

**Publications - Insurance Fraud - Recognition**

**INSURANCE FRAUD - THE RECOGNITION  
AND IDENTIFICATION OF  
INSURANCE FRAUD**

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**INSURANCE FRAUD - THE RECOGNITION AND IDENTIFICATION OF  
INSURANCE FRAUD**

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**Presented to:**

**CHUBB GROUP OF INSURANCE COMPANIES**

**200 St. Paul Place, 23<sup>rd</sup> Floor**

**Baltimore, Maryland**

**By:**

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### **INSURANCE FRAUD - The Recognition and Identification of Insurance Fraud**

Insurance fraud, as it is commonly referred to, consists of the deliberate deception of an insurance claimant in the presentation of an insurance claim for unfair or unlawful personal gain. Injured parties, physicians and other health care providers, as well as attorneys, all may engage in insurance fraud.

Insurance fraud is one of the most significant problems facing the insurance industry today. While efforts to combat insurance fraud have been extensive in the past decade, the cost of insurance fraud remains significantly out of control. It has been estimated that the costs to consumers, the insurance industry and governments of insurance fraud exceeds \$27.6 billion per annum.

Insurance fraud in the United States committed by claimants, providers, employees or insured's is pervasive and costly. The estimated cost attributable to insurance fraud amounts to more than \$1,000.00 per family.

According to a study published by the Coalition Against Insurance Fraud (CAIF), fraud is one of the leading factors among the components which escalate the costs of insurance. The CAIF study the loss estimates related to insurance fraud are broken down as follows:

- Auto - \$12.3 billion
- Homeowners - \$1.8 billion
- Business/Commercial - \$12.0 billion
- Life/Disability - \$1.5 billion
- Total - \$27.6 billion

The most brazen type of fraud is committed by individuals or organized groups who defraud the insurance industry through a myriad of sophisticated fraudulent schemes. The most flagrant fraudulent schemes involve staged automobile accident rings and the filing of multiple fraudulent accident claims involving non existent medical treatment and bogus or non-existent property damage claims.

### **Elements of Fraud**

The foremost successful effort to combat insurance fraud is the necessity to recognize and identify the indicators of fraud. This recognition of the indicators of fraud is the essential first step in the investigation and identification of a fraudulent claim. Usually, this task falls upon the insurance claims adjuster. Because it is the adjuster who first must detect indicia of fraud, it is extremely important for the adjuster to become familiar with the badges or indicators of fraud. It is emphasized that the first line of defense to detect the indicators of fraud is the claims adjuster. It, therefore, is important for each adjuster to be thoroughly familiar with the badges of fraud, so that the adjuster knows what to look for in connection with a potentially fraudulent claim.

A listing of the general indicators for Personal Injury Fraud, Workers' Compensation Fraud, and Property Damage Fraud published by the National Insurance Crime Bureau are attached as *Attachments 1, 2 and 3* to this publication.

Once a “red flag” has been raised, the potentially fraudulent claim must be thoroughly investigated in order to locate and identify evidence of fraud. After the index of suspicion of fraud has been raised by the claims adjuster, the further effort to uncover insurance fraud can best be accomplished by the SIU of the insurance claims department.

### **National Insurance Crime Bureau**

The National Insurance Crime Bureau (NICB) , which was established in January of 1992, is a national organization which is dedicated to the reduction of insurance fraud. Its efforts in combating insurance crime include public education, training and development, investigative efforts and an integrated data base. The NICB has published an excellent publication on Insurance Fraud entitled *Handbook for Insurance Personnel*. The index to the publication is attached hereto as *Attachment 4*.

### **Insurance Fraud Statutes**

In 1990, only eight (8) states had created state agencies which were charged with detecting, deterring and prosecuting cases involving insurance fraud. The decade of the 90's was active in the further creation of such state agencies, commonly referred to as Insurance Fraud Bureaus. At the present time, 46 state fraud units have been created in an effort to combat the growing incidents of insurance fraud. The Model Insurance Fraud Act created by the Coalition Against Insurance Fraud is attached as *Attachment 5*.

A total of 44 states currently define insurance fraud as a specific crime, and 37 states further define certain classifications of insurance fraud as a felony.

Insurance Fraud Statutes have been created in Maryland, the District of Columbia and Virginia. Copies of the acts of each are attached as *Attachments 6, 7 and 8*.

