

New Jersey Office of Insurance Fraud Prosecutor



Annual Report 2001

Insurance Fraud

New Jersey's **FED UP.**

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ANNUAL REPORT
OF THE
OFFICE OF THE INSURANCE FRAUD PROSECUTOR
FOR CALENDAR YEAR 2001

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PREFACE

The Office of the Insurance Fraud Prosecutor (OIFP) was created on May 19, 1998 pursuant to the provisions of the Automobile Insurance Cost Reduction Act (AICRA). *P.L.* 1998, c. 21. As set forth in the legislative statement attendant to the Act, OIFP was established to provide for “more effective investigation and prosecution” of insurance fraud than had previously existed. In its preamble to the Act, the Legislature recognized that, whether in the form of inappropriate medical treatments, inflated claims, staged accidents, or any other form, insurance fraud must be “uncovered and vigorously prosecuted.”

Pursuant to AICRA, the Office of the Insurance Fraud Prosecutor was established within the Division of Criminal Justice in the Department of Law and Public Safety. The Office of the Insurance Fraud Prosecutor is overseen and managed by the Insurance Fraud Prosecutor. The Insurance Fraud Prosecutor is appointed by the Governor, with the advice and consent of the Senate, and reports to the Attorney General.

As a law enforcement agency, OIFP’s primary focus is criminal prosecution. AICRA also required, however, that to ensure the most effective coordination of public and

private anti-fraud efforts, certain civil enforcement functions of the Division of Insurance Fraud Prevention, Department of Banking and Insurance, would be transferred to OIFP pursuant to a plan of reorganization which became effective on August 24, 1998. (Reorganization Plan 0007-98).

As a result, under AICRA, OIFP is responsible for the investigation of all types of insurance fraud and is the focal point for criminal, civil and administrative investigations and prosecutions of insurance and Medicaid fraud in New Jersey. OIFP is also responsible under AICRA for the coordination of all anti-insurance fraud efforts of law enforcement and other public agencies and departments in New Jersey, as well as private industry, to ensure the most effective and well integrated statewide strategy possible for combating insurance fraud.

This report constitutes the third annual report submitted by OIFP pursuant to *N.J.S.A.* 17:33A-24d, which requires OIFP to annually provide a report of activities conducted during the prior calendar year to the Governor and the Legislature.

STATEMENT OF THE PROSECUTOR

OIFP - CRIMINAL

INSURANCE FRAUD UNIT

The Insurance Fraud Unit in OIFP-Criminal investigates and prosecutes all types of insurance fraud, most of which involve health, auto, homeowners or commercial insurance coverages. While OIFP frequently focuses on automobile insurance fraud, during 2001, health insurance also comprised a significant portion of OIFP's criminal caseload. Health care fraud accounts for as much as ten percent of our national health care costs according to the United States Accounting Office. While these losses are initially borne by health care insurers and HMO's, they are ultimately passed on to the health care consumer in the forms of increased premiums and deductibles, and may also result in a reduction in the number of eligible insureds and a narrowing of the scope of coverage provided under health insurance policies.

Automobile insurance fraud frequently overlaps health care claims fraud because automobile insurance policies in New Jersey provide medical benefits.

Health care claims fraud can be committed by health care practitioners such as doctors, chiropractors and dentists, by those providing health care

related services such as invalid transportation and medical billing businesses, or by patients themselves. Health care claims fraud is committed when a business or individual makes a misrepresentation in the course of submitting a claim for benefits under a health insurance policy. *N.J.S.A. 2C:21-4.2.* A patient may commit health care claims fraud, for example, by submitting a claim for treatment expenses for feigned injuries, or by submitting altered medical receipts for reimbursement of legitimate claims. A physician may commit health care claims fraud by knowingly submitting a bill for services that were either unnecessary or not rendered at all.

Health care claims fraud in New Jersey frequently overlaps with automobile insurance claims fraud because automobile insurance policies in New Jersey provide medical benefits for those injured in vehicular accidents. Since the extent of medical treatment is usually considered in evaluating the seriousness of a claimant's injuries, unscrupulous claimants have an incentive to seek more treatment than necessary to enhance their prospects for an inflated monetary insurance settlement.

Uninjured occupants of vehicles involved in a collision are sometimes

contacted by “runners” and encouraged to pursue claims for purported “soft tissue” injuries, such as back sprains, also known as “whiplash.” Such soft tissue injuries are claimed because they often are not verifiable by the use of common diagnostic visualization techniques such as x-rays and MRIs. Instead, proof that a claimant has sustained soft tissue injuries is usually dependent upon subjective factors such as “limitation of motion” and the claimant’s subjective complaints, which can be easily fabricated by unscrupulous claimants seeking to exploit the system.

“Runners” typically receive an illegal fee or commission for recruiting potential claimants and referring them to unscrupulous medical providers and/or attorneys who, in turn, benefit by providing unnecessary medical services or pursuing unwarranted claims for monetary damages.

Some runners resort to the planning and staging of accidents to insure a steady flow of phony injury claimants. Staged accidents typically involve one of several common scenarios such as the passing of an unsuspecting motorist and abruptly stopping, thereby causing a “rear ender” in which the innocent driver appears to be at fault. Another common scenario involves encouraging an unsuspecting motorist to proceed

through a stop sign, or from a parking space, and quickly accelerating to cause a crash, again making it appear that the unsuspecting motorist is at fault. In other cases, a runner or conspirator may claim to have been in an accident where there was no collision at all, such as where a previously damaged vehicle is placed at a public location and it is falsely reported that the vehicle and its occupants were the victims of a crash with a phantom “hit-and-run” vehicle.

The lure of easy money that can be derived from staged accidents has led, in some cases, to the growth of networks of participants known as “staged accident” rings, usually concentrating in heavily populated areas where law enforcement is already stretched thin combating more seemingly urgent urban street crime involving drugs and violence. Staged accident rings typically involve a combination of “players” such as runners, claimants, phony medical and chiropractic mills, auto repair facilities and individuals associated with the legal profession, such as investigators, office managers, paralegals and attorneys.

Another type of automobile insurance fraud prosecuted by OIFP in 2001 involved the staged thefts of automobiles, also known as “give-up” cases. In this type of case, the owner

or lessee of a vehicle abandons the vehicle or turns it over (the “give-up”) to a person who agrees to dispose of the vehicle on behalf of the owner or lessee. Once the vehicle has been disposed of, the owner or lessee typically files a fraudulent police report and insurance claim alleging the vehicle has been stolen.

“Give-ups” are most often perpetrated where the lessee has exceeded the permitted mileage under a lease and is facing a substantial lease end “penalty” payment to the vehicle leasing company, or where an unscrupulous owner seeks to exploit the difference between the apparent “book value” of a worn or damaged vehicle and its true fair market value. The middleman in a “give-up” scheme usually removes the vehicle to a secluded location and attempts to completely destroy it in order to preclude its return to the owner, usually by dousing the vehicle with an accelerant, such as gasoline, and burning it. Sometimes, a vehicle’s owner or lessee turns the vehicle over to members of a stolen car ring who have established relationships with unscrupulous auto body repair shops, also known as “chop shops”, which disassemble vehicles and sell the parts on the black market. Stolen car rings may also smuggle vehicles out of the country for resale at prices significantly below fair market value.

OIFP has, through its Civil Investigative Section, established a proactive program known as the “Give-up Initiative” to seek out and identify phony or staged auto thefts for further investigation and possible civil or criminal prosecution. This Initiative is explained in greater detail in the “OIFP-Civil” section of this report.

MEDICAID FRAUD UNIT

The Medicaid Fraud Unit in OIFP-Criminal investigates and prosecutes Medicaid fraud cases. Medicaid is a state and federally-funded health insurance program that provides reimbursement for the health care expenses of the disabled, economically disadvantaged, and, more recently, those who work, but whose income and health benefits fall below certain levels. In New Jersey, the cost of the program is shared equally by the State and federal government. The State’s share of the Medicaid expenditures represents approximately fifteen percent of its annual budget.

As recognized by the New Jersey Legislature, billions of dollars are spent each year on health care in New Jersey and approximately ten percent of these costs can be attributed to fraud. Medicaid fraud is a serious problem with far ranging consequences, not only for taxpayers, but for those who depend on these programs for their health care. In order to preserve the

financial integrity of the Medicaid health care system in New Jersey, the Attorney General deems it essential to maintain, within the Office of the Insurance Fraud Prosecutor, a Unit designed to investigate and prosecute Medicaid fraud cases.

The Medicaid Fraud Unit receives 75% of its operational funding from the federal government. Since the Medicaid Fraud Unit typically recovers more money in restitution and penalties than the State matched portion of its budget, the Medicaid Fraud Unit constitutes an extremely cost effective means of combating fraud and abuse in the administration of the Medicaid program.

The Medicaid Fraud Unit investigates and prosecutes fraud committed by health care providers, including doctors, dentists, pharmacists, clinics, laboratories, mobility assisted vehicle services, nursing homes, durable medical equipment suppliers and any other ancillary service providers who operate and administer services under the Medicaid program. Medicaid fraud occurs when a provider of Medicaid covered services fraudulently receives medical assistance payments to which he is either not entitled or in a greater amount than that to which he is entitled. In addition, the Medicaid Fraud Unit investigates and prosecutes

cases involving allegations of patient abuse and criminal neglect in health care facilities licensed by the Medicaid program, including nursing homes and related facilities.

Billions of dollars are spent each year on health care in New Jersey and approximately ten percent of these costs can be attributed to fraud.

Changes to federal law authorize the Medicaid Fraud Unit to also prosecute health care fraud in any federally-funded health care programs, including Medicare, when the case involves a connection to Medicaid fraud and the appropriate Inspector General of the involved federal agency consents. Moreover, changes in guidelines issued by the federal government encourage the Medicaid Fraud Unit to negotiate civil settlements in appropriate cases, such as when the evidence may be insufficient to satisfy the higher burden of proof required at a criminal trial but there is enough evidence to make the determination that an overpayment has been made to a provider. The Medicaid Fraud Unit's ability to settle civil cases has proven to be very effective in protecting the Medicaid program from overpayments that would not otherwise be recovered. In addition, by collaborating with Medicaid Fraud Units in 47 other states and the District of Columbia, as

well as federal authorities, OIFP's Medicaid Fraud Unit has been aggressive in utilizing this civil authority to recover monies from providers whose business is national in scope. Most of these cases, which have dramatically increased over the past several years, are initially filed under the Federal False Claims Act. All recoveries and penalties are generally allocated based upon a state's actual Medicaid damages. State and federal prosecutors work as a team on each case, negotiating the best possible settlement for their respective governmental entities. In addition to restitution and possible civil or administrative penalties, all settlements require a corporate integrity agreement and, where appropriate, criminal action against the offending parties.

Medicaid fraud increases commensurately with an increase in program benefits. One provider group in particular, non-emergency transportation providers, continues to generate significant criminal investigations and prosecutions in the Medicaid Fraud Unit. The New Jersey Medicaid program reimburses providers of non-emergency transportation who transport Medicaid recipients between their homes and the place where a Medicaid covered service is rendered. The Medicaid program provides different modes of

transportation based on the recipient's ability to ambulate without physical assistance. Livery transportation is provided to those who can freely ambulate and do not need assistance. Mobility assisted vehicles, formerly referred to as invalid coach transportation services, are provided to those who are wheelchair bound or not able to ambulate on their own due to an existing medical or mental condition.

Fraud in this area is generally committed by providers inflating the mileage claims on services provided, billing for services that were not provided, providing kickbacks to recipients and falsifying prior authorization forms to qualify a recipient for mobility assisted services which are paid at a higher rate than livery service. Non-emergency transportation services provide an inviting target for fraudulent activities because no professional license is necessary, such as that required of a doctor or pharmacist, and the economic barriers to entry are generally low. In an effort to stem the tide of unscrupulous transportation providers participating in the Medicaid program, the Medicaid Fraud Unit assists the State agency in conducting background checks of prospective providers. In so doing, prospective providers who are intent on committing Medicaid fraud are denied Medicaid

provider numbers and thereby denied access to program dollars.

On another front, the Medicaid Fraud Unit continues to combat organized criminal groups whose sole purpose is to defraud the Medicaid program. With the advent of electronic billing, these groups are able to bill quickly, anonymously and for large amounts of dollars. Many of these defendants do not have strong ties to the State. As a result, they fail to appear in response to subpoenas or summonses, which instead serve as signals to flee the jurisdiction. To combat this problem, the Medicaid Fraud Unit has adopted a more aggressive use of search warrants and arrest warrants. These law enforcement tools are used to gain the advantage of surprise and to bring defendants before a judge at the earliest possible time in order to request adequate bail and conditions of bail, such as surrendering passports, to ensure defendants' presence at trial.

Another powerful law enforcement tool is the recently enacted Health Care Claims Fraud Act, which provides enhanced penalties to deter practitioners and other persons from engaging in fraud related to health care. Under the new statute, a provider who commits Medicaid fraud also commits health care claims fraud.

Thus, a practitioner who commits Medicaid fraud can be found guilty of a second degree crime which carries a presumption of imprisonment regardless of the dollar amount of the fraud. In addition to all other criminal penalties allowed by law, a person convicted of second degree health care claims fraud may be subject to a fine of up to five times the pecuniary benefit obtained or sought to be obtained. Additionally, a practitioner convicted of health care claims fraud can be forever barred from the practice of the profession.

ORGANIZATIONAL AND OPERATIONAL STRUCTURE

State Investigators in the Division of Criminal Justice, Department of Law and Public Safety, who are assigned to OIFP, are responsible for conducting OIFP's criminal investigations. OIFP's criminal cases are prosecuted by Deputy Attorneys General within the Division of Criminal Justice, who are similarly assigned to OIFP. These State Investigators and Deputy Attorneys General are assigned to squads in either the Insurance Fraud Unit or the Medicaid Fraud Unit of OIFP.

The Deputy Attorneys General in each squad are supervised by a Supervising Deputy Attorney General, while the State Investigators in each

squad are supervised by a Supervising State Investigator. The Supervising Deputy Attorney General reports to an Assistant Attorney General, who, in turn, reports directly to the Insurance Fraud Prosecutor. Supervising State Investigators report to the Deputy Chief Investigator in charge of criminal investigations, who is supervised by the Managing Deputy Chief Investigator for OIFP. The Managing Deputy Chief Investigator supervises all OIFP investigators, both criminal and civil, and reports directly to the Insurance Fraud Prosecutor and the Chief of Investigators for the Division of Criminal Justice.

The Insurance Fraud Unit of OIFP is staffed by 22 Deputy Attorneys General and 63 Criminal Investigators divided into five squads. Two squads are assigned to each of the Central (Lawrenceville) and Northern (Whippany) regional offices of OIFP. The fifth squad is assigned to the Southern (Cherry Hill) regional office of OIFP. A team of four Analysts, three Technical Assistants, and a Paralegal, supervised by a Senior Analyst, provides support and assistance to the Insurance Fraud Unit in the organization and analysis of documents, records and related data compiled in the course of conducting criminal investigations.

The Medicaid Fraud Unit of OIFP

employs a professional staff consisting of a Supervising Deputy Attorney General, who directs the Unit's seven full time attorneys, 19 Criminal Investigators, including two Supervising State Investigators, and eight support personnel. Three attorneys are housed in OIFP's Central (Lawrenceville) office, three are housed in the Northern (Whippany) regional office, and one is housed in the Southern (Cherry Hill) regional office. The Medicaid Fraud Unit's investigative staff is assigned to all three regional offices. Support personnel include two Auditors, a Paralegal, a Senior Management Assistant, a Technical Assistant, two Legal Secretaries and one Principal Clerk Typist. Support staff assist in case and financial analysis, legal research, case tracking and other administrative functions for the Medicaid Fraud Unit. Both Units operate utilizing a strike force model whereby the Deputy Attorneys General, Auditors, Analysts, Investigators and Paralegals work together, full-time, to investigate and prosecute insurance fraud throughout the State.

OIFP - CIVIL

Civil insurance fraud cases comprise the majority of insurance fraud cases investigated by OIFP each year. Under the New Jersey Insurance Fraud Prevention Act (Fraud Act), *N.J.S.A. 17:33A-1 et seq.*, persons who commit insurance fraud may be subject to the imposition of substantial civil fines in addition to, or as an alternative to, criminal prosecution. The Fraud Act enumerates several dozen categories of civil insurance fraud violations which carry significant monetary penalties for each act or omission constituting such a violation.

Pursuant to the Fraud Act, fines for civil insurance fraud can be as high as \$5,000 for the first violation, \$10,000 for a second violation, and \$15,000 for the third and each subsequent violation thereafter. Notably, each misrepresentation or omission constituting a fraud in a particular claim or application for insurance may constitute a separate violation of the Act giving rise to liability for a civil fine. Where appropriate, restitution and attorneys fees may also be sought by the State. Civil investigators assigned to OIFP-Civil are responsible for investigating suspected instances of violations of the

Fraud Act.

HEALTH CARE FRAUD

As indicated previously, the problem of health care claims fraud, within the context of both health insurance and automobile insurance, is among the greatest challenges faced by OIFP and others engaged in the battle against insurance fraud in New Jersey. In order to ensure the most effective response possible to the many faces of health care fraud, OIFP established a Health Care Fraud Unit within OIFP-Civil in August of 2001. Among the cases falling within the purview of the newly formed Unit are fraudulent billings submitted by medical providers for unnecessary medical procedures, over stated medical procedures (upcoding), or procedures and services not rendered.

The Unit is designed to review, and, where appropriate, investigate most of the health care, dental and prescription fraud cases referred to OIFP-Civil. The Unit staff consists of a Team Leader, Medical Investigative Nurse, and eight Civil Investigators. The creation of this Unit offers the benefit of specialization in this complex area of insurance fraud and enables

OIFP-Civil to effectively consolidate and focus resources on these types of cases. By consolidating resources in a single unit, OIFP-Civil also assures optimum coordination with interested agencies, such as the Division of Consumer Affairs, Enforcement Bureau, as well as referring insurance carriers.

GIVE-UP INITIATIVE

Fraudulent auto theft claims continue to constitute another troublesome area of fraud confronting both insurance companies, through unnecessary losses, and insurance consumers, through the cost of increased premiums attributable to such fraud. Indeed, insurance research professionals estimate that as much as 15 to 40 percent of all auto theft claims may be fraudulent.

OIFP's "Give-Up" Initiative consolidates and focuses specialized resources to identify and penalize insureds who file fraudulent auto theft claims.

To specifically target auto theft fraud in New Jersey, OIFP established a pro-active pilot project in 2000 designated as the "Give-Up Initiative." Similar to the Health Care Fraud Unit, the Initiative is designed to consolidate specialized resources with a focus on finding creative means to both identify and penalize those who file fraudulent auto theft claims. A "give-up" is one of the most common scenarios giving rise to a fraudulent auto theft claim, wherein the owner or lessee "gives up" the vehicle to an intermediary for disposal as a predicate to the filing of a fraudulent insurance claim.

In addition to consolidating OIFP's

expertise, the Give-Up Initiative embarked on a program to closely coordinate its investigative activities with those of other law enforcement agencies most likely to first encounter a fraudulent auto theft claim in the making, such as municipal police departments and County Prosecutors' Offices. That coordination typically entails a combination of activities, including training by OIFP staff in the identification and investigation of auto theft fraud, review by OIFP staff of local charges relating to the filing of false police reports, and the joint investigation of individuals, suspected rings or locations reputed to be the last resting place of possible "give-ups."

The Give-Up Initiative is staffed by a core group of eight Civil Investigators, including a Team Leader. Those assigned to the Give-Up Initiative received specialized training in auto theft forensics and are tasked, among other things, with developing working relationships with law enforcement and other agencies, including fire marshals and other fire officials, who may be helpful in assisting investigators develop leads on new cases.

In 2001, those assigned to the Give-Up Initiative worked closely with law enforcement agencies in Hudson and Ocean Counties in investigating the fraudulent disposal of vehicles

recovered from watery graves in the Hudson River and Asarco Lake, respectively. They also met with representatives of officers of the fire marshals' offices in each of New York City's five boroughs in an effort to establish a mechanism for developing investigative leads with respect to New Jersey vehicles found abandoned and frequently burned in New York City. Similar efforts have led to a cooperative working relationship between Give-Up Initiative investigators and law enforcement authorities in Philadelphia, another urban center where "give-up" vehicles are frequently abandoned.

