

ANNUAL REPORT
OF THE
OFFICE OF THE INSURANCE FRAUD PROSECUTOR
FOR CALENDAR YEAR 2002

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It is with great pride that I present the fourth Annual Report of the Office of the Insurance Fraud Prosecutor (OIFP) to the Governor and Legislature of the State of New Jersey. As we embark upon our fifth full year of operation as New Jersey's lead agency in the battle against insurance fraud, we are pleased to report that we have achieved unprecedented levels of success in our efforts to detect, investigate, and take action against those who commit insurance fraud in our State.

PROSECUTOR'S MESSAGE



The most obvious indicator of OIFP's success in 2002 is our increased productivity, as measured by our substantial gains in prosecutions and sanctions. In 2002, OIFP nearly doubled the number of defendants charged criminally, the number of defendants convicted of insurance fraud and the number of civil sanctions imposed. A more subtle indicator of our success in 2002, however, is evidenced by the emulation of those who look to OIFP as a model for fighting fraud. After just four years of operation, we have grown from an organization assembled from divers State agencies to emerge as one of the nation's foremost fraud fighting institutions.

Although we accomplished much in 2002, we recognize that we have only begun to meet the enormous challenges presented by those who cheat the system by committing insurance fraud. As one car owner is sentenced for fraudulently claiming the theft of his vehicle, several others are laying the groundwork for similar frauds by filing false police reports. No sooner is one driver cited for showing a police officer a phony insurance card than several others are purchasing such cards on the black market. As one unscrupulous doctor is jailed for submitting phony bills for services that were never rendered, others are busy concocting fraudulent schemes to pick the pockets of the insurance buying public.

There is no doubt that our greatest challenges, and our greatest successes, lie before us. Our continuing success in ferreting out and prosecuting insurance fraud ultimately hinges upon the support and cooperation of those beyond OIFP. We recognize that we need the support and cooperation of concerned members of the public, resourceful law enforcement officials, savvy insurance industry investigators and conscientious members of those professions most prone to the breeding of insurance cheats. Without the assistance of these individuals in identifying and reporting suspected insurance fraud, our most industrious efforts

will, at best, fall short.

When we work together in concert, as we did in 2002, we can alleviate the insurance fraud problem in New Jersey. The value of the productive working relationships we have developed with others, such as the insurance industry, cannot be underestimated. We are particularly appreciative of the active role assumed by such organizations as the Insurance Council of New Jersey and the New Jersey Special Investigators Association. Both organizations are recognized leaders in New Jersey's insurance community and play a vital role in our fraud prevention efforts in the State.

We are also appreciative of the leadership of Governor James E. McGreevy and the members of his Administration, particularly former Attorney General David Samson and Acting Attorney General and Director of the Division of Criminal Justice, Peter C. Harvey. Their unwavering support, keen insight and steadfast guidance have empowered our staff and thereby unleashed the true potential of our Office.

I would also like to commend our County Prosecutors and the members of the Insurance Fraud Unit of the New Jersey State Police for their efforts in combating insurance fraud at the local level. Without their contributions, we would not attain the fully integrated and comprehensive law enforcement attack on insurance fraud envisioned by the Legislature when OIFP was created.

Most of all, I would like to acknowledge the untiring efforts of OIFP's team of attorneys, investigators, professional and administrative support staff. In the end, it is through their efforts, their expertise, and their dedication that we fulfill our mission as an agency committed to fighting insurance fraud in every way and on every front. As we reflect on the successes of 2002, we look forward to the greater challenges offered by 2003.

Respectfully Submitted,

Greta Gooden Brown

Greta Gooden Brown
Insurance Fraud Prosecutor

PREFACE

The New Jersey Office of the Insurance Fraud Prosecutor (OIFP) leads New Jersey's fight against insurance fraud. Created by the New Jersey Legislature on May 19, 1998, pursuant to the provisions of the Automobile Insurance Cost Reduction Act (AICRA), OIFP was established to administer a comprehensive and well integrated program to investigate and prosecute insurance fraud as effectively and efficiently as possible. Accordingly OIFP was, vested under AICRA with authority and responsibility for investigating all types of insurance fraud and for conducting and coordinating criminal, civil and administrative investigations and prosecutions of insurance and Medicaid fraud throughout New Jersey. To provide for the most effective and well integrated statewide strategy possible to combat insurance fraud, OIFP's authority under AICRA includes responsibility for the oversight of all anti-insurance fraud efforts of law enforcement and other public agencies and departments in New Jersey, as well as appropriate coordination with private industry.

Pursuant to AICRA, OIFP was established as a law enforcement agency within the Division of Criminal Justice in the Department of Law and Public Safety, with a primary focus on criminal prosecution. In order to unify, both civil and criminal authority for prosecuting insurance fraud in one agency, AICRA also required that certain civil enforcement functions previously handled by the Division of Insurance Fraud Prevention in the Department of Banking and Insurance would be transferred to OIFP pursuant to a plan of reorganization which became effective on August 24, 1998. (Reorganization Plan 0007-

98). Among other things, this reorganization plan effected the transfer of the entire civil investigative staff of the Division of Insurance Fraud Prevention to OIFP.

As provided by AICRA, OIFP is overseen by the Insurance Fraud Prosecutor, who is appointed by the Governor, with the advice and consent of the Senate, and who reports to the Attorney General. Reflecting the consolidation and integration of both criminal and civil insurance fraud responsibilities into one agency, the Insurance Fraud Prosecutor is required under AICRA to have had prior prosecutorial experience, including experience in the litigation of civil and criminal cases. The Insurance Fraud Prosecutor is required under the provisions of *N.J.S.A. 17:33A-24d* to provide an annual report to the Governor and the Legislature, no later than March 1 of each year, summarizing the activities of the Office of the Insurance Fraud Prosecutor for the preceding 12 months, including information as to the number of insurance fraud cases referred, investigated and prosecuted; the number of cases in which professional licensees were sanctioned; the number of convictions procured; and the amount of monies collected in fines and restitution. This is the fourth annual report of the Office of the Insurance Fraud Prosecutor.

EXECUTIVE SUMMARY

Insurance fraud continues to plague us as one of our country's most costly and pervasive white-collar crimes. Costing Americans hundreds of billions of dollars a year in losses, insurance fraud artificially inflates our insurance premiums and threatens the very integrity and viability of the safety net provided by our system of insurance. It can be as simple as lying on an insurance application or as complex as building a staged accident ring, replete with phony accident victims, crooked medical providers and corrupt lawyers. The problem is, perhaps, no more acute than in New Jersey which has, for years, suffered from some of the highest insurance rates in the country.

In recognition of the need to more effectively target insurance cheats by consolidating resources in a single agency and by coordinating the oft times fragmented and disparate efforts of others engaged in the battle against insurance fraud, the New Jersey Legislature established the New Jersey Office of the Insurance Fraud Prosecutor (OIFP) as New Jersey's premier fraud fighting agency in 1998, pursuant to the provisions of the Automobile Insurance Cost Reduction Act (AICRA). As explained by the New Jersey Legislature, OIFP was created in order to provide for "a more effective investigation and prosecution of fraud than exists at the present time." To this end, the legislature designated OIFP as the focal point for the investigation, prosecution and coordination of all criminal, civil and administrative cases of suspected insurance and Medicaid fraud.

In establishing OIFP, the Legislature

recognized that the complex challenges raised by insurance fraud required creative, comprehensive and far-reaching solutions. It provided for the gubernatorial appointment of an Insurance Fraud Prosecutor, who would work closely with, and report directly to, the New Jersey Attorney General. At its inception, OIFP was situated within the New Jersey Division of Criminal Justice to draw upon the resources and expertise of one of the nation's leading law enforcement agencies. In addition to its cadre of criminal investigators and prosecuting attorneys, the Legislature uniquely configured OIFP by incorporating, the entire civil investigative staff formerly within the New Jersey Department of Banking and Insurance.

In its role as the State's leader in combating insurance fraud, OIFP was charged by the Legislature with responsibility for coordinating the insurance related anti-fraud efforts of all State and local agencies and departments, as well as those of private industry, to provide for the most effective and efficient use of fraud fighting resources possible. Consequently, in addition to its traditional law enforcement functions of investigation and prosecution, OIFP offers a comprehensive, integrated roster of programs designed to inform the public, train law enforcement and marshal the resources of the public and private sectors to eradicate insurance fraud.

Consistent with the expectations of those who were instrumental in the formation of OIFP over four years ago, OIFP experienced, in 2002, its most productive year to date, registering increases of 130% in the number of

defendants indicted, 79% in the number of defendants convicted, 115% in the number of defendants sentenced, 91% in the number of civil insurance fraud sanctions imposed and 59% in the amount of the civil consent orders, settlements and judgments obtained. In all, OIFP imposed nearly 4,000 criminal and civil sanctions on those who committed insurance fraud in New Jersey in 2002. OIFP also imposed over \$7.3 million in civil fines and penalties. Together with OIFP funded County Prosecutors' insurance fraud units, in 2002, OIFP accounted for the criminal charging of 502 defendants, the conviction of 302 defendants, the imposition of jail sentences totalling 219 years, and the ordering of restitution in excess of \$8.3 million, on behalf of the citizens of New Jersey .

In order to achieve the increased efficiencies resulting from greater specialization, OIFP underwent a reorganization in 2002 resulting in the creation of separate investigative sections, within both the criminal and civil sides of OIFP, focusing, respectively, on auto fraud, health and life fraud, and property and casualty fraud. In 2002, OIFP also continued to expand upon its programmatic efforts to inform the public and train law enforcement personnel by increasing the dissemination of information regarding OIFP prosecutions, expanding the scope of its training opportunities, releasing the most recent in its series of roll-call training videos, and publishing and distributing to every New Jersey police department a directory of insurance verification hotline telephone numbers called the Uninsured Motorist Identification Directory (UMID).

That OIFP has achieved such a high degree of success has been reflected in the recognition it has received from others in the fraud fighting community in 2002. Its work has been cited in periodicals of national scope and in at least one major criminology textbook, and its assistance has been sought by officials from throughout the United States and Canada. OIFP's Insurance Fraud Prosecutor was invited in 2002 to participate as a keynote speaker at major gatherings of those engaged in fighting insurance fraud, including invitations to address the National Health Care Anti-Fraud Association in Washington, D.C., in November of 2002, and to address the Asia Pacific Fraud Convention in Australia in September of 2003.

OIFP's year of successes culminated in its producing and co-sponsoring, along with the Insurance Council of New Jersey and the New Jersey Special Investigators Association, the New Jersey Insurance Fraud Summit in October of 2002. The Summit showcased OIFP's accomplishments and the effective working relationships it has developed with the insurance industry as well as other law enforcement and government agencies since its birth as an agency in 1998. This year's Summit was attended by over 200 government and insurance industry executives, including New Jersey Governor James E. McGreevy, former Attorney General David Samson, Acting Attorney General Peter C. Harvey, Insurance Fraud Prosecutor Greta Gooden Brown, Commissioner of the

Department of Banking and Insurance Holly Bakke and Director of the Division of Motor Vehicles, Diane Legreide. The Summit served as the forum for Governor McGreevy to unveil his Administration's 2002 agenda to fight automobile insurance fraud.



PART I

OPERATIONAL AND ORGANIZATIONAL OVERVIEW

Introduction

The Office of the Insurance Fraud Prosecutor (OIFP) is organized to provide a comprehensive and integrated approach to combating insurance fraud throughout the State. OIFP is headed by the New Jersey Insurance Fraud Prosecutor and consists of a criminal and civil bureau. Each bureau is comprised of several sections. OIFP-Criminal includes both a Medicaid Fraud Section, which investigates and prosecutes Medicaid fraud, and specialized Insurance Fraud Sections, which investigate and prosecute all other types of insurance fraud.

OIFP-Civil is comprised of specialized teams of civil investigators who investigate cases of possible insurance fraud, and, where appropriate, pursue restitution and the imposition of civil fines. OIFP-Civil is often able to impose fines or obtain restitution in cases where OIFP would otherwise be unable to pursue a successful criminal prosecution because of the heightened burden of proof required in criminal cases. Legal support for OIFP-Civil is provided by Deputy Attorneys General from the Division of Law in the Department of Law and Public Safety.

OIFP's intake unit, the Case Screening Litigation and Analytical Support Section (CLASS), processes incoming referrals from a variety of sources, logging them into the Office's database, cross checking them against current or closed cases, and screening them for subsequent assignment to the criminal and civil sections of OIFP. The Liaison Section of the Office coordinates OIFP investigations, prosecutions and programs with insurance companies, professional licensing boards,

county prosecutors' offices, and other law enforcement and governmental agencies. Administrative support for the Office, including fiscal, human resources and computer operations, is provided by the Administration Bureau of the Division of Criminal Justice.

OIFP maintains a home office in Lawrenceville, New Jersey, as well as regional offices in Cherry Hill and Whippany, New Jersey. Each regional office maintains a staff of deputy attorneys general and criminal and civil insurance fraud investigators, conducting a full range of criminal and civil insurance fraud investigations and prosecutions throughout the State.

OIFP-Criminal General Description

Traditional criminal investigations and prosecutions of insurance and Medicaid fraud are conducted by specialized sections within OIFP-Criminal. These Sections are staffed by experienced Deputy Attorneys General, criminal State Investigators, Analysts and other professional and administrative support staff.

In 2002, these Sections experienced their most productive year to date, opening 508 new insurance fraud investigations, leveling charges against 225 defendants, and obtaining convictions of 154 defendants. A total of 121 years of incarceration and \$7,875,157 in criminal fines and penalties were imposed in 2002. These statistics represent an increase over statistics in 2001 of 24% in the number of new insurance fraud investigations opened, 130% in the number of defendants indicted,

79% in the number of defendants convicted and 115% in the number of defendants sentenced.

In order to ensure the most effective targeting of suspected insurance fraud, OIFP-Criminal underwent a reorganization in 2002. The old structure was replaced by four specialized sections, each headed by a Supervising Deputy Attorney General (SDAG) and Supervising State Investigator (SSI), and devoted, respectively, to auto insurance fraud, property and casualty insurance fraud, health and life insurance fraud, and Medicaid fraud.

Including supervisors, when fully staffed, thirteen Deputy Attorneys General and thirty eight State Investigators are assigned to the Auto Fraud Section, three Deputy Attorneys General and twelve State Investigators are assigned to the Property and Casualty Section, nine Deputy Attorneys General and twenty five State Investigators are assigned to the Health and Life Section and nine Deputy Attorneys General and twenty five State Investigators are assigned to the Medicaid Fraud Section. Supervising State Investigators in OIFP-Criminal report to a Deputy Chief Investigator who, in turn, reports to the agency's highest ranking investigator, the Managing Deputy Chief Investigator. All Supervising Deputy Attorneys General report directly to the Insurance Fraud Prosecutor.

Auto Fraud Section

The Auto Fraud Section targets a variety of insurance frauds which, in one way or another, arise from, or are related to, the use of an automobile. One of the most common types of automobile insurance fraud involves the making of a fraudulent claim for the theft of an automobile which the owner or lessor falsely claims was stolen. In this type of case, also known as a "give-up" because the vehicle in question is often voluntarily given up by the

owner or lessor for disposal by a middleman, a vehicle is purposely reported as stolen in order to make a fraudulent insurance claim.

Owners or lessors who commit this type of insurance fraud are usually motivated by a desire to eliminate a seemingly burdensome monthly loan or lease payment or by a desire to "unload" a damaged or high mileage vehicle which the owner is unable to sell, or which is likely to result in a substantial lease-end payment to the leasing company. Typically, at the behest of the owner or lessor, the middleman takes the vehicle to an isolated location and, to preclude its return to the owner or insurance company, causes as much damage to the vehicle as possible by vandalizing it, burning it, dumping it in a lake or river, or undertaking a similar effort to cause so much damage as to render its repair economically prohibitive.

The vehicles which are "given up" are sometimes "sold" by the owner or lessor to the middleman for a nominal sum, who, in turn may resell the vehicle for illegal export, or for disassembly and the subsequent sale of parts on the black market by a "chop shop." In some cases, the owner or lessor may be so eager to dispose of a vehicle and file a fraudulent claim that the owner is willing to pay the middleman to dispose of the vehicle. To most members of the public, such scheming would seem shocking. However, the sad reality is that somewhere between fifteen percent and twenty five percent of all reported auto thefts are probably fraudulent, according to statistics maintained by the National Insurance Crime Bureau. Even in those cases where a vehicle has actually been stolen, insureds are sometimes tempted to commit insurance fraud by exaggerating the condition or value of the vehicle or items which were in the vehicle when it was stolen.

While many fraudulent auto theft claims are filed by individuals who have plotted the

frauds on their own, many fraudulent auto theft claims involve seasoned criminals. These criminals specialize in disposing of vehicles for owners who are seeking assistance in getting rid of their vehicles to make it appear as though their vehicles were stolen.

Another type of fraud targeted by the Auto Fraud Section is the staging of bogus automobile accidents as a predicate to the filing of fraudulent insurance claims. Claims are filed for medical bills, for damages for purported "pain and suffering" stemming from feigned injuries, and for automobile property damage allegedly sustained in the staged accident. While accidents are sometimes staged by individuals acting alone or with a co-conspirator, accidents are more often staged by a network of conspirators involving a combination of participants. These participants may include drivers and passengers, as well as, in many cases, "runners" (individuals who act as procurers of accident victims for the filing of medical and legal claims), corrupt police officers, individuals affiliated with medical and chiropractic clinics, auto repair shop owners and operators and those employed in the allied legal professions, such as lawyers, paralegals, law office managers and investigators retained by law firms.

Accidents are staged in a variety of ways. Sometimes, vehicles which have been previously damaged are placed at the scene of an alleged collision, accompanied by conspirators posing as drivers and passengers. In other cases, one or more individuals arrive at a police station and falsely report the alleged occurrence of an automobile accident. In these cases, no collision or accident whatsoever has even taken place.

However, in some cases, those who stage accidents may cause actual collisions to take

place, creating a real, immediate and serious threat to the safety of the motoring public. Conspirators may drive separate cars into one another creating an actual "accident" and risking their own safety, as well as the safety of those posing as passengers, other unsuspecting motorists and innocent bystanders in the vicinity.

In other cases, real accidents may be caused by passing an unsuspecting motorist and slamming the brakes to cause the unsuspecting driver to crash into the rear of the perpetrator's vehicle. An accident may also be caused intentionally by the perpetrator inviting the unsuspecting motorist to proceed from a parking space or stop sign, and quickly accelerating to cause a crash which then appears to be the fault of the innocent driver. In both of these cases, the staged accidents are made to appear as if they were the fault of the innocent, unsuspecting party.

OIFP devoted significant resources to the investigation and prosecution of staged accident rings in 2002. As reported at greater length in the section of this report containing criminal case summaries, OIFP made significant progress in the investigation and prosecution of persons who participated in the staged accident ring allegedly headed by Anhuar Bandy for the benefit of his chiropractic practices operated under the umbrella of ABP Chiropractic. In April of 2002, OIFP obtained the indictments of 28 individuals, including Bandy, himself, on charges ranging from conspiracy and racketeering to health care claims fraud and theft by deception. Although the indictments focused specifically on eight automobile accidents, the indictments also generally alleged that the ring was responsible for more than 90 other automobile accidents, which generated phony insurance claims exceeding \$2 million. By the end of 2002, nine of those charged with participating in the ring had pled

guilty to various charges stemming from their involvement.

Automobile accidents which are not staged also give rise to fraudulent insurance claims which are investigated and prosecuted by the Auto Fraud Section. Occupants of a vehicle which has been involved in a collision often view the collision's occurrence as an opportunity to "cash in" on their insurance premiums. Sometimes, fraudulent claims are submitted for fictitious or inflated property damage to the vehicle. In many cases, these occupants feign or exaggerate injuries and seek unnecessary medical treatment in order to file a claim for "pain and suffering." Because the settlement value of a claim for bodily or personal injury may be determined, in large part, by the severity of injuries as measured by the cost and extent of medical treatment rendered to the claimant, claimants may be tempted, or encouraged by unscrupulous lawyers or medical providers, to "run up" their medical bills as high as possible, a practice commonly known as "overtreatment."

Medical bills for treatment for injuries sustained in an automobile accident in New Jersey are typically covered under an insured's automobile insurance policy as Personal Injury Protection (PIP) benefits. PIP fraud is particularly difficult to investigate and prosecute because it is almost always justified by the opinion of a medical professional who, himself, may be the beneficiary of continuing unnecessary medical treatments. Unfortunately, many clinics, sometimes described as "treatment mills," which specialize in the "assembly line" like treatment of those who claim to have been injured in automobile accidents, have arisen in New Jersey. Practitioners who participate in these mills are most effectively prosecuted when it can be proven that they have billed for services which they have not actually provided.

A legitimate automobile accident may give rise to other types of fraudulent claims as well. Occasionally, a driver who has been involved in an accident falsely claims that a friend or members of the driver's family were passengers at the time of the automobile accident when, in fact, the driver's vehicle had no passengers at the time of the accident. This type of claim, known as a "jump in," because imaginary passengers figuratively jump into the vehicle after the accident, is sometimes initiated at the time a claim is submitted to the insurance carrier. At other times, the groundwork is laid by the driver prior to the filing of a claim by fraudulently altering the original accident report prepared by law enforcement officials.

Sometimes, after a bus has been involved in an accident, passersby, hoping to "cash in" by claiming to have been injured in the accident, actually climb on board the bus after the accident has occurred. In one such typical "jump-in" case, reported in our criminal case summaries, OIFP prosecutors obtained the convictions of twin sisters, a daughter and a friend who falsely claimed to have been injured in an accident which never occurred.

The Auto Fraud Section also investigates and prosecutes those who commit a crime by manufacturing, distributing, selling or knowingly displaying a fictitious or fraudulent insurance card which falsely purports to provide mandatory automobile insurance coverage. It has been estimated that more than 10 percent of those who drive in New Jersey do so without having purchased the required automobile insurance. Of those who choose to drive without insurance, many attempt to avoid the penalties for driving without insurance, which includes mandatory loss of license and substantial civil fines, by obtaining these fictitious cards. While OIFP and other agencies in New Jersey explore possible ways to thwart the counterfeiting of

automobile insurance cards, the use of such cards continues to be a major problem in New Jersey.

Property and Casualty Section

The Property and Casualty Section investigates and prosecutes a wide variety of insurance fraud scams which may fall outside the purview of the other specialized sections. Frauds investigated and prosecuted by the Property and Casualty Section typically involve fraudulent claims under homeowners or commercial property insurance policies. The most common types of insurance fraud committed by homeowners involve claims in which homeowners exaggerate or inflate the value of the property that has been destroyed, damaged or stolen. Other fraudulent homeowner claims relate to prior losses for which the homeowner was previously compensated, or may involve a contrived, staged or false claim of loss, such as the case where a homeowner falsely claims to have been the victim of a burglary, and claims to have lost valuable jewelry as a consequence.

Owners of commercial property may make similar fraudulent insurance claims under policies of insurance covering their commercial premises. In some cases, owners of commercial premises, such as restaurants, may purposely arrange for someone to set their premises on fire in order to file a fraudulent claim. They then use the insurance proceeds to rebuild their premises in a different location, or on a grander scale. Other fraudulent claims stemming from a commercial insurance policy may involve a fraudulent claim by a third party who falsely claims to have tripped, fallen and been injured on the commercial premises. Casinos in New Jersey are a particularly vulnerable target of so-called "trip and fall artists," some of whom make a career of falling and filing such insurance claims.

Those who engage in the types of fraud investigated and prosecuted by the Property and Casualty Section are often assisted by others, such as contractors or public adjusters who provide phony or inflated estimates of loss. In one such ongoing case handled by the Section in 2002, OIFP obtained a guilty plea from an individual named Otis Boone. Boone admitted committing arson as part of a conspiracy with Marc Rossi, a licensed public adjuster, in an alleged scheme to burn properties in order to enable Rossi and the other conspirators to profit through Rossi's representation of the properties' owners. One of the owners of the burned properties, Marc Graziano, also pled guilty to participating in the conspiracy, admitting that Rossi, with his consent, arranged to have his florist shop set on fire as part of the conspiracy. Rossi, who has denied his involvement in the alleged arsons, is pending trial.

Still other types of fraud investigated and prosecuted by the Property and Casualty Section stem from insurance agents or insurance company employees who embezzle their clients' premium payments or who engage in schemes to issue fraudulent claim settlement checks. One such case, which was successfully prosecuted by OIFP in 2002, involved a conspiracy in which a former insurance claims adjuster was alleged to have spearheaded a scheme to issue 57 fraudulent settlement claim checks totalling approximately \$625,000. Although the alleged ring leader, Carl Prata, has denied any wrongdoing, many of his 45 alleged co-conspirators pled guilty in 2002 to participating in the scheme. They were sentenced to penalties ranging from incarceration and substantial civil and criminal fines to full restitution. Prata, himself, was indicted on December 18, 2002, and is expected to be scheduled for trial in 2003.

Health and Life Section

The Health and Life Section addresses a wide variety of frauds relating to life insurance, disability insurance, and insurance which provides for the indemnification of medical care expenses. Life insurance fraud may, for example, involve the misrepresentation of an insurable interest, the unauthorized altering of a designation of a beneficiary, the failure of an insured to disclose a disqualifying, pre-existing medical condition, the fraudulent reporting of an insured's death, or even the murder of an insured in order to collect the insurance policy proceeds.

Health insurance fraud may be committed by medical providers and patients, alike. When committed by health care professionals, such as physicians or hospitals, health insurance fraud often takes the form of billing for services that were never rendered to a patient, exaggerating the extent to which services were provided, mischaracterizing the nature of the services rendered in order to charge a higher fee, or knowingly billing for the provision of medical services to patients who fraudulently claimed to have been injured in accidents. When committed by patients, health insurance fraud may take the form of a person using another's insurance card to claim benefits, the seeking of benefits for treatment of phony injuries in conjunction with the filing of a fraudulent pain and suffering claim, or schemes to fabricate and submit phony medical bills for treatment the claimant never received.

Disability insurance fraud most often takes the form of an applicant purposely omitting negative medical information which would either disqualify the applicant from obtaining the insurance, or which would likely result in the payment of higher premiums for the insurance coverage sought by the applicant. It also takes the form of fraudulent claims for disability benefits by insureds who exaggerate or fake injuries which they allege to be

disabling. These frauds are often uncovered after a claim is made and subsequent investigation identifies pre-existing injuries or reveals that the insured is working or engaged in other able-bodied activities while claiming to be totally physically impaired.

In one case of health insurance fraud by a provider handled by OIFP in 2002, for example, OIFP obtained the conviction of Dr. Elliot Heller, a plastic surgeon, who had attempted to bilk insurance companies out of more than \$1 million. Heller mischaracterized cosmetic procedures as "medically necessary," and attributed some of the surgeries he performed to another physician in order to bill insurance companies at higher out of network rates. In all, Heller collected nearly half a million dollars from the victimized insurance companies before he was caught. In December of 2002, Heller was sentenced to serve three years in State prison and ordered to pay \$321,000 in restitution and \$100,000 in civil insurance fraud fines.

In another case handled by OIFP in 2002 involving patient fraud, OIFP obtained the conviction of a purported patient, Michael Forma. Forma submitted 73 false health insurance claims totalling \$12,798 for treatment he had neither received nor for which he had paid. He was sentenced to two years probation, conditioned upon him serving 90 days in the Middlesex County Adult Correctional Center and payment of a \$2,500 criminal fine.

Medicaid Fraud Section

The Medicaid Fraud Section investigates and prosecutes those who commit fraud against New Jersey's Medicaid Program. The Medicaid Program is designed to help New Jersey's disabled and economically disadvantaged citizens with their health care expenses. The cost of the program in New

Jersey is borne equally by the state and federal governments. New Jersey's share for administering the program is significant, constituting nearly 15 percent of the State's annual budget. The Medicaid Fraud Section of OIFP, which receives 75 percent of its operational funding from the federal government, is a highly cost effective way of combating this type of health care fraud, since its efforts typically result in the recovery of far more funds in restitution and penalties than the State expends in its matched portion of its budget.

As in other types of health care related fraud, fraud against the Medicaid Program may be committed by either providers or patients, though the most sophisticated and costly frauds are most often perpetrated by providers, or those purporting to be providers. Provider fraud against the Medicaid Program is typically committed when a provider of Medicaid covered services fraudulently obtains medical assistance payments to which the provider is not entitled. Medicaid fraud also encompasses patient abuse and criminal neglect occurring in health care facilities, such as nursing homes, which receive Medicaid funds.

Among the providers investigated by the Medicaid Fraud Section are doctors, dentists, pharmacists, clinics, laboratories, transportation services, nursing homes, durable medical equipment suppliers and other ancillary service providers who operate and administer services under the Medicaid Program. Increases in Medicaid fraud tend to be driven by increases in program benefits.

Many of the cases handled by the Medicaid Fraud Section involve non-emergency transportation providers. These providers receive reimbursement from the Medicaid Program for transporting Medicaid recipients between their residences and the place where they receive treatment or other services

covered by Medicaid. Medicaid licensed transportation providers include "livery transportation" for patients who can walk on their own, and "mobility assisted vehicles," also known as "invalid coach transportation services," for those who require assistance due to physical or mental infirmity. Fraud by transportation providers is most often committed by inflating mileage claims, providing kickbacks to recipients of their services, and falsifying prior authorization forms to qualify a recipient for mobility assisted services, which are paid at a higher rate than livery transportation. These non-emergency transportation providers are particularly adept at exploiting the Medicaid system because no professional license is required, such as that required of a doctor or pharmacist, and because of the minimal economic investment necessary to engage in this type of business.

One case handled by the Medicaid Fraud Section in 2002 involving M&G Transportation typifies the types of schemes successfully investigated and prosecuted by the Section. In this case, the scheme to defraud the Medicaid program included the paying of kickbacks to patients to induce them to use their service, billing for individuals who were ineligible to receive Medicaid, transporting Medicaid recipients to destinations not allowable under Medicaid regulations, and falsifying information on Medicaid forms. Following his conviction, the owner of M&G Transportation was sentenced to serve four years in State prison.

In addition to investigating and prosecuting transportation providers who defraud the Medicaid Program, the Medicaid Fraud Section assists the State agency in conducting background checks for prospective transportation providers. These investigations enable the State agency to screen out possibly unethical providers who might engage in such

fraud.

The Medicaid Fraud Section also investigates and, when possible, prosecutes those who attempt to commit Medicaid fraud through the use of sophisticated electronic billing schemes. Through these schemes, unscrupulous providers are sometimes able to defraud the Medicaid program of millions of dollars by remotely (from out-of-state), quickly and anonymously submitting electronic claims for enormous sums. In order to combat this problem effectively, the Medicaid Fraud Section has adopted an aggressive approach to the execution of search and arrest warrants. The execution of these warrants arm law enforcement with an element of surprise and enable OIFP to swiftly freeze assets and secure defendants' presence at trial, by obtaining adequate and appropriate conditions of bail before suspects have an opportunity to flee.

Federal law permits the Medicaid Fraud Section to prosecute health care fraud in other federally funded health care programs, including Medicare. The Section is so authorized whenever there is a connection to Medicaid fraud and the Inspector General of the concerned federal agency assents. Federal guidelines also encourage negotiated civil settlements in cases of suspected Medicaid fraud where the evidence would be insufficient to satisfy the higher burden of proof required at a criminal trial.

Under this authority, the Medicaid Fraud Section has successfully collaborated with Medicaid fraud units in 47 other states and the District of Columbia, as well as with federal authorities, in recovering overpayments from providers who operate on a national scale. In these actions, State and federal prosecutors work as a team, filing these cases under the federal False Claims Act, and negotiating the best possible settlements for their respective agencies. Recoveries and penalties are

allocated among the participating authorities according to their respective damages. The settlements also require the execution of corporate integrity agreements by the offending parties, and may also involve criminal action against responsible individuals and corporate entities. Some of the cases in which OIFP's Medicaid Fraud Section obtained settlements for New Jersey in 2002 included a settlement with National Nephrology Associates, which had been overpaid on the submission of claims for Epogen administrations in the sum of \$1,658,778, and a settlement with Gambro Healthcare, Inc., which had also overcharged for Epogen administrations in the sum of \$2,098,291.

OIFP-Civil General Description

The majority of OIFP's insurance fraud investigations are conducted by the civil side of the Office. OIFP-Civil is authorized to seek the imposition of civil penalties against those who commit insurance fraud, under authority of the New Jersey Insurance Fraud Prevention Act (Fraud Act). *N.J.S.A. 17:33A-1 et seq.* The Fraud Act defines several acts or omissions which constitute civil insurance fraud violations. These violations give rise to significant monetary penalties which may be levied against persons who violate the Act.

The Act provides for fines of up to \$5,000 for a first violation, \$10,000 for a second violation, and \$15,000 for third and subsequent violations. Each misrepresentation or fraudulent omission in a claim or application constitutes a separate violation of the Act, triggering liability for the specified fines. In addition to the imposition of civil fines, where appropriate, OIFP-Civil also seeks to recover restitution and attorneys fees from the violator.

Of the 9,530 referrals of suspected insurance fraud received by OIFP in 2002, 4,639 warranted assignment for additional investigation by OIFP-Civil investigators.

Like its counterpart, OIFP-Criminal, OIFP-Civil was similarly restructured in 2002. Within each of its four squads, teams were devoted to investigating the same categories of insurance fraud (with the exception of Medicaid fraud) investigated by OIFP-Criminal. Accordingly, OIFP-Civil now consists of teams which investigate insurance fraud involving either property and casualty, health and life, or automobile insurance coverages.

When fully staffed, and including Team Leaders, 54 investigators are assigned to auto insurance fraud investigations, 34 investigators are assigned to property and casualty insurance fraud investigations, and 43 investigators are assigned to health and life insurance fraud investigations. In addition, another twelve criminal and civil investigators are assigned to various supervisory positions in OIFP-Civil, while another six civil investigators perform various professional support functions in OIFP-Civil, such as maintaining required databases, production of OIFP training videos and other publications, and performing similar tasks requiring a high level of expertise.

OIFP-Civil also completed its most productive year to date in 2002, issuing 1,044 insurance fraud administrative consent orders totalling \$6,344,058 in civil fines. Issuance of these administrative consent orders are authorized under the Fraud Act after an investigation reveals a violation of the Act. An administrative consent order represents a preliminary settlement offer to the violator providing the violator with the earliest opportunity to voluntarily agree to the terms

of the order, the findings of the investigation and the imposition of an agreed upon civil fine. Otherwise, the case is referred to civil attorneys in the Division of Law for litigation. Of the consent orders issued by OIFP-Civil investigators in 2002, 440 were voluntarily executed, totalling some \$1,373,000.