### **Maryland Insurance Fraud Statute**

In 1991, the Maryland General Assembly enacted an anti-fraud section within the Insurance Code requiring insurance companies to file anti-fraud plans with the State Insurance Commissioner and to report suspected fraud to law enforcement agencies.

The Maryland Insurance Fraud statute enacted over a decade ago required insurers to take affirmative action with respect to reporting insurance fraud and required insurers to promulgate, implement and maintain an anti-fraud plan on December 31, 1991. The writer authored a critique of the then newly enacted statute which was published in the “In Brief,” a publication of the Governor’s Executive Advisory Council. A copy of

the article is set forth as *Attachment 9* of this publication. Subsequently, the Maryland legislature amended the statute attempting to cure a number of statutory deficiencies and established a limited form of immunity. The immunity provided in the current statute is immunity for “good faith” compliance in reporting suspected insurance fraud to law enforcement and the Maryland Insurance Commission, but does not provide insurer-to-insurer immunity nor immunity for reporting suspected insurance fraud to the NAIC or NICB.

It is submitted that additional curative legislation is necessary to provide immunity for an insurer, its employees and producer when acting without malice, fraudulent intent, or bad faith and should further extend the immunity for communications to other insurers, the NAIC or NICB.

### **Maryland Insurance Fraud Division**

The Maryland Insurance Fraud Division of the Maryland Insurance Administration is the legislatively mandated state agency which has, as its purpose, the goal of combating insurance fraud throughout the state of Maryland. It is actively engaged in the war against insurance fraud in 23 of Maryland’s counties. It has a successful history in combating insurance fraud of a wide variety of insurance fraud schemes. It has an active website with significant information regarding insurance fraud, insurance fraud publications, the procedural methodology of filing and pursuing complaint and consumer information. A copy of its website’s publication on Insurance Fraud is attached as *Attachment 10*.

### **Recovery of Damages from Insurance Fraud Perpetrators**

While considerable progress has been made in uncovering insurance fraud during the past decade, too little attention has been given to the effort of recovering damages from insurance fraud perpetrators. Notwithstanding the effort on the part of State Insurance Fraud Bureaus to initial civil actions against fraud perpetrators, the lack of staffing and administrative priorities remain formidable handicaps to effective collection efforts. A copy of a separate publication entitled “Insurance Fraud - Recovery of Damages from Insurance Fraud Perpetrators” which was designed to enable an insurance carrier to establish an agenda to recover damages from insurance fraud, is attached as a separate publication for review.

### **Insurance Fraud Investigation and Reporting and the Potentiality of Conflict with the Duties Imposed in the Fair Claims Settlement Acts**

As noted, the fraud reporting statutes, which are in effect in most jurisdictions, inclusive of Maryland, the District of Columbia and Virginia, create certain

affirmative duties on the part of the insurance industry, inclusive of the duty to report suspected cases of insurance fraud. Other statutes also enacted in most jurisdictions also create certain duties which may conflict with the duties imposed by the fraud statutes. Most states have enacted statutory provisions which govern the administration of insurance claims. These statutes are commonly referred to as Fair Claims Reporting Acts. The gravamen of such acts is to ensure the prompt, fair and equitable payment of insurance claims. Among the acts which constitute an unfair settlement practice which subjects the insurer to administrative penalties and monetary damages are the failure to promptly adjust claims; the refusal to pay a claim within a reasonable time; the failure to make a prompt, fair, and equitable good faith attempt to settle claims; and the failure to provide a reasonable explanation of the basis for denial of a claim or the offer of a compromise settlement. A copy of the Fair Claims Reporting Acts enacted in Maryland, the District of Columbia and Virginia are attached as *Attachments 11, 12 and 13*.

## **Overview of the Fair Claims Settlement Acts**

In accordance with United States Congressional intent, as expressed in the McCarran-Ferguson Act, 15 U.S.C §§ 1011 through 1015, each state, and the District of Columbia, have been given the authority to regulate the trade practices of the insurance business industry.

### ***Maryland***

Section 230A(c) of the Maryland Insurance Code sets forth several procedures and acts which if committed by insurance carriers, will be considered unfair claim settlement practices. In addition, subsection (d) sets forth actions which if committed with such frequency as to indicate a general business practice, will also be found to be unfair claim settlement practices.