During 2001, OIFP launched over 600 investigations of individuals suspected of filing fraudulent insurance claims with their insurance companies through the Give-Up Initiative. As part of its efforts to provide insurance fraud training to other law enforcement agencies, and in conjunction with the Give-Up Initiative, OIFP also produced and distributed a package of training materials designed to assist local law enforcement officers in the early detection of fraudulent auto theft claims. The educational package, consisting of a roll call training video and model visor reference cards, highlights a number of "red flag" indicators which should alert the investigating officer to the possibility of an attempted auto theft

fraud.

WORLD TRADE CENTER TASK FORCE

To deter unscrupulous individuals who might seek to profit from the September 11th World Trade Center attacks by committing insurance and other fraud, and to expeditiously address those instances in which such fraud is suspected, OIFP established a World Trade Center Insurance Fraud Task Force after meeting with insurance industry officials in October of 2001. The Task Force consists of experienced criminal and civil investigators from each of OIFP's three regional offices. Task Force investigators review suspected instances of insurance fraud relating to the World Trade Center attacks immediately upon receipt. Insurance fraud associated with a tragedy of the magnitude of the September 11th attacks manifests itself in such forms as inflated claims for minor or non-existent property damage, claims for damaged or destroyed vehicles that were not even near the World Trade Center on September 11th and phony life insurance claims.

ORGANIZATIONAL AND OPERATIONAL STRUCTURE

OIFP-Civil's staff of approximately 120 Civil Investigators are assigned to four Units which are housed in OIFP's three regional offices located in Cherry Hill (South Unit), Whippany (North Unit) and Lawrenceville (Central Units 1 and 2). Supervising State Investigators oversee the regional units, which are each comprised of three squads of ten investigators supervised by Team Leaders. The Supervising State Investigators for each region report to the Deputy Chief Investigator for civil investigations, who reports to the Managing Deputy Chief Investigator, OIFP's top investigative official.

Most cases investigated by OIFP-Civil are the result of referrals from the Special Investigative Units of insurance companies which are required by law to refer matters of suspected insurance fraud to OIFP. OIFP's well publicized hotline and interactive website, as well as other law enforcement and administrative agencies both within and outside of the State, also generate a significant number of referrals of suspected insurance fraud to OIFP.

The reporting of subjects under investigation by County Prosecutors' Offices generates a substantial number of civil insurance fraud investigations

by OIFP. In order to ensure effective coordination between OIFP and County Prosecutors' Offices, OIFP implemented a monthly reporting system in 2001, pursuant to which all subjects under investigation by County Prosecutors' Offices are reported to OIFP on a monthly basis. Regardless of whether those subjects are ultimately prosecuted by the reporting County Prosecutor's Office, the reported subjects are investigated by OIFP-Civil whenever the allegations appear to constitute a violation of the Fraud Act.

Upon receipt of referrals by OIFP, all referrals of suspected insurance fraud are date-stamped, classified by OIFP region and type of insurance fraud, and subjected to an initial screening by a Civil Investigator to determine whether a potential fraud has occurred. The cases are then referred to the Analytical Case Tracking and Information Unit (ACIU) for further processing to include background checks of the subjects. After review by an ACIU Civil Investigator, most referrals are forwarded to OIFP's Case Review Committee, which is comprised of Civil and Criminal Deputy Attorneys General and Investigators, and the County Prosecutor and Professional Boards Liaisons.

The Case Review Committee carefully reviews each referral to determine whether it is suitable for

assignment as a civil or criminal matter, or as a referral to another law enforcement or government agency, such as a County Prosecutor's Office, the New Jersey State Police, the Department of Banking and Insurance, or the Enforcement Bureau of the Professional Licensing Boards.

If the referral is deemed appropriate for a civil investigation, the case is assigned accordingly. At the conclusion of the investigation, if the assigned Civil Investigator determines that the allegation or allegations of fraud are supported by the evidence pursuant to the statute, the investigator prepares and serves the subject with a proposed administrative consent order for execution providing for an appropriate fine under authority of the Fraud Act. The proposed consent order includes a short description of the violation, an admission, and the amount of the fine. In addition, if the subject is a licensed person or entity, such as a physician, nurse, attorney, or auto body shop, the consent order also states that the subject's licensing authority will be notified that the subject entered into a consent order on an insurance fraud matter.

If the subject refuses to sign the proposed consent order, the case is referred to the Division of Law for further action, to include litigation.

Civil litigation by the Division of Law, Insurance Fraud Unit Deputy Attorneys General, is typically pursued where evidence strongly indicates that the subject of the investigation has committed civil insurance fraud, a criminal case is not appropriate, and the subject has refused to execute a consent order or agreement requiring payment of an appropriate insurance fraud fine or to enforce the provisions of a prior fraud settlement where the subject has grown seriously delinquent. As with most litigation, a significant percentage of cases are settled before trial. Regardless of how the Division of Law resolves a matter, the resolution usually entails admissions, fines, attorneys fees, costs and restitution. If the fraud allegation involves automobile insurance, and is adjudicated by court order, the order also requires the suspension of driving privileges for one year. *N.J.S.A. 39:6A-15.*

REFERRALS TO OFFICE OF THE INSURANCE FRAUD PROSECUTOR

OIFP received 7,984 referrals of suspected insurance fraud in 2001, of which 5,519 came directly from insurance carriers. Pursuant to the provisions of the Insurance Fraud Prevention Act, *N.J.S.A. 17:33A-9*, insurance carriers are required to refer all instances of suspected insurance fraud to OIFP for review and, where

warranted, appropriate follow up action. Another 1,553 referrals were provided by conscientious private citizens reporting through one of several mechanisms, including OIFP's toll free insurance fraud hotline, letters, e-mail and the online reporting form provided by OIFP on its web site at: www.njinsurancefraud.org.

The monthly reporting of suspected insurance fraud cases under investigation by County Prosecutors' Offices resulted in the opening of

In 2001, OIFP received 7,984 referrals of suspected insurance fraud.

another 285 civil insurance fraud cases by OIFP, many of which concluded in the imposition of substantial civil penalties by OIFP. Most of the remaining 627 cases originated from OIFP-Criminal investigations and referrals from such other agencies of government as the Department of Banking and Insurance, the Division of Motor Vehicles, the Department of Labor and other sections of the Department of Law and Public Safety.

Of the referrals to OIFP in 2001, Civil Investigators identified 4,986 as warranting further investigation following initial review and screening. Referrals not warranting assignment

after initial screening are entered into OIFP's database for purposes of future reference should additional information pertaining to those matters be obtained at a later point in time. Most referrals identified for investigative follow-up are assigned initially to OIFP-Civil. However, some referrals may be assigned directly for criminal investigation immediately following initial screening procedures. Civil investigations are continually monitored and evaluated with respect to their potential for possible referral for criminal prosecution. Most of the cases prosecuted criminally by OIFP have both civil and criminal components. Many of the criminal prosecutions handled by OIFP-Criminal were, in fact, initiated as civil insurance fraud investigations. This procedure ensures the most efficient allocation of OIFP resources and preserves the confidentiality of privileged law enforcement files.

DISPOSITIONS BY CIVIL INVESTIGATORS

In 2001, OIFP civil investigations resulted in the issuance of 1,211 insurance fraud consent orders providing for the payment of a total of

\$5,119,150 in civil insurance fraud penalties. By year's end, 523 consent orders totaling \$1,148,550 in civil insurance fraud fines were agreed to by subjects admitting to have committed

In 2001, OIFP civil investigations resulted in the issuance of 1,211 insurance fraud consent orders, assessing \$5,119,150 in civil insurance fraud penalties.

insurance fraud. The remaining consent orders which were issued are pending further action in the current year. In appropriate cases, OIFP dockets executed consent orders as judgements pursuant to the provisions of the Penalty Enforcement Act, *N.J.S.A. 2A:58-10 et seq.* Where such consent orders have been "reduced to judgement," the State may obtain a judgement lien against the subject's property or proceed directly to execution of the judgement.

COLLECTIONS

Pursuant to the Insurance Fraud Prevention Act, responsibility for collection of monies resulting from the successful efforts of OIFP Civil Investigators and Deputy Attorneys General, lies with the Department of Banking and Insurance (DOBI). While the chief aim of imposing civil insurance fraud penalties is to deter persons from committing fraud, it is

noteworthy that according to Department of Banking and Insurance records, in the year 2001, \$2,214,777 was recovered by DOBI in payments and 623 accounts receivables were closed by DOBI as having been paid in full during the year.

OIFP LIAISON AND COORDINATION FUNCTIONS

In crafting the Automobile Insurance Cost Reduction Act (AICRA), the Legislature recognized the critical importance of coordinating the diverse activities of the many public and private entities in New Jersey concerned with combating insurance fraud. To address this need, AICRA required that OIFP designate a section of the office to assume responsibility for establishing a liaison and ongoing channels of communication between OIFP and other law enforcement and governmental agencies and insurers. In so doing, AICRA effectively mandates the consolidation of a variety of fraud fighting functions under the umbrella of OIFP. AICRA further requires the use of resources among public agencies to achieve the most effective and integrated system to combat insurance fraud within the law enforcement community.

OIFP's Liaison Section coordinates fraud fighting activities of government and private industry.

The Liaison Section of OIFP is responsible, among other things, for receiving referrals for investigation and prosecution, for receiving notice of suspected fraud from public agencies and private industry, for providing and coordinating the sharing of information among referring entities, and for maintaining appropriate records of those activities. OIFP's Liaison Section is supervised by a Deputy Attorney General who also serves as the designated liaison to the State's 21 County Prosecutors' Offices. Others comprising the staff of the Liaison Section are the Law Enforcement Liaison, the Insurance Industry Liaison and the Professional Boards Liaison.

COUNTY PROSECUTORS' OFFICES

As the local prosecuting authority

in each county, County Prosecutors' Offices play a critical role in OIFP's comprehensive statewide strategy to combat insurance fraud. With the assistance and support of OIFP, County Prosecutors' Offices are particularly well suited, by virtue of their ability to work with local informants and their familiarity with local trends and demographics, to target and prosecute potential cases of insurance fraud that might otherwise remain undetected.

To support and encourage the efforts of County Prosecutors in the investigation and prosecution of insurance fraud, and to enhance their fraud fighting capabilities, AICRA ensures that they receive both technical and financial support. Technical support, including training and coordination, is provided through OIFP's County Prosecutor Liaison, while financial support is provided through a program of grant funding administered by OIFP.

For the second year, during 2001, the Attorney General, through OIFP, provided \$2.5 million in grants to 19 of the 21 County Prosecutors' Offices, up from 16 County Prosecutors' Offices in 2000. County Prosecutors rely upon the grants to purchase equipment for combating insurance fraud and to fund fraud fighting personnel, including nine assistant prosecutors, 34

investigators, one paralegal and four clerical support positions. Funding commitments are scheduled for reconsideration and renewal in June of 2002.

During 2001, OIFP continued its program of training and instruction for County Prosecutor investigative and prosecutorial personnel, conducting a full day seminar in its Lawrenceville Office in June of 2001 and a roundtable discussion at the New Jersey Special Investigators Association (N.J.S.I.A.) Conference in Atlantic City in October of 2001. The June seminar was attended by 34 assistant prosecutors and investigators, representing 19 of the 21 County Prosecutors' Offices. The seminar involved case studies and roundtable discussions presented by Deputy Attorneys General and Investigators from OIFP who had participated in the cases under review. Among the topics included in the instructional seminar were the investigation and prosecution of staged accident and auto theft rings, methods for combating auto theft claims fraud and other pro-active insurance fraud programs.

The N.J.S.I.A. roundtable focused on practical issues of coordination between law enforcement and industry investigators. The program was moderated by the OIFP County

Prosecutor Liaison and included, as panelists, assistant prosecutors from Atlantic, Bergen, Camden, Essex and Ocean Counties. The roundtable was well attended by insurance industry professionals as well as investigators and prosecutors from the law enforcement community.

The OIFP County Prosecutor Liaison is also responsible for the implementation and administration of procedures for the coordination of insurance fraud case referrals, investigations and prosecutions between OIFP and County Prosecutors' Offices as well as other law enforcement agencies. In order to coordinate investigations and prosecutions, avoid duplication of effort among law enforcement agencies and ensure that OIFP identifies appropriate cases for the imposition of civil penalties, County Prosecutors' Offices provide OIFP with a monthly update as to the status of all insurance fraud related matters pending within each County Prosecutor's Office. Information provided by County Prosecutors is entered and maintained in OIFP's broader investigative Law Manager Database. As previously stated, reporting by County Prosecutors of subjects under investigation in their offices enabled OIFP in 2001 to open 285 civil investigations which might have otherwise evaded detection by OIFP-

Civil and the insurance industry.

During 2001, County Prosecutors reported the investigation of over 1400 subjects suspected of committing insurance fraud. As a member of OIFP's Case Review Committee, the County Prosecutor Liaison screens and identifies matters which have been referred to OIFP for possible referral to County Prosecutors' Offices for criminal investigation and prosecution. In 2001, the OIFP County Prosecutor Liaison referred 82 cases to County Prosecutors' Offices for investigation and prosecution.

LAW ENFORCEMENT

AICRA recognized that coordination among law enforcement agencies at every level is crucial to ensuring the effectiveness of a broad-based program to reduce the incidence of insurance fraud. The sharing of information and resources among law enforcement professionals, from the local police officer checking a driver's license and registration to State and federal investigators probing sophisticated insurance scams, is essential to facilitating law enforcement's central role in the battle against insurance fraud. The Law Enforcement Liaison maintains open lines of communication with municipal, county, State and federal law enforcement officials. The Law Enforcement Liaison also provides

assistance to local law enforcement agencies in the identification, investigation and charging of insurance fraud offenses by developing and coordinating insurance fraud training for the law enforcement community.

Except in a relative handful of urban areas which have served as hubs of auto insurance fraud over the years, most local law enforcement agencies have not been trained to deal with the challenges presented by the subtleties and complexities of insurance fraud. To address the need for insurance fraud training in the local law enforcement community, and to enlist the participation of local law enforcement agencies in the battle against insurance fraud, OIFP has developed and administers a comprehensive insurance fraud training program for law enforcement personnel throughout the State. During 2001, the Law Enforcement Liaison continued the administration of OIFP's insurance fraud training program for law enforcement personnel by scheduling, coordinating and administering OIFP's training offerings statewide.

In 2001, the Law Enforcement Liaison also continued to work closely with the County Prosecutor Liaison and OIFP's regional Supervising State Investigators in the periodic scheduling of regional coordination meetings of

municipal, county and federal law enforcement officials. These meetings afford the attendees the opportunity to meet their counterparts in other participating agencies, to establish ongoing channels of communication with one another, and to share information and resources, as appropriate. OIFP's regional coordination meetings also feature a speaker on an insurance fraud related topic, such as various types of organized insurance crime rings, sophisticated identify theft scams and forensic investigative techniques.

In addition, during 2001, the Law Enforcement Liaison continued to establish and maintain contacts with law enforcement agencies and associations such as the New Jersey State Police, the United States Postal Inspector, the New Jersey Chiefs of Police Association, the New Jersey Vehicle Theft Investigators Association, and various regional detective associations. In addition to sharing information and resources with these agencies and associations, these contacts provide important training forums and opportunities to reiterate and reinforce fraud fighting messages at every level of the law enforcement community.

In 2001, the Law Enforcement Liaison also played a key role in coordinating investigative activities

between the insurance industry and law enforcement personnel. In this capacity, the Law Enforcement Liaison was responsible for reviewing and processing requests from OIFP investigators for “pretext” insurance policies provided by the insurance industry for use in conjunction with OIFP’s undercover insurance fraud investigations. Another important responsibility of the Law Enforcement Liaison was to ensure the timely sharing of accident report information by municipal police departments with insurance company investigators pursuant to the requirements of AICRA.

INSURANCE INDUSTRY

Success in the battle against insurance fraud also hinges upon a cooperative and mutually supportive effort between law enforcement and the private insurance industry. OIFP’s Insurance Industry Liaison is primarily responsible for maintaining OIFP’s close working relationship with private industry. In addition, the Insurance Industry Liaison is assigned to coordinate OIFP activities with the New Jersey Department of Banking and Insurance (DOBI), the New Jersey Division of Motor Vehicles (DMV), and various industry trade groups. The Insurance Industry Liaison’s activities have been instrumental in ensuring the continuing progress of our

respective anti-fraud programs.

As the primary point of contact, the Insurance Industry Liaison routinely provides advice, guidance and technical assistance to members of the insurance industry. In 2001, the Insurance Industry Liaison provided technical assistance to industry representatives on over 620 occasions. The Insurance Industry Liaison is also responsible for scheduling, coordinating and administering insurance fraud training programs for industry personnel. In 2001, OIFP provided training on 23 days for over 1,000 insurance industry professionals. OIFP’s training offerings to industry professionals encompassed OIFP operations, the coordination of insurance fraud investigations, and the revised requirements for reporting insurance fraud, as set forth in *N.J.A.C. 11:16-6(b)*.

As a charter member of the New Jersey Special Investigators Association (N.J.S.I.A.), the Insurance Industry Liaison has been instrumental in organizing and promoting the annual two day N.J.S.I.A. Conference, which has served over the years to offer valuable training and networking opportunities for insurance fraud professionals from both the public and private sectors. The Annual N.J.S.I.A. Conference is the most highly attended conference of

its kind in the United States and provides some of the most valuable educational and training opportunities available today for insurance fraud professionals.

As in prior years, the Insurance Industry Liaison played a prominent role in the planning, organization and direction of the 2001 N.J.S.I.A. Conference which was held in Atlantic City on October 15 and 16. The Conference offered a wide variety of seminars and training opportunities addressing diverse subjects of interest to insurance fraud professionals. The Conference concluded with the Fourth Annual Insurance Fraud Summit sponsored jointly by the N.J.S.I.A. and the Insurance Council of New Jersey (I.C.N.J.). At the Summit, the Director of the Division of Criminal Justice, the Insurance Fraud Prosecutor and OIFP senior staff presented the attendees with updates on OIFP's programs and initiatives. Following these presentations, the Summit concluded with OIFP sponsored working groups providing year end activity reports.

In addition, during 2001, OIFP hosted or participated in numerous meetings with various industry and trade groups dedicated to addressing insurance fraud. These meetings included ongoing working groups with industry professionals focusing on such areas of shared concern as fraud

detection and prevention in the auto, health and general casualty markets. During the course of the year, OIFP participated in meetings with the National Insurance Crime Bureau, the Anti-Fraud Association of the Northeast, the N.J.S.I.A. and its Educational Foundation, the Del-Val I.A.S.I.U. and the Insurance Council of New Jersey. In February and March of 2001, OIFP provided advice and technical assistance to New York Underwriting Insurance Fraud Workshops Regulatory Reform Subcommittee. In May of 2001, OIFP made a presentation to 350 attendees of the New York Claims Association, Inc., at its annual conference, explaining OIFP's anti-fraud initiatives. Moreover, OIFP distributed over 725 OIFP fraud awareness posters and 2,000 pamphlets to insurance companies, and made presentations to such diverse civic and community based groups as the New Jersey Vehicle Dealers Association and the National Association of Insurance Women.

OIFP's exceptional coordination with the insurance industry was, perhaps, best exemplified in 2001, by OIFP's prompt response to industry concerns spawned by the World Trade Center attacks of September 11. Alarmed at the prospect of the potential enormity of fraudulent insurance claims arising from the

attack, insurers expressed those concerns to the Insurance Industry Liaison, who responded by organizing an early October meeting with the Insurance Fraud Prosecutor and OIFP senior staff. Insurance industry executives representing health, life, auto, property and workers' compensation lines, among others, briefed OIFP in detail with respect to the most likely scenarios for September 11 related insurance fraud, and discussed possible precautionary measures. As an outcome of this meeting, OIFP created a specially designated internal task force to fast track potentially fraudulent claims stemming from the events of September 11, and to ensure appropriate and effective follow up action.

The Insurance Industry Liaison is also responsible for the referring and tracking of insurance fraud related matters involving businesses and individuals licensed through DMV and DOBI, as well as assisting DOBI in its review and approval of Fraud Detection Plans filed by insurance carriers. In 2001, the Insurance Industry Liaison also continued to serve as OIFP's primary contact person for DOBI. In this capacity, the Insurance Industry Liaison served as a key member in the periodic meetings of the DOBI/OIFP Interface Group. Those meetings were attended by representatives of DOBI's

Enforcement Division, which oversees the tracking and coordination of case dispositions involving licensed producers, public adjusters and real estate agents. In 2001, the group identified 54 cases for tracking, eight of which resulted in "global" dispositions and involved the revocation or suspension of licenses stemming from a licensee's involvement in insurance fraud.