In 2002, OIFP-Civil investigators referred 490 cases to Division of Law Deputy Attorneys General for the filing of civil enforcement actions stemming from the refusal of insurance fraud violators to either voluntarily execute consent orders or to make payments on outstanding consent orders. Civil actions by Division of Law Deputies culminated in 526 judgments and settlements totalling \$5,073,212 in civil penalties. Enforcement actions by DOBI on prior judgments resulted in the recoupment of \$1,981,845 in penalties on behalf of the State.

The investigation of cases of suspected insurance fraud by OIFP-Civil investigators provides law enforcement with an invaluable weapon in the battle against insurance fraud. This mechanism complements the efforts of OIFP-Criminal and provides an avenue for enforcement and penalties where criminal prosecutions are not appropriate. Because the imposition of a civil fine under the Fraud Act requires the lesser burden of proof for civil cases, that of a "preponderance of the evidence," it is often possible to impose civil fines on those who cheat insurance companies, when they would have otherwise avoided responsibility for their actions. Indeed, the ability of OIFP-Civil investigators to catch insurance cheats and hold them accountable by requiring them to pay hefty fines provides a significant disincentive to many who might otherwise consider committing insurance fraud, while providing a mechanism to ensure that the justice system is able to administer proportionate remedies in appropriate cases.

While the imposition of civil fines by OIFP-Civil under the Fraud Act is frequently a viable alternative to an otherwise doubtful criminal prosecution, the imposition of civil fines is not necessarily mutually exclusive of a criminal proceeding against the subject. Most cases which result in a successful criminal prosecution also result in the imposition of civil penalties under the Fraud Act. Conversely, in most cases where OIFP is able to successfully impose civil penalties, the evidence is insufficient to sustain a successful criminal prosecution. In addition, Civil investigators are able to pursue civil penalties in cases where the criminal prosecution is handled by a prosecuting entity other than OIFP-Criminal, such as County Prosecutors' Offices or federal authorities.

Auto Fraud Teams

OIFP-Civil's Auto Fraud investigative teams generally handle the same types of fraud as their counterparts in OIFP-Criminal. Civil investigators additionally handle cases where the fraud, while technically a crime, may not constitute a viable criminal offense, such as cases involving "rate evasion" where an insured misrepresents the garaging location of an insured vehicle in order to obtain a lower premium rate.

OIFP-Civil's Auto Fraud investigators have continued to work closely with local police departments throughout the State. Through its highly successful "Give-Up Initiative," civil investigators identify reported vehicle thefts that may have been falsely reported by the vehicles' owners as a predicate to the filing of a fraudulent insurance claim. In another initiative undertaken by OIFP-Civil's Auto Fraud teams in 2002, investigators have implemented a program to identify contractors who fraudulently register their commercial vehicles as personal vehicles in order to obtain the lower insurance rates which reflect the

lower risks associated with non-commercial vehicle use. The business owners who have been caught in the net cast by this initiative are, in many cases, facing civil fines far in excess of the savings they enjoyed by misrepresenting the use of their vehicles to their insurance companies. Like their counterparts in OIFP-Criminal, investigators assigned to the Auto Fraud teams in OIFP-Civil also investigate other types of fraud associated with automobile insurance, such as phony and exaggerated claims for property damage, phony claims associated with staged accidents, and fraudulent claims by "jump-ins" who falsely claim to have been injured as passengers in an automobile accident, when they were not involved at all.

OIFP-Civil often teams with officials from other law enforcement agencies in its investigative efforts, including those associated with its "Give-Up Initiative." In one such collaboration in 2002, designated "Operation Street Sweep," OIFP-Civil investigators worked closely with law enforcement officers from the New York office of the FBI, the New York Police Department, the Elizabeth Police Department and the District Attorneys' Offices from Brooklyn and Queens in the targeting of auto owners who had voluntarily "given-up" and falsely reported their vehicles stolen, in order to file fraudulent insurance claims.

Health and Life Teams

The Health and Life Teams in OIFP-Civil also handle cases which mirror those investigated and prosecuted by OIFP Criminal, but frequently involve cases with respect to which a criminal prosecution is not warranted. Civil investigators conduct investigations of a variety of schemes perpetrated by both medical providers and patients to bilk insurance companies. Frauds perpetrated by providers include billing for services not rendered, misrepresenting the nature of services rendered

in order to charge a higher fee, and "unbundling," or billing for multiple services when billing for only a single procedure is appropriate. Other frauds perpetrated by providers may involve billing for services rendered beyond the scope of a provider's license, such as where a chiropractor submits a bill for a surgical procedure, or charging for the dispensing of a medication which the provider received as a free sample from a pharmaceutical representative.

Other cases investigated by the OIFP-Civil Health and Life Teams relate to insurance fraud committed by patients or purported patients. These cases include patients submitting fabricated bills for treatments that were never provided, or subjects submitting a bill for reimbursement of a fraudulent prescription.

Property and Casualty Teams

The Property and Casualty Teams in OIFP-Civil also investigate the same types of insurance fraud handled by their counterparts in OIFP-Criminal. As in the case of the other OIFP-Civil investigative teams, these civil investigators are often able to successfully impose civil fines where a criminal prosecution cannot be pursued. These cases arise out of different types of insurance policies, including homeowners insurance policies and commercial insurance policies. Fraudulent claims under these policies often involve the exaggeration or fabrication of claimed losses due to theft, burglary or casualty, or the making of multiple claims for a single loss. OIFP-Civil also investigates instances of suspected insurance agent fraud which typically involves the embezzlement of clients' premiums or the purposeful misrepresentation of information on insurance applications in order to obtain lower rates on behalf of a client.

Case Screening, Litigation And Analytical Support Section (CLASS)

All referrals to OIFP, whether from insurance companies, the OIFP hotline or website, citizen complaint letters or walk-ins, administrative agencies or other law enforcement agencies, are received by the Case Screening, Litigation and Analytical Support Section (CLASS). CLASS, formerly named the Analytical Case Tracking and Information Unit (ACIU), serves both the criminal and civil sides of OIFP. The Section is headed by a Supervising Deputy Attorney General (SDAG) and a Supervising State Investigator (SSI). It is staffed with three Civil Investigators, one Civil Supervisor, six Analysts, one Paralegal, seven Technical Assistants and five clerical/administrative support persons.

Upon receipt of referrals by CLASS, documentation is date stamped. Subjects are then searched and entered into Law Manager, OIFP's case tracking database. Case numbers are subsequently assigned. The information received in the referral is screened by civil investigators who determine whether there is sufficient evidence to initiate a civil and/or criminal investigation. If a referral appears to involve a criminal violation, it is reviewed by the Supervising Deputy Attorney General who decides whether to accept or decline it for criminal investigation. The screening process usually includes obtaining additional background information on subjects from queries of various governmental and public record databases. All cases are then either assigned for investigation, referred to other agencies or closed and referenced for intelligence purposes.

Cases that warrant investigation are coded by type of insurance fraud and assigned by OIFP region. After cases have been assigned, Analysts and Technical Assistants in CLASS

continue to support civil and criminal investigators by providing additional database support, as needed, and in-depth analyses of evidence developed in priority cases. Depending upon the requirements of the investigation, various types of analyses are performed, including association; event flow; insurance claim; commodity flow; financial transaction; times series; telephone record; and statistical analysis. Records that are analyzed can include insurance billings; financial records; corporate filings; investigative reports; surveillance reports; telephone tolls; electronic surveillance transcripts or tapes; interviews; testimony and public databases. Typically, the products generated by the analyst include reports; tables; graphs; charts; flow diagrams and free form charts, many of which are used as Grand Jury or trial exhibits.

Information Management Systems

OIFP maintains several information management systems. These systems contain information for tracking and managing cases referred to, and from, OIFP, as well as information which can be tapped for investigative research to identify possible patterns and trends in insurance fraud. OIFP's Law Manager Database Integrated Computerized Case Tracking System was significantly enhanced in 2002. OIFP's Law Manager Database had previously assimilated all civil case tracking data from a pre-existing database inherited from the Department of Banking and Insurance. In 2002, significant progress was made towards fully integrating the system with information from the criminal case tracking database for the Division of Criminal Justice. The final integration of both systems is scheduled for completion in 2003.

The Law Manager system is used by OIFP's CLASS Section to capture data with respect to incoming referrals to OIFP. The system is also used to record the progress of investigations stemming from those referrals. Responsibility for the maintenance of the Law Manager system is assumed by the Information Management Section of Information Technology Services of the Division of Criminal Justice. Staffers within the Network Services Section of Information Technology Services are responsible for maintaining, and continually upgrading, OIFP's computer network, which provides numerous other computer based services such as e-mail, legal research, word processing, and Internet access.

In addition to the Law Manager Database, OIFP has established several other databases to track various types of specialized information for a variety of purposes. OIFP's criminal investigations continue to be independently entered and tracked by a

database within the criminal investigative section of OIFP. That database incorporates litigation and case status reports, arrest reports, warrant information and other information reflecting the progress of the matter through the criminal justice system. The criminal section of OIFP has also developed, and on a case-by-case basis uses, a database application to analyze complex relationships among individuals, businesses and their financial dealings.

As required by AICRA, databases are maintained in OIFP to record and track information with respect to all matters under investigation by County Prosecutors' Offices, as well as with respect to all matters referred by OIFP to those offices. This information is also forwarded for entry into the Law Manager database. Matters reported by County Prosecutors' Offices are often assigned to OIFP-Civil for civil investigation where it appears that the subject or subjects of the investigation may be liable for civil insurance fraud penalties, in addition to, or in lieu of, criminal prosecution by the county offices.

OIFP also maintains a specialized database containing information with respect to professional and occupational licensees regulated by the Division of Consumer Affairs who are suspected of committing, or participating in, insurance fraud. This database serves to ensure that the activities of the professional licensing boards and OIFP are effectively coordinated and that any licensee who is suspected of involvement in insurance fraud is brought to the attention of both agencies. This information is also incorporated into OIFP's Law Manager database.

Liaison and Coordination

In order to be effective in addressing the problem of insurance fraud, OIFP must be able to marshal and coordinate New Jersey's diverse resources as effectively and efficiently as possible. The New Jersey Legislature provided for this by consolidating responsibility for leading and coordinating New Jersey's fraud fighting efforts under the umbrella of a single agency, OIFP, whose sole purpose is to address insurance fraud.

As required by AICRA, OIFP has established, and maintains, a section of the office designated as the Liaison Section. The Liaison Section ensures that OIFP's efforts to combat insurance fraud are coordinated with those of the private insurance industry and other law enforcement and public agencies which, by virtue of their authority or responsibilities, are likely to encounter the problem of insurance fraud.

The Liaison Section is comprised of four liaisons, and their support staff, assigned to work, respectively, with professional licensing boards, private insurance companies, County Prosecutors and other law enforcement agencies. The responsibilities of the Liaisons include maintaining databases of cases and contacts, holding regularly scheduled coordination meetings and training sessions, coordinating investigations, making and receiving referrals, resolving issues on behalf of their counterparts in other agencies and entities, and implementing programs which further enhance the State's goals in fighting insurance fraud.

County Prosecutors

County Prosecutors in New Jersey play a critical part in the State's efforts to combat insurance fraud. As the local prosecuting agencies in each county, County Prosecutors' Offices are particularly well suited to investigate and prosecute cases which might otherwise "fly below the radar screen" of State authorities. Because of their unique familiarity with local demographics and trends, and their ability to cultivate informants through their own investigations and prosecutions, County Prosecutors provide an important complement to the efforts of the Insurance Fraud Prosecutor.

In recognition of the important role that County Prosecutors play in the fight against insurance fraud, the Legislature authorized OIFP to provide financial and technical assistance and support to enhance their fraud fighting capabilities, and to ensure that their efforts are coordinated

The Press of Atlantic City
June 22, 2002
**19 counties share \$3M. to fight
insurance fraud**

with those of other law enforcement agencies. In 2002, OIFP continued to provide funding to 19 of the 21 County Prosecutors' Offices in New Jersey. This funding, which totaled over \$3 million in grants, supported the salaries of prosecutors, investigators and support staff assigned to insurance fraud units, as well as training and equipment needs of those units. The 2002 funding enabled County Prosecutors' Offices to dedicate nine assistant prosecutors, thirty three investigators and detectives and five technical and administrative support staff to fighting insurance fraud.

OIFP, through the County Prosecutor Liaison, has established, and maintains, a

comprehensive system for the coordination of referrals between OIFP and County Prosecutors' Offices. All County Prosecutors' Offices in New Jersey provide OIFP with a Cumulative Monthly Report which lists the names, addresses and other appropriate identifying information with respect to all subjects under investigation for insurance fraud within their respective offices. These reports are updated monthly and also set forth information as to the nature of the suspected insurance fraud and the current status of any efforts undertaken by the local prosecutor's office in the investigation or prosecution of the reported subject. The information from these reports is added to OIFP's own database as it is received from the counties, and is reviewed to ensure that OIFP's own investigative efforts do not overlap or duplicate those of the reporting counties.

The information from these reports is also used to enable OIFP-Civil to open civil investigations in those reported cases where it appears that the imposition of a civil penalty by OIFP-Civil investigators might be appropriate. Reporting by the counties in 2002 enabled OIFP-Civil to open 505 cases for investigation. Whenever OIFP-Civil opens an investigation resulting from a matter reported by a County Prosecutor's Office, OIFP-Civil contacts an assistant prosecutor or investigator in the reporting office to identify a point of contact and to establish a channel of communication for coordinating the criminal prosecution efforts of the reporting county with the investigative efforts of OIFP-Civil. Through this mechanism, OIFP-Civil is sometimes able to obtain a voluntary consent order requiring the defendant to pay a civil fine in the context of the negotiation of a possible guilty plea. Many of the most significant civil penalties obtained by OIFP-Civil investigators were a direct result of the cooperation and assistance provided by investigators or assistant prosecutors in County Prosecutors'

Offices.

In their most productive year to date, County Prosecutors' fraud units charged a total of 277 defendants by indictment or accusation, obtaining 148 convictions by guilty plea or trial, resulting in the imposition of 97 years of incarceration. Summaries of some of their most notable cases are included in this report.

In 2002, the County Prosecutor Liaison met with assistant prosecutors, county investigators and other law enforcement officials at monthly regional law enforcement coordination meetings hosted by OIFP at its three regional offices. The County Prosecutor Liaison also conducted annual training for assistant prosecutors and county investigators at the OIFP office in Lawrenceville, and conducted roundtables for County Prosecutor personnel at the annual conference of the New Jersey Special Investigators Association and at the New Jersey Insurance Fraud Summit. In addition, the County Prosecutor Liaison attended meetings with several County Prosecutors and their staff at their offices to review OIFP's programs, and to discuss such issues as funding, reporting requirements and the coordination of investigations.

Providing for the exchange of information among law enforcement agencies, and between the law enforcement and insurance industry communities, is a responsibility shared by OIFP's liaisons. Such sharing of information is, however, sometimes complicated by the competing interests of law enforcement in maintaining the integrity and confidentiality of its investigations and observing the privacy interests of those with whom it comes in contact, while observing its legal obligations to provide information to the public and others. In 2002, the County Prosecutor Liaison, along with the Law Enforcement and Insurance Industry Liaisons, worked closely with police departments throughout New Jersey to

provide assistance to insurance company investigators in obtaining automobile accident reports. By serving as immediate, designated contacts to address issues as they arise among agencies and insurers, the liaisons assigned to the Liaison Section ensure that open lines of communication are maintained among all public and private entities in New Jersey concerned with insurance fraud, and that problems and issues are promptly addressed.

Law Enforcement

Because every law enforcement agency in New Jersey has occasion to encounter or investigate some aspect of insurance fraud, it is essential that these law enforcement agencies establish and maintain continuing channels of communication with one another. Accordingly, OIFP has also assigned a liaison to work with law enforcement agencies, other than County Prosecutors' Offices.

OIFP's Law Enforcement Liaison acts as OIFP's representative in coordinating OIFP's activities with other law enforcement agencies at every level of government, whether municipal, county, state or federal, and in facilitating avenues of communication among these agencies in the realm of insurance fraud. The Law Enforcement Liaison also represents OIFP at leadership meetings of law enforcement officials, including the annual conference of the New Jersey Chiefs of Police Association and periodic meetings of the Mid-Atlantic States Insurance Fraud Association. In addition, the Law Enforcement Liaison processes and maintains a database of requests for fictitious insurance cards and "pretext insurance policies" for use in undercover investigations by OIFP and other law enforcement agencies.

Among the responsibilities of the Law Enforcement Liaison are the scheduling and hosting of regional law enforcement

coordination meetings on a quarterly basis in each of OIFP's three regional offices. Officials from law enforcement agencies both within and without New Jersey are invited to attend and participate in these meetings. These meetings offer guest speakers with expertise in an insurance fraud related subject. These meetings also provide an opportunity to share information and intelligence and establish professional relationships with counterparts in other law enforcement agencies assigned to work in the area of insurance fraud.

Guest speakers at the 2002 regional coordination meetings included, among others, experts in the areas of heavy construction equipment thefts, insurance fraud databases and ethnic crime rings. Those in attendance included representatives from the Federal Bureau of Investigation, the Bureau of Alcohol, Tobacco and Firearms, the New Jersey State Police, the United States Postal Inspectors' Office, the Philadelphia District Attorney's Office, the Pennsylvania Office of the Attorney General, various New Jersey County Prosecutors' Offices and several local police departments throughout New Jersey. In 2002, the Law Enforcement Liaison laid the groundwork to expand the participation of local police officers in these regional meetings by publicizing the time and place of the regional coordination meetings in the "*New Jersey Police Chief*," the official publication of the New Jersey Chiefs of Police Association.

Local police departments have been a particularly important focal point of the activities of OIFP's Law Enforcement Liaison in 2002 because of their unique place at the front lines in the battle against insurance fraud. Due to the importance of addressing immediate local concerns relating directly to the safety of their neighborhoods, such as violent crime and traffic control, most municipal police departments have not historically been attuned or equipped to

identify or investigate cases of suspected insurance fraud.

Municipal police are often, however, the first officers likely to encounter many situations in which there are indicators of possible insurance fraud. This is particularly true with respect to one of the most common types of insurance fraud, which involves the possession, display or manufacture of a counterfeit or fictitious automobile insurance card. Quite simply, if an officer who undertakes a motor vehicle stop fails to identify a possibly fictitious insurance card, it is unlikely that the person exhibiting that card will be caught. Similarly, if an officer who responds to the report of a residential burglary, a car theft or an accident fails to recognize the common indicators of insurance fraud, it is likely that the person who makes such a false report as the predicate to the filing of a fraudulent insurance claim will succeed in "beating the system."

OIFP has undertaken a number of steps to enhance the ability of local police officers to identify the indicators of various types of insurance fraud which they are likely to encounter, and to undertake the appropriate investigative steps following that detection. OIFP, through the direction and oversight of the Law Enforcement Liaison, offers a comprehensive roster of training opportunities for local police officers at county police training academies throughout New Jersey, which are tailored to the level of experience of the officers in attendance. OIFP also conducts direct training for some of the State's largest police departments and for recruits at the Division of Criminal Justice Training Academy at Sea Girt, New Jersey.

OIFP has also produced and distributed to local police departments statewide roll-call training videos addressing fictitious insurance cards, staged accidents and fraudulent auto

theft claims. OIFP has also published and disseminated to local police a publication known as the Uninsured Motorist Identification Directory (UMID). UMID provides information to enable local police officers to verify the authenticity and current validity of automobile insurance cards by making direct contact with appropriate insurance company personnel.

In 2002, OIFP's Law Enforcement Liaison was also instrumental in providing assistance and support to industry investigators seeking to obtain automobile accident reports from police departments. Over the past year, the Law Enforcement Liaison has fielded dozens of requests for assistance from insurance carriers and provided guidance to many police departments with respect to the guidelines for releasing information to the public and insurance company investigators.

Insurance Industry

As recognized by AICRA, success in the battle against insurance fraud requires an effective partnering of the public and private sectors. OIFP has facilitated this partnership in New Jersey by assigning an Insurance Industry Liaison within OIFP's Liaison Section to establish and maintain a close working relationship with insurance industry executives, insurance industry trade groups, insurance company special investigations units, and officials from New Jersey's Department of Banking and Insurance and Division of Motor Vehicles. Since most of the cases of suspected insurance fraud referred to OIFP originate with insurance carriers, and since the insurance industry has a significant stake in the success of law enforcement's efforts to combat insurance fraud, it is important that OIFP and the industry maintain open and ongoing channels of communications.

In his role as the primary point of contact with the insurance industry, the Insurance Industry

Liaison routinely provides advice, guidance and technical assistance on a wide variety of matters, including the sharing of information, the release of accident reports and investigative information from law enforcement officials to insurance company investigators, and statutory requirements relating to the referral of insurance fraud matters to OIFP.

In 2002, the Insurance Industry Liaison and his assistant logged 710 instances in which they provided assistance or guidance through telephone contacts or e-mail inquiries.



The Insurance Industry Liaison is also responsible for scheduling and hosting the OIFP/ Insurance Industry Working Groups, OIFP's primary vehicle for engaging in the discussion of issues of most importance to the insurance industry. Both the Property & Casualty and Life & Health Working Groups serve as sounding boards for the consideration of fresh ideas to improve our common efforts to fight fraud, and as forums to discuss issues of policy and coordination. Some of the ideas which have evolved from the working groups have been embodied in recommendations for regulatory and legislative reform, including some of the recommendations which have been included in OIFP's annual reports.

In 2002, OIFP established another working group of industry representatives and OIFP

executive staff designated the All Claims Database Working Group. This working group was created to provide OIFP with industry input with respect to OIFP's efforts to implement the All Paid Claims Database required under AICRA. This working group has met periodically to review and discuss OIFP proposals and offer appropriate

feedback. Proposals from this working group will be reflected in the publication of proposed regulations in 2003.

Through the Insurance Industry Liaison, OIFP also participates in meetings of other insurance associations, which provide the opportunity for the candid exchange of ideas and information. In 2002, the Insurance Industry Liaison represented OIFP at meetings of the Anti-Fraud Association of the Northeast, the Insurance Council of New Jersey, the New Jersey Vehicle Theft

Investigators Association, the New Jersey Special Investigators Association, and the Del-Val International Association of Special

Investigative Units.

In addition, in 2002, the Insurance Industry Liaison provided training to more than 1,350 insurance industry professionals from several insurance companies doing business in New Jersey. These sessions addressed the coordination of insurance fraud investigations, OIFP operations, and insurance company

Industry and OIFP officials speak to the press.
 Left to right: Insurance Fraud Prosecutor Greta Gooden Brown; OIFP Insurance Industry Liaison John Butchko; John Tiene, President, Insurance Council of New Jersey; Ken Pringle, Esq., General Counsel, N.J.S.I.A.; Acting Attorney General Peter C. Harvey

reporting requirements pursuant to *N.J.A.C* 11:16-6(b), which sets forth the criteria pursuant to which insurance companies in New Jersey are required to refer suspicious insurance claims to OIFP.

The Insurance Industry Liaison also acts as the principal point of contact with respect to the flow of information between OIFP and the Department of Banking and Insurance. A major aspect of this responsibility is the coordination and tracking of OIFP cases involving licensed producers, public adjusters and real estate agents. In 2002, 46 such cases were identified for tracking. As a result of OIFP's investigations, the Department of Banking and Insurance revoked the licenses of three of the 46 licensees, all of whom were licensed insurance producers.

In 2002, the Insurance Industry Liaison was also responsible for overseeing production of OIFP's most recent roll-call training video, "Identifying the Suspicious Auto Theft," which was distributed to each police department and County Prosecutor's Office in New Jersey. In addition, the Insurance Industry Liaison established a mechanism in 2002 to distribute OIFP press releases to over 125 individuals within the executive and investigative staffs of insurance carriers, industry trade groups and various governmental agencies in order to keep them apprised of significant events in the prosecution of OIFP cases.

Over the course of the year, the Insurance Industry Liaison also distributed thousands of Fraud Awareness posters and brochures to community and civic groups. Further, the Insurance Industry Liaison participated in and played a key role in the planning of the Annual Conference of the New Jersey Special Investigators Association and the New Jersey Annual Insurance Fraud Summit, which were attended by key leaders of government and industry.

Professional and Occupational Boards

OIFP also coordinates its activities with New Jersey's professional and occupational boards within the Division of Consumer Affairs. Because insurance fraud is frequently committed by, or involves the participation of, licensed professionals such as physicians, chiropractors, dentists, pharmacists, therapists, insurance agents, allied medical providers and lawyers, it is imperative that prosecuting and professional licensing authorities pursue their respective responsibilities in tandem. Without a mechanism for ongoing communication and coordination, complaints of fraud received by professional licensing boards might otherwise escape criminal investigation. Conversely, without a protocol for sharing information, matters under investigation by OIFP and County Prosecutors' Offices could escape the scrutiny of the agencies which regulate the conduct of, and may take disciplinary action against, the licensees under their jurisdiction.

The Professional Boards Liaison within OIFP's Liaison Section is responsible for maintaining a comprehensive database of insurance fraud complaints involving professional licensees, which includes information concerning the nature and source of the information and its status within the Enforcement Bureau of the Division of Consumer Affairs. Pursuant to the procedures established for OIFP by the Professional Boards Liaison, OIFP provides prompt notification to the professional licensing boards whenever it commences an investigation of one of their licensees. These procedures provide similarly for professional licensing boards to notify OIFP with respect to complaints they have received against licensees suspected of engaging in insurance fraud.

OIFP's Professional Boards Liaison also schedules quarterly meetings to review the status of the investigation or prosecution of every licensee in the active database maintained by the Professional Boards Liaison.

These meetings are attended by supervisory investigative and prosecutorial OIFP staff and key members of the Division of Consumer Affairs Enforcement Bureau. In 2002, this group, known as the Liaison and Continuing Communications Group, monitored 549 active insurance fraud related cases. Since its establishment in October of 1998, the group has reviewed and disposed of 545 cases by way of civil or criminal dispositions by OIFP, licensing sanctions by the appropriate professional board or administrative closure. In 2002, seven monitored licensed professionals were indicted, ten pled guilty or were found guilty after trial, and seven received sentences which

ranged from two years of probation with restitution and fines, to terms of three to five years in State prison and fines. This collaborative effort also facilitated disciplinary action by professional and occupational boards within the Division of Consumer Affairs against 29 individuals in 2002, as follows:

2002 Disciplinary Actions by Professional and Occupational Boards					
	Suspension	Revocation	Voluntary Surrender	Reprimand	TOTAL
Accountancy	0	0	0	0	0
Chiropractic	3	4	0	0	7
Cosmetology	0	0	1	0	1
Dental	4	0	0	0	4
Medical	4	6	1	1	12
Nursing	0	1	0	0	1
Pharmacy	1	0	0	0	1
Psychology	0	1	0	0	1
Social Worker	0	0	0	1	1
X-ray	0	0	0	1	1
TOTAL	12	12	2	3	29

As OIFP's point of contact with respect to matters touching upon licensee conduct, the Professional Boards Liaison also provides technical assistance and advice as needed to the professional licensing boards, and works

closely with OIFP's Case Screening Litigation and Analytical Support Section (CLASS) to ensure that matters involving professional licensees are properly assigned and coordinated within OIFP.

Other Coordination and Liaison Activities

In addition to the Liaisons assigned to OIFP's Liaison Section, others in OIFP work closely with other agencies and associations on a continuing basis. OIFP criminal and civil investigators conduct many of their investigations jointly with other law enforcement agencies, including local police departments, County Prosecutors' Offices and various federal agencies. OIFP investigators also, on occasion, work together on investigations with law enforcement and other governmental agencies outside of New Jersey. In 2002, for instance, OIFP investigators worked with officials from the Pennsylvania Attorney General's Office with respect to the investigation of interstate rate evaders, as well as with officials from several law enforcement agencies in New York and Tennessee with respect to the investigation of an interstate auto theft ring.

OIFP's Medicaid Fraud Section has historically worked closely with its counterparts throughout the United States, and continued to do so in 2002. The Supervising Deputy Attorney General of the Medicaid Fraud Section has, over the past seven years, served as a member of the Executive Committee of the National Association of Medicaid Fraud Control Units (NAMFCU), which is comprised of the Medicaid Fraud Control Units from 47 other states and the District of Columbia.

NAMFCU serves as a vehicle for coordinating the activities of states' Medicaid Fraud programs throughout the country, and facilitates, in particular, the investigation, prosecution and settlement of civil and criminal claims against Medicaid providers whose activities transcend state borders. OIFP's Medicaid Fraud Section continued in 2002 to actively participate in nationwide

settlements with NAMFCU involving providers who had submitted billings under New Jersey's Medicaid Program. NAMFCU also provides a forum for the sharing of general information on matters relating to Medicaid Fraud and provides training for its members, which is accredited by the Federal Law Enforcement Training Center.

Representatives from OIFP, including the Special Assistant to the Insurance Fraud Prosecutor and the Law Enforcement and County Prosecutor Liaisons, continued to participate in 2002 in the Mid-Atlantic States Insurance Fraud Association (MASIFA). MASIFA is a group of law enforcement officials from insurance fraud agencies in New York, Pennsylvania, Maryland, Delaware, Virginia and Washington, D.C., who meet regularly to discuss matters of common interest and share information and intelligence with respect to current insurance fraud investigations and trends.

Throughout the past year, OIFP's executive staff have met on many occasions with their counterparts in other state agencies, such as the Department of Banking and Insurance, the Department of Health, the Department of Human Services, the Division of Motor Vehicles and the Department of Labor to discuss issues of mutual concern and to explore remedial measures. These measures include possible proposals for legislative and regulatory reform relating to those issues.

New Jersey State Police

In 2002, OIFP continued to fund, and work closely with, the Insurance Fraud Unit of the New Jersey State Police. Created in 1999 under a grant provided by OIFP, the State Police Insurance Fraud Unit has established itself as a key agency in the State's efforts to combat motorist related insurance fraud. The Unit is staffed by two squads of five Troopers under the supervision of a Sergeant. While the

principal focus of the Unit's activities has been the identification and investigation of fraudulent motor vehicle insurance identification cards, the Unit has also conducted or participated in investigations involving workers compensation fraud, auto theft fraud and auto injury claims fraud.

In 2002, the State Police Insurance Fraud Unit conducted 170 investigations of insurance fraud, most of which targeted counterfeit insurance cards. Investigations by the Unit resulted in the arrests of 177 insurance fraud suspects. The Unit's investigations also resulted in uncovering approximately \$400,000 in potential insurance fraud. As an adjunct to its investigative efforts, the Unit also participated in OIFP's law enforcement training program, instructing officers in the detection and investigation of motorist related insurance fraud.

OIFP has also continued to maintain an ongoing working relationship with the New Jersey State Police Auto Unit. That Unit conducts a wide variety of investigations relating to motor vehicles, including counterfeit documentation, salvage title operations, odometer rollbacks and auto thefts, sometimes giving rise to the investigation of different types of vehicular insurance fraud.

Insurance Fraud Training Programs and Publications

Central to its mission to combat insurance fraud on every front is OIFP's comprehensive training program. In addition to ensuring that all OIFP personnel receive adequate and continuous training, OIFP provides training opportunities for industry and law enforcement insurance fraud investigators of every level of experience. In 2002, OIFP provided insurance fraud training on nearly 100 occasions for over 3,300 law enforcement and industry professionals. Among those receiving training were members of all 21 County Prosecutors' Offices in New Jersey, 62 other New Jersey law enforcement agencies as well as insurance fraud investigators from numerous insurance companies.

OIFP Basic Training Course for Civil Investigators

All OIFP Civil investigators are required to successfully complete a five-week training program which is designed to provide a broad foundation in basic investigative skills and insurance principles. The training program includes the review of various types of insurance coverage and training in basic investigative tools and techniques associated with insurance fraud investigations. Newly minted civil investigators are also provided with information regarding investigative resources and case management techniques. They also receive intensive training in the techniques of writing reports, conducting surveillance and interviewing witnesses and subjects. Other areas of instruction introduce civil investigators to the intricacies of computer fraud, relevant areas of the rules of evidence and techniques to cultivate and manage informants. The training program concludes with a training exercise in which the trainees apply their skills to a hypothetical case scenario, which includes the preparation of a

report reflecting their investigative efforts and testifying as a witness in a moot court trial.

OIFP In-Service Training

OIFP also offers in-service training opportunities for civil and criminal investigators and Deputy Attorneys General. OIFP staff participate in the same in-service training opportunities provided to all employees of the Division of Criminal Justice. These training opportunities allow experienced OIFP staff to build upon their existing investigative and prosecutorial skills. Training in a variety of subject matter areas is provided for Deputy Attorneys General through the New Jersey Attorney General Advocacy Institute. Criminal investigators within the Division of Criminal Justice are provided training opportunities through the Division of Criminal Justice Academy. In addition, computer training for all OIFP staff is available through regular computer training programs offered by the Department of Law and Public Safety. Additional training opportunities in a variety of subjects are also available to OIFP employees through the Human Resource Development Institute of New Jersey.

In 2002, the OIFP Insurance Industry Liaison laid the groundwork for implementing a new training program utilizing the expertise of insurance industry professionals designated as the OIFP/Industry Joint Training Program. This program will offer training to all investigators and Deputy Attorneys General, both civil and criminal, within OIFP, encompassing a broad range of subjects germane to the investigation and prosecution of various types of insurance fraud. By enlisting the expertise of insurance fraud investigators with years of experience in the insurance industry, the training will complement the instruction offered by law enforcement professionals by adding an industry perspective and familiarizing OIFP staff with an array of the insurance industry's

investigative tools which have proven to be valuable over the years. The training will be conducted at OIFP's home office in Lawrenceville, New Jersey, and telecast to its regional offices in Whippany and Cherry Hill. OIFP also plans to make this training available to assistant prosecutors and County Prosecutor investigative personnel.

County Prosecutors' Offices Training Program

In conjunction with its program to offer financial and technical assistance to County Prosecutors' Offices in the investigation and prosecution of insurance fraud, OIFP also provides insurance fraud training to assistant prosecutors and County Prosecutor investigative personnel. The goal of this training program is to acquaint those in attendance with the most current trends, technologies and techniques to combat insurance fraud. At its annual training for County Prosecutor personnel on June 13, 2002, OIFP provided a day of training entitled "Tips, Tools and Techniques for Fighting Insurance Fraud." Presentations included instruction in electronic surveillance and lock and key analysis in conjunction with fraudulent auto theft investigations. The training also provided information regarding new quarterly statistical reporting requirements, and an update with respect to monthly case reporting requirements. The training concluded with panel discussions presented by OIFP investigators and Deputy Attorneys General, who reviewed actual case studies of investigations and prosecutions of schemes involving a staged accident ring, provider fraud and life insurance fraud.

