

**INITIAL REPORT
OF THE
OFFICE OF INSURANCE FRAUD PROSECUTOR**

PURSUANT TO N.J.S.A. 17:33A-24d

March 1, 1999

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March 1, 1999

Honorable Christine Todd Whitman
Members of the New Jersey Legislature
State House
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Re: **Initial Report of the Office of Insurance Fraud Prosecutor**

Dear Governor Whitman and Members of the Legislature:

We are pleased to provide to you this initial Report by the Office of Insurance Fraud Prosecutor.

The report includes investigative and prosecutorial statistics and significant criminal cases and describes the substantive coordination and liaison work being done. Finally, and significantly, we set forth a blueprint of plans for future actions to be taken by OIFP. As you know, OIFP has not yet been in existence a full year. Nevertheless, OIFP has achieved important accomplishments to date and is dedicated to fulfilling its promised mission.

Respectfully submitted,

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Times of change are difficult for all concerned, and the transfer of the responsibility for conducting civil insurance fraud investigations from the Division of Insurance Fraud Prevention (DIFP) in the Department of Banking and Insurance to the Office of Insurance Fraud Prosecutor in the Division of Criminal Justice is certainly no exception. The following people who were formerly with the DIFP contributed tirelessly of their experience, time and talents to ease the way. Their role in establishing the Office of Insurance Fraud Prosecutor is hereby acknowledged with gratitude and appreciation.

Roy Bloom, former Director of DIFP
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The Insurance Fraud Prosecutor would also like to thank the following people for their contributions to preparation of this report:

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PREFACE

On May 19, 1998, the Automobile Insurance Cost Reduction Act of 1998 (AICRA) was enacted. *P.L. 1998, c. 21.* Pursuant to that Act, the Office of Insurance Fraud Prosecutor was created in the Division of Criminal Justice, Department of Law and Public Safety, to be headed by an Insurance Fraud Prosecutor, who would be under the direction and supervision of Attorney General Peter Verniero. *N.J.S.A. 17:33A-16.* According to the accompanying legislative statement, the Office of Insurance Fraud Prosecutor (OIFP) was created to “provide for a more effective investigation and prosecution of fraud than exists at the present time.”

AICRA provided that the personnel charged with civil investigatory work in the Division of Insurance Fraud Prevention in the Department of Banking and Insurance would be transferred to OIFP, as determined by the Attorney General and the Commissioner of Banking and Insurance, in accordance with a plan of reorganization. *N.J.S.A. 17:33A-17.* On June 25, 1998, Governor Christine Todd Whitman delivered Reorganization Plan No. 007-1998 to the Legislature. It required that the Plan become effective in 60 days. Under the Reorganization Plan, the functions, powers and duties, under the “New Jersey Insurance Fraud Prevention Act” (*N.J.S.A. 17:33A-1 et seq.*), of the Commissioner of Banking and Insurance and the Division of Insurance Fraud Prevention were continued and transferred to the Attorney General. In accordance with the Reorganization Plan, on August 24, 1998, the Division of Insurance Fraud Prevention (DIFP) in the Department of Banking and Insurance became part of the Office of Insurance Fraud Prosecutor within the Department of Law and Public Safety.

Under AICRA, OIFP is charged with investigating all types of insurance fraud and serves as the focal point for all criminal, civil and administrative prosecutions of insurance fraud. OIFP is additionally charged with the responsibility for coordinating all insurance-related anti-fraud activities of State and local departments and agencies in order to enhance the State’s fully integrated law enforcement system. In short, the creation of OIFP will improve the State’s overall ability to investigate and prosecute insurance fraud and will result in a cohesive, uniform Statewide strategy for combating insurance fraud.

On October 28, 1998, Edward M. Neafsey was sworn in as the Insurance Fraud Prosecutor. Pursuant to *N.J.S.A. 17:33A-24d*, which requires that an annual report be made to the Governor and Legislature by March 1 of each year, as to the activities of the Insurance Fraud Prosecutor during the preceding twelve months, this is the initial report of the Office of Insurance Fraud Prosecutor. In accord with the two major purposes of the Office, this report will relate the efforts and results of the fledgling OIFP in its investigative and prosecutorial function and its liaison and coordination function. Because OIFP has not been in operation for a full year, this report will focus primarily on the activities of the Office between October 28, 1998, when the Insurance Fraud Prosecutor took office, and March 1, 1999, the date of this report. The report will additionally include some data obtained for calendar year 1998 which relates to the State's anti-insurance fraud activities and issues related to the transition from DIFP to the newly created OIFP.

STATEMENT OF THE INSURANCE FRAUD PROSECUTOR

Behind the enactment of AICRA creating OIFP is a legislative mandate for more effective investigation and prosecution of insurance fraud. Indeed, the fact that the Legislature determined to move the civil insurance fraud investigatory function from the Department of Banking and Insurance to the Division of Criminal Justice demonstrates the legislative intent that a premium be placed on criminal prosecution. The recent enactment of the Health Care Claims Fraud Act, *N.J.S.A. 2C:21-4.2 et seq.*, further reveals the Legislature's purpose in criminally targeting purveyors of insurance fraud. Under that Act, practitioners who knowingly submit fraudulent insurance claims have committed a second degree crime, for which the practitioner can be sentenced to a term of imprisonment of between five and ten years. With this legislative emphasis in mind, and because practitioners play a major role in the processing of all types of insurance claims, one of OIFP's chief missions will be to target practitioners who submit false and inflated claims to private or government insurance providers. Thus, the criminal effort of OIFP is divided into insurance fraud and Medicaid fraud units.

This emphasis on criminal investigation and prosecution does not negate the importance of taking civil enforcement action, when appropriate. Indeed, in many less serious cases involving fraud, OIFP will pursue a civil penalty as the appropriate penalty. Nor will OIFP hesitate to recommend license revocation for practitioners who are subjected to civil or criminal enforcement, because loss of a professional license is a substantial sanction. In short, OIFP intends to utilize every enforcement tool provided by law. Nevertheless, because I view criminal prosecution and the stigma of criminal conviction as one of the most effective ways to deter white collar crime, I begin this report with a brief summary of some of the criminal case highlights occurring since my appointment.

Edward M. Neafsey
Insurance Fraud Prosecutor

CRIMINAL CASE HIGHLIGHTS

Since the transition to OIFP on August 24, 1998, important events have occurred in several notable criminal cases handled by OIFP-Criminal litigation. For some of these cases, charging documents and press clippings are included in the Appendix to this Report. It is hoped that the message being delivered will aid in deterring insurance fraud. Among the more significant criminal cases are the following:

Insurance Fraud

- ***State v. Jayen C. Shah, M.D.*** An example of good communication between industry and law enforcement concerning ongoing insurance fraud which provided good results is typified by the case of Jayen C. Shah, M.D. On January 7, 1999, Dr. Shah was sentenced to five years in prison on his guilty pleas to second degree attempted theft and third degree theft. Dr. Shah had taken out disability insurance policies which would have paid him over \$5,000 per month. Thereafter, he falsely claimed to have been paralyzed in a bus accident. While pretending to be confined to a wheelchair in order to collect insurance money, Dr. Shah, disguised in a wig and sunglasses, was filmed by representatives of New York Life Insurance Company walking to a fast food restaurant. The insurance company forwarded the film to the Division of Criminal Justice for investigation and prosecution. A law enforcement “sting” operation was set up, whereby Dr. Shah was lured back from India under the guise of receiving settlement money, and he was arrested. He pleaded guilty on November 2, 1998. In addition to his prison sentence, Dr. Shah paid full restitution to the defrauded carriers, repaid over \$70,000 in undeserved disability payments to the Social Security Administration and paid a \$45,000 civil penalty. Dr. Shah’s medical license was revoked by the Board of Medical Examiners.
- ***State v. Dr. Richard Finder.*** Where a licensed professional commits insurance fraud, license revocation can be an important and substantial sanction for the State. Dr. Finder, a Fort Lee chiropractor, was sentenced on January 8, 1999, to three years probation, \$20,000 in civil penalties and \$18,511 in restitution. Between April 1990 and August 1994, Dr. Finder de-

frauded 11 insurance companies of a total of \$22,254 and attempted to obtain approximately \$5,300 from the New Jersey Market Transition Facility and the New Jersey State Health Benefits Program. On November 8, 1998, Dr. Finder pleaded guilty to theft by deception and falsifying records, admitting a four year pattern of billing for no show visits, back-billing for treatments, billing for treatments in the names of covered patients and double billing by charging automobile insurance and health carriers for the same treatment without coordinating benefits. Dr. Finder pleaded guilty to the maximum charge which could be brought under State law, since his actions predated the 1998 Health Care Fraud Claims Act making similar practitioner insurance claims fraud a second degree crime. After sentencing, OIFP referred his case to the State Chiropractic Board for a license revocation hearing.

- ***State v. Edmund S. Greenberg.*** On December 17, 1998, a registered pharmacist pleaded guilty to defrauding the City of Orange of more than \$23,000 by submitting fraudulent prescriptions. For nearly three years, between December 1992 and November 1995, Greenberg falsified billings to Paid Prescriptions, Inc., the third party administrator of the city's employee prescription plan. Greenberg forged the names of existing city employees on the claims forms for prescriptions which were not issued to them. As part of the plea agreement, OIFP is seeking restitution. Upon sentencing, OIFP will forward a record of Greenberg's conviction to the New Jersey Board of Pharmacy for a license revocation hearing.
- ***State v. Carl Lichtman, et al.*** One of the largest insurance fraud and public corruption prosecutions in State history advanced significantly on February 2, 1999, when 37 indictments were returned by a State Grand Jury, charging 65 people with having conspired with former psychologist Carl Lichtman to defraud the State Health Benefits Plan and other health insurers of \$3.5 million for no-show treatments for "neurotic depression." Lichtman enlisted approximately 200 people, many of whom were public employees, to provide insurance information to him so that he could bill 35 insurance carriers or other insurance plans for treatments which were never rendered. While Lichtman pocketed the money received for the bogus treatments, he would kickback 25% to those individuals who were purportedly receiving services from him.

Lichtman would also pay “referral fees” to individuals for bringing additional persons into the conspiracy. It is alleged that the conspirators each received between \$425 and approximately \$14,000 in the scheme. Lichtman, who agreed to cooperate, previously had been sentenced to five years in prison. Additionally, cases involving 112 other conspirators have previously been resolved by guilty plea or other court disposition.

