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SIU Perspectives

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WELCOME TO SIU PERSPECTIVES

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2013 has been a year of first impressions and new challenges for the insurance industry, and 2014 promises more of the same. New fee schedules, revised PIP laws, natural disasters and an active plaintiffs bar harken the carrier community to be on guard for fraudulent activities and prepared for the likely influx of litigation in the coming year.

Understanding the landscape of SIU claims is the first step in maintaining a successful defensive posture. For example, recently-enacted legislation in Florida relative to personal injury protection (PIP) benefits is almost certain to trigger a new wave of litigation over the entitlement of PIP benefits, eligibility and Examinations Under Oath. Coupled with the nuance of bad faith, Florida continues to be a state to watch in the coming year.

For states bordering the eastern seaboard that felt the wrath of Super Storm Sandy, public adjuster-related claims and complaint filings are expected. Though the media primarily focused on private homeowner losses, numerous coastal resorts and amusement entities were also greatly impacted by the storm. As such, we are seeing an increase in fraud-related claims relative to inventory, commercial industry and business interruption. Given the publicity of Sandy's wrath, extra-contractual suits are also starting to emerge. To that end, individual carriers should be vigilant in respecting the contractual privity between insurer and insured while thoroughly and appropriately investigating suspect claims.

Medical provider fraud issues continue to plague our industry from coast to coast. Interventional pain management and non-listed procedures are directly responsible for large outlays of PIP benefits. Other forms of medicine, notably acupuncture and physical therapy, continue to be on the rise as a way for an injured party to further bolster its Uninsured Motorist/Bodily Injury claim. Durable medical equipment, pharmaceutical bills and generic "services not rendered" cases continue to grow and expand from region to region. Although this type of fraud is rarely self-evident, we must be steadfast in our resolve to pay claims for services that were actually rendered under the construct of individual state laws.

An uneasy economy continues to place financial strain on ordinary household incomes. Such pressure in the past has led to an increase in theft of scheduled items and automobile "give ups." Seeking to understand the individual and personal situation of the claimant can help guide carriers to a good faith perspective as opposed to making rash decisions or jumping to pre-conceived notions. It is better to be tempered and conduct a full investigation than to deny the claim for the sake of closing one's file.

As 2013 winds down and we prepare for the challenges of the coming year, Marshall Dennehey is committed to identifying and understanding the contemporary trends and emerging issues that will impact the industry and our clients. We welcome the opportunity to be your counsel and litigation partner in an effort to lead you toward a successful outcome in the arena of SIU-related claims. II

HB119 BRINGS WELCOME CHANGES FOR FLORIDA CARRIERS

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Sweeping changes to the Florida Motor Vehicle No Fault Law through House Bill 119 became effective January 1, 2013. For new claims stemming from policies written after this date, many of the revisions to the statute provide additional and stronger tools to fight insurance fraud and manage exposure. Insurers need to be aware of these changes in order to remain competitive and be effective in their Florida PIP SIU departments. Here's an analysis of some of the more notable revisions to the law:

- "Fraudulent insurance act" is now defined to include licensure application fraud and a claimant's submission of a claim when the claimant knows the clinic has committed licensure application fraud.

  Analysis: Discovery of licensure fraud by the insurer creates an obligation to report to the Division of Insurance Fraud, not just a viable defense on a case. If reported by a properly licensed SIU investigator, that individual and the insurance carrier will have the protection of civil immunity.

- Requirement of diagnosed "emergency medical condition" in order to receive full $10,000 in PIP benefits.
  - Diagnosis must be made by an M.D. or D.O. physician. The diagnosis cannot be made by a chiropractor or any other medical professional.

Analysis: Medical doctors have been advertising their services to medical providers since the passing of this law. This will create additional relationships between medical doctors and clinics which did not previously exist, and may create further interaction with Florida Statute § 817.234 which governs what constitutes the criminal act of improper solicitation.

- Failure to obtain diagnosis of "emergency medical condition" results in limitation on PIP benefits to $2,500.
  Analysis: This provision is worded in such a manner that challenges to the interpretation of the statute are likely. The question becomes, what happens if the reports are silent as to whether an emergency medical condition is present?
- Only "follow-up care upon referral from one of the initial care providers, which is consistent with the underlying diagnosis made in the initial care phase," may be reimbursed after the first 14 days following an accident.
  Analysis: Medical providers have an incentive to fabricate fraudulent claim submissions to fall within the first 14 days following an accident. Such misrepresentations would constitute criminal acts of insurance fraud under Fla. Statute. § 817.234.