As it has done in the past, OIFP also provided training at the 2002 Annual N.J.S.I.A. Conference in Atlantic City, moderating a panel discussion of assistant prosecutors. These discussions addressed the manner in

which County Prosecutor personnel coordinate their activities with insurance industry investigators and other law enforcement agencies. Assistant prosecutors also reviewed some of their most significant insurance fraud cases over the prior year. The OIFP County Prosecutor Liaison also hosted a roundtable discussion for County Prosecutors and other law enforcement executives at the New Jersey Insurance Fraud Summit in October, 2002. This discussion provided information regarding OIFP's programs and the manner in which OIFP coordinates its activities with other law enforcement agencies.

Municipal Police Departments Training Program

OIFP also conducts an ambitious training program for local police officers, which is tailored to each officer's level of experience. For police officer recruits who are enrolled in the basic training course in a police training academy, OIFP offers an introductory insurance fraud training class on a level consistent with basic police recruit training objectives. For experienced officers, OIFP offers a number of training modules of varying length and content, depending upon the needs and interests of the officers receiving the training. Training is conducted at county training academies throughout New Jersey, as well as at some of New Jersey's largest police departments, and at the New Jersey State Police and Division of Criminal Justice training academies at Sea Girt, New Jersey. In 2002, OIFP conducted training for nearly 790 police officers from over 62 different police agencies during 29 separate training sessions.

OIFP also offers training for police officers through a series of roll-call training videos addressing various types of insurance fraud a police officer is likely to encounter. In 2002, OIFP produced the third, and most recent, of the series, entitled "Identifying the Suspicious Auto Theft." Earlier videos offered training in

the identification of counterfeit and fictitious automobile insurance cards and in the investigation of suspicious "automobile accidents". The videos include enactments of situations commonly encountered by most police officers in the course of their daily duties. The videos provide information on "red flag" indicators of fraud as well as practical tips on investigative steps that may be undertaken by police officers who suspect possible insurance fraud. The videos provide police departments with flexibility by enabling police officers to view them when most convenient. OIFP has distributed each of the training videos to every police department and County Prosecutor's Office in New Jersey. The value of the training videos has been recognized by police departments in other states, which have requested copies for their own training needs.

Insurance Industry Training Program

OIFP also offers training for insurance industry professionals. Training is provided on industry reporting requirements relating to insurance fraud. Training is also provided on OIFP operations in general and the coordination of carriers' Special Investigations Units with OIFP investigations. In 2002, the OIFP Industry Liaison provided training to approximately 1,350 industry professionals, often providing training at the carriers' own offices for the convenience of their employees. Others in OIFP offered training to industry professionals in 2002, including the Special Assistant to the Insurance Fraud Prosecutor, and the OIFP County Prosecutor and Law Enforcement Liaisons.

OIFP Publications

In 2002, OIFP published and disseminated the first edition of the Uninsured Motorist Identification Directory (UMID). UMID was published by OIFP to enable law enforcement officials to telephonically contact insurance

companies for the purpose of confirming whether a driver who presents proof of insurance is, in fact, insured with the insurance company set forth on the insurance identification card. The Directory is divided into two parts. Insurance companies authorized to insure vehicles in New Jersey are listed alphabetically in Part A of the Directory. Part B of the Directory lists insurance companies numerically by their three digit DMV code number. In some cases, the telephone number provided for a given insurance company is the general telephone number of a parent company with one or more subsidiaries or affiliated companies. Due to a variety of factors such as corporate restructuring, withdrawal from the New Jersey automobile insurance market and telephone number reassignments, it is anticipated that some of the information contained in the Directory will change periodically. As a result, OIFP anticipates updating UMID on a regular basis.

Public Awareness Programs

Insurance fraud, and its impact upon the citizens of New Jersey, remains an issue of great interest to the public. As the designated agency to lead New Jersey's fight against insurance fraud, OIFP continues to conduct programs to educate the public about insurance fraud and solicit public support in the detection of insurance fraud. These programs are designed to help the public recognize insurance fraud in the making as well as to convey the consequences of committing insurance fraud as a deterrence.

These programs also communicate methods by which members of the public can report insurance fraud to OIFP.

OIFP Media Campaign

In 2002, OIFP continued to air its professionally produced, award-winning multi-media campaign, consisting of television and radio ads, billboard and bus posters and Internet website banner ads. The theme of the campaign is to underscore the fact that New Jersey has a "no tolerance" policy with respect to the commission of insurance fraud and fraudsters will be criminally prosecuted to the fullest extent of the law. The advertisements continued to feature an affluent "yuppie," known as Richard, who has been caught committing insurance fraud and is facing the consequences in the criminal justice system.

For the first time, in 2002, the media campaign was also publicized by way of publication of newspaper ads in the print media. In addition to setting forth a clear message of deterrence, the media campaign encourages members of

the public to report insurance fraud. The campaign further directs members of the public to various methods for reporting instances of suspected insurance fraud to OIFP.



New Jersey Governor unveils insurance fraud agenda. Left to right: Governor James E. McGreevey; former Attorney General David Samson; Insurance Fraud Prosecutor Greta Gooden Brown

Follow-up tracking studies,

the most recent of which were completed by the media campaign vendor in June of 2002, have clearly demonstrated the effectiveness of OIFP's media campaign in raising public awareness of the insurance fraud problem. The studies demonstrate that the media campaign's deterrent message has been memorable, influential and effective. All tracking measures in the most recent study either remained at prior tracking levels, or showed improvement over prior tracking studies. The studies have demonstrated that the campaign has raised awareness of the issue of insurance fraud, memorably promoted the idea that insurance fraud is a serious crime, and effectively conveyed that insurance fraud carries significant penalties, including jail time and fines. It also effectively communicated that insurance fraud is a problem that has a significant and direct monetary impact upon

New Jersey residents. The tracking studies also demonstrate the effectiveness of the media campaign in making the public aware of OIFP's toll-free telephone hotline.

The most recent tracking study conducted in 2002 was based on interviews with 486 New Jersey residents between the ages of 35 and 64. Among the highlights of the tracking studies are the following findings:

- Awareness of the issue of insurance fraud increased as a result of the campaign. Forty one percent of those surveyed responded that they were “extremely” or “very” familiar with insurance fraud, compared with a prior response rate of 32 percent.
- The perceived importance of insurance fraud to New Jersey residents increased as a consequence of the media campaign. Seventy five percent of those surveyed indicated that they felt that insurance fraud was a substantial problem in New Jersey, an increase of 17 percent over prior tracking studies.
- The media campaign convinced more New Jerseyans that insurance fraud is costing them money. Eighty nine percent of those surveyed believed that insurance fraud was costing them money and that it was worth the effort to combat the problem of insurance fraud. This figure compares with 68 percent and 73 percent of respondents in prior tracking studies.
- Awareness of the OIFP media campaign had increased markedly by the time the most recent tracking study was conducted. Among the target audience, 60 percent indicated that they had seen advertising about insurance fraud within the prior three

months, compared to 39 percent and 50 percent in prior tracking studies.

OIFP expects to resume its media campaign in the latter part of 2003.

OIFP Website

OIFP's state-of-the-art website, at www.njinsurancefraud.org, is an integral part of OIFP's overall program to provide the public with timely and comprehensive information regarding insurance fraud. It provides general information regarding OIFP's mission and activities, as well as specific information about OIFP's criminal prosecutions. The website includes examples of common types of insurance fraud and posts press releases reporting the indictment, conviction and sentencing of defendants prosecuted by OIFP. Comprehensive historical information regarding OIFP may be found in OIFP's prior Annual Reports, which are also posted in their entirety on the website.

The website also provides several alternative means for the reporting of insurance fraud to OIFP by members of the public. These include the posting of OIFP's toll-free hotline telephone number, an on-line reporting form, and OIFP's e-mail address for reporting fraud. OIFP's media campaign television ads may also be easily viewed by visiting the OIFP website and clicking on the image links featuring the characters portrayed in the media campaign.

The OIFP website also serves the interests of the insurance industry. The website provides access to forms which the insurance industry is required to use for reporting insurance fraud to OIFP. Requirements for Fraud Prevention Detection Plans, which the industry must periodically file with the Department of Banking and Insurance, are also provided on the website as a convenience to the industry.

OIFP Community Outreach

In addition to its media campaign, website and news offerings, OIFP conducts a multi-faceted program to inform and enlist the support of the public through participation in a variety of private and public agencies and organizations. In 2002, the Insurance Fraud Prosecutor continued to appear as a frequent speaker before audiences seeking to learn more about insurance fraud and the activities of OIFP. The Prosecutor's speaking engagements in 2002 included appearances before the Anti-Fraud Association of the Northeast, the New Jersey Auto Theft Summit, the New Jersey Healthcare Financial Management Association, the Association of Black Women Lawyers of New Jersey, the 24th Annual Training Seminar of the New Jersey Vehicle Theft Investigators Association, the Annual Conference of the New Jersey Special Investigators Association, the Annual Symposium of the Insurance Council of New Jersey, the National Health Care Anti-Fraud Association and the New Jersey Insurance Fraud Summit. In December of 2002, the Insurance Fraud Prosecutor was also invited to participate as a keynote speaker at the Asia Pacific Fraud Convention scheduled for September of 2003 in Australia.

OIFP's Insurance Industry Liaison was also a frequent speaker on behalf of OIFP, acting as moderator at the New Jersey Insurance Fraud Summit and appearing as a guest speaker at insurance companies throughout New Jersey. He also addressed gatherings of the New Jersey Special Investigators Association, the New Jersey Vehicle Theft Investigators Association and the Insurance Council of New Jersey Insurance Symposium. He also spoke on behalf of OIFP at meetings of such civic and community groups as the Lions Head Civic Group and the Ansche Chesed Synagogue. The OIFP Law Enforcement and County Prosecutor Liaisons also spoke on behalf of OIFP, moderating a session at the New Jersey Insurance Fraud Summit for County Prosecutors and other law

enforcement executives and offering presentations in other venues such as the annual New Jersey Chiefs of Police Conference.

OIFP also staffed informational and display booths at such functions as the New Jersey League of Municipalities Annual Conference, the New Jersey Special Investigators Association Annual Conference, the New Jersey Chiefs of Police Annual Exposition and the New Jersey Insurance Fraud Summit. These booths enabled OIFP to distribute informational materials such as OIFP brochures and to showcase its law enforcement training materials, such as its line of roll-call training videos. OIFP's public awareness efforts are designed to reach as many people as possible, and are tailored to provide information of the greatest interest and relevance to the particular audience.

Public Recognition

OIFP's accomplishments as New Jersey's leader in the battle against insurance fraud have not gone unnoticed by others in the fraud fighting community, both here and abroad. In recent years, OIFP's Medicaid Fraud Section has been nationally recognized for its

Prevention Bureau, OIFP hosted a meeting of the Mid-Atlantic States Insurance Fraud Association (MASIFA) in October to provide the Canadian Bureau with an overview of OIFP's operations and fraud training methods. OIFP also responded to requests for assistance



achievements. OIFP's media campaign has received awards for its excellence in addressing insurance fraud. OIFP's roll-call training videos have been requested by officials throughout the United States. OIFP's cases have been regularly reported by national publications. In addition, OIFP's officials have been sought out for guidance and advice from many other jurisdictions.

OIFP's reputation as a national leader in the fight against insurance fraud continued to grow in 2002. Responding to a request for assistance from Canada's Insurance Crime

and advice from other states, from New York to Hawaii. In May of 2002, Hawaiian authorities consulted with OIFP to obtain guidance with respect to conducting covert, undercover criminal investigations into automobile insurance fraud. OIFP also continued to respond to numerous requests from officials from other states for copies of OIFP's roll-call training videos, which offer instruction to local police on the identification and investigation of staged accidents and staged auto thefts.

OIFP's investigations and prosecutions

continued to be reported by national publications, such as Mealey's Insurance Fraud Litigation Report and Fraud Focus, published by the Coalition Against Insurance Fraud, as well as by newspapers of regional and national scope. OIFP's experience was also cited favorably in a leading college textbook, Criminology, as an example of one of the few states in the country that has undertaken such an effective effort to fight fraud at all levels.

OIFP Investigators and Deputy Attorneys General were also recognized for their achievements in 2002. In its Fraud Quarterly Bulletin, the American International Group, Inc., recognized an OIFP investigator for his efforts in leading a successful undercover investigation which led to the arrests of a Passaic County physician and his office manager on charges of conspiracy, health care claims fraud, theft by deception and using runners. In its May, 2002, newsletter, the

The extent to which OIFP's reputation has grown in the insurance fraud community is, perhaps, best reflected by the stature of the organizations which, in 2002, sought the participation of the Insurance Fraud Prosecutor as a keynote speaker at their most important conferences. These organizations include the New Jersey Vehicle Theft Investigators Association, the New Jersey Special Investigators Association, the Insurance Council of New Jersey, the New Jersey Chapter of the Healthcare Financial Management Association, the National Health Care Anti-Fraud Association, and the Asia Pacific Fraud Convention in Australia.

Detectives Crime Clinic of Metropolitan New Jersey and New York commended OIFP Deputy Attorneys General and Investigators for their efforts in successfully investigating and prosecuting a complex insurance fraud case involving fraudulent billings by an optometrist.

**PART II
CASE STATISTICS AND SUMMARIES**

OIFP Criminal Investigations and Prosecutions

<i>Statistics</i> January 1, 2002 - December 31, 2002	
New Cases Opened in 2002	508
Indictments/Accusations Filed	173
Number of Defendants Charged	225
Number of Defendants Convicted	154
Number of Defendants Sentenced	159
Number of Defendants Sentenced to State Prison	22
Total Number of Years	107
Number of Defendants Sentenced to County Jail	24
Total Number of Years	14
Total Criminal Fines Imposed	\$ 177,680.00
Total Civil Medicaid Fines Imposed	\$ 909,832.00
Total Restitution Imposed	\$6,787,645.00

Narrative

In 2002, OIFP-Criminal opened 508 new investigations of persons suspected of committing insurance or Medicaid fraud, 24% more than the number of new cases opened in 2001. OIFP also lodged criminal charges by accusation or indictment against 225 defendants, and obtained convictions of 154 defendants, representing increases of 91% and 79%, respectively, over 2001 figures. In addition, OIFP's conviction rate exceeded the statewide average. OIFP's criminal prosecutions resulted in the imposition of sentences totalling 121 years in jail for defendants convicted of insurance or Medicaid

fraud. In addition, defendants prosecuted by OIFP in 2002 were required to pay criminal fines totalling \$177,680, \$909,832 in civil Medicaid fraud fines, and \$6,787,645 in restitution to their victims. The following case summaries highlight some of the most significant developments in OIFP's criminal prosecutions in 2002.

Criminal Case Summaries

AUTO FRAUD

Altering Vehicle Identification

State v. Rafael "Bugzy" Ramos, Ceaser Labrego

In August 2002, OIFP investigators arrested Rafael "Bugzy" Ramos and Ceaser Labrego on charges of conspiracy to alter motor vehicle trademarks. The complaint alleged that Ramos and Labrego engaged in a scheme to sell re-tagged vehicles, including high end luxury vehicles, in some cases using fraudulently generated automobile documentation. The matter is pending presentation to a Grand Jury.

Vehicular Theft

State v. Leonard Wise, et al.

On January 10, 2002, Leonard Wise and Lamont Sconiers were arrested by OIFP investigators on charges of attempted theft and conspiracy. The two were accused of scheming to steal a pair of Infiniti Q45's, each valued at \$60,000, from an Elizabeth, New Jersey storage lot rented by the Port Authority to Foreign Auto Prep Services, an automobile importer. Sconiers subsequently pled guilty on May 3, 2002, to an Accusation charging him with attempted theft and hindering apprehension or prosecution. He was admitted into the Pre-Trial Intervention Program (PTI). Wise also pled guilty to an Accusation on June 20, 2002, and was sentenced to three years probation. Another participant in the scheme, Willie Hopkins, was arrested on February 5, 2002, and charged with two counts of forgery and conspiracy to receive stolen property. Hopkins was accused of selling a fictitious temporary New Jersey motor vehicle registration tag and

inspection sticker to an undercover State Investigator. The documents Hopkins sold were for a stolen 2002 Jaguar, valued at over \$75,000, which Hopkins was driving. On June 3, 2002, Hopkins pled guilty to an Accusation charging him with conspiracy. Hopkins was sentenced on August 30, 2002 to three years in State prison. As part of the same investigation, on February 15, 2002, Terron Sessions was arrested by OIFP investigators with assistance from officials of Conrail, the Port Authority and the Irvington Police Department. Sessions was charged with receiving stolen property and conspiracy to commit fencing. Sessions' case is pending Grand Jury action.

State v. James Sanocki

On August 8, 2002, OIFP investigators, in cooperation with the Jefferson County, Kentucky Police Department, arrested James Sanocki and charged him with receiving stolen property and fencing. The complaint alleges that Sanocki was involved in a multi-state theft and fencing ring targeting motorcycles, automobiles, ATV's, construction equipment and jet skis. On the same date, search warrants were executed at Sanocki's residence in Ewing, Mercer County, and at his parents' residence in Frenchtown, Hunterdon County. Sanocki's case is pending Grand Jury action.

Courier Post

March 28, 2002

**Cop, retired officer
indicted**

Criminal Use of Runners

State v. Lt. Jerome Bollettieri, Sgt. Thomas DiPatri (ret.), Sgt. Philip Ferrari (ret.), & Charles Warrington, II

On March 27, 2002, a State Grand Jury returned an indictment charging former Camden Police Department Lt. Jerome Bollettieri and retired Sgt. Thomas DiPatri with conspiracy, official misconduct, bribery, and criminal use of runners. At the time of the

conduct alleged in the indictment, Bollettieri was the officer in charge of the Camden Police Department's Traffic Records Bureau. According to the indictment, DiPatri, a retired Camden police officer, illegally obtained police accident reports from Bollettieri by paying him bribes. The indictment also alleges that DiPatri obtained the police accident reports to identify persons who were in automobile accidents in order to solicit prospective patients for treatment at American Spinal Care, Inc. (ASC), a Collingswood chiropractic facility. Both DiPatri's and Bollettieri's cases are pending trial. Also on March 27, 2002, a separate but related State Grand Jury indictment was returned against retired Sgt. Philip Ferrari and Charles Warrington II, charging them with conspiracy, bribery in official matters and criminal use of runners. According to the indictment, Ferrari, a retired Camden police officer, and Warrington, a registered agent for ASC, requested and paid for the illegally obtained police accident reports in order to solicit prospective patients for treatment at ASC. Ferrari's and Warrington's cases are also pending trial.

State v. Cyrano Green

On October 17, 2002, following a 12 day jury trial, Cyrano Green was convicted for his role in paying bribe money to an undercover police officer. The jury found Green guilty of seven counts of bribery for purchasing Newark Police Department automobile accident reports from an undercover Newark Police Officer. Acting as a "runner," Green intended to solicit accident victims listed in the reports as insurance claimants. Green awaits sentencing.

State v. Michael Gardiner & Kim Robinson

On November 19, 2002, a State Grand Jury returned an indictment against Michael Gardiner, a licensed chiropractor, charging him with conspiracy, health care claims fraud, theft by deception, and criminal use of a runner. His office assistant, Kim Robinson, was also charged with conspiracy and health care claims fraud. The indictment alleges that between

April and July of 2000, Gardiner paid a person he believed to be a "runner," but who was actually an undercover investigator for OIFP, to provide Gardiner with patients for his chiropractic practice so that he could generate Personal Injury Protection (PIP) insurance claims. The indictment alleges that the undercover investigator, posing as a "runner," brought two persons to Gardiner's chiropractic office, both of whom Gardiner believed to be patients, but who were actually undercover Newark Police Officers. According to the indictment, Gardiner submitted fictitious PIP bills to GSA Insurance Company, falsely claiming that he had provided health care services. The indictment also alleges that Kim Robinson knowingly prepared the fraudulent PIP bills for submission to GSA. The State intends to prove at trial that the fraudulent billing submitted by Gardiner and Robinson totaled approximately \$4,980.

Fraudulent Automobile "Give-Up" Claims

State v. Bindraban Deosaran & Percy Hudson

On July 26, 2002, Percy Hudson pled guilty to an Accusation charging him with conspiracy to commit attempted theft by deception. Hudson admitted conspiring with Bindraban Deosaran to file a fraudulent auto theft claim with Liberty Mutual Insurance Company for the purported theft of Deosaran's 1986 Chevrolet Corvette. After Deosaran falsely reported to the Newark Police Department that his Corvette had been stolen, Deosaran left the car with Hudson and paid him \$200 to "strip" his car. On November 22, 2002, Hudson was sentenced to three years probation and 36 days in the county jail. Deosaran also pled guilty to an Accusation which charged him with attempted theft by deception and conspiracy. Deosaran was admitted into the PTI program on March 22, 2002, and ordered to serve 50 hours of community service. He also paid a \$5,000 civil insurance fraud fine.

State v. Michael Nardone, et al.

On March 5, 2002, Michael Nardone entered the PTI program and was ordered to pay \$29,500 in restitution to Liberty Mutual Insurance Company after pleading guilty to an Accusation which charged him with theft by deception and conspiracy. Nardone, who was leasing a 1997 Ford Mustang from VP, Inc., admitted that, in order to avoid making further lease payments, he solicited Joseph Marchitto to assist him in disposing of the vehicle. Nardone reported the vehicle stolen to the Sea Bright Police Department and filed a false vehicle theft insurance claim with Liberty Mutual. Nardone's fraud resulted in Liberty Mutual issuing a settlement check in the amount of \$29, 250.

State v. Joseph Marchitto

As part of the Nardone investigation, above, on January 8, 2002, Joseph Marchitto pled guilty to an Accusation charging him with conspiracy to commit theft by deception. Marchitto admitted picking up Nardone's 1997 Ford Mustang after being notified of its location by a co-conspirator and eventually turning it over to another co-conspirator to hide so that Nardone could avoid making further lease payments for the vehicle. On March 22, 2002, Marchitto was sentenced to three years probation and ordered to pay a \$1,000 criminal fine. Marchitto was also previously ordered to pay a \$4,000 civil insurance fraud fine.

State v. John Wilson & James Christensen

On February 15, 2002, a Grand Jury returned an indictment against John Wilson and James Christensen charging them with conspiracy and theft by deception as part of the Nardone conspiracy, above. Christensen was also charged with criminal mischief. According to the indictment, Wilson conspired with Michael Nardone to have Nardone's 1997 Ford Mustang left at or near Wilson's place of business with the key in the ignition, where it was to be removed by co-conspirator Joseph Marchitto. The indictment also alleged that

Christensen took possession of the vehicle from Marchitto and dismantled it, in order to facilitate its disposal and prevent its recovery, so that a stolen vehicle insurance claim could be filed by Nardone. Following the entry of guilty pleas, on June 28, 2002, Wilson was sentenced to three years probation, conditioned upon serving 50 hours of community service and paying a \$4,000 civil insurance fraud fine. Christensen was sentenced to two years probation.

State v. Scott Walterschied

On December 6, 2002, Scott Walterschied was sentenced to 13 years in State prison and ordered to pay \$120,000 in restitution to State Farm Insurance and First Union Bank after pleading guilty to charges related to conspiracy, theft, criminal usury and insurance fraud. Walterschied had been indicted for conspiring to file fraudulent automobile insurance theft claims with Chubb Insurance Company, State Farm Insurance Company, Liberty Mutual Insurance Company and Hanover Insurance Company. Among the vehicles Walterschied falsely claimed were stolen were a 1996 Lexus ES300, a 1997 Land Rover Discovery and its contents, a 1999 Volkswagen Passat and a 1996 Jaguar XJ 6.

State v. Ben Yu Chang

As part of the investigatin into the automobile give-up scheme involving Walterschied above, on May 28, 2002, Ben Yu Chang, a friend and former employer of

pled guilty to an Accusation charging him with false swearing. Chang admitted that, on June 24, 1999, he gave false information regarding the purported theft of 1997 Land Rover. Chang admitted that, under oath, he falsely told a representative of Hanover Insurance Company that [redacted] had called him (Chang) on his (Chang's) cell phone and told him that his Land Rover had been stolen from the parking lot of a restaurant, and that he had asked Chang for a ride home. On May 28, 2002, Chang was accepted into the PTI Program and was ordered to pay a \$2,000 civil insurance fraud fine.

State v. Doreen Badaan

On March 4, 2002, Doreen Badaan pled guilty to theft by deception for falsely reporting the theft of her BMW to the New York City Police Department. Badaan had actually "given-up" the car to another person in order to get out from under her rental lease. Following the false police report, she submitted a fraudulent insurance claim with State Farm Insurance Company. State Farm paid the BMW Finance Company over \$40,000 to satisfy the balance on the lease and relieve Badaan of any further financial obligation. She was admitted into PTI on the day of her plea conditioned upon her payment of \$17,000 in restitution and payment of a \$2,500 civil insurance fraud fine.

State v. Randy Tavaréz

On November 7, 2002, Randy Tavaréz pled guilty to an Accusation charging him with possession with intent to distribute a controlled dangerous substance and conspiracy to commit theft as part of an automobile give-up scheme. Tavaréz admitted that Guadalupe

Sotomayer, the owner of the vehicle, "gave-up" the vehicle to another to be disposed of so as to prevent its recovery by law enforcement authorities. On March 23, 1999, Sotomayer had reported the vehicle stolen to the Union City Police Department and on April 8, 1999, Sotomayer submitted a false Affidavit of Vehicle Theft to Allstate Insurance Company, resulting in the issuance of claim checks totalling \$7,141.06. While investigation of the give-up scheme was underway, Tavaréz was also arrested for possession of cocaine with intent to distribute. On December 20, 2002, Tavaréz was sentenced to seven and a half years in State prison for the drug charges and a concurrent four year State prison sentence for the conspiracy charge, with a 30 month period of parole ineligibility and credit for 306 days served. This investigation resulted from the cooperation of Pablo Cordero, who agreed to assist State law enforcement authorities after his arrest for his participation in a "chop shop" ring. Cordero had previously been sentenced for his role in the ring to three years probation, conditioned upon his cooperation in subsequent investigations.

State v. Jose Alvarez

On September 27, 2002, a State Grand Jury returned an indictment against Jose Alvarez for conspiracy, theft by deception, tampering with public records and falsifying records. The indictment charges that, on September 7, 1999, Alvarez, a former West New York Police Officer, arranged the "give-up" of his 1997 Toyota Camry with co-conspirator, Alen Hernandez, for the purpose of submitting a fraudulent theft claim with his insurance carrier. Alvarez allegedly turned the vehicle over to Hernandez and reported to the Jersey City police that the vehicle had been stolen. The indictment also alleges that Alvarez submitted a fraudulent



Affidavit of Vehicle Theft to New Jersey Manufacturers Insurance Company resulting in a payment to Alvarez of \$15,665 to settle his claim. This case also resulted from Cordero's cooperation with authorities. Alvarez is awaiting trial.

State v. Cathy Pitbladdo

On March 1, 2002, a Grand Jury indicted Cathy Pitbladdo for attempted theft by deception, alleging that, on May 18, 2000, she falsely reported her 1993 Dodge Intrepid stolen from the Garden State Plaza Mall parking lot to a Paramus Mall Security Guard and a Paramus Police Officer. The indictment alleged that the vehicle was actually recovered in Newark, New Jersey, by the Newark Police Department's Arson Squad on May 15, 2000, three days before Pitbladdo claimed it had been stolen in Paramus. According to the Arson Squad, the vehicle was found engulfed in flames, was a total loss, and arson was suspected. On August 9, 2002, Pitbladdo was admitted into PTI conditioned upon paying a \$4,000 civil insurance fraud fine.

State v. Daniel Mazur, James Freeman & Douglas Powell

On March 14, 2002, a Grand Jury returned an indictment charging Daniel Mazur, James Freeman and Douglas Powell with conspiracy and theft. Mazur was also charged with falsifying or tampering with records. According to the indictment, Mazur, Freeman and Powell conspired to make it appear that Mazur's 1997 Toyota RAV-4 was stolen from the Cherry Hill Mall so that Mazur could file a fraudulent theft claim and avoid further lease payments for the vehicle. The indictment further alleged that Mazur and Freeman brought the vehicle to Ultimate Collision II, which was owned by Powell, left the keys in the vehicle and arranged to have it removed from Ultimate Collision. Mazur and Freeman then allegedly returned to the Cherry Hill Mall, where Mazur falsely reported the RAV-4 stolen to the Cherry Hill Police Department. Mazur subsequently submitted a claim to

Liberty Mutual Insurance Company, resulting in Liberty Mutual's issuance of a check of \$16,085 to the leasing company. All three were ultimately admitted into the PTI Program conditioned upon their jointly paying restitution to Liberty Mutual in the amount of \$16,085.

State v. Anna Sypniewski

On June 14, 2002, Anna Sypniewski pled guilty to an Accusation charging her with attempted theft by deception. She admitted that, on June 13, 2001, she had falsely reported to the Woodbridge Police Department that her 1999 Toyota 4Runner had been stolen from the Woodbridge Mall parking lot. Sypniewski also admitted filing a false Affidavit of Vehicle Theft with Motor Club of America Insurance Company in conjunction with her insurance claim. According to Sypniewski, at the time of the alleged theft, her vehicle was actually parked in the long term parking lot at JFK Airport. On September 18, 2002, Sypniewski was admitted into the PTI Program, ordered to pay restitution in the amount of \$1,327.34 and agreed to pay a civil insurance fraud fine of \$5,000.

State v. Geuris Valdez-Fernandez

On September 26, 2002, Geuris Valdez-Fernandez pled guilty to an Accusation charging him with conspiracy. He admitted that, on October 17, 2001, he purposely gave his 1998 Toyota Camry to another individual to dispose of in order to file a fraudulent insurance claim and have the insurance company pay off his outstanding loan obligation.

False Automobile Insurance Claims

State v. Peter Halabi

On December 19, 2002, Peter Halabi was admitted into the PTI program conditioned on paying a civil insurance fraud fine of \$1,000, continuing gainful employment, and community service. Halabi previously pled

guilty to an Accusation charging him with conspiracy for lying to a fraud investigator from American International Group regarding a fraudulent automobile insurance claim filed by a colleague.

State v. Okpon Inokon

On January 16, 2002, a Grand Jury returned an indictment charging Okpon Inokon with conspiracy, attempted theft by deception, tampering with public records or information and falsifying records. The indictment alleged that Inokon rented a car from Alamo Rent-A-Car for one day and purchased a Personal Property Protection Plan insurance policy offered by Alamo. Inokon allegedly subsequently reported to the Newark Police Department that the rental car had been broken into and that personal items valued at \$4,800 were stolen from the vehicle. The indictment further alleged that Inokon filed a false Personal Effects Loss Report to the insurance claims administrator for Alamo, claiming the value of the items stolen totaled approximately \$6,821.96. On August 22, 2002, Inokon was arrested on unrelated charges and was remanded to the Hudson County Jail on both the unrelated charges and the fugitive bench warrant issued in this case. Inokon subsequently pled guilty to conspiracy, attempted theft by deception, and tampering with public records or information. On December 19, 2002, Inokon was admitted into PTI, conditioned upon performing 100 hours of community service and paying a \$1,500 civil insurance fraud fine.

State v. Narendra Solanki

On December 12, 2002, Narendra Solanki pled guilty to an Accusation charging him with falsifying records. Solanki admitted that, on May 29, 1998, he falsely reported to the North Brunswick Police Department that his car had been burglarized and that his car had been looted of approximately \$8,000 in cash and gift items. Solanki also admitted that he made a fraudulent theft claim to State Farm Insurance Company in the amount of \$8,000.

In order to support his claim, Solanki admitted submitting phony receipts that were provided to him by Timetron Watch Company, located in Edison, New Jersey. This investigation is continuing, and additional civil or criminal insurance fraud penalties against other persons who may have assisted Solanki are pending.

False Automobile Insurance Theft Claims

State v. James Calabrese

On January 4, 2002, James Calabrese was sentenced to 120 days in the electronic monitoring program, two years probation, and ordered to pay restitution in the amount of \$2,240. Calabrese pled guilty to attempted theft by deception for falsely reporting the theft of his Cadillac to a Margate City police officer the day before the car's lease was to expire. After reporting the theft to police, he filed a fraudulent theft claim with his insurance company, Prudential. The car had been found abandoned by Philadelphia police officers prior to the day on which Calabrese claimed the vehicle had been stolen.

State v. Trisha Townsend

On June 25, 2002, Trisha Townsend was indicted and charged with attempted theft by deception. According to the indictment, on May 26, 2001, Townsend falsely reported to the Trenton Police Department that her 1994 Dodge Intrepid had been stolen. Townsend allegedly filed a fraudulent auto theft claim with her insurance company, New Jersey Manufacturers Insurance Company, four days later. Townsend's case is pending trial.

State v. Ivan Alas

On October 25, 2002, Ivan Alas was sentenced to three years probation and ordered to pay a \$4,500 civil insurance fraud fine. Alas pled guilty to attempted theft by deception for filing a fraudulent insurance claim for the theft of his 1996 Dodge Stratus.

State v. Antonio Gil

On August 22, 2002, Antonio Gil pled guilty

to an Accusation charging him with falsifying records. Gil admitted that on June 18, 2001, he knowingly submitted a false Affidavit of Vehicle Theft to Palisades Safety and Insurance Association for the purpose of obtaining insurance claim money under false pretenses. Gil was admitted into the PTI Program, conditioned upon paying restitution in the amount of \$3,391. Gil was also ordered to pay a civil insurance fraud fine in the amount of \$2,500.

State v. Robert E. Smith

On October 17, 2002, a Grand Jury returned an indictment charging Robert E. Smith with theft by deception, unsworn falsification to authorities and falsifying or tampering with records. According to the indictment, sometime between October 14 and November 22, 1999, Smith reported to the Moorestown Police Department that his former wife's 1994 Saab 900 had been stolen from the Moorestown Mall parking lot. The indictment further alleges that on October 26, 1999, Smith signed and submitted an Affidavit of Theft to Allstate Insurance Company falsely stating that the vehicle had been stolen from the Moorestown Mall and that Allstate Insurance Company paid approximately \$12,000 on the theft claim. The State intends to prove that, two weeks prior to the purported date of theft on October 14, 1999, the car had been involved in a police chase and abandoned in Camden City. Investigation revealed that the Camden police impounded the car and that it was towed to a garage in Pennsauken where it remained until June 18, 2001. Smith's case is pending trial.

State v. Anna White

On December 19, 2002, a Grand Jury returned an indictment charging Anna White with

falsifying records. According to the indictment, on June 2, 2001, White submitted a falsified Affidavit of Theft for her 1992 Dodge Caravan to Ohio Casualty Insurance Company in conjunction with a fraudulent insurance claim. The State intends to prove that White had, in fact, loaned her van to another person who was then involved in an accident, but instead, White wanted the insurance carrier to believe her car was damaged because it was stolen. White's case is pending trial.