- ***State v. Karen A. Lawder, L.C.S.W.*** The first case to be prosecuted under the new Health Care Claims Fraud Act, N.J.S.A. 2C:21-4.3, by OIFP involved a school counselor and licensed clinical social worker who submitted \$4,000 in bogus personal medical bills to Blue Cross/Blue Shield. Lawder falsified claim forms and invoices in order to be paid by an insurer for counseling sessions she had neither attended nor paid for. On December 23, 1998, Lawder pleaded guilty to one count of second degree health care claims fraud. At her sentencing, which is scheduled for April 1999, she is facing a three to five year prison term and loss of her job as a school counselor. Upon sentencing, OIFP will forward a record of Lawder’s criminal conviction to the New Jersey Board of Social Work Examiners for appropriate professional licensing action.
- ***State v. Lexington Chiropractic.*** On February 18, 1999, a State Grand Jury indictment was returned charging Lexington Chiropractic and Esther DelPino, the office manager of Lexington, with second degree theft by deception, conspiracy and several counts of falsifying medical records. The indictment is the result of an undercover investigation in which State Investigators posed as accident victims, went to Lexington on more than 50 treatment days, received kick-backs and received instructions on how to ensure the success of their personal injury claims. For the three investigators who finished “treatment” for their non-injuries, Lexington over billed by adding another 40 false treatment dates to the bills submitted to carriers. DelPino is charged

with inflating personal injury protection (PIP) billings to automobile insurers by including treatments which were not in fact rendered. The indictment alleges that DelPino paid cash fees to people who referred accident victims to the clinic and that the inflated billings were used to bolster bodily injury claims.

- ***State v. Hani K. Elias.*** On February 23, 1999, the State Grand Jury indicted Hani Elias for criminal contempt of court and for selling falsified automobile insurance identification cards under a criminal statute which went into effect in April 1998, N.J.S.A. 2C:21-2.1a. While these are only third and fourth degree crimes, criminal indictment was warranted because Elias persistently violated Department of Banking and Insurance rules and a court order. Elias was an insurance agent, whose license had been revoked in 1994 for sundry violations. Nevertheless, Elias continued to sell what purported to be insurance, now without a license, and the Department of Banking and Insurance obtained an injunction against him in August 1998. The indictment alleges that Elias thereafter continued to sell insurance in violation of the injunction. In particular, it charges him with selling fraudulent auto insurance cards, for which no real policy of insurance existed, on four separate occasions. Providing fraudulent automobile insurance cards enables persons to drive without insurance, thereby increasing the risk of uncompensated injury to the public, and shifts the costs of injuries caused by uninsured motorists to the general motoring public.
- ***State v. Arthur Johnson.*** On February 25, 1999, the State Grand Jury returned an indictment charging Arthur Johnson with third degree theft by deception and forgery for stealing the proceeds of a death benefit from the policy's beneficiary. Johnson, formerly a licensed insurance agent and an account representative at MetLife from 1987 to 1995, allegedly informed a life insurance beneficiary, upon the death of the insured, that the policy had lapsed. In fact, it is alleged that Johnson falsified documents and collected the \$50,000 life insurance policy himself. Johnson, as an insurance agent, was in a unique position to mislead the beneficiary to believe that no insurance payments were due her, and allegedly took advantage of his position by filing the appropriate forms and collecting the beneficiary's money himself.

- ***State v. Steven Usarzewicz.*** On February 22, 1999, the State Grand Jury indicted Usarzewicz for second degree theft and second degree misapplication of entrusted property. The indictment alleges that Usarzewicz, a former insurance agent and securities dealer, stole approximately \$140,000 from a client. The indictment alleges that Usarzewicz was a trustee of the client's trust account and that he unlawfully took the money from the trust account and used it for unauthorized purposes. Unscrupulous conduct by the agents of insurance companies will be targeted for appropriate action by OIFP.
- ***State v. Jack B. Chesner.*** On January 21, 1999, the State Grand Jury charged Chesner with second degree attempted theft by deception and falsifying records because of his purchase of property insurance with backdated checks after the property had been destroyed through an accidental explosion. On January 28, 1994, an apparent gas leak caused an explosion which destroyed a strip mall housing the Ramapo Cinema, an X-rated theater owned by Chesner. It is alleged that hours later Chesner obtained two property insurance policies on the theater, indicating in the applications that the property was worth more than \$100,000, although he knew that, having been destroyed through the explosion, it was then worthless. Chesner thereafter attempted to collect on the policies, but the insurers, suspicious of fraud, referred the matter to the State. Although Chesner never received any money, he is being prosecuted for his attempted theft.
- ***State v. Yolanda Benning.*** On January 19, 1999, Benning, a clerk typist employed by the City of Trenton, was indicted by the State Grand Jury for defrauding an insurer of \$2,987.87 between February 1996 and February 1998. The indictment charged that Benning presented forged prescriptions for a controlled dangerous substance to various pharmacies in the Trenton area, causing the cost of the medication to be billed to her prescription drug plan carrier, BlueCross/BlueShield of New Jersey. Because Benning is a public servant, the forfeiture of office provisions of N.J.S.A. 2C:51-2 will apply if she is convicted.

- ***State v. Domingo Almodovar, et al.*** On February 18, 1999, ten New Jersey residents were arrested for their involvement in a “give up” scheme to defraud insurance companies. It is alleged that the defendants sold their vehicles to middlemen for later sale in New York City (the “give up”). Thereafter, it is alleged that the defendants falsely reported to various police departments and to their insurance carriers that their motor vehicles had been stolen. Eight different insurance carriers paid over \$155,000 to these New Jersey claimants. In each case, the date of the purchase preceded the date of theft reported to police and the insurance carrier. The investigation was a referral from the New York City Police Department, which had conducted an undercover operation. The investigation was conducted jointly by the New Jersey State Police Auto Unit and OIFP-Criminal investigators.

Medicaid Fraud

- ***State v. Morris Dicker, et al.*** On September 28, 1998, Dicker pleaded guilty to, *inter alia*, racketeering and second degree distribution of a controlled dangerous substance, based on his buying phony Medicaid cards and writing phony prescriptions. The plea was part of a larger case in which three doctors, their office manager and eight street level drug dealers were indicted for a prescription scam that cost the Medicaid program hundreds of thousands of dollars. The doctors wrote prescriptions to Medicaid recipients in exchange for cash payments. Some of the recipients used several Medicaid cards during each visit and obtained prescriptions under each. The prescriptions called for multiple expensive medications. The pharmacists filled these prescriptions and billed them to Medicaid. The recipients then sold the medications to Dicker and his accomplices for pennies on the dollar. Dicker then sold the drugs back to the pharmacies who would restock their inventories. This cycle repeated itself with Medicaid paying several times for the same item. Three individuals have pleaded guilty and were sentenced to State prison. The three doctors are scheduled for trial. The licenses of two of the

doctors, Jose Rios, M.D., and Aftab Siddiqui, M.D., have been temporarily suspended pending final hearing before the Board of Medical Examiners. The third doctor, Carlos Campos, M.D., is only permitted to practice under supervision. This case marks the first time the State's racketeering statute has been used in a case of alleged health care fraud.

- ***State v. Tahir S. Sherani.*** Sherani was convicted of third degree Medicaid fraud on January 27, 1999, following a three week jury trial, for his role in a Medicaid fraud scheme in which millions of dollars in unnecessary blood tests were sent to an Manalapan medical laboratory during 1995 in exchange for kickbacks. ***Mohammad A. Javid***, the manager of United Diagnostic Laboratories in Manalapan paid more than \$1.7 million in kickbacks to Ilyas, Zuberi, Kahn and Sherani, who operated clinics in northern New Jersey, for sending blood samples to Javid's laboratory. Javid then billed Medicaid for unnecessary tests. Javid pleaded guilty in March 1997 and agreed to cooperate with the State. Sherani owned clinics in Irvington and Newark and would purchase blood and send it to the lab for unnecessary tests. The blood samples were often drawn from drug-addicted Medicaid recipients, who received prescriptions in return. Other samples were drawn from people willing to sell their blood for money and sent to the lab under the names of Medicaid recipients. Javid is scheduled to be sentenced on February 26, 1999, to up to 14 years in State prison with seven years of parole ineligibility, a fine of up to \$200,000, restitution to be determined by the Court, and debarment from the Medicaid program. Sherani is scheduled to be sentenced on April 1, 1999, and faces up to five years imprisonment, fines of up to \$60,000 and restitution as determined by the Court.

- ***State v. Rehan Zuberi.*** On December 23, 1998, Zuberi, a former medical clinic operator, and codefendant with Sherani, pleaded guilty to taking part in the Medicaid fraud scheme in which millions of dollars in unnecessary blood tests were sent to a Manalapan laboratory in exchange for kickbacks in 1995. Zuberi, with his partner Arshad Kahn, ran two clinics in Paterson and one in Newark and submitted \$1.2 million in bogus Medicaid claims. Kahn is a fugitive. Sentencing for Zuberi is scheduled for March 12, 1999. At his sentencing, Zuberi is facing a possible sentence of six years. As part of his plea, Zuberi also agreed to pay \$50,500 in restitution and a \$10,000 fine.
- ***State v. Leonid Giller and Felix Zak.*** On November 20, 1998, and on December 16, 1998, Giller and Zak, respectively, pleaded guilty to third degree Medicaid fraud for over billing the program for transportation services provided to Medicaid recipients by F & L Medical Transportation. Giller and Zak are scheduled to be sentenced on April 1, 1999. Under the plea agreement, each defendant may be sentenced to a term of imprisonment of 364 days as a condition of probation and may be ordered to pay fines and restitution totaling \$162,168.
- ***State v. Tommy Murry, Jr., and The Excel Center, Inc., et al.*** On October 9, 1998, the State Grand Jury returned an indictment charging Murry and the Excel Center with conspiracy, theft and Medicaid fraud. Murry, the executive director of the Excel Center, an outpatient drug and alcohol abuse center affiliated with the Newcomb Medical Center, billed the Medicaid

program, through Newcomb, over \$500,000 for services not rendered to patients. On February 11, 1999, Newcomb Medical Center entered into a civil settlement with the State which obligates it to pay the State \$1,000,000 by July 31, 1999. Additionally, Newcomb will turn over to the State, by March 4, 1999, \$1.7 million currently held in an escrow account. The criminal case will proceed in the Mercer County Superior Court.

Workers' Compensation Insurance Fraud

- ***State v. Edward E. Sandy.*** On February 8, 1999, the State Grand Jury returned an indictment charging Sandy with the fourth degree crime of failing to provide workers' compensation coverage. It is alleged that Sandy failed to carry insurance for his employees and failed to reimburse the State Uninsured Employers Fund for payments made from the State fund to employees injured on the job. Sandy's actions resulted in an injured employee and the State being required to pay \$16,000 in costs related to the injury.
- ***State v. Naeem Shaikh and Dawn-to-Dusk.*** Dawn-to-Dusk, a commercial livery company and its owner, Shaikh, were indicted on February 8, 1999, for failing to provide workers' compensation coverage. The case involves Trenton's largest taxi company (Yellow Cab) and a cabbie who was shot during a robbery while on duty for the company. Shaikh had no workers' compensation coverage, so the wounded employee was left with \$120,000 in medical costs and lost wages.

Unemployment Insurance Fraud

- ***State v. Cynthia DiNiglio; State v. Joseph Boniello.*** On February 8, 1999, DiNiglio and Boniello were separately indicted for third degree theft by deception and fourth degree unsworn falsifications to authorities. The indictment alleges that DiNiglio and Boniello were each initially eligible for unemployment benefits, but failed to notify the State Department of Labor when they

subsequently secured employment. It is further alleged that they thereafter improperly continued to collect unemployment benefits, while simultaneously misrepresenting on documents filed with the Department of Labor that they were not employed. DiNiglio was herself working for the State Department of Human Services during the time she allegedly was fraudulently collecting \$3,637 in unemployment benefits. Boniello allegedly obtained \$3,132 in benefits through his misrepresentations.