In accordance with this section, a violation does not create a separate cause of action, but provides administrative relief only. The Maryland Insurance Commissioner may, however, require that the insurer pay restitution to the claimant who has suffered actual economic damages as a result the insurer's violation of the statute.

### ***District of Columbia***

The District of Columbia does not contain a section listing the specific acts which if engaged in by an insurer, would constitute an unfair claim settlement practice. Rather D.C. Code §35-1706(b) provides a catch-all provision which states that, "no group, association or organization shall engage in any unfair or unreasonable practice in the

conduct of its business.” A violation of this section could result in the suspension or revocation by the Commissioner. D.C. Code §35-1706(4).

## ***Virginia***

The Virginia legislature has adopted the Insurance Unfair Trade Practices Act which is codified as Va. Code §§ 38.2-500 through 517 (1997), and designed to define and prohibit all practices in the Commonwealth that constitute unfair methods of competition or unfair or deceptive acts or practices. Specifically, Va. Code §38.2-510, outlines numerous practices, which if committed or performed with such frequency as to indicate a general business practice in violation of Va. Code § 38.2-510.

Additionally, this section does not serve to create a private cause of action, but rather, it solely provides an administrative remedy.

## **Insurance Fraud Exemplars**

**Insurance** fraud scams take a number of forms and are ever increasing. Among the types of fraud frequently encountered are the following:

- Staged automobile accidents resulting in personal injury
- Staged slip and fall incidents resulting in personal injury
- Professional fraud by unethical medical and legal practitioners working in concert with clients and patients to create fictitious accident related injuries to collect on fraudulent claims of personal injury
- Workers compensation fraud involving false and fraudulent claims of personal injury involving employees who falsely report injuries or inflate the extent of injury to collect workers compensation benefits
- Vehicular scams involving intentional conduct in creating an accident to collect money
- False property loss claims
- Arson for profit claims
- Exaggerated claims by fraudulent claimants who overstate their loss for profit
- False property theft claims of expensive jewelry and money to collect insurance funds
- Exaggerated personal injury claims which are fraudulent

## **Exaggerated Personal Injury Claims Which Are No Fraudulent and Those Which Are Tantamount to Fraud**

One of the most problematic areas of suspected insurance fraud is the exaggerated personal injury claim. As all defense counsel and insurance claims personnel are unfortunately aware, a significant number of personal injury claims involve claims of Plaintiffs who exaggerate the nature and extent of their personal injury. This is done both by claimants who present claims themselves, as well as those represented by Plaintiffs' counsel who represent the claimant through the litigation process. Often times the complaints of personal injury are not only subjective in nature, but totally inconsistent with the objective medical findings of any injury. The difficulty is separating the "soft fraud" claim involving exaggerated personal injury claims which does not constitute fraud from the truly fraudulent claim.

In the event an SIU of a claims department too aggressively jumps to the conclusion that the badges of fraud or the indicators of fraud establishes a fraudulent claim, i.e. confuses the suspected fraud claim with a claim which involves fraud, not only can the Fair Claims Settlement Act be violated resulting in consequential administrative penalties and damages, but can subject the insurance company and adjusters to civil litigation and significant damages, inclusive of punitive damages.

The following case study is presented of a suspected fraudulent claim which had the indicia of a fraudulent claim due to the existence of the indicators of fraud predicated upon an exaggerated personal injury claim, but for which evidence was not obtained to document an insurance fraud claim.

### **Case Study**

The following is an actual recent case in litigation which was handled by an SIU of an insurance claims department of a major insurance carrier in which the insured Defendant was represented by insurance defense counsel retained by the insurance carrier. The names of the parties have been fictionalized, as well as the names of the insurance carrier and defense counsel, to assure confidentiality of the information developed in the actual case. The information, facts and data set forth are, however, real.

The civil suit is predicated on a motor vehicle accident occurring on June 4, 2001 in a parking lot located at Towson University in Towson, Maryland. The insureds in the action are Mr. Insured and his son, Also Insured, the latter of whom was the driver of the insured vehicle involved in the accident.

Defendant Also Insured was liable for the accident by rear-ending Plaintiff's vehicle, in which Mrs. Golddigger was in the driver seat and Young Golddigger was in the

passenger seat. No liability for Mr. Insured who was named in the suit as an employer of Also Insured. Mr. Insured is Also Insured's father and not his employer.