The Insurance Industry Liaison also worked closely with DOBI in 2001 to ensure the smooth implementation of revised regulations providing for the referral of suspected insurance fraud to OIFP by insurance carriers. The Insurance Industry Liaison provided technical support in the administrative process of re-adopting those regulations, found at *N.J.A.C. 11:16-6*, by assisting in the review of, and response to, public comments thereon; by updating the referral forms required thereunder; and by developing, distributing and explaining the updated instructions for completion and submission of the new forms.

The Insurance Industry Liaison also continued to work with DMV on issues of mutual concern, including the development of a mechanism to enable insurers to more efficiently obtain DMV data for underwriting and investigative purposes. As a result of this collaboration, DMV's Information

Technology Section confirmed that its existing online information system could be adapted to enable insurers to more effectively access vehicular title history. Previously, auto insurers have had to manually request such information from local DMV agencies or through regional DMV service centers. DMV has completed its technical review of the initiative and has forwarded it for legal and financial analysis prior to presentation to the insurance industry. As an outgrowth of this dialogue, DMV continues to explore the feasibility of offering the insurance industry more sophisticated data mining and information retrieval capabilities, as well.

P R O F E S S I O N A L A N D O C C U P A T I O N A L B O A R D S

Committing civil or criminal insurance fraud can result in professional license suspension, revocation or other disciplinary actions. Coordination is necessary to ensure that professional licensing boards are alerted promptly when an OIFP investigation reveals insurance fraud related conduct by a licensee which may subject the licensee to administrative sanctions such as license revocation or suspension. Responsibility for coordinating OIFP's activities with those of the professional and occupational boards is assigned to OIFP's Professional Boards Liaison who, prior to joining OIFP in 1998, served as an Executive Director of the New Jersey State Medical Board. Procedures implemented by the Professional Boards Liaison provide for prompt notification of the professional licensing boards by OIFP when licensees are the subject of OIFP investigations. These procedures also provide for reciprocal notification of OIFP by the professional licensing boards so that OIFP can initiate a civil or criminal investigation, as warranted. Additionally, the Professional Boards Liaison provides technical advice and assistance as needed to the professional licensing boards and serves on OIFP's Case Review Committee to screen insurance fraud

cases involving professional licensees.

Committing civil or criminal insurance fraud frequently results in professional license suspension or revocation.

The specific duties of the Professional Boards Liaison involve, among other things, the maintenance of a comprehensive database of insurance fraud complaints involving professional licensees, including information as to the nature of such allegations, the source of the referral, and the status of the matter within the Division of Consumer Affairs Enforcement Bureau and OIFP. To provide for the periodic review and discussion of licensees under suspicion for insurance fraud, as required by statute, the Professional Boards Liaison also established and chairs the Liaison and Continuing Communications Group. The Group is comprised of intermediate and upper level OIFP supervisory staff and representatives of the Division of Consumer Affairs Enforcement Bureau. The Group meets monthly to track active cases of professional licensees under investigation by either agency. Maintaining the database and convening the monthly meetings facilitate the ongoing exchange of information necessary for the detection and investigation of insurance fraud

committed by professional licensees. During 2001, the Liaison and Continuing Communications Group continued to monitor 423 active insurance fraud related cases, an increase of 24 over the previous year. Since its establishment in October of 1998 through the end of 2001, the Group reviewed and resolved 346 cases through administrative closure, civil or criminal disposition by OIFP, or licensing sanctions by the appropriate professional board. Through this collaborative effort, professional and occupational boards within the Division of Consumer Affairs took disciplinary action against 29 individuals in 2001, as follows:

	Suspension	Revocation	Voluntary Surrender	Reprimand	TOTAL
Accountant	0	1	0	0	1
Chiropractic	4	0	0	1	5
Medical	5	4	0	0	9
Nursing	2	1	0	0	3
Dental	1	0	0	1	2
Pharmacy	2	0	1	0	3
Physical Therapy	0	0	0	0	0
Social Worker	4	0	0	1	5
Opticians	0	0	0	0	0
Optometry	0	0	0	1	1
TOTAL	18	6	1	4	29

GOVERNMENT ASSOCIATIONS

OIFP coordinates with various other governmental agencies and associations. For the past six years, the Supervising Deputy Attorney General of the Medicaid Fraud Unit has served as a member of the Executive Committee of the National Association of Medicaid Fraud Control Units (NAMFCU), which is comprised of the Medicaid Fraud Control Units of 47 states and the District of Columbia. NAMFCU facilitates the nationwide sharing of information on matters relating to Medicaid fraud investigations and provides training for its members which is accredited by the Federal Law Enforcement Training Center. NAMFCU provides essential coordination for State Medicaid programs throughout the nation and facilitates the investigation, prosecution and settling of both civil and criminal matters against Medicaid providers who operate throughout the country. During 2001, the New Jersey Medicaid Fraud Unit within OIFP participated actively in these nationwide settlements by NAMFCU where targeted providers billed the New Jersey Medicaid program.

In 2001, OIFP also continued to participate in the Mid-Atlantic States Insurance Fraud Association (MASIFA), a multi-state group of representatives from law enforcement and other public

agencies targeting insurance fraud. The group includes members from New York, Pennsylvania, Maryland, Delaware, Virginia and Washington, D.C., and meets regularly to share intelligence and information on current insurance fraud trends, as well as provide assistance to one another with respect to inter-jurisdictional matters.

In October of 2001, the Insurance Fraud Prosecutor attended the Annual State Fraud Directors' Conference, a gathering of Insurance Fraud Prosecutors and Directors from across the United States. Topics at the conference included impending insurance fraud legislation, anti-fraud initiatives, relationships between fraud bureaus and special investigative units of insurance companies, effective office management tools, noteworthy insurance fraud patterns and trends and significant cases.

NEW JERSEY STATE POLICE

The New Jersey State Police is assigned an important role in OIFP's statewide effort to combat insurance fraud. Since January of 1999, OIFP has funded an Insurance Fraud Unit within the New Jersey State Police which targets the use of fraudulent motor vehicle insurance cards. The Unit is comprised of two squads of five troopers each. In addition to pro-active investigations, Unit members provide

training to other law enforcement agencies in the detection of fraudulent motor vehicle insurance cards.

In 2001, the New Jersey State Police Insurance Fraud Unit undertook 150 investigations resulting in the arrests of 145 individuals on criminal charges as well as the issuance of 29 traffic summonses. In addition to investigations involving the presentation and manufacture of fictitious motor vehicle credentials, the Unit investigated cases involving workers compensation fraud, auto theft fraud and auto injury claims fraud. The New Jersey State Police Insurance Fraud Unit uncovered approximately \$820,000 in insurance fraud in calendar year 2001. The Unit also provided training in 2001 on the detection and investigation of insurance fraud to approximately 3000 law enforcement and other public officials over 75 sessions.

Within the New Jersey State Police, there is also an Auto Theft Unit. OIFP continues to coordinate its activities with those of the New Jersey State Police Auto Theft Unit in the joint investigation and prosecution of cases stemming from a staged auto theft “give-up” ring, situated in northern New Jersey. The investigation has resulted in the seizure of over \$100,000 worth of vehicles, the forfeiture of substantial sums of illegal proceeds, and the arrest

of numerous individuals. As the only statewide law enforcement agency specifically targeting auto thefts, the New Jersey State Police Auto Theft Unit is particularly well positioned to identify and provide OIFP with information regarding organized criminal activities relating to staged auto thefts.

OIFP TRAINING

As New Jersey's designated leader in the State's comprehensive response to combat insurance fraud, OIFP aggressively promotes a wide array of training opportunities for the law enforcement community and private industry. In 2001, OIFP provided insurance fraud training to over 3,000 members of law enforcement agencies and insurance companies comprising nearly 100 different training programs. Incorporating several types of training formats, OIFP's program of insurance fraud training addresses a wide variety of insurance fraud related subjects. OIFP's program provides training for its own staff of attorneys, investigators and support staff, as well as for every level of law enforcement and private industry. OIFP's training programs utilize instructors from OIFP and from other agencies, such as the New Jersey State Police Insurance Fraud Unit and County Prosecutors' Offices. These programs are an important tool for expanding law enforcement's insurance fraud expertise to the municipal police level.

OIFP BASIC TRAINING COURSE FOR CIVIL INVESTIGATORS

OIFP requires that all Civil Investigators complete a c o m p r e h e n s i v e

five week training program providing a sound foundation in basic insurance principles and basic investigative skills.

In 2001, OIFP provided training to over 3000 law enforcement and insurance industry professionals.

The program encompasses a review of the common types of insurance coverage and training in the investigative tools and techniques associated with the types of fraud corresponding to those coverages. The curriculum also focuses on investigative resources and case management techniques, and addresses such pertinent areas as report writing, interviewing and surveillance techniques, rules of evidence, computer fraud, and the cultivation and management of informants. The program concludes with a practical training exercise in which trainees apply their newly acquired investigative skills to one of several "real case" scenarios. The trainees complete the exercise by preparing a report documenting their investigative activities and by testifying as witnesses in a moot court setting.

OIFP IN-SERVICE TRAINING

As employees of the Division of Criminal Justice, OIFP staff are eligible for the same in-service training opportunities that are open to all Division of Criminal Justice employees. These internal training opportunities are designed to enable experienced staff to improve upon their existing investigative and prosecutorial skills. Practical training through seminars for government attorneys is offered through the New Jersey Attorney General Advocacy Institute. Skill building for criminal investigators is offered through the Division of Criminal Justice Academy. Computer training for all staff is offered through the Department of Law and Public Safety. Additionally, a variety of programs are offered to all staff through the Human Resource Development Institute of New Jersey.

COUNTY PROSECUTORS' OFFICES TRAINING

To encourage and assist County Prosecutors' Offices in the investigation and prosecution of insurance fraud, OIFP provides funding, training and technical support. As previously indicated, nineteen of the State's 21 counties applied for, and received, funding in 2001. All 21 counties have insurance fraud units or programs in place. To ensure that prosecutorial and investigative staff of County

Prosecutors' Offices are familiar with current trends, techniques, technologies, and coordination protocols for investigating and prosecuting insurance fraud in New Jersey, OIFP sponsors annual training for County Prosecutor personnel at its central office in Lawrenceville, New Jersey. In 2001, Assistant Prosecutors and investigative personnel from 19 of the State's 21 counties attended this training, which focused on staged accident rings, auto theft rings, investigative interview techniques and pro-active programs to target auto theft claims fraud.

OIFP also provided training and solicited County Prosecutor personnel participation at the 2001 Annual N.J.S.I.A. Conference in Atlantic City. In addition to N.J.S.I.A.'s own offering of insurance fraud training seminars relating to a variety of topics, OIFP presented a seminar and panel discussion concerning the manner in which the insurance fraud programs of OIFP and the respective County Prosecutors' Offices coordinate their efforts with those of the special investigative units of the insurance industry. In 2001, County Prosecutor personnel also participated in other training opportunities offered by OIFP to local law enforcement agencies, either as instructors in joint training efforts or as attendees.

MUNICIPAL POLICE TRAINING

OIFP conducts a comprehensive statewide training program directed to providing police departments with the investigative expertise required to successfully identify and investigate insurance fraud. Training is offered through county and municipal police training academies, as well as through the New Jersey State Police and Division of Criminal Justice training academies at Sea Girt, New Jersey. Training offerings range from basic insurance fraud instruction for new police recruit classes to more specialized in-service training for experienced law enforcement officers.

In 2001, OIFP provided over 70 training sessions in 22 law enforcement training academies to approximately 2700 local law enforcement officers. As a supplement to its training sessions for both new and experienced police officers, OIFP continued to distribute its roll call training videos and related training materials instructing municipal police officers in the detection of fraudulent insurance cards, staged automobile accidents, and, most recently, staged auto thefts.

INSURANCE INDUSTRY TRAINING

OIFP conducts an active training program for the benefit of insurance industry professionals, providing them with information on OIFP operations and advice on the most effective ways of coordinating their activities with those of OIFP. The Insurance Industry Liaison offered training for over 1,000 industry professionals on 23 different dates in 2001. In addition, as previously indicated, the Insurance Industry Liaison played a prominent role in organizing and promoting the 2001 Annual N.J.S.IA. Conference in Atlantic City, which offered many additional training opportunities for insurance industry professionals involved in fighting fraud.

OIFP INFORMATION SYSTEMS

LAW MANAGER DATABASE

In 2001, OIFP completed the initial phase of implementation of the Law Manager Database Integrated Computerized Case Tracking System. All case tracking data which had previously been maintained on a database established by, and inherited from, the Department of Banking and Insurance, and which was previously known internally as "the hub," has been fully transferred and integrated into OIFP's new Law Manager Database. The Law Manager Database has also assimilated substantial historical data with respect to prior criminal insurance fraud investigations and prosecutions conducted by the Division of Criminal Justice prior to the establishment of the OIFP. Future plans provide for the complete integration of all criminal case tracking information maintained by the Division of Criminal Justice, including, but not limited to, those matters involving insurance fraud.

ALL PAID CLAIMS DATABASE

Pursuant to *N.J.S.A. 17:33A-22*, OIFP is required to maintain an insurance fraud database which includes information provided by insurers on all paid claims relating to stolen vehicles and automobile

accidents. The information to be included in the database encompasses information relating to the dates, locations and types of injuries sustained in automobile accidents as well as the identity of vehicle owners, drivers, passengers and treating health care providers. The primary purpose of the All Paid Claims Database is to enable OIFP to identify patterns of possible fraudulent activity and to share that information with County Prosecutors, the New Jersey State Police and other law enforcement officials.

OIFP made significant progress in 2001 towards establishment of this database. Following the rejection of three initial bids as non-responsive to the Request for Proposals (RFP), a Request for Proposals was again issued in 2001 in accordance with the Public Contracts Law, which mandates the awarding of certain public contracts to the lowest responsible bidder following public advertisement for bids. Bids were subsequently received from 16 eligible bidders. After careful evaluation, a contract to design and implement the database was awarded to INDUS Consulting Services of Paramus, New Jersey, on October 12, 2001.

OIFP has worked closely with

INDUS in soliciting information from insurance carriers which will facilitate the design of the database and ensure its compatibility with existing industry standards to the greatest extent possible. Work on the first phase of the database is scheduled for completion by March 2002. Once the initial phase of the database has been implemented, OIFP plans to add additional "data mining" capabilities to enhance the investigative utility of the database for identifying otherwise obscure patterns of possible fraudulent activities. OIFP will work closely with the insurance industry in sharing any significant information which is generated by the database once it is fully implemented.

SPECIALIZED INTERNAL INFORMATION TRACKING SYSTEMS

OIFP employs several additional specialized information tracking systems for various purposes. All OIFP criminal investigations are independently entered and tracked by a database maintained within the criminal investigative section of OIFP. This database includes certain types of information not maintained within the Law Manager Database, particularly sensitive information requiring highly restrictive access, such as identifying information on informants, and information generated in the course of

grand jury proceedings.

As required by AICRA, OIFP also maintains databases which log information on all matters referred from OIFP to County Prosecutors' Offices, as well as information reported to OIFP by County Prosecutors' Offices. This information includes all subjects under investigation for insurance fraud in the County Prosecutors' Offices. Information maintained in these databases is also incorporated into OIFP's broader Law Manager Database.

As an adjunct to its "Give-Up Initiative," OIFP also maintains a specialized database containing information on all OIFP investigations of suspected auto theft claims fraud. The information in this database is designed to identify possible trends or patterns in suspicious auto theft claims and to thereby ascertain commonalities suggesting collusive or conspiratorial criminal activity. The information in the "give-up" database is also included within the Law Manager Database.

As previously indicated, the Professional Boards Liaison also maintains a specialized database of insurance related information pertaining to professional and occupational licensees regulated by the Division of Consumer Affairs. This information is maintained to ensure

that OIFP and the professional licensing boards maintain optimal coordination of their respective activities, and that no licensee who may have committed insurance fraud escapes the detection of either agency. The Law Manager Database also incorporates this information.

OIFP PUBLIC AWARENESS ENDEAVORS

Insurance fraud and its concomitant high insurance rates remain a matter of significant public concern. OIFP continues an active program to inform the public of the consequences of insurance fraud, and to encourage the public to assist in the mission of combating insurance fraud.

MEDIA CAMPAIGN

“Repetition gains retention” is an advertising adage that, if followed, ensures the maximum impact from an advertising campaign. In 2001, the Office of the Insurance Fraud Prosecutor Public Awareness Campaign adopted this adage as its course of action. Entering its third year, the award winning campaign featured a repeat of its 1999 and 2000 advertising plans. In November and December of 2001, OIFP echoed its 1999 plan by focusing the public’s attention on the problem of insurance fraud, by informing citizens of OIFP’s mission,

and by encouraging them to report instances of suspected insurance fraud. The bilingual advertising consisted of television and radio spots, as well as billboards, bus transit and Internet banner ads. The theme of the first phase of the campaign was “New Jersey’s Fed Up.” It featured two sets of television ads portraying respectively, an affluent ‘professional’ named Richard, who accumulated his wealth by filing false insurance claims, and a youthful woman named Susan, who is an injury claimant healthy enough to dance the night away at a night spot. Citizens are encouraged to respond by reporting suspected insurance fraud.

In January and February of 2002, the second flight of advertising will shift its messaging from the “call to action” to a strong message of deterrence. The theme of the second phase of the campaign will be “Don’t Do It. Don’t Tolerate It.” In this repeat

performance of the 2000 advertising plan, the focus is once again on Richard as he is arrested, convicted and possibly jailed for his crimes. Both phases of the public awareness campaign prominently feature the OIFP toll-free hotline number for reporting insurance fraud, as well as the OIFP website address.

OIFP contracted three tracking studies to evaluate the campaign's effectiveness: a Pre-Wave study, completed in October 1999, as a baseline prior to the first advertising campaign; a Wave 1 study, completed in December 1999, after the first phase of advertising; and a Wave 2 study, completed in May 2001, after the second phase of advertising. The results of the Wave 2 tracking study show that the Phase 2 deterrent message has been memorable, influential and effective. All key tracking measures either remained at 2000 levels or showed movement in the desired direction. The 2001 Tracking Study indicated that the OIFP campaign has raised awareness of the issue of insurance fraud, memorably promoted the idea that insurance fraud is a serious crime, and communicated that insurance fraud carries significant penalties such as jail time and fines. It has also continued to promote effectively that insurance fraud is an issue that costs New Jerseyans money.

Finally, the campaign has shown the ability to increase awareness of the New Jersey Office of the Insurance Fraud Prosecutor and its toll-free telephone hot line. In short, the study demonstrated that the campaign continued to meet its objectives in its third year and, in so doing, provided objective support for the campaign's continuance in FY 2002. Although the campaign is apparently making an impact, there is still room for increased awareness, however. For example, in the latest tracking study, 41% of those surveyed said they were "Extremely or Very Familiar with Insurance Fraud." Although this compares favorably with a response rate of 32% in the previous survey, there is still room for improvement since 58% of those surveyed reported that they are "Not very or Not at all Familiar with the issue of Insurance Fraud."

OIFP WEBSITE

As part of its public awareness campaign, OIFP maintains a state-of-the-art website at www.njinsurancefraud.org. The website offers general information about OIFP, its mission and its activities. The website provides examples of the most common types of insurance fraud and access to copies of OIFP's prior annual reports. The website further provides alternative means for the public to report suspected insurance

fraud to OIFP, including an online reporting form, an e-mail link to OIFP and OIFP's fraud reporting toll-free hotline telephone number.

OIFP's website, www.njinsurancefraud.org provides alternative means to report insurance fraud, including an online reporting form, an e-mail link to OIFP, and OIFP's fraud reporting toll-free hotline telephone number.

To inform the public of its efforts, OIFP regularly issues news releases documenting important events in significant criminal cases. In addition to its normal distribution channels, OIFP posts the releases on its web site for easy public access. The OIFP web site also enables visitors to the web site to view the public service announcements produced in conjunction with OIFP's award winning media campaign, described above.