State v. Donald Bracco

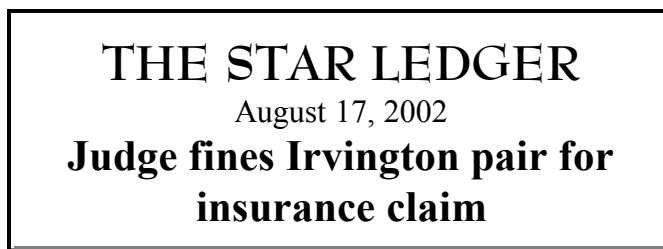
On December 23, 2002, Donald Bracco pled guilty to an Accusation charging him with tampering with public records or information. Bracco admitted that, on November 30, 2001, he submitted a fraudulent report to the Old Bridge Police Department, claiming that his 2001 Ford Explorer, which he was leasing from Ford Motor Credit, had been stolen. Bracco knew that the vehicle had not been stolen, but had, in fact, been abandoned in Marlboro, New Jersey where it was recovered by the Marlboro Police Department.

Phony Personal Injury Protection (PIP) Claims

State v. Richard Williams, Suzette Tanner & William Ebron

On June 6, 2002, Suzette Tanner and William Ebron pled guilty to separate Accusations each charging theft by deception. In their pleas, Tanner and

Ebron admitted that they, along with two other persons who have not yet been charged, were involved in a phony automobile accident on May 16, 2001, in Newark. The staged accident had been reported as a hit and run to the Newark Police Department and listed Tanner as the driver and Ebron and two other persons as passengers. PIP claims in the



approximate amounts of \$5,593 for Tanner and \$5,622 for Ebron, as well as property damage claims in the approximate amount of \$5,248 for damage allegedly sustained to the vehicle in the phony accident, were submitted to Metropolitan Property and Casualty Insurance. Metropolitan paid only the property damage claim to Tanner in the amount of \$5,248. Tanner and Ebron also admitted that, on August 6, 2001, they had falsely reported to the East Orange Police Department that Tanner's 2000 Ford Focus had been stolen, when they had actually hidden it behind a house near their residence in Irvington. Ebron and another person stripped parts from the vehicle and attempted to sell the parts to an auto body shop in Newark. Tanner and Ebron also submitted a fraudulent stolen vehicle insurance claim to Metropolitan, for which they received \$9,442. On July 26, 2002, Tanner was sentenced to four years probation, ordered to pay \$14,690 in restitution and a \$5,000 civil insurance fraud fine. On August 16, 2002, Ebron was sentenced to four years probation and ordered to pay \$14,690 in restitution and a \$5,000 civil insurance fraud fine.

State v. Dolores Stover

On July 17, 2002, Dolores Stover pled guilty to an Accusation charging her with attempted theft by deception. Stover admitted that she had submitted a false PIP claim to Liberty Mutual Insurance Company for an automobile accident that took place on April 5, 2001, in Newark, New Jersey. Stover explained that, although the automobile accident actually did occur as claimed, she had not been injured in the accident. Stover's phony claim for \$5,094 was denied by Liberty Mutual. On September 17, 2002, Stover was sentenced to four years probation and ordered to pay a \$5,000 civil insurance fraud fine.

State v. John Datus & Bellamy Antoine

On January 4, 2002,

Bellamy Antoine was sentenced to five years probation, conditioned upon 200 hours of community service, and ordered to pay restitution in the approximate amount of \$12,000 and a civil insurance fraud fine of \$7,500, on charges of conspiracy, health care claims fraud and theft by deception. The theft by deception charges stemmed from an automobile accident which Antoine admitted to staging on July 16, 1997. Following that staged accident, Antoine began a course of chiropractic treatment at Allied Trauma and Health Care Center for injuries alleged to have been sustained in the purported accident. PIP claims for Antoine's treatment were submitted to Newark Insurance Company, for which Newark Insurance Company paid \$4,619.75. Antoine, a former Irvington resident, also filed a bodily injury claim for non-economic losses with Allstate Insurance Company and settled it for \$4,500. The conspiracy and health care claims fraud charges related to another scam in which he had conspired with John Datus to assume a fictitious identity and fake injuries from a purported automobile accident. Datus had previously been sentenced to four years probation, payment of restitution in the amount of \$2,500 and payment of a civil insurance fraud fine in the amount of \$2,500 for his role in that scheme.

State v. Yvonne Blakney, et al.

On November 15, 2002, Lareen Blakney-Reed and Danielle Miller were sentenced for their roles in a conspiracy to falsely claim that they were injured in an automobile accident in order to generate substantial bills for medical treatment, which was paid by the General Accident Insurance Company. The scheme started when Loreen Blakney falsely reported to the Camden Police Department on August 9, 1997, that, while driving, her vehicle was struck by an unidentified hit and run driver. She also claimed that Lareen Blakney-

<p style="text-align: center;">THE STAR LEDGER January 6, 2002 Ex-Irvington man gets probation and fine for car insurance scam</p>
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Reed, Loreen's twin sister, Yvonne Blakney, Lareen's daughter, and Danielle Miller, a friend, were passengers in the vehicle. Following the falsely reported accident, all four allegedly received treatment from medical service providers, causing General Accident Insurance to pay PIP medical payments totalling over \$47,000. Lareen Blakney-Reed was sentenced to 18 months probation and ordered to pay \$12,041 in restitution, while Danielle Miller was sentenced to one year probation and ordered to pay \$9,143 in restitution. On December 13, 2002, Loreen Blakney was sentenced to three years probation and ordered to pay \$15,916 in restitution.

State v. Ali Harvey, Roy Bailey & Irene Smith

On September 30, 2002, a Grand Jury returned an indictment charging Roy Bailey and Irene Smith with conspiracy and attempted theft by deception. According to the indictment, on February 11, 1997, Ali Harvey, Bailey and Smith reported to the Newark Police Department that they were passengers in an automobile which was struck by another vehicle that ran a stop sign and fled. The indictment alleges that the accident never occurred and that they treated at an East Orange chiropractic clinic for purported injuries they claim to have sustained in the phony accident so that PIP claims could be submitted to the insurance company. The indictment further alleges that, Harvey, Bailey and Smith submitted phony bodily injury and PIP claims to State Farm Insurance, which claims were denied. Harvey had previously pled guilty to an Accusation charging him with conspiracy for his role in the alleged scheme. He was later admitted into the PTI Program and ordered to complete 50 hours of community service. On November 22, 2002, Bailey was arrested pursuant to a bench warrant issued for unrelated charges and arraigned in Essex County Superior Court. Bailey's and Smith's cases are now pending trial.

State v. Rene Obredor

On November 18, 2002, Rene Obredor pled guilty to an Accusation charging him with attempted theft by deception. Obredor admitted that he caused a purported Glenwood Police Department automobile accident report to falsely reflect that, on February 11, 1999, he had been injured in an automobile accident. Obredor also admitted that he used the falsified police accident report to pursue an automobile insurance PIP claim which he submitted, along with several other falsified claim documents, to First Trenton Indemnity Insurance Company and New Jersey Manufacturers Insurance Company. At his guilty plea hearing, Obredor admitted that he sought medical treatment for purported injuries arising from the accident, even though he was not really injured as he had claimed to the insurance companies. Fraudulent PIP claims totalling approximately \$5,000 were submitted to the insurance companies before the scam was uncovered. The insurance companies denied the claims, however, and referred the case to OIFP for investigation.

State v. Philip Major, et al.

This complex OIFP case advanced significantly during the past year as 21 defendants pled guilty to charges of theft or attempted theft by deception as part of the continuing investigation and prosecution of former East Orange police officer, Philip Major, and others. Major previously pled guilty to official misconduct and related charges for writing false police accident reports to be used in making phony insurance claims. The pleas from these 21 defendants accounted for some \$193,000 of the approximately \$900,000 in fraudulent PIP insurance claims which have been tied to Major's malfeasance. Of the 21 defendants, all have been sentenced to terms ranging from admission into the PTI Program to five years probation, and ordered to pay restitution in the approximate total amount of \$48,094.06. It is anticipated that additional subjects may be charged.

Nicholas Rosania & Annette Licea

On April 12, 2002, Nicholas Rosania, co-owner of the West New York Chiropractic Center, was sentenced to four years in State prison following his conviction for conspiracy, official misconduct and bribery after a February, 2002 jury trial. Rosania paid an intermediary, Annette Licea, to bribe a North Bergen Police Department Communications Supervisor to obtain accident reports, including computer printouts. The reports and printouts were obtained to identify persons who had been involved in accidents who might be recruited as patients in order to submit PIP medical claims to insurance companies. Previously, on March 15, 2002, Licea was sentenced to two years probation and ordered to pay a \$1,000 civil insurance fraud fine.

Receiving Stolen Property

State v. Paul Struller

On April 12, 2002, Paul Struller was sentenced to five years State prison, and ordered to pay \$111,243.93 in restitution and a \$10,000 civil insurance fraud fine for pleading guilty to receiving stolen vehicles. Struller, the owner and operator of an auto body shop in Garfield, New Jersey, had received, or brought into New Jersey, a 1997 Land Rover truck, a 1997 BMW, a 1995 BMW and a 1999 Acura, knowing that the automobiles had been stolen. The vehicles, having a total "book value" in excess of \$140,000, had been reported stolen and their owners had submitted theft claims to several insurance companies, including Liberty Mutual Insurance Company, Allstate Insurance Company, and First Trenton Insurance Company.

State v. Frank Thomas Holgate

On June 24, 2002, Frank Thomas Holgate pled guilty to an Accusation charging him with receiving stolen property. Holgate, the owner of Best Buys Auto Parts and an auto scrap yard, admitted to receiving approximately 48 vehicles, and parts of other vehicles, which were identified by the West Milford Police Department, the New Jersey State Police and OIFP as having been previously reported stolen. Some of the automobiles were involved in owner initiated "give-ups" so that fraudulent auto insurance claims could be filed by their owners. Holgate is awaiting sentencing.

Staged Accidents

State v. ABP Chiropractic, Anhuar Bandy, Alejandro Ventura, Elvin Castillo, Raynaldo Cuevas, Cesar Caba, Victor Almonte and 22 Other Defendants

OIFP made significant progress in 2002 in its first large scale investigation and prosecution under the Health Care Claims Fraud Act involving a staged accident ring. On April 15, 2002, a grand jury returned ten indictments charging 28 defendants with a variety of charges, including racketeering, conspiracy, health care claims fraud, attempted theft and theft by deception, use of a 17 year old or younger juvenile to commit a criminal offense and possession of a weapon without a permit. The indictments allege that the defendants

participated in phony automobile accidents in and around Union County in order to submit false insurance PIP claims. Arrest warrants were issued in conjunction with the unsealing of the indictments on May 16, 2002. In the ensuing days, 11 of the defendants were arrested. Six of the 28 defendants, Anhuar Bandy, Alejandro Ventura, Elvin Castillo, Raynaldo Cuevas, Cesar Caba and Victor

**THE BERGEN
RECORD**
April 13, 2002
**Shop owner gets 5 years in
stolen-vehicles case**

Almonte, were charged as racketeers. These six defendants, including Anhuar Bandy, who owned, controlled and/or operated as the chief corporate officer of six North Jersey chiropractic clinics, allegedly "constructed" eight phony automobile accidents. As a result of these phony automobile accidents, PIP insurance claims in excess of \$331,000 were allegedly submitted to several insurance companies. In addition, the ring was allegedly responsible for more than 90 other automobile accidents, generating insurance claims in excess of \$2 million. According to the indictments, accidents were staged or "constructed" by obtaining vehicles to be used in the crashes, recruiting people to act as drivers and passengers, causing the crashes to occur, and sending the recruited drivers and passengers to treat as patients at chiropractic clinics in order to generate phony medical bills under their PIP insurance coverage.

One of the indictments alleges that Ventura, Castillo, Cuevas, Caba, and Almonte acted as "runners" and recruited persons to participate

in the phony automobile accidents. According to the indictments, the persons who participated in the phony accidents became patients at several of the Bandy owned, controlled or operated chiropractic clinics, as well as at other medical service provider offices, even though they had not been injured in any of the phony accidents. As explained in the indictment, the runners were sometimes known as "constructors" because they allegedly constructed these automobile accidents. In some of the phony accidents, the people occupying the cars were allegedly aware of the phony nature of the automobile accidents, while, in others, they were not.

The remaining twenty two defendants were charged as participants in the eight phony automobile accidents, allegedly submitting, or causing to be submitted, fraudulent PIP insurance claims for chiropractic treatments

rendered by the Bandy or other clinics to insurance companies for injuries allegedly sustained. The indictments, collectively, allege that, in total, PIP claims were submitted to approximately 24 insurance companies, including Allstate Insurance Company, Kemper Insurance Company, MDA/Newark Insurance Company, Prudential Insurance Company, Republic Western Insurance Company (U-Haul of Arizona), Selective Insurance Company, Sentry Insurance Company, State Farm Insurance Company, Bayside Casualty, Clarendon National, Continental Insurance, Farm Family Insurance Company, Liberty Mutual Insurance Company, Maryland Insurance Company, The Moxon Company, National Continental Progressive, National General Insurance Company, N.J. Cure, Ohio Casualty Insurance Company, Parkway Insurance, Progressive

Casualty, Red Oak Insurance Company, United States Automobile Association (USAA), and New Jersey Manufacturers Insurance Company.

Home News Tribune
July 24, 2002
Insurance-fraud ring is claimed

Some counts of the indictments also allege that defendants used children to participate in these fake accidents and file phony insurance claims. Ventura was charged with two counts of using a 17 year old or younger juvenile to commit a criminal offense, both counts in the first degree. Additionally, Angelita Guerrero was charged with use of a 17 year old or younger juvenile to commit a criminal offense. The juveniles were not charged. Ventura was also charged with one count of possession of a weapon without a permit. The weapon was located and confiscated during the execution of a search warrant by OIFP. Previously, as part of the investigation leading to these indictments, on July 13, 1999, OIFP obtained 12 arrest warrants and arrested 11 persons for charges related to this investigation. In addition to the 1999 arrests, OIFP executed search

warrants at five chiropractic clinics which were allegedly Bandy owned, operated or controlled, namely, the Elizabeth Injury Center, Inc., P.C., the Amboy Injury Center, Inc., Prospect Spinal Trauma Center, Plainfield Injury Center, Inc., and Golden Medical Center, P.C. Search warrants were also executed at Bandy's and Ventura's private residences. Of the eleven persons arrested in July of 1999, OIFP has obtained guilty pleas from six. Three additional defendants, who were not arrested as part of the July 1999 raid, have also pled guilty. A number of the conspirators pled guilty to various counts in the indictments in 2002, stemming from their participation in the ring. On October 31, 2002, Raynaldo Cuevas pled guilty to conspiracy to commit racketeering. On August 13, 2002, Dignorah Flores pled guilty to theft by deception for submitting a false PIP insurance claim. On September 16, 2002, Humberto Diaz pled guilty to theft by deception, also for submitting a false PIP insurance claim. On September 23, 2002, Mayreni Guerrero pled guilty to theft by deception for submitting a false PIP insurance claim. On September 26, 2002, Mohammed Attalla pled guilty to theft by deception based on the submission of a false PIP insurance claim. On October 7, 2002, Joel Cuevas pled guilty to conspiracy to commit health care claims fraud. On November 4, 2002, Widania Montanez pled guilty to theft by deception. On November 8, 2002, Angelita Guerrero pled guilty to theft by deception and using a minor to commit a criminal offense. On November 12, 2002, Ramon Reyes pled guilty to conspiracy to commit health care claims fraud and theft by deception.

State v. John Groff, et al.
On September 25, 2002, John Groff pled guilty to attempted theft by deception. Groff admitted that he conspired with more than two dozen other defendants to stage

**BURLINGTON
COUNTY TIMES**
October 29, 2002
**Woman admits role in
fake car accident**

automobile accidents in various municipalities in and around Camden County. Groff and Luis Ruiz, a co-defendant, essentially acted as "runners" in conspiring with 27 other defendants to stage a total of seven automobile accidents involving some 27 claimants. The phony accidents resulted in the submission of false police reports to police departments in Pennsauken, Voorhees, Cherry Hill, Belmawr, Camden and Gloucester Township and the submission of fraudulent PIP medical insurance claims totalling more than \$96,000 to five insurance carriers. These carriers included Allstate Insurance Company, State Farm Insurance Company, Liberty Mutual Insurance Company, Prudential Insurance Company and Material Damage Adjustment Corporation. When the insurance carriers became suspicious of the claims, they declined to make any payments to the conspirators. Groff's main co-defendant, Luis Ruiz, was sentenced on March 15, 2002, to three years State prison, with a one year period of parole ineligibility. Ruiz was also ordered to pay a \$20,000 civil insurance fraud fine. On May 15, 2002, another participant, Anthony Flores, was sentenced to three years probation and ordered to pay a \$1,000 civil insurance fraud fine after pleading guilty to his participation in the conspiracy. On May 17, 2002, another participant, Elvin Flores, was sentenced to 364 days as a condition of probation, which he was permitted to serve under house arrest after pleading guilty. Elvin Flores also signed a consent order agreeing to pay a \$1,000 civil insurance fraud fine. Eighteen other defendants were admitted into PTI, conditioned upon their payment of a \$1,000 civil insurance fraud fine and cooperation with the State in its prosecution of Groff. Groff is now awaiting sentencing.

*State v. Robin Ellison,
Denise Gaines, Patricia
Oglesby & Deborah
Thomas*

On October 21, 2002, Denise Gaines, Patricia Oglesby, and Deborah Thomas each pled guilty to theft by deception for falsely claiming that they had been injured in an automobile accident while passengers in an automobile driven by co-defendant, Robin Ellison, in Philadelphia, Pennsylvania, on April 10, 1998. They admitted that, despite Ellison's report to her insurance company, State Farm, to the contrary, no accident had occurred, nor had they sustained any injuries as passengers in Ellison's vehicle. Ellison, herself, pled guilty to conspiracy and health care claims fraud on October 28, 2002. All four are awaiting sentencing.

State v. Nelson Soares

On December 20, 2002, a State Grand Jury returned an indictment charging Nelson Soares with conspiracy, theft by deception, and hindering apprehension. The indictment alleges that, on August 21, 1998, Soares and several others, who were not identified in the indictment, rented a U-Haul truck with the intent to use it to purposely cause an accident to generate a phony insurance claim. The indictment specifically alleges that Soares drove the U-Haul truck into a 1994 BMW and falsely reported to the Newark Police Department that an automobile accident had occurred. This case is pending trial.

Fictitious Documents

State v. Jenette Thomas-Malik, Regina Bryan, Yolanda Daniels a/k/a Yolanda Adams & Kareem Young

On March 8, 2002 a Grand Jury indicted Jenette Thomas-Malik and Yolanda Daniels, a/k/a Yolanda Adams, charging them with conspiracy, theft by deception, simulating a motor vehicle card, forgery and possession of CDS. The indictment specifically alleges that for a fee of \$600, Thomas-Malik, Regina Bryan and Daniels sold "insurance" in the form of phony identification cards and phony declaration pages. On February 26, 2002, Kareem Young, a co-conspirator who had pled

guilty to theft by deception, was sentenced to 27 days in jail as a condition of a three year probationary sentence. He was also ordered to seek, obtain and maintain employment as a condition of probation. On February 26, 2002, Regina Bryan, another conspirator who had previously pled guilty to conspiracy, was sentenced to one year probation, conditioned upon maintaining employment and continued attendance in a drug rehabilitation program. On October 15, 2002, Thomas-Malik pled guilty to conspiracy, simulating a motor vehicle insurance card, and possession of a controlled dangerous substance. Thomas-Malik is awaiting sentencing. Daniels' case is pending trial.

State v. Herbert Jackson & Hector Torres

On April 17, 2002, a Grand Jury returned an indictment charging Herbert Jackson and Hector Torres with conspiracy, sale of simulated documents and forgery. Jackson and Torres allegedly obtained personal information from several individuals and used these personal identifiers to create and sell fictitious motor vehicle licenses for \$450 each. Both pled guilty. On November 1, 2002, Jackson was sentenced to 3 years probation and ordered to serve 150 hours of community service. Torres awaits sentencing.

Jorge Fonseca & Joe Hojas

On July 9, 2002, in the course of a Division of Motor Vehicles related investigation into the sale of fraudulent motor vehicle documents, OIFP investigators arrested and charged Jorge Fonseca with conspiracy to commit official misconduct and the sale or transfer of a simulated document. Joe Hojas was also arrested and charged with official misconduct and sale or transfer of a simulated document. Bail was set at \$500,000 for Fonseca and \$100,000 for Hojas. These cases are pending action by the Grand Jury.

State v. Lisa Brown

On October 15, 2002, Lisa Brown pled guilty to an Accusation charging her with simulating

a motor vehicle insurance identification card. Brown admitted that, on February 13, 2002, she presented a counterfeit automobile insurance identification card, purportedly issued by State Farm Insurance, while having her automobile inspected at the DMV Inspection Station in Lawrenceville. On December 6, 2002, she was admitted into PTI, conditioned upon serving 25 hours of community service.

State v. Jimmy Gurzkovic

On September 26, 2002, a Grand Jury returned an indictment charging Jimmy Gurzkovic with simulating a motor vehicle insurance identification card. According to the indictment, between May 16 and 21, 2001, Gurzkovic, who owned and operated F&G Auto Repair, sold two phony, blank automobile insurance identification cards to an undercover State Investigator. The case is pending trial.

State v. Axel Aviles

On August 23, 2002, Axel Aviles pled guilty to an Accusation charging him with simulating a motor vehicle identification card. Aviles also pled guilty to a separate Accusation charging him with receiving stolen property. The investigation leading to his guilty pleas began when State Police detectives went to Aviles' residence on May 13, 2002, to serve a fugitive bench warrant and arrest him for prior unrelated charges for possessing a controlled dangerous substance. When the officers arrived at Aviles' residence, they located a computer and related equipment which Aviles used to create phony New Jersey insurance identification cards in the name of the Camden Fire Insurance Association. In the back of Aviles' residence, New Jersey State Police also located a 2001 Suzuki GSX 600 motorcycle which had been reported stolen on February 24, 2002, in Camden. Aviles was arrested by the State Police and charged with fraudulent insurance identification cards and receiving stolen property. On October 4, 2002, Aviles was sentenced to three years in State prison.

State v. Eddy Joseph

On November 4, 2002, Eddy Joseph pled guilty to an Accusation charging him with sale of simulated documents. Joseph admitted that he produced counterfeit U.S. Department of Defense DD214 Discharge forms. A DD214 form is used to verify military service and discharge status and can be used for identification purposes to obtain a driver's license. On December 16, 2002, Joseph was admitted into PTI, conditioned upon serving 50 hours of community service.

State v. Gerry Frederique

On November 26, 2002, a Grand Jury returned an indictment charging Gerry Frederique with simulating a motor vehicle insurance identification card. The indictment alleges that, on August 2, 2001, Frederique presented a phony motor vehicle insurance identification card to an Irvington Police Officer, knowing that the insurance I.D. card, purportedly issued by the Colonial Penn Insurance Company, was fake. Frederique allegedly presented the card to the Irvington Police Officer when the police officer questioned him about an illegally parked 1999 Honda Accord. Frederique's case is pending trial.

State v. Regina Lasane

On November 26, 2002, a Grand Jury returned an indictment charging Regina Lasane with simulating a motor vehicle insurance identification card. Lasane is accused of presenting a phony motor vehicle insurance identification card to an Irvington Police Officer, knowing that the insurance I.D. card, purportedly issued by the Allstate Insurance Company, was counterfeit. Lasane was trying to retrieve her impounded 1989 Honda from the Irvington Police Department impound yard. When asked for proof of insurance, she allegedly presented the fictitious I.D. card. Lasane's case is pending trial.

State v. Howard Greenberg

On December 6, 2002, Howard Greenberg pled guilty to an Accusation charging him with

simulating a motor vehicle insurance identification card. Greenberg admitted that he created a fictitious automobile insurance I.D. card, purportedly issued by General Accident Insurance Company, and displayed it at the Division of Motor Vehicles as proof of insurance. DMV personnel, suspecting the card was fake, called the State Police. Greenberg is awaiting sentencing.

State v. John Galiuzzi

On December 3, 2002, John Galiuzzi pled guilty to an Accusation charging him with simulating a motor vehicle insurance identification card. Galiuzzi admitted that he produced and sold phony motor vehicle insurance identification cards, purportedly issued by Selective Insurance Company of America and the Barclay Insurance Company. He also admitted presenting a fictitious motor vehicle insurance identification card to a law enforcement officer during a traffic stop. Galiuzzi is awaiting sentencing.

State v. Jose Rafael Perez

As part of the ABP Chiropractic staged auto accident investigation, in which 28 defendants were indicted for racketeering, conspiracy, theft and health care claims fraud, on October 7, 2002, Jose Rafael Perez was charged by an Accusation with one count of fourth degree sale of a simulated document, a false driver's license. The case is pending trial.

**HEALTH, LIFE AND DISABILITY
FRAUD**

Provider Fraud

State v. Larry Kramer

On July 11, 2002, Larry Kramer owner and

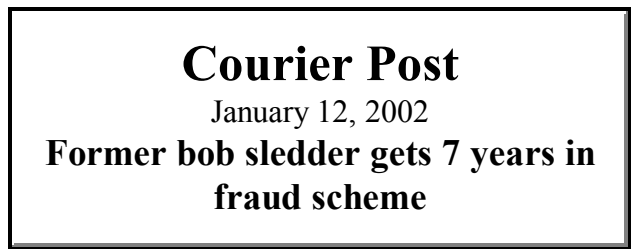
operator of Englewood Cliffs Pharmacy, pled guilty to an Accusation which charged him with theft by deception. Kramer admitted that, between December of 1996 and March of 1999, he submitted approximately \$60,000 in fraudulent prescriptions to PAID Prescriptions, LLC, a third party payor, by making it appear that eight doctors had examined patients and prescribed the medications when, in fact, the doctors had not seen the patients or prescribed the medicines. Kramer thereafter falsely billed PAID Prescriptions as if his pharmacy had filled the prescriptions. Previously, on December 13, 2000, the State Board of Pharmacy revoked Kramer's pharmacist license based on this conduct. On September 20, 2002, Kramer was sentenced to five years probation and ordered to pay \$46,760 in restitution to PAID Prescriptions, LLC. He was also ordered to pay costs and fines of the Pharmacy Board in the amount of \$27,000.

State v. John Amabile

On January 11, 2002, John Amabile, formerly a licensed optometrist from Monmouth County, was sentenced to seven years State prison, and ordered to pay a criminal fine of \$100,000 and \$97,975 in restitution.

In addition, the State began the process of imposing \$810,000 in civil insurance fraud penalties. Amabile had previously been convicted, following a 34 day jury trial, of

conspiracy, theft by deception, falsifying records, and falsification of records relating to medical care. Amabile had attempted to defraud 29 insurance carriers and health benefits plans of more than \$200,000 by submitting false health insurance claims. Amabile attracted large numbers of patients to his offices by offering routine eye exams and glasses at little or no cost. Amabile then used the patients' insurance information to bill their



carriers for optometric services which he had not provided. Amabile directed his staff to create approximately 997 false patient records and charts in the event an insurance company conducted an audit of the health insurance claims Amabile submitted for payment. Amabile's license had previously been revoked by the State Board of Optometrists and a \$1.1 million civil penalty had already been imposed. Prior to his prosecution by OIFP, Amabile had gained recognition as a member of the Puerto Rican National Bobsled Team that participated in the 1998 Winter Olympics.

State v. David Fink, Ph.D.

On August 5, 2002, David Fink, a licensed psychologist, was sentenced to three years probation and ordered to pay a civil insurance fraud fine of \$3,000 after pleading guilty to health care claims fraud. Fink admitted submitting fraudulent claims to Oxford Health Plans for medical services he never provided. Fink had been paid \$1,198 for the phony claims. Fink also surrendered his psychologist's license.

State v. Elliot Heller, M.D.

On December 18, 2002, Dr. Elliot Heller, a plastic surgeon who owned and operated the Ear, Nose, Throat Group of N.J./Plastic Surgery Associates of N.J. ENT in Edison, was sentenced to three years State prison for fraudulently billing for plastic surgery related procedures he had not rendered. Heller had also paid \$321,000 in restitution and a \$100,000 civil insurance fraud fine prior to his sentencing. Heller apparently committed the crimes because most health insurance companies will ordinarily not pay for plastic surgery related to the nose or sinuses unless that surgery is necessary to correct an underlying medical condition. Otherwise, such surgery is deemed to be "cosmetic" and not medically necessary. If patients of ENT did not have a serious enough underlying medical sinus condition to justify payment for the surgery by the health insurance carriers, Heller billed the insurance companies for multiple

sinus procedures that he fraudulently reported as "medically necessary," but which he never performed. Heller also bilked insurance companies by performing a surgical procedure which was compensable by health insurance, but billed the insurance companies as if an out-of-network doctor provided the service, so that Heller could bill for a greater amount for the surgery. As a result, the insurance carrier would reimburse Heller and ENT at the higher out-of-network rate based on the misrepresentation that the other doctor had performed the surgery. Heller also altered or added diagnosis codes and service codes on patient records that were submitted to the insurance carriers in order to inflate the amount of the reimbursements he received from them. In total, Heller submitted bills exceeding \$1 million, which generated payments of approximately \$500,000 from the victimized insurance carriers, which included Aetna, All America Financial, Blue Cross/Blue Shield, Celtic Life, Chubb Colonial Life, Cigna, Great West Life and Annuity, MetraHealth, New Jersey Car, Pacific Life, Prudential, Unicare, United Healthcare, Guardian, HealthNet, Humana, Indecs Corp., MagnaCare, USI Administrators, U.S. Life, Allstate, Insignia Financial Group, Oxford Health, U.S. Healthcare, and Local 734 Employee Welfare Fund of AFL-CIO.

State v. Robert Cohen

As part of OIFP's investigation into the fraud committed by Dr. Heller, above, Robert Cohen pled guilty to an Accusation on March 15, 2002, charging him with conspiracy and theft by deception. Cohen, licensed as a Certified Registered Nurse Anesthetist (CRNA), was an independent contractor who administered anesthesia to patients undergoing surgical procedures in Heller's medical office. Cohen admitted that, as a CRNA, he submitted approximately \$11,600 in fraudulent billings to insurance companies for anesthesia services he falsely claimed to have administered to patients at the Ear, Nose, Throat Group of N.J./Plastic Surgery Associates of N.J. (ENT), in Edison,

New Jersey. Cohen collected approximately \$8,800 from the insurance companies for these fraudulent billings before he was caught. On May 20, 2002, Cohen was sentenced to two years probation and ordered to pay \$9,677.35 in restitution and a \$4,000 civil insurance fraud fine.

State v. Maria Cacoilo

In another case stemming from the Heller investigation, above, on June 14, 2002, Maria Cacoilo pled guilty to an Accusation charging her with falsification of medical records relating to several thousand dollars of fraudulent billings. Cacoilo, who was Heller's office manager, admitted that she falsified certain records to obtain insurance coverage from certain health insurance carriers for patients. Among the records she falsified were records that insurance carriers required to "pre-certify" certain sinus surgical procedures before they would agree to pay for those procedures. Carriers will ordinarily not pay for plastic surgery related to the nose or sinuses unless that surgery is necessary to correct an underlying medical condition. If the patient did not have a serious enough underlying medical sinus condition to justify payment for the surgery by the health insurance carriers, Cacoilo, in some cases, would falsify the "pre-certification" forms by "cutting and pasting" from the records of other patients. In so doing, Cacoilo made it appear as if a particular patient had a more serious underlying sinus condition so that the plastic surgery related to the nose would be paid by the carrier. The investigation conducted by OIFP identified several files where false pre-certification forms

were submitted to health insurance carriers to induce them to pay for surgery. On September 27, 2002, Cacoilo was sentenced to three years probation and ordered to pay a civil insurance fraud fine of \$2,500.

State v. Martin Weinstein, D.P.M.

On November 18, 2002, OIFP investigators arrested Martin Weinstein, a licensed podiatrist, on a bench warrant issued for his failure to appear at a contempt hearing. The hearing pertained to his failure to respond to a Subpoena demanding that he produce records during the course of an insurance fraud investigation. It is alleged that between 1997 and 1998, Weinstein billed Horizon Blue Cross/Blue Shield more than \$250,000 for podiatric services he never rendered. The investigation is continuing.

State v. Arthur Dinkel

On December 17, 2002, Arthur Dinkel, a former psychologist who owned and practiced at two Paramus psychotherapy clinics, pled guilty to an Accusation charging him with theft by deception. Dinkel admitted that, between January of 1998 and March of 1999, he submitted fraudulent billings to various insurance carriers. These fraudulent billings

included overbilling for psychological services rendered, falsely billing the insurance policies of certain patients for psychological services rendered

knowing that these psychological services were rendered to other patients not covered for psychological health benefits under their insurance policies and billing for services purportedly performed by a staff medical doctor on dates prior to the medical doctor's employment or dates after the termination of the medical doctor's employment. Dinkel was paid by the various insurance companies for these fraudulent billings in the amount of

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\$45,281.40. Dinkel awaits sentencing.

False Health Care Claims

State v. Michael Forma

On January 28, 2002, Michael Forma was sentenced to two years probation, conditioned upon serving 90 days in the Middlesex County Adult Correctional Center, and ordered to pay a \$2,500 criminal insurance fraud fine. Forma pled guilty and admitted submitting approximately 73 false health insurance claims to Oxford Health Insurance/Oxford Health Plans for reimbursement for medical treatments he neither received nor for which he paid. Forma previously made restitution to Oxford Health Insurance in the amount of \$12,798.

State v. Jennifer Bozsik

On January 11, 2002, Jennifer Bozsik, a billing clerk in a doctor's office, was sentenced to three years probation and ordered to pay \$34,044.10 in restitution and a civil insurance fraud fine of \$5,000. Bozsik pled guilty to theft by deception. She admitted submitting approximately 74 claims to Prudential Insurance Company of America for medical services that were either never rendered or were rendered to her free of charge. The claims submitted to Prudential totaled more than \$46,000, of which approximately \$34,000 was paid to Bozsik.