- Insurer must send a written notice to the claimant that the claim is being investigated for fraud if insurer has reasonable belief that a "fraudulent insurance act" has occurred.
- Notice must be sent within 30 days of receipt of claim.
- "Fraudulent insurance act" now licensure application fraud.
- If notice is timely, insurer obtains an additional 60 days to investigate the claim before it becomes overdue.
  Analysis: Insurers are given more time to obtain [EUOs, IMEs], accident reconstruction reports or perform other investigations. However, seeking that additional time would indicate to the medical provider that an investigation was ongoing and potentially cause witnesses to react.

- EUOs are now a condition precedent to PIP coverage.
  Analysis: It appears to clarify the Custer issue which was so strongly litigated by plaintiffs. Claimants now have more of an incentive to attend EUOs. Failure to attend an EUO can result in complete denial of a claim, provided there was reasonable suspicion of fraud, coverage defense or some other reasonable basis for requesting the EUO such that the failure to obtain the EUO results in prejudice to the insurer.
- Failure to attend an IME twice is presumed unreasonable.
  Analysis: The presumption shifts the burden from the insurer—who previously had to establish prejudice by the failure to attend the IME—to the insured, who now has to rebut the presumption that the failure to attend was unreasonable. ||

TENDING TO YOUR CLAIMS GARDEN: WEEDING OUT FRAUDULENT CLAIMS

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The Northeast is still reeling from the deluge of large loss property claims resulting from Super Storm Sandy. The rise in claims, unfortunately, also contributes to the rise of dishonest individuals who will attempt to take advantage of the situation. As a result, the industry needs to be diligent in reviewing all claims to ensure that, not only is legitimate damage rectified, but also that fraudulent claims are detected.

Contractor fraud can be a big part of the problem as with property and premises damage comes clean up and repair. However, educating your insured will be part of the solution. Insureds should be encouraged to seek out licensed and bonded contractors and to avoid solicitations from less qualified contractors who may be aggressively marketing their services. Once contractors are identified, the bonding company should be contacted to verify coverage and the amount of insurance available. References should be called, and a minimum of three different bids should be reviewed prior to signing a contract. The contract should contain a guarantee; any contractor who is unwilling to guarantee their work is a contractor not worth dealing with. Insureds should be encouraged not to pay in cash and not to pay in full until all work is completed. Finally, the insured should be advised to notify the industry in an event where questionable practices are at issue.

Recently, there has been an uptick in claims involving public adjusters in which damages are inflated or intentionally caused, oftentimes without your insured's knowledge. Time and time again, we have spoken with insureds who advised that a public adjuster pointed out damage which they "couldn't see" or "weren't aware of," only to have an expert conclude that the claimed damage could not have occurred based upon the cause of loss. Unfortunately, as the public adjusters hold themselves out as "experts in the field," our insureds may not question their conclusions.

There are several avenues the industry can take to weed out legitimate claims from those which are fraudulent in nature. Most importantly, the carrier should request pictures of the alleged damage **prior to** any remediation taking place. Recently, there has been a rash of destructive tear-out cases in which the premises is effectively gutted prior to the insurer having an opportunity to inspect the residence. Sometimes this is done prior to the insurance company being put on notice of the claim. However, it must be remembered that it is the insured's burden to prove that a covered loss occurred. Therefore, an insurance company should require that, at a minimum, the insured provide actual proof of the damage. Moreover, in instances where there is a destructive tear-out, we recommend that the insurer secure an expert to review the alleged damage, as well as conduct examinations of both the insured and the public adjuster, to determine the true extent of the loss. As always, all questionable claims should be reported to the proper authorities. ||

ACUPUNCTURE BILLING HAS PIP CARRIERS ON PINS AND NEEDLES

By Nicholas D. Bowers, Esq., Philadelphia, PA (215.575.2742 or ndbowers@mdwcg.com)

At an increasing rate, New Jersey medical providers, often chiropractors, are employing and/or partnering with acupuncturists. The effect of this activity has been a substantial increase in the amount billed per patient, per day to PIP carriers in New Jersey for pain management care following an automobile accident. Should these PIP carriers be "stuck" with the bill? Not always.

Chiropractors frequently make "referrals" within the first few weeks of treatment to acupuncturists who treat patients at the same facility. A reason for the increase in acupuncture care is that chiropractic treatment is capped out at $99 per day, but not acupuncture. Under the recently amended New Jersey Fee Schedule, N.J.A.C. 11:3-29.4(m), most acupuncture treatment now falls under the increased daily cap of $105 per day—although an acupuncturist can avoid this cap altogether by simply not billing for acupuncture on the same dates as chiropractic care. Thus, when determining whether to pay benefits for acupuncture treatment, a PIP carrier's analysis should not stop at medical necessity. Additional winning legal defenses and strategies are available.