The insurance industry is also served by OIFP's website. The OIFP website provides access to the forms which the insurance industry is required to use for the reporting of insurance fraud to OIFP. Fraud Prevention Detection Plan requirements are also provided on the OIFP web site as a convenience to the insurance industry.

PUBLIC OUTREACH EFFORTS

In addition to its award winning media campaign, news release distribution and web site offerings, OIFP conducts a multi-faceted outreach program to a variety of private and public agencies and organizations. During 2001, the Insurance Fraud Prosecutor was a frequent guest speaker before audiences desiring to learn more about OIFP's programs. Members of OIFP's Liaison Section were also frequently requested to offer presentations to specific organizations corresponding to their particular assigned liaison responsibilities. For example, the County Prosecutor and Law Enforcement Liaisons were invited to make a presentation before the New Jersey Chiefs of Police Association at their 2001 Annual Convention. In addition, the Insurance Industry Liaison made appearances before a number of insurance industry trade groups in 2001. Further, in August 2001, an OIFP executive staff member appeared as a guest of the radio program "Inside the Law," to inform senior citizens of current legal issues involving insurance fraud. During that appearance, an overview of the various functions performed by OIFP was provided and insurance fraud related issues of particular relevance to senior citizens were discussed. Listeners called into the show to ask insurance fraud related questions of the OIFP representative.

OIFP also provides informational booths at appropriate functions such as the New Jersey League of Municipalities Annual Conference, the New Jersey Chiefs of Police Annual Exposition, and the New Jersey Special Investigators Association Annual Conference. OIFP's outreach efforts are designed to communicate with as many members of the public as possible, as well as members of public and private agencies and organizations, and are tailored to provide information of the greatest interest and relevance possible to those in attendance.

PUBLIC RECOGNITION

Since its inception in May of 1998, OIFP has been consistently recognized as a national leader in the fight against insurance fraud. In June of 2001, OIFP's Medicaid Fraud Unit was featured prominently throughout a United States General Accounting Office report as a notable example of a Medicaid Fraud Control Unit which is particularly effective and well run. The report, GAO-01-662, State Efforts to Control Improper Payments Vary (2001), recognized New Jersey's Medicaid Program for its stringent

From its inception in May of 1998, OIFP has been consistently recognized as a national leader in the fight against insurance fraud.

enrollment requirements, its use of readily available software to analyze claims for aberrant patterns prior to making payment, and for conducting pre-enrollment site visits to the premises of high risk prospective enrollees. The report recognized New Jersey as a State where its Medicaid Agency and its Medicaid Fraud Control Unit (OIFP's Medicaid Fraud Unit) have worked together "to further each agency's efforts through close cooperation." *Id.* at 22.

The report specifically cites the Medicaid Fraud Unit for combining the use of advanced technology with special investigative protocols, stating...

New Jersey conducted special audits of transportation services, cross-matching data on transportation claims to beneficiary medical appointments, and sometimes contacting providers to confirm that the beneficiary actually arrived and was treated. Also, using billing trend reports, New Jersey audited pharmacies with abnormally large numbers of claims for a newly covered high-priced drug, and then audited the pharmacies' purchases from wholesalers, thus discovering that these pharmacies were

billing for a larger amount of this drug than had been shipped to them. Ibid.

Consistent with its recognition of OIFP's Medicaid Fraud Unit as one of the most innovative in its efforts to identify and respond to improper payments, OIFP's Medicaid Fraud Unit was one of only four selected nationally by GAO for a site visit in preparing its report.

During 2001, OIFP's acclaimed public awareness insurance fraud campaign also received national attention, having been the subject of several requests for copies of the public awareness campaign TV commercial spots entitled, "Living It Up," "Richard," and "Don't Do It." In March, the Defense Research Institute - Life, Health and Disability Insurance Law Committee requested the use of OIFP's public awareness videos "Living It Up," "Richard," and "Don't Do It," to be exhibited at its seminar on April 5 and 6, 2001. This seminar was attended by members from around the country and increased exposure nationwide to New Jersey's efforts in combating insurance fraud. In September 2001, the Puget Sound Special Investigators (PSSI) in Washington State, a chapter of the International Association of Special Investigative Units, requested OIFP's public awareness videos "Living It Up," "Richard," and "Don't Do It." PSSI

held its Annual Insurance Fraud Awareness Conference in October 2001 and used the videos to further efforts to combat insurance fraud. These commercials aired in Washington State for four months. In November 2001, the video tapes of the commercials were again requested for exhibition at a similar insurance fraud training seminar being conducted in Des Moines, Iowa.

OIFP has also been looked to as a model for other jurisdictions, ranging from Manitoba to New York. These jurisdictions have sought to establish or enhance their own insurance fraud programs with OIFP's assistance. Following the issuance of an Executive Order by New York Governor George Pataki in May of 2001 directing the establishment of an insurance fraud program in New York, New York government officials sought assistance from OIFP in the design and implementation of their own statewide program. In response, in July of 2001, OIFP senior staff, including the New Jersey Insurance Fraud Prosecutor, hosted a full day's presentation for New York officials, providing a detailed overview of OIFP's programs, functions and activities. As a national leader in the fight against insurance fraud, OIFP remains at the ready to respond to such requests for assistance.

In November of 2001, OIFP's

initiative in establishing a task force to investigate possible insurance fraud relating to the September 11th attacks on the World Trade Center was acknowledged by Mealey's Litigation Report: Insurance Fraud, a national legal publication. OIFP was also recognized in November of 2001 in the newsletter published by the New Jersey Vehicle Theft Investigators Association for OIFP's "impressive education program" to heighten law enforcement awareness of auto theft fraud, with particular reference to OIFP's in-house produced "roll call" training video entitled, "The Give-Up." In October of 2001, Insurance Fraud Prosecutor Greta Gooden Brown opened the Eleventh Annual New Jersey Special Investigators Association Conference in Atlantic City. In recognition of the continuing support and guidance provided by OIFP to the Association in 2001, Prosecutor Brown was presented with the NJSIA's Annual Appreciation Award.

OIFP CRIMINAL INVESTIGATIONS AND PROSECUTIONS STATISTICS

January 1, 2001 - December 31, 2001

Cases Pending at end of 2000	388
Individual Subjects of Pending Cases	1134
New Cases Opened	409
Individual Subjects of New Cases	627

Cases Investigated (pending plus opened during period)	797 1665
Persons Investigated	
Indictments/Accusations Filed	92
Persons Charged	118
Convictions (Pleas/Trial Convictions)	86
Sentencings	74
Total Prison/Jail Time Imposed	107 years, 142 days
Total Probationary Periods Imposed	175 years, 180 days
Total Fines (Includes Civil Penalties in Criminal Cases)	\$980,412
Total Restitution	\$6,839,862

NARRATIVE

In 2001, OIFP-Criminal opened 409 investigations of 627 subjects suspected of involvement in the commission of insurance or Medicaid fraud. OIFP lodged criminal charges by indictment or accusation against 118 defendants, and obtained 86 convictions and 74 sentences over the course of the year. Of the sentences imposed, 23 defendants were sentenced to a total of more than 107 years of incarceration.

accomplishments in criminal prosecutions over the past year.

In addition, sentences imposed on defendants prosecuted by OIFP in 2001 required that defendants be placed on over 175 years of probation and pay \$6,839,862 in restitution and \$980,412 in criminal and civil penalties. The case summaries contained herein highlight some of OIFP's more significant

OIFP CRIMINAL

FALSE IDENTITY

State v. John Datus and Bellamy

Antoine On February 9, 2001, a State Grand Jury returned an indictment charging John Datus and Bellamy Antoine with conspiracy, health care claims fraud, attempted theft by deception and falsification of medical records. The indictment alleged that both Datus and Antoine assumed a fictitious identity ("Lloyd Inch") in order to fake injuries relating to an automobile accident claim, hire a lawyer, and submit false automobile insurance claims. The indictment resulted in a violation of probation for Datus who was sent to jail in default of bail on April 4, 2001 where he served approximately 107 days.

On June 6, 2001, Datus pled guilty to conspiracy and health care claims fraud. On July 20, 2001 Datus was sentenced to 4 years probation, restitution in the amount of \$2,500, and a civil insurance fraud fine in the amount of \$2,500. On October 5, 2001, Antoine pled guilty to the conspiracy and health care claims fraud counts of the indictment. Also on October 5, 2001, Antoine pled guilty to an Accusation charging him with additional charges of conspiracy and theft by deception. The additional charges related to an automobile

accident which Antoine admitted he staged on July 16, 1997. Following the accident, Antoine began a course of chiropractic treatment at Allied Trauma and Health Care Center for injuries alleged to have been sustained in the purported accident. Claims for Antoine's treatment were submitted to Newark Insurance Company for which Newark Insurance Company paid \$4,619.75. Antoine also filed a bodily injury claim for non-economic losses and settled it for a \$4,500 payment from Allstate Insurance Company. Antoine's sentencing is scheduled for January 4, 2002.

OFFICE MANAGER FRAUD

State v. Esther DelPino On September 17, 2001, Esther DelPino pled guilty to conspiracy and theft by deception. DelPino, the manager of Lexington Chiropractic Center in Passaic, admitted submitting fraudulent insurance claims for chiropractic treatments for patients who had been in automobile accidents when, in fact, the treatments were never rendered. The claims were paid under the personal injury protection (PIP) portion of automobile insurance policies. DelPino also admitted directing employees of Lexington Chiropractic Center to prepare other false and inflated bills for chiropractic

treatments which were not rendered. Those bills were submitted to two dozen insurance companies. At the guilty plea hearing, DelPino admitted referring patients of the chiropractic office to attorneys as clients in exchange for payments. A referral has been made to the Office of Attorney Ethics. On November 9, 2001, DelPino was sentenced to three years probation conditioned on paying \$50,000 in restitution and ordered to pay a \$10,000 civil insurance fraud fine.

INSURANCE AGENT FRAUD

State v. Shawn L. Carpenter On January 16, 2001, a Grand Jury returned an indictment, charging Shawn L. Carpenter, a licensed insurance agent in New Jersey, with theft by failure to make required disposition and misapplication of entrusted property. Carpenter was alleged to have stolen insurance premium money from insurance purchasers in the amount of \$1,171, and to have used the money for his personal benefit.

On May 7, 2001, Carpenter pled guilty to the charge of theft by failure to make required disposition. Carpenter was admitted into the Camden County Pre-Trial Intervention Program for 2 years, conditioned on paying restitution and performing 50 hours of community service. Because

he was a licensed insurance agent, OIFP referred Carpenter's case to the Department of Banking and Insurance for appropriate action with respect to Carpenter's insurance agent license.

State v. Joseph Greenfield Joseph Greenfield, a licensed insurance agent in New Jersey, previously pled guilty to an Accusation charging him with theft by deception. Greenfield stole approximately \$65,232 in insurance premiums for a variety of insurance policies, including commercial, auto and multi-peril insurance, accident/sickness coverage, and workers compensation, all of which he had sold to the Marlboro Township Board of Fire Commissioners, Fire District #2. Greenfield had purposely overcharged the fire district for the insurance coverage and used the excess money he obtained for his own purposes.

On January 12, 2001, Greenfield was sentenced to three years probation and ordered to pay \$65,232 in restitution. Because he was a licensed insurance agent, OIFP referred Greenfield's criminal conviction to the Department of Banking and Insurance for appropriate action with respect to Greenfield's insurance agent's license.

State v. David W. Buys On October 22, 2001, David W. Buys, a licensed insurance agent, pled guilty to an Accusation charging him with misapplication of entrusted property. Buys, the trustee of a trust established to benefit a friend's children, admitted that, following the death of the children's mother, he wrote approximately 100 unauthorized checks from the trust account totaling about \$85,000, and used the money for his own purposes.

State v. Thomas K. Begyn On October 16, 2001, Thomas K. Begyn, a licensed insurance agent in New Jersey, was charged by a Grand Jury with theft by deception and misapplication of entrusted property. The indictment alleged that Begyn, an insurance agent with Unity Mutual Life Insurance Company (Unity), failed to remit premium payments to Unity for 12 policies he serviced. All of the premiums were paid in cash directly to Begyn who allegedly took the money and used it for his own benefit. A bench warrant was issued after Begyn failed to appear at his pre-arraignment hearing on November 13, 2001, and he was arrested on November 29, 2001.

State v. Steven B. Freymark On December 5, 2001, Steven B. Freymark, an insurance agent licensed in New Jersey, pled guilty to an Accusation charging him with theft by failure to make required disposition of property

received. Freymark admitted collecting approximately \$15,000 in insurance premiums for automobile insurance policies from approximately 24 individual insureds and failing to remit the premium payments to the insurance carrier. Instead, Freymark deposited the premium payments into his own bank account. Freymark is scheduled to be sentenced on February 1, 2002.

PREMIUM FINANCING FRAUD

State v. Stanley Gulkin and National Premium Plan On November 30, 2001, Stanley Gulkin, an attorney licensed in the State of New Jersey and operator of the National Premium Plan, an insurance premium financing company, pled guilty to an Accusation charging him with conspiracy and theft by deception. Gulkin admitted arranging approximately \$4 million in bogus insurance premium financing loans that resulted in losses to the banks which financed the loans, and to several investors who had invested in National Premium Plan, Inc., a company that brokered insurance premium financing loans for small businesses. Gulkin's sentencing is scheduled for February 4, 2002.

INSURANCE PREMIUMS REFUND FRAUD

State v. David Boatswain, et al. On October 26, 2001, a Grand Jury returned three separate indictments charging David Boatswain, Daniel Kern and Gerald Plummer each with theft by deception. According to the indictment, Boatswain, Kern and Plummer ordered auto insurance over the telephone from Prudential Insurance Company, and advised Prudential that they would pay the premium via wire transfer. Although the defendants allegedly never wired the money for the premiums, they called Prudential, canceled the policies, and requested a cash premium refund. The total attempted thefts were approximately \$37,000. Prudential actually sent “refund” checks of \$6,288 to Boatswain, \$3,337 to Kern, and \$2,488 to Plummer.

FALSE HEALTH CARE CLAIMS

State v. Vincent T. Kelly On January 11, 2001, Vincent T. Kelly, a licensed private investigator in New Jersey, pled guilty to a six count Accusation charging him with forgery of health care claims forms in connection with a disability insurance claim. Kelly forged claims forms, including doctors’ signatures, over a three year period, and submitted disability insurance claims to Security Assurance Life Insurance, totaling \$12,342.04. On

March 23, 2001, Kelly was sentenced to 2 years probation conditioned on maintaining employment, 75 hours community service, \$10,942.04 in restitution to JMIC (James Moran Insurance Company, formerly Security Assurance Life Insurance Company), and a \$2,500 civil insurance fraud fine.

State v. Barbara Moran Barbara Moran pled guilty to health care claims fraud and forgery for obtaining approximately \$5,982.40 from Prudential Insurance Company by submitting false claims between May 1996 and June 1998. On January 19, 2001, Moran was sentenced to two years probation, restitution in the amount of \$5,982.40, a \$5,000 civil insurance fraud fine, and a \$500 criminal fine. Moran previously had paid restitution to Prudential Insurance Company in the amount of \$5,982.40.

State v. Carl Lichtman, et al. The Lichtman case, one of the largest insurance fraud and public corruption cases in the State’s history, continued to progress through the criminal courts to a conclusion during the past year. Carl Lichtman, a former licensed psychologist, had conspired with nearly 200 people (many of whom were public employees) to defraud the State Health Benefits Plan (SHBP) and approximately 35 other insurance carriers or health care plans out of more than \$3.5 million for no show treatments for

“neurotic depression”. Lichtman pocketed the money he received for the bogus treatments and then “kicked back” 25 percent to those persons who had provided their insurance information to him to submit the fictitious claims. Lichtman established a referral system in order to recruit new “patients” so he could fraudulently bill their carriers. Lichtman would typically pay \$750 to a “recruiter” for each person brought into the scheme. Some of the conspirators recruited as many as a dozen people into the scheme.

By the close of 2001, nine additional co-conspirators pled guilty for their involvement in the Lichtman conspiracy, and were variously sentenced to terms of up to three years probation. To date, OIFP has prosecuted over 190 people in this conspiracy.

State v. Michael and Karen Marker On March 15, 2001, Michael and Karen Marker pled guilty to an Accusation charging theft by deception. As a dentist’s office manager, Karen Marker received dental services for free as an employment benefit, but she submitted claims for reimbursement to the insurance carrier as if she had been billed for those dental services. On April 20, 2001, Michael and Karen Marker were sentenced to five years probation and a \$5,000 civil insurance fraud fine.

State v. Lorna Kitson On March 19, 2001, Lorna Kitson, a former Hackensack University Medical Center employee, pled guilty to a State Grand Jury indictment charging her with attempted theft. Kitson admitted submitting bills on behalf of herself and her two dependent children, between January 1995 and September 1997. The bills were submitted to Provident Life and Accident Insurance Company and to Connecticut General Life Insurance (CIGNA) for approximately \$173,518. Kitson received approximately \$146,367 from the insurance companies as reimbursement for treatments never received from six medical providers. On April 27, 2001, Kitson was sentenced to three years State prison and ordered to pay restitution to Provident Life and Accident Insurance Company and CIGNA in the amount of \$146,367.

State v. Debra L. Schug On July 23, 2001, Debra Schug pled guilty to health care claims fraud for using her daughter’s name to have 34 prescriptions filled and billed to the State Health Benefits Plan. Schug’s daughter was covered under the State health plan. On August 24, 2001, Schug was sentenced to five years probation, conditioned on 270 days in county jail to be served on weekends. She was also ordered to pay \$334.57 in restitution.

State v. Nathaniel Sladkin On April 24, 2001, Nathaniel Sladkin pled guilty to an Accusation charging him with theft by deception. Sladkin fraudulently received dental services from Delta Dental by using the name Joseph Slover in order to submit claims under Slover's dental insurance plan. On June 1, 2001, Sladkin was sentenced to one year probation, conditioned on restitution in the amount of \$595 to Delta Dental. He was also ordered to pay a \$5,000 civil insurance fraud fine.

State v. Frank Renshaw, Jr. On June 6, 2001, Frank Renshaw, Jr. pled guilty to an Accusation charging him with theft by deception. Renshaw misrepresented his birth date by 13 years to extend the time that he would have been eligible to receive disability insurance benefits from his employer. Renshaw had sustained injuries at his place of employment and was paid in excess of \$27,000 in disability benefits as a result of the fraudulent application. On July 20, 2001, Renshaw was sentenced to five years probation, ordered to pay restitution in the amount of \$27,459.32, and a \$1,500 civil insurance fraud fine.

State v. Susan Lynn Harris On August 15, 2001, Susan Harris pled guilty to an Accusation charging her with health care claims fraud. Harris, a former school Employee Relations Manager, had altered the dates of service on 102 health care claims and

falsely alleged she had received services and paid bills to fraudulently obtain money from Aetna U.S. Healthcare, which had taken over for Prudential Insurance Company. Harris' fraudulent claims totaled \$13,499.34, of which she was paid \$7,331.11. On September 28, 2001, Harris was sentenced to 4 years probation, conditioned on serving 364 days in the Atlantic County Jail. She was also ordered to pay restitution in the amount of \$7,064.71, and a civil insurance fraud fine in the amount of \$5,000.

State v. Nateasha Robinson On September 7, 2001, a State Grand Jury returned an indictment charging Nateasha Robinson with conspiracy, health care claims fraud and theft by deception. The indictment alleged that Robinson and another unidentified person agreed that Robinson would provide her health insurance policy to the unidentified person so that health insurance claims could be submitted to Horizon Blue Cross/Blue Shield for health services that were never rendered. The indictment also alleged that Robinson received four claim checks from Horizon Blue Cross/Blue Shield based on the false claims submitted, in the total approximate amount of \$35,030. On November 26, 2001, Robinson pled guilty to conspiracy, health care claims fraud and theft by deception.

State v. Vivian Borges, et al. On

September 20, 2001, a State Grand Jury returned five separate indictments charging five employees of a doctor's billing service company with health care claims fraud, theft by deception and falsifying records. According to the indictment, Vivian Borges, Ana Rivera, Sobeida Velazquez, Lashunda Smith and Anna Murphy, all of whom were employees of University Physician Associates (UPA), a billing service used by physicians working for the University of Medicine and Dentistry of New Jersey (UMDNJ), and University Hospital, were charged with submitting phony health insurance claims to Guardian Life Insurance Company of America.