State v. Vivian Borges, Ana Rivera, Sobeida Velazquez, Lashunda Smith & Anna Murphy

Five employees of University Physician Associates (UPA), a billing service used by physicians working for the University of Medicine and Dentistry of New Jersey and University Hospital (UMDNJ), were sentenced in 2002 for their participation in a scheme to submit phony health insurance claims to

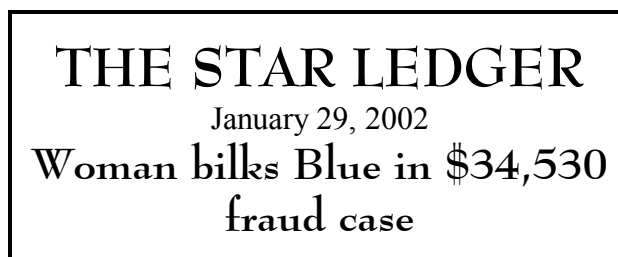
Guardian Life Insurance Company of America. Ana Rivera, Vivian Borges and Anna Murphy had submitted approximately 22 fraudulent health care claims to Guardian on behalf of themselves or their children totalling \$15,960, for which they received approximately \$12,297.50 from Guardian. Lashunda Smith and Sobeida Velazquez had submitted fraudulent health care claims to Guardian on behalf of themselves and their children totalling \$62,965, for which they received approximately \$38,072.55 from Guardian. On January 25, 2002, Rivera was sentenced to three years probation, ordered to pay \$8,745 in restitution to Guardian and a \$5,000 civil insurance fraud fine. On April 19, 2002, Velazquez was sentenced to five years probation, ordered to pay restitution in the amount of \$5,854.87 and signed a Civil Consent Order for \$5,000. On April 26, 2002, Smith was sentenced to three years State prison and ordered to pay restitution in the amount of \$31,638.68. Borges and Murphy were each sentenced to two years probation and ordered to pay restitution in the amounts of \$3,102.50 and \$450, respectively. All three are required to each pay a \$5,000 civil insurance fraud fine.

State v. Nateasha Robinson

On January 25, 2002, Nateasha Robinson was sentenced to five years probation and ordered to pay restitution to Blue Cross/Blue Shield in the amount of \$34,530.58. Robinson pled guilty and admitted her role in a scheme to submit fraudulent claims to Horizon Blue Cross/Blue Shield for health services that had not been rendered. Robinson had received four claim checks totalling \$35,030 before she was caught.

State v. Matt Lilienfeld

On December 6, 2002, Matt Lilienfeld was



sentenced to two years probation, conditioned upon serving 180 days in the County jail, for committing health care claims fraud, theft by deception and the falsification of records. He was also ordered to pay \$30,000 in restitution and a \$5,000 civil insurance fraud fine. Between January 15 and December 17, 1998, Lilenfeld submitted approximately 121 phony prescription receipts from two Rahway, New Jersey, pharmacies to Celtic Life Insurance Company for reimbursement for prescriptions that he neither received nor for which he paid. The phony receipts he submitted exceeded \$38,000.

State v. Karl Stass & Tina Streater

On July 26, 2002, Karl Stass was sentenced to five years probation, conditioned upon serving 364 days in County jail, for allowing Tina Streater, a friend, to assume his wife's identity in order to avail herself of his wife's health insurance coverage under the State Health Benefits Plan, which is administered by Horizon Blue Cross/Blue Shield. Stass and Streater submitted health insurance claims to Horizon, resulting from Streater's stay at Greenville Hospital in Jersey City, totalling some \$86,000, of which more than \$57,000 was paid. Streater was sentenced to four years State prison. Joint restitution was imposed on both defendants in the amount of \$57,595.

State v. Claudia Bellino

On May 29, 2002, Claudia Bellino, an office manager at a medical office, was sentenced to two years probation and ordered to pay restitution to the Prudential Insurance Company in the amount of \$476. She was also ordered to pay a civil insurance fraud fine of \$2,000. Bellino pled guilty to theft by deception and admitted submitting nearly \$600 of medical claims for services that she never received.

State v. Ruth Schwartz

On June 5, 2002, a State Grand Jury returned an indictment against Ruth Schwartz charging her with health care claims fraud and theft by deception. According to the indictment, Schwartz submitted a number of legitimate prescriptions to several pharmacies, but intentionally did not pick them up or pay for them. The State intends to prove that Schwartz knew that she would receive payment for these prescription drugs from Horizon Blue Cross and Blue Shield, administrator of her husband's prescription plan, even if she never received them. Schwartz was reimbursed \$19,569.20 by Horizon for the prescriptions. Schwartz's case is pending trial.

State v. Lev Natovich

On March 13, 2002, OIFP investigators arrested Lev Natovich and charged him with health care claims fraud. Natovich had been under investigation for practicing dentistry without a license. At his arraignment, Natovich was required to post \$100,000 bail. This case is pending presentment to a Grand Jury.

State v. Andrea Wahlig

On October 1, 2002, Andrea Wahlig pled guilty to an Accusation charging her with health care claims fraud. Wahlig admitted submitting claims for prescription reimbursements to which she was not entitled. Wahlig was injured at LML Supermarkets in the course of her employment at the supermarket and subsequently filed a Workers Compensation Claim with New Jersey Manufacturers Insurance Company, which covered her medical services and prescription medications. Wahlig was also covered under her husband's prescription plan, which required a co-pay of \$5 per filled prescription. Wahlig



admitted that, between 1997 and 2000, she submitted false insurance claims to New Jersey Manufacturers for full reimbursement of her prescription medications, when in fact, her husband's prescription plan had paid for the covered prescriptions, less the \$5.00 co-pay. New Jersey Manufacturers paid Wahlig a total of \$11,771.15 for the full cost of 18 prescription transactions, though Wahlig should have only been reimbursed for her actual co-payments.

State v. Patricia & Paul Sullivan

On August 22, 2002, two indictments were returned by a State Grand Jury against Patricia and Paul Sullivan. Patricia Sullivan was charged in the first indictment with health care claims fraud, theft by deception and destruction, falsification or alteration of records relating to medical care. The first indictment alleges that, between July 27 and November 2, 2000, Patricia Sullivan submitted fraudulent claims to MetLife Auto and Home Insurance Company in order to seek reimbursement for prescriptions purportedly paid for by her, when, in fact, she was not entitled to reimbursement for the cost of the prescriptions. The indictment also alleges that Patricia Sullivan altered and/or falsified prescription medication records in support of the fraudulent claims. In a separate indictment, Patricia, along with her husband Paul Sullivan, were charged with conspiracy, health care claims fraud, attempted theft by deception and destruction, falsification or alteration of records relating to medical care. The second indictment alleges that between December 17, 2001 and March 5, 2002, Patricia Sullivan, in concert with her husband, Paul Sullivan, conspired to defraud Blue Cross/Blue Shield by submitting fraudulent insurance claims

totalling over \$75,000 for reimbursement for prescriptions they purportedly purchased from Marquet Pharmacy when, in fact, the medications were not purchased by the Sullivans. According to the indictment, they falsified medical records and submitted them to Blue Cross/Blue Shield in support of their phony claim. The Sullivans' case is pending trial.

State v. Xun-Cheng Huang

Previously, a State Grand Jury returned a ten count indictment against Xun-Cheng Huang, a former professor of mathematics at New Jersey Institute of Technology (NJIT). Huang was charged with one count of health care claims fraud, three counts of theft by deception, falsification of records relating to medical care, and three counts of forgery. The indictment alleges that from January 1995 through September 1996, while employed at NJIT, Huang submitted over 100 false claims for medical services in excess of \$40,000 for reimbursement through the State Health Benefits Program. Upon leaving his employment at NJIT, he is alleged to have submitted an additional 20 fraudulent claims in excess of \$2,500 under insurance coverage obtained by his daughter while a student at the University of Pennsylvania. For most claims, the named medical provider did not exist and

was allegedly a fictitious provider created by Huang. For those claims where the medical provider did exist, the claimed services were allegedly never provided. Huang failed to appear for

his arraignment and a warrant for his arrest was issued. On August 26, 2002, OIFP caused Huang to be arrested on a fugitive bench warrant in Florida and to be extradited to New Jersey to answer to the charges in the indictment. On December 18, 2002, Huang was sentenced to five years probation and



ordered to pay restitution in the amount of \$40,425 following his guilty plea. Prior to being sentenced, Huang served 116 days in county jail.

Fraudulent Disability Claims

State v. Dr. Ngan Hirai

On March 19, 2002, a State Grand Jury returned an indictment charging Dr. Ngan Hirai, a licensed dentist, with theft by deception for filing a fraudulent disability claim. According to the indictment, Hirai falsely claimed to be disabled but continued to practice dentistry while she collected total disability insurance payments in the approximate amount of \$155,399 pursuant to a disability insurance policy issued through General American. The insurance company terminated her benefits after determining that she had been practicing dentistry despite the purported disability. Hirai's case is pending trial.

State v. W. Lance Kollmer, M.D.

On May 31, 2002, a State Grand Jury returned an indictment charging Dr. W. Lance Kollmer, a board certified plastic surgeon licensed to practice medicine and surgery in New Jersey, with theft by deception. According to the indictment, Kollmer filed false disability claims with Sentry Insurance Company and American General Insurance Company, claiming that he was totally disabled and unable to engage in the practice of medicine as a plastic surgeon. Additionally, Kollmer claimed that he had not performed any surgery since the commencement of the total disability. The State intends to prove at trial that Kollmer performed over 60 surgical procedures during the period he claimed to be disabled. The amount of claims paid to Kollmer by both Sentry Insurance Company and American General Insurance Company totaled \$300,000. Kollmer's case is pending trial.

State v. Virginia Fatato

On December 2, 2002, a State Grand

Jury returned an indictment charging Virginia Fatato, a chiropractor, with attempted theft by

deception and falsifying records. Fatato had previously been convicted of theft by deception and falsifying records in 1999 for submitting phony PIP insurance claims to insurance companies from her Hammonton chiropractic practice. On May 21, 2001, the Chiropractic Board suspended Fatato's chiropractic license for a period of five years for her earlier crimes. According to the current indictment, following her criminal conviction for insurance fraud related to her chiropractic practice, Fatato submitted a disability claim with Massachusetts Mutual Life Insurance Company, seeking \$14,982 in disability payments per month for a two year period, with decreasing amounts thereafter during the course of her lifetime. She allegedly advised the insurance company that she was unable to work as a chiropractor following an injury suffered in an automobile accident in 1994. The State intends to prove, however, that, not only did Fatato work out regularly at a Hammonton, New Jersey gym, but that she also obtained employment as a chiropractor at another gym located in Turnersville, New Jersey. Fatato's case is pending trial.

State v. Gerard Zaccardi

On March 8, 2002, a State Grand Jury returned an indictment charging Gerard Zaccardi with theft by deception and falsifying records. The indictment charges that Zaccardi fraudulently applied for disability insurance benefits with the Social Security Administration (SSA) following a "slip and

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Ex-chiropractor charged with

fall" at his place of employment and termination of temporary benefits payments from workers compensation. On the SSA application, Zaccardi allegedly claimed an inability to return to work and function normally at home due to his disability. The State will prove that during the time period in question, Zaccardi was employed at an auto body shop and did not appear to be disabled. Zaccardi's case is pending trial.

State v. Zena Lecoff a/k/a Zena Lecoff-Walker

On July 22, 2002, Zena Lecoff-Walker, a/k/a Lecoff-Walker, was sentenced to five years probation conditioned upon serving 100 days in county jail, and ordered to pay a \$500 criminal fine. She was also ordered to pay \$23,917 in restitution to the Social Security Administration and an additional \$250 criminal fine. Lecoff pled guilty to theft by deception. She admitted receiving Social Security and Workers Compensation disability benefits following a work related injury while she was also earning an income from flea market businesses, violating social security regulations.

State v. Laura Panagos

On July 26, 2002, Laura Panagos was sentenced to five years probation and ordered to pay restitution of \$18,260 and a \$1,500 civil insurance fraud fine. Panagos pled guilty and admitted attempting to defraud the Travelers Insurance Company by failing to notify the company of her husband's death, fraudulently endorsing her husband's name and cashing his worker's compensation checks for three years following his death.

State v. Albert Beebe

On August 5, 2002, a State Grand Jury returned an indictment charging Albert Beebe with theft by deception and falsifying records. The indictment alleges that, between December 11, 1997 and May 24, 1999, Beebe committed theft in connection with his receipt of insurance disability benefits when he

knowingly failed to notify Hartford Insurance Company that he had also begun to receive Social Security benefits. According to the indictment, Beebe's disability insurance benefits had to be "coordinated" with any disability benefits he also received from Social Security, which would reduce his disability proportionately. The indictment also alleges that in support of Beebe's alleged thefts, on two occasions when Hartford sent Beebe an "Other Income Questionnaire," Beebe allegedly falsely answered "no" to the questions which asked whether he was receiving, or expected to receive, Social Security benefits. Beebe is alleged to have wrongfully received over \$29,000 in disability benefits from Social Security. Beebe's case is pending trial.

Health Insurance Application Fraud

State v. Fred D'Avanzo & Ralph D'Avanzo

On August 12, 2002, Fred D'Avanzo pled guilty to an Accusation charging him with theft by deception and falsifying or tampering with records. His brother, Ralph D'Avanzo, pled guilty to a separate Accusation charging him with theft by deception. Fred D'Avanzo, president of Coverall Staff Services, Inc., a temporary employment agency, admitted that, in October of 1995, he had obtained health insurance through a Small Group Health Benefits Policy insurance contract with Horizon Blue Cross and Blue Shield of New Jersey. The health insurance policy required that employees eligible for group health care benefits under the policy be permanent, full-time employees who worked a minimum of 25 hours per week for Coverall. Between September 1997 and October 2000, Fred D'Avanzo illegally obtained health insurance under the policy for his brother, Ralph, and two other persons, by signing a New Jersey Small Employer Certification falsely claiming that his brother Ralph and two other persons were full time employees of Coverall who worked 40 hours or more per week. Ralph D'Avanzo admitted that he was wrongfully

enrolled in Coverall's group health insurance policy, that he was not a full time employee of Coverall and was, in fact, residing in Florida. Ralph also admitted submitting \$104,750.33 in insurance claims to Blue Cross/Blue Shield, of which Blue Cross/Blue Shield paid \$53,178.49. The brothers are awaiting sentencing.

Phony "Slip and Fall" Claims

State v. Brian Butler

On August 19, 2002, Brian Butler pled guilty to theft by deception for falsely claiming to have slipped and fallen while a passenger on a Coach USA/O.N.E. bus operating in Elizabeth, New Jersey. OIFP's investigation leading to the guilty plea revealed that Butler had submitted an insurance claim to Aetna/U.S. HealthCare for injuries purportedly sustained in the bus accident and that Aetna paid the claim money directly to Butler's medical service providers. Butler also fraudulently submitted an insurance claim for personal injuries to ACE Property and Casualty Company, the insurance carrier for Coach USA/O.N.E., and was paid approximately \$3,000. Butler awaits sentencing.

State v. Bruce Robert Tarlowe

On November 8, 2002, following a 12 day jury trial, Bruce Robert Tarlowe, an insurance agent, was found guilty of health care claims fraud and attempted theft by deception for planning and staging a phony "slip and fall" accident at a supermarket. Tarlowe falsely claimed that, on April 12, 1999, he "slipped and fell" on a piece of lettuce on the floor of the product aisle while shopping at the A&P Supermarket on Galloping Hill Road in Union Township. Tarlowe had further claimed that he had sustained serious and permanent injuries and was unable to work as a result. Tarlowe, however, was unaware that his phony "slip and fall" at the supermarket was being recorded on videotape by a store camera. Between April 12, 1998 and March

10, 1999, Tarlowe submitted 20 health insurance claims to the United States Life Insurance Company for medical bills incurred as a result of the "phony slip and fall" totalling \$5,730. The United States Life Insurance Company paid out a total of \$3,002 to the medical service providers on these claims. Tarlowe is awaiting sentencing.

State v. "John Doe", a/k/a Nick Miles, a/k/a Nick Freeman, a/k/a Chris Bradley

On May 21, 2002, a Grand Jury returned an indictment charging "John Doe", a/k/a Nick Miles, a/k/a Nick Freeman, a/k/a Chris Bradley with theft by deception and attempted theft by deception. According to the indictment, "John Doe," using different aliases on three separate occasions, falsely claimed to have sustained nose injuries after reporting phony "slip and fall" accidents while patronizing commercial businesses. The indictment specifically alleges that the first phony claim was for injuries by a "Nick Miles" on October 27, 1998, at the Sea Gull Restaurant in Hazlet, New Jersey, and resulted in a fraudulent insurance claim to the Security Indemnity Insurance Company which paid "Nick Miles" \$9,000 to settle the claim. The indictment also alleges that the defendant, using the alias "Nick Freeman," submitted a phony claim to the Great American Insurance Company for injuries he allegedly sustained on June 25, 1999, at the Sony/Loews movie theater in Secaucus, New Jersey. This claim, for \$5,975, was denied by Great American. Finally, the indictment accuses the defendant of filing a fraudulent insurance claim for \$7,450, using the alias "Chris Bradley," for injuries allegedly sustained on July 22, 1999, at the General Cinema in Clifton, New Jersey. This movie theater's carrier, Liberty Mutual, also refused payment on the claim. The defendant is currently a fugitive.

Life Insurance Fraud

State v. L.C. Thomas, William & Mollie Conyers

On May 7, 2002, following a 17 day jury trial,

William Conyers, a licensed owner and manager of a funeral home, was found guilty of two counts of attempted theft by deception, one count of witness tampering, four counts of falsifying records, and two counts of forgery. Conyers was convicted for his role in a scheme to obtain fraudulent life insurance policies in the names of persons suffering from terminal illnesses. The jury also found his wife, Mollie Conyers, guilty of one count of attempted theft by deception. The life insurance policies fraudulently obtained by Conyers named members of his family as beneficiaries so that he could collect the proceeds of the life insurance policies when the insureds passed away. L.C. Thomas, a licensed insurance agent, allegedly assisted Conyers by writing fraudulent multiple policies and placing them with several insurance companies. Death claims were submitted on some of the policies, but the claims were denied due to various misrepresentations made on the life insurance applications. William Conyers was sentenced on June 28, 2002, to serve an aggregate term of 11 years in State prison. He also received a \$10,000 criminal fine. On September 27, 2002, his wife, Mollie Conyers, was sentenced to two years probation, conditioned upon serving 364 days in county jail. On September 13, 2002, L.C. Thomas pled guilty to theft by deception. Following his guilty plea, Thomas was remanded to the Bergen County Jail in lieu of \$10,000 cash bail. In his plea, Thomas admitted that he had assisted William and Mollie Conyers in falsifying several life insurance applications which were submitted to the American National Insurance Company and the Lincoln Benefit Life Insurance Company. On October 25, 2002, Thomas was sentenced to five years probation, conditioned

**THE BERGEN
RECORD**
May 8, 2002
**Hackensack funeral home owner
guilty of fraud**

upon serving 500 hours of community service and paying a \$5,000 civil insurance fraud fine. His case was also referred for action with respect to his insurance agent's license.

State v. Lucille Dennis

On January 28, 2002, Lucille Dennis pled guilty to two counts of attempted theft by deception, one count of falsifying records and one count of forgery for attempting to collect accidental death benefits for her late husband and brother, both of whom had previously died natural deaths. Dennis admitted that, between 1995 and 1998, she altered police reports and death certificates to reflect accidents which never occurred, one of which she used in an

attempt to collect on a \$1 million accidental death policy for which she enrolled her husband three months after his death. On September 6, 2002, Dennis was sentenced to five years probation, conditioned on her having served 143

days in county jail. She was also ordered to pay a \$23,000 civil insurance fraud fine.

**INSURANCE AGENT, INSURANCE
EMPLOYEE AND PUBLIC ADJUSTER
FRAUD**

Insurance Agent Fraud

State v. David Buys

On March 15, 2002, David Buys, formerly a licensed insurance agent, was sentenced to two years probation, conditioned upon paying restitution in the amount of \$86,755.61, for embezzling that amount from a trust he administered on behalf of two trust beneficiaries. Buys' probation was also conditioned upon his performance of 200 hours of community service, continued

participation in an alcohol treatment program and maintaining gainful employment. He also signed a Consent Order to surrender his insurance producer's license.

State v. Farid Elgebaly

On March 12, 2002, a Grand Jury returned an indictment charging Farid Elgebaly with theft by deception, misapplication of entrusted property and simulating a motor vehicle insurance identification card. The indictment charges that Elgebaly, formerly a licensed insurance producer who transacted business on behalf of the New Jersey Personal Automobile Insurance Plan (PAIP), accepted money from various individuals for automobile insurance premiums but failed to remit the money to PAIP or secure automobile insurance for the individuals who paid the premium money. The indictment also alleges that Elgebaly distributed fraudulent insurance identification cards to some of his clients. Elgebaly's insurance producer's license was revoked in February of 2001. His case is pending trial.

State v. Steven Freymark

On February 1, 2002, Steven B. Freymark was sentenced to two years probation, conditioned upon serving 180 hours of community service, ordered to pay restitution in the amount of \$11,471 to Farm Family Insurance Company, and surrender his New Jersey insurance licenses. Freymark pled guilty to an Accusation charging him with theft by failure to make required disposition of property received. Freymark, a licensed insurance agent, admitted collecting approximately \$15,000 in insurance premiums for automobile insurance policies from approximately 24 individuals and keeping the monies for his own use instead of remitting the premium payments to the insurance carriers.

State v. Stanley Gulkin & National Premium Plan Inc.

On March 8, 2002, Stanley Gulkin, an attorney licensed in the State of New Jersey and operator of National Premium Plan Inc., was sentenced to five years in State prison. Gulkin pled guilty to theft by deception. He admitted engaging in a conspiracy by arranging approximately \$5.6 million in bogus insurance premium financing loans that resulted in losses to the banks which financed the loans as well as to several investors who invested in National Premium Plan, Inc. Gulkin made restitution of approximately \$5 million prior to sentencing.

State v Michael Miller, National Premium Plan, Inc., & A-1 Credit Corporation and Agency Services, Inc.

On June 18, 2002, Michael Miller, a licensed insurance producer and former owner and operator of County Insurance Agency, Inc., pled guilty to an

Accusation charging him with conspiracy and theft by deception for fabricating phony insurance premium finance loans, totalling approximately \$5.6 million. Miller was assisted by Stanley Gulkin, above, in preparing and submitting the phony insurance premium financing loans. On September 3, 2002, Miller was sentenced to six years in State prison and ordered to pay restitution in the amount of \$843,963.77. His corporation was also sentenced to five years probation and

ASBURY PARK PRESS
October 30, 2002
**Ex-Stafford insurance agent
faces 7 years for fraud**

The Associated Press
June 19, 2002
**Former Insurance agent admits stealing
more than \$5 million in premiums**

restitution in the same amount. The case was also referred for action with respect to Miller's insurance agent's license.

State v. Robert Massa, Massa & Miller Agency, Inc., & the Associated Programs Agency, Inc.

On October 28, 2002, Robert Massa, a licensed insurance producer and operator of an insurance business in Lakewood, New Jersey, pled guilty to an Accusation which charged him with conspiracy and theft by deception. Massa admitted his part in a conspiracy with Stanley Gulkin and Michael Miller, above, to fraudulently obtain and cash checks totalling approximately \$5.6 million from National Premium Plan, A1 Credit Corporation and Agency Services, Inc., premium finance companies that loaned small businesses funds to pay for their business insurance. The case will also be referred for action with respect to Massa's insurance agent's license.

State v. Marissa Fischer

On May 6, 2002, a State Grand Jury returned an indictment charging Marissa Fischer, a licensed insurance agent and owner of Marrick Corporation, with theft by failure to make required disposition of property received, misapplication of entrusted property and misconduct by a corporate official. According to the indictment, between July 20, 1997 and September 30, 1998, Fischer misappropriated approximately \$131,965 in insurance premiums which she was required to remit to GAN for general liability and commercial automobile insurance policies for three ambulette companies, Medivan, State Ambulette Service, Inc., and Community Transportation, Inc. Fischer is alleged to have used some of the money for her own personal expenses. Her case is pending trial.

State v. Thomas Begyn

On May 10, 2002, Thomas Begyn, a licensed insurance agent with Unity Mutual Life Insurance Company, was sentenced to five years probation and ordered to pay \$22,660.32

in restitution. Begyn pled guilty to theft by deception and admitted stealing cash premium payments entrusted to him for 12 of the insurance policies he serviced on behalf of clients.

State v. John Buhl

On August 2, 2002, John Buhl, an independent licensed insurance agent who sold policies for American Investors Life Insurance Company, Inc., was sentenced to five years probation and ordered to pay \$41,374 in restitution. Buhl pled guilty to theft by deception and admitted stealing money from an annuity insurance policy belonging to an insured. The case was also referred for action with respect to Buhl's insurance agent's license.

State v. Peter Pascarella, Jr.

On December 6, 2002, Peter Pascarella, Jr., a licensed insurance agent, was sentenced to 18 months probation and ordered to pay a \$12,500 civil insurance fraud fine. Pascarella pled guilty to theft by deception for fraudulently attempting to obtain claims money from the Pacific Mutual Company under a policy of life insurance on the life of Jose Aguiar. Pascarella, the owner and operator of Associated Consulting Group, an insurance sales and financial consulting business, submitted a phony enrollment form to Pacific Mutual Company claiming that Jose Aguiar was an employee who was eligible for health and life coverage under an employer sponsored plan. Pascarella attempted to fraudulently obtain insurance claims money from Pacific Mutual Company by claiming that Jose Aguiar had a valid life insurance policy with Pacific Mutual Company and that Pascarella was entitled to collect benefits as a beneficiary upon the death of Aguiar. Aguiar was not, however, an employee and thus not eligible for life or health insurance coverage.

State v. Vito Gruppiso

On May 30, 2002, OIFP investigators, armed with an arrest warrant for Vito Gruppiso and

a search warrant to search his business premises located in Parsippany, Cedar Knolls and Washington, New Jersey, seized the books and records of Gruppосо's insurance agency and insurance premium finance businesses. Gruppосо, a licensed insurance agent, was arrested and charged with three counts of theft by failure to make required disposition of insurance premiums obtained from various insurance customers. Gruppосо is alleged to have wrongfully engaged in insurance premium financing transactions and to have embezzled insurance premiums entrusted to him by insureds. Gruppосо was arraigned and bail was set in the amount of \$100,000. Gruppосо's case is currently pending Grand Jury action.

State v. Joseph Binczak

On November 8, 2002, a State Grand Jury returned an indictment against Joseph Binczak, a licensed insurance agent, charging him with theft by deception and falsifying records. According to the indictment, Binczak was employed by the Ukrainian National Association (UNA) as an insurance sales manager responsible for maintaining life insurance annuity accounts for members of UNA. Binczak allegedly withdrew over \$600,000 from the annuity accounts of seven members of UNA without authorization, deposited the money into his own bank accounts and used the money for his own purposes. The indictment also alleges that Binczak falsified two documents purportedly authorizing him to withdraw \$30,000 and \$45,000, respectively, from two insured's UNA annuity accounts. Binczak's case is pending trial.

State v. Robinson Barleycorn

On August 14, 2002, a State Grand Jury returned an indictment against Robinson Barleycorn, a licensed insurance agent, charging him with theft by failure to make required disposition of funds received. According to the indictment, Barleycorn was employed by the Capacity Marine Insurance Agency, in Montvale and Upper Saddle River,

New Jersey, as an insurance agent. The indictment alleges that between June 1, 1994 and September 15, 1997, Barleycorn, while acting as an insurance agent for Capacity Marine Insurance, received \$321,000 in insurance premium payments from a Connecticut tugboat operator to purchase marine insurance for the corporation's tugboat operation. According to the indictment, Barleycorn used the money to pay his own personal expenses instead of forwarding it to the insurance carrier. Barleycorn was arrested in Louisiana on August 21, 2002 and was extradited to New Jersey on September 4, 2002 to answer to the charges in the indictment. The case is pending trial.

State v. Vincent Bickler

On August 19, 2002, Vincent Bickler, a licensed insurance agent, pled guilty to an Accusation charging him with failure to make required disposition of funds received. Bickler admitted that he forged the names of his insurance clients to several life insurance premium refund checks, deposited the forged checks into his own account, and used the money for his own personal expenses. Bickler also took several checks from another client, which should have been deposited into an insurance policy investment account managed by Bickler's employer, the Equitable Life Assurance Company, but instead deposited the checks without the client's knowledge or consent into Bickler's personal account. Bickler then used that money to pay personal expenses. On November 12, 2002, Bickler was admitted into the PTI Program and ordered to pay \$15,500 in restitution. The case was also referred for action with respect to Bickler's insurance agent's license.

State v. Douglas Ross

On August 23, 2002, OIFP investigators arrested Douglas Ross, a licensed insurance agent, and charged him with two counts of theft by failure to make required disposition of

property received and one count of selling phony insurance cards. The case is pending Grand Jury presentment.

State v. Marc Flora

On November 7, 2002, Marc Flora, a licensed insurance agent, pled guilty to an Accusation charging him with theft by deception and falsifying records. Flora admitted that, between January of 1998 and December of 2001, he fraudulently cashed 11 checks totalling \$284,882.48 from the Metropolitan Life Insurance Company and kept the proceeds for himself. Four of the checks had been payable to Flora's clients while seven of the checks had been made payable to Metropolitan Life. Flora's case will be referred for action with respect to his insurance agent's license.

Insurance Carrier Employee Fraud

State v. Carl Prata, et al.

On December 18, 2002, Carl Prata, formerly employed as an insurance claims adjuster with the St. Paul Insurance Company and Allmerica Insurance Company, was indicted by a State Grand Jury and charged with conspiracy and theft by deception. The indictment alleges that Prata issued approximately 57 fraudulent bodily injury automobile insurance settlement checks totalling some \$625,000 to co-conspirators who were not entitled to them. Prata is accused of accessing his company's claims computer and issuing insurance claims settlement checks for injuries purportedly sustained by individuals who had not actually been in automobile accidents. He would then allegedly accept part of the stolen money from the co-conspirators as a kickback. In the course of the investigation, which has spanned several years, a number of alleged co-conspirators have pled guilty and been sentenced for participating in the alleged scheme with Prata. In addition to the defendants specifically identified below, between January 4 and December 31, 2002, the following defendants in the Prata

investigation pled guilty to Accusations charging them with theft by deception: Michael Schmidberger, Frances Leston, William Totaro, Steven Mattison, Carol Rios, Farima Ianuale, Erica Rosedietcher, Jackie Seife, Jeremias Toledo, Antonio Meola, John Tolla, George Bottarini, Michele Scurti, Luke Serafin, John Woodburn, Kimberly Zito, Tyrone Harmon, George Garcia, Donna Langerap and Lance Howell. All have either been placed on probation or entered into the PTI Program and ordered to pay restitution in an amount equal to the amount of the claim checks they received. Each of these defendants was also ordered to pay civil insurance fraud fines ranging from \$2,500 to \$8,000. In total, approximately 45 individuals allegedly received and cashed fraudulent bodily injury automobile insurance settlement checks in this conspiracy.

State v. Peter Nicholson

On April 26, 2002, Peter Nicholson pled guilty to an Accusation charging him with conspiracy and theft by deception. Nicholson admitted that he had personally accepted a fraudulently obtained settlement check issued by Allmerica Insurance Company in the amount of \$13,500. Nicholson also admitted depositing the settlement check into his bank account and giving \$4,500 to Prata and another co-conspirator. Nicholson also admitted that he recruited eight people to participate in the conspiracy. These eight individuals later received fraudulent settlement checks totalling \$68,500. Seven of these eight people have pled guilty to theft by deception for their roles in the conspiracy. On July 1, 2002, Nicholson was sentenced to five years probation, conditioned upon serving 364 days in the county jail, ordered to pay restitution to Allmerica Insurance Company in the amount of \$13,500 and required to pay a civil insurance fraud fine in the amount of \$15,000.

State v. Anastasios Apostolopoulos

On April 26, 2002, Anastasios Apostolopoulos pled guilty to an Accusation charging him with

conspiracy and theft by deception in the above alleged Prata scheme. Apostolopoulos admitted that he had accepted two fraudulently obtained settlement checks issued by Allmerica Insurance Company in the amounts of \$12,000 each. Apostolopoulos admitted endorsing one of the settlement checks over to Good Nature Foods, a business which Apostolopoulos owned, and to depositing the second settlement check into his bank account. Apostolopoulos also cashed several checks, totalling \$28,000, at the request of Mustafa Azme, another conspirator. Apostolopoulos kept \$9,333 from these checks and gave the balance to Azme. Apostolopoulos further admitted that he recruited one person to participate in the conspiracy. That recruit later received \$10,000. That recruit has also pled guilty to theft by deception for his role in the conspiracy. On July 1, 2002, Apostolopoulos was sentenced to five years probation. He was also required to serve 120 days in the county jail at the end of the probationary period, ordered to pay restitution to Allmerica Insurance Company in the amount of \$24,000 and required to pay a civil insurance fraud fine in the amount of \$10,000.

State v. Mustafa Azme

On June 4, 2002, Mustafa Azme pled guilty to an Accusation charging him with conspiracy and theft by deception in the above alleged Prata scheme. Azme admitted that between January of 1998 and November of 2000, he conspired with several others to defraud Allmerica Insurance Company and the St. Paul Insurance Company by falsely claiming to have been injured in automobile accidents and fraudulently accepting insurance settlements for these bodily injury insurance claims. Azme accepted one settlement check in the amount of \$12,500 from Allmerica and settlement checks from the St. Paul Insurance Company in the amounts of \$10,000 and \$38,000. Azme recruited nine other conspirators to receive additional fraudulent insurance claims

checks. The nine persons recruited by Azme received nine insurance settlement checks totalling \$113,500. Of the nine persons

recruited by Azme, six have pled guilty to charges of conspiracy and/or theft by deception, while charges against the remaining three persons are pending.

State v. Christopher Nangano

THE DAILY RECORD
September 6, 2002
Randolph man sentenced to jail for taking part in insurance fraud

On September 5, 2002, Christopher Nangano pled guilty to an Accusation charging him with conspiracy and theft by deception in the above alleged Prata scheme. Nangano admitted that, between January and October of 2000, he conspired with others to defraud the Allmerica Insurance Company and the St. Paul Insurance Company by claiming to have sustained bodily injury in automobile accidents and fraudulently accepting insurance claim checks from Allmerica and St. Paul as compensation for his phony injuries. Nangano accepted one settlement check from Allmerica in the amount of \$10,000 and another from St. Paul in the amount of \$9,100. As part of the conspiracy, Nangano recruited four other persons to receive fraudulent insurance claims checks. The four persons recruited by Nangano were issued four insurance settlement checks totalling \$35,000. On November 22, 2002, Nangano was sentenced to five years probation, conditioned upon serving 364 days in the county jail. He was also ordered to pay \$40,810 in restitution to Allmerica Insurance Company and St. Paul Insurance Company, as well as a \$14,500 civil insurance fraud fine.

State v. Carol Cappuccio

On December 18, 2002, a State Grand Jury returned an indictment charging Carol Cappuccio with conspiracy and theft by deception. According to the indictment, Cappuccio was recruited by Mustafa Azme in the above alleged Prata scheme and accepted a fraudulently obtained settlement check issued by Allmerica Insurance Company in the amount of \$16,000 for a purported accident in which she was not involved. Cappuccio allegedly deposited the settlement check into her bank account and kept \$4,000 after giving \$12,000 to Azme. The indictment also alleges that Cappuccio recruited three more persons to participate in the conspiracy. These three received settlement checks totalling \$23,500 and have since pled guilty to theft by deception for their roles in the conspiracy. Cappuccio's case is pending trial.