Initially, under personal injury protection law, a patient can only treat with an acupuncturist upon a referral from a licensed physician. N.J.S.A. 39:6A-4(a). The acupuncture regulations provide that the referral must contain a diagnosis and a pre-evaluation by the physician. N.J.A.C. 13:35-9.11(a). Additionally, an acupuncturist must prepare contemporaneous treatment notes that reflect a referral or diagnosis by a physician, as well as the name of the physician. If a proper referral was not provided before treatment commenced, no benefits are owed for all dates of service preceding an appropriate referral.

The referral also must be more than a generic form and must contain substantive medical findings regarding the claimant's diagnoses to direct the acupuncturist's care. For example, in *Golden Flower Acupuncture a/s/o S.B. v. Travelers*, NJ No. 1425373 (2012), the arbitrator found that failure to perform acupuncture pursuant to a sufficient physician referral and pre-evaluation was cause for denial of reimbursement, even though some or all of the acupuncture care billed for was pre-certified by the carrier. Additionally, the arbitrator found that the mere provision of an "Acupuncture Referral Form" was insufficient to establish compliance. Rather, the records must evidence that an actual physician evaluation occurred and that the pre-evaluation findings were reviewed by the acupuncturist.

The second key requirement for the lawful provision of acupuncture is that the patient must have provided prior informed, written consent. In other words, the risks of, and alternatives to, acupuncture must be reviewed with the patient before commencing treatment, and such a review must be evidenced via a signed writing under N.J.A.C. 13:35-9.11(b). Some of the risks associated with acupuncture include nerve damage, lung puncture, organ puncture and spontaneous miscarriage. If an informed consent form is not signed by a patient before acupuncture treatment commences, or the signed form insufficiently sets forth the applicable risks and alternatives, no benefits are owed. Moreover, patient testimony indicating that risks associated with acupuncture were not verbally explained will often support a denial, even where an otherwise acceptable form was executed.

An example of such a proposition can be found in the matter of *CARE Center of South Jersey a/a/o J.C. v. Allstate*, NJ No. 1331753 (2011). In that case, the arbitrator held that N.J.A.C. 13:35-9.11(b) was violated where the "Informed Consent to Treatment" form signed by the patient did not sufficiently outline the risks associated with acupuncture care and alternative treatment options available. The arbitrator also found that failure to comply with N.J.A.C. 13:35-9.11(b) would support denial of a claim for reimbursement, even though the care at issue was pre-certified. *See also NJ Acupuncture a/s/o MD v. High Point*, NJ No. 1434637 (2012) (arbitrator denied acupuncture provider's claim where the patient testified she was not advised of potential risks and complications, despite the fact that an executed "Informed Consent" form was found in the patient's medical file).

Finally, acupuncture claims are often defensible under the New Jersey Insurance Fraud Prevention Act (NJIFPA), N.J.S.A. 17:33A-1, et seq. Acupuncturists frequently bill for the rendition of their services on a single office visit via multiple CPT codes. Specifically, billing under CPT 97810 (acupuncture, initial 15 minutes) and 97811 (acupuncture, each additional 15 minutes, with re-insertion of needles) or 97813 (acupuncture with electric stimulation) and 97814 (acupuncture with electric stimulation, each additional 15 minutes, and re-insertion of needles) is common. The submission of billing under CPT 97811 and/or CPT 97814 requires an additional 15 minutes (30 minutes total) of patient contact, as well as "re-insertion of needles." *See e.g., Eastern & Western v. State Farm Ins. Co. North-N.J.*, NJ No. 1285951 (2010) (wherein the Forthright arbitrator determined that "to bill . . . under CPT code 97814 there must be a re-insertion or repositioning of the needles. . . . [The] acupuncture records do[] not reveal any mention whatsoever about needle placement or re-insertion. As such, billing under CPT code 97814 is unsupported and is therefore denied.")

Thus, an acupuncturist cannot submit billing under CPT 97811 and/or 97814 in the absence of an **additional** 15 minutes of care, as well as the "re-insertion of needles." Acupuncture patients, however, commonly testify that treatment lasted no longer than 15 minutes in duration and that "re-insertion" of needles never occurred. As such, billing for acupuncture with needle re-insertion when such service was never actually provided, a violation of NJIFPA, is an effective defense to acupuncture claims. Further, as NJIFPA violations call for awards of treble damages to a successful plaintiff, improper billing under CPT 97811 and/or 97814, when documented via consistent patient testimony, will often support the filing of affirmative fraud litigation from both a legal and economic perspective.