OIFP COORDINATION FUNCTION

Coordination of Government and Law Enforcement

The New Jersey Legislature, in enacting AICRA, declared that

[F]raud, whether in the form of inappropriate medical treatments, inflated claims, staged accidents, falsification of records, or in any other form, has increased premiums, and must be uncovered and vigorously prosecuted, and while the pursuit of those who defraud the automobile insurance system has heretofore been addressed by the State through various agencies, it has been without sufficient coordination to aggressively address insurance fraud

AICRA placed responsibility for coordination of State agencies and the creation of a Statewide insurance fraud enforcement policy with the Attorney General through OIFP.

Transition Meetings

In recognition of OIFP's leading role in coordinating enforcement strategies among all State agencies charged with responsibility for combating insurance fraud, OIFP conducted several meetings with several State agencies and with the insurance industry.

Beginning on or about May 28, 1998, through February 5, 1999, at least 15 meetings were conducted among representatives from the Department of Banking and Insurance and the Department of Law and Public Safety, specifically the Division of Consumer Affairs/Professional Boards, the Division of Law and OIFP, to identify transition issues and to devise a joint and coordinated strategy to address those issues. Among the issues addressed were the following: (1) new regulations regarding insurance carrier referrals to OIFP; (2) civil subpoena authority and its delegation within OIFP; (3) insurance fraud civil penalty collections and cases involving delinquent consent agreements; (4) a new form of consent order, which would include admissions in certain cases; (5) training; and (6) structure of

OIFP, among other related issues. As a result of these meetings, working relationships among the various State agencies charged with insurance fraud enforcement were developed.

Liaison and Continuing Communications Group

As part of the OIFP's statutory coordination function, a liaison working group was established to deal with professionals licensed by the various professional licensing boards within the Division of Consumer Affairs. The group, which includes representatives of OIFP-Civil and OIFP-Criminal, the Division of Law and the Professional Boards and the Enforcement Bureau of the Division of Consumer Affairs, has been conducting monthly meetings since October 1998. The group focuses on the best way to use resources in investigating cases of overlapping jurisdiction, which State agency within the group will investigate and/or monitor the case and the manner in which the other State agencies can provide assistance. The group has established a running list of active cases which primarily involve licensed medical service providers and health care providing entities under investigation by OIFP-Civil, OIFP-Criminal and the DCA Enforcement Bureau. These monthly meetings will continue.

State Police

For fiscal year 1999, OIFP funded additional New Jersey State Troopers who are assigned to investigate insurance fraud cases. On January 20 and 21, 1999, the new troopers attended a two day training course. As part of this training, OIFP provided a deputy attorney general to instruct the troopers on proofs needed for a successful insurance fraud prosecution. The troopers, in addition to using the theft and forgery criminal statutes, will focus on

enforcement of *N.J.S.A. 2C:21-2.1a*, which criminalizes simulating a motor vehicle insurance identification card.

Health Care Claims Fraud Coordination

On January 15, 1998, the Health Care Claims Fraud criminal statute became effective.

N.J.S.A. 2C:21-4.2 et seq. The statute imposes serious criminal penalties on persons or medical practitioners who knowingly or recklessly commit health care claims fraud. Additionally, the Health Care Claims Fraud statute required the Attorney General to develop guidelines for Health Care Claims Fraud investigations and prosecutions and to disseminate those guidelines to the county prosecutors. OIFP has assumed responsibility for assisting county prosecutors in implementing those guidelines.

The Health Care Claims Fraud guidelines were designed to insure the Health Care Claims Fraud statute will be applied fairly and uniformly across the State of New Jersey. To facilitate this coordinated and uniform implementation of the Health Care Claims Fraud statute, county prosecutors are required to consult with OIFP whenever a health care claims fraud investigation is initiated. The guidelines also provide that OIFP will review any proposed accusation or indictment that the county prosecutors intend to file which charges either a person or practitioner with violation of the Health Care Claims Fraud Act.

Since the effective date of the Health Care Claims Fraud statute on January 15, 1998, records indicate that five Health Care Claims Fraud investigations or prosecutions have been initiated by both county prosecutors' offices and OIFP. Specifically, DCJ/OIFP consulted with county prosecutors with respect to four separate cases of alleged Health Care Claims Fraud.

Additionally, OIFP recently filed a criminal case charging a person who was a licensed social worker with violation of the Health Care Claims Fraud statute (See *State v. Karen A. Lawder*, in Criminal Highlights, *supra*).

Department of Labor

On December 17, 1998, the Insurance Fraud Prosecutor and members of his supervisory staff met with the Director and other representatives of the Division of Workers' Compensation, Department of Labor, in order to discuss issues regarding fraud in the workers' compensation system and possible cooperative methods of addressing some of these issues. In addition to discussing the development of wage and hour "sting" operations targeted to areas of persistent violation, it was agreed that cases where employees attempted to fraudulently obtain disability benefits would be forwarded to OIFP, which would review and, if appropriate pursuant to *N.J.S.A. 34:15-57.4*, prosecute the cases or refer them to county prosecutors' offices. OIFP and Department of Labor representatives also discussed using a task force approach to target employers who make misrepresentations in their applications for disability insurance in order to obtain a lower premium rate.

Finally, OIFP agreed to investigate and, in conjunction with the Labor Prosecutions Unit of the Division of Criminal Justice, prosecute certain employers who fail to provide workers' compensation insurance. By failing to provide workers' compensation insurance, these employers expose employees to a lack of adequate insurance coverage for work-related injuries and expose the State to huge claims directed towards the UEF (uninsured employers fund). The assistance of county prosecutor offices in handling these crimes needs to be further considered and coordinated.

Interstate Insurance Fraud Coordination

On September 22, 1998, personnel from OIFP attended a meeting of the Mid-Atlantic State Insurance Fraud Association in Dover, Delaware. The Association was created by representatives of New Jersey, Delaware, Maryland and Pennsylvania in order to establish a unified multi-state effort to address insurance industry issues of fraud detection, public education and misconduct by the industry. Presently, the Association is developing procedures for inter-agency cooperation, including sharing of expertise and experience, and procedures for exchanging intelligence or investigative information. At the Delaware meeting, the participants discussed rate evader investigation issues and other issues of mutual interest to the member states.

On January 27, 1999, key supervisory personnel from OIFP attended a second meeting of the Mid-Atlantic State Insurance Fraud Association in Harrisburg, Pennsylvania. At the January meeting, representatives of the Pennsylvania Attorney General's Office and the Pennsylvania Department of Insurance discussed recent cases prosecuted in Pennsylvania, anti-fraud initiatives and the possible creation of a database that includes the names of health care professionals and insurance agents who have been convicted or civilly sanctioned for insurance fraud related violations.

Participation in these meetings permits OIFP to develop working relationships with those agencies in other states charged with insurance fraud enforcement. This can be of critical importance, especially with regard to conducting investigations of suspected insurance fraud rings, which frequently move from state to state or which cross contiguous state borders.

Interstate Medicaid Fraud Coordination

Through the Medicaid Fraud Control Unit, the OIFP is an active participant in all National Association of Medicaid Fraud Control Units (NAMFCU) global settlements where the targeted provider does business with New Jersey Medicaid. A NAMFCU negotiating team, comprised of Medicaid fraud prosecutors from different states, works with attorneys from the United States Department of Justice in Washington, D.C., to negotiate these settlements. Individual units provide claims data and assistance as necessary. This has been a highly successful and ongoing endeavor. Since 1994, New Jersey has received approximately \$2,000,000 as its share in the results of these efforts.

NAMFCU also provides a forum for nationwide sharing of information including intelligence and training concerning Medicaid matters. It fosters interstate cooperation on all issues affecting the units and is a coordination point for New Jersey's efforts, with the Department of Justice, in negotiating civil settlements against national providers.

Government and Industry Coordination

July 29, 1998, Informal Carrier Meeting

On July 29, 1998, representatives from five insurance carriers, DIFP, the Division of Law and the Division of Criminal Justice met to identify issues primarily involving insurance carrier fraud detection plans and case referral regulations (*N.J.A.C. 11:16-4.1 and 5.1*). At the meeting, basic problems underlying the insurance carrier referral processes to DIFP were identified and potential solutions to those problems were discussed. Informal insurance carrier input into this critical subject was solicited and it was identified as a major transition issue.

October 13, 1998, Insurance Carrier Summit

On October 13, 1998, a Summit meeting was held in Long Branch, New Jersey, between insurance company executives, insurance fraud investigators and representatives of OIFP. At the meeting, Attorney General Peter Verniero addressed 600 attendees of the New Jersey Special Investigators Association Annual Educational Conference. The focus of the Summit was on strengthening insurance fraud detection and prosecution efforts through better communication between industry and the State.

One of the topics discussed during the Summit was the problem of confronting professional fraud rings in New Jersey. The attendees recognized that, in order to identify patterns of fraud, it was necessary that cooperation be strengthened between government agencies charged with law enforcement and insurance companies, particularly the Special Investigations Unit of insurance companies, and that cooperative efforts be improved among industry.

Additionally, insurance industry representatives expressed concern about being caught in a possible “compliance triangle,” where regulations promulgated by the Department of Banking and Insurance could be applied inconsistently with the requirements of the anti-fraud enforcement activities of OIFP. In order to facilitate communication between industry and law enforcement, the position of industry liaison was created within OIFP.

January 13, 1999, Automobile Insurer Mini-Summit

As a follow-up to the October 1998 Summit, the Insurance Fraud Prosecutor hosted a Mini-Summit of the 12 largest automobile insurance companies in New Jersey. It is anticipated that such meetings will be periodically held in order to ensure that important issues regarding the investigation,

prosecution and prevention of insurance fraud can be addressed in a cooperative manner. The purpose of the Mini-Summit was to discuss specific issues regarding automobile insurance fraud and propose methods and procedures by which OIFP and companies can work together to achieve the most effective approach. The meeting produced spirited discussions on some of the most difficult issues facing both industry and OIFP, including, among others, the case referral process and the potential for conflict between OIFP's standards and the regulatory standards of the Department of Banking and Insurance for industry referrals of cases.

OVERVIEW OF TRANSITION ISSUES

Beginning in July 1988, the Division of Criminal Justice conducted criminal investigations and prosecutions of insurance fraud, primarily through its Insurance Fraud Unit, and through the Medicaid Fraud Control Unit for cases involving the Medicaid program. With the creation of OIFP, those criminal prosecution functions remain as before within the Division of Criminal Justice, but are incorporated under OIFP, along with the civil investigatory function, which was transferred from the former Division of Insurance Fraud Prevention. The function of litigating civil cases involving insurance fraud remains with the Division of Law within the Department of Law and Public Safety. The function of collecting civil insurance fraud penalties currently remains with the Department of Banking and Insurance.

