SLIP AND FRAUD

When a Slip and Fall is Intentional

By Gene Kissane and Jeffrey Schneider

Slip and fall claims have been around since businesses first opened their doors. It may not even be surprising to think of Ugh, in his cave slipping and falling on a rock and blaming his friend Argh. Throughout the country, these types of claims have been so prevelant over the last 10 years due to legal standards in favor of the plaintiffs. What is even more troubling is the number of slip and fall claims that are not in good faith. The cost of those claims to the public, the business and insurance companies, is significant.

The setup for a fraudulent claim varies from case to case. In a typical grocery store scenario, two or more people enter the store at separate times. They roam the store, ensuring that they do not look suspicious. One individual will then pour liquid on the floor and keep moving. The second individual will go down that same aisle and slip and fall in the liquid. The first individual comes back to help the second and serves as a witness as the individual who fell makes a claim. Investigating these claims costs insurers and businesses thousands of dollars each year.

Investigating this kind of setup grocery store claim usually involves an insurance adjuster contacting the claimant through his or her attorney. At this point, the scheme will split into two categories: one where the attorney is furthering the fraud and two where the attorney is unaware of the fraud.

The treating doctors add another layer to these cases. The term "soft-fraud" is now used to describe a doctor's billing technique when different billing codes are used to create upcharges and increase medical expenses to make the injury appear worse than it is. This soft fraud has resulted in the emergence of medical bill coding experts. When fighting these cases of fraud, it may be beneficial to use these medical bill coding experts.

According to the Coalition Against Insurance Fraud, insurance fraud steals at least $80 billion every year. There was also a 12 percent increase in cases submitted to the National Insurance Crime Bureau between 2010 and 2011. Clearly, fraud is not going away any time soon.

However, the industry must continue to fight back. Fraudulent schemers believe that the industry simply will not prosecute offenders. Combatting these claims must begin with the industry itself because consumers may not assist at first because of poor perceptions of the insurance industry. One way to fight back is with current, advanced surveillance technology. Surveillance video can capture crucial evidence that can make the difference in a fraud case. Just as important, employees must be educated in the importance of preserving surveillance video of incidents. It is recommended to save video from 30 minutes before and 30 minutes after each incident. This critical piece of evidence may save millions of dollars per year.

Employees are the first line of defense in investigating fraud. Just as if employees were the defense of a football team, they should review film of previous incidents to ensure they know what they are trying to identify during their own initial investigation. Additionally, understanding the opposition, the fraudulent claimants, is important.

RED FLAGS

During an investigation, there are several red flags that have been identified to assist in spotting insurance fraud. Here are just some of those red flags:

- Claimant's injury lacks witnesses
- Claimant waits to report injury
- Claimant has multiple versions of the incident; details are vague and/or contradictory
- Claimant is retiring or on disability
- Claimant's Social Security does not belong to/match claimant
- Claimant wants a quick settlement
- Claimant has a history of subjective injuries; lack of memory on prior loss information
- Claimant has known financial difficulties
- Claimant starts up his/her own business (using benefits to supply start-up costs)
- Claimant is involved in sports
- Claimant doesn't return calls or is never at home
- Claimant frequently changes physicians
- Claimant refuses to provide answers to routine questions or is evasive
- Only witnesses are family members
- No video surveillance is in the area of the accident in a store with multiple cameras (suggests prior knowledge of the camera layout)
- An attorney's withdrawal of representation, especially during the negotiation process

Insurance fraud is a costly offense to everyone — businesses, insurers and consumers. It is also a serious criminal offense. In Florida, it is an offense that must be prosecuted. If the fraud is less than $20,000, it is considered a felony of the third degree, in Florida. If it is more than $20,000 but less than $100,000, it is felony of the second degree. If it's more than $100,000, it is felony of the first degree.

Taking a proactive stance to all fraudulent claims is important. Train front line people to investigate and gather evidence. Make sure they know how to use and preserve video surveillance. Also, understand that along with fraudulent claims, there will be genuine claims and a proactive approach will help resolve those as well. Lastly, consumers must be informed that fraudulent claims affect them as the cost is ultimately passed to them. With all parties working together, fraudulent claims can be efficiently and properly extinguished. LM

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