Rivera, Borges and Murphy were charged with theft by deception and falsifying records for allegedly submitting a total of approximately 22 fraudulent health care claims to Guardian on behalf of themselves or their children in the total approximate amount of \$15,960, for which they received approximately \$12,297.50.

Smith and Velazquez were likewise charged with theft by deception and falsifying records, as well as health care claims fraud, since some of the claims they submitted post-dated the Health Care Claims Fraud statute which became effective after January 15, 1998. Smith and Velazquez were charged with submitting fraudulent health care claims to Guardian on behalf of themselves and their children

in the total approximate amount of \$62,965, for which they received approximately \$38,072.55.

On November 26, 2001, Rivera and Murphy pled guilty to the indictments in Essex County. On December 10, 2001, Borges and Smith also pled guilty before Judge Schott. Borges and Smith are scheduled to be sentenced on March 22, 2002. Murphy and Rivera are both scheduled to be sentenced on January 25, 2002.

State v. Jennifer Bozsik On November 2, 2001, Jennifer Bozsik pled guilty to an Accusation charging her with theft by deception. Bozsik, a billing clerk in a doctor's office, had submitted approximately 74 claims to Prudential Insurance Company of America for medical services that were either never rendered or had been rendered to her free of charge. The claims submitted to Prudential totaled more than \$46,000, of which approximately \$34,000 was paid to Bozsik.

State v. Michael Forma On November 7, 2001, Michael Forma pled guilty to an Accusation charging him with health care claims fraud. Forma admitted that he had submitted approximately 73 false health insurance claims to Oxford Health Insurance/Oxford Health Plans for reimbursement for medical treatments that he had neither received nor paid for. Forma previously made

restitution to Oxford Health Insurance in the amount of \$12,798.

DENTIST FRAUD

State v. Dr. Philip Schrager On February 1, 2001, Dr. Philip Schrager was sentenced to one year probation, conditioned on restitution of \$36,362.15 to be paid to 16 insurance carriers and a \$20,000 civil insurance fraud fine. Schrager, a licensed dentist and the owner of North Brunswick Dental Center, previously pled guilty to an Accusation charging him with theft by deception. Dr. Schrager admitted submitting several hundred false claims to approximately 16 dental plans and insurance carriers from 1996 to 1998 for dental services that were either never performed or that were different than described in the claims submitted. OIFP referred the Schrager case to the dental licensing board for appropriate action with respect to Schrager's dental license.

State v. Dr. Anthony B. Spain On February 16, 2001, after previously pleading guilty to an Accusation charging him with falsifying records, Anthony B. Spain, a licensed dentist, was sentenced to probation for 18 months, conditioned on maintaining employment. Dr. Spain submitted false dental bills to Delta Dental, misrepresenting the dates those services were performed and concealing

the fact that he had previously been paid for those services. OIFP referred the Spain case to the dental licensing board for appropriate action with respect to Spain's dental license.

DOCTOR FRAUD

State v. George Patterson, M.D. On July 3, 2001, George Patterson, a licensed medical doctor, pled guilty to an Accusation charging him with falsifying or tampering with records for submitting bogus certificates of malpractice insurance from 1996 to 1998 to the Somerset Medical Center and St. Peter's University Hospital where he had privileges. No claims of malpractice were filed against Dr. Patterson. On July 25, 2001, Dr. Patterson was admitted into the Pre-Trial Intervention (PTI) Program conditioned on his paying a civil insurance fraud fine in the amount of \$1,000 and performing 200 hours of community service. Because Dr. Patterson is a licensed physician, the matter was referred to the State Board of Medical Examiners which entered a Consent Order suspending his medical license for three years, but which stayed the suspension.

State v. Dr. Angel Lobo & Mercy Lobo

On October 30, 2001, a State Grand Jury returned an indictment charging Angel Lobo, M.D., and Mercy Lobo with conspiracy, health care claims fraud, theft by deception, criminal use of runners and falsification of medical records. Angel Lobo, a licensed medical service provider, and his office manager, Mercy Lobo (no relation), operated the Pain Management Clinic located in Paterson, New Jersey. The indictment alleged that Dr. Lobo and Mercy Lobo paid persons to act as “runners” to procure patients for the medical practice for the purpose of submitting insurance claims to Parkway Insurance Company and AIG Claims Services, Inc. for medical services rendered. It was also alleged that Dr. Lobo and Mercy Lobo prepared false patient records to reflect that certain health care services were rendered when those services were not, in fact, rendered, so that bills could be submitted to the insurance carriers. All of the claims which formed the basis of the health care claims fraud charges were for services purportedly provided to OIFP State Investigators working undercover as patients of the Pain Management Clinic. Parkway Insurance paid claims in the approximate amounts of \$3,413 and \$3,068; and AIG Claims Services, Inc. paid claims in the approximate amount of \$2,150. This matter will be referred to the Medical Licensing Board for appropriate licensing action. This case is pending trial.

CHIROPRACTOR FRAUD

State v. Michael Baer On November 27, 2001, a State Grand Jury returned an indictment charging Dr. Michael Baer with health care claims fraud, criminal use of runners, and theft by deception. The indictment alleged that Baer, a chiropractor who owned and operated his own chiropractic practice, allegedly submitted false health care claims on behalf of patients, who were actually undercover investigators, to Hanover Insurance Company and Parkway Insurance Company, totaling approximately \$20,153. The indictment also alleged that Dr. Baer knowingly used, solicited, or employed runners to procure patients for his chiropractic practice. This matter will be referred to the Chiropractic Licensing Board for appropriate licensing action. The case is pending trial.

State v. Mohsen Mosslehi On November 27, 2001, a State Grand Jury returned an indictment charging Dr. Mohsen Mosslehi with health care claims fraud, criminal use of runners, and theft by deception. According to the indictment, Mosslehi, a chiropractor who owned and operated his own chiropractic practice, submitted false health care claims on behalf of patients, who were actually undercover investigators, to Colonial Penn Insurance Company and Parkway Insurance Company totaling approximately \$4,363. The indictment

also alleged that Dr. Mosslehi knowingly used, solicited, or employed runners to procure patients for his chiropractic practice. This matter will be referred to the Chiropractic Licensing Board for licensing action. The case is pending trial.

health benefits plans of more than \$200,000 by submitting false health insurance claims. Amabile attracted large numbers of patients to his offices by offering routine eye exams and glasses at little or no cost, and then used the patients' insurance information to bill their carriers for optometric services which he had not provided. Amabile directed his staff to create approximately 997 false patient records and charts in the event an insurance company conducted an audit of the health insurance claims Amabile submitted for payment. Amabile's license had previously been revoked by the State Board of Optometrists and a \$1.1 million civil penalty had already been imposed. Amabile was sentenced to seven years State prison, ordered to pay an insurance fraud fine of \$100,000 and \$97,975 in restitution. Amabile was previously a member of the Puerto Rican National Bobsled Team that participated in the 1998 Winter Olympics.

OPTOMETRIST FRAUD

State v. John Amabile On October 29, 2001, following a 34 day jury trial, John Amabile was convicted of conspiracy, theft by deception, falsifying records, and falsification of records relating to medical care. Amabile, a former licensed optometrist, attempted to defraud 29 insurance carriers and

POLICE ACCIDENT REPORT FRAUD

State v. Philip Major, et al. OIFP's investigation and prosecution of this case advanced significantly during the past year. By the end of calendar year 2001, 21 defendants had pled guilty to charges of theft or attempted theft by deception as part of the continuing investigation and prosecution of former East Orange police officer Philip Major

and others. Major, himself, had previously pled guilty to official misconduct and related charges for writing false police accident reports. The guilty pleas from these additional 21 defendants accounted for some \$193,000 of the approximately \$900,000 in fraudulent insurance claims which have been tied to Major's malfeasance. Of the 21 defendants, all have been sentenced to terms of up to five years probation and ordered to pay restitution in the approximate total amount of \$48,094.06. It is anticipated that additional subjects may be charged.

Mark Bendet As part of the Major case, on May 16, 2001, Mark Bendet, a disbarred attorney, pled guilty to both counts of a two count State Grand Jury indictment charging him with conspiracy and bribery in official matters. On that same date, Bendet also pled guilty to an Accusation charging him with bribery in official matters and theft by deception for his role in paying bribe money to an undercover investigator for automobile accident reports. These reports were used so that his medical service provider business, known as Metro Medical Services, could recruit persons to become patients and submit insurance claims. On July 26, 2001, Bendet was sentenced to 13 years State prison with three and a half years parole ineligibility, restitution in the

amount of \$10,506 and a \$5,000 civil insurance fraud fine.

Imelda Toquero As part of the Major investigation, the State Grand Jury returned an indictment against Imelda Toquero, a registered nurse, charging her with conspiracy and bribery in official matters. On March 2, 2001, Toquero pled guilty to both counts. She admitted paying bribe money to a person she thought was an Irvington Police Officer in order to obtain automobile accident reports so that her husband's medical service provider business, Metro Medical Services, could recruit persons to become patients and submit insurance claims. The "Irvington Police Officer" was actually an OIFP undercover investigator. On August 16, 2001, Toquero was sentenced to one year of probation, conditioned upon her serving 364 days in the County jail.

Eddie Boyd As part of the Major investigation, the State Grand Jury also returned an indictment against Eddie Boyd, a runner, charging him with conspiracy and bribery in official matters. Boyd had used police reports to recruit persons to become insurance claimants. On March 15, 2001, Boyd pled guilty to conspiracy and to an Accusation charging him with aiding official misconduct. Boyd, who had worked as a runner for Toquero, Major, Metro Medical Services and others, paid

bribes to undercover investigators for automobile accident reports to be used to solicit persons named in those reports to become insurance claimants. On May 15, 2001, Boyd was sentenced to a 364 day jail sentence as a condition of five years probation and payment of restitution in the amount of \$11,974.43 to Allstate Insurance Company.

Ruvim Krupkin On March 7, 2001, Dr. Ruvim Krupkin pled guilty to an Accusation charging him with perjury. Krupkin admitted lying under oath to a State Grand Jury about a purported automobile accident involving his wife and son, which accident he knew never took place. On May 2, 2001, Krupkin was admitted into the Pre-trial Intervention Program (PTI) with the condition that he continue to cooperate with the State's investigation.

James Lee Campbell As part of the Major investigation, a State Grand Jury returned an indictment charging James Lee Campbell, a runner working for health care providers, with conspiracy and bribery in official matters. Campbell pled guilty to conspiracy and one count of bribery for paying undercover police officers more than \$1,000 to obtain police accident reports to get the names of people he could recruit to file insurance claims. On June 5, 2001, Campbell was sentenced to five years probation, conditioned on his serving 180 days in jail.

State v. John B. Fagan John Fagan, a former West Orange police officer, pled guilty to an Accusation charging him with official misconduct for falsifying a police report for another person. Fagan also admitted falsifying a second police report related to his own vehicle, in order to facilitate the submission of phony automobile insurance theft claims as part of an automobile insurance "give up" conspiracy. On January 12, 2001, Fagan was sentenced to three years State Prison, \$9,056 in restitution payable to New Jersey Manufacturers Insurance Company, and \$8,000 in civil insurance fraud penalties.

FALSE AUTO INSURANCE (PIP) CLAIM

State v. Joanne Sullivan On February 16, 2001, Joanne Sullivan was sentenced to three years probation, conditioned on payment of restitution in the amount of \$11,755 to First Trenton Indemnity Company, and payment of a civil insurance fraud fine in the amount of \$5,000, after previously pleading guilty to an Accusation charging theft by deception. Sullivan admitted that, for approximately a ten month period in 1998 to 1999, she submitted false automobile insurance Personal Injury Protection (PIP) claims to First Trenton Indemnity, fraudulently seeking insurance claim money for lost wages and essential services in connection

with an automobile insurance claim.

State v. Anthony DePasque On August 7, 2001, Anthony DePasque pled guilty to an indictment charging him with forging the signature of a Parsippany-Troy Hills Police Officer on an amended accident report reflecting that a second vehicle was involved in an automobile accident in which he (DePasque) was involved, in order to make a PIP claim under his automobile insurance. In the original accident report, DePasque stated that he lost control of his car and made no mention of a second vehicle. On October 12, 2001, DePasque was sentenced to probation and payment of a \$1,000 criminal insurance fraud fine.

INSURANCE CARRIER EMPLOYEE FRAUD

State v. Carl Prata, et al. Carl Prata, a former insurance claims adjuster with the Allamerica and St. Paul Insurance Companies, was arrested by OIFP investigators on November 28, 2000, for his role in a scheme in which he allegedly issued approximately 59 insurance settlement checks totaling nearly \$630,000 to people he recruited, both directly and indirectly, to fraudulently pose as victims of automobile accidents. Prata would then allegedly receive a portion of the fraudulent payments as a kickback. On the same date, Mustafa Azme was

arrested and charged with conspiracy and theft by deception for his role in the criminal enterprise. As part of the Prata investigation, on July 26, 2001, OIFP investigators arrested [REDACTED] on charges of conspiracy, theft by deception and terroristic threats for his role in accepting six of the phony bodily injury insurance settlement checks in the amount of \$54,000 while utilizing several aliases. He was committed to the Middlesex County jail in default of bail. Between April 27, 2001 and December 21, 2001, the following defendants pled guilty to Accusations charging them with theft by deception as part of the investigation into the Prata theft conspiracy: Christopher Sharpe; Michael Espinosa; Robert Moore; Nicholas Diamond; Bessie Nicholson; Joseph Pearce; Aminullah Dadkhan; John Tsividakis; Bryan Lovelace; Michael Joyce; Nicholas Grotzky; Demetri Angelopolous; Laura Bursheim; Noorudin Azme. These defendants were either placed on probation or admitted into the Pre-Trial Intervention Program. Three were ordered to pay restitution in an amount equal to claim checks they had received and each was ordered to pay civil insurance fraud fines in the amount of \$2,500. The investigation is ongoing.

State v. Charlene Neal On June 15, 2001, Charlene Neal, an insurance claims examiner, pled guilty to an Accusation charging her with attempted

theft by deception for submitting phony medical bills to Eagle Insurance for medical services she falsely claimed as a result of an automobile accident. Eagle Insurance was the insurer for another vehicle involved in an accident. Neal was paid legitimate PIP benefits from her own carrier, Liberty Mutual. On August 1, 2001, Neal was admitted into the Pre-Trial Intervention Program (PTI), and was ordered to pay a \$5,000 civil insurance fraud fine.

State v. Joseph Scafidi On October 15, 2001, Joseph Scafidi was charged in a State Grand Jury indictment with theft by deception and theft by unlawful taking. Scafidi, formerly employed as a Regional Director at CIGNA Insurance Company, allegedly stole approximately \$33,800 in employee incentive checks, as well as a digital camera for which CIGNA had paid \$1,264. The incentive checks had been earmarked to award insurance carrier employees who reported to Scafidi as bonuses for extraordinary work accomplishments, but Scafidi allegedly took the bonus checks to “reward” himself, instead. The case is pending trial

PUBLIC INSURANCE ADJUSTER FRAUD

State v. Michael Winberg On February 5, 2001, Michael Winberg pled guilty to theft for misappropriating two insurance claim checks totaling approximately \$16,000 from two insureds who suffered storm damage to their homes. On March 16, 2001, Winberg was sentenced to three years probation and ordered to pay restitution in the amount of \$15,337. Because Winberg is a licensed public insurance adjuster, this matter was referred to the Public Insurance Adjuster Licensing Board.

State v. Frank Rose On December 14, 2001, Frank Rose was sentenced to five years probation after pleading guilty to arson and conspiracy to commit theft by deception for conspiring with a public adjuster to burn his barn and submit a fraudulent insurance claim yielding a \$44,000 settlement. Rose’s sentence was conditioned upon his cooperation with the State’s investigation of the public adjuster with whom Rose conspired.

PERSONAL INJURY CLAIMS ADJUSTER FRAUD

State v. Joseph DeGregorio On November 7, 2001, a State Grand Jury returned an indictment charging Joseph DeGregorio with theft by

unlawful taking. The indictment alleges that DeGregorio, who worked as an adjuster/paralegal for personal injury lawyers, misappropriated approximately \$87,000 in insurance claim settlement checks from various claimants. The settlement checks were allegedly deposited into DeGregorio's bank account which was in the name of JRD Adjusting, a corporation he created. Following indictment, DeGregorio fled to Florida where he was arrested on November 15, 2001.

“GIVE UP” CLAIMS

State v. Robert Cavill On February 21, 2001, Robert Cavill was sentenced to one year probation, \$4,500 in restitution and a \$2,500 civil insurance fraud fine after pleading guilty to an Accusation charging him with theft by deception. Cavill admitted that between September 4, and October 13, 1998, he submitted a \$4,190 fraudulent insurance claim to State Farm Insurance Company claiming that his 1998 Yamaha motorcycle was stolen. He admitted that he had previously sold the motorcycle to another person and collected money from its sale.

State v. Linda and Reginald Hart

On August 27, 2001, Linda and Reginald Hart pled guilty to an Accusation charging them each with theft by deception for falsely reporting to the Winslow Township Police Department in Camden County and the State Farm Insurance Company, that their automobile was stolen. They received \$15,774 from State Farm as a result of this fraudulent claim. On the same date, the Harts were each sentenced to five years probation, payment of restitution in the amount of \$25,000 to State Farm Insurance, and a civil insurance fraud fine in the amount of \$2,500.

State v. Pablo Cordero, et al.

Previously, New Jersey State Police Auto Theft Unit and OIFP investigators arrested Pablo Cordero and several other New Jersey residents for their roles in “giving-up” their vehicles to a New York Police Department police

months. Pelkowski also filed a false auto theft report with the Philadelphia Police Department. On September 28, 2001, Pelkowski was sentenced to two years probation, and ordered to pay a civil insurance fraud fine of \$2,500.

State v. Wei “Arthur” Cao and Haruna Okada On August 3, 2001, a State Grand Jury returned an indictment charging Wei Cao and Haruna Okada with conspiracy, theft by deception and false swearing. The indictment alleged that Cao and Okada conspired to file a false automobile insurance theft claim with Liberty Mutual Insurance Company. The indictment also alleged that Okada filed a false police vehicle theft report with the University of Pennsylvania Police Department stating that her 1999 Nissan Pathfinder had been stolen, when in fact, the vehicle was in the possession of Cao. Liberty Mutual paid \$35,484 for this claim.

Following indictment, Okada failed to appear for her arraignment. In an effort to have her bail returned, a motion was filed which alleged Okada had died and had been buried in Japan. In support of the motion, a Japanese death certificate reflecting Okada’s death was submitted to the Court. OIFP investigators determined the death certificate was fictitious. This case is pending trial.

State v. Bindraban Deosaran and Percy Hudson On December 17, 2001, Bindraban Deosaran and Percy Hudson pled guilty to Accusations charging them with attempted theft by deception and conspiracy. Deosaran admitted that he falsely reported to the Newark Police Department that his 1986 Chevrolet Corvette had been stolen, when in fact, he had conspired with Hudson to “make the car disappear” so Deosaran could file an insurance claim with Liberty Mutual Insurance Company. Deosaran also filed a fraudulent automobile theft affidavit with Liberty Mutual which denied the theft claim because of fraud.

State v. Doreen Badaan On December 5, 2001, a Grand Jury returned an indictment charging Doreen Badaan with theft by deception. The indictment alleged that Badaan reported her BMW stolen to the New York City Police Department, when in fact she “gave up” the car to another in order to get out of an automobile rental lease. She also filed an allegedly false claim with State Farm Insurance Company for automobile theft. As a result of the claim, State Farm paid BMW Finance Company \$40,047.50 to satisfy the lease and to relieve Badaan of her obligation to pay for the car. This case is pending trial.

State v. Michael Nardone On December 17, 2001 Michael Nardone pled guilty to an Accusation charging him with theft by deception and conspiracy to commit theft. Nardone, who was leasing a 1997 Ford Mustang from VT, Inc., admitted that he solicited a co-conspirator to assist him in disposing of the vehicle in order to avoid making further lease payments on the vehicle. Nardone reported the vehicle stolen to the Sea Bright Police Department and filed a false vehicle theft insurance claim with Liberty Mutual Insurance. Liberty Mutual subsequently issued an insurance claim check to Nardone and the leasing company in the amount of \$29,250, which Nardone endorsed over to the leasing company. Nardone's sentencing is scheduled for March 8, 2002.