To accommodate both the pre-existing criminal investigation responsibility of State Investigators in the Division of Criminal Justice and the newly transferred civil investigatory function, OIFP is structurally divided into OIFP-Criminal and OIFP-Civil. Therefore, State Investigators in OIFP are assigned to one of these branches. Deputy Attorneys General assigned to OIFP in the Division of Criminal Justice remain, as before, criminal prosecutors and are allocated to the criminal branch of OIFP. Deputy Attorneys General in the Division of Law retain responsibility for conducting civil litigation involving insurance fraud.

At the time of the August 24, 1998 transition, DIFP employed approximately 130 investigators who had been responsible for investigating civil insurance fraud violations set forth in *N.J.S.A. 17:33A-4* and *N.J.S.A. 17:33A-5*. Under AICRA, approximately 100 of them transferred to the Division of Criminal Justice. To incorporate this influx of new personnel, the

Division of Criminal Justice's existing chain of command for investigators had to be modified to accommodate the expansion of resources and to fulfill the mandate of the Act.

Additionally, during the transition process, several areas of coordination were identified for improvement.

1. THE NUMBER AND QUALITY OF INSURANCE CARRIER REFERRALS

Perhaps the most significant issue confronted by OIFP following the August 24, 1998, transition was the volume of cases referred to DIFP and (after August 24, 1998, to OIFP), by the insurance industry. Many of the cases of "suspected fraud" referred to DIFP by insurance carriers could have been more thoroughly investigated by the investigative units within the insurance carriers prior to referral. Because they were not, these cases presented no reasonable investigative leads or opportunities, and were referred to the State without identification being made of the specific acts or conduct which were suspected to have violated the Insurance Fraud Prevention Act. The industry felt compelled to refer these matters to DIFP because clear regulatory guidance about what facts trigger a case referral did not then exist. Thus, DIFP's investigations, which were necessary to develop the quality and quantity of evidence needed for criminal prosecution or civil litigation, did not have a proper basis on which to begin. Furthermore, DIFP was faced with an overwhelming number of matters referred to it and was therefore unable to effectively identify cases or set priorities which were appropriate for further investigation.

2. TRAINING

Another substantial issue encountered during transition was the fact that DIFP staff required further training in the conduct of insurance fraud investigations. In point of fact, as the July 17, 1998 Memorandum of Agreement between the Department of Banking and Insurance and the Department of Law and Public Safety acknowledged, the Department of Law and Public Safety has special expertise in investigating, coordinating and prosecuting insurance fraud matters. As is described more fully hereinafter, following the transition on August 24, 1998, OIFP conducted a series of training courses in order that the former DIFP investigators transferred to OIFP would develop the necessary expertise in conducting insurance fraud investigations.

3. CONSENT AGREEMENTS

The Insurance Fraud Prevention Act, at *N.J.S.A. 17:33A-5d*, provided that the Commissioner of the Department of Banking and Insurance could enter into a written agreement with a person or practitioner, wherein the person or practitioner would agree to pay a civil insurance fraud penalty without admitting or denying having violated the law. DIFP long considered its primary mission to be obtaining consent agreements with persons or practitioners suspected of violating the law in order to impose civil insurance fraud fines. At times, DIFP was so focused on obtaining consent agreements that it did not conduct underlying insurance fraud investigations that would support any subsequent civil litigation or criminal prosecution.

Consent agreements, as they were imposed in the past by DIFP, only constituted a mere promise to pay and did not contain stipulated facts between the subject and the State which established the civil insurance fraud. Thus, it became additionally apparent during the transition process that consent agreements should recite agreed to facts which demonstrate that the subject of the consent agreement committed a civil insurance fraud violation.

4. COLLECTIONS

As discussed hereinafter, DIFP historically did not view collection of the civil insurance fraud penalties which had been imposed as a priority. Accordingly, while DIFP entered into a substantial number of consent agreements, payments under those agreements were frequently delinquent and there was no uniform or consistent policy of enforcing such agreements. At the time OIFP was established, there was a considerable backlog of delinquent penalties.

These issues were identified during the transition as requiring special attention. What follows in this report is an explanation of the problem presented by each issue and the solution developed to address it.

OBTAINING QUALITY CASES BY INDUSTRY REFERRAL

Problem

The Insurance Fraud Prevention Act (*N.J.S.A. 17:33A-1 et seq.*, specifically at *N.J.S.A. 17:33A-9*), requires that OIFP (formerly DIFP) be notified whenever a person (which includes all licensed insurance carriers doing business in New Jersey) believes that a “violation” of the Act has been or is occurring. The regulations enacted to effectuate this provision mandated that insurance carriers refer “suspicious applications and claims” to DIFP (now OIFP). The primary problem was that neither the statute nor the regulations provided the referring insurance carriers with any concrete guidance as to what facts and circumstances constituted a “violation” of the

Act, nor what constituted “suspicious applications and claims.” This led to two separate but closely related problems.

The first problem was the sheer volume of referrals. In calendar year 1997, it was reported that DIFP received 16,555 referrals. In calendar year 1998, DIFP/OIFP received 15,878 referrals. Such staggering numbers of referrals do not allow for adequate review, investigation, analysis or litigation.

The second problem is closely related to the first. During the transition process, it was noted that, of the thousands of insurance industry referrals, only a small percentage presented a case sufficiently focused on the facts and circumstances to provide the State with reasonable investigative leads or opportunities. In other words, while the insurance industry referred, and DIFP/OIFP received, 15,878 referrals involving a “suspicion” of insurance fraud, many of those referrals were not substantiated by facts or evidence upon which to base a civil or criminal insurance fraud investigation. These referrals provided the State with no reasonable leads from which to conduct an investigation that would support civil litigation or criminal prosecution.

Solution

In order to address the above two problems, OIFP began the process of drafting and proposing new regulations governing the referral of cases from the insurance industry. The new regulations (with accompanying case referral forms) suggested by OIFP are currently under review by the Department of Banking and Insurance and will provide substantially more guidance to the insurance industry as to what constitutes a “violation” of the Act and what constitutes “suspicious applications and claims” for purposes of making referrals to OIFP.

Pursuant to *N.J.S.A. 17:33A-15*, every insurer writing health or private passenger automobile insurance is required to develop and file a plan for preventing and detecting fraudulent insurance applications and claims. As part of the implementation of their fraud plans, insurance companies are required by regulation to establish Special Investigations Units (SIUs) to investigate those suspected fraudulent claims or applications which are referred to them by the company's claims or underwriting personnel. If an SIU functions properly, it should refer cases to OIFP only after the SIU has fulfilled its responsibility of performing an initial investigation of the suspected fraud which develops some corroborating evidence. This makes good systemic and investigative sense because any insurance fraud investigation, by logical necessity, begins within the insurance carrier which possesses the documents and records which constitute the suspect claim.

In essence, these new regulations being proposed by OIFP to the Department of Banking and Insurance require insurance carrier underwriting, claims and SIU personnel to identify specific facts and circumstances and to develop some minimal corroborating evidence which, taken together, create a reasonable suspicion that an insurance application or an insurance claim is fraudulent. An insurance fraud case referral from the insurance industry to OIFP which is sufficiently focused on facts and circumstances and supported by some corroborating evidence will provide OIFP with the reasonable investigative leads and opportunities necessary to develop the quality and quantity of evidence which can support civil insurance fraud litigation or criminal insurance fraud prosecution in a greater number of cases. Referrals of this caliber will be a vast improvement over insurance fraud referrals from the insurance industry to DIFP, which were

often based on an insurance carrier employee's unguided interpretation of what constituted a "violation" of the Act or a "suspicious" application or claim.

The new regulations suggested by OIFP will establish two categories: case referrals and notices. Case referrals will require suspicious facts and circumstances and some corroborating evidence. These referrals will present reasonable investigative leads or opportunities for OIFP to develop evidence sufficient to support civil litigation or criminal prosecution.

Those matters which constitute mere notice of violations or of suspicious applications and claims are those where suspicious facts and circumstances have been identified by the insurance carrier, even though the insurance carrier has been unable to develop any corroborating evidence. OIFP will develop an investigative database for further analysis and law enforcement use from the claims information derived from these notices, in order to identify patterns of insurance fraud. OIFP believes this regulatory change will provide for greater investigative coordination between industry and government and for more effective allocation of investigative resources.

TRAINING

Problem

One of the primary problems identified in the operations of the former Division of Insurance Fraud Prevention (DIFP) is that its Training and Prevention Bureau focused primarily on informing the public about insurance fraud issues and did not train DIFP investigators. Indeed, DIFP investigators received very little training regarding the conduct of investigations or the operation of the insurance industry. Essentially, training consisted of a one week period where investigators reviewed the DIFP investigative standard operating procedures book and may have been assigned to work with another DIFP investigator for a short period.

Historically, DIFP's function was not to fully investigate allegations of insurance fraud but to obtain a consent agreement whereby the target of an investigation would agree to pay a civil insurance fraud penalty. The quality and quantity of evidence necessary to justify approaching an insurance fraud target to obtain a consent agreement to pay a civil penalty is far less than that required to support litigation proving the allegations in court. Accordingly, many of the cases concluded by a DIFP investigator would not support further action in the absence of a consent agreement, and would not support enforcement of the agreement if the subject later challenged its entry. In short, DIFP did not view its mission as investigating to obtain the necessary quality and quantity of evidence to support litigation in court or before professional licensing boards.

Solution

The primary mission of OIFP is to thoroughly investigate allegations of insurance fraud in order to fully develop the facts and evidence of each case. Once that is done, the State is able to make a reasoned and informed decision as to how to best allocate its resources, whether by proceeding with a criminal prosecution, civil insurance fraud enforcement, licensing revocation or suspension, or some combination of these legal remedies.

To fully develop the facts and evidence of each case, it became clear that training of civil investigators had to be an initial and significant focus in setting up OIFP. Therefore, OIFP set out to develop a substantive course list which would best serve the needs of the civil investigators and to implement training standards.

It was determined that all civil investigators, in order to successfully perform the task of thoroughly investigating each assigned case, needed to receive the same level of basic investigative skills training that criminal investigators in the Division of Criminal Justice receive. Indeed, it was recognized that the civil investigative personnel would often be required to make the initial assessment of whether a case should proceed as a civil matter or should more appropriately be referred to the criminal branch of OIFP for possible criminal prosecution. Therefore, OIFP made it a priority to create an appropriate program of training for civil investigators and to implement training for those investigators who transferred from DIFP, as well as for all newly hired civil investigators.

To insure that civil investigators could effectively construct an insurance fraud case, the Insurance Fraud Prosecutor and OIFP supervisory investigative staff, all experienced law enforcement officers, developed a training program for civil investigators which uses the same criteria set forth by the New Jersey Police Training Commission in establishing the New Jersey Basic Course for Investigators in the Division of Criminal Justice. Accordingly, it was decided that an effective training course for civil investigators must include basic law enforcement instruction, such as report writing, ethics, chain of command, evidence handling and documentation, development of information sources, interview techniques, physical surveillance, computer fraud, rules of evidence, preparation of witnesses and courtroom testimony.