State v. Timothy Hanjian

On December 18, 2002, a State Grand Jury returned an indictment charging Timothy Hanjian with conspiracy and theft by deception. The indictment alleges that Hanjian accepted a fraudulently obtained settlement check issued by Allmerica Insurance Company in the amount of \$9,200 for a purported accident in which he was not involved. Hanjian is alleged to have deposited the settlement check into his bank account and recruited four other persons to participate in the conspiracy. Those four persons recruited by Hanjian accepted settlement checks totalling \$59,200. They have since pled guilty to theft by deception for their roles in the conspiracy. Hanjian's case is pending trial.

State v. Joseph Scafidi

On June 7, 2002, Joseph Scafidi, formerly employed as a Regional Director at CIGNA Insurance Company, was sentenced to two years probation and ordered to pay \$33,800 restitution to CIGNA. Scafidi admitted stealing employee incentive checks or bonuses which had been issued to reward employees reporting to Scafidi for their extraordinary work accomplishments.

State v. Max Birtcil

On February 11, 2002, Max Birtcil pled guilty to an Accusation charging him with theft by deception and falsifying records. Birtcil, a claims representative for Cunningham Lindsey Claims Management, Inc., a third party administrator of workers compensation claims for Legion Insurance Company, admitted to submitting several false workers compensation claims through Coordinated Medical Consultants, an entity Birtcil wholly owned and controlled. Cunningham Lindsey paid a total of approximately \$25,230 to Coordinated Medical Consultants for these false claims. On March 15, 2002, Birtcil was sentenced to three years probation, conditioned upon paying restitution to Cunningham Lindsey in the amount of \$25,230 and ordered to pay a \$2,500 civil insurance fraud fine.

State v. [REDACTED] & Leticia Waymer

On October 8, 2002, a Grand Jury returned an indictment charging [REDACTED] with conspiracy and theft by deception. According to the indictment, [REDACTED], a customer service representative for Great West Life and Annuity Insurance Company, conspired with Leticia Waymer and fraudulently authorized and issued six Great West insurance claim checks to Waymer, totalling approximately

\$7,415, for a phony insurance claim. [REDACTED]' case is pending trial. Previously, on June 20, 2002, Leticia Waymer pled guilty to an Accusation which charged her with conspiracy. Waymer admitted that between June 3 and August 8, 1998, she received from [REDACTED], four fraudulently issued claim checks drawn by the Great West Life and Annuity Insurance Company, totalling \$3,965. She also admitted cashing the checks and turning over the balance of the proceeds to [REDACTED] after keeping \$800 for herself. Waymer admitted knowing that [REDACTED] worked for an insurance company when he approached her to see if she wanted to make some money. On August 6, 2002, Waymer was admitted into the PTI Program, subject to providing full cooperation with the State in its case against [REDACTED]. Waymer was ordered to maintain gainful employment and make full restitution to the Great West Life and Annuity Insurance Company.

State v. Le T. Harlin

On October 30, 2002, a State Grand Jury returned an indictment against Le T. Harlin, a claims specialist in the Mt. Laurel office of Ohio Casualty Insurance Company, charging him with theft by deception and forgery.

According to the indictment, between July 17, 2000 and March 27, 2002, Harlin stole approximately 44 checks from third parties which were payable to Ohio Casualty, forged endorsements on the checks using an Ohio Casualty rubber stamp, and deposited the checks into his bank account. Harlin's case is pending trial.

The Trentonian
July 20, 2002
Former Mercer County detective Marc Rossi has been indicted by a state grand jury as the "mastermind" of a Trenton-Hamilton area arson-for-profit and insurance fraud scheme, it was

**Public/Insurance
Adjuster Fraud**

State v. Joseph DeGregorio

On December 6, 2002, Joseph DeGregorio pled guilty to theft by deception for

misappropriating as much as \$87,000 in insurance claims settlement checks from various claimants, while working as an adjuster/paralegal for personal injury lawyers. Following his indictment, DeGregorio had fled to Florida, where OIFP investigators tracked and arrested him.

State v. Marc Rossi

On July 18, 2002, a State Grand Jury returned an indictment charging Marc Rossi, a licensed public insurance adjuster, with conspiracy, arson for hire, theft by deception, forgery and falsifying records. As described below, four other defendants were also charged as a result of this investigation. According to the indictment, Rossi, President of Rossi Adjustment Services, conspired with and paid several of his employees, including Otis Boone, Michael Winberg and Jerome Adderley, to commit arson fires or acts of vandalism to cause property damage so Rossi Adjustment Services could obtain commissions by representing the insureds in their insurance claims. The indictment alleges that in some cases, the owners of the properties were aware of the fraudulent nature of the insurance claims, while, in other cases, the defendants targeted properties where the owners had no

idea their properties had been purposely damaged. Rossi's case is pending trial.

State v. Michael Winberg

On May 28, 2002, a State Grand Jury returned two indictments against Michael Winberg, a licensed public insurance adjuster, each charging him with theft by deception, conspiracy and arson for hire. According to the indictments, Winberg participated in the planning and setting of several arson fires which were part of the Rossi Adjustment Services conspiracy. On December 3, 2002, a State Grand Jury handed up superseding indictments charging both Rossi and Winberg with four additional fires involving a residence located at 506-510 West Hanover Street, Trenton, a rental property located at 41-43 Prospect Street, Trenton, a residence located at 1732 East State Street, Hamilton Township and a residence located at 350 St. Joes Avenue, Trenton. Winberg's case is pending trial.

State v. Otis Boone

On February 27, 2002 a State Grand Jury returned an indictment against Otis Boone, a licensed insurance agent and public adjuster with Rossi Adjustment Services, charging him with theft by deception, conspiracy, arson for hire and possession of a weapon for unlawful purposes. Boone pled guilty on October 21, 2002, to conspiracy and six counts of aggravated arson for his role in the alleged Rossi Adjustment conspiracy. Boone awaits sentencing.

State v. Jerome Adderley

On December 20, 2002, Jerome Adderley, who was also associated with Rossi Adjustment Services, was sentenced to two years probation, conditioned upon time served

of 364 days in county jail. Adderly admitted his role in the alleged Rossi conspiracy, which involved setting an arson fire at Graziano's Florist Shop.

State v. Marc Graziano

On February 11, 2002, Marc Graziano, owner of the former Graziano Florist Shop, pled guilty to an Accusation charging him with conspiracy to commit arson and theft by deception. Graziano admitted that, with his consent, Marc Rossi arranged to have Graziano's florist shop set on fire as part of the alleged Rossi Adjustment Services conspiracy. Graziano awaits sentencing

State v. William Taintor, III

On June 3, 2002, William Taintor, III, a licensed public insurance adjuster, was charged in two separate State Grand Jury indictments. The first indictment charged Taintor with theft by failure to make required disposition of property and alleged that, in September of 2001, Taintor received an insurance claim settlement check in the amount of \$3,743 on behalf of an insured and kept the proceeds for himself. The second indictment charged Taintor with attempted theft by deception and forgery. According to this indictment, in order to inflate a property damage claim, Taintor submitted a forged invoice to Omaha Property Insurance Company bearing the purported signature of another insured Taintor

represented. The allegedly phony invoice, dated October 10, 1995, purported that T&K Kitchens had previously repaired damage to property located in Avalon, New Jersey. It is alleged, however, that the previous damage had not been repaired by T&K Kitchens and that the invoice did not accurately reflect the repairs done. The State intends to prove that

The Trentonian
October 22, 2002
A Trenton man yesterday pleaded guilty to his role as "the torch" in the Trenton-Hamilton arson ring allegedly run by former Mercer County Detective

Taintor submitted the forged invoice to obtain a larger commission in his capacity as the public adjuster representing the insured in settling the insurance claim. Taintor's case is pending trial.

PROPERTY AND CASUALTY FRAUD

False Homeowners Claims

State v. Dorothea Longo

On April 11, 2002, Dorothea Longo pled guilty to an Accusation charging her with attempted theft by deception. Longo admitted that she had submitted a false lost property claim with Great Northern Insurance Company on March 10, 2001, alleging that she had lost her engagement and wedding rings at the Taj Mahal Casino in Atlantic City. She also submitted two appraisals from Gemological Appraisal Laboratory of America, Inc., dated February 15, 1999 in support of the claim. Investigation revealed that Longo had previously filed a similar claim with Newark Insurance Company on July 27, 1999, relying upon the same two appraisals, and claiming the same two rings had been stolen. Longo withdrew her 2001 claim with Great Northern Insurance Company before it was paid. On May 24, 2002, Longo was admitted into the PTI Program and required to pay a \$2,500 civil insurance fraud fine.

State v. Donna Segarra

State v. Kevin Healy

On April 15, 2002, Donna Segarra pled guilty to an Accusation charging her with theft by deception. Segarra admitted making three different insurance claims for the same alleged water damage to her residence. In November of 1996, Segarra submitted the first claim for property damage to her residence, allegedly caused by the defective installation/construction of a shower stall. That claim was settled by the manufacturer of the shower stall. In October 1997, however, Segarra submitted a second claim for the same water damage to Selective Insurance

Company. Segarra never repaired the November 1996 water damage nor disclosed that the November 1996 water damage had occurred and that there had been an earlier insurance claim. Segarra also used the same photographs from the November 1996 water damage claim in support of the October 1997 water damage claim. Unaware of the earlier water damage claim, Selective Insurance paid Segarra \$2,220.25. Then, in March of 1998, Segarra submitted yet another claim for "newly discovered" water damage, all based on the same November 1996 water damage at her home. Segarra admitted that, in order to substantiate this third claim, she and a carpenter, Kevin Healy, of Massapequa Park, New York, submitted a phony receipt for carpentry services which purported that the "newly discovered" damages had been repaired at an approximate cost of \$4,000. This third claim was denied by Selective Insurance Company. Following her guilty plea, Segarra was admitted into PTI and ordered to pay a civil insurance fraud fine of \$7,000. She had previously paid restitution to the insurance carrier. On May 13, 2002, Kevin Healy pled guilty to an Accusation charging him with falsifying a record. Healy admitted that he provided Segarra with the false receipt indicating that he had repaired the damage to Segarra's floor. Healy stated, and Segarra corroborated, that he was not aware of Segarra's earlier Selective claim. Healy was also admitted into the PTI Program and ordered to pay a \$1,000 civil insurance fraud fine.

State v. Martha Rivera

On July 1, 2002, a Grand Jury returned an indictment charging Martha Rivera with attempted theft by deception. According to the indictment, Rivera filed a false property loss claim with Liberty Mutual Insurance Company, her homeowners insurance carrier. Rivera allegedly falsely reported to police that a burglary had occurred in her apartment. Rivera allegedly claimed that the value of the stolen property, which supposedly included an

engagement ring and other jewelry, as well as a camera and \$2,000 in cash, totaled approximately \$15,800. Liberty Mutual denied the claim. On October 7, 2002, Rivera was admitted into the PTI Program, on condition that she serve 75 hours of community service.

State v. Sharon Cox

On August 21, 2002, a Grand Jury returned an indictment charging Sharon Cox with attempted theft by deception and forgery. According to the indictment, Cox submitted a homeowners insurance claim to State Farm Fire and Casualty Company with a phony receipt reflecting that Somertime Pool and Spa Supplies of Millville, New Jersey, had made repairs to her swimming pool which had allegedly sustained wind damage. The indictment charges that Somertime Pool and Spa Supplies did not do the repairs to Cox's swimming pool and that she had altered the receipt to reflect that the pool had been repaired in order to collect damages on her insurance policy. Cox's case is pending trial.

State v. Tracie Connelly

On August 8, 2002, a Grand Jury returned an indictment charging Tracie Connelly with four counts of forgery. The indictment alleges that State Farm Insurance Company issued four homeowners insurance settlement claim checks, payable jointly to Tracie Connelly and Michael Connelly, Tracie's estranged husband, and that Tracie Connelly illegally endorsed the checks by forging Michael's name on the back of the checks. The checks which gave rise to the charges totalled \$8,595.35. Connelly's case is pending trial.

False Commercial Claims

State v. Kevin Bui

On February 15, 2002, Kevin Bui pled guilty to an Accusation charging him with attempted theft by deception. Bui, the owner of P.I. Nails Salon, had reported to the Vineland Police Department that his business had been burglarized. Bui submitted a total claim in the amount of \$15,496.80 to North American Risk for stolen items and property damage. In admitting his guilt, Bui acknowledged that he had submitted a fraudulent receipt to North American Risk for items he purportedly purchased, falsely reflecting a value of \$10,035. On June 10, 2002, Bui was admitted into PTI and ordered to pay a \$3,500 civil insurance fraud fine.

State v. Eugene Chusid

On February 1, 2002, Eugene Chusid was sentenced to five years probation, conditioned on serving 364 days in county jail. He was also ordered to pay a \$2,500 civil insurance fraud fine. Chusid pled guilty to attempted theft by deception. Chusid, who was the principal agent for IEIEC World Headquarters Corporation and Russian White House Restaurant, Inc., filed a fraudulent claim with

<p style="text-align: center;">THE BERGEN RECORD February 2, 2002 Fair Lawn man gets year in jail for fraud</p>

the Reliance Insurance Company claiming that a water pipe had burst in the Russian White House Restaurant and damaged the

hardwood floors. Chusid admitted that the damage to the hardwood floors had, in fact, been caused by flood waters, which was not covered under his insurance policy. Chusid also submitted phony invoices in support of the \$52,311 claim, and swore under oath that G.V. Construction Company had repaired the leaky water pipe. The claim was denied by Reliance Insurance Company.

Premium Refund Fraud

State v. David Boatswain, et al.

A Grand Jury returned three separate

indictments charging David Boatswain, Daniel Kern and Gerald Plummer each with theft by deception. According to the indictments, Boatswain, Kern and Plummer ordered auto insurance over the telephone from Prudential Insurance Company and advised Prudential that they would pay the premium via wire transfer. They allegedly called Prudential, canceled the policies, and requested a cash premium refund without having ever wired the money for the premiums. Prudential sent refund checks to Boatswain for \$6,288, to Kern for \$3,337, and to Plummer for \$2,488. On October 4, 2002, Boatswain was sentenced to serve three years in State prison and ordered to pay \$6,288 in restitution to Prudential following his guilty plea. Kern's and Plummer's cases are pending trial.

INSURANCE FRAUD RELATED CASES

State v. Elvin Castillo

On April 10, 2002, a State Grand Jury handed up two indictments against Elvin Castillo, a primary defendant in the ABP Chiropractic case. In the first indictment, Castillo is charged with theft by deception, forgery and falsification of records relating to an allegedly phony mortgage loan application. The indictment alleges that Castillo submitted a fraudulent residential mortgage application, as well as phony documentation in support of the application. It also alleges that the information on the loan application, on the tax returns submitted with the loan application and on two letters submitted in support of the loan application were all fraudulent. In addition, it is alleged that Castillo's primary source of income, which was from a business he allegedly worked for known as the Spinal Health Center of Elizabeth, a chiropractic clinic targeted as part of the ABP investigation, was not operating as a business at the time Castillo applied for the residential loan. Finally, it is alleged that the 1998

income tax returns that Castillo submitted for purposes of calculating his monthly income were not filed with the New Jersey Division of Taxation. In the second indictment, Castillo is charged with filing a false or fraudulent New Jersey income tax return, failure to file a New Jersey income tax return and failure to pay New Jersey gross income tax. It is alleged that Castillo failed to pay State income taxes for the years 1997, 1998, 1999 and 2000.

State v. Dr. Samuel Evenstein

On November 22, 2002, Dr. Samuel Evenstein pled guilty to an Accusation charging him with failure to pay New Jersey gross income tax with intent to evade. The crime was uncovered during a suspected insurance fraud joint investigation between OIFP and the New Jersey Division of Taxation. Evenstein admitted that he failed to report over \$500,000 in income in 1999 and, consequently, that he owed over \$50,000 in New Jersey State Income Taxes for the unreported income.

MEDICAID FRAUD

Medicaid Criminal Cases

State v. Frieda Hankerson

On January 4, 2002, Frieda Hankerson was sentenced to two years probation, conditioned upon serving 364 days in the Bergen County Jail. She was also ordered to pay \$7,500 in restitution. Hankerson pled guilty to Medicaid fraud. She admitted fraudulently obtaining prescriptions for vials of Neupogen, a drug used for serious blood disorders, with a value of approximately \$2,590.52.

State v. Facilities Management Associates, Inc. (FMA), Paul Steffens, & Hudson Behavioral Treatment Center

On December 20, 2002, Paul Steffens, Executive Director of the Hudson Behavioral Treatment Center, an outpatient drug and alcohol treatment center managed by FMA, pled guilty to Medicaid fraud for submitting claims to the Medicaid Program for group

therapy services that were not provided. Steffens is awaiting sentencing.

State v. Marcus Solomon, et al.

On September 6, 2002, Marcus Solomon, a principal in Solomon's Invalid Coach, was sentenced to serve three years in State prison for Medicaid fraud. Solomon admitted billing the Medicaid Program for mileage reimbursements for trips never taken, services not rendered, mileage claims greater than the amounts allowed by law and misrepresenting his expenses on his 1999 State income tax return. Solomon was also ordered to pay \$10,742 to the State for restitution for unemployment insurance and \$414 to the Division of Taxation for tax fraud. Jennifer Solomon, his wife, was sentenced to three years probation for defrauding Medicaid (NJ Kidcare) by illegally collecting medical benefits for her two minor children. Both were also ordered to pay restitution in the amount of \$59,450, a civil false claims penalty in the amount of \$25,000, and \$911 to the Medicaid Program for defrauding the Kidcare program. They were also permanently disqualified from participation in the Medicaid Program.

State v. Hanan Selim, Wael Aly & Paterson Community Pharmacy

On May 2, 2002, Hanan Selim and Wael Aly, owners and operators of the Paterson Community Pharmacy, were each sentenced to three years in State prison and debarred from the Medicaid Program for a minimum period of five years for Medicaid fraud. Selim and Aly admitted engaging in a scheme in which they purchased prescriptions for Serostim, an expensive anti-AIDS medication, and submitted false claims for reimbursement to the Medicaid Program, fraudulently receiving approximately \$170,000 in Medicaid payments. Selim and Aly also submitted false invoices to the Medicaid Program in order to establish that their inventory contained the amount of drugs allegedly provided. Both were ordered to pay restitution to the Medicaid Program in the amount of \$166,532.

Selim, a licensed pharmacist, had her pharmacy license suspended for one year. The case is being referred to the Pharmacy Professional Boards for further review of Selim's pharmacy license.

State v. M&G Livery and Transportation Inc., Gregory Sverdlov & Raisa Zeltser

Gregory Sverdlov, Raisa Zeltser and their corporation, M&G Livery and Transportation, Inc., were indicted and variously charged with conspiracy, Medicaid fraud, theft by deception and misconduct by a corporate official in connection with their operation of their livery transportation company. On October 31, 2002, Sverdlov was sentenced to four years State prison, following the entry of a guilty plea. Sverdlov admitted fraudulently operating M&G Livery and Transportation, Inc., by paying kickbacks to induce Medicaid recipients to use their company, billing for people ineligible to receive Medicaid, transporting Medicaid recipients to destinations not allowable under Medicaid regulations and submitting false information on Medicaid forms to avoid Medicaid scrutiny. He was also ordered to pay restitution to the Medicaid Program in the amount of \$214,840, and consented to disqualification as a Medicaid provider for eight years. On the same date, his wife and business partner, Raisa Zeltser, applied to the PTI Program and also agreed to be disqualified as a Medicaid provider for eight years. Their corporation, M&G Livery and Transportation, Inc., was also disqualified from being a Medicaid provider for eight years.

State v. L&Z Corporation & Gregory Sverdlov

On March 8, 2002, Gregory Sverdlov and his company, L&Z Transportation, Inc., pled guilty to an Accusation charging Medicaid fraud. Sverdlov admitted fraudulently operating L&Z Transportation, Inc., by paying kickbacks to induce Medicaid recipients to use the company. A consent order for debarment from participation in the Medicaid Program for

eight years was signed for L&Z .

***State v. Venditti Clinical Laboratory,
Iftikhar Hussain,***

& Abdul Hafeez Raja

On June 14, 2002,

Iftikhar Hussain and Abdul Hafeez Raja, owners and operators of Venditti Clinical Laboratory, were sentenced for their participation in a Medicaid fraud scheme in which almost \$347,000 in kickbacks were paid to encourage clinic owners to submit blood samples to the laboratory to undergo an expensive panel of diagnostic tests which were not related to any medical diagnoses or conditions. All the samples submitted were from Medicaid recipients and paid for by the Medicaid Program. The scheme also involved the concealment of the kickback payments by writing checks from the Venditti business account to fictitious business owners. On June 14, 2002,

Hussain was sentenced

to three years probation conditioned upon serving 90 days in county jail and fined \$1,000 for Medicaid fraud. Raja was sentenced to three years probation, conditioned upon serving 30 days in county jail and fined \$1,000 for Medicaid fraud.

***State v. I&I Transportation, Imad Elbashir,
& Imadelin A. Khair***

Imad Elbashir, Imadelin Khair and their company, I&I Transportation, an invalid coach provider that provided non-emergency

medical transportation to Medicaid recipients, were indicted and charged with conspiracy, health care claims fraud, theft by deception, Medicaid fraud and corporate misconduct. The indictment alleges that I&I inflated mileage on claims submitted to the Medicaid Program and received \$90,000 more than it was entitled to for services rendered. In addition, defendants allegedly paid cash kickbacks to several Medicaid recipients in exchange for their continued patronage. Elbashir's, Khair's and I&I's cases are pending trial.

THE STAR LEDGER
February 21, 2002
**Pharmacist accused of
insurance fraud**

***State v. Michael
Stavitski, et al.***

On February 20, 2002, Michael Stavitski, a licensed pharmacist, was arrested by OIFP investigators and charged with theft by

deception, health care claims fraud, and Medicaid fraud. The complaint alleges that Stavitski, the owner of four pharmacies located in Belmar, Avon-By-The-Sea, Wall Township and Spring Lake Heights, submitted fraudulent reimbursement claims to, and received payment from, the Medicaid Program for medications that he falsely claimed were

dispensed to Medicaid recipients. On December 17, 2002, a State Grand Jury returned an indictment against Stavitski charging him with health care claims fraud, corporate misconduct and Medicaid fraud. Three of the four pharmacy corporations were also charged with

health care claims fraud and Medicaid fraud. The pharmacies operated as retail walk-in pharmacies and filled prescriptions for residents of approximately 30 nursing home/assisted living facilities, in addition to providing services to Medicaid and private insurance recipients. According to the

**MEALEY'S LITIGATION
REPORT**
VOLUME 8, ISSUE #10 3
March 2002
***New Jersey Lab Owner,
Managers Plead Guilty to
Medicaid Fraud***

indictment, between May of 1996 and February of 2002, Stavitski and the three pharmacies submitted numerous claims for payment which falsely reflected that medications or refills of medications were provided to Medicaid and privately insured patients. Additionally, in many instances, Stavitski allegedly billed for providing medications that were never prescribed by physicians. Stavitski's case is pending trial.

State v. Family Enrichment, et al.

On April 1, 2002, following a month long jury trial, Alan Daniel, clinical director of the Family Enrichment Institute of Burlington, was found guilty of health care claims fraud and Medicaid fraud. The indictment charging Daniel was the first Medicaid fraud indictment filed under the Health Care Claims Fraud Act. The same jury acquitted his co-defendant, Theresa Daniel. Harold Peart, a third defendant in this case, was acquitted of a health care claims fraud charge. However, the jury deadlocked on the remaining counts of conspiracy and Medicaid Fraud, resulting in a mistrial as to the deadlocked counts. During the trial, the jury found that Daniel submitted more than 1,100 claims totalling approximately \$24,675 to the Medicaid Program for counseling services that were never rendered. The jury also found that Daniel submitted eight claims to Medicaid for counseling services rendered to a patient who had died prior to the dates the services were purportedly rendered. The jury further found that Daniel submitted approximately 350 claims for counseling services for patients twice per week, when the patients were

**BURLINGTON COUNTY TIMES
SEPTEMBER 23, 2002
JURY CONVICTS MAN OF**

actually treated only once per week. The total of these claims was approximately \$7,435. On July 1, 2002, Daniel was sentenced to five years in State prison and ordered to pay a criminal fine of \$10,000. Daniel's social worker's license was also permanently revoked. Peart subsequently pled guilty to Medicaid fraud on December 24, 2002, and was sentenced to two years probation, conditioned upon permanent revocation of his social worker's license.

State v. Hispanic Counseling & Family Services, Inc., et al.

On May 31, 2002, a State Grand Jury returned an indictment charging Eliezer Martinez, Olga Marquez, Olga Bonett, Juanita Melendez, Jose Jimenez, Bartolo Moreno and Luz Senquiz with health care claims fraud and Medicaid fraud. According to the indictment, Martinez, Marquez, Bonett, Melendez, Jimenez, Moreno and Senquiz, were counselors employed at the Hispanic Counseling and Family Services of New Jersey, Inc., a drug and alcohol counseling center owned and operated by Martinez. Defendants allegedly submitted fraudulent health care claims to the Medicaid Program seeking reimbursement for medical services that were never provided. The cases as to Hispanic Counseling and the defendants are pending trial.

The Inquirer
June 1, 2002
**Mental-health workers
indicted on fraud charges**

State v. Happy Hearts & Gilda Hernando

On April 3, 2002, Gilda Hernando, billing coordinator at Happy Hearts, formerly a Medicaid provider that provided mental health counseling to Medicaid recipients, pled guilty

to recklessly submitting health care claims and wrongfully billing the Medicaid Program. Happy Hearts was previously suspended as a Medicaid provider. Hernando was ordered to pay \$200,000 in restitution and a criminal fine of \$7,500 following her guilty plea.

State v. Seymour Blau

On October 15, 2002, Seymour Blau, formerly a licensed podiatrist, pled guilty to Medicaid fraud. Blau admitted submitting approximately 150 prescriptions for both legend drugs and C.D.S., valued at more than \$6,000, in the names of four of his former patients who had been enrolled in the Medicaid Program. The former patients never received the drugs. Instead, Blau picked them up himself from the pharmacies. Blau awaits sentencing.

State v. Maximus, Inc., et al.

On July 31, 2002, a State Grand Jury returned indictments against Ifeanyi Akemelu, Kattia Bermudez, Rayonne Clark, Victor Cordero, Lenora Grant, Iris Sabres, and Akbar Oliver, charging them with multiple counts of Medicaid fraud. Defendants were employees of Maximus, Inc., a company the State contracted to assist with the task of enrolling eligible persons into the New Jersey Family Care Program. The indictments alleged that the seven defendants fraudulently obtained benefits from the New Jersey Family Care Program by providing false information about income and dependents on the applications for the Program. The Program provides health insurance benefits to the “working poor,” people who work and earn too much money for Medicaid coverage, but not enough money for privately purchased health insurance. The indictments also alleged that Akemelu and Oliver assisted others in preparing false applications for the Program.

On November 12, 2002, Akemelu, Bermudez, Cordero, Grant, Sabres, and Oliver were admitted into the PTI Program, conditioned upon each serving 50 hours of community service. On December 16, 2002, Clark pled

guilty to Medicaid fraud and is awaiting sentencing.

State v. S Brothers Pharmacy, Shahid Khawaja, Milton Barasch & Dr. Axat Jani

On November 8, 2002, a State Grand Jury returned an indictment charging Shahid Khawaja, who was the owner of the S Brothers Pharmacy, Milton Barasch, a licensed pharmacist, and Dr. Axat Jani, with theft by deception, Medicaid fraud, and health care claims fraud. The indictment alleges that defendants participated in an alleged scheme to bill the Medicaid Program approximately \$293,815 for medications which were either never dispensed, or were dispensed to persons using someone else’s Medicaid recipient number. In some cases, phony bills were allegedly submitted to the Medicaid Program for medications prescribed for Medicaid recipients who had died years before. These cases are pending trial and will also be referred to the appropriate Professional Licensing Boards for action. Previously, on August 9, 2002, Azam Khan, an alleged co-conspirator in the S Brothers Pharmacy scheme, pled guilty to an Accusation charging him with health care claims fraud. Khan awaits sentencing.

State v. Harvey Lee Bellamy & Bernice Bellamy

On October 28, 2002, a State Grand Jury returned an indictment charging Harvey Lee Bellamy and Bernice Bellamy with health care claims fraud and Medicaid fraud. Harvey Lee Bellamy was the corporate president of H&B Medical Transportation Services, Inc., (H&B). H&B, a Medicaid licensed mobility assistance patient transportation service located in Magnolia, Camden County, provided transportation to Medicaid patients requiring transport to and from their medical treatment appointments. Bernice Bellamy was allegedly in charge of the billing for H&B. According to the indictment, Harvey and Bernice Bellamy, through H&B Medical Transportation Services, Inc., falsely billed the Medicaid

Program for the use of extra crew members who purportedly provided assistance to Medicaid recipients during the vehicle transports. The State intends to prove that the Bellamys submitted false bills to Medicaid for transportation services rendered to approximately 14 Medicaid patients totalling \$22,860. Their case is pending trial.

State v. Kwadwo Oei Agyemang & Victory Pharmacy, Inc.

On December 13, 2002, a State Grand Jury returned an indictment charging Kwadwo Oei Agyemang, a licensed pharmacist, with health care claims fraud, Medicaid fraud, and corporate misconduct. Victory Pharmacy, a corporation owned and operated by Agyemang, was also charged in the indictment with health care claims fraud and Medicaid fraud. The indictment alleges that, between November of 2001 and June of 2002, Agyemang submitted in excess of \$27,000 in fraudulent bills to the Medicaid Program through Victory Pharmacy, Inc., for legend drugs which were never dispensed. The false claims were allegedly submitted on behalf of undercover OIFP investigators who were posing as Medicaid recipients. Agyemang's case is pending trial.

State v. Howard Williams, III

On December 23, 2002, Howard Williams pled guilty to an Accusation charging him with health care claims fraud. Williams admitted that, between March of 2000 and February of 2002, he fraudulently used the names of Medicaid recipients to obtain, and have filled, phony prescriptions for the non-narcotic drugs, Diflucan, Viracept and Epivir. The Medicaid Program was billed approximately \$75,388.05 for the phony prescriptions filled by Williams. Williams had been arrested by officers of the West New York Police Department on February 8, 2002 and was found to have in his possession a small amount of heroin, as well as Diflucan, Viracept, and Epivir. Williams awaits sentencing.

Medicaid Civil Case Settlements

Eckerd Corporation, Inc.

A civil Medicaid fraud settlement was reached between the federal government and Eckerd Corporation, in which New Jersey will receive \$206,167 as its share. The settlement stemmed from a lawsuit filed by several states, including New Jersey, which alleged that Eckerd had billed the Medicaid program for the full amount of prescriptions that were only partially filled.

State v. Corning, Inc., et al.

A civil Medicaid fraud settlement was reached between the federal government and Corning, Inc., in which New Jersey will receive \$13,125.00. The settlement stemmed from a lawsuit brought on behalf of several states, which alleged federal false claims violations.

State v. SJ Nurses, Inc.

A civil Medicaid fraud settlement was entered into with SJ Nurses, Inc., requiring SJ Nurses to pay \$20,570 to the State of New Jersey. SJ Nurses was alleged to have billed for personal care assistance services that were not rendered.

State v. Ambulatory Pharmaceutical Services & Raymond Mirra

A civil Medicaid fraud settlement with Ambulatory Pharmaceutical Services (APS) was entered providing for payment of \$1,300,000 to the State of New Jersey. APS allegedly provided higher priced brand medication, rather than generic, even when generic medications were available.

State v. National Medical Care, et al.

A civil Medicaid fraud settlement was entered with National Medical Care in which New Jersey received \$178,122 in restitution and penalties. National Medical Care allegedly overbilled for providing end stage renal disease treatment.

Renex Corp.

A civil Medicaid fraud settlement agreement was executed by the State with National Nephrology Associates. Several dialysis facilities, known as Renex, were overpaid on the submission of Medicaid claims for Epogen administrations. The recovery for the State, including the New Jersey federal share, was \$1,658,778.68.

Gambro Healthcare Inc.

A partial civil Medicaid fraud settlement was reached with Gambro Healthcare, Inc., which overcharged the Medicaid program more than \$1 million for Epogen, a blood enhancing substance for dialysis patients. The total settlement for New Jersey was \$2,098,291.87.

County Prosecutors' Offices Criminal Investigations and Prosecutions

Case Summaries

Atlantic County

Prison for their roles in the conspiracy.

State v. Cedric Williams, Dolores Perry & Shelly Perry

In May of 2002, Cedric Williams was sentenced to 10 years in State prison on charges of arson for hire and conspiracy in connection with the burning of a home insured for \$224,500 in Pleasantville, New Jersey. Williams had conspired with his sisters, Shelly Perry and Dolores Perry, to burn their home for \$800 as a predicate to their filing a fraudulent insurance claim on the loss of the home. Williams was to receive an additional \$50,000 for his services upon payment of the insurance claim. In January and February 2003, Shelly and Dolores Perry were also sentenced, respectively to 10 years in State

State v. Thomas Scott

In July 2002, Thomas Scott, formerly a police officer with the Pleasantville Police Department, was sentenced to 364 days in the Atlantic County Jail, forfeiture of his employment as a police officer, and payment of \$4,700.62 in restitution, fines and assessments for his part in a conspiracy to file a fraudulent insurance claim for the alleged theft of a motorcycle. Scott had previously borrowed the motorcycle from codefendant, Norman Gordy, and informed Gordy that the motorcycle had been stolen. Scott advised Gordy to reinstate his lapsed insurance policy and report the motorcycle as having been stolen on a later date in order to provide

coverage for the loss. In April 2002, Scott had been convicted by a jury on charges of theft by deception after only 15 minutes of deliberation. At his trial, Scott appeared wearing a fez and waving a small Moorish flag, claiming that he was not subject to the jurisdiction of the court because he was no longer a United States citizen but was, rather, Oman Valord Bey, a free Moor exempt from prosecution pursuant to an ancient treaty with the Moors who had inhabited Spain in the Middle Ages. Scott was, nevertheless, convicted in *absentia* after walking out of the trial when the court rejected his novel defense. Gordy had previously been accepted into PTI and agreed to testify for the State against Scott.

Bergen County

State v. John Georgas

On November 12, 2002, John Georgas, owner and operator of Tri-State Services in Ridgely, New Jersey, pled guilty to charges of conspiracy, attempted theft by deception, hindering apprehension, and providing false information to law enforcement officials. Georgas falsely reported that his business had been burglarized and subsequently filed a fraudulent insurance claim for alleged losses of over \$27,000 in stolen currency and computers. Georgas had conspired with another individual to obtain false business invoices to support his fraudulent claim.

State v. Johnny Garcia

On November 14, 2002, Johnny Garcia was sentenced to 18 months in State prison after pleading guilty to conspiracy to commit theft by deception, hindering apprehension and providing false information to law enforcement officials. Garcia participated in a scheme to file a fraudulent insurance claim with First Trenton Indemnity Company for the theft of a friend's vehicle, a 2000 Toyota 4-Runner.