State v. Aaron Stanberry On June 19, 2001, Aaron Stanberry pled guilty to an Accusation charging him with theft by deception. Stanberry admitted to retagging Vehicle Identification Numbers (VIN) on a vehicle that he had previously reported stolen and for which he received approximately \$14,000 from the insurance company. Three years later, he reported the same vehicle stolen again. On October 12, 2001, Stanberry was sentenced to three years probation, conditioned on paying \$300 per month in restitution and a \$5,000 civil insurance fraud fine.

State v. James S. Calabrese On October 5, 2001, James Calabrese pled guilty to attempted theft by deception for filing a fraudulent auto theft claim with his insurance company. Calabrese had falsely reported the theft of his Cadillac to a Margate City police officer one day before the lease on the vehicle was set to expire. Philadelphia police officers, however, recovered the abandoned vehicle prior to the day Calabrese claimed it had been stolen.

FALSE HOMEOWNERS INSURANCE CLAIM

State v. Athena Tomasso On March 7, 2001, Athena Tomasso pled guilty to attempted theft by deception after a State Grand Jury returned an indictment charging her with attempted theft by deception and forgery. Tomasso had falsely claimed that her residence was burglarized and vandalized on September 28, 1997 and submitted fraudulent receipts to Cumberland Mutual Fire Insurance Company. Some of the items she reported stolen had actually been returned to the merchants shortly after they had been purchased, but she used the receipts to falsely substantiate her burglary claim. On April 6, 2001, Tomasso was sentenced to 2 years probation.

State v. William Shappell On May 11, 2001, William Shappell was sentenced to five years probation and ordered to pay a \$5,000 civil insurance fraud penalty, after pleading guilty to an Accusation charging him with attempted theft by deception. Shappell had attempted to obtain \$4,000 from Prudential Insurance Company by falsely reporting that certain property had been stolen in a residential burglary, when, in fact, it was not.

STAGED ACCIDENTS

State v. ABP Chiropractic, et al. The investigation and prosecution of this alleged large scale staged accident ring advanced significantly in 2001. Previously, OIFP arrested ten people and executed search warrants at eight chiropractic medical offices in several New Jersey locations in this Office's first large scale investigation and prosecution of an organized auto insurance fraud ring under the new Health Care Claims Fraud Act. Arrest warrants were also obtained for two additional defendants who remain at large. The complaints charged Anhuar Bandy with being a leader of organized criminal activity, and with conspiracy to commit racketeering and health care claims fraud. Bandy is specifically charged with allegedly paying people to stage automobile collisions in order to obtain patients for numerous chiropractic clinics he owned and

operated, thereby generating billings under the Personal Injury Protection (PIP) portion of automobile insurance policies. As a result of its investigation, OIFP has identified numerous allegedly fraudulent claims submitted to insurance carriers throughout the State. Another target of this investigation, Alejandro Ventura, was arrested and charged with conspiracy to commit racketeering and health care claims fraud for allegedly arranging the automobile collisions and recruiting the participants. Also, as part of this investigation, on August 31, 2001, Alfredo Rivera Echevarria pled guilty to an Accusation charging him with conspiracy to commit theft by deception and acting as a runner. He admitted recruiting persons to serve as patients at ABP Chiropractic so they could submit automobile insurance Personal Injury Protection (PIP) claims and bodily injury claims to various insurance companies. Echevarria also admitted staging a phony accident on September 29, 1997 and providing false information to an Elizabeth Police Officer who responded to the staged accident. The investigation is ongoing.

State v. John Groff, et al. On July 27, 2001, a State Grand Jury returned an indictment charging John Groff, Luis Ruiz and others with conspiracy and attempted theft by deception. Groff and Ruiz, allegedly acted as "runners", and conspired with 27 others to stage

automobile accidents in or around Camden County. A total of seven automobile accidents were allegedly staged involving the 27 claimants. As a result of these phony accidents, claims were submitted to five insurance carriers, including Allstate Insurance Company, State Farm Insurance Company, Liberty Mutual Insurance Company, Prudential Insurance Company, and Material Damage Adjustment Corp. in the total approximate amount of \$96,842. False police reports were also submitted to 6 police departments including Pennsauken, Voorhees, Cherry Hill, Bellmawr, Camden and Gloucester Townships. When carriers became suspicious of the claims, the State began an investigation, and the claims were denied.

Between November 26, 2001 and December 31, 2001, 18 defendants were admitted into the Pre-Trial Intervention Program (PTI) conditioned upon paying a \$1,000 civil insurance fraud fine and cooperating with the State to include truthfully testifying against the main defendant, John Groff.

FALSE AUTOMOBILE INSURANCE CLAIMS

State v. Peter Halabi On December 6, 2001, Peter Halabi pled guilty to an Accusation charging him with conspiracy for lying to a fraud investigator from American International Group, Inc. regarding a purported theft insurance claim filed by a co-conspirator. Following his guilty plea, Halabi was admitted into the Pre-trial Intervention Program conditioned on paying a civil insurance fraud fine of \$1,000, continuing gainful employment, performing community service and cooperating with the State to include truthfully testifying in the prosecution of the co-conspirator.

LIFE INSURANCE FRAUD

State v. L.C. Thomas, William Conyers and Mollie Conyers On August 15, 2001, the State obtained a superseding indictment charging L.C. Thomas and William Conyers with attempted theft by deception, falsifying

records, forgery and witness tampering. L.C. Thomas, a licensed insurance agent and William Conyers, a licensed owner and manager of a funeral home, allegedly conspired to obtain fraudulent life insurance policies in the names of persons believed to have terminal illnesses. The policies named members of Conyers' family as beneficiaries. Thomas allegedly assisted by writing fraudulent multiple policies and placing them with several insurance companies. Death claims were submitted on some of the policies, but the claims were denied due to alleged misrepresentations made on the life insurance applications. Mollie Conyers, William Conyers' wife, was also indicted as an accomplice with Conyers and Thomas. This case is pending trial.

State v. Daouda Traore On December 5, 2001, Daouda Traore was arrested on two charges of attempted theft by deception in Essex County by OIFP State Investigators. Traore allegedly attempted to collect over \$400,000 in fictitious life insurance claims for a wife and son he claimed died in an automobile accident on the Ivory Coast in Africa when the investigation revealed that the wife and son never existed. The purported accident allegedly took place 3 weeks after Traore purchased the life insurance policies. This case is pending presentation to the State Grand Jury.

RECEIVING STOLEN PROPERTY

State v. Paul Struller On September 7, 2001, a State Grand Jury returned an indictment charged Paul Struller with receiving stolen vehicles. The indictment charged that Struller, the owner and operator of an auto body shop in Garfield, New Jersey, received or brought into the State a 1997 Land Rover truck, a 1997 BMW, a 1995 BMW and a 1999 Acura, knowing that these automobiles had been stolen. The vehicles had previously been reported stolen and automobile insurance claims had been submitted by the owners to several insurance companies, including Liberty Mutual Insurance Company, Allstate Insurance Company, and First Trenton Insurance Company. These vehicles had a total "book value" of approximately \$140,000. This case is pending trial.

FICTITIOUS INSURANCE I.D. CARDS AND MOTOR VEHICLE DOCUMENTS

State v. Kareem Young On December 14, 2001, Kareem Young pled guilty to an Accusation charging him with conspiracy and theft by deception for his role in a conspiracy with others to fraudulently sell "insurance" in the form of phony cards and phony declaration pages. The phony documents were sold to various individuals, including 2 undercover State Investigators, for \$600.

State v. Autoworks, Inc., Kamillah Ali and Julia Ali On December 12, 2001, OIFP Investigators executed an arrest warrant for Kamillah Ali, doing business as Autoworks, Inc., for charges of conspiracy to receive stolen property and sale of fake Motor Vehicle documents, including car registrations, titles, and drivers' licenses. Ali and Julia Ali were charged with selling fictitious New Jersey drivers' licenses, phony New Jersey automobile titles, phony New Jersey registration tags and phony insurance identification cards in connection with stolen cars. These allegedly stolen vehicles included new high end luxury vehicles stolen from a Conrail Port Authority storage lot located in Elizabeth, New Jersey. The lot was used to store cars being transported by Conrail.

COMMERCIAL PROPERTY FRAUD

State v. Hassan Bilal (a/k/a Elliott Crooms) and Kristal L. Dargon

Previously, a State Grand Jury returned an indictment charging Hassan Bilal (a/k/a Elliott Crooms) and Kristal L. Dargon variously with racketeering, conspiracy, leader of organized crime, arson, aggravated arson, attempted theft by deception, tampering with a witness, and attempted hindering apprehension or prosecution. According to the indictment, Bilal and Dargon located residential and/or commercial properties in Newark,

Irvington and Plainfield, New Jersey, obtained owner's or renter's contents insurance on the properties, secured fictitious "tenants" to give the false impression that certain units in the properties were occupied, and started fires at the properties for the purpose of collecting insurance proceeds on the properties

On the eve of trial, Dargon pled guilty to an amended count of theft by deception and, on June 22, 2001, was sentenced to two years probation conditioned on serving 100 hours of community service. On June 4, 2001, following a jury trial in Essex County, Bilal was convicted of various counts of conspiracy to commit racketeering, racketeering, leader of organized crime, conspiracy, arson, aggravated arson, theft, and attempted theft by deception. On July 23, 2001, Bilal was sentenced to 72 years State prison for which he must serve 36 years before becoming eligible for parole.

MEDICAID FRAUD

State v. Facilities Management Associates, Inc. (FMA)

State v. Tommie Murry and The Excel Corporation, Inc.

On January 5, 2001, defendants Tommie Murry and the Excel Center, Inc., a subsidiary of Facilities Management Associates, Inc., were sentenced in Mercer County. Murry was sentenced pursuant to his

guilty plea to theft by deception to three years in State Prison. The Excel Center, Inc., a corporation, was sentenced to a \$10,000 fine. Murry, formerly the Executive Director of the Excel Center, together with the corporation, admitted defrauding the Medicaid Program of approximately \$600,000 through the submission of false claims for group and individual therapy sessions which never occurred. The Excel Center had operated as a substance abuse treatment center in Vineland, New Jersey. Both defendants also consented to an Order debaring them from participation in the Medicaid Program and waived any claims to approximately \$1.7 million in Medicaid claim money that had previously been forfeited in connection with the case.

State v. Genady Chulak, Elena Bilenkin and GGE Impact Corporation trading as Medical

On February 5, 2001, Elena Bilenkin was sentenced to four years probation, 100 hours of community service and forfeiture of any rights to approximately \$1 million in Medicaid claims money obtained in connection with charges filed against her. Following a seven day jury trial in Middlesex County, her former partner, co-defendant Genady Chulak had previously been convicted of two counts of Medicaid fraud. Chulak subsequently failed to appear for his scheduled sentencing and a bench warrant was issued for his arrest.

Chulak and Bilenkin had been the owner/operators of Medical, a corporation which transported patients to and from medical service providers for medical treatment and which billed Medicaid for transportation services rendered. The defendants submitted false claims to Medicaid for transportation services in an amount in excess of \$505,000.

State v. Amir Ahmed On July 19, 2001, Amir Ahmed was sentenced to 2 years probation and a criminal fine of \$2,500 for his part in a scheme to submit false transportation bills to the Medicaid program relating to the transportation of Medicaid recipients to and from the offices of medical service providers.

State v. Vadim Bouguslaviskiy On July 30, 2001, Vadim Bouguslaviskiy was sentenced to five years probation, conditioned on serving 60 days in the Middlesex County jail and restitution in the amount of \$42,153 for his role in a conspiracy to defraud Medicaid of \$120,000 by falsely billing for transportation services for Medicaid recipients. Previously, Bouguslaviskiy's co-conspirators, Alexander Soyfer and Boris Milman, were similarly sentenced in this case.

State v. Rafik Raziq On April 24, 2001, Rafik Raziq pled guilty to an Accusation charging him with theft by

deception. Raziq, the owner, manager and corporate officer of Absolute Transport and Limousine Services, Inc., a medical service transportation provider, admitted defrauding the Medicaid program in excess of \$75,000 by preparing and submitting phony transportation bills to the Monmouth County Division of Social Services for transportation services purportedly rendered to Medicaid patients. Raziq admitted that the services for which he billed the Medicaid Program were either inflated or entirely fictitious. On September 7, 2001, Raziq was sentenced to three years in State prison, ordered to pay restitution in the amount of \$42,033 and debarred from participating in the Medicaid Program or other similar health insurance programs for a minimum of five years.

State v. Donna Amos On August 24, 2001, Donna Amos pled guilty to an Accusation charging her with Medicaid Fraud. Amos, a Medicaid recipient, used approximately 61 fraudulent prescriptions to obtain Hydrocodone from various pharmacies in Cumberland County. On October 5, 2001, Amos was sentenced to three years probation, conditioned on serving 16 days in the Cumberland County Jail with credit for time served. She was also ordered to pay restitution in the amount of \$118.21.

State v. Sherin Harrek On September 21, 2001, Sherin Harrek pled guilty to an Accusation charging her with falsifying or tampering with records. Harrek admitted to submitting to the Division of Medical Assistance and Health Services a pharmacist's license falsely representing that she was a licensed pharmacist. The investigation revealed that Harrek filled numerous prescriptions for controlled dangerous substances and other prescription legend drugs while posing as a licensed pharmacist.

On December 7, 2001, Harrek was sentenced to three years probation conditioned upon 60 days house arrest under the Hudson County bracelet program. She was also ordered to perform 100 hours community service, be gainfully employed, and pay a civil insurance fraud fine of \$15,000. Harrek was also ordered as a condition of probation to refrain from any employment in a pharmacy. Harrek was suspended from the Medicaid program and related programs for a minimum period of five years.

State v. Frieda Hankerson On November 5, 2001, Frieda Hankerson pled guilty to an Accusation charging her with Medicaid Fraud for obtaining Medicaid benefits to which she was not entitled or in a greater amount than that to which she was entitled by obtaining prescriptions for vials of

Neupogen, a drug used for serious blood disorders, with a value of approximately \$2,590.52.

State v. David Hofstetter, Nancy Tofani & Stone Arch Health Care Center

A State Grand Jury previously returned an indictment charging David Hofstetter, Nancy Tofani and the corporate entity, Stone Arch Health Care Center, with Medicaid Fraud and theft by deception. On October 2, 2001, Hofstetter and Tofani pled guilty to the Medicaid Fraud charge, and Stone Arch pled guilty to the charge of theft by deception. Hofstetter, the former owner of the Stone Arch Health Care Center of Pittstown, and Tofani, the former facility administrator, admitted obtaining \$106,000 from the Medicaid Program from 1993 to 1996, by submitting false expenses on the cost reports they were required to file annually with the Medicaid Agency. A civil false claims action was also brought against Hofstetter, Tofani and Stone Arch in which the defendants were ordered to pay \$106,000 in restitution and \$160,000 in civil false claims penalties. The total recovery to the State was approximately \$266,000. On December 21, 2001, Hofstetter and Tofani were each sentenced to five years probation, conditioned on serving 180 days in the county jail, and performing 350 hours of community service. The criminal sentence also obligated them to pay \$106,000 in restitution to the Medicaid

Program, and \$160,000 in civil false claims penalties, as established in the civil claim. In addition, all defendants will be debarred from participation in the Medicaid Program for a period of eight years.

State v. Seymour H. Blau

On October 3, 2001, an arrest warrant was obtained charging Seymour Blau, a podiatrist, with obtaining a controlled dangerous substance by fraud and Medicaid fraud. Bail was set in the amount of \$10,000. Blau was specifically charged with writing prescriptions in the names of Medicaid recipients and filling these prescriptions at various pharmacies. The recipients in whose names the prescriptions were written never received the prescriptions or medications but the Medicaid Program was charged with the cost of the medicine. This case is pending Grand Jury action.

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

A State Grand Jury previously indicted Hanan Selim, Wael Aly and Paterson Community Pharmacy charging them with conspiracy and Medicaid fraud. Additionally, Selim, a licensed pharmacist, was charged as a practitioner with health care claims fraud. Aly was also charged with health care claims fraud as a non-practitioner. Selim and Aly owned and operated Paterson Community Pharmacy in

Paterson. According to the indictment, Selim and Aly purchased prescriptions for Serostim, an expensive anti-AIDS medication. Although they did not dispense the drug, they allegedly submitted claims for reimbursement to the Medicaid Program and received approximately \$170,000 in Medicaid payments. The indictment also alleged that Selim and Aly submitted false invoices to the Medicaid Program in order to establish that their inventory contained the amount of drugs provided. On December 17, 2001, Selim and Aly both pled guilty to one count each of health care claims fraud.

COUNTY PROSECUTORS' OFFICES CRIMINAL CASE SUMMARIES

ATLANTIC COUNTY

State v. Charles Walton On January 29, 2001, Charles Walton of Philadelphia, Pennsylvania, was sentenced to three years in New Jersey State Prison for filing a fraudulent auto theft claim after he abandoned and burned his vehicle on the Garden State Parkway in the summer of 2000. Walton had been arrested after New Jersey State Troopers found photographs of Walton in the glove compartment of the charred and abandoned vehicle. The case was investigated jointly by the Atlantic County Prosecutor's Insurance Fraud Task Force and the New Jersey State

Police.

State v. Cedric Williams, Dolores Perry, Shelly Perry On May 10, 2001, Cedric Williams was indicted for arson for hire, aggravated arson, arson and conspiracy. Williams allegedly set fire to a home in Pleasantville, New Jersey. On October 12, 2001, sisters Shelly Perry and Dolores Perry were arrested and charged with arson for hire, aggravated arson and arson. Shelly Perry had allegedly offered to pay Williams and her sister, Dolores Perry, to burn her house as a predicate to the filing of a fraudulent insurance claim. This case is pending.

State v. Thomas Hauck, Anthony Miranda, Rodolfo Farfan On May 30, 2001, Thomas Hauck, Anthony Miranda and Rodolfo Farfan were indicted for conspiracy and theft by deception. Defendants allegedly conspired to stage the theft of Farfan's 1997 Toyota Avalon and disposing of it with a "chop shop" in Philadelphia, Pennsylvania. According to the indictment, Miranda was to report Farfan's vehicle stolen and arrange for Hauck to take the car to the "chop shop." The fraud investigation commenced when the Longport Police Department found that the vehicle had previously been reported stolen while running a routine check. The prosecution resulted in Farfan being sentenced to five years probation and

restitution in the sum of \$23, 906.29. In addition, Hauck was sentenced to five years probation, conditioned on serving 60 days in the Atlantic County Jail, and performing 100 hours of community service, while Miranda was admitted into the Pre-Trial Intervention Program.

BERGEN COUNTY

State v. Domingo Espinal, Richardo Mercado, Gregorio Rodriguez, Omar Torres, Maria Melendez, Anthony Lindsey, Mark Rose, Edward D. Ford

On April 6, 2001, a Bergen County Grand Jury indicted Domingo Espinal, Richardo Mercado, Gregorio Rodriguez, Omar Torres, Maria Melendez, Anthony Lindsey, Mark Rose and Edward D. Ford for staging a motor vehicle accident in Fort Lee, New Jersey. All eight were indicted on charges of conspiracy to defraud State Farm and Travellers insurance companies for medical expenses and property damage. On August 16, 2001, six of the eight pled guilty and two received Pre-Trial Intervention. The two main defendants, Lindsey and Rose, face up to 364 days in the Bergen County Jail.

State v. David Mickiewicz On May 7, 2001, a Bergen County Grand Jury indicted David Mickiewicz for theft by deception and writing bad checks. Mickiewicz had defrauded Prudential Insurance Company out of \$3,250 by manipulating Prudential refund

procedures regarding automobile insurance. He accomplished this by forwarding a bad check, in excess of monies owed, knowing that Prudential would automatically issue a refund check prior to his check clearing. Mickiewicz knowingly issued a bad check for \$3,285 to pay an outstanding premium of \$35. He pled guilty and was sentenced to 364 days in the Bergen County Jail on October 12, 2001.

State v. Lawrence Knoepfler On June 15, 2001, Lawrence Knoepfler was sentenced to three years probation and restitution of \$20,800 after he pled guilty to theft by deception. Knoepfler had convinced two elderly women to consolidate their COBRA health insurance premium payments by sending checks to him for forwarding to Cigna Health Insurance. Instead, he kept the checks for himself and let their health insurance lapse.