On the day of the accident, Also Insured was driving a 1995 Jeep Grand Cherokee to Towson University to attend his high school graduation from Pikesville Senior High School. In the passenger seat of the insured vehicle was Young Thing, a friend of Also Insured. When Also Insured attempted to park the insured vehicle, the left front bumper corner collided with the back right bumper corner of Plaintiff Mrs. Golddigger's vehicle, a white 1992 Mitsubishi Diamante. Young Golddigger, Mrs. Golddigger's son, was in the passenger seat of the Plaintiff's vehicle. The Jeep was titled in Mr. Insured's name.

The Golddiggers assert they were sitting in their vehicle, with the engine off for five (5) to ten (10) minutes, with their safety belts on, preparing to attend the high school graduation of Young Golddigger.

The anticipated testimony of the witnesses for each of the parties differed in the degree of impact which is alleged to have taken place.

Also Insured and Young Thing were expected to each testify that the collision was very light; that the vehicles "scraped" or lightly tapped each other. Specifically, that the front left of the Jeep lightly tapped the right rear bumper of the Golddigger's vehicle when Also Insured attempted a left hand turn into the empty parking space to the right of the parked Golddigger's vehicle.

However, the recollection of Also Insured and Young Thing as to the events surrounding the accident differ. Also Insured's recollection is that the Golddigger vehicle did "move a little bit." Also Insured's recollection is also that he was able to park, even with tapping the Golddigger vehicle, without having to stop the Jeep. Young Thing was expected to testify that upon colliding with the Golddigger vehicle, Also Insured had to stop the Jeep, reverse it, and reposition the Jeep so it would clear the Golddigger vehicle when making its turning apex.

The Golddiggers were expected to testify that at approximately 6:30 p.m., on June 4, 2001, immediately prior to the accident, Mrs. Golddigger and Young Golddigger were sitting in their vehicle for approximately five (5) to ten (10) minutes, and that each of them were wearing their seat belt. The Golddiggers were expected to testify that their vehicle was struck suddenly from the rear by the Jeep, the impact occurring at the right rear of the Golddigger vehicle by the front part of the Jeep. Plaintiff Mrs. Golddigger was expected to testify that the accident rated a "9" on a 10-point scale, 10 being the most severe. Mrs. Golddigger was expected to testify that the impact to her vehicle moved her body forward and backward, left and right.

The Golddiggers were expected to testify that immediately following the accident, Also Insured said to one or both of them, "I am so sorry, it was my fault." Lastly, that the Golddiggers continued to the graduation and afterwards went home.

No ambulance or police were called to the scene and none of the parties went to the emergency room immediately after the accident. Both parties continued to the graduation ceremony, with the Golddiggers walking behind Also Insured and Young Thing. Both vehicles were driven from the scene.

Subsequent inspection of both vehicles revealed that both vehicles suffered property damage. Repair estimates for the cost of structural repair for the Plaintiff's vehicle, i.e., to repair and repaint the bumper, was \$520.10. The estimate to repair the Jeep, consisting of a small scuff, was \$192.00. Both vehicles have since been sold.

Two (2) days following the accident, June 6, 2001, Mrs. Golddigger was seen by Dr. Overtreat, M.D. of Overtreat Clinic. She complained of injuries to her neck, both shoulders, both forearms, to her upper and lower back, and headaches, attributing these injuries to the rear end collision. On a scale of 0 to 10, Mrs. Golddigger advised that pain in her neck and lower back was at "#8," pain in her both shoulders and left forearm was at "#6," and pain in other injured areas was at "#7." She experienced previously a neck and back injury in 1998 to which she advised she has had complete recovery. She also advised she has no familial or genetic history which contributes to her injuries. Clinical physical evaluation of her neck by Dr. Overtreat revealed spasm and pain on palpation of the cervical paravertebral musculature. Due to pain, active flexion was limited to 15 degrees, extension and tilt to the left to 0 degrees, tilt to the right to 20 degrees rotation to the right to 35 degrees, rotation to the left to 30 degrees. Also, that the spinous processes C4-C6 were tender. With respect to her upper back, palpation of the upper back showed pain and spasm. Palpation of the lower back revealed spasm and pain. Due to the pain, active flexion was limited to 50 degrees, extension to 15 degrees, tilt to the left to 10 degrees, tilt to the right and rotation to the left to 20 degrees. Also, there was tenderness upon palpation of both shoulders and both forearms. Secondary to pain, active flexion of the right shoulder was limited to 130 degrees, abduction to 95 degrees, internal rotation to 50 degrees, external rotation to 70 degrees. Active flexion of the left shoulder was limited to 150 degrees. Abduction to 140 degrees, internal and external rotation to 60 degrees.