State v. Renata Popiolek

On April 6, 2002, Renata Popiolek was

sentenced to three years probation and ordered to pay restitution of \$7,949 for filing fraudulent insurance claims over a period of six months for various dental procedures that she had never received.

State v. JoAnn McGrady

On December 20, 2002, JoAnn McGrady, a.k.a. JoAnn Schmidt, pled guilty to theft by deception in connection with a scheme to divert Medicare payments from a physician to her own account.

Burlington County

State v. Auronda Barnes

On August 19, 2002, Auronda Barnes pled guilty to health care claims fraud. Barnes fraudulently obtained prescription drugs in her name and in the names of others, and filed fraudulent insurance claims to pay for those prescriptions. The investigation was conducted jointly with the Mercer County Prosecutor's Office. Barnes is awaiting sentencing.

State v. April Hines, Maurice Key & Linda Haw

On September 13, 2002, April Hines, Maurice Key and Linda Haw were charged with conspiracy and attempted theft by deception for conspiring to file a fraudulent insurance claim for the theft of Hines' 1999 Lexus SUV. Hines had reported her vehicle stolen on August 2, 2002. The vehicle, driven by Maurice Key, was subsequently stopped by the New Jersey State Police on August 24, 2002, when Key allegedly admitted that he had agreed with Hines, through her aunt, Linda Haws, to take the vehicle and have it crushed in a North Philadelphia industrial compactor so that it could be reported stolen. Instead of having it crushed, as agreed, however, Keys allegedly continued to drive the vehicle for the ensuing 22 days as though he were the owner.

State v. Raelisa Kroll aka Jean Croll

On August 16, 2002, Raelisa Kroll, aka Jean

Croll, was sentenced to three years probation, conditioned upon serving 364 days in county jail, for health care claims fraud. Kroll fraudulently obtained prescription drugs from several pharmacies and used her former husband's and father's insurance cards to pay for them.

Camden County

State v. James Merritt

On May 3, 2002, James Merritt was sentenced to three years probation for attempted theft by deception. Merritt filed a fraudulent \$13,000 homeowners insurance claim with the Hartford Insurance Company, for an alleged burglary, using the very same receipts he had presented in a prior insurance claim.

State v. Joseph Shaw

On August 16, 2002, Joseph Shaw was sentenced to five years in State prison on charges of aggravated arson and attempted theft by deception. Shaw set fire to his Clementon, New Jersey home and attempted to collect nearly \$190,000 in insurance proceeds from the Peerless Insurance Company. The fire killed the three family dogs and resulted in the injury of a firefighter who responded to fight the blaze. Shaw also agreed to a civil consent judgment for \$17,500 in favor of the insurance company to reimburse it for the payment it had to make to Shaw's wife for the loss of her home under the "innocent spouse" doctrine.

State v. Frank Sanchez & Sonya Sanchez

On April 22, 2002, Frank Sanchez pled guilty to theft by deception. Sanchez falsely reported the theft of his 2000 Ford Ranger from Veteran's Stadium in Philadelphia, Pennsylvania, as a predicate to the filing of a fraudulent insurance claim by his wife and codefendant, Sonya Sanchez. Frank Sanchez and Sonya Sanchez, who were admitted into PTI, agreed to make restitution to the First Trenton Indemnity Company in the amount of \$17,418.90 and agreed to pay civil insurance

fraud fines of \$3,500 and \$1,500, respectively.

State v. Carol Nesbitt

On June 14, 2002, Carol Nesbitt was sentenced to four years in State prison and ordered to make restitution of \$9,309.55 to American Bankers Insurance, the Camden County Board of Social Services, the New Jersey Division of Taxation and the Division of Medical Assistance and Health Services. Nesbitt fraudulently collected credit disability payments by forging her doctor's signature on disability claim forms. Nesbitt also committed welfare fraud, Medicare fraud, and tax evasion and was held in contempt of court. The latter crimes were discovered when Nesbitt lied to the Probation Department after an earlier plea to only the credit disability fraud charges. The earlier plea would have required only four years of probation, 270 days in a house arrest program and restitution of \$4,295.80. Nesbitt, however, lied to the Probation Department regarding her income, which led to an investigation by the Camden County Board of Social Services which revealed that she had submitted the same forged disability forms to that agency. The ensuing investigation further revealed that Nesbitt had forged a letter of employment to the house arrest program and had attempted to obtain another letter of employment from a school board despite having been previously barred by court order from public office. The investigation also revealed that Nesbitt had failed to collect the required State sales tax while conducting a retail business.

State v. Sebastian Bryant & Tanya Bundick

On October 28, 2002, Sebastian Bryant pled guilty to theft by deception. Bryant admitted his role in a scheme to add his name as a passenger to an accident report in order to fraudulently collect first party insurance benefits from the State Farm Insurance Company and file a bodily injury claim against the driver insured by Prudential Insurance

Company. After Bryant's codefendant, Tanya Bundick, had been involved in an automobile accident on April 9, 2000, Bryant and Bundick falsely reported to the police that Bryant had been a passenger in Bundick's vehicle at the time of the accident. An interview by the Prudential SIU investigator with the driver of the other vehicle revealed that there had been no adult male passenger in Bundick's vehicle, after which Bundick confessed to the fraud. Bundick was admitted into PTI and ordered to pay restitution in the amount of \$2,095 to State Farm Insurance Company. Bryant is awaiting sentencing.

Cape May County

State v. John McHugh

On October 22, 2002, John McHugh of Philadelphia, Pennsylvania, was indicted and charged with theft by deception and filing a false police report. The indictment alleges that he falsely reported his boat stolen in Lower Township, New Jersey, in August of 2002, in order to file a fraudulent insurance claim for over \$24,000. The boat was subsequently recovered at the home of a friend of McHugh in East Pennsboro, Pennsylvania, in November of 2002. The case is pending trial.

State v. Robert Tommassello & Alfred Natale

On June 4, 2002, Robert Tommassello and Alfred Natale were indicted and charged with theft by deception and conspiracy. The indictment alleges that the two submitted a fraudulent insurance claim for wind damage at Tommassello's business in Wildwood, New Jersey. After pleading guilty, Natale was sentenced on November 18, 2002, to two years probation and payment of \$1,000 in restitution. Tommassello is pending trial.

Cumberland County

State v. Pete Walsh

On September 20, 2002, Pete Walsh was

sentenced to three years probation, conditioned on 90 days in county jail, and ordered to pay restitution of \$12,311 to the Progressive Insurance Company. Walsh had his 1996 Ford Explorer abandoned and burned in Maurice River Township, New Jersey, in order to file a fraudulent insurance claim. Prior to filing the fraudulent insurance claim, Walsh had reported to the Newark, Delaware Police Department, that the vehicle had been stolen from his residence.

Essex County

State v. Vielka Morales

On October 8, 2002, Vielka Morales was indicted and charged with aggravated arson, conspiracy and attempted theft by deception. Morales allegedly falsely reported her 2001 Hyundai Santa Fe stolen in Harrison, New Jersey. Although Morales claimed to have driven the vehicle to work on May 16, 2002, the vehicle had allegedly been discovered burned the day before. The State intends to prove that the fire had been set to the interior of the car and there was no attempt to strip the vehicle of its components.

State v. Fausto Acosta-Ceballos & David Acosta

On December 10, 2002, Fausto Acosta-Ceballos was indicted and charged with aggravated arson, conspiracy and attempted theft by deception. Acosta-Ceballos allegedly falsely reported his 1998 Lexus LS400 stolen in Union City, New Jersey. The State intends to prove that when the vehicle was burned in Newark on February 24, 2002, the fire had been started by an accelerant poured on the driver's seat and ignited. The fire ultimately extinguished itself for lack of oxygen because the windows had been left closed. Acosta-Ceballos' son, David Acosta, was also indicted for attempted theft by deception for making the false insurance claim.

State v. Samuel Gonzalez & Raffaele Arcidiacono

On December 10, 2002, Samuel Gonzalez and Raffaele Arcidiacono were indicted and charged with arson for profit. Arcidiacono allegedly paid Gonzalez \$500 to burn his 2001 Chrysler L. H. S. The State intends to prove that the vehicle was equipped with a transponder and was ignited in its interior in East Orange, New Jersey.

State v. David Hill

On January 25, 2002, David Hill, a former law enforcement officer, pled guilty to theft by deception. Hill was sentenced to one year probation and a \$250 fine and forfeited his right to ever work again as a law enforcement officer in New Jersey. Hill falsely reported his car stolen and filed a fraudulent insurance claim for its theft.

Essex County Vehicle Fire Initiative

Funded by an OIFP grant, the Essex County Prosecutor's Office has undertaken an initiative to target insurance cheats who have their cars burned in order to collect the insurance proceeds. The Initiative operates as a separate unit in the Prosecutor's Arson Task Force and works closely with local police detectives and insurance company investigators to ensure that every suspicious motor vehicle fire is thoroughly investigated by trained personnel as quickly and effectively as possible. It is expected that the Initiative could serve as a prototype for similar efforts in other New Jersey counties. In operation since October of 2002, the Vehicle Fire Initiative has opened over 80 cases involving over \$1.6 million in insurance claims.

Gloucester County

State v. Isabella Abriola-Parker

On April 22, 2002, Isabella Abriola-Parker pled guilty to filing 26 separate fraudulent personal injury claims, totalling over \$265,000, over a six year period in municipalities throughout South Jersey. On June 7, 2002, Abriola-Parker was sentenced to four years in State prison, and agreed to pay civil fines

totalling \$140,000.

State v. James Ambrose & Joshua Mettinger

On August 23, 2002, and July 26, 2002, James Ambrose and Joshua Mettinger, respectively, were sentenced to 90 days in county jail and three years of probation for theft by deception. Ambrose and Mettinger were involved in an automobile theft which the State sought to charge as an owner "give-up" based upon the automobile owner's alleged suggestion to Ambrose to "steal" his (the owner's) vehicle. The undisputed facts revealed that James Ambrose and Joshua Mettinger were neighbors of the vehicle's owner and took the vehicle from the owner's driveway one evening with the intention to resell the vehicle in Philadelphia. Another friend, Bernard Pozzi, was to follow them to the point of sale and provide them with a ride home. Upon reaching their destination, Ambrose and Mettinger were held up at gunpoint and, unable to provide the robbers with cash, gave them the car instead. Meanwhile, observing the plight of his comrades, Pozzi promptly departed the vicinity, leaving his friends to rely upon public transportation to find their way home to New Jersey. Ambrose and Mettinger ultimately pled guilty to theft by deception, and Pozzi was admitted into the PTI program. No charges were filed against the owner.

Hudson County

State v. Edgar Saldana

On April 30, 2002, Edgar Saldana, owner of a state licensed auto body repair shop in Union City, was indicted and charged with receiving stolen property. Saldana allegedly operated a "chop shop." Based upon information supplied by one of Saldana's former employees, authorities executed a search warrant which yielded stolen automobile parts, including a car frame, which was allegedly used in a scheme to sell a salvage title vehicle to a purchaser who was actually an undercover investigator.

State v. Josner Rivadineira & Oscar Perez

On July 24, 2002, Josner Rivadineira and Oscar Perez were indicted for conspiring to falsely report the theft of a Ducate motorcycle owned by Rivadineira. The motorcycle was allegedly actually being hidden in Rivadineira's brother's garage, after the title had been transferred to Perez. The investigation leading to the indictment was prompted by an argument between the brothers, which caused Rivadineira's brother to report him to authorities. Universal Underwriters paid Rivadineira \$11,356 on the fraudulent claim before his brother turned him in.

State v. Diaz

On August 14, 2002, a Hudson County Grand Jury handed up the indictment of 22 individuals alleged to have been involved in the staging of four collisions intended to form the basis of a series of fraudulent insurance claims. Two of the indicted defendants pled guilty before the end of the year, and additional guilty pleas are expected in 2003. Among the charges faced by the remaining defendants are conspiracy, theft by deception, health care claims fraud, unsworn falsification, aggravated assault and employing a minor in the commission of a crime.

Staged Accident Ring Investigation

In 2002, the Hudson County Prosecutor's Office continued with the prosecution of defendants previously indicted in a staged accident ring. In the course of 2002, 43 defendants entered guilty pleas resulting in the ordering of over \$105,000 in restitution to victimized insurance carriers. Many of the defendants remain fugitives. This investigation also resulted in the indictment of 32 additional defendants in 2002.

Mercer County

State v. Piotr Stachowicz & Piotr Jadczyk

On March 11, 2002, Piotr Stachowicz pled guilty to aggravated arson and attempted theft by deception. Stachowicz burned his sport

utility vehicle in Hopewell, New Jersey, in October of 2001, and reported it missing in order to file a fraudulent insurance claim. Stachowicz and an accomplice, Piotr Jadczyk, had been spotted in the vicinity of the burning vehicle by a passerby who tipped off the police and provided them with the license plate number of another vehicle in the area, which turned out to be driven by Jadczyk. Stachowicz was released on probation after serving three months in jail. For his part in the scheme, Jadczyk was also sentenced to three years probation.

State v. Douglas White

On February 21, 2002, Douglas White was sentenced to one year probation after pleading guilty to an Accusation charging him with attempted theft by deception. White falsely claimed that his vehicle had been stolen from a secured area and filed a fraudulent insurance claim with the Clarendon Insurance Company.

Monmouth County

State v. Marc Gallucci

On September 3, 2002, Marc Gallucci pled guilty to theft by deception and false swearing. Gallucci falsely reported that his car had been stolen from a shopping mall in Woodbridge, New Jersey, on December 16, 2000, and subsequently filed a fraudulent insurance claim with the Prudential Insurance Company. Prior to reporting his car stolen, Gallucci had crashed his Lincoln Town Car into a sign outside of a nightclub while intoxicated, and fled the scene. Police officials did not believe Gallucci's story and cited him for motor vehicle violations, to which he pled guilty in Municipal Court.

Morris County

State v. Danielle Peine

On November 19, 2002, Danielle Peine pled guilty to an Accusation charging her with theft by deception. Peine filed a fraudulent claim

for the theft of her 2001 Chrysler Sebring. Peine had paid someone \$500 to "steal" her vehicle so that she could obtain an insurance settlement from her insurance company.

State v. Mark J. Romeo & John A. Sedlock

On December 12, 2002, Mark J. Romeo and John A. Sedlock pled guilty to Accusations charging them with conspiracy and theft by deception stemming from a sting operation in which they unwittingly contracted to "steal" a vehicle so that the purported owner could file a fraudulent insurance claim. Romeo and Sedlock were recorded by a confidential informant making arrangements to steal an undercover vehicle which had actually been supplied by the Allstate Insurance Company. They were arrested while attempting to take the vehicle at the Rockaway Townsquare Mall.

Ocean County

State v. Jeffrey Halpern

On December 13, 2002, Jeffrey Halpern was sentenced to 12 years in State prison on multiple charges of theft by deception. Halpern fraudulently took title to a home by filing a fraudulent deed, generating a false mortgage commitment letter and using another person's identity to obtain a homeowners insurance policy and a home equity line of credit with life insurance.

State v. John Brundage

On August 9, 2002, John Brundage was sentenced to four years in State prison on charges of theft by deception and attempted theft by deception in connection with the filing of fraudulent insurance claims involving the alleged theft of two different automobiles in August and December of 1999. The investigation revealed that one of the vehicles had become stuck in the mud as the tide rose while Brundage was four wheeling, and Brundage had arranged for the other vehicle to be removed from a mall parking lot and taken to a storage facility.

State v. William Becica & Jessica Becica

On December 4, 2002, William Becica and his wife, Jessica Becica, were indicted and charged with health care claims fraud, theft by deception and the obtaining of prescription painkillers by fraud in connection with a scheme in which William Becica obtained over 2,000 prescription painkiller pills from over 40 doctors dating from May of 2000.

State v. Yong Jim Kim

On August 6, 2002, Yong Jim Kim, a Tom's River acupuncturist, was indicted and charged with health care claims fraud and the unlicensed practice of medicine for allegedly providing services and billing for them without the required medical license. His office manager, Karen Garone, was also indicted for health care claims fraud for allegedly submitting a misleading bill.

Passaic County

State v. Jose Siri

On August 8, 2002, Jose Siri was sentenced to four years in State prison for arranging nine separate staged accidents between 1994 and 1997. Siri registered and insured the vehicles in various fictitious names, recruited passengers and paid drivers to stage or cause accidents. He would then steer the passengers to medical providers in the City of Passaic for treatment. In return, Siri received a "runner's" fee of \$800 per patient. Losses to insurance companies resulting from Siri's actions totaled approximately \$230,000. In addition to his prison sentence, Siri was fined \$135,000 in civil insurance fraud penalties.

State v. Crystie Anthony

On September 2, 2002, Crystie Anthony was sentenced to two years probation on charges of forgery for producing and selling fraudulent insurance cards from her home in Paterson, New Jersey. After making several undercover purchases from Anthony, detectives executed a search warrant and seized several computers and computer components Anthony used to

produce the counterfeit cards. The investigation was conducted jointly with the Passaic County Sheriff's Department.

State v. Christopher Mazzo, D.C.

On November 12, 2002, Paterson chiropractor Christopher Mazzo pled guilty to paying a runner to procure several patients in 2001, including an investigator who was working undercover for the Passaic County Prosecutor's Office. Mazzo was entered into PTI and agreed to pay a \$5,000 civil insurance fraud fine.

State v. Gilda Santos

On November 15, 2002, Gilda Santos pled guilty to theft by deception. Santos falsely reported her car stolen on September 25, 2001, and subsequently filed a fraudulent insurance claim with the Allstate Insurance Company for its alleged theft. Santos' fraud was discovered after her vehicle was recovered in a New York City parking lot in December of 2001 and New York police determined that her car had been in the parking lot since September 18, 2001, approximately a week before Santos had claimed her vehicle was stolen. Santos was admitted into PTI and ordered to pay \$1,584.78 in restitution to the insurance company and \$5,506.61 to Universal Fidelity Corporation.

Salem County

State v. Leslie Mosley

On August 5, 2002, Leslie Mosley was charged with theft by deception and unlawful taking. Mosley allegedly falsely reported the theft of her leased 1998 BMW M3 in 1999, in order to avoid her lease obligations, while allegedly retaining the vehicle in a rented storage space in Carney's Point, New Jersey. Based upon the alleged report by Mosley, the State Farm Insurance Company paid the BMW Leasing Company \$43,598.76.

State v. Rachel Harrison

On August 29, 2002, Rachel Harrison was charged with fraudulently obtaining over \$100,000 in welfare and Medicaid benefits over a period spanning from January to August of 2002. Harrison is alleged to have obtained the benefits by misrepresenting her needs, her living situation, and her financial and marital status when making application for benefits.

State v. Russell Daniel, Andrea Richardson, Elnora Townsend, Martha Brown, Mary Daniel, Mischelle Raymond, Anothony Oliver, Jennifer Hooks, Douglas Slappey, Devon Dowe & Dawud Rakeem

In July and August of 2002, a joint investigation between the Salem County Prosecutor's Office and the Carneys Point Police Department led to the arrest and charging of 11 defendants in conjunction with schemes to produce, sell or possess fraudulent or fictitious motor vehicle insurance identification cards. The investigation also led to the apprehension of Andrea Richardson, a fugitive from the State of Delaware, and the seizure of a firearm allegedly possessed by Russell Daniel who was on parole at the time of his arrest.

Somerset County

State v. Richard Chang

On November 26, 2002, Richard Chang, a collections coordinator in the finance department of the corporate owner of the Arbor Glen Retirement Community, was indicted and charged with theft by deception. Chang allegedly stole 40 checks totalling \$206,000 paid by residents of the community and their insurance companies for the benefits of living in the retirement community. The case is pending trial.

State v. Daniel Gardner

On September 13, 2002, Daniel Gardner pled guilty to theft by deception. Gardner falsely reported the theft of his leased Ford Explorer

in March of 2001 and subsequently filed a fraudulent insurance claim which resulted in Liberty Mutual Insurance Company's payment of \$21,320 to satisfy the existing lien. The vehicle was found burning in the woods along Interstate 80 by the Pennsylvania State Police after its reported theft. Gardner is awaiting sentencing.

\$38,718.38 in July of 2000, only four months before she allegedly falsely reported it stolen. She is currently a fugitive from justice.

Sussex County

State v. Melissa Ermel

On October 18, 2002, Melissa Ermel was sentenced to two years probation, 30 days SLAP and fines of \$280 for exhibiting a fictitious insurance card on two separate occasions in February of 2002 in Newton, New Jersey.

Union County

State v. Diana Stephan

On June 7, 2002, Diana Stephan, who had been employed in her father's Rahway, New Jersey, insurance agency for over 20 years as a policy writer, was sentenced to three years probation and payment of restitution in the sum of \$6,322, for theft by deception. Stephan embezzled the insurance premiums of ten of the agency's customers and failed to obtain insurance on their behalf. Stephan was also barred from working in the insurance industry as a condition of her probation. The matter was referred to the Department of Banking and Insurance for further administrative review.

Warren County

State v. Grace Swass

On July 17, 2002, Grace Swass was indicted and charged with false swearing. Swass allegedly falsely reported the theft of her 2000 Ford Expedition in November of 2000 for the purpose of filing a fraudulent insurance claim with the Security Indemnity Insurance Company. Swass had financed the vehicle for

OIFP Civil Investigations and Litigation

Statistics

January 1, 2002 - December 31, 2002

Civil Investigations	Number	Dollar Amount
New Cases Opened	9,530	
Cases Forwarded for Investigation	4,639	
No Investigation Warranted	4,891	
PRE-LITIGATION DISPOSITIONS		
Warning Letters Issued	1,713	
Consent Orders Issued	877	\$6,010,275
Consent Orders Executed	440	\$1,373,000
Consent Order Judgments Filed	167	\$ 333,783
LITIGATION (Division of Law)		
Number of Referrals Received by Division of Law	490	
Number of Cases Resolved	526	\$5,073,211
Division of Law Enforcement Actions	161	\$ 542,255
Division of Law Original Settlements	365	\$4,530,956
COLLECTIONS (Department of Banking and Insurance)¹		
Number of OIFP Accounts Paid in Full	650	
Total Amount Received		\$1,981,845

¹ The Collections function remains in the Department of Banking and Insurance. These figures were reported by the Department of Banking and Insurance.

Narrative

OIFP received 9,530 referrals of suspected cases of insurance fraud in 2002, of which 4,639 were forwarded for further investigation by OIFP-Civil. Investigations by OIFP's Civil Investigators resulted in the issuance of 877 consent orders totalling \$6,010,275 in civil penalties. By year's end, 440 consent orders were executed by subjects charged with insurance fraud violations. Those subjects agreed to pay a total of \$1,373,000 in civil fines in 2002. One hundred and sixty seven consent order judgments were also filed in 2002 totalling \$333,783. Deputy Attorneys General in the Division of Law received 490 insurance fraud referrals for enforcement actions in 2002, most of which came from OIFP Civil Investigators.

The Division of Law resolved 526 matters in 2002, including the successful conclusion of 161 enforcement actions and the resolution of 365 original settlements. Enforcement actions totaled \$542,255, while settlements negotiated by civil Deputy Attorneys General accounted for \$4,530,956. Mirroring the success of OIFP-Criminal, OIFP-Civil also experienced its most productive year to date registering a 59% increase in the total dollar amount of its consent orders, settlements and judgments, and a 32% increase in the number of successful resolutions obtained. The case summaries which follow highlight a number of OIFP-Civil's successful investigations and several of OIFP's more significant actions brought by Deputy Attorneys General in the Division of Law.

Civil Investigative Case Highlights

In the Matter of ABP Chiropractic

As part of the ABP Chiropractic criminal investigation, handled by OIFP-Criminal, approximately 14 subjects were issued Consent Orders for civil insurance fraud fines ranging from \$1,500 to \$5,000 each, for a total of \$54,000. The ABP Chiropractic investigation involved the staging of auto accidents by the owner/operator of several chiropractic clinics and his co-defendants in order that PIP claims could be submitted to insurance companies.

In the Matter of Carl Prata

In late 2001 and during the course of 2002, 37 subjects executed Consent Orders totalling \$149,500 for participating in a scheme in which Carl Prata, a former employee of the Allmerica Insurance Company and the St. Paul Insurance Company, allegedly fabricated phony accident claims by inputting fictitious claims information into the companies' computerized claims databases. Prata allegedly caused the issuance of settlement claim checks in the names of the other participants in the scheme, who cashed the checks and split the proceeds with Prata. Many of those who entered into Consent Orders requiring them to pay civil fines were also prosecuted criminally by OIFP, as reported in the criminal case highlights section of this report. Prata, himself, has denied the allegations and was indicted on December 18, 2002 for issuing approximately 57 fraudulent claim checks totalling some \$625,000.

In the Matter of Dr. Elliot Heller

On October 4, 2002, Dr. Elliot Heller entered into a Consent Order to pay \$100,000 for knowingly billing various insurance companies for services he did not render and for submitting falsified surgical records for reimbursement at a higher "out-of-network" compensation rate than that to which he was entitled. Dr. Heller was also sentenced to three years in prison and ordered

to pay \$321,000 in restitution in a companion criminal matter prosecuted by OIFP.

In the Matter of Christopher Illenye

On May 29, 2002, Christopher Illenye entered into a Consent Order to pay \$5,000 for falsely reporting to Casualty Insurance Company that his vehicle had been stolen. Evidence showed that the vehicle had, in fact, been found crashed and abandoned prior to the reporting of the alleged theft.

In the Matter of Wanda Rios

On November 8, 2002, Wanda Rios entered into a Consent Order to pay \$5,000 for knowingly forging her husband's signature on the back of a PMA insurance benefit check and unlawfully depositing the funds into her own personal account.

In the Matter of Duvan Cardona

On June 28, 2002, Duvan Cardona entered into a Consent Order to pay \$5,000 for falsely reporting to Allstate Insurance Company that his vehicle had been stolen. The vehicle had actually been found burning prior to the reporting of the alleged theft.

In the Matter of Kenneth Lugo

On August 2, 2002, Kenneth Lugo entered into a Consent Order to pay \$3,000 for falsely reporting his vehicle stolen to Allstate Insurance Company. Evidence revealed the vehicle had been involved in an accident and abandoned prior to the reporting of the alleged theft.

In the Matter of Cathy Pitbladdo

On August 20, 2002, Cathy Pitbladdo entered into a Consent Order to pay \$4,000 for falsely reporting her vehicle stolen to Allstate Insurance Company. The vehicle had been recovered prior to the reporting of the alleged theft. Pitbladdo was also prosecuted criminally by OIFP in conjunction with this matter.

In the Matter of Scott Biroc & Nicholas Alcuri

On November 5, 2002, Scott Biroc entered into a Consent Order to pay \$10,000 for reporting to Cumberland Insurance Company that he had no involvement in the arson of his restaurant, Cucina d'Amore, when in fact he conspired with Nicholas Alcuri to purposely destroy the property to collect the insurance proceeds. Biroc and Alcuri were prosecuted by the Bergen County Prosecutor's Office. On September 30, 2002, Nicholas Alcuri entered into a Consent Order to pay \$5,000 for conspiring to commit arson with Biroc in an effort to collect the unlawfully obtained insurance proceeds.

In the Matter of Dimitrios Zacharias

On December 10, 2002, Dimitrios Zacharias entered into a Consent Order to pay \$20,000 for participating in an auto "give-up" scheme. Zacharias caused the reporting of four false auto thefts and a false homeowners claim, for contents allegedly in one of the vehicles at the time of the theft, to various insurance companies.

In the Matter of Marietta Lee Urban-Falk

On November 8, 2002, Marietta Lee Urban-Falk entered into a Consent Order to pay \$3,000 for failing to disclose to Hanover Insurance Company, a prior homeowners claim for similar damage for which she had previously recovered an insurance settlement.

In the Matter of David Moslowitz

On October 22, 2002, David Moslowitz entered into a Consent Order to pay \$5,000 for falsely reporting his vehicle stolen to State Farm Insurance Company. Moslowitz was also prosecuted by the Essex County Prosecutor's Office in conjunction with this matter.

In the Matter of Roben Brookhim

On June 4, 2002, Dr. Roben Brookhim entered into a Consent Order to pay \$15,000

for billing the Delta Dental Plan of New Jersey for services which had already been submitted to and paid for by another dental insurance company.

In the Matter of Dr. Gina Garcen-Ciallella

On July 9, 2002, Dr. Gina Garcen-Ciallella entered into a Consent Order to pay \$15,000 for conspiring with others to solicit individuals to obtain medical treatment at Downtown Chiropractic Center and to submit claims to various insurance companies for PIP benefits. Five other individuals also entered into Consent Orders in this case. Henry Robinson, a runner, entered into a Consent Order for \$5,000 on July 8, 2002. Judy Hechavarría, the receptionist, entered into a Consent Order for \$2,500 on September 12, 2002. Konstantin Zeva, the office manager, entered into a Consent Order for \$5,000 on September 12, 2002. Maria Mejias Wright, a former employee of the Jersey City Police Department, entered into a Consent Order for \$5,000 on September 12, 2002. Charnette Hillireo, a former employee of the Jersey City Police Department, entered into a Consent Order for \$5,000 on November 18, 2002. The case was also investigated by the Hudson County Prosecutor's Office.

In the Matter of Phillip Pigninelli

On June 4, 2002, Phillip Pigninelli entered into a Consent Order to pay \$12,000 for conspiring with Robert Castellano to file a fraudulent claim with the Great American Insurance Company for damages allegedly incurred to his boat. The criminal investigation in this case was handled by the Ocean County Prosecutor's Office.

In the Matter of Daniel Mazur

On June 4, 2002, Daniel Mazur entered into a Consent Order to pay \$5,000 for conspiring with two other individuals to give-up his vehicle and falsely report it stolen to Liberty Mutual Insurance Company. On June 4, 2002, James Freeman entered into a Consent Order requiring him to pay \$5,000 for conspiring

with Mazur. On July 31, 2002, Douglas Powell also entered into a Consent Order requiring him to pay \$5,000 for conspiring with Mazur. The criminal investigation was handled by OIFP-Criminal.

In the Matter of Alfred M. Smith

On January 16, 2002, Alfred M. Smith entered into a Consent Order to pay \$5,000 for misrepresenting the garage location of five commercial vehicles registered to his Atlantic City cleaning business. Smith claimed the vehicles were garaged in Northfield, New Jersey, when, in fact, the investigation revealed the proper garaging location to be Atlantic City.

In the Matter of Harvey Snyder, MD

On February 15, 2002, Harvey Snyder entered into a Consent Order to pay \$7,500 for misrepresenting his principal residence and the garage location of his vehicle. Snyder had registered his vehicle to a New Jersey address, when it was actually principally garaged in Philadelphia, Pennsylvania.

In the Matter of Luis Ruiz

On March 15, 2002, Luis Ruiz entered into a Consent Order to pay \$20,000 for his part in a staged automobile accident conspiracy in the Camden County area, in which fraudulent claims in excess of \$90,000 were submitted to Allstate, State Farm, Liberty Mutual, Prudential and Material Damage Adjustment Corporation insurance companies. The twenty-four co-defendants also executed Consent Orders for their roles in the scheme. The criminal case was handled by OIFP-Criminal.

In the Matter of Linda & Reginald Hart

On April 5, 2002, Linda and Reginald Hart each entered into Consent Orders requiring them to pay \$2,500 for their participation in the fraudulent automobile theft claim submitted to State Farm Insurance Company. The Harts claimed that their vehicle had been stolen, when the investigation revealed that the

vehicle was inoperable and had been towed by the Harts to a location in Philadelphia, Pennsylvania, where it was ultimately recovered.

In the Matter of Tse Cheung

On April 22, 2002, Tse Cheung entered into a Consent Order to pay \$5,000 for providing false information to Clarendon Insurance Company regarding his residency and the garage location of his vehicle. The investigation revealed that Cheung was residing in Staten Island, New York, rather than Trenton, New Jersey, as he had stated on his application for insurance and on his auto theft questionnaire.

In the Matter of Kumar Sirjoosingh

On May 9, 2002, Kumar Sirjoosingh entered into a Consent Order to pay \$5,000 for providing false information to Selective Insurance Company regarding the policy address and garage location of his vehicle. As a result of a PIP claim submitted by Sirjoosingh, Selective discovered a Queens, New York address where he had been residing and garaging his vehicle since 1999.

In the Matter of Robert McKee

On May 9, 2002, Robert McKee entered into a Consent Order to pay \$3,500 for submitting a fraudulent claim for a loss to his property in September 1998, which had been previously submitted and paid as a result of a November 1997 loss. McKee failed to make the repair following the earlier loss and resubmitted it as a new loss nearly two years later.

In the Matter of Dr. Donna Segarra

On June 4, 2002, Donna Segarra entered into a Consent Order to pay \$7,000 for submitting a claim to Selective Insurance Company for damage for which she had previously been paid.

In the Matter of Kerri Lampropoulos

On September 12, 2002, Kerri Lampropoulos, entered into a Consent Order to pay \$5,000

for submitting an altered document to Prudential in support of her fraudulent claim for disability insurance. At the time of the submission, Lampropoulos was actively employed as an agent with the Prudential Insurance Company.

In the Matter of Assunta Cuadra

On September 20, 2002, Assunta Cuadra entered into a Consent Order to pay \$20,000 for submitting a claim for water damage allegedly resulting from a broken pipe, when the investigation revealed that the damage existed at the time she had purchased the home.

In the Matter of Thomas Boselli

On October 28, 2002, Boselli entered into a Consent Order to pay \$100,000 for submitting claims for allegedly providing chiropractic care. The investigation revealed that Boselli was not actually licensed to practice chiropractic medicine at the time he claimed to have provided the services.

In the Matter of Sobeida Velazquez

On May 6, 2002, Sobeida Velazquez entered into a Consent Order to pay \$5,000 for submitting fraudulent bills to the Guardian Life Insurance Company. In this same case, a Consent Order for Vivian Borges executed on June 4, 2002, and a Consent Order for Lashunda Smith executed on July 9, 2002, required both Borges and Smith to pay \$5,000. These three individuals were employees of University Physicians Associates, a billing service for University Hospital (UMDNJ), when they submitted fraudulent health care claims for themselves. The criminal case was handled by OIFP-Criminal.

In the Matter of Mark Biddle

On May 9, 2002, Mark Biddle entered into a Consent Order to pay \$5,000 for submitting a fraudulent Workers Compensation claim to Crum & Forster Insurance Company.

In the Matter of Ellis Haynes

On July 31, 2002, Ellis Haynes entered into a Consent Order to pay \$5,000 for submitting a fraudulent credit disability claim to JMIC Insurance Company.

In the Matter of Franklin Webb

On May 6, 2002, Franklin Webb entered into a Consent Order to pay \$5,000 for submitting a fraudulent automobile theft claim to Metlife Auto and Home.