BURLINGTON COUNTY

State v. Raelisa J. Croll aka Jean L. Croll On February 27, 2001, Raelisa J. Croll, aka Jean L. Croll, was arrested and charged with health care claims fraud. Croll was charged with fraudulently obtaining prescription drugs and committing health care claims fraud by placing fraudulent prescriptions with multiple pharmacies and presenting her former husband's

and father's insurance cards to pay for the prescriptions. The charges resulted from a joint investigation

CAMDEN COUNTY

State v. James Dalessandro On February 5, 2001, James Dalessandro pled guilty to theft by deception for padding the claim he had submitted to First Trenton Companies for the contents of a stolen trailer. Dalessandro also pled guilty to two counts of tax evasion after the Division of Taxation entered into a joint investigation with the Camden County Prosecutor's Office Insurance Fraud Unit. On March 9, 2001, Dalessandro was sentenced to a term of five years probation and ordered to pay \$5,000 in restitution to First Trenton Companies and \$9,464 in restitution and penalties to the State Division of Taxation.

State v. Tracy Langlois On February 8, 2001, Trooper I Mark Wilhelm of the Insurance Fraud Unit of the New Jersey State Police arrested Tracy Langlois and charged her with 36 counts of forgery and 24 counts of failure to make required disposition, all arising out of her employment with Michael Vassey Insurance Agency in Cherry Hill. Langlois confessed to taking cash and checks from clients for premium payments for automobile insurance and converting the money to her own use, leaving more than a dozen clients

uninsured. To cover her tracks, Langlois had stolen money from her elderly grandmother to pay several outstanding claims. The scheme was uncovered by Rutgers Casualty Insurance and reported to the State Police Insurance Fraud Unit. In July 2001, Langlois was admitted into the Pre-Trial Intervention Program and ordered to pay \$24,854.20 in restitution to various victims.

State v. Edwin Cruz On April 2, 2001, Edwin Cruz pled guilty to conspiracy to commit arson for arranging the torching of his cousin's car which resulted in a fraudulent theft report and insurance claim. Cruz was sentenced on May 25, 2001, to a term of four years probation, conditioned on serving 270 days in the county jail, the balance of which was suspended.

State v. Rocco Grande On June 25, 2001, Rocco Grande, a suspended Camden Police Officer, pled guilty to attempted theft by deception admitting that he had falsely claimed his pick up had been stolen from the Moorestown Mall in February, 1999. Grande confessed that he had arranged for the disappearance of his truck in order to make an insurance claim. As part of his plea agreement, Grande forfeited his position as a police officer. On August 10, 2001, Grande was sentenced to 4 years probation with 270 days in the house arrest program. Grande was also

ordered to pay \$3,786 in restitution to First Trenton Companies for costs related to their investigation.

State v. Lynda Dodds Following the return of a 38 count indictment against Lynda Dodds on August 22, 2001, Dodds entered a guilty plea on September 21, 2001, to the first count, charging her with health care claims fraud for a recommended alternative sentence of 7 years in New Jersey State Prison or Drug Court supervision. The federally-funded Drug Court program provides intensive court supervision of drug-addicted defendants living in Camden County. Dodds admitted that she had obtained medication with forged and stolen prescriptions between February 1999 and September 2000, charging the prescriptions to the prescription plan of her former husband, a private plan administered by his union. As part of the plea agreement, Dodds will be ordered to repay \$1,200 in prescription costs to the union fund.

CAPE MAY COUNTY

State v. Joseph Palombaro On August 24, 2001, Joseph Palombaro was sentenced to two years probation, conditioned on serving one day in county jail, with credit for time served, for submitting approximately \$7,000 in fraudulent contractors' bills in conjunction with a claim for losses

resulting from a burglary at his Wildwood nightclub, Club Shakers.

State v. Mary Mitchell On June 5, 2001, Mary Mitchell pled guilty to theft of services for making a claim for medical benefits using the identity and insurance policy of another person, and failing to remit the proceeds to satisfy the medical bills she had incurred. Mitchell failed to appear for sentencing and a warrant has been issued for her arrest.

CUMBERLAND COUNTY

State v. David Bowen On June 20, 2001, David L. Bowen was indicted on charges of aggravated arson and arson. Bowen had reported to the New Jersey State Police that his 1998 Dodge Caravan had been stolen. The vehicle was found the day after the report was filed and observed to have sustained extensive damage from an attempted arson. Bowen admitted to the State Police that the stolen vehicle report was false. Bowen explained that he accidentally damaged the back seat of his vehicle with a cigarette he had been smoking and that he decided, after viewing the damage, to attempt to destroy the vehicle completely. The insurance claim was denied and Bowen paid for the repair to the vehicle and continued to make the required payments on the vehicle to Chrysler Credit Corp. On September 5, 2001,

Bowen was admitted into the Pre-Trial Intervention Program.

GLOUCESTER COUNTY

State v. Amariles Flores On August 13, 2001, Amariles Flores pled guilty to filing a false police report for falsely reporting that her vehicle was stolen. She was admitted into the Pre-Trial Intervention Program. Her co-defendant, Elvin Rivera, pled guilty to arson for burning her vehicle and was sentenced to three years probation. An anonymous tip had resulted in the investigation leading up to the filing of charges against the defendants.

State v. Corey Marsella, Dana Passarella, Francis Marsella, Christopher Hall, Anthony Imbesi, James DePiano, and Frederick Naegele In February of 2001, Corey Marsella, Dana Passarella, Francis Marsella, Christopher Hall, Anthony Imbesi, James DePiano, and Frederick Naegele were charged with health care claims fraud for allegedly using fraudulent prescription forms to obtain Oxycontin, a prescription painkiller often used on the street for its heroin like effect, and submitting claims for reimbursement under various prescription insurance programs.

HUDSON COUNTY

IMO Staged Accident Rings The Hudson County Prosecutor's Office continued in 2001 in its investigation and prosecution of two major staged accident rings.

In the first of the two rings under investigation, over 185 individuals have been indicted for their alleged actions involving at least 20 staged collisions. Among those indicted were two chiropractors, an office manager, an attorney and 21 alleged "runners." As many as 25 additional staged accidents associated with this ring have been identified and are under investigation. To date, several ring members have pled guilty and are awaiting sentencing.

The second of the two staged accident rings under investigation is considered particularly dangerous because it allegedly randomly selected the vehicles of unsuspecting motorists to strike in order to generate new fraudulent insurance claims. To date, this investigation has identified as many as eight staged collisions attributable to this ring.

MERCER COUNTY

State v. Ann Marie Roberts On July 20, 2001, a Mercer County Grand Jury returned an indictment against Ann Marie Roberts for identity theft and

theft by deception, alleging that Roberts assumed her daughter's identity to obtain \$14,534.64 from the Mercer County Surrogate's Office, which represented settlement funds the Surrogate's Office had been holding in trust for Roberts' daughter. A warrant has been issued for Robert's arrest.

State v. Ernest Smith On May 25, 2001, Ernest Smith was indicted for forgery and tampering with records for allegedly presenting a fictitious insurance card to a municipal judge and a municipal prosecutor when appearing to answer charges of driving without insurance. The alleged conduct relating to the charges was discovered by the police officer who had initially cited Smith, after the officer checked the court record of Smith's appearance and found that Smith had apparently used the very same fictitious insurance card in court that he had initially presented to the officer.

MIDDLESEX COUNTY

State v. Theodore Vontish and Judith Smith On February 22, 2001, Judith Smith was sentenced to five years probation, conditioned on serving 119 days in the county jail, with credit for time served, after pleading guilty to conspiracy to commit arson in conjunction with her filing a fraudulent insurance claim for the purported theft of her 1998 KIA Sportage. Smith had been behind in her car payments and

conspired with her boyfriend, Theodore Vontish, to burn the vehicle so that she could file a false police report of the theft, followed by the filing of a fraudulent insurance claim. For his part in the conspiracy, which included burning the vehicle for his girlfriend, Vontish was sentenced on April 2, 2001 to four years probation, conditioned on serving 364 days in county jail.

State v. Timothy Hinchman and Kyle Gliese Timothy Hinchman and Kyle Gliese were indicted on November 28 and December 13, 2001, respectively, for conspiracy to dispose of Hinchman's 2000 Mercury Cougar when Hinchman could no longer afford to make payments on the vehicle's lease. Hinchman was indicted for attempted theft by deception for filing an allegedly fraudulent insurance claim for the vehicle's purported theft, while Gliese was indicted for aggravated arson and arson for higher for allegedly burning the vehicle.

MONMOUTH COUNTY

State v. Stephen Penalver and Faith Penalver Stephen Penalver and his mother, Faith Penalver, were indicted on December 17, 2001, on charges of aggravated arson, theft by deception and conspiracy for allegedly setting fire to their home and filing a fraudulent insurance claim for losses resulting from the fire.

State v. Alaeddin Agha On April 23, 2001, Alaeddin Agha was indicted for theft by deception for allegedly falsely claiming his vehicle was stolen from an Ocean County shopping mall.

State v. Charles Thompson Charles Thompson, a corrections officer at the Monmouth County Correctional Institution, was indicted on April 23, 2001 for perjury and worker's compensation fraud for allegedly lying under oath at the worker's compensation trial that he had no pre-existing back injury at the time he was allegedly injured on the job.

MORRIS COUNTY

State v. Timothy A. Rogers On November 7, 2001, Timothy Rogers entered a conditional guilty plea to charges of theft by deception and leaving the scene of an accident for falsely claiming that his vehicle had been stolen after it was damaged in a motor vehicle accident in which he had been involved. Rogers agreed to pay over \$30,000 in restitution and civil insurance fraud penalties, and was admitted into the Pre-Trial Intervention Program at the time of his plea.

State v. Raymond Roth Raymond Roth was sentenced on December 14, 2001, to a probationary term and community service after pleading guilty to attempted theft by deception and

leaving the scene of an accident. Roth had filed a fraudulent auto theft claim after fleeing an accident, abandoning his vehicle and falsely claiming to have been assaulted.

OCEAN COUNTY

State v. Lisa Morelos On September 28, 2001, Lisa Morelos, a mother of two young children, pled guilty to health care claims fraud in conjunction with obtaining over 11,000 tablets of the powerful painkiller, Oxycontin, without a prescription. Lisa Morelos, a suspended registered nurse, visited over 30 doctors in six counties to obtain prescriptions for the drug. During the 15 month period she visited doctors, her health insurance company paid out over \$20,000 in fraudulent prescriptions. The investigation was conducted in conjunction with the Ocean County Narcotics Strike Force. Under the plea agreement, the defendant may avoid a seven year prison term if she successfully completes a one year in-patient substance abuse program.

State v. Phillip Pigninelli & Robert Castellano Defendants Phillip Pigninelli and Robert Castellano pled guilty to submitting a false insurance claim for the sinking of a 36 foot sportfishing vessel. Great Eastern Insurance Company had paid out in excess of \$112,000 for the vessel and

an additional \$25,000 in environmental clean up costs. Subsequent investigation revealed that the vessel was not insured by Great Eastern at the time of the loss and the ownership documents had been altered so it would appear to have been insured on the date of sinking. Pigninelli paid a marine surveyor \$25,000 to alter ownership documents and submit the claim so that it appeared to be covered under Castellano's policy. The investigation was undertaken with the assistance of the FBI Red Bank office. Defendants were sentenced to a 5 year term of probation and payment of \$20,000 in civil fines. Restitution of \$50,000 was paid to Great Eastern Insurance Company on September 21, 2001, the date of sentencing.

PASSAIC COUNTY

State v. Wilton Mendez On July 16, 2001, Wilton Mendez, a taxi driver, pled guilty to a charge of theft by deception for staging an alleged hit-and-run accident and falsely reporting it to the Paterson Police Department. Mendez later admitted to staging the accident and that there was no second vehicle. Mendez agreed to pay \$18,500 in restitution.

State v. Daniel Fontanella On March 15, 2001, Totowa chiropractor Daniel Fontanella pled guilty to theft by deception in the amount of \$500,000 stemming from his knowing and purposeful double billing of several

hundred patients during 1996 and 1997. Fontanella's guilty plea culminated a three year investigation into his billing practices by the Passaic County Prosecutor's Office.

State v. Clarence Anderson On September 21, 2001, Clarence Anderson, a city of Paterson employee, was sentenced to probation and ordered to pay \$12,858 in restitution after pleading guilty to theft by deception in conjunction with a fraudulent worker's compensation claim. Anderson had filed a worker's compensation claim while he was an employee of the County of Passaic, and obtained employment during the period of his purported disability with the city of Paterson, performing virtually identical duties.

State v. David Harris On November 27, 2001, Dr. David Harris, a Paterson chiropractor, was indicted on charges of health care claims fraud, attempted theft by deception and the use of a "runner." Harris allegedly submitted fraudulent billing statements to Selective Insurance Company and paid a "runner" to procure patients for his practice.

SALEM COUNTY

State v. Matadamas-Briceno On April 4, 2001, Patricia Matadamas-Briceno was charged with forgery, selling or offering for sale documents simulating driver's licenses or other documents issued by a government

agency and production or sale of simulated insurance identification cards. Due to the volume and type of documents seized as a result of the execution of a search warrant on the defendant's residence, the case was referred to the Department of Justice Immigration and Naturalization Service. Matadamas subsequently pled guilty to federal charges of possession of counterfeit immigration documents and production of phony social security cards.

SOMERSET COUNTY

State v. Jason Narbonne On March 14, 2001, a Somerset County Grand Jury returned an indictment charging Jason Narbonne with perjury in connection with his testimony as a defendant in Somerset County Superior Court. Narbonne was on trial for re-plating the VIN's on two stolen motor vehicles which concluded with a verdict of guilty. In an attempt to increase his credibility with the jury, he testified that he was a Rutgers University graduate. It was later learned that Narbonne had never matriculated at any of the Rutgers campuses. Since Narbonne's declaration could have affected the outcome of the proceeding, Narbonne was charged with perjury.

State v. Kon Yen On May 14, 2001, a Somerset County Grand Jury returned an indictment charging Kon Yen with attempted theft by deception. On July 18, 2000, Yen had reported his motorcycle stolen to the Raritan Borough Police Department and the Rider Insurance Agency. Yen allegedly subsequently admitted to falsifying the report and told investigators that he abandoned the motorcycle in an attempt to collect the insurance money because he could no longer afford the financing payments.

State v. Diana Ramos-Rolon On October 22, 2001, a Somerset County Grand Jury indicted Diana Ramos-Rolon for theft by unlawful taking. Ramos-Rolon had been employed as a receptionist for a North Plainfield dentist when she allegedly stole 74 insurance checks that were remitted on behalf of patients over a nine month period. Ramos-Rolon allegedly forged the dentist's endorsement to deposit the checks into her personal bank account. Detectives determined that she stole approximately \$27,000 from the dental practice.

WARREN COUNTY

State v. Francis Lippay and Diane Lippay On June 20, 2001, a Warren County Grand Jury returned a six count indictment charging Francis and Diane Lippay with aggravated arson,

arson, conspiracy, hindering apprehension or prosecution and false incrimination. A joint investigation by the Lopatcong Police Department and the Warren County Prosecutor's Office Insurance Fraud Unit revealed the couple had allegedly set fire to their leased 1999 Jeep Grand Cherokee in a scheme to defraud the One Beacon Insurance Company and the Balboa Insurance Company of \$21,462.82 in insurance claims.

OIFP CRIMINAL - CIVIL CASE SETTLEMENTS

Multi-State Lawsuits

Bayer Corporation In August 2001, OIFP's Medicaid Fraud Unit participated in a national civil settlement with Bayer Corporation. This joint state and federal investigation of drug price misrepresentation by a pharmaceutical manufacturer resulted in a \$14 million recovery to the participating states' Medicaid programs of which New Jersey received \$416,773.79. More significant than the financial recovery was the commitment by Bayer Corporation to cooperate in providing a more accurate Average Wholesale Price to the Medicaid programs. This should result in lower Medicaid payments for Bayer products in the future.

CVS Corporation In September 2001, OIFP's Medicaid Fraud Unit participated in a national civil settlement with CVS

Corporation, a major retail pharmaceutical chain. The civil settlement recovered overpayments based upon the submission by CVS of Medicaid claims for partially filled prescriptions. This situation arose when a CVS Pharmacy did not have enough stock on hand to fill the prescription that was presented by the Medicaid beneficiary. The prescription was partially filled but Medicaid was billed as if the entire prescription was filled. If the beneficiary did not return to the pharmacy to pick up the remainder of the prescription, the medication was returned to stock but the pharmacy did not make any adjustment to the claim. The total settlement to the participating states was \$4 million, of which New Jersey received \$123,133.76.

TAP Pharmaceuticals In September 2001, OIFP's Medicaid Fraud Unit participated in a national settlement with TAP Pharmaceutical relating to TAP's marketing of one of its pharmaceuticals, Lupron Depot which was primarily used for the treatment of prostate cancer. TAP manipulated the Average Wholesale Price by providing free samples to physicians and not factoring this in as part of the Average Wholesale Price. Additionally, TAP supplied free quantities of Lupron to Urologists and other physicians knowing that these free samples would be billed to the Medicaid program. This

settlement resulted in a recovery of \$56.7 million in restitution and penalties to the participating state Medicaid programs. As a result, New Jersey received a total Medicaid settlement of \$1,876,683.93.

New Jersey Lawsuits

Gambro Health Care Inc. In August 2001, OIFP's Medicaid Fraud Unit reached a settlement with Gambro Health Care, Inc., wherein Gambro agreed to pay \$1,693,469.38 to the New Jersey Medicaid program. This settlement was reached after the investigation determined that while Gambro overcharged the Medicaid program for administration of Epogen, a blood enhancing pharmaceutical for dialysis patients, there was insufficient evidence to prove criminal culpability.

Renex Corporation In November 2001, OIFP's Medicaid Fraud Unit reached a settlement agreement with National Nephrology Associates on behalf of Renex Corporation. Similar to Gambro Health Care Inc., several Renex affiliated dialysis facilities were overpaid based on their submission of claims to the Medicaid program for administration of Epogen. The settlement with Renex resulted in a recovery to New Jersey of \$1,622,056.45.

OIFP 2001: PRISON/JAIL TIME IMPOSED BY DEFENDANT/FRAUD TYPE

Name of Defendant	Date of Sentencing	Jail Time	Type of Insurance Fraud
Murry, Tommie (Excel Center)	1/5/01	3 years	Medicaid fraud (false drug & counseling claims)
Fagan, John (Waltershied)	1/12/01	3years	Writing a false police report for a stolen vehicle
Kitson, Lorna	4/27/01	3 years	Theft by deception (false medical claims)
Davis, Vonda (Lichtman)	5/11/01	37 days	False health care claims
Boyd, Eddie (Major)	5/16/01	364 days	“Runner” (official bribery; aiding official misconduct)
Campbell, James (Major)	6/5/01	180 days	“Runner” (bribed police officer to obtain police accident reports)
Datus, John	7/20/01	180 days	False PIP claim
Bilal, Hassan a/k/a Elliott Crooms	7/23/01	72 years	Aggravated arson, insurance fraud, racketeering, conspiracy
Bendet, Mark (Major)	7/26/01	13 years	False auto insurance claim
Boguslavskiy, Vadim (A&B Invalid Coach)	7/30/01	60 days	Medicaid fraud (false transportation claims)
Toquero, Imelda (Major)	8/16/01	364 days	Conspiracy
Schug, Deborah	8/24/01	270 days	False health care claims
Vasquez, Alex (Cordero II)	8/28/01	3 years	Auto “give-up”
Raziq, Rafik (Absolute Transport)	9/7/01	3 years	Medicaid fraud (false transportation claims)
Harris, Susan	9/28/01	364 days	False health care claims fraud
Amos, Donna	10/5/01	16 days	Medicaid fraud (receiving unauthorized prescriptions)
Daniels, Samuel (Lichtman)	10/12/01	15 days	False health care claims fraud
Walker, Keshia (Lichtman)	11/20/01	3 days	False health care claims
Decree, Vivian (Lichtman)	11/30/01	1 year, 59 days	False health care claims
Harrek, Sherin	12/7/01	60 days	Falsifying prescriptions (unlicensed pharmacist)
Hofstetter, David (Stone Arch)	21/21/01	180 days	Medicaid fraud
Tofani, Nancy (Stone Arch)	12/21/01	180 days	Medicaid fraud
TOTAL:	107 years - 142 days		

OIFP CIVIL INVESTIGATIONS AND LITIGATION STATISTICS

January 1, 2001 - December 31, 2001

CIVIL INVESTIGATIONS	Number	Dollar Amount
New Cases Opened	7,984	
Number Forwarded for Investigation	4,986	
No Investigation Warranted	2,998	
PRE-LITIGATION DISPOSITIONS		
Consent Orders Issued	1,211	\$5,119,150
Consent Orders Executed	523	\$1,148,550
LITIGATION (Division of Law)		
Number of Referrals Received by Division of Law	694	
Number of Cases Resolved	377	
Enforcement Actions by Division of Law	189	\$573,744
Division of Law Original Settlements	188	\$2,320,837
COLLECTIONS (Department of Banking and Insurance)*		
Number of OIFP Accounts Paid in Full	623	
Total Amount Received		\$2,214,777

*As reported to OIFP by DOBI

NARRATIVE

In 2001, OIFP Civil received 7,984 referrals of suspected insurance fraud, of which 4,986 were forwarded for further investigation. OIFP civil investigations resulted in the issuance of 1,211 consent orders in 2001 providing for the payment of a total of \$5,119,150 in civil insurance fraud penalties. By the end of 2001, 523

consent orders totaling \$1,148,550 in civil insurance fraud fines were agreed to by subjects admitting to have committed insurance fraud.