Dr. Overtreat Jr. opined that Mrs. Golddigger's complaints and data of his examination were a result of the automobile accident on June 4, 2001. He thereafter placed her on the following treatment plan: (1) Physical therapy evaluation and treatment, (2) start home exercises, prescribed (3) Flexeril, (4) Ibuprofen, and to

submit to an (5) X-ray examination of the cervical and lumbar spine. She was instructed to return for follow- up visits.

On June 12, 2001, Dr. Quack prepared a report concerning his evaluation of Mrs. Golddigger following X-rays of her body. Dr. Quack noted, among other things, that Mrs. Golddigger's cervical spine had a "mild S-shaped configuration of the cervical lordosis, which may be due to muscle spasm or patient positioning. Intervertebral disc space narrowing is seen at C5/6 with anterior and posterior marginal lipping and uncovertebral joint hypertrophy." His impression of her cervical spine was (1) degenerative joint and disc disease at C5/6, and (2) no evidence of fracture or dislocation. Dr. Quack found nothing abnormal with Mrs. Golddigger's lumbosacral spine.

Mrs. Golddigger's physical treatment took place from June 6, 2001 through July 16, 2001 at Overtreat Clinic. Her treatment consisted of hot/cold packs, electrical stimulation, ultrasound, massage, and exercise.

On July 16, 2001, Mrs. Golddigger attended her last visit with Dr. Overtreat Jr. On that date, he observed that her headaches and injuries to both forearms have been resolved. He further observed that her cervical, thoracic, and lumbar strain and injuries to both shoulders have not completely resolved, but were sufficient enough for discharge. She was thus discharged, but it was recommended that she continue a revised program of home exercises. She was instructed to discontinue medications and physical therapy treatment.

In total, Mrs. Golddigger attended three (3) orthopaedic appointments and seventeen (17) physical therapy appointments. The total cost for these services known to date and running from June 6, 2001 through June 16, 2002 is \$4,141.50.

Young Golddigger was also seen two (2) days following the accident, June 6, 2001, by Dr. Overtreat of Overtreat Clinic. He complained of injuries to his back and both shoulders consisting of soft tissue injuries, as well as headaches, attributing these injuries to the rear end collision. On a scale of 0 to 10, Young Golddigger advised that pain in his left shoulder was a "#8," and pain in the other injured areas was at

"#7." He advised Dr. Overtreat that prior to this accident he did not have these complaints. Clinical physical examination of Young Golddigger's neck by Dr. Overtreat revealed spasm and pain on palpation of the cervical paravertebral musculature. Due to the pain, active flexion, rotation to the right and tilt to the left were limited to 30 degrees, rotation to the left to 50 degrees, tilt to the right and tilt to the left were limited to 30 degrees, rotation to the left to 50 degrees, tile to the right to 15 degrees. The spinous processes C4-C6 were tender. His upper back demonstrated spasm and pain upon palpation of the upper back. Due to pain, active flexion of his right shoulder was limited to 145 degrees, abduction of the right shoulder and flexion of the left shoulder to 120 degrees, abduction of the left shoulder and internal rotation of both shoulders to 70 degrees. Also, Dr. Overtreat observed there was adequate range of active and passive motion of all other extremities without pain.

Dr. Overtreat opined that Young Golddigger's complaints and data of his examination were a result of the automobile accident on June 4, 2001. He thereafter placed Young Golddigger on the following treatment plan: (1) Physical therapy evaluation and treatment, (2) start home exercises, prescribed (3) Flexeril, (4) Motrin, and to submit to an (5) X-ray examination of the cervical and lumbar spine. He was instructed to return for follow-up visits.

In total, Young Golddigger attended three (3) orthopaedic appointments and eighteen (18) physical therapy appointments. The total cost for these services known to date and running from June 6, 2001 through June 17, 2001 is \$3,869.15.

The Court has consolidated Mrs. Golddigger's and Young Golddigger's respective claims so that the Court might hear both simultaneously. Additionally, an Amended Complaint (the "Complaint") has been filed which named both Mr. Insured and Also Insured as Defendants.