In the Matter of Bindraban Deosaran

On June 18, 2002, Bindraban Deosaran entered into a Consent Order to pay \$5,000 for submitting a fraudulent automobile theft claim to Liberty Mutual Insurance Company. The criminal case was handled by OIFP-Criminal.

In the Matter of Ryan Delvecchio

On June 4, 2002, Ryan Delvecchio entered into a Consent Order to pay \$5,000 for submitting a fraudulent automobile theft claim to State Farm Insurance Company.

In the Matter of Manuel Correia

On September 19, 2002, Manuel Correia entered into a Consent Order to pay \$5,000 for conspiring to submit a fraudulent automobile theft claim to Liberty Mutual Insurance Company.

Division of Law Case Highlights

State v. Daniel Fontanella

On October 15, 2002, the State filed suit to impose \$2,390,000 in civil insurance fraud fines against jailed Passaic County chiropractor Daniel Fontanella. The suit charges Fontanella with violating the Insurance Fraud Prevention Act by submitting falsified patient and billing records for 478 of his patients to 36 insurance carriers over a period of two years. An analysis performed by OIFP revealed that Fontanella's billing to the defrauded insurance carriers during that span of time totaled \$2,264,190. In the related criminal case, handled by the Passaic County Prosecutor's Office, Fontanella pled guilty and admitted fabricating 45 percent of those billings by filing purported claims for treatment for dates on which his patients did not appear in his office or receive any treatment. On his criminal conviction, Fontanella was sentenced to serve three years in State prison and pay \$500,000 in restitution. He had also previously surrendered his chiropractic license in 1998, but petitioned to obtain authorization to continue practicing as a chiropractor in New York while participating in a prison work release program. The complaint filed by the State seeks the imposition of a \$5,000 penalty for each of the 478 patients for whom Fontanella submitted fraudulent claims.

State v. Samuel Davit, M.D.

On November 12, 2002, the State obtained a consent judgment for an insurance fraud fine in the sum of \$50,000 against Samuel Davit, M.D. Davit, through his company, Global Diagnostics, committed multiple violations of the Insurance Fraud Prevention Act, including the preparation of false and misleading test results and billing for services not rendered. Davit also entered into a settlement with the Board of Medical Examiners pursuant to which he agreed to a revocation of his license to practice medicine in New Jersey and to pay additional civil penalties in the sum of

\$50,000, restitution in the amount of \$175,000 to First Trenton Indemnity Company, as well as attorneys fees and costs of suit.

State v. John Thompson, III, Christopher Jarrett, Raymond Waters & Louis Page

On November 18, 2002, the State obtained a default judgment against John Thompson, III, for fines and restitution in the amount of \$481,179 for his part in a conspiracy to defraud his employer, Rutgers Casualty Insurance Company, by issuing 32 fraudulent settlement checks totalling \$488,000 to his friends between 1995 and 1999. On November 18, 2002, the State also obtained a default judgment against one of Thompson's co-conspirators, Christopher Jarrett, in the sum of \$45,224. The other co-conspirators, Raymond Waters and Lewis Page, entered into Stipulations of Settlement and executed Consent Judgments, respectively, in the amounts of \$60,000 and \$55,000. All four had previously pled guilty to their thefts in federal court, where they were each sentenced to at least one year of prison and ordered to pay restitution.

State v. Muhammad A. Nasir

On November 15, 2002, a unanimous panel of the New Jersey Appellate Division upheld a summary judgment against Muhammad Nasir. The judgment had held him civilly liable for insurance fraud for purposely omitting information regarding a disabling medical condition affecting him at the time he applied for disability insurance coverage. Nasir had visited his family physician several times because of escalating symptoms of pain in his back and numbness in his hands and fingers and underwent an MRI prior to filing an application for disability insurance on April 27, 1996. Nasir learned of the MRI results on April 29, 1996, which revealed a herniated disc in his cervical spine that required spinal fusion surgery. When he filed a disability claim

following surgery on July 3, 1997, Nasir claimed that he first suffered symptoms on May 7, 1996. In upholding the ruling of the trial court, the Appellate Division also upheld an assessment of penalties, attorneys fees and costs under the Insurance Fraud Prevention Act because they were rationally related to the State's expenses in prosecuting him.

In the Matter of Michael Lio, D.C.

On March 25, 2002, Michael Lio, a licensed chiropractor, entered into a settlement agreement in which he admitted causing a December 3, 1999, fire in his vacation home in order to file a fraudulent insurance claim. Lio paid a \$10,000 civil penalty and is facing disciplinary action by the New Jersey Board of Chiropractic.

State v. Jettie D. Sailor

On December 28, 2002, the New Jersey Appellate Division, in what became the first published decision addressing the issue, agreed with the State that defendants in actions brought under the Insurance Fraud Prevention Act are not entitled to a trial by jury.

PART III
LEGISLATIVE AND REGULATORY RECOMMENDATIONS

Recommendations Pursuant to *N.J.S.A. 17:33A-24*

The Office of the Insurance Fraud Prosecutor submits the following recommendations under authority of *N.J.S.A. 17:33A-24*, which requires OIFP to formulate and evaluate proposals for legislative, administrative and judicial initiatives to strengthen insurance fraud enforcement and to provide an annual report to the Governor and Legislature:

A. Uninsured Motorists

1. *Statement of the Problem:* Drivers who are cited for driving without insurance pursuant to *N.J.S.A. 39:6B-2* are often able to avoid conviction by promptly obtaining insurance on the day they are cited. Since many automobile insurance policies are routinely issued retroactive to 12:00 AM on the date of issuance, drivers are then able to present court officials with documentation that purports to provide coverage prior to the time of the issuance of the summons charging the driver with driving without insurance.

Proposed Solution: In order to prevent drivers from escaping punishment for driving without insurance by obtaining documentation which purports to provide insurance coverage prior to the time the driver is cited, a regulation should be adopted requiring that automobile insurance coverage may only be provided prospectively, and that any documentation issued by insurance companies substantiating coverage provide information conforming to this requirement.

2. *Statement of the Problem:* The statute which makes it a crime to exhibit a fictitious or counterfeit insurance card does not criminalize the knowing display of an insurance card

which was valid when initially issued, but which has been lawfully canceled for nonpayment of premium or other policyholder breach. Consequently, drivers may circumvent the mandatory automobile insurance laws of New Jersey and avoid being charged under *N.J.S.A. 2C:21-2.3* for exhibiting a fictitious insurance card by obtaining a valid insurance card, making an initial installment payment and allowing the underlying policy to lapse for nonpayment of premium.

Proposed Solution: *N.J.S.A. 2C:21-2.3*, which makes the exhibiting of a fictitious or counterfeit insurance card a crime, should be amended to include the display or exhibiting of a validly issued insurance card which has subsequently been canceled for nonpayment of premium or other legal cause, and which the person displaying the insurance card knows is no longer valid.

3. *Statement of the Problem:* Uninsured drivers who display fictitious insurance cards are not subject to the same civil penalties under the Insurance Fraud Prevention Act as are other types of insurance fraud cheats. While a person who lies on an application for insurance may be heavily fined under the provisions of the Insurance Fraud Prevention Act, a person who displays a fictitious insurance card to a law enforcement officer is not subject to any civil penalties whatsoever.

Proposed Solution: The Insurance Fraud Prevention Act should be amended to include, among the violations enumerated therein, the possession, display, distribution or manufacture of a fictitious insurance card.

4. *Statement of the Problem:* The statute

which makes it a crime to exhibit or display a fictitious insurance card applies, by its terms, only to the display or exhibition of the fictitious card to a law enforcement officer or a person authorized to conduct a motor vehicle inspection. Drivers seeking to avoid compliance with the mandatory automobile insurance laws of New Jersey who resort to the use of fictitious insurance cards sometimes display or exhibit their fictitious or counterfeit insurance cards for inappropriate purposes to deceive other governmental officials or individuals in the private sector. The use of fictitious insurance cards in this fashion does not constitute a violation of *N.J.S.A. 2C:21-2.3*.

Proposed Solution: *N.J.S.A. 2C:21-2.3* should be amended to expand the class of persons to whom the fictitious card is exhibited from law enforcement officers to any person acting in an official capacity.

5. Statement of the Problem: Drivers who are subjected to auto insurance verification checks sometimes attempt to prove they are insured and avoid prosecution by exhibiting fictitious or fraudulent documentation purporting to substantiate insurance coverage other than fictitious insurance cards, such as documents which purport to be a binder, declarations page or face page of an insurance policy. The statute which makes the exhibiting or display of a fictitious insurance card a crime does not, by its own terms, extend to the exhibiting or display of other fictitious documents purporting to substantiate insurance coverage.

Proposed Solution: To ensure that an uninsured driver who falsely claims to be insured is not able to evade prosecution by virtue of the nature of the fictitious documents purporting to provide coverage, the statute making it a crime to exhibit or display a fictitious insurance card, *N.J.S.A. 2C:21-2.3*, should be expanded to include the exhibiting or display of any document purporting to

substantiate insurance coverage.

B. Criminal Statutory Provisions

1. Statement of the Problem: The highest grading for any theft offense, whether committed against an individual, a business, the State or an insurance company, is that of a second degree crime. A second degree crime provides for a maximum penalty of ten years of incarceration and a criminal fine of \$150,000. These penalties often do not reflect the significant harm caused by thefts of substantial sums, and may be insufficient to deter those who are willing to risk the penalties of a second degree crime to accomplish such thefts.

Proposed Solution: The Health Care Claims Fraud Act and other criminal theft statutes should be amended to provide that thefts of \$500,000 or more constitute crimes of the first degree with a maximum penalty of 20 years imprisonment.

2. Statement of the Problem: The "Runners Statute," *N.J.S.A. 2C:21-22.1*, which makes it a crime for a provider to pay another person to procure a client, patient or customer, has been interpreted by at least one court as not applying to payments from one provider to another. The court reasoned that such referrals are an exception to the statute as being "otherwise authorized by law." Accordingly, under this interpretation of the statute, an attorney may not be held criminally liable for paying a provider such as a chiropractor for the referral of bodily injury clients, and vice versa, because such referrals might be interpreted as "otherwise authorized by law."

Proposed Solution: The "Runners Statute" should be amended to provide that, "for purposes of this provision, the referral of a client, patient or customer from a provider to another provider, not of the same profession as the referring provider, shall not be considered

as otherwise authorized by law."

C. Civil Fraud Act Provisions

1. *Statement of the Problem:* Significant numbers of New Jersey residents fraudulently use out of state addresses to register and insure vehicles which they garage at their full-time residences in New Jersey. In some cases this is done to obtain less expensive insurance policies than would otherwise be available in New Jersey. In other cases, migrant workers avail themselves of "one-stop shopping" in neighboring urban centers, such as Philadelphia, where they are able to obtain their vehicle's title, registration and insurance from a single dealer, who speaks their native tongue, for a low flat fee. This growing practice constitutes a form of "reverse rate evasion" which is subject to neither the civil penalties of the Insurance Fraud Prevention Act nor prosecution under the criminal laws of New Jersey because the act of obtaining the questionable insurance has taken place in another state and often involves an insurance carrier which does not underwrite automobile insurance in New Jersey. The practice may negatively impact insurance carriers in New Jersey by depriving them of the higher insurance premiums they might have charged had the insurance been properly obtained in New Jersey. New Jersey residents who suffer bodily injury or property damage resulting from an accident with such "reverse rate evaders" are put at risk because these out of state policies may provide lesser coverage than would otherwise be mandated under a policy issued in New Jersey, or may be voided altogether in the event of a claim on the basis of misrepresentations made by the policyholder having falsely claimed to reside, or garage the insured vehicle, in the neighboring state.

Proposed Solution: The Insurance Fraud Prevention Act should be amended to make the practice of "reverse rate evasion" a violation thereof subject to the prescribed civil

penalties for other violations of the Act.

2. *Statement of the Problem:* The Insurance Fraud Prevention Act does not include fraud against an HMO as one of the offenses for which a civil fine may be imposed. Consequently, those who commit fraud against an HMO are not subject to the civil penalties provided by the Fraud Act.

Proposed Solution: The Insurance Fraud Prevention Act should be amended to include fraud against an HMO as one of the acts constituting a violation of the Fraud Act, by adding an HMO as one of the enumerated "insurance company" entities in *N.J.S.A. 17:33A-3*.

3. *Statement of the Problem:* In order to reduce their premium payments, some businesses defraud their Workers Compensation insurance carriers by understating or failing to disclose the full extent of the risks for which they have obtained Workers Compensation coverage, such as by understating the business' number or nature of employees or by failing to disclose significant additions to a business vehicle fleet. This type of insurance fraud does not currently constitute a violation of the Insurance Fraud Prevention Act, thereby depriving the State of the ability to impose appropriate civil penalties when such fraud is detected. Oftentimes the State is left without a viable remedy to address such fraud unless it is able to prove its case in criminal court with its enhanced burden of proof.

Proposed Solution: The Insurance Fraud Prevention Act should be amended to provide that Workers Compensation premium fraud constitutes a violation of the Act, subjecting the offender to the civil penalties provided therein.

4. *Statement of the Problem:* The acts of fraud which constitute violations of the

Insurance Fraud Prevention Act do not generally include acts of fraud against public entities and programs providing various types of insurance coverage, such as the various types of insurance indemnification provided by joint insurance funds and various social insurance programs such as those providing for unemployment and temporary disability benefits. Whether an insurance cheat is subjected to civil penalties provided by the Insurance Fraud Prevention Act should not depend upon whether the victim is a private business or public entity.

Proposed Solution: The Insurance Fraud Prevention Act should be amended to include that the acts identified therein as fraud against private insurance companies also constitute violations of the act when committed against public insurance programs and public entities providing various types of insurance coverage.

D. Civil Fraud Act Omissions

1. Statement of the Problem: Because the Insurance Fraud Prevention Act is silent as to the burden of proof to be borne by the State in civil enforcement actions filed thereunder, legal resources are sometimes unnecessarily wasted in the litigation of this issue .

Proposed Solution The Insurance Fraud Prevention Act should be amended to set forth that the appropriate burden of proof to be borne by the State in bringing an action thereunder is that of a "preponderance of the evidence".

2. Statement of the Problem: Although the Automobile Insurance Cost Reduction Act of 1998 transferred authority for most insurance fraud enforcement functions from the Department of Banking and Insurance to the Office of the Insurance Fraud Prosecutor, numerous references to the Commissioner of the Department of Banking and Insurance remain in the Insurance Fraud Prevention Act, which inaccurately depict the Commissioner as

having retained such previously transferred authority.

Proposed Solution: The Insurance Fraud Prevention Act should be amended to replace, where appropriate, all references to the Commissioner of the Department of Banking and Insurance with references to the Insurance Fraud Prosecutor.

3. Statement of the Problem: Civil enforcement actions brought on behalf of the Office of the Insurance Fraud Prosecutor are sometimes challenged on the basis that the actions were not filed within the appropriate statute of limitations. Because the Insurance Fraud Prevention Act is silent as to the applicable statute of limitations with respect to the filing of an action thereunder, this matter is often subject to needless litigation and the waste of legal resources by the State.

Proposed Solution: The Insurance Fraud Prevention Act should be amended to incorporate the applicable 10 year statute of limitations as set forth in *N.J.S.A. 2A:14-1.2*.

E. Health Care Claims Forms

1. Statement of the Problem: The claim forms which medical service providers submit to insurance carriers to obtain reimbursement for services which are covered under their patients' insurance policies are conducive to the commission of health care and PIP claims fraud because they fail to adequately affix legal responsibility for the truth of the assertions which they contain, and because, all too often, they allow for the reporting of vague or imprecise information. Since claim forms are often prepared by employees within a medical service provider's office, or by an independent contractor which specializes in billing on behalf of service providers, it is often difficult, if not impossible, to hold the actual licensed medical service provider legally responsible when claim forms contain false or misleading information. Further, in order to determine

whether services by a medical provider are properly compensable by insurance, insurers must be able, among other things, to ascertain the overall context of treatment within which the service was rendered, whether the claimed service was properly coded, and whether it was rendered in whole or in part by a licensed medical service provider.

Proposed Solution: Insurance claim forms, whether filed electronically or in “hard copy” paper forms, should require the inclusion of information specifically identifying the type of procedures, medical services and medical supplies provided, amounts actually paid by the patient, the identification of any persons in the provider’s office providing the services billed for, whether such persons are licensed, the professional license number, and all taxpayer identification numbers (TIN) associated with the licensed medical service provider and with any person or entity identified in the claim form as having provided any of the services set forth therein. Claim forms should also incorporate a certification which affixes personal legal responsibility for the claim’s accuracy with the appropriate licensed medical service provider. An example of such a certification follows: “I (name of medical service provider) certify that I have reviewed this claim form and that all of the information contained herein is accurate and truthful. I further certify that my signature on this claim form, whether that be an original signature or a stamp facsimile signature, or whether the signature block is simply noted ‘signature on file’, attests to the fact that I have reviewed this claim form and that the information contained herein is truthful and accurate. I further certify that I personally rendered the services described on this claim form, or that I directed, managed and supervised the person who provided the services described on this claim form. I further certify that this claim form accurately contains my professional license number and that of any other person whom I directed, managed and supervised in performing the services

described herein. I further certify that I understand that no payment can be made for the services claimed herein without my review and completion of this certification.”

F. Insurance Company Access to Accident Information

1. Statement of the Problem: When investigating claims arising out of an automobile accident in which the sobriety of a driver is in question, insurance carriers have a legitimate need to obtain and evaluate reports prepared by law enforcement officials setting forth the results of various sobriety tests, including the results of tests pertaining to the BAC (blood alcohol content) of a driver involved in the accident. Under current law, *N.J.S.A. 17:33A-29*, investigators employed by insurers are entitled to obtain accident reports from police departments within 24 hours of the occurrence of the accident which is the subject of the report. There is no comparable authority, however, enabling insurance company investigators to obtain the referenced information as it pertains to sobriety unless it is set forth in the accident report, itself. Accordingly, despite an equally compelling need by insurance carriers to obtain records relevant to the sobriety of an insured, or a party making a claim against the insured, results of sobriety tests are, as a practical matter, unavailable to insurance company investigators.

Proposed Solution: *N.J.S.A. 17:33A-29* should be amended to include a requirement that law enforcement officials release the results of sobriety testing to insurance company investigators in the same manner as they are obliged to release accident report information.

2. Statement of the Problem: Insurance company claims adjusters and third party businesses contracted by insurance carriers to obtain police accident reports on their behalf are sometimes denied access to accident reports by police departments under

N.J.S.A.17:33A-29 on the ground that they do not qualify as "investigators employed by insurers." Those individuals, are, in fact, duly authorized by carriers to perform the function of insurance company investigators.

Proposed Solution: N.J.S.A.17:33A-29 should be amended to read "investigators, claims adjusters, and businesses authorized to act on behalf of, or employed by, insurers..."

G. Law Enforcement Access to Records

1. Statement of the Problem: Records of vehicles transiting toll booths in New Jersey maintained by the EZ Pass system are an important investigative resource for law enforcement agencies investigating a variety of different types of suspected crimes, including a type of insurance fraud known as the automobile "give-ups," where an owner falsely reports a vehicle stolen in order to file a fraudulent claim for its alleged theft. Fraud by an owner in these cases can sometimes be proven by establishing that the vehicle was actually in use at a particular location, such as an EZ Pass toll booth, at a time inconsistent with the owner's version of events. Law enforcement investigators are often thwarted in their attempts to obtain and use as evidence, EZ Pass records, by a law which requires a court order before such records can be released but which, nonetheless prevents such records from being used as evidence.

Proposed Solution: The legislation requiring a court order to release EZ Pass records to law enforcement investigators should be amended to allow for the release and evidentiary use of those records pursuant to a law enforcement subpoena.

H. Insureds' Rights

1. Statement of the Problem: Corporations sometimes obtain life insurance on low level employees without their knowledge or consent in order to provide tax free funding for

employee benefits, such as post-retirement health benefits. This type of corporate owned life insurance differs from "key man" insurance because the deaths of the insured employees would ordinarily not be expected to negatively impact the economic viability of the corporation. Sometimes referred to as "janitors insurance" or "peasants insurance," it is attractive to corporations because the death benefits are tax free, and typically provide little or no benefit to the families of those whose lives are insured.

Proposed Solution: Legislation should be enacted to either require notice to or the consent of the insured employee when such insurance is contemplated, or to prohibit the practice altogether unless it can be demonstrated that the insured employee would qualify as a person eligible for "key man" insurance.

PART IV: APPENDIX

EXHIBIT A

OIFP CRIMINAL/CIVIL INSURANCE FRAUD PENALTIES IMPOSED COMPARISON 2001 - 2002 JANUARY - DECEMBER

ACTION TAKEN	TOTAL SANCTIONS IMPOSED 2002	TOTAL SANCTIONS IMPOSED 2001	PERCENTAGE INCREASE
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OIFP CRIMINAL CASES FILED					
OIFP Accusations Filed		88		57	54%
OIFP Defendants Charged by Accusation		87		58	50%
OIFP Indictments Filed		85		35	143%
OIFP Defendants Charged by Indictment		138		60	130%
OIFP Convictions (Guilty Pleas & Trials)		154		86	79%
OIFP Sentences		159		74	115%
GRAND TOTAL OIFP DEFENDANTS CHARGED		225		118	91%
OIFP FINES IMPOSED					
Criminal	\$ 177,680.00		\$ 16,750.00		
Civil	\$ 909,832.00		\$ 951,437.00		
Restitution	\$6,787,645.00		\$6,839,862.00		
GRAND TOTAL OIFP CRIMINAL FINES IMPOSED	\$7,875,157.00		\$7,808,049.00		1%

CIVIL SANCTIONS IMPOSED						
OIFP WARNINGS/ CONSENT ORDERS/JUDGMENTS FOR CIVIL INSURANCE FRAUD FINES	Warning Letters Issued		1,713		0	—
	Consent Orders Issued		1,044		1,211	—
	TOTAL Dollar Amount	\$6,344,058.33		\$5,119,150.00		24%
OIFP & DIVISION OF LAW CONSENT ORDERS / SETTLEMENTS / JUDGMENTS	Current Resolutions		966		734	32%
	TOTAL Dollar Amount	\$6,446,211.02		\$4,043,131.38		59%
GRAND TOTAL CIVIL INSURANCE FRAUD SANCTIONS IMPOSED			3,723		1,945	91%
		\$12,790,269.35		\$9,162,281.38		40%

GRAND TOTAL OIFP CRIMINAL AND CIVIL PENALTIES IMPOSED		3,948		2,063	91%
GRAND TOTAL OIFP CRIMINAL AND CIVIL MONETARY SANCTIONS IMPOSED		\$20,665,426.35		\$16,970,330.38	22%

EXHIBIT B

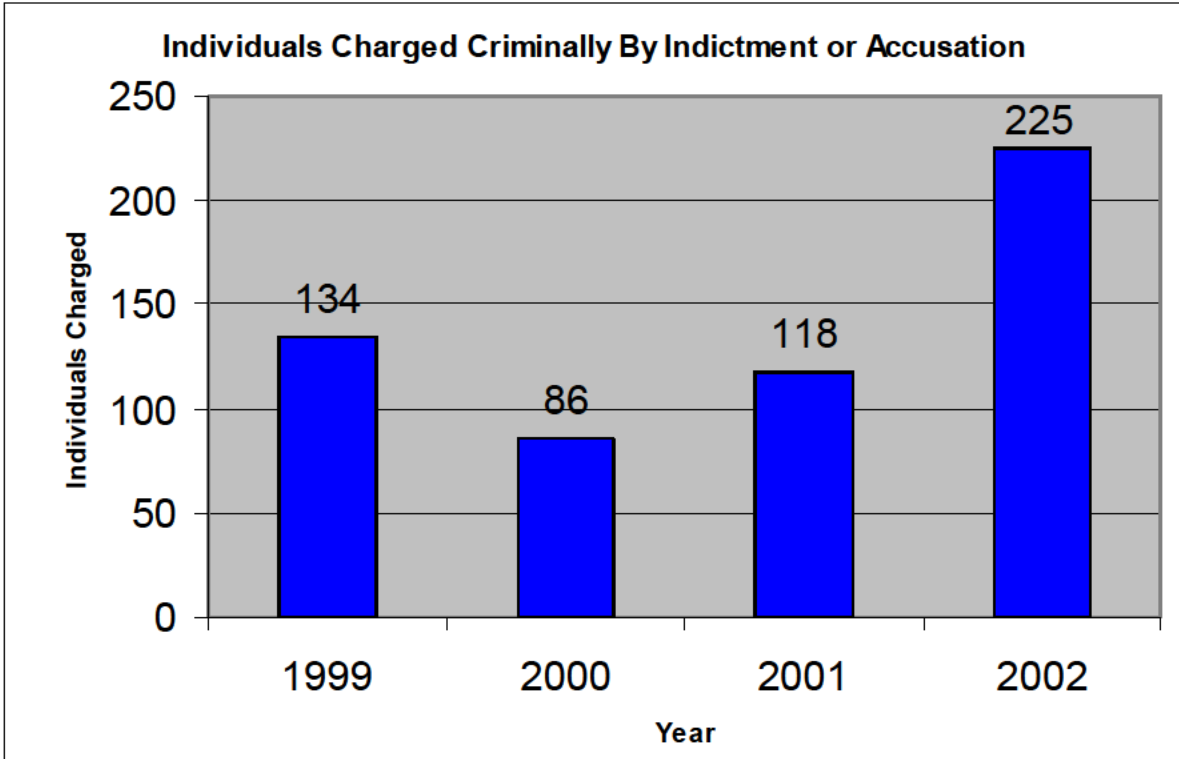


EXHIBIT C

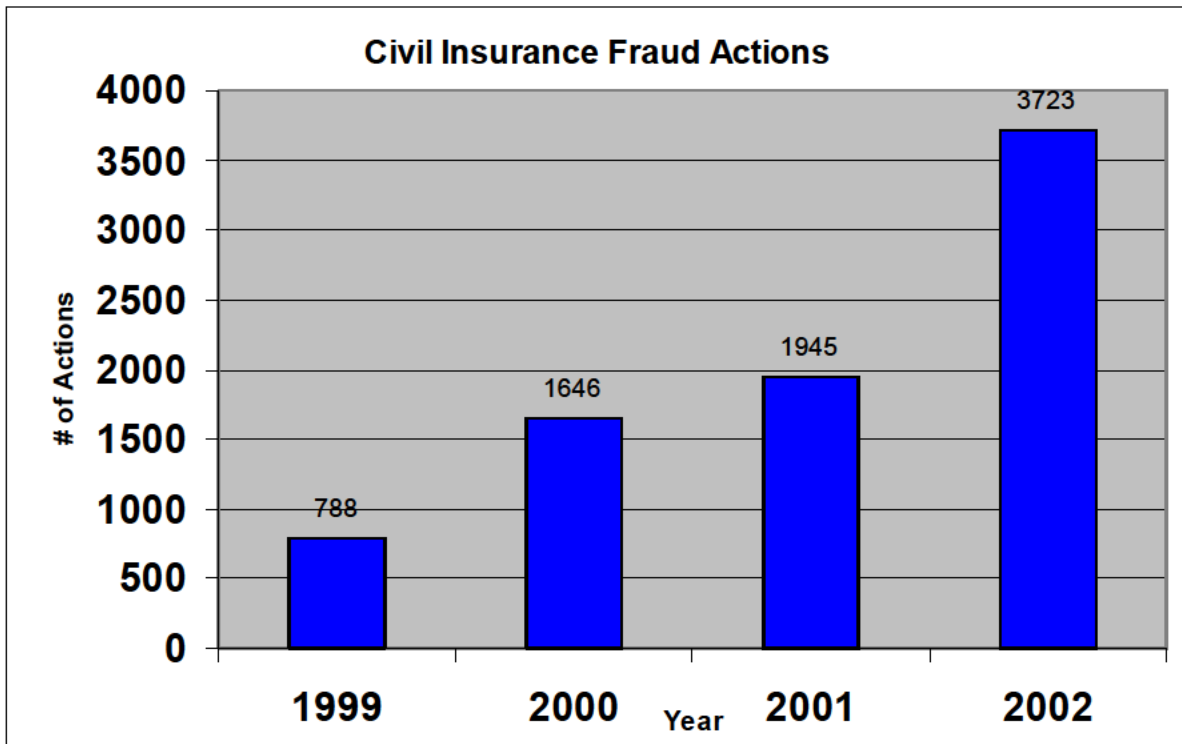


EXHIBIT D

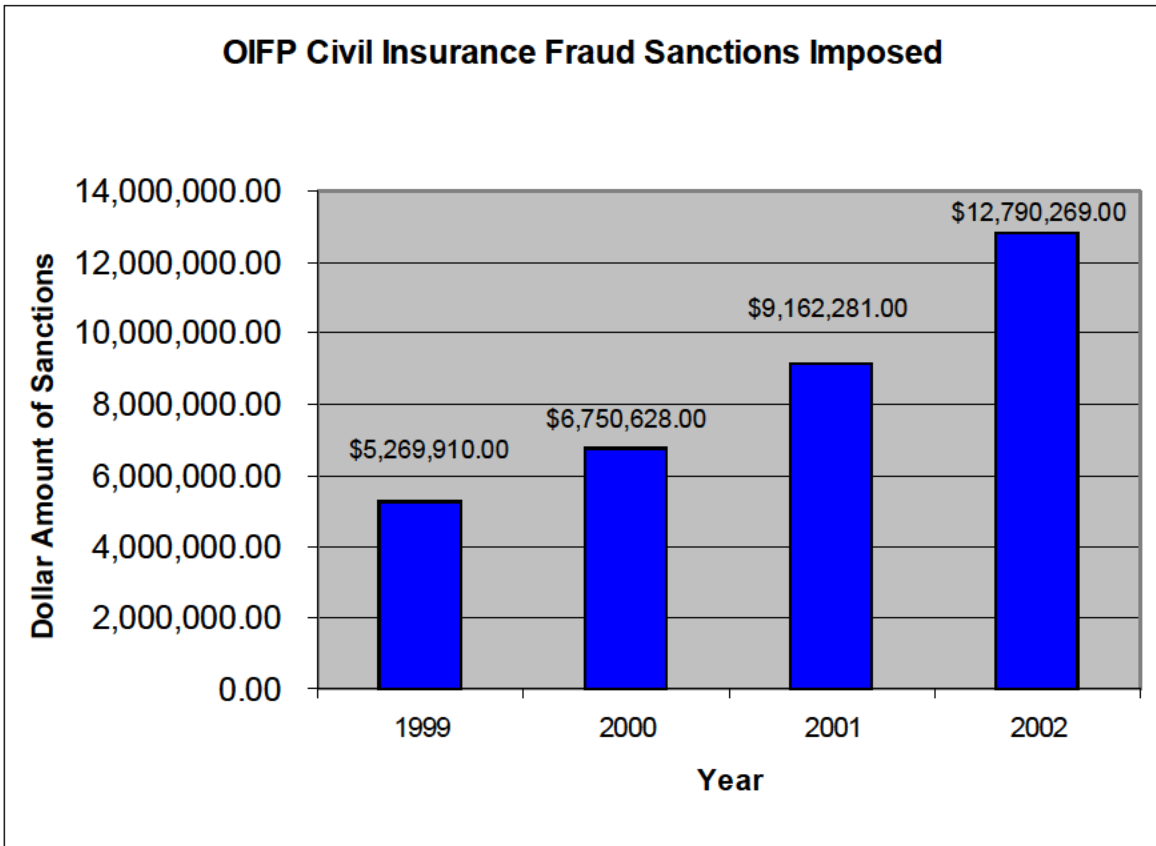


EXHIBIT E

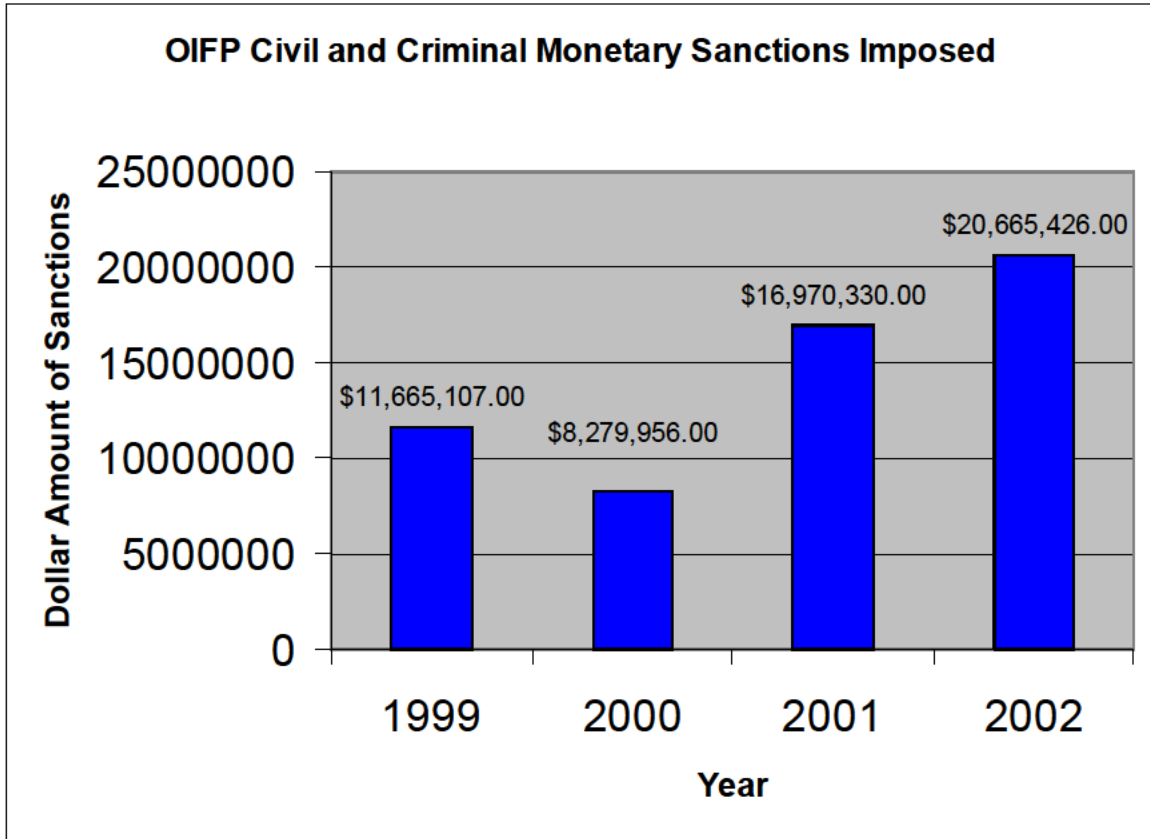


EXHIBIT F

Criminal Cases Investigated by Type of Insurance

Fraud in 2002