In an effort to further insure that all new OIFP related objectives were met, additional classes of instruction, specifically tailored to the law relevant to insurance fraud cases were added to the course developed for civil investigators. Therefore, the basic course developed for civil investigators also includes instruction in insurance-related laws, such as the New Jersey Fraud Prevention Act (*N.J.S.A.*

17:33A-1 *et seq.*), the Health Care Claims Fraud Act (*N.J.S.A. 2C:21-4.2 et seq.*), and the Automobile Insurance Cost Reduction Act of 1998 (*P.L. 1998, c. 21*), as well as instruction in civil procedures, definitions of insurance terms and the practical aspects of enforcing and targeting insurance fraud. Accordingly, each new civil investigator hired into OIFP will now be required to meet much of the training standards of the Division of Criminal Justice as well as those specific requirements of OIFP itself. Each new investigator hired by OIFP will be required to attend the Division of Criminal Justice Academy in Sea Girt and pass the three and one-half week course of training which was established by the Insurance Fraud Prosecutor.

Training began immediately upon the transfer of authority from DIFP to OIFP. On August 24 through August 26, 1998, the staff of investigators transferred from DIFP attended a three day orientation course in which they were informed regarding the policies and procedures required by the Department of Law and Public Safety, Division of Criminal Justice.

To assure that the civil investigators would be able to comply with the mission of the new OIFP to thoroughly investigate all cases of alleged insurance fraud, among the first courses required following the transition from DIFP to OIFP were report writing and interview methods and procedures. Accordingly, on November 23, 1998, 63 civil investigators who had recently been transferred to OIFP attended a course in report writing. On December 16, 1998, 53 civil investigators received training in interview methodology, in order that each would be able to make better use of investigative opportunities when speaking with a subject of an insurance fraud

investigation or with a potential witness. On January 5, 1999, 61 investigators were instructed in civil investigative techniques.

On January 7, 1999, 54 of the transferred civil investigators received more advanced training in evidence collection procedures, identification of information sources, the legal requirements of search and seizure law and the potential legal implications on litigation of the pendency of both civil and criminal proceedings. On February 3, 1999, the entire civil investigative staff received training in civil case preparation and case litigation preparation.

On February 22, 1999, the Division of Criminal Justice Academy in Sea Girt received the first class of investigators to attend the standard course for civil investigators developed by OIFP. (See course schedule in Appendix.) The class consists of 35 newly hired civil investigators assigned to OIFP-Civil. In the future, the three and one-half weeks course of intensive training will be required of all newly hired civil investigators, and the second class of approximately 25 new civil investigators is scheduled at the Academy for its three and one-half weeks of instruction beginning on April 19, 1999. At the course which began on February 22, 1999, the civil investigators studied the history and development of law enforcement and received information regarding the criminal justice system, including the appropriate chain of command and organizational structure, as well as policies and procedures, of the Division of Criminal Justice. The investigators have been instructed in note taking and report writing, ethics and interviewing techniques. The statutory law which the investigators are charged with enforcing will also be studied in detail as part of the course, including the New Jersey Insurance Fraud Prevention Act, the Health Care Claims Fraud Act of 1998 and AICRA.

Before their Division of Criminal Justice Academy training is complete, the investigators will receive training in the practical aspects of enforcement under *N.J.S.A. 17:33A-1 et seq.*, and will be tested on their knowledge and understanding. The investigators will be instructed on insurance terminology and be required to pass tests demonstrating their understanding of various terms used in insurance policies and laws. As part of their OIFP training, the investigators will receive an insurance manual and be instructed in the various types of insurance fraud, including automobile, PIP, homeowners, workers compensation, premium and application fraud, rate evasion and health insurance fraud.

While at the Academy, the investigators will receive training in civil procedure, sources of information, including Autotrack, the Division of Motor Vehicles, Social Security Administration, Dunn & Bradstreet and the Property Insurance Loss Registry, and basic investigative procedures and responsibilities, including field activities and information analysis. The investigators will receive an explanation of the use of a case diary system, and instruction in how to manage their time and their investigative files. The investigators will receive additional training in the implications of parallel civil, administrative and criminal proceedings and be involved in conducting a mock trial scenario.

IMPOSING CIVIL PENALTIES WITH THE SUBJECT'S CONSENT

Problem

The Insurance Fraud Prevention Act, at *N.J.S.A. 17:33A-5d*, provided that the Department of Banking and Insurance (DOBI) could enter into a written agreement with a person or practitioner, wherein the person or practitioner would agree to pay a civil insurance fraud penalty without admitting or denying violating the Act. Because of the enormous volume of cases referred to it, DIFP emphasized

reducing the caseload by having investigators work to obtain consent agreements whenever possible.¹ This focus undermined DIFP's ability to conduct insurance fraud investigations in a thorough manner that would support civil litigation or criminal trials.

Attempts to negotiate consent agreements without sufficient evidence to demonstrate to the subject of the consent agreement that the State was in a position to *prove* the civil insurance fraud or to *prove* an insurance fraud related crime, resulted in DIFP's acceptance of insurance fraud fines in any amount the subject would agree to pay in order to make the case "go away." These consent agreements, entered on insufficient underlying facts, were subsequently very difficult to enforce if the subject of the consent agreement failed to pay the agreed fine or if the consent agreement was later nullified for other reasons. This left the State in the position of possessing insufficient evidence to prove the insurance fraud in court.

Also, because consent agreements, as they were imposed in the past by DIFP, only constituted a mere promise to pay and did not contain stipulated facts between the subject and the State which established the civil insurance fraud, it became apparent during the transition process

¹ It should be noted that the imposition of civil insurance fraud fines pursuant to a consent agreement often requires little investigative effort. Unsophisticated persons, persons not represented by counsel and persons willing to pay a civil insurance fraud penalty to make an insurance fraud case "go away" frequently would enter into a consent agreement to pay a civil insurance fraud penalty despite the fact that sufficient evidence to prove a civil or criminal insurance fraud or crime in court, or in another legal forum, had not been developed by a detailed and thorough underlying investigation.

that consent agreements should recite agreed to facts which demonstrate that the subject of the consent agreement committed a civil insurance fraud violation.

Solution

As a pilot project, OIFP is seeking to obtain consent orders which contain factual recitations demonstrating that the subject committed the civil insurance fraud violation. Moreover, OIFP will obtain consent *orders* rather than consent agreements. A consent order has the force and effect of a judgment in favor of the State and will obviate the former practice which required the Division of Law to litigate the DIFP consent agreement in order to obtain a judgment in favor of the State. This will result in conservation of the State resources allocated to these cases and will improve the results obtained by the State in these matters.

COLLECTING CIVIL PENALTIES

Problem

Historically, *collecting* civil insurance fraud fines, as opposed to merely obtaining a consent agreement-based promise to pay a civil insurance fraud fine, was never a DIFP priority. By statute, such fines are used to offset the debts incurred by the New Jersey Joint Underwriters Association (JUA) and/or the New Jersey Market Transition Facility Auxiliary Funds (MTF). DIFP engaged in civil insurance fraud fine collections by having the investigator assigned to the case continue to occasionally prod the subject of the consent agreement into making payments over time. Sometimes the DIFP collections section would send dunning letters to the subject of a civil insurance fraud consent agreement in order to attempt to collect the insurance fraud fine.

In some instances, DIFP forwarded delinquent consent agreement cases to the Division of Law within the Department of Law and Public Safety for the filing of a lawsuit, based on the consent agreement, to obtain a judgment against the subject of the consent agreement. If the Division of Law was successful in obtaining a judgment, the case might thereafter be referred to the civil judgment collection section within the Division of Law for appropriate collection action based on that judgment. However, overall, DIFP's approach to collecting civil insurance fines was neither regular nor systematic, and it did not result in the actual collection of the amount of insurance fraud fines that should have been collected.

Solution

Subsequent to the transition, OIFP investigative personnel identified approximately 1,700 insurance fraud cases from the DOBI database in which the civil consent agreement to pay a civil insurance fraud fine was delinquent. Following the identification of those delinquent cases, OIFP devised a collections protocol to address these delinquent collection cases. On the weekend of January 16 through 18, 1999, attorneys in the Division of Law, allocated to OIFP-Civil, reviewed all of these delinquent cases.

Of the cases reviewed, OIFP attorneys identified approximately 1,232 cases which would support a collection action to obtain a civil insurance fraud fine for the State. The OIFP's plan of action to collect these delinquent civil insurance fraud fines includes first issuing demand letters and, if the delinquent insurance fraud fine is not then obtained, filing a complaint to initiate a civil lawsuit based on the consent agreement. This project is currently in its early stages and is continuing. Beginning in January 1999 and continuing to date, approximately 1,042 demand letters were sent. As of February 17, 1999, this effort to collect civil insurance fraud fines had realized a total of \$25,943.03, in 63 cases of delinquent insurance fraud fines based on payments to be made under consent agreements which had been entered into by DIFP.

STAFFING

Problem

It appears that primarily due to the volume of pending cases at DIFP, basic issues regarding the conduct of insurance fraud investigations were not addressed. Field investigative efforts were largely unmonitored and procedures for increased accountability of personnel were often not implemented. This led to problems in maintaining evidence, monitoring the progress of investigations and following up all legitimate leads. Each of these steps is fundamental to bringing an investigation to a successful conclusion.

Solution

In OIFP, the investigatory staff of the Division of Insurance Fraud Prevention was consolidated with experienced criminal investigatory staff from the Division of Criminal Justice. The purpose and result of this combination was to create a comprehensive law enforcement agency dedicated to combatting insurance fraud.

The first decision in OIFP was the decision to appoint experienced and capable criminal investigators as supervisors of the civil investigative process. Criminal Justice Director Paul Zoubek selected law enforcement supervisors with proven administrative abilities to lead the investigative side of the office. Thus, on September 17, 1998, three Deputy Chief Investigators and nine supervising state investigators were sworn in to begin their duties supervising OIFP

civil and criminal investigations. (See *Biographies* in Appendix). Their appointment signaled that the primary focus of OIFP is to ensure that investigators conduct quality investigations.

Investigator Supervisors

One of the Deputy Chief Investigators (DCI) was assigned as Managing Deputy Chief Investigator and is responsible for overseeing all civil and criminal investigations. Of the other two DCIs, one is in charge of investigations conducted by OIFP-Criminal and the other oversees investigations conducted by OIFP-Civil.

OIFP-Civil investigations are divided regionally, with a Supervising State Investigator (SSI) being assigned to each region — North, Central and South. Another OIFP-Civil SSI is assigned to supervise the intake and screening unit, which receives and tracks by computer all referrals, whether from insurance companies, anonymous tips or other sources. In addition to assigning the case or tip a case or file number and entering information regarding it into the database maintained by the intake unit, the unit also performs preliminary research on cases by searching the in-house and public databases (such as DMV, Labor, Dunn & Bradstreet, etc.) for information on the persons or companies named, and assigns the case to a regional investigative unit.

Seven Supervising State Investigators are assigned to OIFP-Criminal investigations, with four of these assigned to the Insurance Fraud Unit in the Division of Criminal Justice and two to the Medicaid Fraud Control Unit. Each of the seven SSIs in OIFP-Criminal reports directly to the DCI in charge of OIFP-Criminal. Additionally, one of the seven Supervising State Investigators was assigned to serve as OIFP's liaison to the law enforcement community. All

Supervising State Investigators assigned to OIFP were selected based on their law enforcement experience and their investigative and management skills.

