if honest and well-meaning physicians announce a conflict of interest when referring patients to labs and clinics, would doctors with a criminal bent do the same? And if they did, would that be news to “patients” with whom they are colluding to swindle an insurance company?

The college acknowledges that there are serious problems with self-referral, but proving fraud, conspiracy and collusion are devilishly hard.

Bob Graves, Toronto manager of the Insurance Crimes Prevention Bureau, contends that there is probably some “wilful blindness” among the “select number of physicians” who seem to attract the bulk of the questionable auto-insurance cases. He wonders how “all these people [with fraudulent intent] can have the guile to be able to dupe [the same physicians] continuously.”

Difficult diagnoses and the honest MD

Where does that leave the vast majority of physicians — the conscientious doctors who are always honest and ethical? Even they, says Toronto FP Marjorie Keymer, can be innocent dupes. “I would say, by and large, most of the fraudulent cases probably have well-meaning docs who think they’re advocating on behalf of their sincerely disabled clientele,” says Keymer, past president of the Canadian Life Insurance Medical Officers Association.

She notes that the biggest growth in disability claims has been in areas such as musculoskeletal pain, depression, fibromyalgia and chronic fatigue syndrome — conditions that are difficult to diagnose and that lack objective measures of treatment success. “A number of these conditions are particularly vulnerable or apt to be used in fraudulent situations because there’s no absolute proof that they did or did not exist.” Even casualty insurers often lack the in-house medical experts to assist in controversial cases, Keymer notes.

Treatment for soft-tissue injuries has changed radically in recent years. Routine prescriptions for cervical collars and bed rest have been replaced by multidisciplinary approaches that encourage rapid return to normal function.

Quebec, through its public insurance plan, the Société d’assurance automobile du Québec (SAAQ), was among the first jurisdictions in Canada to attempt to understand soft-tissue injuries to the cervical spine. The SAAQ sponsored a special task force, which in 1995 reported on the

prevention, diagnosis and treatment of whiplash injuries. In light of the dearth of reliable information on the subject, the task force began by defining the key terms.

“Whiplash” is the acceleration-deceleration mechanism of energy transfer to the neck caused in automobile collisions; the resultant bony or soft-tissue damage is the “whiplash injury”; the ensuing range of clinical manifestations are known as “whiplash-associated disorders,” or WAD.

The task force next established a system to diagnose and categorize WAD cases. Based on the best available research, and the task force emphasized that there was precious little, researchers came up with general treatment protocols and presumed recovery times appropriate for each WAD category. Overall, the task force said, these injuries tend to be self-limiting and are best treated by mobility, reassurance and a return to normal activity as soon as possible. Rest, immobilization and a host of other unconventional interventions are considered anywhere from useless to detrimental.

Among the other provinces, the government-run Insurance Corporation of British Columbia has gone furthest in responding to the Quebec whiplash study. It is doing 2 things to improve and rationalize its handling of whiplash cases, which account for more than 70% of personal-injury claims. First, it has launched a multidisciplinary Soft-Tissue Injury Recovery Management Project involving doctors, occupational therapists, employers, unions and others who should be involved in helping a patient regain normal function as rapidly as possible. Second, it is funding the BC Whiplash Initiative, a \$650 000 multi-agency project designed to educate physicians about the care and treatment of soft-tissue injuries. The University of British Columbia is monitoring the progress and behaviour of physicians to ensure the most up-to-date and relevant information reaches the province’s practising doctors.

Elsewhere, however, the nature of automobile injuries and appropriate treatments remain matters of some contention. For the past 2 years in Ontario the insurance industry has been funding designated assessment centres (DACs), which offer neutral, nonbinding evaluations of disputed treatment options. According to a government official, insurance companies usually refer cases to 1 of the province’s 200 DACs after about 10.5 months of treatment. Claimants who disagree with a DAC report can pursue a dispute-resolution procedure overseen by the Ontario Insurance Commission.

Although the adjustment of personal accident-insurance claims is at best an inexact science, insurers know that fraud is a problem the industry has to solve — whether it involves someone who would malingering for an extra week or 2, or an organized-crime ring.



Most companies take the challenge seriously. The Insurance Corporation of BC, for example, has a high-profile antifraud campaign that supports legal action against people who make fraudulent claimants for compensation and damages.

Elsewhere, public and private auto insurers have joined police, fire services and consumer advocacy groups to form the Coalition Against Insurance Fraud. Among other things, it works with professional groups such as physiotherapists, psychologists and rehabilitation

therapists to watch for patient scams. Many insurers have set up their own investigation units, agreed on protocols to sharpen their business practices and launched the process of sharing client information.

Sadly, none of that helps Amal Sayah. Her insurer stopped paying her \$1000-a-month benefits after a year, and declined to pay for the physiotherapy ordered by her doctor. Meanwhile, the driver of the other car and his companions are alleged to have pocketed \$60 000 from their insurers before charges were laid.?

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