The Amended Complaint contained One Count sounding in negligence. It claims that Also Insured, "operated his vehicle at a rate of speed greater than was reasonable and proper under the traffic conditions then and there existing, without proper control thereof, without proper lookout for the vehicle of the Plaintiff, as aforesaid, without due regard to the presence of and proximity to said automobile, failed to yield the right of way to the vehicle operated by [Mrs. Golddigger], and was otherwise reckless and careless, collided into the rear of the [Golddigger] vehicle with great force and violence." It also claims that Mr. Insured owned the vehicle Also Insured was driving, and that Also Insured was driving the vehicle in the course of his employment with Mr. Insured. Lastly, that as a direct result of the negligence of Mr. Insured and Also Insured, the Plaintiffs suffered their injuries and property damage.

Goodguy & Goodguy, P.C. was retained to defend the interests of the insureds. Greed & Greed represented the interests of the Plaintiffs.

A paper defense IME was performed by Dr. Good, the defense medical expert witness. Dr. Good opined that the number of areas injured, i.e. five (5) for Young Golddigger (neck, mid back, right shoulder, left shoulder and head) and eight (8) for Mrs. Golddigger were unusual for a low impact injury to a restrained person. He opined that in the event the impact was in fact a minor impact that no real treatment would be indicated other than time and natural healing.

Counsel for the insured obtained an opinion from Dr. Good regarding the question of over treatment by the Plaintiffs' physicians and the existence of fraud predicated upon the exaggeration of the nature and extent of treatment. Dr. Good could not opine to a reasonable degree of medical certainty that either fraud or overtreatment occurred.

The following advice was furnished by I.B.A. Goodguy, of Goodguy & Goodguy, to Trustworthy Insurance Company:

**Dear Goodfaith SIU Adjuster:**

Please be advised that I conducted a telephone conference with Dr. Good to discuss the potentiality of further investigating and substantiating a potential fraud claim arising out of this civil matter.

Dr. Good indicated that in the event the accident impact was as severe as the Plaintiffs are expected to testify, for example, a "9" out of "10," and in the event that the Plaintiffs did have spasm and pain where they indicated, then the nature and extent of their treatment is not so excessive as to constitute fraud.

Dr. Good also advised that, in the absence of the ability to perform an IME and physical clinical examination for spasms, it is not possible for him to further determine the validity of the complaint and, specifically, to further assist in the identification of any fraud.

In view of Dr. Good's erstwhile advice and opinions concerning the nature and extent of the treatment rendered to the Plaintiffs, it is our recommendation to see if the claims can be resolved at a reasonable basis, and, if the demand is deemed not within reason, to present at trial the Defendants' side of the accident. We will, of course,

communicate and demand for settlement issued, however, please be advised no demand has been tendered to date. Furthermore, please be advised that with liability, and the testimony and claimed damages are accepted by the trial Court, judgment may be awarded from between seven to ten thousand dollars for each Plaintiff.

Please be advised that a review of the file reveals that we are not in possession of the original photographs of the vehicles taken after the accident. Please forward the photographs to this office at your earliest convenience.

For claims in which the index of fraud is seemingly more apparent, it is recommended that, in addition to a simple appraisal of the vehicles involved in such accidents, that a forensic examination be immediately performed as well by an **accident reconstructionist** and/or an appropriate **biomechanist**. The objective of such an inspection as an initial claims assessment device would be to determine when possible the amount of force generated by the accident in order to further substantiate or cast doubt into the likelihood of any claimed resulting injuries or the extent of such claimed injuries. Such an examination would be best performed prior to the initiation of any suit, particularly when suit is often filed long after the accident and the sale of the subject vehicles, and, in the instance of Maryland district court actions, where compulsive discovery is not as far-reaching as it is for example in Maryland's circuit courts.

Very truly yours,

I.B.A. Goodguy

Goodguy & Goodguy, P.C.

The damages claimed and the history of the demands and settlement negotiations for this case are as follows:

Total Specials for :

Mrs Golddigger:    **\$4,141.50**

Young Golddigger:   **\$3,869.15**

Property damage to vehicle:   **\$520.10**

No loss wage claim for either Mrs. Golddigger or Young Golddigger.