On November 5, 1998, Team Leaders were assigned to assist the SSIs in managing the civil investigative function. Four of the eight Team Leaders named were drawn from the criminal branch of OIFP and four were drawn from the investigative staff that had transferred from DIFP and were now assigned to OIFP-Civil investigations. Each team leader heads a squad of investigators and reports directly to an SSI in OIFP-Civil.

Staff Augmentation

Investigators

On August 14, 1998, prior to the transfer of authority and personnel, DIFP staff consisted of 129 investigators. By August 17, 1998, the DIFP investigative staff available for transfer to OIFP-Civil investigations was reduced to 111 investigators, because 18 former DIFP investigators had been selected to attend the Division of Criminal Justice Academy to become criminal investigators in OIFP-Criminal.

With the transfer of statutory and reorganizational authority from DIFP in DOBI to the newly created OIFP on August 24, 1998, 81 investigators transferred from DIFP to become civil investigators within OIFP.² Thirty members of the DIFP staff remained in DOBI with a redefined function. By January 7, 1999, the staff of civil investigators with OIFP was again reduced when another 14 investigators were selected to attend the Division of Criminal Justice Academy and were sworn in as criminal investigators with OIFP-Criminal.

² In addition, three administrative persons from DIFP also transferred to OIFP.

Since the transition, OIFP has hired approximately 45 new investigators to be assigned to OIFP-Civil, in part to replace those DIFP investigators who transferred to OIFP-Criminal investigations or left for other reasons. Thirty-four civil investigators are currently attending the Civil Investigator training program at the Division of Criminal Justice Academy in Sea Girt which began February 22, 1999. Another 25 civil investigators are expected to attend the Civil Investigator training program in April 1999. It is anticipated that, as of April 1999, the total number of civil investigators will be 111, excluding supervisory staff.

OIFP Investigators: ³	Civil	Criminal
August 24, 1998	85	30
February 22, 1999	118	78

Deputy Attorneys General

In addition to investigators, the OIFP has hired several new attorneys to litigate criminal cases. As of February 10, 1999, there were approximately 22 deputy attorneys general assigned to prosecute OIFP criminal cases, including those assigned to both the Insurance Fraud Unit and to the Medicaid Fraud Control Unit. This DAG staff includes some newly hired deputy attorneys general. It is anticipated the litigation staff of OIFP-Criminal will be increased to a total of approximately 30 deputy attorneys general. From October 9, 1998, through February 2, 1999,

³ These numbers include all supervisory investigative staff except MDCI Anne M. Kriegner, who supervises both the civil and criminal investigations.

seven deputy attorneys general were hired into the Insurance Fraud Unit of the OIFP and one additional deputy attorney general was hired to prosecute Medicaid fraud cases.

OIFP-Criminal Attorneys:⁴	Insurance Fraud	Medicaid Fraud
August 24, 1998	9	5
February 22, 1999	16	6

⁴ These numbers include Supervising Deputy Attorneys General John Kennedy and John R. Krayniak who, respectively, are the Chiefs of the Insurance Fraud Unit and the Medicaid Fraud Control Unit. In addition, and not included in these numbers, are the Insurance Fraud Prosecutor Edward M. Neafsey, Assistant Attorney General John J. Smith, Jr., who is in charge of OIFP-Criminal, and Deputy Attorney General Victoria Curtis Bramson, who serves as a Special Assistant to the Insurance Fraud Prosecutor.

OIFP-CRIMINAL

Insurance Fraud Unit

The Insurance Fraud Unit of the Division of Criminal Justice was incorporated for management purposes into OIFP's criminal branch. The Insurance Fraud Unit conducts investigations and criminal prosecutions of all types of insurance fraud. The Unit places a high priority on cases involving automobile insurance fraud and cases involving health care fraud, particularly fraud committed by providers. Nonetheless, the Unit has prosecuted people who have stolen money from nearly every type of insurance plan. The Unit has prosecuted cases of staged auto accident rings; medical providers billing for treatments not rendered; persons faking disability to collect undeserved disability insurance; homeowners or commercial property owners padding property damage claims; body shop employees or independent appraisers inflating auto collision damage claims; insurance industry employees embezzling money; auto insurance rate evaders; insurance producers (agents) who steal insurance premiums by failing to remit, and premium financing fraud, among others.

The unit currently consists of one Supervising Deputy Attorney General, 16 Deputy Attorneys General, five Supervising State Investigators, 35 State Investigators, one analyst, one technical assistant and three secretaries. In addition, 22 investigators are currently attending the Division of Criminal Justice Academy and are scheduled to graduate in May 1999 and join the Insurance Fraud Unit in OIFP.

During calendar year 1998, the Insurance Fraud Unit opened 101 new cases. During the same period, the Unit obtained 55 criminal convictions; as a part of the convictions, restitution of \$371,067

was ordered and fines and monetary penalties of \$417,125 were imposed. During 1998, the Unit assisted in obtaining the suspension or revocation of four professional licenses. From the time the Insurance Fraud Prosecutor was sworn into office until the date of this report, that is, from October 29, 1998, to February 28, 1999, the Unit opened 45 new criminal investigations and prosecuted, that is, indicted or received pleas to accusations, against 80 defendants. From October 29, 1998, through February 28, 1999, restitution of \$177,901 was ordered and fines of \$114,775 were imposed. (See ***Table 1***).

OIFP Criminal - IFU Statistics Summary
1/1/98-2/28/99

	1/1/98-12/31/98	10/29/98-2/28/99	1/1/98-2/28/99
Cases Referred	101	45	136
<hr/>			
Cases Investigated			
(pending plus opened during period)	177	123	212
<hr/>			
Licenses Surrendered/Suspended/			
Revoked*	4	1	4
<hr/>			
Subjects Prosecuted			
(Indictments/ Accusations)	46	80	119
Convictions (Pleas/Sentences)	55	23	67
<hr/>			
Total Fines	\$417,125	\$114,775	\$505,650
<hr/>			
Total Restitution	\$371,067	\$177,901	\$508,630

* (OTHER PROFESSIONAL LICENSING ACTIONS TAKEN FROM 1/1/98 TO 2/28/99:

Revocations and Suspensions on cases referred by DCA and DOL - 4; Revocations and Suspensions on cases referred by other state or federal agencies - 5; Restrictions on cases referred by OIFP/DCJ - 2; Reprimand on case referred by OIFP/DCJ - 1.)

TABLE 1

Medicaid Fraud Control Unit

As part of OIFP, the Medicaid Fraud Control Unit has the Statewide authority to investigate and prosecute violations of the criminal laws with respect to fraud in the provision or administration of medical assistance under a State plan implementing Title XIX of the Social Security Act. The unit also participates in national cases through the National Association of Medicaid Fraud Control Units (NAMFCU).

The organizational structure consists of a Supervising Deputy Attorney General, five deputy attorneys general, two Supervising State Investigators, 12 State Investigators, one Special State Investigator, a paralegal and two analysts. Presently there are three candidates attending the Division Criminal Justice Basic Course for Investigators who, it is anticipated, upon graduation will augment the investigative staff. The Medicaid Fraud Control Unit is planning to add two auditor positions in order to handle the increasing case load and increasingly complex prosecutions.

The Medicaid investigative staff receives the same training that insurance fraud investigators receive, and additionally have attended or will be attending the National Association of Medicaid Fraud Control Units (NAMFCU) Basic Medicaid Fraud Training program. The more experienced personnel have either attended or will be attending the NAMFCU Advanced Medicaid Training Program.

During calendar year 1998, the Medicaid Fraud Control Unit opened 46 new cases and obtained 11 criminal convictions. Restitution of \$1,231,651 was also ordered during this same period, and fines and monetary penalties of \$117,761 were imposed. Since the Insurance Fraud Prosecutor took office, the Unit has opened 16 new cases, obtained four convictions and recovered \$2,700,000 in restitution. (See **Table 2**).

OIFP - Medicaid Fraud

1/1/98-2/28/99

	<u>1/1/98 - 12/31/98</u>	<u>10/29/98 - 2/28/99</u>	<u>1/1/98 - 2/28/99</u>
Number of Cases Referred to			
Medicaid Fraud Section	46	16	49
Number of Cases Investigated	94	73	97
Licenses Suspended	0	0	0
Defendants Prosecuted	7	4	7
Number of Convictions	11	4	12
<hr/>			
Total Fines and Penalties *	\$117,761	\$0	\$117,761
<hr/>			
Total Restitution Amount **	\$1,231,651	\$2,700,000	\$3,931,651

* Total fines figure includes \$16,306 in global civil settlement monies.

** Total restitution figure includes \$37,827 in global civil settlement monies and
\$2,700,000 in State civil settlement monies.

TABLE 2

OIFP-CIVIL

Although the criminal insurance fraud investigation and prosecution function in the Division of Criminal Justice has remained within OIFP and the civil investigative function has been newly subsumed within OIFP, the Division of Law retains responsibility for the civil litigation of insurance fraud cases. Thus, these deputy attorneys general, while assigned to litigate OIFP-Civil cases, are not assigned to OIFP. In its budget for FY '99, OIFP is providing funding in the amount of \$1,218,670 to the Division of Law. This funding supports the salaries of attorneys, clerical and paralegal technicians in the Division of Law who litigate civil insurance fraud cases.

As indicated by the following table (see *Table 3*), during 1998, OIFP-Civil litigation attorneys opened 286 new cases by the filing of civil complaints.⁵ The attorneys resolved 246 cases by stipulation of settlement or by judgment. Thus, in 67 cases, the defendants stipulated to payments due, amounting to a total of \$199,530. Default judgments in the amount of \$849,008 were obtained in 110 cases. In 62 cases, judgments in the amount of \$195,576 were obtained with the defendant's consent. Another \$112,471 was imposed by summary or other judgments. In addition, OIFP-Civil attorneys litigated 54 enforcement matters resulting in imposition of \$170,798 in monetary penalties. In 50 cases

⁵ Only 135 complaints were able to be served, however, due to difficulties in locating the subjects of the complaints.

where payments being made pursuant to DIFP investigator-obtained consent agreements were delinquent, the Division of Law attorneys collected \$88,636.⁶

In the four months since the Insurance Fraud Prosecutor took office, OIFP-Civil litigation attorneys have resolved 73 matters by stipulation of settlement or judgment. In these cases, a total of \$262,537 in monetary penalties was imposed. During this same period, 68 civil complaints were filed, although in only 23 instances were the defendants able to be located and the complaints served. In this period, \$107,871 of penalties were collected in 126 matters which had been delinquent under consent agreements entered into by DIFP investigators. (See

Table 3).

While simultaneously investigating cases for possible imposition of civil fines, OIFP-Civil investigations forwards cases involving uninsured motorists (possession of forged insurance identification cards) to the Auto Fraud Unit of the New Jersey State Police. Between the transition date of August 24, 1998, and February 8, 1999, OIFP Civil investigations has made 53 referrals to this State Police Unit.