With the increase in arbitration demands by acupuncturists in New Jersey, an aggressive, proactive approach to defense is both warranted and necessary. The specific approaches set forth in this article have proven highly effective in minimizing exposure to excessive acupuncture billing. II

OHIO: PRIVILEGE PROTECTION DWINDLES FOR INSURERS' CLAIMS FILES

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The claims file can be the strongest shield against a bad faith claim, or it can be the plaintiff's most piercing sword to imposing liability. Ohio's highest court has eroded the attorney-client privilege and work product doctrines that previously protected the claims file.

In Ohio, the attorney-client privilege is first governed by statute. In circumstances not addressed by statute, the common law controls. Generally, the statutory privilege governs communications directly between an attorney and a client necessary to obtain legal advice.[1] The primary purpose of the communication must be to solicit legal, instead of business, advice.

In 1986, in one of the first such decisions in the country, the Ohio Supreme Court allowed a plaintiff to obtain an insurer's claim file.[2] The Court stated that any attorney-client communications in the claims file were not discoverable. In 1994, the Supreme Court found that "documents and other things showing the lack of good faith effort to settle by a party or the attorneys acting on his or her behalf are wholly unworthy of the protections afforded by any claimed privilege."[3] Both of those decisions involved claims for pre-judgment interest.

The Supreme Court did not stop there. In 2001, the Court extended those decisions to bad faith lawsuits.[4] It held that an insured is entitled to discover attorney-client communications in the claims files *created prior to the denial of coverage*. It reasoned that discovery of the claims file was allowed because the action alleged bad faith and the documents involved the decision of whether coverage existed. The critical inquiry, and the famous buzzwords from the case, was whether the documents "may cast light on whether the insurer acted in bad faith."

In 2007, Ohio's legislature intervened. Its stated intention was to protect the attorney-client privilege and to modify the earlier common law cases. In response to the courts' calling the communications "wholly unworthy" of protection, the legislature stated that attorney-client communications "are worthy of the protection of the privilege."

As such, it enacted R.C. § 2317.02(A)(2). It provides that, notwithstanding the attorney-client privilege, an attorney may be compelled to testify regarding his communications with his client. But the plaintiff must first put forth evidence of a prima facie showing of bad faith. It also requires the court to conduct an in-camera inspection of the privileged materials before production.

Even if the legislature's intention was clear, the statute itself was vague in some regards. For example, it is ambiguous as to whether it restricts attorney testimony or if it applies to the disclosure of documents as well. Thus, the statute—and its ambiguities—were left to the courts' interpretations.

In 2006, the Ohio Supreme Court found that the statute's testimonial privilege applies not only to prohibit testimony at trial but also to protect from discovery those documents showing the attorney and client's communications.[5] In 2011, the Northern District of Ohio, however, found that the statute does not apply to documents but rather only to a party's attempt to compel testimony from an attorney at deposition or for trial.[6]

If the statute only prevents an attorney from testifying at trial or deposition to attorney-client communications, then the common law privilege stated by the Ohio Supreme Court still applies to documents: that any documents containing attorney-client communications related to the issue of coverage created prior to the denial of coverage are not protected by the privilege.

Thus, under the common law standard, courts permit discovery of materials contained in the claim's file, but the statute sets forth that an attorney could be compelled to testify to his communications with the client. Under the common law standard, the plaintiff only had to set forth mere allegations of bad faith. The statute imposes a greater burden, requiring a prima facie showing of "bad faith, fraud, or criminal misconduct by the client."

Another difference is that the common law limited discovery to those items generated prior to a coverage decision. The statute, however, does not give any such limitation but instead uses the work "on-going" to imply communications occurring after the coverage decision may also be discoverable. The statute requires the court to review the documents prior to releasing the communications to the insured.

Thus, because of the fiduciary relationship between the insured and the insurer, Ohio courts are finding that the attorney-client communications before the denial of coverage do not deserve the protection of the privilege. Thus, the claims file should also be viewed as evidence, a testimonial of the carrier's efforts that will be scrutinized and shown to others. II

[1] R.C. § 2317.02(A).
[2] *Zigler v. Allstate Ins. Co.*, 2007 U.S. Dist. LEXIS 26117 (N.D. Ohio 2007).
[3] *Moskovitz v. Mt. Sinai Med. Ctr.*, (1994) 69 Ohio St.3d 638.
[4] *Boone v. Vanliner Ins. Co.*, (2001) 91 Ohio St.3d 209.
[5] *Jackson v. Greger*, (2006) 110 Ohio St.3d 488.
[6] *Little Italy Development v Chicago Title Ins.*, 2011 U.S. Dist. LEXIS 119698 (N.D. Dist. 2011).