By August 3, 2001 letter, prior to suit filing, demand for settlement for:

Mrs. Golddigger: \$28,800

Young Golddigger: \$24,250

On July 3, 2002, demand for settlement was made for:

Mrs. Golddigger: \$8,500

Young Golddigger: \$8,000

Trial date was July 11, 2001 in the District Court of Maryland for Baltimore County.

This claim ultimately settled on the day before trial for the sum of \$7,500.00, at a figure of less than the medical special damages and included the sum of \$500.00 in property damage as to which there was no dispute.

Although discovery is limited in the District Court, prior medical records of both Golddiggers were obtained which documented a prior injury for both, which took place on August 18, 1998, which were sustained by both Golddiggers when they were seat belted passengers of a vehicle that collided with another vehicle. The identical parts of their body were previously injured. They were treated by different health care providers. Their treatment was nearly identical and involved visual evoked potential tests and Brainstem evoked potentials.

The medical records were reviewed by Dr. Good who issued a modified report which was received twelve (12) days after the settlement. Dr. Good indicated that despite the fact that the vehicular accident that both Mrs. Golddigger and Young Golddigger were involved in in 1998 was a completely different type of impact, their injuries were to essentially the identical areas as occurred in the accident of June 4, 2001, i.e. cervical, thoracic and lumbar spines, left shoulder and headaches. He opined to a reasonable degree of medical certainty that the probability of both these claimants sustaining essentially identical injuries to five (5) separate body parts (neck, mid back, low back, left upper extremity and head) is so unlikely as to be highly doubtful.

- In a case such as this, where it is determined initially that the insured and a third-party witness in the insured's vehicle both maintain there was only a light scraping or tapping between the insured vehicle and the claimants vehicle which was parked in a parking lot at the time of the occurrence, and the occupants in the claimant's vehicle are asserting that the impact was a "9" on a scale of 1 to 10, the claim is of a suspicious nature and an indicator of fraud is clearly present.

- It is important for the adjuster to immediately refer the case to the SIU for a potential fraud investigation. The SIU should immediately initiate a fraud investigation.
- This case has several indicators of fraud, namely: 1) It involved a low impact accident 2) Neither Golddigger required or received emergency medical treatment or any immediate medical care for any injuries in the time period immediately following the alleged trauma; 3) the claims of both Golddiggers were exaggerated claims 4) the treatment that both Golddiggers received was nearly identical 5) each had prior claims involving identical injuries to the same multiple areas of the body
- However, the case also involved several factors which were either not consistent with fraud, namely: 1) there was no evidence that the accident was staged 2) the claimants both described the impact as a significant impact i.e. "9" on a scale of "1 to 10." 3) The physical findings of the treating physician for both Plaintiffs described limitation of motion and muscle spasms and documented the nature and extent of injury to each part of the body claimed to have been injured 4) no permanent injuries were claimed for either Plaintiff 5) the medical expenses and treatment were not deemed excessive in the event that injuries and symptoms were bona fide, and 6) the nature and extent of the claimed injuries were documented by medical records of a presumably bona fide health care provider 7) the length of time that the claimants were treated was not excessive for the injuries claimed and 8) the total medical expenses are not grossly excessive for the injuries claimed, and 9) neither the attorney nor the treating physician is known to be a fraudulent professional and appear to be bona fide.
- The indicators of fraud on the part of the Golddiggers and on the part of the treating physicians are clearly present and any additional claims of a similar nature should be thoroughly investigated by the SIU should any further claims be filed.
- It would be important to determine if there is any pattern which exists between the health care provider and the attorney for the Golddiggers in terms of similar claims.

**Conclusion:** This claim certainly involved a clear cut claim of exaggeration of the nature and extent of personal injury. It clearly evidenced indicators of fraud. Although the index of suspicion for an insurance fraud case is high, no clear cut evidence of fraud was established during the investigation nor the District Court litigation which could establish insurance fraud by clear and convincing evidence.

## **Fraud Publications**

There are a number of publications on Insurance Fraud which are valuable tools to the understanding, detection and prevention of such fraud. One such publication, an expose and history of fraud in this country entitled "*Accidentally, on Purpose: The Making of a Personal Injury Underworld in America*" authored by Ken Dornstein.