⁶ While other monetary penalties are paid to the State based on actions taken by Division of Law attorneys handling civil insurance fraud matters, the Insurance Fraud Unit of the Division of Law does not maintain records of the totals actually collected on judgments because the money is paid directly to DOBI. It is anticipated that the case tracking system now being developed by OIFP will collect this information for inclusion in the next OIFP report to the Governor and Legislature.

OIFP - Civil
Case Summary and Judgment Totals
1/1/98-2/28/99

	1/1/98-12/31/98	10/29/98-2/28/99	1/1/98-2/28/99
Complaints Filed	286	68	309
Complaints Served	135	23	147
Enforcement Actions	54	44	62
Amounts Imposed	\$170,798	\$135,712	\$189,926
Number of PIFS*	50	126	156
Amount Collected	\$88,636	\$107,871	\$161,110
Number of Cases Resolved			
Stipulations of Settlement	67	19	81
Consent Judgments	62	33	87
Default Judgments	110	17	114
Summary Judgments	4	3	5
Other Judgments	3	1	4
Judgment Amount Totals			
Stipulations of Settlement	\$199,530	\$57,566	\$238,851
Consent Judgments	195,576	96,205	263,143
Default Judgments	849,008	64,637	860,492
Summary Judgments	83,721	39,989	88,739
Other Judgments	28,750	4,141	32,891
TOTALS	\$1,356,585	\$262,537	\$1,484,116

*PIF (Paid in Full) is a settlement induced through Deputy Attorney General intervention. The defendant paid the balance in full of a delinquent consent agreement without institution of litigation.

TABLE 3

ONE YEAR ACTION PLAN

1. REGIONALIZATION OF OFFICES - DIVISION OF CRIMINAL JUSTICE AND OFFICE OF INSURANCE FRAUD PROSECUTOR

The Division of Criminal Justice currently has offices located throughout the State to which its employees, including members of OIFP who conduct fraud investigations and litigation, are assigned. The Division of Criminal Justice will consolidate its personnel into three regional offices: north, central and south. This consolidation is fueled by OIFP's legislative mandate to ensure a coordinated statewide enforcement approach to investigating and prosecuting civil, administrative and criminal cases against all types of insurance fraud, including health care claims fraud. Regionalization will foster a more coordinated statewide enforcement effort, as well as better case-specific management, by bringing civil and criminal insurance fraud investigators together in each region.

DCJ appointed three Supervising State Investigators in OIFP to manage civil insurance fraud investigators on a regional basis. The next logical step is to concentrate the enforcement focus by physically locating civil and criminal investigations in the same building.⁷ Leases for the central office and the northern office have been approved by the "Space Planning and Management Board." Occupancy is expected in May 1999. The lease for a southern office is being negotiated.

⁷ Appropriate efforts have been made to ensure that legal issues implicated by parallel civil and criminal proceedings are addressed.

2. COUNTY PROSECUTOR COMMUNICATION AND STAFFING

Under AICRA, OIFP is required to establish a liaison unit and to engage in continuing communication with certain state agencies and with each county prosecutor's office. In order to meet the statutory mandate and build a coordinated Statewide strategy of criminal enforcement, OIFP plans to set-up and fund a secure at-once communication system linking the 21 county prosecutors with OIFP/DCJ. This will provide for the immediate dissemination of critical information from OIFP to county prosecutor offices, and vice versa. Additionally, DCJ will identify a two year dedicated source of funding to establish an insurance fraud unit or to increase the resources detailed in such a unit for any county prosecutor's office. The amount of funding for any particular county prosecutor's office will be based upon the nature of the county proposal and OIFP's approval. The Insurance Fraud Prosecutor will also designate a liaison to the county prosecutors in the liaison unit, who will be specifically assigned to monitor investigations and prosecutions of insurance fraud, including health care claims fraud cases, in county prosecutor offices.

3. THE ROLE OF MUNICIPAL POLICE IN COMBATING INSURANCE FRAUD

As part of the OIFP's mission to bring all of the State's anti-insurance fraud weapons to bear on insurance fraud, OIFP intends to produce and distribute to the State and local police forces a "roll call" video on ways police officers can help combat auto insurance fraud stemming from staged motor vehicle accidents. Some examples, equally applicable in cases involving both serious and less serious alleged

injuries, include: listing the identities of every person who was in the car at the time of the accident, and asking for verification of identity; crossing out all blank lines on completed motor vehicle accident reports, to prevent “add on” or “jump in” occupants; noting on the police accident report whether the police officer responded to the scene of the accident or took the accident report as a “walk in” at the station; and documenting any suspicious aspects of the claimed accident. Designed to be played at roll call before the start of a shift, such videos efficiently disseminate information to police officers — those in the front line detecting fraudulent auto accidents — without adding a burden to already busy police schedules.

Similarly, OIFP will work to ensure that penalties for driving without insurance are enforced locally. That is, OIFP will assist State and local police by providing information to them on how to check the validity of auto insurance identification cards presented during road stops and about the recently enacted penalties for possessing or exhibiting fraudulent auto insurance cards. *See N.J.S.A. 2C:21-2.1a and N.J.S.A. 39:3-38.1* (amendments effective April, 1998). Also, OIFP will work with auto insurers to identify ways to ease the process by which police officers can check the validity of an auto insurance identification card. Finally, with the assistance of the 21 county prosecutors, training materials on insurance fraud will be provided to municipal prosecutors. The Insurance Fraud Prosecutor has designated a law enforcement liaison to handle these issues.

4. HEALTH CARE FRAUD

Under the Health Care Claims Fraud Act, a practitioner convicted of health care claims fraud committed in the course of providing professional services shall have his or her professional license suspended or forfeited. *N.J.S.A. 2C:51-5.* Under AICRA, OIFP has a broad mandate to refer any licensed professional guilty of any type of insurance fraud, including Medicaid fraud, to the appropriate licensing board for suspension or revocation of the license. *N.J.S.A. 17:33A-25.* OIFP's Liaison and Communication section, established pursuant to *N.J.S.A. 17:33A-18*, which includes representatives of DOBI, the Division of Consumer Affairs/Professional Board and the Division of Law, will improve the State's ability to efficiently refer those who have committed fraud to the appropriate professional licensing board for licensing action. Since October 1998, there have been 5 meetings of the section and these monthly meetings shall continue during 1999.

5. STREET OPERATIONS (RATE EVADER SWEEPS)

As part of OIFP's civil enforcement effort, rate evader sweeps are presently planned for the next six months. Rate evaders are typically from areas deemed to be high insurance risk locales. OIFP plans to focus on Brooklyn, New York; Staten Island, New York; and Philadelphia, Pennsylvania.

The crackdown will be part of an ongoing effort by OIFP to reduce the millions of dollars paid annually by New Jersey policyholders to settle claims on vehicles owned by out-of-staters who submit claims on out-of-state vehicles fraudulently registered in New Jersey.

The OIFP investigative strategy is as follows: Step 1) upon completion of the multi-location sweep, the license plates obtained will be run on the Division of Motor Vehicle (DMV) computer system; Step 2) visit each suspect's address and perform a visual inspection to determine if the risk vehicle is at the location and to determine the status of the residence (*i.e.*, vacation home); Step 3) perform a TRW search on the owner of the vehicle to ascertain any possible out-of-state addresses (if steps 1-3 do not provide sufficient evidence to verify and prove New Jersey residency, the investigation will be assigned an OIFP case number and the matter further investigated); Step 4) at this stage of the investigation the necessary postal, tax assessor and voter registration mailings will occur; additionally, interviews of neighbors or other potential witnesses will commence to prove or disprove residency; Step 5) the DMV computer system will again be utilized to ascertain insurance policy information about the subject, and after obtaining the necessary DMV computer information, the subject's insurance carrier will be contacted to obtain policy information, as well as a copy of the current and previous year's policies; 6) at this stage of the investigation, the subject will be contacted and informed of the ongoing investigation and asked to submit proof of residency to the OIFP in the form of tax records, utility bills and other documentation. If sufficient proof of New Jersey residency is not provided, the subject will then be informed that he or she has violated *N.J.S.A. 17:33A-4* and may be

subject to a penalty. It is anticipated that this initiative will take approximately two months to complete.

6. STATE POLICE OPERATIONS

The Division of State Police's (DSP) Insurance Fraud Unit became fully operational in January of 1999 with the assignment of uniformed troopers specifically dedicated to the cooperative insurance fraud initiative. These troopers are currently deployed throughout the State and have been specially trained in identifying fraudulent, altered and/or counterfeit documents to include motor vehicle related documents, such as driver's licenses and insurance identification cards. One of their missions is to conduct random checks at State and private inspection and reinspection facilities. They will enforce and help to ensure compliance with the credential verification segment of the State's comprehensive vehicle registration and inspection program.

Additionally, the troopers will relay their specialized knowledge to other troopers and police officers during Statewide educational and training sessions. This specialized, uniformed function augments the investigative function being performed by the DSP's existing Auto Unit and the OIFP Investigators.

The DSP's Auto Unit will continue to conduct and assist in investigations involving stolen motor, construction and marine vehicles and/or equipment. Additionally, all personnel will work closely with DMV, as DMV is the entity that controls numerous data banks and document submission. The DSP has an extensive history of cooperation with DMV in investigating fraudulent matters. The State Police

Auto Unit also serves as a liaison for interstate cooperation on insurance fraud related criminal conspiracies which cross jurisdictional boundaries.

DSP's Auto Unit and Insurance Fraud Unit will perform inspections at Newark Bay and Camden Terminals to investigate and interdict shipments of stolen vehicles and/or parts overseas.

The uniformed troopers will also assist at DWI check points. While ensuring that motorists are complying with the State's drinking/driving laws, the Unit will also be ensuring compliance with additional Driving While Insured laws. The troopers will also conduct audits at driving schools and check that these private vendors are complying with State regulations.

7. COMPUTER ENHANCEMENT

The Department of Law and Public Safety is currently working with the State Purchase Bureau to acquire a vendor to implement a comprehensive case management system. This new OIFP system will provide a single information resource for managing cases, provide multi-case analysis and decision-making across all cases, full text searching and bar coding of evidence. A single database incorporating information from the existing DOBI, DCJ and Division of Law databases will significantly advance the vital process of gathering, analyzing and exchanging information, and enhance OIFP's case tracking abilities.

8. PUBLIC AWARENESS

Working with OIFP, the Attorney General's Public Affairs Office is launching a comprehensive public awareness initiative designed to inform New Jerseyans that insurance fraud is a crime, costs everyone money and carries serious consequences.

Initial steps include billboard advertising, paid radio advertising accompanying radio traffic reports, radio public service announcements and paid advertising in major daily newspapers.

Longer range public awareness efforts, which are expected to be in place by the start of the new fiscal year, will include a more extensive public relations campaign coordinated by the Office of the Attorney General and OIFP, but developed by a private firm. Currently, requests for proposals are being prepared by the Office of the Attorney General for the contracting of this service.

The awareness campaign, which will build on the initial public awareness efforts, is expected to include paid television advertising, direct mail advertising and op-ed pieces for weekly newspapers.

CONCLUSION

The initial report of OIFP details the hard work that has taken place to date in setting up the Office and the blueprint for its future. Based upon the experience gained by a full year of operation, and as contemplated by AICRA, OIFP expects to be able to formulate proposals to strengthen insurance fraud enforcement throughout the State in its next Annual Report.