Deputy Attorneys General in the Division of Law, Insurance Fraud Unit, received 694 matters for litigation in 2001, most of which resulted from

referrals from OIFP's civil investigative section. These civil attorneys resolved a total of 377 cases in 2001, including 189 enforcement actions totaling \$573,744. In addition, civil attorneys concluded or obtained settlements in 188 cases totaling \$2,320,837. They also obtained awards of attorneys fees in those cases on behalf of the State totaling \$50,436. The case summaries contained herein highlight some of OIFP's more significant accomplishments in civil prosecutions over the past year.

Division of Law

State v. Muhammed A. Nasir On September 24, 2001, the State obtained a judgement for an insurance fraud fine in the sum of \$2,500 against Muhammed A. Nasir, an insurance producer and real estate licensee, for misrepresenting when he first had notice of a medical condition which would have qualified him for group disability benefits. Previously, on April 12, 2001, the State had obtained summary judgement on another count alleging Nasir's failure to accurately disclose relevant prior medical history when making application for his participation in the group long term disability policy offered through his employer, Northwestern Mutual Life. The court imposed a total of \$7,500 in civil penalties and awarded the state an additional \$36,210 in attorneys fees for a total award to the State of \$43,710.

OIFP notified the Department of Banking and Insurance and the Board of Realtors of its proceedings in order to enable those agencies to determine whether to take action to revoke Nasir's insurance producer and realtor licenses.

State v. David Switalski In July of 2001, the State obtained a consent judgement for an insurance fraud fine in the sum of \$8,500, representing a \$5,000 civil penalty and an award of \$3,500 in attorneys fees to the State. After filing for disability benefits, Switalski had been videotaped working in his lawn maintenance business. After two days of trial, Switalski agreed to voluntarily pay the levies for having falsely claimed disability benefits.

State v. Brian Aikens On February 5, 2001, the State obtained a \$450,000 default judgement representing an insurance fraud fine against Brian Aikens, who, while employed as a claims representative for Travellers Insurance Company, wrote 31 claim checks totaling \$164,000 payable to his girlfriend.

State v. Angelo Valenti On July 9, 2001, the State obtained a consent judgement requiring Angelo Valenti to pay a \$12,500 civil insurance fraud penalty and \$12,500 in restitution for falsely claiming his vehicle had been stolen while he was attending a funeral.

In fact, Valenti had left his vehicle at an airport parking facility in Philadelphia the night before. His vehicle was finally recovered at the airport several months after he falsely reported it stolen.

State v. Robert Konner On May 15, 2001, Robert Konner consented to pay \$20,125 in restitution and a \$5,000 civil insurance fraud penalty in conjunction with his fraudulent insurance claim which alleged that his Ebel watch was stolen by a mugger in New York City in March of 1992. The fraud was discovered when, in the midst of divorce proceedings, Konner's estranged wife informed authorities of the fraudulent claim and the fact that Konner still possessed the watch in question. Because Konner is a licensed automobile dealer, OIFP notified the New Jersey Division of Motor Vehicles of the settlement for appropriate action with respect to his license.

Civil Investigative Dispositions

In the Matter of Arthur Charych On April 20, 2001, Arthur Charych entered into a Consent Order requiring him to pay a civil fine of \$10,000 for submitting four altered checks to Cumberland Mutual Fire Insurance Company for a fire loss on November 23, 1998. Charych had increased the face value of three of these checks by \$10,000, and increased a fourth by \$1,000 for a total fraud of \$31,000.

In the Matter of Joanne Rodriguez

On July 23, 2001, Joanne Rodriguez entered into a Consent Order to pay \$15,000 for submitting false dental claims to MetLife for services allegedly rendered to several family members. Rodriguez falsely collected more than \$45,563 under four different Social Security numbers.

In the Matter of Fred Rossi

On January 16, 2001, Agent Fred Rossi entered into a Consent Order to pay \$3,500 for fraud committed by knowingly backdating the date of loss on his insurance claim to bring it within the effective policy period.

In the Matter of Ignacious Antico

On July 17, 2001, Ignacious Antico entered into a Consent Order for \$3,000 for submitting a fraudulent claim to Liberty Mutual Insurance Company falsely claiming that his vehicle sustained damages as a result of being hit by a deer.

In the Matter of Michael Arizechi

On July 12, 2001, Michael Arizechi entered into a Consent Order to pay \$5,000 for submitting a fictitious receipt for a laptop computer to Blue Ridge Insurance Company in conjunction with a homeowner's claim.

In the Matter of Antonio Moya

On August 6, 2001, Antonio Moya entered into a Consent Order to pay \$3,500 for

submitting a false automobile theft claim to Warner Claims Service.

In the Matter of Enrique Sumano

On September 18, 2001, Enrique Sumano entered into a Consent Order for payment of \$5,000 for knowingly submitting a false automobile theft claim to Allstate Insurance Company.

In the Matter of Joseph Herman

On October 6, 2001, Joseph Herman entered into a Consent Order to pay \$2,500 in fines for purposely failing to inform State Farm Insurance Company that he had moved and changed the garaging location of his insured vehicle from Wyckoff, New Jersey, to New York, New York. Herman withheld the information to prevent his insurance rates from being increased by moving to an area of higher risk.

In the Matter of Neil J. Tobenkin and Madeline R. Miller

On June 7, 2001, Neil J. Tobenkin and Madeline R. Miller entered into a Consent Order requiring them to pay \$5,000 in civil penalties for submitting a fraudulent homeowner's insurance claim to the Federal Insurance Company regarding the purported loss of a diamond engagement ring.

In the Matter of Thomas Fricchione

On December 29, 2001, Thomas Fricchione signed a Consent Order obligating him to pay \$5,000 in civil

fines for submitting a homeowner's claim to USAA Insurance Company fraudulently claiming the loss of a \$7,500 diamond engagement ring. Investigation of the claim revealed that Fricchione's former fiancée refused to return the ring to him after the engagement terminated, and that she later sold the ring to a jewelry store.

In the Matter of Barbara Moran

On January 23, 2001, Barbara Moran signed a Consent Order requiring her to pay civil fines of \$5,000 for submitting 99 false claims through her employee health benefits plan administered by Prudential Insurance Company. The fraudulent receipts, which had been altered or photocopied, indicated that she had paid for medical services which she had not actually received. The fictitious receipts totaled \$5,982.

In the Matter of Ronald Schreyer, William Campion and Keith Genovese

During the first four months of 2001, Ronald Schreyer, William Campion and Keith Genovese each signed Consent Orders requiring them to pay civil fines in the amount of \$3,000 in conjunction with a fraudulent vehicular theft claim they filed with Travellers Insurance Company. Campion and Schreyer provided false statements to the New Jersey State Police and to the insurance company in support of the claim, while Genovese arranged for the

disposal of the vehicle.

In the Matter of Vincent Kelly On January 12, 2001, Vincent Kelly executed a Consent Order in the amount of \$2,500 for fraudulently collecting \$13,043 in disability benefits by submitting forged physician statements to JMIC Insurance Company.

In the Matter of Micah Pierce On February 12, 2001, Micah Pierce signed a Consent Order obligating him to pay \$3,000 in civil fines for fraudulently claiming \$5,000 in losses for custom wheels on a vehicle which he had reported stolen.

In the Matter of Jose Janeira On March 10, 2001, Jose Janeira entered into a Consent Order requiring him to pay fines of \$3,000 for fraudulently claiming that his vehicle had been stolen when he had, in fact, arranged for the vehicle to be disposed of as a predicate to the filing of the fraudulent claim.

In the Matter of Jacqueline Rodriguez On April 12, 2001, Jacqueline Rodriguez signed a Consent Order requiring her to pay \$3,000 in civil penalties for falsely reporting her vehicle as stolen to the USAA Insurance Company. The New York City Department of Sanitation had recovered the allegedly stolen vehicle two days prior to the time when she claimed it

had been stolen.

In the Matter of Kenneth Baker On June 30, 2001, Kenneth Baker signed a Consent Order for \$3,000 in civil penalties for submitting a fraudulent auto theft claim to the State Farm Insurance Company. Baker unwittingly provided information regarding the location of the car to an undercover New York City police detective who was supposed to dispose of the car on Baker's behalf.

In the Matter of Rosemary Vigliotti On May 19, 2001, Rosemary Vigliotti signed a Consent Order pursuant to which she agreed to pay \$4,000 in civil fines for fraudulently claiming her vehicle had been stolen when, in fact, it had been found burning in New York City approximately eight hours prior to the time she claimed to have last seen the vehicle.

In the Matter of Amira Little On April 16, 2001, Amira Little executed a Consent Order pursuant to which she agreed to pay a fine of \$3,500 for her part in falsely claiming to have been in an accident which did not occur. Little had provided false information on a police report, on an application for PIP benefits and on an affidavit of no insurance in conjunction with a fraudulent insurance claim. Investigation of three other persons who claimed to have been in the alleged accident is ongoing.

In the Matter of Alicia Rivera On June 22, 2001, Alicia Rivera agreed to a Consent Order requiring her to pay \$4,000 in civil fines for submitting forms to her insurance company, which falsely claimed that she was continuing to receive medical treatment, for the purpose of extending disability benefits.

In the Matter of Rhonda Mosely-Holmes On June 1, 2001, Rhonda Mosely-Holmes signed a Consent Order obligating her to pay a civil penalty of \$4,000 in conjunction with her fraudulent auto theft insurance claim wherein she submitted a written statement indicating that her car had been stolen when, in fact, she had arranged for her vehicle to be taken.

In the Matter of Ana Aguilar Ana Aguilar executed a Consent Order requiring her to pay civil fines of \$3,500 in November of 2001 for fraudulently claiming her vehicle had been stolen. Her vehicle had, in fact, been left with a “chop shop” which was under surveillance by the New York City Police Department and the FBI. Aguilar was subsequently charged criminally by the New York City Police Department.

In the Matter of Kenneth Ruskowski On June 6, 2001, Kenneth Ruskowski signed a Consent Order pursuant to which he agreed to pay civil penalties of \$2,500 for submitting altered receipts

to the State Farm Insurance Company for reimbursement of rental expenses in an amount greater than that to which he was entitled.

In the Matter of Guy Bentley On July 2, 2001, Guy Bentley executed a Consent Order in the amount of \$3,000 for fraudulently claiming his vehicle had been stolen when it had actually been involved in a hit and run accident.

In the Matter of Ernest Myron Baugh On August 15, 2001, Ernest Myron Baugh signed a Consent Order requiring him to pay a civil fine in the amount of \$2,500 for fraudulently endorsing and cashing disability checks issued in the name of Denise Williams who had passed away. Baugh also pled guilty to theft by deception in conjunction with related charges filed by the Bergen County Prosecutor’s Office.

In the Matter of William Mainegra On September 17, 2001, William Mainegra signed a Consent Order to pay \$4,000 in civil fines for filing a fraudulent personal injury claim in conjunction with a purported accident which was determined, upon further investigation, to have been staged.

In the Matter of Lula Perpepaj On November 30, 2001, Lula Perpepaj signed a Consent Order requiring her to pay a \$3,000 civil fine for submitting a fraudulent auto theft claim to Material

Damage Assessment, in which she alleged her vehicle was stolen when it had actually been abandoned.

In the Matter of George J. Balzer

On October 5, 2001, George Balzer agreed to pay \$3,000 in civil penalties pursuant to a Consent Order, for fraudulently inflating commercial losses in his business by submitting altered receipts to Travellers Insurance Company.

In the Matter of Tae Wong Um and Jeanne Choi

Tae Wong Um conspired with Jeanne Choi by presenting an Oxford HMO Insurance Card, belonging to Choi, to Hackensack Hospital indicating that Tae Wong Um was her husband, for the purpose of obtaining medical benefits for Um. Um and Choi were issued Consent Orders in the amount of \$3,000 and \$3,500, respectively. Um and Choi signed the Consent Orders on December 3 and October 26, 2001, respectively.

In the Matter of Clarence Anderson

On October 31, 2001, Clarence Anderson signed a Consent Order pursuant to which he agreed to pay a civil fine in the amount of \$3,500 for false statements he made to the County of Passaic involving a worker's compensation claim. Anderson had indicated that he was disabled when he was actually working for the Paterson Public Library. Anderson also pled guilty to theft by deception in related

charges filed by the Passaic County Prosecutor's Office.

In the Matter of Tamika Pressley

On December 4, 2001, Tamika Pressley signed a Consent Order obligating her to pay a civil fine of \$2,000 for fraudulently submitting altered disability forms to her employer, Kessler Rehabilitation Center, which forwarded those forms to the PMA Insurance Group to extend the length of her disability claim.

In the Matter of Jessica Ramos

On October 3, 2001, Jessica Ramos agreed to a Consent Order requiring her to pay a \$5,000 civil fine for falsely reporting her 1999 Pontiac stolen from the Cherry Hill Mall. She later admitted that the car had never been at the mall, and that she had arranged for her cousin to burn her vehicle because she could no longer afford the payments and wanted to collect the insurance proceeds.

In the Matter of Dawn Ducat

On September 27, 2001, Dawn Ducat signed a consent order obligating her to pay \$5,000 in civil penalties for fraudulently collecting insurance settlement proceeds for injuries she purportedly sustained in an automobile accident. Ducat had received a settlement from an insurance company when a friend who worked for the insurance company added her name as a passenger on a pending claim, despite

the fact that she had not even been present at the scene of the accident.

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

In accordance with *N.J.S.A. 17:33A-24*, which requires OIFP to make appropriate legislative and regulatory recommendations, the following recommendations are submitted for consideration:

I. **Statement of the Problem:** OIFP is expressly empowered under *N.J.S.A. 17:33A-5c* to use administrative proceedings to seek restitution for insurance carriers victimized by insurance fraud. However, *N.J.S.A. 17:33A-5b*, which authorizes the filing of a civil suit by OIFP on behalf of insurance carriers, omits reference to restitution as an available remedy.

Proposed Solution: For the sake of consistency and to clarify that OIFP has authority to seek restitution on behalf of an insurance carrier when filing suit to impose civil fines against an insurance fraud violator, OIFP recommends that *N.J.S.A. 17:33A-5b* be amended to expressly add “restitution” as an available remedy thereunder.

II. **Statement of the Problem:** The Insurance Fraud Prevention Act subjects those who commit insurance fraud against insurance companies to substantial monetary penalties. Insurance companies, as defined by the Act, do not expressly

include other entities which provide similar protection against insurable risks, such as health maintenance organizations (HMOs), joint insurance funds administered by consortiums of governmental agencies (JIFs), and companies which conduct their own insurance programs on behalf of their employees (self-insureds). Consequently, while a substantial civil insurance fraud fine can be imposed against a person who submits a fraudulent claim to an insurance company, a person who submits a virtually identical fraudulent claim to an HMO, JIF or self-insured entity is not subject to the imposition of such sanctions.

Proposed Solution: To achieve parity and equity in this area, OIFP recommends that the Insurance Fraud Prevention Act be amended to extend civil liability for the commission of insurance fraud to those who would defraud entities, other than insurance companies, that provide similar indemnification or other financial protection against insurable risks, such as HMOs, JIFs and self insureds.

III. **Statement of the Problem:** Despite the recent enactment of legislation increasing the penalties for producing or using fraudulent insurance cards, the manufacture,

sale and use of such cards continue to constitute an ongoing problem of significant proportion in New Jersey.

Proposed Solution: To deter the production of counterfeit auto insurance cards, and to aid law enforcement in the identification and detection of those who produce or manufacture such cards, OIFP recommends that legislation be enacted to require automobile insurance carriers to employ available anti-counterfeit document security technology in the manufacture of their cards, and to file same with the Department of Banking and Insurance.

IV. **Statement of the Problem:**

Current law requires that every state and local law enforcement agency, including the New Jersey State Police, provide accident report information to insurance company investigators within 24 hours of the occurrence of an accident. However, depending upon varying circumstances specific to each occurrence and each law enforcement agency, the time within which accident reports are completed may take upwards of several days. As a result, the current 24 hour period is unrealistic and, as a practical matter, often makes law enforcement compliance virtually impossible.

Proposed Solution: To achieve optimum compliance, OIFP recommends that the statute be amended to modify the 24 hour time frame to seven calendar days.

V. **Statement of the Problem:**

Pursuant to *N.J.S.A. 17B:17-13*, insurance agents and brokers who continue to illegally sell insurance after losing their licenses are subject to prosecution for the commission of a misdemeanor. Classification of this type of criminal behavior as a misdemeanor is not congruent with the classification of analogous behavior under New Jersey criminal laws. Moreover, anecdotal data has demonstrated that prosecution of this conduct as a misdemeanor poses such an insignificant threat as to achieve little or no deterrent value.

Proposed Solution: To achieve a greater deterrent impact and to bring the offense into conformance with the New Jersey Criminal Code, OIFP recommends that this section of the statute be repealed and replaced with appropriate legislation making such conduct a crime of the third degree under the New Jersey Criminal Code.

VI. **Statement of the Problem:**

Significant revenues and a weak regulatory framework combine to make the diagnostic imaging

industry in New Jersey an attractive target for potentially unscrupulous operators. Any private citizen, regardless of experience in the medical and allied medical professions, may own a diagnostic imaging facility, as long as the facility is affiliated with a licensed medical provider. Moreover, while prospective owners of a diagnostic imaging facility are required to provide information regarding any prior criminal history, the Department of Health, which licenses such facilities, lacks the authority to conduct the necessary criminal background checks to determine whether the information provided by the prospective owner is accurate. Even where a prospective owner discloses or is found to have a prior criminal history, that fact may not necessarily in and of itself disqualify that person from owning or obtaining a license to operate such a facility. Since diagnostic imaging is commonly prescribed for those involved in automobile accidents, the diagnostic imaging industry is particularly vulnerable to infiltration by those who seek to profit by committing insurance fraud. Affiliation with, or ownership of, such a facility would be particularly attractive to those who employ runners or stage fraudulent automobile accidents for the purpose of filing fraudulent

insurance claims.

Proposed Solution: In order to protect the integrity of the diagnostic imaging industry, OIFP recommends the enactment of legislation requiring comprehensive criminal background checks of applicants for diagnostic imaging facility licenses and automatically disqualifying from licensing or ownership of such facilities any person who has been convicted of designated crimes.

VII. **Statement of the Problem:** As OIFP has previously indicated, insurance companies are unable to cancel the insurance policies of those who commit insurance fraud and may, in some circumstances, be required to afford coverage in the voluntary automobile insurance market to those who commit insurance fraud. Under current law, an insurance carrier's only recourse upon learning that an insured submitted a fraudulent insurance application is non-renewal of that person's policy at its expiration, rather than cancellation during the policy's term. Further, an applicant for automobile insurance who has committed insurance fraud may not be denied status as an "eligible person" to be afforded coverage in the voluntary automobile insurance market unless that fraud resulted in a criminal

conviction or the denial of an automobile insurance claim in excess of \$1,000.

Proposed Solution: In order to prevent insurance fraud violators from benefitting from omissions in the statute, OIFP again recommends the enactment of legislation which denies status as an “eligible person” and which would allow mid-term policy cancellation where the applicant or insured has “admitted violating, or has been adjudicated to have violated” the Insurance Fraud Prevention Act.