This publication documents the making of America's most peculiar underworld. It is not centered on the traditional activities of organized crime, but rather an underworld built from the raw material of faked personal injuries. It extends back to the late nineteenth century to the earliest slip and fall artists, one of whom was "Banana Anna," who feigned injuries for money by slipping on banana peels on steam trains throughout the Midwest. It then

covers the "ambulance chasers" and "shysters" of old New York who pioneered the personal injury trade; the accident racketeers of the 1920's; the excesses of self mutilation for profit during the Depression; and the whiplash industry of the 1960's and 1970's.

Through original interviews, Dornstein also reports on contemporary gangs whose members travel the streets of cities around the country staging car accidents for insurance money - the "cappers" who script accidents, the "dummies" who sit in cars for crashes, and the doctors and lawyers who call the shots from behind the scenes. The publication tells the story about a culture in which greed, desperation, and freemarket incentives in the legal system gave transformed accidents and injuries from random instances of bad luck into the solid foundations of a secret economy.

Another publication of interest is *"Personal Injury Insurance Fraud: The Process of Detection. A Primer for Insurance and Legal Professionals"* by Joseph Lichtor M.D.

This publication exposes a wide spectrum of personal injury insurance fraud which is commonly defined as deliberate deception for unfair or unlawful personal gain. Dr. Lichtor presents many examples of accidental injury, such as auto accidents, slip and falls, home hazards, and more. He focuses on the ways to investigate claims and discover whether a claimant has truly been injured. You will also read about the current methods of prevention.

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Topics covered in this treatise include:

- \_ Definitions and history of personal injury fraud
- \_ Fraud prevention
- \_ Accident investigation

- \_ Accident history (records)
- \_ Symptoms, diagnoses and treatment
- \_ Examination and tests for physiological dysfunction
- \_ Aggravation of pre-existing conditions
- \_ Whiplash and back injury
- \_ Traumatic fibromyalgia
- \_ Repetitive motion injury
- \_ Impairment, disability and fraud
- \_ Abnormal illness behavior for personal gain
- \_ Workers' compensation fraud
- \_ Federal fraud enforcement

## **Summary**

Insurance fraud in this country is rampant and permits billions in loss payments to be paid out every year by the insurance industry on suspicious and fraudulent insurance claims. Millions are lost because suspicious claims are not recognized and there is a lack of knowledge to recognize and identify the indicators of fraud followed by a lack of proper investigation to properly identify and evidence a fraudulent claim.

The first line of defense to defeat a fraudulent claim is the insurance adjuster. It is important that the adjuster be thoroughly familiar with the indicators of fraud. Once the index of suspicion is raised with respect to a fraudulent claim, a thorough specialized investigation is thereafter needed to uncover and evidence the fraudulent conduct or scheme.

The necessary special investigation is best performed by a well trained SIU in the claims department which has the ability to investigate suspected fraud, to identify and document the fraud being committed and to report criminal activity in accordance with the statutes requiring the reporting of insurance fraud.

The line between exaggerated personal injury claims which are not fraudulent and those which are fraudulent is often a difficult one to determine. This is so because

most tort claims are exaggerated predicated upon the desire for personal gain. The legal system is a catalyst for such claims which are orchestrated by the Plaintiffs bar and encouraged by liberal jurists and juries.

In addition to reporting suspect fraud, the insurance carrier must also establish an agenda to recover from insurance fraud perpetrators. This is so because while criminal penalties exist to punish fraud perpetrators, the current statutory provisions do not provide for civil remedies.

### **LIST OF ATTACHMENTS**

1. General Indicators for Personal Injury Fraud
2. General Indicators for Workers' Compensation Fraud
3. General Indicators for Property Damage Fraud
4. Index to publication entitled "*Handbook for Insurance Personnel*" by the National Insurance Crime Bureau
5. Model Insurance Fraud Act
6. Insurance Fraud Statute for Maryland
7. Insurance Fraud Statute for District of Columbia
8. Insurance Fraud Statute for Virginia
9. Maryland Insurance Fraud Statute - *In Brief* Volume 2, No. 5 Summer 1992  
Article by Jeffrey R. Schmieler
10. Insurance Fraud publication by the Maryland Insurance Administration
11. Unfair Claim Settlement Practices for Maryland
12. Unfair Claim Settlement Practices for District of Columbia
13. Unfair Trade Practices for Virginia

The information you obtain at this site is not, nor is it intended to be, legal advice. You should consult an attorney for individual advice regarding your own situation.

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