SIU Sightings—Our Attorneys are Popping Up Everywhere…

James Cole and **Jeffrey Rapattoni** will attend the New Jersey Special Investigators Association (NJSIA) annual conference, October 21 – 23, in Atlantic City, NJ. Join them at the Casbah Night Club on October 21, from 8 p.m. – 12 a.m., when Marshall Dennehey hosts the NJSIA Industry Party.

Beau Hollowell and **Jeffrey Rapattoni** will present "Effectively Managing Contemporary Insurance Fraud Issues" at the National Society of Professional Insurance Investigators' 2013 Advanced Insurance Fraud Seminar, November 11 – 12 in St. Louis, MO.

Jeffrey Rapattoni co-authored the article "What's in Your Manual? A Three-Step Guide for Windstorm Claims Management," appearing in the August 2013 issue of *Claims Management* magazine. http://claims-management.theclm.org/home/article/Whats-in-Your-Windstorm-Claims-Manual.

James Cole will discuss fraudulent claims at the National Association of Mutual Insurance Companies (NAMIC) Claims Conference, February 11 – 13, 2014, in St. Augustine, FL.

SIU CASE CAPSULES

No Fault Law Is No Fun for Fraudulent Health Care Providers

VENUE: Brooklyn, New York

Government Employees Insurance Company, et al v. Uptown Healthcare Management Incorporated, et al, No. 11-CV-1453, E.D. N.Y.; 2013 U.S. Dist. LEXIS 70575

In this action, GEICO filed litigation against certain health care providers and a health care center for fraudulent billing predicated on being improperly licensed under the New York No Fault law. Specifically, GEICO alleged that from 2008 through 2011 the defendants billed for services even though the treatment center was not eligible for reimbursement under the no fault law. Moreover, GEICO claims that the medical provider operated without a legitimate medical director and violated its operating certificate and paid kick-backs for patient referrals. Subsequent to filing, the defendants moved to dismiss the complaint.

The Honorable Frederick Block denied the defendant's Motion to Dismiss, holding that it was proper for GEICO to challenge the defendant's fraudulent conduct. Judge Block also held that GEICO properly plead their complaint for fraud and RICO. In making his decision, the bench stressed that the Supreme Court of New York has recognized that RICO can be applied in unison with this state's insurance regulation. To further make the point, Judge Block noted that RICO "supplements rather than disturbs New York's insurance regime by providing another vehicle by which to carry forth the substantive policies of the State of New York." II

Cardiologist Takes Fraud to Heart

VENUE: Richmond, Virginia

United States of America v. John R. McLean, No. 115130, 4th Cir.; 2013 U.S. App. LEXIS 8160

In this case, the defendant, an interventional cardiologist, appealed his conviction and sentencing for health care fraud in making false statements in connection with the delivery of health care services. In so doing, defendant noted that the government failed to present sufficient evidence that he committed fraud as opposed to "medical malpractice." To further the point, the defendant argued that the fraud statute is constitutionally vague, therefore, his conviction must be overturned.

In upholding the conviction of the defendant, the court noted that the fraud statute makes it a crime to "knowingly and willfully execute and exchange in fraud any health care benefit program; or to obtain, by means of false or fraudulent representations, any money of any health care benefit program in connection to the delivery of or payment for health care benefits, items or services." To that end, the court rejected the contention that the statute was vague and ambiguous. Moreover, the court found that there was sufficient evidence that the defendant made misrepresentations in fabricating injuries to further create the appearance of medical necessity. Given the record below, the conviction was upheld, and the defendant was properly sentenced. II

Indictment of Florida Auto Ring Is No Accident

VENUE: Miami, Florida

United States of America v. Vladimir Lopez, et al, No. 11:90106, S.D. Fla.

On May 16, 2013, an indictment against 33 defendants in a Florida federal court was filed, alleging a scheme to recover no fault insurance benefits from or occurring out of a staged automobile accident ring. The indictment alleged that the defendants submitted fraudulent personal injury protection claims for chiropractic and massage therapy treatments and that said defendants would also recruit individuals to participate in staging said losses. In bringing suit, the government is alleging various improprieties, including mail fraud, money laundering and conspiracy. II