A P P E N D I X

Course Schedule for Civil Investigators

Biographies of Key OIFP Personnel

BIOGRAPHIES

OIFP-Criminal Litigation

- **John J. Smith, Jr.** AAG Smith received a law degree in 1981 and, in 1993, received a Master of Laws degree in taxation from Temple University. From 1982 through 1985, AAG Smith served as a Captain in the United States Army's Judge Advocate General's Corps, and prosecuted criminal cases as a military trial counsel. He joined the Division of Criminal Justice in 1985 and has worked in the Casino Prosecutions Section and the Insurance Fraud Unit. In 1996, he was appointed Supervising Deputy Attorney General in charge of the Economic Crimes Bureau, and in 1997 was promoted to Assistant Attorney General. An experienced criminal trial attorney, AAG Smith is currently a Lieutenant Colonel in the United States Army Reserve, Judge Advocate General's Corps.
- **John Kennedy.** John Kennedy has been with the Division of Criminal Justice since 1987. During that time, he has worked in the Appellate Bureau and the Environmental Crimes Bureau, before being promoted in 1997 to Supervising Deputy Attorney General in charge of the Insurance Fraud Unit.
- **John R. Krayniak.** After serving as a police officer for eight years in Pasadena, California, SDAG Krayniak became a deputy district attorney in Los Angeles. For the past ten years, SDAG Krayniak has been a deputy attorney general with the Division of Criminal Justice and, for the past five years, has been Chief of the Medicaid Fraud Control Unit. In his time with the Division of Criminal Justice, he has also served as Supervising Deputy Attorney General in the Organized Crime and Racketeering Bureau and as Chief of the Statewide Narcotics Bureau. SDAG Krayniak has been actively involved in health care fraud issues for the past four

years through NAMFCU in Washington, DC, where he is a member of the Executive Committee and a member of the Legislation, Training and Finance Committees. SDAG Krayniak lectures on issues involving health care fraud for the Institute of Continuing Legal Education in New Jersey and serves on the Criminal Law Subcommittee of the Governor's Health Care Fraud Task Force.

Investigations

Deputy Chief Investigators

- ***MDCI Anne M. Kriegner.*** Managing DCI Kriegner has been an investigator with the Division of Criminal Justice since 1978 and a Supervising State Investigator since 1993. She was appointed Managing Deputy Chief Investigator of OIFP to coordinate and oversee all criminal and civil investigative operations within OIFP. MDCI Kriegner answers directly to the Insurance Fraud Prosecutor and to the Chief of Investigators of the Division of Criminal Justice. In addition to her long years of experience and service as a criminal investigator, MDCI Kriegner holds a degree in Business Administration. Since joining Criminal Justice in 1978, MDCI Kriegner has worked with the Drug Diversion Investigation Unit, the Medicaid Fraud Section and the Institutional Abuse Unit.

- ***DCI Quinton W. Collins, Sr.*** DCI Collins was appointed Deputy Chief Investigator in charge of criminal investigations. After serving as an investigator for 12 years with the Mercer County Prosecutor's Office, DCI Collins joined the Division of Criminal Justice in 1988. He was appointed a Supervising State Investigator in 1994. He has worked as an investigator within the Litigation Unit and Major Fraud Section of Criminal Justice and he served as a Supervising State Investigator in the Medicaid Fraud Section. DCI Collins is responsible for overseeing all criminal investigations, and directly manages five units investigating insurance fraud and two

sections investigating Medicaid fraud.

- **DCI Thomas J. Kiselica.** DCI Kiselica joined the Division of Criminal Justice in 1975, after working as an auditor with an accounting firm and spending two years with the United States Army Finance Corps. He has an undergraduate degree in accounting, as well as a master's degree in business administration. DCI Kiselica has worked as an investigator with the Casino Prosecutions Section, the Program Integrity Section, the Organized Crime and Racketeering Bureau and the Corruption/Antitrust Bureau. He served as a Supervising State Investigator since 1983, with the responsibility of managing and directing field investigations. He also has been responsible for overseeing the financial investigations associated with organized crime cases. He is a certified fraud examiner, has been qualified as an accounting expert in Superior Court and is a certified instructor with the New Jersey Police Training Commission.

Supervising State Investigators - OIFP-Civil Investigations

- **SSI Joseph S. Buttich.** SSI Buttich has been with the Division of Criminal Justice since 1986 and lectures extensively throughout the country on law enforcement, particularly at the federal Law Enforcement Training Center in Glynco, Georgia, and the Division of Criminal Justice Training Academy. Before joining the Division, SSI Buttich worked as an environmental scientist with the Environmental Protection Agency and as a hazardous site mitigation specialist with the New Jersey Department of Environmental Protection. SSI Buttich has also published several articles in the area of environmental crimes.
- **SSI Marie B. Crescenz.** SSI Crescenz joined the Division in 1987 and was assigned to the Corruption/Antitrust Bureau. Prior to becoming a State Investigator,

SSI Crescenz worked for the Division of Gaming Enforcement for nine years and, prior to that, taught accounting, business administration and economics. She has a degree in mathematics and an MBA in Accounting. She is a certified public manager.

- ***SSI Martin J. Schwartz.*** Before joining the Division of Criminal Justice in 1987, SSI Schwartz was a police officer for ten years and, in that capacity, received the Medal of Honor. He regularly instructs at the federal Law Enforcement Training Center in Glynco, Georgia, and served three years in the Air Force Security Police. SSI Schwartz was previously assigned to the Environmental Crimes Bureau.
- ***SSI Walter L. Braxton III.*** SSI Braxton has been with the Division of Criminal Justice since 1989. Before joining OIFP, SSI Braxton worked in the Civil Remedies and Forfeiture Bureau and the Narcotics Racketeering Bureau of the Division of Criminal Justice. He holds an MBA in accounting and is a certified fraud examiner. Prior to coming to the Division of Criminal Justice, SSI Braxton worked as a Special Agent in the Office of the Inspector General in the United States Department of Labor and as an Internal Revenue Agent in the Special Enforcement Program of the IRS. SSI Braxton has expertise in computer operations and is essential in implementing the directives of AICRA which relate to establishing case tracking and creating a fraud database.

Team Leaders - OIFP-Civil Investigations

Civil Supervising Investigators:

- ***CSI Ronald Dellano***
- ***CSI Joseph Fleming***
- ***CSI Michael Palumbo***

- **CSI Harry Polihram**

State Investigators:

- **SI Joseph Abrams**
- **SI Rita Binn**
- **SI Brian Harshman**
- **SI James MacInnes**

Supervising State Investigators - OIFP-Criminal Investigations

Insurance Fraud:

- **SSI Edward Buttimore.** SSI Buttimore joined law enforcement in 1979. Prior coming to the Division of Criminal Justice in 1985, he was a County Investigator with the Passaic County Prosecutor's Office and the Morris County Prosecutor's Office and served as a special agent with the United States Secret Service. While at the Division, SSI Buttimore has been assigned to Major Fraud and Insurance Fraud investigations. SSI Buttimore holds a degree in Administration of Criminal Justice and has extensive experience in electronic surveillance. He has often lectured on wiretap law and procedures at the Division of Criminal Justice Academy.
- **SSI Richard A. Falcone.** Before beginning work at the Division of Criminal Justice in 1987, SSI Falcone was an investigator with the Passaic County Prosecutor's Office. While at the Passaic County Prosecutor's Office from 1976 to 1987, SSI Falcone worked for the Major Crimes Unit and investigated many homicide cases. He holds a bachelor of science degree in criminal justice and is a certified polygraph examiner. Since coming to the Division of Criminal Justice, SSI Falcone has been assigned to the Medicaid Fraud Section, the Environmental Crimes Bureau and the Organized Crime and Racketeering Bureau.

- **SSI William Frey.** SSI Frey came to the Division of Criminal Justice in 1986, after serving for nine years as an investigator with the Hudson County Prosecutor's Office. Since joining the Division, SSI Frey has been assigned to the Major Fraud Unit and has been the lead investigator on several of the Division's high priority fraud cases. SSI Frey holds a degree in accounting.
- **SSI Jules Mateo.** For 16 years, SSI Mateo has been a State Investigator with the Division of Criminal Justice. He previously worked as an investigator for the Gloucester County Prosecutor's Office and worked as a sheriff's officer with the Camden County Sheriff's Office . He has also been an investigator with the Puerto Rico Police Department. SSI Mateo was assigned to the Environmental Crimes Bureau before joining OIFP.

Medicaid Fraud:

- **SSI Nancy M. Beiger.** SSI Beiger joined the Division in 1985 and was assigned to the Office of the Attorney General for three years, conducting investigations involving the Department of Law and Public Safety. Other assignments have included the Office of Legal Affairs, the Insurance Fraud Unit and Institutional Abuse Unit. SSI Beiger is a physical training instructor at the Division of Criminal Justice Academy. Under DCI Collins, SSI Beiger, in conjunction with SSI Quinoa, supervises Medicaid investigations.
- **SSI Manuel P. Quinoa.** After serving as an insurance adjuster for two years, SSI Quinoa joined the Division of Criminal Justice in 1979. SSI Quinoa holds a degree in accounting and has been assigned to the Medicaid Fraud Section, Program Integrity Section and the Major Fraud Section.

Liaison to the Law Enforcement Community - Craig W. Perrelli

- SSI Perrelli was appointed as the OIFP's liaison to the law enforcement community. SSI Perrelli has been with the Division of Criminal Justice for 23 years. During his tenure, he has been assigned to the Statewide Narcotics Task Force, the Environmental Crimes Section, the Organized Crime and Racketeering Bureau, the Casino Prosecutions Section and the Drug Diversion Section. SSI Perrelli holds a bachelor of science degree and a master's degree. SSI Perrelli was also selected to serve on a confidential task force to study health care fraud in New Jersey. Since 1990, SSI Perrelli has been a certified instructor for the Police Training Commission, and he is a Physical Fitness Instructor at the Division of Criminal Justice Academy in Sea Girt.

Liaison to Licensing Boards - Charles A. Janousek

- Charles A. Janousek, an administrator and regulator with 24 years of experience in positions of responsibility, has served as Executive Director of the New Jersey State Board of Medical Examiners, the Medical Practitioner Review Panel, the New Jersey Chiropractic Board, the New Jersey Veterinarian Medical Examiners and the New Jersey Occupational Therapy Advisory Council. He has also served as Acting Executive Director of the New Jersey Board of Dentistry. Between 1968 and 1970, he served in Vietnam as a Sergeant in the United States Army. In addition to a bachelor's degree in marketing, Charles Janousek holds a master's degree in business administration.

Liaison to Industry - John Butchko

- John Butchko was selected as the OIFP's liaison to the insurance industry. Between 1989 and 1993, while working at the DIFP, he served as President of the New Jersey Special Investigators Association, a non-profit organization of profes-

sional insurance fraud investigators. John Butchko began working at the Department of Insurance in 1979 and was the first investigator hired by DIFP in 1983. He served in many supervisory capacities during his tenure at DIFP.

Selected Criminal Case Details and Press Clip-pings